

**RECENT DEVELOPMENTS IN MANAGED CARE LIABILITY
EXPOSURES**

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***BCS Insurance Company
Professional Liability Conference
September 23, 2002***

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I. Noteworthy Judicial Trends

A. Reversal of “Shock” Verdicts in Non-ERISA Bodily Injury Cases

Fortunately for the managed care industry and its insurers, there have been no reported “shock verdicts” against managed care organizations in the last two years, and the previous shock managed care verdicts (i.e., Chipps v. Humana, Goodrich v. Aetna, and Fox v. HealthNet) have all been reversed and/or settled for considerably less money (e.g. between \$2 million and \$30 million) on appeal. We attribute this favorable development largely to the fact that managed care organization defendants and their insurers have stepped up their efforts to settle potentially dangerous managed care cases prior to trial. Nevertheless, the risk of run-away managed care verdicts still exists in cases not governed by the Employee Retirement Income Security Act (ERISA).¹

B. Good News and Bad News on the ERISA Front: Courts Have Been Reluctant to Expand Fiduciary Duties and Liabilities under ERISA, But Have Been Narrowing the Scope of ERISA Preemption Protection

1. *Breach of Fiduciary Duty Under ERISA*

- a. In Pegram v. Herdrich, 530 U.S. 211 (2000), the U.S. Supreme Court refused to find that an HMO, making “mixed eligibility and treatment decisions” through its physician owners, was acting as an ERISA fiduciary. Thus, it dismissed the plaintiff’s breach of fiduciary duty claims under ERISA.

2. *Duty to Disclose Financial Incentives Under ERISA*

Absent a specific inquiry or some other compelling circumstance, the majority of courts appear unwilling to impose upon a health plan an

¹ ERISA governs most private employer sponsored health insurance and does *not* currently permit jury trials or awards of extra-contractual damages to ERISA plan participants who allege wrongful denial of health insurance benefits.

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affirmative duty under ERISA to disclose provider compensation/financial incentives. See, Horvath v. Keystone Health Plan East, 2002 WL 265023 (E.D. Pa 2002), Peterson v. Connecticut General Life Insurance, 2000 WL 1708787 (E.D. Pa) and Ehlmann v. Kaiser Foundation Health Plan of Texas, 198 F.3d 552 (5th Cir. 2000); But see, Shea v. Esensten, 107 F.3d 625, (8th Cir.), cert. denied, 522 U.S. 914 (1997), appeal after remand, 208 F.3d 712 (8th Cir. 2000) (Eighth Circuit court held that an HMO had a fiduciary duty to plan participants to disclose fully any compensation arrangements with providers that discourage referrals to medical specialists because those are material facts that could adversely affect the participant's interest)

3. *RoadBlocks to Enforcement of Plan's Subrogation Provision Under ERISA*

- a. Until recently, in many Circuits, an employee benefit plan administrator seeking to enforce the plan's subrogation rights would file an action under ERISA sec. 503(a)(3), framing the claim as one for equitable relief, namely restitution of the funds belonging to the plan and to prevent unjust enrichment.² However, in Great-West Life & Annuity Ins. Co. v. Knudson, 122 S.Ct. 708 (2002), the U.S. Supreme Court ruled (5-4) that when tort proceeds had already been distributed, a suit for reimbursement of funds from a beneficiary was not "appropriate equitable relief" under ERISA.³

Declining to construe Great West's complaint as seeking a remedy that was "typically available in equity," the court reasoned that Great-West essentially sought "to impose personal liability on [the Knudsons] for a contractual obligation to pay money-relief that was not typically available in equity." Significantly, the Court also held that the relief that Great-West sought did not constitute

² ERISA sec. 502(a)(3), 29 U.S.C. sec. 1132(a)(3), allows a fiduciary to "enjoin any act or practice which violates any provision of this title or the terms or the plan, or to obtain other equitable relief (i) to redress such violations; or (ii) to enforce any provisions of this title of the terms of the plan."

³ The plan beneficiary in this case was rendered a quadriplegic in a car accident. At the time, she was covered by her husband's employee benefit plan. The "stop-loss" insurer under the plan paid all but \$75,000 toward her covered medical expenses of \$411,157. Under the terms of the plan, the plan had the right to recover from the beneficiary any benefits paid by the plan that the beneficiary was entitled to recover from a third party. The plan assigned its rights under this provision to the stop-loss insurer. The beneficiary sued the car manufacturer in state court and negotiated a settlement under which \$13,828, representing past medical expenses, was allocated to satisfy her obligation under the reimbursement provision. Rather than accepting the \$13,828, the insurer filed suit under ERISA in federal court seeking the entire amount it had paid for the beneficiary's medical expenses.

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restitution in equity. Distinguishing restitution in equity from restitution at law, the Court defined restitution in equity as a “form of constructive trust or equitable lien, where money or property identified as belonging in good conscience to the plaintiff could clearly be traced to particular funds or property *in the defendant’s possession*”⁴.” *Id.* at 714. The court reasoned that Great-West did not seek restitution in equity because the proceeds of the settlement to which Great-West maintained it was entitled were not in the Knudson’s possession, but were in a special needs trust. The Court left open the issue of whether Great West could have obtained relief from the Knudson’s attorney and the trustee of the special needs trust.

- b. Although health plans are understandably concerned about their ability to seek reimbursement after the U.S. Supreme Court issued its decision in Great West, several post Great West decisions have found that health plans may enforce the reimbursement provisions in their agreements with plan participants under ERISA provided the participants have possession of the funds. See, Great-West Life & Annuity Insurance v. Brown, 192 F. Supp.2d 1376 (M.D. Ga. 2002). The Great West court noted that other options for health plans seeking to enforce subrogation rights include: (1) intervening in the state court case; or (2) bringing a direct state-court action against the Knudsons for breach of contract (i.e., subrogation agreement). However, a state court action regarding a plan’s subrogation rights may be preempted by ERISA or run afoul of the state’s anti-subrogation laws.⁵

4. ***Continued Erosion of ERISA Preemption, Particularly In Cases Involving Mixed Benefit and Treatment Decisions***

a. ***Pre-Herdrich ERISA Preemption Standard:***⁶

⁴ In contrast, the Court defined restitution at law as a remedy available to a plaintiff who “could not assert title or right to possession of particular property, but in which nevertheless he might be able to show just grounds for recovering money to pay for some benefit the defendant had received from him.” *Id.*

⁵ See, Arana v. Ochsner Health Plan, Inc. 2002 WL 1878714 (5th Cir. 2002)(Court held ERISA does not completely preempt a health plan participant’s claim that the plan administrator’s attempt to obtain subrogation and reimbursement from the participant’s personal injury settlement was void under Louisiana law); But see, Carducci v. Aetna U.S. Healthcare, D.N.J. (May 2002) (The U.S. District Court refused to remand matter to state court since it held ERISA completely preempts state law unjust enrichment claims brought by ERISA HMO enrollees against various HMOs seeking a return of money the participants paid over to the plans in satisfaction of the plans’ subrogation provisions).

⁶ ERISA preemption is significant because ERISA’s civil enforcement provisions do not provide the range of remedies typically available under state law. ERISA effectively restricts a claimant’s recourse to benefits due under

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Activities relating to the *administration of healthcare benefits* are deemed preempted by ERISA, whereas activities relating to the *quality of healthcare* are deemed not preempted by ERISA (See, Dukes v. U.S. Healthcare, Inc. 57 F.3d 350 (3d Cir. 1995)) The distinction between the financing and the delivery of healthcare is blurred in the context of managed care, leading to great debate over whether lawsuits challenging managed care activities, such as utilization review and the use of healthcare provider financial incentives, are preempted.

Pre-Herdrich courts disagreed over whether financial incentive litigation is preempted by ERISA. Some courts have found that state law claims alleging the existence of inappropriate financial incentives that discourage providers from providing medically appropriate care are not preempted by ERISA (See, Stewart v. Berry Family Health Center, 105 F.Supp.2d 807 (S.D. Ohio 2000)(Court found state law claims alleging negligent establishment of financial incentive programs for hospital impacted the quality of care the plaintiff received from her physicians while at the hospital and, thus, characterized her claim as challenging a medical decision to deny proper treatment rather than an administrative decision to deny benefits). Other courts have concluded that ERISA preempts these state law claims. (See, Lancaster v. Kaiser Foundation Health Plan of Mid-Atlantic States, Inc., 958 F.Supp. 1137 (E.D.Va 1997) (Court determined that a claim for negligently establishing an incentive program, which induced plaintiff's physicians not to order additional testing, constituted a claim for benefits under ERISA). According to the Lancaster court:

The direct negligence claim and the fraud claim . . . attack an administrative decision, not a medical one. Properly construed, these claims focus on Kaiser's administrative decision to curb rising health care costs by employing a system of financial incentives that rewarded physicians for not ordering tests or treatments. In other words, [these claims] . . . challenge an administrative decision that had the effect of denying benefits to Lancaster as a plan participant because it inappropriately influenced Campbell and Pauls to take certain non-medical factors, most notably, their incomes, into account when prescribing treatment. These claims for direct negligence

the plan and equitable relief to enforce the plan terms. 29 U.S.C. sec. 1132 (a)(1)(B). Attorneys fees and costs may also be awarded at the court's discretion. Extra-contractual and punitive damages are not available to claimants alleging violation of ERISA plans.

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and fraud against Kaiser trigger [ERISA] sec. 1132(a)(1)(B)
Id. at 1146-1147

Pre-Herdrich courts also disagreed over whether ERISA preempts utilization review decisions. Some courts found state law claims challenging utilization review decisions are preempted by ERISA. Corcoran v. United HealthCare, Inc., 965 F.2d 1321 (5th Cir. 1992); Hull v. Fallon, 188 F.3d 939 (8th Cir. 1999)(Missouri law); Tolton v. American Biodyne, Inc. 854 F.Supp. 505 (N.D. Ohio 1993) *aff'd*, 48 F.3d 937 (6th Cir. 1995). However, some courts deem a managed care organization's utilization review decision to be a medical determination, which should be evaluated under state law governing medical malpractice claims. (See, Bauman v. U.S. Healthcare, Inc. 193 F.3d 151 (3d Cir. 1999), in which the court held direct negligence claims of New Jersey parents against an HMO in connection with their newborn daughter's death from severe, undiagnosed infection following an allegedly improper discharge from the hospital in accordance with U.S. Healthcare's utilization policy of discharging newborn infants within 24 hours after their delivery were not preempted by ERISA. The court emphasized that the claim addressed the quality of care provided and not the denial or benefits and was, therefore, directed toward the HMO in its capacity as a provider of health care rather than an as a benefits administrator).

- b. ***The U.S. Supreme Court Implies A New ERISA Preemption Standard For 'Mixed Eligibility and Treatment' Decisions in Pegram v. Herdrich, 530 U.S.211 (2000).***
- c. ***Conflicting Post-Herdrich Preemption Cases:***
 - (i) ***Cases Finding ERISA Does Not Preempt Challenges to Managed Care Activities***

In the wake of Pegram v. Herdrich, *some* courts are more reluctant to find ERISA preemption when managed care organizations or healthcare providers employ medical judgment in determining benefit eligibility. See, Pappas v. Asbel, 564 Pa 407, 768, A.2d 1089 (2001) where the Pennsylvania Supreme Court ruled that ERISA does not preempt a state law claim asserting that an HMO was negligent in providing medical benefits to a plan member

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when it refused to authorize coverage at a non-HMO hospital recommended by the treating physician, stating:⁷

Instead of referring Pappas [the HMO enrollee] to Jefferson, a non-HMO hospital, as [his treating physician] recommended, Dr. Leibowitz [the HMO Medical Director] referred Pappas to one of three other facilities for medical care. He did not, in the Supreme Court's words, only make a "simple yes or no" decision as to whether Pappas' condition was covered; it clearly was. Rather, Dr. Leibowitz also determined where and, under the circumstances, when Pappas' epidural abscess would be treated. His was a mixed eligibility and treatment decision, the adverse consequences of which, if any, are properly redressed, as Pegram teaches, through state medical malpractice law.

See also, Lazorko v. U.S. Healthcare et al., 237 F.3d 242 (3rd Cir. 2000), where the Third Circuit Court of Appeals held that ERISA does not preempt a Plaintiffs' claim that U.S. Healthcare's financial incentives caused the premature discharge of their newborn from the hospital.

(ii) ***Cases Finding ERISA Preempts State Law Challenges to Managed Care Activities***

However, many other post-Herdrich courts have held that ERISA preempts challenges to managed care activities under ERISA governed plans.

Pryzbowski v. U.S. Healthcare, 2001 WL 292997 (3rd Cir. 2001)(New Jersey law) (Court found that Plaintiff's claim that her HMO delayed approving treatment by an out-of-network doctor was preempted by ERISA. It noted that determinations of whether requested treatment is covered under a health plan relate to plan administration. According to the Pryzbowski court, holding that the plaintiff's claims against U.S. Healthcare are not completely preempted would open the door for legal challenges to core managed care practices (e.g. the policy

⁷ Pappas was admitted to a hospital's emergency room for treatment and was delayed in being transferred to a facility adequately equipped and immediately available to handle his neurological emergency while his physicians contacted the HMO to get transfer authorization; he was eventually admitted to an HMO-affiliated hospital. Pappas sued the first hospital and its physicians for negligence and malpractice, alleging that the delay in transfer caused his permanent paralysis. Defendants filed third-party complaints against the HMO for refusing to authorize the transfer to the facility selected by the medical staff.

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of favoring in-network specialists over out-of-network specialists) which the Herdrich Court rejected in light of congressional policy of promoting HMOs.

See also, Shusteric v. United Healthcare Ins. Co. of Illinois, 2000 WL 1263581 (N.D. Ill. 2000)(Court found that claim challenging HMO's delay in agreeing to pay for physical therapy following dental surgery on grounds of lack of medical necessity was completely preempted by ERISA. The court rejected the plaintiff's argument that, since the HMO employed medical judgment in rejecting the plaintiff subscriber's request for therapy, Pegram v. Herdrich required the court to conclude that her suit was not preempted by ERISA. The Schusteric court rejected this contention and found that: "Pegram's discussion of whether the plaintiff could state a claim for breach of fiduciary duty under ERISA says nothing about whether a negligence claim of the type alleged is completely preempted by sec. 502(a)[of ERISA]."

See also, Roark v. Humana Inc., 2001 WL 585874 (N.D. Tex. May 25, 2001) (Court held ERISA preempts plaintiff's complaint about Humana's delays in approving and refusals to authorize particular types of care, devices or facilities since plaintiff made no real complaint about the quality of medical care she received.) (on appeal); Calad v. CIGNA Healthcare of Texas, 2001 WL 705776 (N.D. Tex. June 21, 2001) (Court held ERISA preempts Plaintiff's utilization review claim, stating:

despite the negligence labeling under which she claims direct liability against her HMO under Texas law, Calad's claim is fundamentally one in which she challenges the quantity of care she received as a result of CIGNA's utilization review. To the extent that CIGNA's employee, agent or representative (as alleged here, CIGNA's hospital discharge nurse), may have "negligently adhered" to the HMO's medical necessity criteria, she was performing a function of ERISA plan administration. This is certainly the case with respect to the *pre-surgery* authorization of one day of hospitalization for Calad, which the Court notes is consistent with the ERISA plan's provisions. Regarding the alleged *post-surgery* determination that Calad did not meet the criteria for additional hospitalization coverage, the conclusion is ultimately the same. CIGNA's decision

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impacted on Calad's care to the extent that any medical necessity determination impacts an insured; the decision, however, was essentially one regarding the amount and type of services for which Calad was covered under the plan.

See also, Marks v. West Virginia Department of Health Human Resources, 181 F. Supp.2d 639 (U.S. S.D. West Virginia 2002), Rubin-Schneiderman v. Merit Behavioral Care and Empire Blue Cross and Blue Shield, 2001 WL 363050 (S.D. N.Y. April 10, 2001) (Court held that ERISA completely preempts Plaintiff's claim for wrongful refusal to authorize coverage for in-patient care for Plaintiff's psychiatric illness. Significantly, the court distinguished Pegram and certain Third Circuit cases on the grounds that they: "involved UR determinations by an HMO's doctors or administrators, not by independent UR agents for a more traditional fee-for-service plan. An HMO, as a managed care entity, takes on the role of medical provider *and* plan administrator . . . courts rely on the fact that the HMO was acting as "medical provider" rather than "administrator" in finding that negligence claims are not completely preempted." The court further stated:

Unlike an HMO, Empire Blue Cross never sought to undertake responsibility for Plaintiff's treatment. In providing UR services, Merit's role was confined to informing a patient *before* receiving treatment whether that treatment would be covered under the plan. Merit's doctors were not Plaintiff's treating physicians, nor did Merit purport to provide Plaintiff with medical services. Thus, the UR determination involved plan administration, not provision of medical services. *See Dukes*, 57 F.3d at 360-61. As such, *Pegram's* suggestion that an HMO's negligent mixed eligibility decision may not be completely preempted is inapposite.

(iii) ***Can These Apparently Conflicting ERISA Preemption Decisions Be Reconciled?***

Central to the Pryzbowski and other court decisions finding ERISA preempts utilization review decisions was the fact that, unlike the HMO at issue in Herdrich, the defendant HMO had not assumed the dual role of an administrator of benefits and a provider of medical services. However, in Isaac v. Seabury & Smith, 2002 WL 1461710 (S.D.

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Ind.)(July 5, 2002), the U.S. District Court for the Southern District of Indiana rejected the notion that the nature of the enterprise--HMO or third party administrator--was a determinative factor as to whether ERISA would preempt a mixed eligibility and treatment decision. Significantly, in holding that ERISA does not completely preempt a state law tort action arising from a third party administrator's mixed eligibility and treatment decision⁸, the Isaac court noted:

First, the Pegram court did not focus on the treatment of covered beneficiaries or on who provided the treatment. It focused on *decisions*: eligibility *decisions*, treatment *decisions*, and mixed *decisions* of treatment and eligibility. Regardless of who makes these decisions, they are all decisions which affect beneficiaries. We find no principled way to distinguish between a mixed decision of eligibility and treatment rendered by a physician employed by an HMO (as in Pegram) and a mixed decision eligibility and treatment rendered by a physician engaged by a third-party administrator to make such decisions (as in the instant case). . . [W]e fail to see how, under the Pegram regime, the nature of the enterprise—HMO or third party administrator—is a pertinent factor in determining whether ERISA completely occupies the field.

5. ***Divided U.S. Supreme Court Finds Illinois State Law Requiring Independent Review of Health Plan Benefit Decisions is Not Preempted by ERISA***

- a. Currently 41 states and the District of Columbia provide patients with the right to an independent, outside review of a managed care organization's denial of health care benefits. The external review programs vary significantly from one state to another. The Illinois Health Maintenance Organization Act (hereinafter "HMO Act") is one state external review law⁹ which the U.S. Supreme Court

⁸ The plaintiff-employee was a beneficiary of an ERISA governed "fee for service" health plan. The plan was funded by a health insurance policy issued to the plaintiff's employer by an insurance company which retained a separate third party administrator to make benefit decisions. Plaintiff-employee contracted leukemia and on August 10, 1999, her treating physician requested authorization to perform a bone marrow transplantation. By letter dated August 25, 1999, the third party administrator denied coverage since it was not "medically necessary." This initial decision was modified on September 23, 1999, when the third party administrator gave "conditional approval" for the transplant. The plaintiff-employee died on October 7, 1999, before any transplant was undertaken.

⁹ Section 4-10 of the HMO Act requires an HMO to submit for independent physician review any dispute between a patient's primary care physician and the HMO that involves treatment being refused on the grounds of "medical necessity." In the event the independent reviewer determines that treatment is medically necessary, the HMO Act requires the insurer to cover the treatment.

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recently reviewed in light of the federal circuit court split on whether ERISA preempts a state's external review provisions. See, Rush Prudential HMO Inc. v. Moran, 122 S.Ct. 2151 (2002).¹⁰ On June 20, 2002, a divided U.S. Supreme Court upheld a decision by the U.S. Court of Appeals for the Seventh Circuit which held that the Illinois external review provision was **not** preempted by ERISA, because it regulates insurance.¹¹ According to the Court of Appeals, HMOs are, "insurance vehicles under Illinois law." Moran v. Rush Prudential HMO, Inc., 230 F.3d 959 (7th Circuit 2000)¹².

While the Illinois law at issue clearly "relates to" ERISA within the meaning of Section 514, the U.S. Supreme Court found that the law is nonetheless saved from ERISA preemption because, from a "common sense view," it regulates the insurance industry¹³. According to the court, the Illinois law clearly regulates integral parts of policy relationships between insurers and the insured by adding "an extra layer of review when there is internal disagreement about an HMO's denial of coverage." While the

¹⁰ The plaintiff in Moran requested that her HMO, Rush Prudential, cover a particular kind of surgery that an out-of-network physician had recommended to treat the decreased mobility that she was experiencing in her right shoulder. Rush denied coverage for that surgery and instead offered to cover all of the costs associated with a different type of surgery to be performed by an HMO affiliated doctor. Moran sought external review of Rush's denial of coverage, and in the meantime, paid for the surgery recommended by the out-of-network physician herself at a cost of \$95,000. An independent reviewer found the services provided to Moran by the out-of-network physician were medically necessary, but Rush still denied Moran's claim. Moran then sought reimbursement under Section 4-10 of the Illinois HMO Act by bringing an action in state court. Rush removed the action to federal court on ERISA preemption grounds. Eventually, the U.S. District Court for the Northern District of Illinois determined that Moran made a claim for benefits that was preempted by ERISA.

¹¹ While ERISA preemption invalidates any state law which "relates to" a covered employee benefits plan, the most notable exception is the savings clause, which holds that a state law which "relates to" an ERISA plan may avoid preemption if the state law "regulates insurance."

¹² Four months prior to the Seventh Circuit's decision in Moran, the U.S. Court of Appeals for the Fifth Circuit reached the opposite conclusion and held that the independent review provisions of the Texas Health Care Liability Act are preempted by ERISA. See, Corporate Health Insurance Inc. v. Texas Department of Insurance, 215 F.3d 526 (5th Cir. 2000). On June 24, 2002, the high court vacated and remanded the Fifth Circuit decision in Corporate Health for reconsideration in light of its Rush decision.

¹³ In rejecting Rush's argument that HMOs should be immune from state regulation as members of the insurance industry since HMOs also provide health care, the Court held that "nothing in the saving clause requires an either-or choice between health care and insurance in deciding a preemption question, as long as providing insurance fairly accounts for the application of state law, the savings clause may apply." Likewise, the majority rejected Rush's argument that the Illinois HMO Act "sweeps too broadly within the definitions capturing organizations that provide no insurance, and by regulating non-insurance activities of HMOs that do."

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state law may “settle the fate of a benefit claim, “ the Court held that the law “does not enlarge the claim beyond the benefits available in any action under ERISA’s civil enforcement provision.”

The majority in Moran also found that the state law did not interfere with Congress’ intention to provide a uniform regime under ERISA. The court distinguished the independent review statute from arbitration provisions, saying the independent review provisions were more similar to a doctor’s “second opinion” than a binding arbitral decision. “The Act does not give the independent review a free-ranging power to construe contract terms, but instead, confines review to a single term; the phrase “medical necessity” used to define the services covered under the contract.”

- b. The Moran decision is a mixed bag for HMOs. The decision is unfavorable for HMOs because: (1) it confirms that they must comply with a patchwork quilt of state independent review laws; and (2) fails to address whether a state could supplant health plan language by adopting a new or different definition of “medical necessity” or standard of review for the second opinion. Some believe it would have been better if the court had upheld the independent review law with the caveat that the reviewer is to use the definition of medical necessity contained in the plan. The Moran decision is favorable to HMOs in that that it reaffirms an expansive reading of the “relate to” provision in ERISA’s express preemption provision. The members of the Court agreed that if the state independent review law was not an insurance regulation, it would be preempted as a provision related to an ERISA plan. Also, the ruling arguably reaffirms that a state law purporting to regulate insurance may nonetheless be preempted by ERISA if it conflicts with remedies established under the federal law. Lastly, the impact of Moran will be limited since it only applies to insured plans and has no effect on self-funded health benefit plans.
- c. The utility of the Supreme Court’s decision in Moran is of limited value because the Court did not address the question of whether newly proposed federal external review standards preempt state standards. Both the Senate and House bills on federal patient rights propose amending ERISA to establish a federal right to independent external review of a health plan’s benefit denials for consumers in all types of health plans, including self-insured employer plans currently exempt from state regulation. However, the House and Senate bills take a different approach to already

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enacted state external review laws. The Senate bill would set a minimum standard for external review that could preempt weaker state programs, while the House bill would set a single standard to preempt all state programs. The managed care industry and consumers are closely monitoring these judicial and legislative developments and their impact on existing state external review laws.

6. ***In the Wake of Moran Decision, Two Federal Court Judges in Same District Reach Differing Conclusions On ERISA Preemption of Pennsylvania Statutory Bad Faith Actions Against Insurers***

- a. In Rosenbaum v. Unum Life Insurance Company of America, 2002 WL 1769899 (E.D. Pa July 29, 2002), Senior U.S. District Court Judge Clarence Newcomer held that ERISA does not preempt an employee's statutory bad faith claim¹⁴ against his long term disability carrier for its wrongful denial of benefits. While District Courts in Pennsylvania have consistently held that Pennsylvania's bad faith statute is preempted by ERISA, Judge Newcomer reexamined the issue in light of a "new trend in federal law." In a pair of recent decisions from the high court—Unum Life Insurance Co. of America v. Ward in 1999 and Rush Prudential HMO Inc. v. Moran in 2002—Judge Newcomer found that the U.S. Supreme Court justices significantly changed the test for assessing whether a state law qualifies for ERISA's Savings Clause, which exempts from preemption "any law of any state which regulates insurance." According to Judge Newcomer, the savings clause can now protect a state law from preemption even if the law does not meet all three factors of the McCarran-Ferguson Act which include whether the practice: (1) has the effect of transferring or spreading a policyholder's risk; (2) is an integral part of the policy relationship between the insurer and the insured; (3) is limited to entities within the insurance industry. While the Pennsylvania bad faith statute may not satisfy the first factor in that it does not have the effect of transferring or spreading a policyholder's risk since it is special

¹⁴ Pennsylvania's bad faith statute, 42 Pa.C.S. sec. 8371, provides:

In an action arising under an insurance policy, if the court finds that the insurers has acted in bad faith towards its insured, the court may take all of the following actions:

1. Award interest on the amount of the claim from the date the claim was made by the insured in an amount equal to the prime rate of interest plus 3%;
1. Award punitive damages against the insurer;
1. Assess court costs and attorney fees against the insurer.

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damages section, the Rosenbaum court found that it satisfies the second and third factors. According to Judge Newcomer, the bad faith statute plays an integral part in the policy relationship between the insurer and the insured as it creates the right of an insured to pursue punitive damages, attorneys fees and interest¹⁵ and it is limited to entities within the insurance industry.

- b. Less than one month later, in Sprecher v. Aetna U.S. Healthcare Inc., 2002 WL 1917711 (E.D. Pa. August 19, 2002), U.S. District Judge Ronald Buckwalter reached the opposite conclusion and held that the bad faith statute was preempted¹⁶. Judge Buckwalter disagreed with Judge Newcomer on two key points. On the second factor of the McCarran-Ferguson test, Judge Buckwalter found that the bad-faith statute does not serve as “an integral part of the policy relationship between the insurer and the insured” because it doesn’t “change the bargain between an insurer and insured.” According to the Sprecher court, insurers already have the obligation to act in good faith and “state statute providing a remedy for breach of this obligation does not have the effect of creating a new, mandatory contract term.” Instead, the Sprecher court found the bad faith statute simply creates an opportunity for a policyholder whose claim has been improperly handled by the insurer, to seek punitive damages and interest penalties.”

Secondly, Judge Buckwalter found that, even if he were to hold that the bad faith law qualified for protection from preemption under ERISA’s savings clause, the law would nonetheless be preempted because “its provision for interest penalties and punitive damages, is more akin to an “alternative remedy” which is categorically preempted by ERISA.” Because Pennsylvania’s bad faith statute provides a form of ultimate relief in a judicial forum that adds to the judicial remedies provided by ERISA, Judge Buckwalter found it is incompatible with ERISA’s exclusive enforcement scheme. See, also, Caffey v. Unum Life Insurance Co., 2002 WL 2001526 (6th Cir. Tenn)(Sept. 3, 2002)(In finding that ERISA preempts Indiana tort of bad faith by an insurer, the Caffey court, made note of the U.S. Supreme Court decision in Rush:

¹⁵ In Pilot Life Ins. Co v. Dedeaux, 481 U.S. 107 (1987) the U.S. Supreme Court found that the Mississippi law of bad faith did not satisfy the second factor of the McCarran–Ferguson test. However, Pilot Life dealt with common law claims of bad faith unspecific to the insurance industry, while the bad faith claim before the Court in Rosenbaum derived from a statute specific to the insurance industry.

¹⁶ In Sprecher, the plaintiff, an enrollee under an ERISA benefits plan, filed suit against his health insurer for its partial failure to pay hospital expenses he incurred after suffering a heart attack. Count I of plaintiffs complaint was filed under ERISA to recover benefits while Count II is a state statutory bad faith claim.

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In its most recent pronouncement on the subject, the Supreme Court again confirmed that any state law “providing a form of ultimate relief in a judicial forum that add[s] to the judicial remedies provided by ERISA patently violates ERISA’s policy of inducing employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and wards when a violation has occurred.”

C. **Large U.S. Health Insurers and Managed Care Organizations Continue to Be Plagued With Costly Provider and Subscriber Class Action Lawsuits Challenging the Propriety of Fundamental Managed Care Methodologies**

1. *Subscriber Class Actions*

a. RICO Violations:

- (i) Humana v. Forsyth, 119 S.Ct. 710 (1999) (U.S. Supreme Court held that the McCarren-Ferguson Act did not preempt a subscriber class action against a health insurer alleging its failure to disclose provider discounts in marketing to healthcare subscribers violated RICO. Suit subsequently settled for \$28.8 million).
- (ii) Maio v. Aetna, 221 F.3d 472 3d Cir. (2000) (U.S. Court of Appeals for the Third Circuit upheld a lower court’s dismissal of a purported RICO class action by subscribers on standing grounds. The subscribers essentially alleged that defendants made misrepresentations in marketing their health plans to subscribers by failing to disclose internal managed care cost control mechanisms. The subscribers alleged that the hidden cost control measures rendered the health plans worth less than those for which the subscribers bargained. None of the subscribers alleged actual denial of benefits, delay in care or other concrete injury).
- (iii) Multi-District Litigation. Various subscriber class actions have been filed against the largest for-profit health insurers and HMOs, alleging RICO violations similar to those in Maio as well as ERISA violations. These actions have been consolidated for pre-trial purposes in In re: Humana Managed Care Litigation.

(a) On February 20, 2002, in a long-awaited ruling, Judge Moreno refused to dismiss the

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subscribers' RICO claims for lack of standing. (In re Managed Care Litigation, S.D. Florida, No. 1334, ruling February 20, 2002). Judge Moreno declined to follow the Third Circuit Court of Appeals' no-standing ruling in Maio v. Aetna, Inc., but granted the defendant managed care organizations the right to seek immediate review of his standing ruling by the U.S. Court of Appeals for the 11th Circuit stating that immediate review of the RICO issue could "materially advance the termination of the litigation." In concluding that the plaintiffs have standing to sue under RICO, Judge Moreno likened the plaintiffs' racketeering claims to the tort of fraudulent inducement which he found may be filed independently of any contract claim. Despite this pronouncement, Judge Moreno concluded that the McCarran-Ferguson Act barred the RICO claims of 10 of the 16 subscriber plaintiffs.¹⁷ These 10 subscribers resided in states that had enacted insurance fraud laws.

b. ERISA Violations:

- (i) In Doe v. Blue Cross Blue Shield of Maryland, 2001 WL 1159037, the U.S. District Court for the District of Maryland dismissed a lawsuit by a purported class of individuals insured by employer-sponsored policies issued by Blue Cross Blue Shield of Maryland alleging ERISA violations through failure to disclose cost controls. The District Court based its dismissal decision on lack of standing.
- (ii) In the Multi-District litigation, the plaintiff subscribers allege that the defendants breached their fiduciary duty under ERISA by misrepresenting benefits in plan

¹⁷ The court ruled that the McCarran-Ferguson Act, a law that Congress passed to prohibit federal lawsuits that encroach upon each state's right to regulate insurance, barred the ten plaintiffs from California, Florida, New Jersey and Virginia from maintaining their RICO suits. In support, the court pointed to the insurance fraud laws in these four states that do not allow individuals to maintain private causes of action. Rather, these actions must be filed by the appropriate government regulatory body. Thus, the court found that the state insurance fraud laws barred the subscriber's federal RICO claims since such claims would encroach upon each state's regulatory decision to not allow private causes of action.

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summaries, determining “medical necessity” using financial criteria and not disclosing that criteria, and interfering with communication between doctors and patients. As a result of these alleged misrepresentations, the plaintiffs claim to have sustained injury in that they paid more for insurance coverage than they would have absent the HMO’s alleged misrepresentation and exaggerations of plan benefits. The plaintiff subscribers asserted all of their breach of fiduciary duty claims under ERISA’s “catch all” claim provision which allows subscribers and, in some cases, former subscribers to bring a civil action to enjoin any act which violates the term of the Plan or any provision of ERISA and to obtain appropriate equitable (including restitution and monetary damages) and injunctive relief.

- (iii) In his February 20, 2002 ruling, Judge Moreno dismissed a number of the subscribers’ ERISA claims, including the ERISA medical necessity fiduciary duty claims by subscribers who are still enrolled in their health plans under the ERISA catch all claim section. Since the subscribers are essentially alleging fraudulent inducement to purchase an insurance contract by misrepresenting medical necessity criteria, Judge Moreno held that their claims should be characterized as an ERISA claim for benefits rather than as an ERISA breach of fiduciary duty claim.¹⁸ The ruling is significant as it drastically restricts the remedies available to those plaintiffs to health benefits, and possibly plaintiffs’ attorneys’ fees. However, Judge Moreno allowed all subscribers to maintain their claims that the defendants breached their fiduciary duties under ERISA by “improperly interfering with physician-patient communication by imposing “gag orders” on doctors” and

¹⁸ As to the subscribers who are no longer members of a plan, Judge Moreno noted that they have no adequate remedy under ERISA’s claim for benefits provision for their breach of medical necessity fiduciary duty claims since this section of ERISA limits those who can seek recourse to current subscribers only. Thus, the former plaintiff subscribers’ only recourse to recover for the defendants’ alleged misrepresentation is under the ERISA catch all claim provision which presumably allows the plaintiff former subscribers to pursue restitutionary and other equitable relief. Judge Moreno cautioned the former subscribers that their medical necessity misrepresentation claims must conform with his prior rulings that neither the summary plan document requirements nor ERISA’s general fiduciary duty obligations require a plan administrator to disclose financial incentives paid to physicians or employees. *“If, in the end, the plaintiffs’ misrepresentation claim boils down to an allegation that the Defendants mislead their subscribers by failing to give enough information about cost-suppression incentives to place the medical necessity terminology in proper context, it would be precisely the sort of omission-based claim that this Court has already rejected. . . Such a claim would be fatally imprecise and subject to dismissal,”* according to Judge Moreno.

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not discharging their duties “solely in the interest” of the participants and beneficiaries. While most managed care organizations no longer utilize gag orders in their contracts with providers, the subscriber suits challenge managed care methodologies employed by the defendants dating back to 1991.

2. *Provider Class Actions*

a. **RICO Violations:**

- (i) Healthcare providers and several state medical associations have filed class actions against the largest for-profit health insurers and HMOs alleging RICO violations through fraudulent and extortionate predicate acts. The provider RICO class actions have been consolidated in In Re: Humana Managed Care Litigation. The providers generally assert that, contrary to defendants’ contracts and representations, defendants implemented internal policies and procedures secretly designed to systematically obstruct, reduce, delay and deny healthcare payments to the providers.¹⁹ The providers also allege that the defendants extorted them into participating in their managed care health plans and into rationing medical care through economic coercion (e.g., ‘all products’ requirements and wielding their dominant market power). The providers claim to have sustained substantial economic losses as a result of the defendants’ alleged misconduct. The court found that *the providers have standing to sue under RICO because they sufficiently pled injury to their business or property*.
- (ii) Although many of the provider contracts with the defendant managed care organizations contain arbitration clauses, on March 14, 2002, the 11th Circuit Court of Appeals ruled that *the providers’ RICO claims are not subject to arbitration if the applicable arbitration provisions preclude extra-contractual or punitive damage awards*. In re Humana Inc. Managed Care Litigation, 11th Cir., NO. 01-10247. Several of the managed care defendants filed a petition for certiorari requesting that the U.S. Supreme

¹⁹ As discussed in Section D3 below, many providers have also been alleging antitrust violations and unfair trade practices.

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Court review the issue in light of conflicting case law from other Circuits. In re Humana Inc. Managed Care Litigation v. Book, U.S. No. 02-215, petition filed 8/6/02.

- (iii) The providers have requested the court to certify the matter as a class action. Judge Moreno has allowed the plaintiffs to engage in limited discovery with respect to those factual issues which will impact the court's decision on class certification. See, In re: Managed Care Litigation, 2001 WL 1400245 (S.D. Fla. May 9, 2001).

b. ERISA Violations

- (i) The providers in the In Re Humana Managed Care Litigation also made a claim for "unpaid benefits" under ERISA. (Their ERISA claim was asserted in the alternative to their state law breach of provider contract claims which the defendants asserted were preempted by ERISA.) The defendants moved to dismiss the providers' ERISA claims for lack of standing (the providers were suing in their own rights, not under assignments of the rights of plan participants or beneficiaries) and for failure to exhaust administrative remedies. The court has not addressed these arguments because it held that the providers' breach of contract claims are not preempted by ERISA.

D. Increased Frequency of Individual Provider Suits and Attorney General Suits Against Managed Care Organizations Arising Out of Claim Payment Practices

1. Violations of Prompt Payment Statutes

- (a) Most states have prompt or clean payment statutes which require health insurers to timely pay undisputed health benefit claims within 30 to 45 days of receipt of all necessary claim documentation. Individual healthcare providers, their medical associations, and the state attorney generals are filing complaints against managed care organizations, challenging the timing and/or amount of provider claim reimbursement payments. For example, last year the Texas Attorney General announced agreements requiring 17 insurance carriers and health maintenance organizations to pay tens of millions of dollars in restitution to

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providers and \$9.25 million in fines to resolve complaints about claim processing under the Clean Claim Act, which requires claim payments on undisputed claims within 45 days.²⁰

Pacificare has filed suit challenging the constitutionality of the Clean Care Act.

2. **Twice-Pay Litigation**

- (a) Providers have also been instituting legal action against health insurers to recover fees owed by insolvent independent physician associations (IPAs) for services the providers rendered to the insurers' subscribers and beneficiaries. The recent filing by the Texas Attorney General against Pacificare of Texas on February 11, 2002 alleging violation of the state's prompt payment statute and deceptive trade practices act for its failure to reimburse providers for covered services in the wake of the bankruptcy filing of three contract provider networks is illustrative of this trend. See, Texas v. PacifiCare of Texas, Tex. Dist. Ct., No GV200718, Filed 2/11/02.
- (b) Whether providers will ultimately recover their unpaid fees in these actions will depend largely on each state's statutory scheme. Some state statutes, such as Colorado House Bill 97-1122, expressly require managed care plans to pay all providers for uncompensated covered benefits provided to plan members in the event of the insolvency of an intermediary for managed care contracts. In contrast, other state statutes, such as California's statute, do not require health insurers or HMOs to pay twice in the event of the insolvency of their intermediaries. For example, a California court dismissed an action filed by the California Medical Association against Blue Shield of California and seven co-defendant Health Care Plans on behalf of its member physicians to recover an estimated \$65-70 million in fees owed by FPA Medical Management of California, Inc. (FPA-CA), a now defunct physician practice management company under contract with the Health Plans, to California physicians providing health care services to the defendant Health Plans' enrollees. In December 2001, a California appellate court affirmed the lower court's January 6, 2000 ruling that California Health Plans have no liability under California state law if they delegate their insurance risk to insolvent entities. See, California Medical Ass'n Inc. v.

²⁰ Among the insurers and HMOs agreeing to the settlement were: Blue Cross and Blue Shield of Texas, Cigna Healthcare of Texas, Humana Health Plan of Texas and United Healthcare Insurance Co.

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Aetna U.S. Healthcare of California, Inc., 94 Cal.App.4th 151 (2001). Central to the court's rationale was the fact the California statute under which the providers sought recovery pertained to a Managed Care Organization's payment of claims in a timely manner and, unlike the Colorado statute, did not expressly require health plans to act as financial guarantors for their insolvent intermediaries.

3. Provider De-Selection

Some courts are demonstrating more reluctance to sustain provider de-selection claims for monetary damages in light of the immunity provided by the Health Care Quality Immunity Act (HCQIA). For example, on August 27, 2002, the U.S. Court of Appeals for the First Circuit affirmed a lower court ruling that a provider *may not* challenge the managed care organization's peer review process, even when it draws critical conclusions about the providers' practice, where the managed care organization undertakes "professional review" actions with respect to the physician in order to determine clinical privileges. Singh v. Blue Cross and Blue Shield of Massachusetts, 2002 WL 1941472 (1st Cir)(Massachusetts law). While the plaintiff provider charged the managed care organization was not acting out of concern over improving quality patient care, but rather, was motivated by its profit margin to reduce over-utilization of services, the court ruled the managed care organization could not be held liable since its actions met the HCQIA standards in that they were taken: (1) in the reasonable belief that they were needed to further quality of healthcare, (2) after a reasonable effort to obtain the facts, (3) after adequate notice and hearing; and (4) in the reasonable belief that the actions were warranted.

III. Noteworthy Legislative Developments

A. FEDERAL PATIENT BILL OF RIGHTS LEGISLATION

1. Proposed Legislation:

For some time prior to the events of September 11, 2001, Congress debated passage of patient protection legislation. The Senate and House passed differing versions of the legislation in June and August 2001, respectively. *See*, S. 1052 and *H.R. 2463*. Both measures would amend ERISA to allow subscriber-patients to sue health insurers for injuries caused by their wrongful denial of benefits to the extent the insurer exercised medical judgment. The

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bills differ with respect to the scope of the patient-subscriber's available remedies.²¹ President Bush has said that he would veto the Senate passed bill. Senate aides and White House representatives are reportedly negotiating the terms of compromise legislation, which will pass muster in Congress and meet White House approval. Sponsors of the Senate-passed bill are seeking to name conferees to merge the competing Senate and House bills. It is unlikely any form of legislation will be passed before 2003.

2. Some Comparisons Between Senate and House Bills

While the Senate bill would allow subscribers to file suit in state court under state law to recover *unlimited* economic and non-economic damages if the subscriber is challenging the managed care organization's medical judgment, the bill passed by the United States House of Representatives sets limits in actions maintained by subscribers in state or federal court (under the House bill a health plan subscriber may maintain an action in state or federal court but federal law must be applied) by *capping the amount of a subscriber's non-economic damages at \$1.5 million and punitive damages at \$1.5 million*. President Bush believes that the limits are needed to discourage the filing of frivolous lawsuits and to hold down insurance costs. However, many legislators will likely insist on higher damage caps.

The problem facing Congress is balancing the rights of health plans and employers, patient subscribers, and the individual states to self-govern. Health plans want uniform standards to apply with respect to insurance regulations. While patient subscribers also want uniformity, they believe the current web of federal and state laws often leaves them without proper recourse for injury due to a managed care organization's wrongful denial of benefits.²² State officials are concerned that the House version of the federal legislation will override their state patient protection laws, which often provide greater protection to patients.²³ The House Bill will not allow state

²¹ In denial of benefit cases involving medical judgment, the Senate bill would permit a subscriber that has suffered injury or death to pursue all available relief under state law, including extra-contractual relief. However, the House version of the bill would cap non-economic damages at \$1.5 million and punitive damages at \$1.5 million. Moreover, under the House version of the bill, punitive damages would only be available if a health plan failed to comply with the independent medical reviewer's decision that the claim for health benefits should be granted.

²² For example, many courts still broadly interpret ERISA to preempt subscriber's challenges to a MCO's benefit determination. Alternatively, those states which have patient protection legislation in place (*i.e.*, laws which require MCOs to establish external review procedures of adverse health benefit determinations or allow patients to sue MCOs directly) do not apply to self-insured employer sponsored plans.

²³ Ten states have passed laws giving patients a right to sue health plans for damages caused by the delay or denial of care. The states are Arizona, California, Georgia, Louisiana, Maine, New Jersey, Oklahoma, Texas, Washington, and West Virginia.

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officials to seek permission from the federal government to enforce state laws (*i.e.*, external review laws) that “substantially comply” with proposed federal standards.

Under the House bill, managed care organizations also retain a special status, as they cannot be held fully accountable in state court for their negligent actions in the same way as a physician or hospital defendant. Not only is liability capped under the House Bill, but also patients face a much higher evidentiary standard in trying to prove that the managed care organization acted negligently. Under the House Bill, there is a presumption that the managed care organization exercised ordinary care in making benefit decisions if an independent medical reviewer upholds the managed care organization’s initial determination denying coverage.

3. Comment on Proposed Legislation

Passage of federal patient rights legislation will most likely result in the filing of additional subscriber lawsuits against managed care organizations. Managed care organizations will no longer be able to invoke ERISA’s broad preemptive shield to defend against wrongful denial of benefit cases involving medical judgment. The frequency and severity of these claims is more likely to increase to the extent the subscribers are able to file their new brand of ERISA benefit denial claims in state court and try their cases before a jury. Some of the same factors which are contributing to the escalating medical malpractice awards (*i.e.*, the lottery type mentality of juries and anti-managed care sentiment) may increase the severity of jury awards returned against managed care organizations. Ultimately, the extent to which the industry experiences increases in claim frequency and severity will depend on which version of the legislation is passed. The House bill with its liability caps and high evidentiary standard is obviously more favorable to managed care organizations.