

## **ERISA AND MANAGED CARE LIABILITY UPDATE**

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*BCS Insurance Company  
Twentieth Annual  
Professional Liability Conference  
Colorado Springs, Colorado  
September 10-13, 2006*

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### **I. Continued Absence of “Shock” Managed Care Verdicts in Individual 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 individual bodily injury cases since the late 1990s (i.e., the \$80 million verdict in *Chippis v. Humana*; the \$120 million verdict in *Goodrich v. Aetna*; and the \$89 million verdict in *Fox v. HealthNet*). We attribute this favorable development largely to the fact that managed care organization defendants have: (1) abandoned the more problematic managed care methodologies, (2) introduced internal and external review systems which enable members to appeal denial of benefit determinations<sup>1</sup>, and (3) 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).<sup>2</sup>

### **II. The *Davila* Decision On ERISA Preemption of Managed Care Cases**

In *Aetna Health Inc. v. Juan Davila*, 542 U.S. 200, 124 S. Ct. 2488 (2004), the Supreme Court tackled the decisive issue of when the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 et seq. (“ERISA”) completely preempts state laws or state court litigation concerning benefit decisions made in

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<sup>1</sup> The majority of 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 in their scope, accessibility, independence, and timeliness, as well as other respects. A 2006 New York State External Appeal Program report found that the external appeal program results for 2004 favored the consumer in 45% of the cases involving medical necessity denials. The percentage of rulings in favor of the consumer was 51% in claims involving denials of benefits on experimental or investigational grounds.

<sup>2</sup> 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.

## ERISA AND MANAGED CARE LIABILITY UPDATE

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the context of managed care. ERISA preemption of managed care decisions is controversial because prospective benefit denials under ERISA-governed plans can lead to bodily injury and emotional distress, and courts have historically interpreted ERISA as *not* affording recovery of such extra-contractual damages.<sup>3</sup>

Prior to *Davila*, ERISA plan participants/beneficiaries who received adverse benefit determinations often attempted to avoid ERISA preemption and recover extra-contractual damages in state court proceedings by characterizing their causes of action as relating to the *quality* of health care (an area reserved for state regulation), as opposed to the administration of health care benefits (an area governed by ERISA). Lower courts were deeply divided on the circumstances in which ERISA preempted litigation over managed care decisions. The *Davila* ruling quelled this debate: it clarified that, *where an ERISA plan participant/beneficiary challenges a benefit decision made by a party other than the physician or the physician's employer, ERISA and its limited remedies apply, even if the benefit decision required the exercise of medical judgment by the plan administrator, and even where the claim is brought as a tort or under a state statute purporting to impose an independent duty on ERISA plan fiduciaries.*

### **III. The Concurring Opinion in *Davila* Invites Managed Care Litigants To Redouble Their Efforts To Obtain Consequential Damages As “Make Whole” Equitable Relief Under Section 502(a)(3)**

*Comments in Davila by a few of the Justices invite claimants to shift their focus from circumventing ERISA preemption to attempting to obtain broader remedies, including extra-contractual relief, under ERISA.* Specifically, a footnote in the majority opinion in *Davila* states: “some individuals in respondents’ positions could possibly receive some form of ‘make-whole’ relief under ERISA § 502(a)(3).” *Davila*, footnote 7. Likewise, in her concurring opinion, Justice Ginsburg (joined by Justice Breyer) states “fresh consideration of the availability of consequential damages under § 502(a)(3) is plainly in order.” ERISA Section 502(a)(3) allows “a participant, beneficiary or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) *to obtain other appropriate equitable relief* (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of this plan.” (Emphasis added) Justice Ginsburg predicted that, one day, the Supreme Court or Congress will confirm Congress’ intent that ERISA provide “make-whole relief.”

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<sup>3</sup> ERISA remedies are narrower than those available under many state laws. ERISA plan participants/beneficiaries who sue for wrongful denial of, or failure to preauthorize, healthcare benefits have only been able to recover benefits due under their plan, equitable relief to enforce the plan (e.g. a declaration that particular benefits are covered), and plaintiffs’ attorneys’ fees. 29 U.S.C. sec. 1132 (a)(1)(b).

## ERISA AND MANAGED CARE LIABILITY UPDATE

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### IV. The *Davila* Legacy

#### A. Courts Continue To Find ERISA Preempts Denial of Benefits Cases Dressed Up As Medical Malpractice Or Other State Law Torts

In the wake of *Davila*, courts have been consistently rejecting plaintiffs' attempts to avoid ERISA preemption by pleading state law tort causes of action for what amounts to denial of coverage for medical care under ERISA-regulated plans.

1. *Kuthy v. Mansheim*, 124 Fed.Appx. 756, (3d Cir. 2004) (Unpublished) ERISA completely preempts state law medical malpractice and wrongful death claims by widower of cancer patient against decedent's HMO (Carelink Health Plans), its parent company (Coventry Health Care) and two physicians who worked for Carelink and Coventry. Plaintiff alleged the physicians breached their standard of care by denying coverage for an experimental bone marrow procedure recommended by the treating physician. Citing *Davila*, the court held that "the decision to deny coverage was based upon their interpretation of a provision in the insurance plan that excluded experimental treatments. Kuthy's claim therefore falls within the scope of ERISA."
2. *Land v. CIGNA Healthcare of Fla.*, 381 F.3d 1274 (11<sup>th</sup> Cir. 2004) On remand from the Supreme Court, the 11<sup>th</sup> Circuit Court of Appeals reversed its initial decision and ruled that ERISA completely preempts a medical negligence claim against CIGNA by Land, a subscriber to a healthcare plan administered as an HMO by CIGNA. After Land's treating physician admitted him to the hospital for aggressive antibiotic treatment of an infection in his hand, a CIGNA approval nurse authorized outpatient, rather than inpatient, treatment of his infection and he was discharged from the hospital. The outpatient treatment was unsuccessful, resulting in amputation of his finger. The 11<sup>th</sup> Circuit held: "Land's causes of action brought to remedy the denial of benefits under an ERISA regulated benefit plan, fall within the scope of, and are completely preempted by, ERISA 501(a)(1)(B)."
3. *Mayeaux v. La. Health Serv. & Indem. Co.*, 376 F.3d 420 (5<sup>th</sup> Cir. 2004) ERISA preempts plaintiff's state law tort claims based upon health insurer's denial of coverage for high dose antibiotic treatment of insured's connective tissue illness on the grounds that the treatment was excluded as experimental.

## ERISA AND MANAGED CARE LIABILITY UPDATE

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### **B. ERISA Plan Participants' Post *Davila* Attempts To Expand ERISA's "Make-Whole" Relief to Include Extra-Contractual Damages**

The Supreme Court has described Section 502(a)(3) of ERISA 29 U.S.C. §1132(a)(3) as a "catch all" remedial section "offering appropriate equitable relief for injuries caused by violations that Section 502 does not elsewhere adequately remedy." *Variety Corp. v. Howe*, 516 U.S. 489, 512 (1996). Section 502(a)(3) permits ERISA plan participants to recover individual remedies that are "equitable" in nature.

To date, courts have consistently declined to expand the relief available under Section 502(a)(3) of ERISA to include compensatory money damages.

1. *Zavala v. Trans-System, Inc.*, 2006 WL 898019 (2006), 38 Employee Benefits Cas. 1604 (D.Or. Apr. 4, 2006). Zavala filed suit in federal District Court for the District of Oregon on behalf of decedent's estate against the decedent's employer and the third party administrator of the employer's health plan. Zavala alleged wrongful denial of health benefits under ERISA. The decedent had been diagnosed with non-Hodgkin's lymphoma for which he requested authorization from the plan for an allogenic peripheral blood stem cell transplant. After authorizing the procedure, the plan's third party administrator notified the decedent that the reinsurer requested further investigation before the procedure could be authorized. The decedent died before receiving the treatment. Zavala sought restitution, back pay, front pay, prejudgment interest, attorney fees and other "make-whole" equitable relief under Section 502(a)(3) of ERISA. The court found that *the compensatory money damages sought by Zavala for an alleged breach of fiduciary duty constituted a legal remedy which was not available under Section 502(a)(3) of ERISA*. It stated: "[u]nfortunately, without action by Congress, there is nothing we can do to help [plaintiff] and others who may find themselves in this same unfortunate situation."
2. *Rubin –Schneiderman v. Merit Behavioral Care Corp., et al.*, 2006 WL 2381776 (2<sup>nd</sup> Cir. N.Y. Aug. 14, 2006) (Unpublished) The plaintiff, Eric Rubin-Schneiderman, sued his health insurer (Empire Blue Cross and Blue Shield) and the company that performs utilization review of mental health services for Empire (Merit Behavioral Care Corp.) under ERISA Section 502(a)(3). Plaintiff alleged that the defendants breached their fiduciary duties by failing to authorize in-patient psychiatric care, resulting in his failed suicide attempt and serious bodily injury. Citing Justice

## ERISA AND MANAGED CARE LIABILITY UPDATE

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Ginsberg's suggestion in her concurring opinion in *Davila*, that monetary relief under Section 502(a)(3) may be more widely available in suits against ERISA fiduciaries than against non-fiduciaries, Rubin-Schneiderman sought to recover monetary relief from the defendants under ERISA Section 502(a)(3).

The Second Circuit Court of Appeals held: "...the fact that a defendant is a fiduciary does not change the requirement of Section 502(a)(3) that the relief sought be 'equitable'..." *Because Rubin-Schneiderman is seeking compensatory monetary damages, a legal remedy, he cannot proceed under ERISA Section 502(a)(3)*".

3. *Knieriem v. Group Health Plan, Inc.* 434 F. 3d. 1058 (8<sup>th</sup> Cir. 2006) Knieriem, decedent's personal representative, sued the insurer of decedent's employer-sponsored health plan and its chief medical officer alleging breach of fiduciary duty under ERISA through their refusal to pre-authorize benefits for treatment of the decedent's non-Hodgkin's lymphoma. Knieriem sought restitution of the money the deceased paid for health benefits in trust which he maintained should have been released for the requested procedure and a "surcharge" in the amount of the ancillary profit to the plan and its trustee as a result of the denial of the benefit (e.g. interest).

The Eighth Circuit Court of Appeals held that Knieriem sought money damages unavailable under ERISA Section 502(a)(3). It stated: "*Merely re-labeling the relief sought as 'restitution' or a 'surcharge' does not alter the nature of a remedy from monetary to equitable.*" The Court further found that a surcharge was not available as an equitable remedy to the plaintiff since the decedent did not receive the requested procedure and never incurred any related benefits payable. Thus, the plan did not hold any readily identifiable funds or property belonging to the decedent's estate to form the basis of a constructive trust for equitable restitution.

4. *Coan v. Kaufman*, 457 F.3d 250 (2d Cir. 2006) Coan, a former employee and retirement plan participant, brought an ERISA action against former trustees of the retirement plan for mismanagement of the plan and its investments. Coan sought an injunction requiring the defendants to restore funds to a defunct retirement plan to be distributed to its former participants. The Second Circuit Court of Appeals concurred with the District Court's finding that Coan's *artful pleading did "not transform what is effectively a money damages request into equitable relief."*

## ERISA AND MANAGED CARE LIABILITY UPDATE

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5. *McDonald v. Household Int'l and United Healthcare Corp.*, 2006 U.S. Dist. LEXIS 53318 (S.D. Ind. 2006). Citing the concurring opinion in *Davila*, on August 1, 2006, an Indiana federal judge declined to dismiss the plaintiff, James McDonald's claims against his employer, Household International, and the insurer of Household's employee health benefit plan, United Healthcare, for "make whole" relief under Section 502(a)(3) of ERISA. McDonald seeks to recover lost wages and damages for his impaired earning capacity to 'make him whole' for the defendants' breach of their fiduciary duty by failing to timely add him to Household's employee health benefit plan. McDonald alleges that his inability to obtain promised benefits for his blood pressure medication rendered him unable to fill his prescription and caused him to suffer a catastrophic hypertensive stroke. Following his stroke, McDonald's status as a plan beneficiary was confirmed and the plan has paid his health care expenses.

The defendants moved to dismiss McDonald's ERISA claim on the grounds that the type of make whole relief he seeks is not available as all of his health benefits have now been paid. The defendants argue that McDonald's is a "straight forward denial of benefits case where a participant is seeking extracontractual damages for consequential injuries." Citing the United State's Supreme Court's decisions in *Great-West Life & Annuity Ins. Co. v. Knudson*, and *Mertens v. Hewitt Assoc.*, defendants argue that Section 502(a)(3) has been construed as "not authorizing an award of money damages against a *non-fiduciary*." Defendants assert the same result should obtain with respect to Section 502(a)(3) claims for monetary damages against *fiduciaries*, as the Supreme Court did not distinguish between fiduciaries and non-fiduciaries in *Great West* and *Mertens*. Finally, defendants argue that their alleged failure to add McDonald to the plan was a ministerial function, not a fiduciary responsibility.

The court declined to dismiss McDonald's claim, finding that the record lacked evidence as to the cause of the failure to timely add McDonald to the benefit plan and whether it entailed the exercise of discretionary authority in the administration of the plan. It stated: "*The likelihood that plaintiffs will establish facts that might allow their case to squeeze past the existing limitations on ERISA's equitable remedy may be remote, but without the benefit of an evidentiary record, the court cannot say that it is*

## ERISA AND MANAGED CARE LIABILITY UPDATE

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*impossible.*” The defendants are seeking an interlocutory appeal to the Seventh Circuit Court of Appeals.

### V. ***Sereboff*: The United States Supreme Court’s Most Recent Pronouncement on the “Equitable Relief” Available Under ERISA**

On May 15, 2006, in *Sereboff v. MidAtlantic Medical Services, Inc.*, 126 S.Ct. 1869 (2006), the United States Supreme Court provided some helpful guidance to the health insurance industry on the circumstances in which ERISA plan fiduciaries may enforce third party recovery provisions contained in ERISA governed health plans.

In *Sereboff*, an ERISA plan fiduciary sued two plan beneficiaries (the Sereboffs) under ERISA Section 502(a)(3) for reimbursement of approximately \$75,000 in medical expenses the plan paid on their behalf after they were involved in an automobile accident. The plan fiduciary had previously notified the Sereboffs that the plan was asserting a lien on any tort recovery. Following the Sereboffs’ recovery of \$750,000 in their tort action, the plan sued to enjoin dissipation of the settlement funds and the Sereboffs agreed to set aside \$75,000 of their recovery in an investment account pending the outcome of the reimbursement action.

The employee benefit plan at issue in *Sereboff* contained an “Acts of Third Parties” provision that applied “when [a beneficiary is] sick or injured as a result of the act or omission of another person or party” and requires the beneficiary who “receives benefits” under the plan for such injuries to “reimburse” [the plan] for those benefits from “[a]ll recoveries from a third party (whether by lawsuit, settlement or otherwise.” The provision further states that the plan’s “share of the recovery will not be reduced because [the beneficiary] has not received the full damages claimed, unless [the plan] agrees in writing to a reduction.”

The *Sereboff* recovery action was brought under Section 502(a)(3)(B) of ERISA which authorizes ERISA plan fiduciaries to obtain “appropriate equitable relief ... to enforce ... the terms of the plan.” The issue before the Supreme Court in *Sereboff* was *whether the reimbursement sought by the plan constituted “equitable relief” under ERISA Section 502(a)(3)*. The Supreme Court ruled that the relief was equitable because the plan sought (1) “specifically identifiable” funds (2) within the Sereboffs’ “possession and control,” namely the portion of the tort settlement due to the plan under its recovery provision, which had been set aside by the Sereboffs and preserved in an investment account.

The Court noted that, not only must the relief sought be equitable, but the *basis for the claim must also be equitable*. The Court differentiated between (1) *equitable liens as a matter of restitution* (which require the plaintiff to trace the funds at issue to the fund against which the lien is asserted) and (2) *equitable liens*

## ERISA AND MANAGED CARE LIABILITY UPDATE

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*by agreement or assignment* (which do not require tracing to specific funds). The Court held that, *to assert an equitable lien by agreement or assignment, the plaintiff is only required to assert the lien against the fund identified by the agreement.* In *Sereboff*, the plan identified the lien target as “... all recoveries from a third party.” The Court rejected the Sereboffs’ argument that, for the relief to be equitable, the plan fiduciary must show that the fund against which the lien was asserted contained the health plan benefits originally paid by the plan to the beneficiary. (In most instances, this would be a practical impossibility as plan benefits are typically paid directly to the beneficiary’s medical providers). The Court also rejected the Sereboffs’ argument that the fund against which the lien was asserted had to be in existence when the agreement containing the lien provision was executed.

The Court did not address the Sereboffs’ argument that the relief sought by the plan was not “appropriate” equitable relief within the meaning of Section 502(a)(3) because it contravened the “make whole doctrine.” The Sereboffs contended that the plan should be required to (1) compromise its claim at the same level the Sereboffs compromised their claim against the third parties and (2) give credit for attorneys fees they incurred to obtain their third party recovery. The Court did not reach this issue because it had not been raised in the lower court.

### **VI. Despite *Davila*, Plaintiffs Can Still Circumvent ERISA Preemption Through Careful Construction of Independent State Law Claims**

Plaintiffs can still circumvent ERISA preemption and its restrictive remedies fashioning independent state law claims against health insurers and other managed care organizations, sounding in medical negligence or other theories distinct from denial of insurance benefits.

The \$4.2 million Texas state court verdict against Humana Health Plan in *Smelik v. Humana* (2005) is a case in point. In that case, the plaintiffs succeeded in holding Humana, along with the treating physician defendants, liable for the death of Joan Smelik, a 66 year old woman who died after her treating physicians apparently failed to diagnose and appropriately treat her chronic kidney disease. Ms. Smelik received her medical insurance through an ERISA-governed employee benefits plan which was administered by Humana. The treating physicians were independent contractors who participated in Humana’s provider network.

Humana denied any responsibility for Ms. Smelik’s death, arguing that it approved every referral request and paid every medical bill submitted on behalf of

## ERISA AND MANAGED CARE LIABILITY UPDATE

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Ms. Smelik.<sup>4</sup> The plaintiffs’ argued that Humana was required to do much more than that because of promises it made to manage the care provided to Ms. Smelik by its network physicians. For example, according to the plaintiffs’ Second Amended Complaint, in its Member Handbook, Humana promised to “work with” members’ physicians, to “review” their health services, and to “assess whether the treatment provided is appropriate.” The plaintiffs further argued that Humana was grossly negligent because, despite its awareness of Ms. Smelik’s chronic kidney condition, Humana: failed to refer her to a kidney specialist or to a disease management program; approved benefits for a drug that was contra-indicated and toxic to those suffering from kidney disease; and otherwise failed to assess the quality of health care provided by the treating physicians. Thus, Humana was held responsible for the substandard medical treatment provided to Ms. Smelik due to Humana’s failure to fulfill promises it made in its Member Handbook. Humana appealed the verdict against it to the Texas Fourth Court of Appeals, but the case settled on appeal.

### **VII. Is *Smelik* A Prescription for Plaintiffs’ Attorneys Looking To Ring The Bell In The Current Non-Managed Care Environment?**

The *Smelik* verdict is potentially groundbreaking for ERISA plan participants. Ironically, Plaintiffs’ attorneys looking for new legal theories against health insurers and managed care organizations which no longer aggressively manage care on a prospective basis (e.g. through pre-admission review or other pre-certification of benefits) are increasingly arguing that health insurers and managed care organizations are liable for medical negligence based upon their failure to properly perform promised case management, utilization management and disease management. In other words, some of the same plaintiffs’ attorneys who, in the managed care heyday, argued that managed care improperly interfered with healthcare providers’ medical treatment, are now arguing that health insurers and managed care organizations have a duty to second-guess and correct provider treatment decisions and should be held liable if they fail to do so.

It remains to be seen whether these legal arguments will have any widespread success. As a threshold matter, to succeed, the plaintiffs would need to prove that medical negligence occurred, and that the health insurer or managed care organization assumed a heightened duty to monitor the care rendered to its members through commitments to perform case management, utilization management or disease management. Such theories are also more likely to succeed where marketing materials are poorly phrased (e.g. promises to work “with” providers and “assess” the propriety of treatment). Additionally, the more

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<sup>4</sup> This may explain why the court did not submit Smelik’s alternative cause of action under ERISA Section 502(a)(1)(B) to the jury. (The Texas state court had concurrent jurisdiction over this count.) Significantly, the plaintiffs alleged that their claim for ERISA benefits did not extend to the utilization management, concurrent review, medical case management and quality assurance services Humana promised, but failed, to perform.

## ERISA AND MANAGED CARE LIABILITY UPDATE

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information the health insurer/ managed care organization possesses concerning a member's condition (or a provider's history), the easier it will be for a skilled plaintiff's attorney to hold it responsible for not disapproving particular treatment or medication prescribed by the provider which appeared to be contra-indicated.

### VIII. Other Noteworthy ERISA Preemption Decisions in 2006

- A. On August 16, 2006, in *Louisiana Health Service & Indemnity Co. v. Rapides Healthcare System*, \_\_\_ F.3d \_\_\_, 2006 WL 2361696 (5<sup>th</sup> Cir. La.), the Fifth Circuit Court of Appeals held that ERISA does not preempt a Louisiana state statute requiring insurance companies to honor all assignment of benefit claims made by patients to hospitals.

This decision conflicts with earlier decisions by the Eighth and Tenth Circuits, which have concluded that ERISA preempts similar assignment statutes. (See *Arizona Blue Cross and Blue Shield v. St. Mary's Hospital, Inc.* 947 F.2d 1341 (8<sup>th</sup> Cir. 1991); *St. Francis Regional Medical Ctr. v. Blue Cross & Blue Shield of Kansas, Inc.* 49 F.3d 1460 (10<sup>th</sup> Cir. 1995).

- B. In *Quality Infusion Care, Inc. v. Aetna Health, Inc.*, 206 WL 1155254 (S.D. Tex.), 38 Employee Benefits Cas. 2021 (April 27, 2006), the District Court for the Southern District of Texas held that ERISA completely preempts claims under the Texas Any Willing Provider Statute.

### IX. Commentary On Other Existing Or Anticipated Managed Care Litigation Trends