Resolution Adopted by the House of Delegates
of the American Bar Association
February, 1999

RECOMMENDATION

RESOLVED, that the American Bar Association supports enactment of federal legislation to amend the federal Employee Retirement Income Security Act (ERISA) to allow causes of action to be brought in the state and territorial courts against employer-sponsored health care plans under state and territorial health care liability laws.

FURTHER RESOLVED, that the American Bar Association supports and encourages utilization of alternative dispute resolution (ADR) mechanisms prior to the filing of such causes of action.

REPORT

In 1974, the Employee Retirement Income Security Act of 1974 (ERISA) was enacted. ERISA expressly preempts any and all state laws that relate to any employee benefit plan. 29 U.S.C. 1144 (a). Under ERISA, companies that contract with ERISA employers to provide health care coverage have largely been able to shield themselves from liability for health care treatment decisions that cause harm to enrollees.

Because managed care plans with an emphasis on cost containment did not exist when Congress passed ERISA, the legislation was not written to address such plans. More importantly, only in recent years have we begun to see the fallout of ERISA preemption of employer-sponsored health care plans. An example of such fallout is set forth in the case of *Corcoran v. United Healthcare, Inc.,* 965 F.2d. 1321 (5th Cir.), cert. denied, 506 U.S. 1033 (1992). In the *Corcoran* case, the plaintiffs filed suit against their HMO regarding a medical decision made in relation to the denial of certain plan benefits. The plaintiffs alleged that the negligent actions of their ERISA plan=s utilization reviewer had caused the death of their unborn child. After the plaintiff was diagnosed with a high-risk pregnancy, her doctor requested pre-certification from the insurer to hospitalize her. Her insurer=s utilization reviewer refused to authorize the inpatient stay. Contrary to her doctor=s requests, the reviewer authorized part-time home nursing care. When no nurse was on duty in the home, the fetus went into distress and died. In their wrongful death action, the plaintiff parents alleged that the reviewer negligently denied their physician=s recommended care.

Noting the breadth of the ERISA preemption clause, the court concluded that the plaintiffs= claims Arelated to@ an ERISA plan and were therefore preempted. In dicta, the court said that there is a wide disparity within the federal courts as to whether ERISA preempts state laws regulating quality of care issues in cases against managed care organizations; and further, it urged Congress to reevaluate the scope of the ERISA preemption to ensure that patients are not left with no remedy, state or federal, for what may be a serious mistake. Specifically, the court said:

> The result ERISA compels us to reach means that the Corcorans have no remedy, state or federal, for what may have been a serious mistake. This is troubling for several reasons. First, it eliminates an important check on the thousands of medical decisions routinely made in the burgeoning utilization review system. With liability rules generally inapplicable, there is theoretically less deterrence of substandard medical decisionmaking. Moreover, if the cost of compliance with a standard of care (reflected either in the cost of prevention or the cost of paying judgments) need not be factored into utilization review companies= cost of doing business, bad medical judgments will end up being cost-free to the plans that rely on these companies to contain medical costs. ERISA plans, in turn, will have one less incentive to seek companies that can deliver both high quality

> services and reasonable prices.
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> Second, in any plan benefit determination, there is always some tension between the interest of the beneficiary in obtaining quality medical care and the interest of the plan in preserving the pool of funds available to compensate all beneficiaries.
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> Finally, cost containment features such as the one at issue in this case did not exist when Congress passed ERISA. While we are confident that the result we have reached is faithful to Congress=s intent neither to allow state-law causes of actions that relate to employee benefit plans nor to provide beneficiaries in the Corcorans= position with a remedy under ERISA, the world of employee benefit plans has hardly remained static since 1974. Fundamental changes such as the widespread institution of utilization review would seem to warrant a reevaluation of ERISA so that it can continue to serve its noble purpose of safeguarding the interests of employees. Our system, of course, allocates this task to Congress, not the courts, and we acknowledge our role today by interpreting ERISA in a manner consistent with the expressed intentions of its creators. (at page 1338.)

Some courts, such as the court in *Corcoran v. United Healthcare, Inc.,* have held that 29 U.S.C 1144 (a) preempts claims under state health care liability laws that seek to hold an HMO liable for injuries resulting from the HMO=s negligent administration of a health care plan. Under ERISA, a patient who is injured because appropriate care was denied or delayed by an ERISA-regulated health care plan cannot bring an action in state court under the state tort laws. He or she can bring an action in federal court, but the only remedy he or she would have is the payment of the costs of health care services for which coverage was denied.

Other courts have ruled that enrollees can sue their plans in state courts for vicarious liability for medical negligence of the plan=s providers.

ERISA preemption of state tort laws unjustly prevents patients from holding managed health care plans accountable for negligent care. As a result, numerous bills were introduced in the 105th Congress to clarify that ERISA does not preempt state causes of action against ERISA plan administrators. A major piece of legislation, H.R. 1415, introduced by Congressman Charles Norwood (R-GA) in the House, had 234 cosponsors. It was introduced in the Senate by Senator Alfonse D=Amato (R-NY) as S. 644. H.R. 1415 and S. 644 would have provided for a broad set of protections for beneficiaries of employer-sponsored managed care plans, including a provision in Section 4 of the bills to permit a cause of action against an HMO under state law for recovery of damages for medical malpractice. Specifically, Section 4 of H.R. 1415 would have amended ERISA to clarify that ERISA=s preemption clause (the ERISA shield) Adoes not preclude any State cause of action to recover damages for personal injury or wrongful death against any person that provides insurance or administrative services to or for an employee welfare benefit plan maintained to provide health care benefits.@

Managed care legislation, developed by a coalition of House and Senate Democrats, was introduced in the Senate as S. 1890 (Daschle, D-SD) and in the House as H.R. 3605 (Dingell, D-MI). These two bills deal with a host of issues, including provisions that would have permitted a cause of action under state medical malpractice laws. The bills would amend ERISA to allow enrollees in employer-sponsored plans, under certain circumstances, to sue their health plans under state law for damages resulting from personal injury or wrongful death. The bills would protect employers and other plan sponsors from lawsuits if the action that led to the suit did not reflect the exercise of discretionary authority by the employer or sponsor.

The House and Senate Republican Leadership also developed legislation (S. 2330 and H.R. 4250) to provide some consumer protections for managed care patients. However, neither bill would have amended ERISA to give patients the ability to bring a cause of action under applicable state tort laws. All the bills died at the end of the 105th Congress. The 106th Congress is expected to give attention to these issues early in the Congress.

In addition, the State of Texas enacted legislation that establishes liability for managed care entities that make health

care treatment decisions that cause harm to enrollees. The Texas law is the subject of litigation. This law imposes a duty of ordinary care upon certain entities when making health care treatment decisions and holds those entities liable for damages proximately caused by a failure to exercise that duty. Tex. Civ. Prac. & Rem. Code Ann. ' 88.002(a) (West 1998). A challenge to the Texas law was recently struck down by the U.S. District Court for the Southern District of Texas in *Corporate Health Insurance Inc., et al., vs. the Texas Department of Insurance, et al.*, Civil Action NO. H-97-2072. The court found that a suit may be brought in state court under state laws challenging the quality of care received. The decision is being appealed.

When managed care plans make a determination of medical necessity, they are making decisions about medical treatment and are serving as medical decision-makers. They should be held accountable for their medical decisions. The remedies available under ERISA are inadequate in that they allow patients to recover only the cost of a treatment or test and not compensatory damages. Some HMOs have denied coverage for treatments or tests despite the recommendations of the patients= treating physicians. By the time an HMO is ordered to pay for a benefit that should have been provided in the beginning, the patient may be irrevocably harmed or have died because the benefit was not provided when it should have been. HMOs that consistently provide appropriate coverage are not rewarded under this system and may find themselves at a competitive disadvantage against those who do not provide the care they should provide.

Opponents of legislation to permit patients to sue their employer-sponsored health plans for damages under state law say that such legislation will result in employers being forced to offer more restrictive or no health care benefits to their employees due to increased litigation costs. This would not be the case. ERISA does not affect enrollees who buy insurance directly rather than through an employer or enrollees who are covered as an employee of a state or local government. A recent report by the Henry J. Kaiser Family Foundation studied the extent of litigation in certain insurance programs where consumers currently have the ability to sue health plans. The study found very low rates of litigation against the public insurance systems it researched, ranging from 0.3 to 1.4 cases per 100,000 enrollees per year (with estimated monthly costs from $0.03 to $0.13 per enrollee).[1] For plans that currently make an effort to cover what should be covered, the premiums would not be expected to increase much, if at all, under the proposals to remove the ERISA Shield. For those insurers that do not now cover what they should cover, premiums would of course rise more. Thus the Kaiser study undoubtedly reflects what would happen for most insurers. The Congressional Budget Office estimates that removing the ERISA shield would add 1.2 percent to health care premiums. Since we believe that most HMOs currently act appropriately, we believe the CBO estimate is too high.

On October 23, 1997, Texas Senator David McAdams Sibley testified before the House Education and the Workforce Subcommittee on Employer-Employee Relations on the new Texas law discussed above and stated that A[c]ritics argue that@ the new law in Texas Awill increase litigation and will substantially increase health care costs. The law has been in effect since September 1 and has not resulted in a flood of litigation as predicted by the insurance lobby.@ He issued a press release on August 12, 1998, that says that Anot a single lawsuit has been filed against a managed care plan since the law took effect Sept. 1, 1997.@

Philip H. Corboy, Chair
Special Committee on Medical Professional Liability
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[1] See Impact of Potential Changes to ERISA: Litigation and Appeals Experience of CalPERS, Other Large Public Employers and a Large California Health Plan, June, 1998, Prepared for the Kaiser Family Foundation by Coopers and Lybrand, L.L.P.