

**PIERCING THE ARMOR: APPROACHES TO MANAGED CARE  
LIABILITY**

**Thomas W. Williamson, Jr., Esq.  
Joshua D. Silverman, Esq.  
Williamson & Lavecchia, L.C.  
Richmond, Virginia**

**I. Introduction**

- A. Managed care organizations (MCOs) frequently make medical decisions through the utilization review process impacting upon the quality of medical care. Holding MCOs accountable under the current law for injuries caused by their malfeasance calls for innovative thinking. The political currents portend changes in the offing. For a discussion on the political pressures weighing on MCOs *see* Angela M. Easley, Comment, *A Call to Congress to Amend ERISA Preemption of HMO Medical Malpractice Claims*, 20 CAMPBELL L. REV. 293, 316-18 (1998).
- B. This outline discusses approaches to imposing liability on MCO's based on either the organization's or the provider's acts and omissions.
- C. For recent articles addressing vicarious liability of HMOs for the negligence of member physicians, *see*, William E. Milks, *Liability of Health Maintenance Organizations (HMOs) for Negligence of Member Physicians*, 51 A.L.R.5th 271 (1998); and *HMO Liability for the Medical Negligence of Member Physicians* 43 VILL. L. REV. 499 (1998). On the Internet, the Health Administration Responsibility Project (HARP), is constantly updating its site with links to cases and law journals addressing managed care liability. [Http://www.harp.org/](http://www.harp.org/)
- D. A patient's ability to recover compensatory damages for denial of coverage is often contingent on whether or not she is insured through an Employees Retirement Security Act (ERISA) plan. 29 U.S.C. § 1001 et seq. *See*, Theresa A. DiPaola, *Wrongful Denial of Health Insurance Benefits*, TRIAL, Mar. 1990, at 74 (analyzing court decisions on whether a "plan" exists).
  - 1. An ERISA plan is defined as
    - a) "any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their

beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits in the event of sickness, accident, disability....” ERISA § 3(1), 29 U.S.C. § 1002(1).

- b) Typically the employer pays for all or part of the plan and/or is involved in its administration.
  - c) The Fourth Circuit has found that there is no set formula for determining if a plan exists, but instead a plan exists “if from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and the procedures for receiving benefits.” *Madonia v. BC/BS of Virginia*, 11 F.3d 444, 447 (4<sup>th</sup> Cir. 1993) quoting *Donovan v. Dillingham*, 688 F.2d 1367, 1373 (11<sup>th</sup> Cir. 1982) (en banc).
2. According to the Department of Labor, DOL Reg, 29 CFR § 2510.3-1(j), the plan is not an ERISA plan if:
- a) the employer did not contribute to the plan;
  - b) participation in the plan was voluntary;
  - c) the employer’s involvement in the plan was limited to collecting premiums and remitting them to the insurance company; and
  - d) the employer received no profit from administering the plan.

## II. Theories of Liability

- A. Vicarious Liability: The plaintiff does not need to allege that the MCO was negligent. Liability is based on an agency relationship between the MCO and the provider.
- 1. Vicarious liability claims against MCOs have successfully avoided ERISA’s limitations on compensatory damages. Courts have held that a cause of action against an MCO is not preempted because the MCO’s liability is based on the physician’s negligence, and there is no need to reference the ERISA plan to resolve the controversy. *Pacificare v. Burrage*, 59 F.3d 151 (10<sup>th</sup> Cir. 1995); *Rice v. Panchal*, 65 F.3d 637 (7<sup>th</sup> Cir. 1995). While the Fourth Circuit has not addressed this issue, in *Prihoda v. Shpritz*, 914 F.Supp. 113 (D-Md. 1996), the court predicted that the Fourth Circuit would adopt

the rationale of other circuits and hold that vicarious liability claims are not preempted by ERISA.

2. For a plaintiff to recover, he must prove the following:
  - a) Malpractice of a provider;
  - b) Existence of employment relationship between the provider and the defendant MCO. This will often be a factual issue to be determined by a jury. *See McDonald v. Hampton Training School for Nurses*, 254 Va. 79, 486 S.E.2d 299 (Va. 1997); and
  - c) Provider was acting within scope of employment.
3. The most difficult challenge is proving an employment relationship between the provider and the MCO. The MCO will likely claim the provider is an independent contractor. Under *McDonald*, 254 Va. at 81, 486 S.E.2d at 301, the following factors are relevant:
  - a) Manner of selection and engagement;
  - b) Payment of compensation;
  - c) Power of dismissal; and
  - d) Power to control the work of the individual. This factor is determinative.
4. Where to look for evidence of control to prove agency:
  - a) Contracts between the MCO and the provider;
  - b) Member handbooks showing that members must use MCO selected primary care physicians;
  - c) MCO contracts with members;
  - d) Advertising brochures;
  - e) Claims forms; and
  - f) Financial records detailing the method and amount of payment to providers.
5. Ostensible Agency: alternative to proving actual agency
  - a) Restatement provisions:

- (1) “One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or by his servants, is subject to liability for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as though the employer were supplying them himself or by his servants.” RESTATEMENT (SECOND) TORTS § 429 (1965).
- (2) “One who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.” RESTATEMENT (SECOND) AGENCY § 267 (1958).

b) Factors for finding ostensible agency:

- (1) Whether the patient looks to the MCO, rather than the physician for health care. *Pomeroy v. Johns Hopkins* 868 F.Supp. 110, 113 (D-Md. 1994).
- (2) Whether the MCO holds out the physician as an employee which creates the appearance of an employment relationship in the mind of a reasonable patient. *Boyd v. Albert Einstein Medical Center*, 547 A.2d 1229 (Pa. Super. Ct. 1988).
  - (a) MCO identifies the provider on MCO documents;
  - (b) MCO lists doctor in phone book;
  - (c) MCO provides workplace for physician; and
  - (d) Promotional materials.

c) Ostensible agency is a question of fact for the jury. *Boyd v. Albert Einstein*, 547 A.2d 1229 (Pa. Super. Ct. 1988).

6. In an often cited Virginia federal district court decision on whether an MCO can be held liable for a patient’s injury, the court held that

neither state medical malpractice claims against physicians nor vicarious liability claims based on a physician's negligence are preempted. *Lancaster v. Kaiser*, 958 F.Supp. 1137 (E.D. Va. 1997).

7. The Seventh Circuit has likewise held that a plaintiff's vicarious liability claim against an MCO is not preempted because the court can resolve the claim without referencing the ERISA plan. *Rice v. Panchal*, 65 F.3d 637 (7<sup>th</sup> Cir. 1995).
8. *Elsesser v. Hospital of Philadelphia College*, 802 F.Supp. 1286 (E.D. Pa. 1992)
  - a) MCO can be held liable under agency or apparent agency theories.
  - b) ERISA does not preempt state profession malpractice actions.
  - c) However, this court held that an MCO is not directly liable for compensatory damages caused by its own negligence. *But see, infra*, cases holding that plans can be held liable in claims based on the quality of benefits.
9. *Pacificare of Oklahoma v. Burrage*, 59 F.3d 151 (10<sup>th</sup> Cir. 1995). The impact of this case on managed care liability is discussed in Seema R. Shah, *Loosening ERISA's Preemptive Grip on HMO Medical Malpractice Claims: A Response to Pacificare of Oklahoma v. Burrage*, 80 MINN. L. REV. 1545 (1996).
  - a) In *Burrage*, an ERISA plan beneficiary sued the MCO alleging it was liable for its physician's negligence based on state law.
  - b) The court found that the proper issue is whether the medical malpractice claim "relates to" the ERISA plan. If it "relates to" the plan, the state law claim is preempted.
  - c) The court discussed four categories of laws that "relate to" an employee benefit plan:
    - (1) Laws regulating types of benefits or terms of an ERISA plan;

- (2) Laws creating reporting, disclosure, funding or vesting requirements;
  - (3) Laws that provide rules for the calculation of the amount of benefits; and
  - (4) Laws providing remedies for misconduct in the administration of ERISA plan.
- d) The court held that “[j]ust as ERISA does not preempt the malpractice claim against the doctor, it should not preempt the vicarious liability claim against the HMO if the HMO has held out the doctor as its agent.” *Id.*
10. In a case not involving an ERISA plan, the Indiana appellate court held that whether an agency relationship exists between a provider and an MCO is a question of fact not ripe for summary judgment. *Sloan v. Metropolitan Health Council*, 516 N.E.2d 1104 (Ind. App. 1987).
11. *DeGenova v. Ansel*, 555 A.2d 147 (Pa. Super. 1988) found that plaintiff’s vicarious liability claim was not preempted. The court stressed that absent a state law claim the plaintiff would be without a remedy. Other courts have refused to consider the fact that ERISA may deprive the plaintiff of a remedy.
12. *Jass v. Prudential Health Plan*, 88 F.3d 1482 (7<sup>th</sup> Cir. 1996):
  - a) An RN, who was an agent of Prudential, was sent to evaluate the plaintiff after she underwent knee replacement surgery. The RN determined that physical therapy was not necessary and as a result plaintiff was prematurely discharged which proximately caused her to suffer permanent injury. She sued the RN for medical malpractice and the MCO vicariously for the RN’s negligence.
  - b) The court held that she was merely disguising an ERISA claim as a state law medical malpractice claim, and the court dismissed the suit.
  - c) The court also rejected her vicarious liability claim because the agency relationship “related to” an ERISA plan. The court found that without the ERISA plan, there would be no agency relationship.

- d) As a matter of policy the court found that allowing vicarious liability claims would subject plans to a myriad of state laws regulating employee benefits.

B. Tortious Interference with Contract

1. A person or entity that intentionally interferes with a contract is liable in tort. *Duggin v. Adams*, 234 Va. 221, 225-26, 360 S.E.2d 832, 835 (1987).
2. A contractual relationship exists between a doctor and a patient, and an MCO that interferes with the relationship may be liable in tort. *See Lyons v. Grether*, 218 Va. 630, 633, 239 S.E.2d 103, 105 (1977) (recognizing that a physician-patient relationship arises from an express or implied contract and a “patient is entitled to damages resulting from a breach of a physician’s duty”).
3. Elements of tortious interference with a contract. *See, Chaves v. Johnson*, 230 Va. 112, 335 S.E.2d 97 (1985); *See also Duggin v. Adams*, at 226, 360 S.E.2d at 835 (1987):
  - a) Existence of a contract;
  - b) Knowledge of the contract by the defendant;
  - c) Intentional interference;
  - d) Inducing or causing breach; and
  - e) Damages.
4. Burden of Proof
  - a) The initial burden is on the plaintiff to show that the defendant intentionally interfered with a contract and that the plaintiff suffered damages.
  - b) The burden then shifts to the defendant to show the interference was “justified, privileged, or not improper.” *Duggin v. Adams*, 234 Va. at 226, 360 S.E.2d at 836 (1987).
5. Damages: It is an open question in Virginia whether or not expectancy damages are recoverable in the health care context. In a business context, the Virginia Supreme Court has held that to

establish a prima facie cause of action for business expectancy for a third party interference with the contract, the following must be shown:

- a) Contract had an expectancy;
- b) Third party knew of the expectancy;
- c) Third party intentionally interfered with the expectancy;
- d) Use of improper means or methods to interfere with the expectancy; and
- e) Loss as a result of the disruption of the expectancy.  
*Maximus Inc. v. Lockheed Information Management Systems Co*, 254 Va. 408, 414, 493 S.E.2d 375, 378 (1997).

6. Application in medical malpractice context:

- a) *Curtis v. Fairfax Hospital*, 34 Va. Cir. 290, 294 (Fairfax 1994), *aff'd* 254 Va. 437, 492 S.E.2d 642 (1997):
  - (1) Woman alleged malpractice in the treatment of her infant child causing the child's death. The physician disclosed the mother's medical records to defense counsel and she sued for disclosing confidential medical records under a theory of tortious interference with a contract.
  - (2) Tortious interference with a contract rejected because plaintiff failed to prove the existence of a contract. Applying *Glisson v. Loxley*, 235 Va. 62, 366 S.E.2d 68 (1988), the court found there was no special arrangement with the physician creating a contract.

C. Conspiracy

1. Civil conspiracy is a combination of two or more persons acting to accomplish an unlawful purpose or to accomplish a lawful purpose by unlawful means. *Commercial Bus. Sys. v. Bellsouth Servs.*, 249 Va. 39, 453 S.E.2d 261 (1995); *Glass v. Glass*, 228 Va. 39, 321 S.E.2d 69 (1984). For example, an action in tort will lie for conspiracy to induce breach of contract. *Worrie v. Boze*, 198 Va. 533, 95 S.E.2d 192 (1956).

2. Managed care scenarios often involve several different entities or persons: the health care providers, health maintenance organizations, insurance companies, and audit and review groups. If all the involved players are part of the same corporate structure, they are protected from conspiracy by the intra-corporate immunity doctrine. *See Fox v. Deese*, 234 Va. 412, 362 S.E.2d 699 (1987); *Bowman v. State Bank of Keysville*, 229 Va. 534, 331 S.E.2d 797 (1985). However, a conspiracy theory may be viable when the MCO successfully argues that the treating physician is an independent contractor to avoid being held vicariously liable.

D. Breach of Contract

1. The utility of a breach of contract action against a health care provider is that the claim is not subject to medical malpractice cap. *Glisson v. Loxley*, 235 Va. 62, 366 S.E.2d 68 (1988)
2. The cause of action must allege the following:
  - a) Existence of a contract where MCO agrees to provide competent medical services;
  - b) MCO breached contract by failing to provide qualified medical providers;
  - c) Causation; and
  - d) Damages. It is an open question in Virginia whether a patient can recover for pain and suffering in a breach of contract action arising from medical malpractice. *Glisson v. Loxley*, 235 Va. 62, 69, 366 S.E.2d 68, 72 (1988).
    - (1) In the non-health care context, Virginia has held that consequential damages may be recovered if the circumstances were contemplated by the parties. *Najla Associates, Inc. v. Griffith & Co.*, 253 Va. 83, 86-87, 480 S.E.2d 492, 494 (1997); *See generally Roanoke Hospital Assoc. v. Doyle & Russell Inc.*, 215 Va. 796, 214 S.E.2d 155 (1975).

3. Cases:

- a) *Yunker v. Kaiser Foundation Health Plan*, 460 Or. App. 165, 611 P.2d 314 (1980) Plaintiff alleged that the MCO breached their contract by failing to pay for treatment of his gallbladder condition. While the court dismissed the case, it opened the door for future cases by suggesting that liability may attach when plaintiff alleges that the MCO agreed to provide competent medical diagnostic services. *Id.* at 317-318 n. 3.
- b) *Williams v. Health America*, 535 N.E.2d 717 (Ohio App. 1987) Plaintiff alleged that her MCO breached their contract by failing to refer her to a specialist to treat her abdominal pain. Court re-characterized her cause of action as one arising in tort for failure to pay her claim in good faith.
- c) *McClellan v. HMO of Pa.*, 604 A.2d 1053 (Pa. Super. 1992) *aff'd* 686 A.2d 801 (Pa. 1996) Plaintiff sued physician and MCO alleging that the primary care physician was negligent in removing a mole without testing it for malignancy. The court held that the plaintiff's allegations that the MCO had a contractual duty to provide reasonably competent primary care physicians and referrals, and the allegation that the MCO breached the duty was sufficient to withstand a demurrer.

E. Breach of Fiduciary Duty: Allegation that the MCO's decision to deny care was tainted by self-interest.

1. A fiduciary relationship exists when special confidence has been reposed in one who in equity and good conscience is bound to act in good faith and with due regard for the interests of the one reposing the confidences. *Allen Realty Corp. v. Holbert*, 227 Va. 441, 318 S.E.2d 592 (1984).
2. While Virginia courts have not addressed directly whether a physician is a fiduciary, accountants (*Allen Realty Corp. v. Holbert*, 227 Va. 441 Va., 318 S.E.2d 592 (1984) and lawyers (*Martin v. Phillips*, 235 Va. 523, 369 S.E.2d 397 (1988)) have been found to be fiduciaries. It is likely that a physician meets the definition of a "fiduciary." The Virginia Supreme Court has recognized the physician patient relationship is a confidential relationship. *Diehl v. Butts*, 255 Va. 482, 489, 499 S.E.2d 833, 838 (1998). In *James v. Jane*, 221 Va. 43, 51, 282 S.E.2d 864, 867-68

(1980), the Court described the relationship in language evocative of a fiduciary one: “The physician owes his best professional efforts on behalf of the patient, and the patient expects, and has a right to expect, the same care and attention from the physician that he would receive if he were in a private hospital and the physician in private practice. The exercise by the attending physician of his professional skill and judgment in treating his patient, and the means and methods used, from the very nature of things are not subject to the control direction of others.”

3. Under Virginia common law, once a physician-patient relationship is created, the physician’s duties continue until the relationship is terminated. The physician may not terminate the relationship unless the patient has a reasonable opportunity to acquire the services of another physician. *Lyon v. Gethers*, 218 Va. 630, 634, 239 S.E.2d 103, 106 (1977).
4. Those who interfere with the a physician-patient relationship run the risk of incurring liability for tortious interference with the contractual relationship. MCOs, by placing limitations on treatments, may be liable for interfering with a fiduciary relationship. If the MCO is working in concert with an independent reviewer to interfere with the physician-patient fiduciary duty, a cause of action may exist for “conspiracy to breach fiduciary duties.”
5. In addition to interfering with the fiduciary relationships between patients and physicians, MCOs have fiduciary duties to their members. However, these duties appear in conflict with its objective of minimizing costs. To protect itself from liability for breaching its fiduciary duty to members, MCOs often use outside consultants to review health care decisions.
6. While ERISA tolerates conflicts of interest, the conflicts must not infect a fiduciary’s duty to act “solely in the interest of the participants and beneficiaries.” ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1).
7. Standard of review for denial of benefits:
  - a) By showing that the MCO has conflicting interests, the court may review the decision de novo instead of abuse of discretion, or at least give the MCO less discretion.

- b) De novo review is the appropriate standard for denial of benefits, unless the plan gives the administrator discretion. “Arbitrary and capricious” standard should not be applied on a wholesale basis. *Firestone Tire & Rubber v. Bruch*, 489 U.S. 101, 109 S.Ct. 948 (1989).
  - c) If the ERISA plan gives the administrator discretionary authority to determine eligibility for benefits, the decision should not be disturbed absent an abuse of discretion. *Murphy v. IBM*, 23 F.3d 719 (2<sup>nd</sup> Cir. 1987) cert. denied 513 U.S. 876 (1994). Because of the inherent conflicts of interest within the structure of an MCO, courts have been much less deferential to MCO decisions and have applied a “sliding scale” of deference depending on the extent of the conflict of interest. See *infra*.
8. In *Brown v. Blue Cross and Blue Shield of Alabama*, 898 F.2d 1556 (11<sup>th</sup> Cir. 1990) cert. denied. 898 U.S. 1040 (1991), the court reversed summary judgment finding that BC/BS had a conflict of interest by being both the administrator and insurer. BC/BS had the burden of proving that it was not tainted by self interest.
  9. In *Weaver v. Phoenix Home Life Mutual Insurance Company*, 990 F.2d 154 (4<sup>th</sup> Cir. 1993), the court refused to give deference to the plan’s decision to limit hospital stay where the case management reviewer refused to justify the decision.
  10. In *Salley v. E.I. DuPont de Nemours & Co.*, 966 F.2d 1011 (5<sup>th</sup> Cir. 1992), the court applied the abuse of discretion standard, but held that the administrator abused his discretion by failing to seek appropriate information.
  11. In *Herdrich v. Pegram*, 154 F.3d 362 (7<sup>th</sup> Cir. 1998), the court upheld a claim for breach of fiduciary duties. The court held that when an MCO refuses to pay for an ultrasound to diagnose a ruptured appendix, the MCO can be liable to the plan to reimburse the added medical costs incurred as a result of medical complications arising because of its failure to pay for the ultrasound.

F. Non-delegable duty.

1. When an entity assumes a duty and then delegates the duty to an independent contractor, the entity may be liable for the independent contractor’s negligence. See *Love v. Schmidt*, 239 Va. 357, 389

S.E.2d 707 (1990) (landlord's duty to maintain premises is non-delegable); *Richmond v. Branch*, 205 Va. 424, 428, 137 S.E.2d 882, 885 (1964) (holding the city's duty to maintain its streets is non-delegable).

2. Applied in 1922 in *Jenkins v. Charleston General Hospital & Training School*, 110 S.E. 560 (W.Va. 1922) *cf.* *Bagley v. Insight Comm. Inc.*, 658 N.E.2d 584, 586 (Ind. 1995). In *Jenkins*, the court found that the hospital's contractual duty to an employer to provide medical care was non-delegable and the hospital could not escape liability by labeling the negligent doctor as an independent contractor. Likewise in the landmark decision of *Stuart Circle Hospital Corp. v. Curry*, 173 Va. 136, 3 S.E.2d 153 (1939), the Court held that hospitals can be held liable for breach of contract to provide medical services, even if the breach was by an employee. This theory may apply to an MCO that contracts with physicians to provide care that the MCO is contractually bound to provide to patients. See Charles H. Baumberger, *Vicarious Liability Claims Against HMOs*, TRIAL, May 1998, at p.30.

G. Direct Negligence in the Utilization Review Process: MCOs frequently use utilization review committees to determine if and what treatments will be provided to members. The committees, like primary care physicians, make medical decisions as to whether a particular course of treatment is appropriate.

1. Under ERISA, the plan is not liable for damages arising from administrative decisions regarding the quantity of benefits provided, but can be held liable for damages for the quality of care provided. *Dukes v. U.S. HealthCare*, 57 F.3d 350 (3d Cir. 1995) *cert. denied* 516 U.S. 1009(1995). Most of the rulings in favor of the plaintiff since 1995 have been based on *Dukes*.
2. The Eastern District of Virginia has recognized a distinction between the quality and the quantity of benefits, but has also held that claims based on MCO incentive plans to keep costs down are preempted as administrative decisions regarding the quantity not quality of benefits. *Lancaster v. Kaiser*, 958 F.Supp. 1137 (E.D. Va. 1997).
3. Recently, the Connecticut federal district remanded a suit against an MCO holding that the plaintiff's allegations concern the quality of care, not the quantity of care. *Moscovitch v. Danbury Hospital*, 25 F.Supp.2d 74 (D. Conn. 1998). There, plaintiff's son, Nitai, was taken to Danbury Hospital after he attempted suicide. Soon

thereafter, his MCO transferred him to Norwalk's Vitam Youth Treatment Center, a drug treatment facility, where he committed suicide. The court recognized that the plaintiff was not alleging a negligent denial of care, but instead was suing based on the poor quality of the care provided.

4. In *Tolton v. American Biodyne Inc.* 48 F.3d 937 (6<sup>th</sup> Cir. 1995) the court held that the failure to provide in-patient psychiatric care based on utilization review procedures relates to an administrative decision regarding the quantity of benefits provided and is preempted.
5. In *Corcoran v. United Health Care Inc.*, 965 F.2d 1321 (5<sup>th</sup> Cir. 1992), the court held that when an MCO refuses to pay for more than 10 hours of home nursing despite doctor's request for 24 hour per day home nursing, the state law claim is preempted by ERISA.
6. *Wilson v. Blue Cross of Southern California*, 271 Cal. Rptr. 876 (Cal.App. 2 Dist. 1990) The MCO hired Western Medical to provide utilization review which refused to pay for further in-patient care of patient suffering from major depression. The patient subsequently committed suicide. Plaintiff alleged that as a result of a negligent medical review, MCO tortiously breached contract that caused him to be denied benefits and subsequent death.
  - a) Court found no public policy to immunize MCO.
  - b) Case is unique in that treating physician admitted his decision to discharge was based on insurance companies cost containment policy. Rarely will a physician admit his medical decisions are influenced by economics.

#### H. Misrepresentation/ False Advertising

1. A claim for misrepresentation may be made if the health plan misrepresents the standard or quality of care and the plaintiff can show detrimental reliance.
2. In *McClellan v. HMO of Pa.*, 604 A.2d 1053 (Pa. Super Ct. 1992), *aff'd* 686 A.2d 801 (Pa. 1996), the court permitted a claim containing the following allegations:
  - a) MCO solicited members and disseminated advertising containing misrepresentations of care, screening and review process for physicians, and access to specialists;

- b) MCO knew the information was misleading and untrue; and
- c) MCO knew the public would rely on the information to their detriment.

I. Negligent Retention/Supervision (Corporate Negligence or Negligent Credentialing)

- 1. Theory: MCO owes an independent duty to exercise reasonable care in selection physicians.
- 2. In *McClellan v. HMO of Pa.* 604 A.2d 1053 (Pa. Super Ct. 1992), the court found that the plaintiff must show that the MCO has undertaken:
  - a) To render services to plaintiff;
  - b) Services the MCO should recognize as necessary to the protection of the subscriber;
  - c) MCO failed to exercise reasonable care in selecting, retaining, and/or evaluating the primary care physician; and
  - d) MCO's failure to exercise reasonable care has increased the risk of harm to the subscriber.
- 3. U.S. District Judge Spencer recently recognized a cause of action for negligent retention in a discrimination suit. *Deci Call v. Shaw Jewelers*, Civ. No. 3:98CV449, VLW # 099-3-008 (E.D. Va. Jan. 7, 1999).

J. Breach of Warranty

- 1. Theory: MCO makes assurances of high quality of care through marketing material.
- 2. Cases:
  - a) *Pulvers v. Kaiser Foundation Health Plan*, 99 Cal. App.3d 560, 160 Cal. Rptr. 392 (1979): Plaintiff alleged breach of warranty based on literature assuring higher standard of care than non-negligence. Court found the assurances mere puffery. The assurances must be clear and unequivocal.

- b) *Boyd v. Albert Einstein Medical Center*, 547 A.2d 1229 (Pa. Super. Ct. 1987): The concurring opinion found that it is an issue of fact as to whether literature had been disseminated to plaintiff.

#### H. Racketeer Influenced and Corrupt Organizations Act (RICO)

1. RICO, 18 U.S.C. § 1961, *et. seq.* provides for criminal penalties and civil liability when entities or individuals engage in “predicate acts” determined to establish a pattern of racketeering activity. In the context of civil RICO, the most commonly alleged predicate acts are mail and wire fraud.
2. It has been recently held that health insurers are not insulated from civil RICO liability by the McCarran-Ferguson Act, 15 U.S.C. § 1012(b) which cedes regulations of insurance to the states. *Humana v. Forsyth*, \_U.S.\_, 119 S.Ct. 710 (Jan. 20, 1999). In so holding, the Supreme Court relied upon *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983) which held a state anti-discrimination law is not preempted by ERISA. *Humana* seems to suggest civil RICO claims against insurers and MCO’s will not be preempted by ERISA.
3. ERISA plans have been the subject of criminal RICO prosecutions. *See, e.g., United States v. Pieper*, 854 F.2d 1020 (7<sup>th</sup> Cir. 1988).
3. Civil RICO provides for an award of treble damages for injury to business or property and attorney fees. 18 U.S.C. § 1962. Personal injuries are not compensable under RICO. *Fleischhauer v. Feltner*, 879 F.2d 1290 (6<sup>th</sup> Cir. 1989), *cert. denied* 493 U.S.1074, *cert. denied* 494 U.S. 1027.
4. Civil RICO is a vehicle for invoking federal jurisdiction and pursuing a class action.

### III. ERISA - General Analysis

#### A. Introduction

1. Employee Retirement Income and Security Act of 1974 was signed on Labor Day with the expectation of giving employees “more benefits and rights and success in the area of labor management than almost anything in the history of this country ....” Remarks of President Gerald Ford on the Signing of HR 2, (Pub L No. 93-406, 88 Stat. 829), *The Employee Retirement Income and Security Act and Related White House and Labor Department Documents reprinted in ERISA PRACTICE AND PROCEDURE*, § 1:1 p. 1-1 (2<sup>nd</sup> Ed. 1996).
2. ERISA has been described as the most sweeping and comprehensive law regulating labor and benefits. *ERISA PRACTICE AND PROCEDURE*, § 1:1 p. 2-2 (2<sup>nd</sup> Ed. 1996).

#### B. Removal From State Court

1. “any civil action brought in a State court of which the district courts of the United States have original jurisdiction may be removed by the defendant or the defendants, to the district court of the United States . . .” 28 U.S.C. § 1441(b).
2. Removal is proper if there is a federal question which arises “under the Constitution, laws, or treaties of the United States.” 28 U.S.C. § 1331.

#### C. Well Pledged Complaint Rule

1. “cause of action arises under federal law only when the plaintiff’s well pleaded complaint raise issues of federal law.” *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987). Plaintiff is the “master of the complaint.” *Caterpillar v. Williams*, 482 U.S. 386, 398-99 (1987).
2. Federal cause of action does not normally arise by a making a federal defense to a state cause of action. *Rice v. Panchal*, 65 F.3d 637 (7<sup>th</sup> Cir. 1995).

- D. Complete Preemption Exception: If a state law claim has been completely displaced by federal law to the extent that the claim can properly be “re-characterized” as federal, then the claim is completely preempted by ERISA. *Rice, id.; Taylor*, 481 U.S. at 60 (extending complete preemption

doctrine to certain ERISA claims to make all suits that are cognizable under ERISA's civil enforcement provisions federal questions suits). For a more detailed analysis of ERISA preemption *see* Susan O. Scheutzow, *A Framework for Analysis of Erisa Preemption in suits against Health Plans and a Call for Reform*, 11 J.L. & HEALTH 195 (1996-1997).

1. Distinction from Conflict Preemption. There are two preemption issues facing most ERISA cases: complete preemption and ERISA or conflict preemption.
  - a. A case is completely preempted when the state law causes of action fit within the scope of ERISA's civil enforcement provisions including an action for the recovery of benefits under ERISA § 502, 29 U.S.C. § 1132 (*See infra* for a discussion of benefits). If the federal court, after removal, concludes that the malpractice suit is merely a suit alleging damages arising because of the denial of benefits, the case is completely preempted and the suit will most likely be dismissed under FED. R. CIV. P. 12(b)(6). A common standard for determining if the state law claim is simply a disguise for an ERISA claim, is whether the claim can be resolved without "referencing" the plan.
  - b. The second preemption issue, often called ERISA preemption derives from ERISA language stating the act "shall supersede any and all State laws insofar as they may now or hereafter **relate to** any employee benefit plan ..." ERISA § 514(a), 29 U.S.C. § 1144(a) (emphasis added). The meaning of the term "relate to" has been the subject of countless litigation. *See infra*.
  - c. The distinction is significant. "When the doctrine of complete preemption does not apply, the plaintiff's state claim is arguably preempted under § 514(a), the district court, being without removal jurisdiction cannot resolve the dispute regarding preemption. It lacks the power to do anything other than remand to the state court where the preemption issue can be addressed and resolved." *Dukes v. U.S. HealthCare*, 57 F.3d 350, 355 (1995), *cert.denied*, 115 S.Ct. 564 (1995). ERISA § 514 has been described as a defense to state law claims, but not a grounds for removal. *Moscovitch v. Danbury Hospital*, 25 F.Supp.2d 74 (1998).
  - d. There is an interplay between complete and conflict preemption. If a claim is completely preempted under §

502, it is necessarily preempted under § 514. But the reverse is not necessarily true. *Rice v. Panchal*, 65 F.3d 637, 646 n.10 (1995).

2. There is a presumption that Congress did not intend to supplant state law. *N.Y. State Conf. Of BC/BS Plans v. Travelers Insurance Co.*, 514 U.S. 645, 654 115 S.Ct. 1671, 1676 (1995). In examining a tax on HMOs, the *Travelers* Court looked beyond the text of ERISA, and examined the objectives of avoiding a multiplicity of regulation. The Court found an indirect economic effect on ERISA plans does not mean the statute “relates to” or has a “connection with” an ERISA plan. The Court reaffirmed a prior holding that preemption does not occur “if the state law has only a tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability.” *Id.* at 661, 115 S.Ct. at 1680. This decision has been interpreted as a major change in ERISA jurisprudence, and while the court did not directly overturn any prior decisions, the case makes broader interpretations of ERISA preemption less persuasive. The *Travelers* decision is analyzed in Karen A. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Preemption*, 13 YALE J. REGULATION 255 (1996).
3. A state cause of action relates to ERISA if the law “impinges on the functioning of an ERISA plan.” *Spain v. Aetna* 11 F.3d 129 (9<sup>th</sup> Cir. 1993) (note the decision was prior to the Supreme Court’s *Travelers* decision).

#### E. Savings Clause

1. The “savings clause” provides an exception for “any law of any State which regulates insurance, banking or securities.” ERISA § 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A).
2. The state law must not only have an impact on the insurance industry, “but must be specifically directed toward that industry.” *Pilot Life Insurance Co. v. Dedeax*, 481 U.S. 41, 54, 107 S.Ct. 1549, 1556 (1987). For an article discussing the impact of *Pilot Life*, on state common law bad faith actions see Theresa A. DiPaola, *Wrongful Denial of Health Insurance Benefits*, TRIAL, Mar. 1990, at 74.
3. District Court in Texas has held that a state law allowing individuals to sue health insurers for negligence in making health care decisions is not preempted by ERISA. *Corporate Health*

*Insurance v. Texas Department of Insurance*, 12 F.Supp.2d 597 (S.D. Tex. 1998).

4. The 6<sup>th</sup> Circuit has held that a plaintiff's state law claim of insurance bad faith was not saved from ERISA preemption. *Tolton v. American Biodyne*, 48 F.3d 937, 942 (6<sup>th</sup> Cir. 1995).

F. "Deemer" Clause

1. Text: "neither an employee benefit plan (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(B)(2)(b).
2. The "deemer clause" has the effect of restricting backdoor state regulation of ERISA.

G. Examples of State Law Claims Held Not Preempted

1. *Pappas v. Asbel*, \_\_\_ A.2d \_\_\_, 1998 WL 892074 (Pa. 1998) (finding that negligence claims against an HMO do not "relate to" an ERISA plan).
2. *Dukes v. U.S. HealthCare*, 57 F.3d 350, 358 (3d Cir. 1995), *cert.denied*, 115 S.Ct. 564 (1995), is the leading federal case making the distinction between quality and quantity of care. In dicta the court states that patients deserved to be free of medical malpractice regardless of whether or not they are insured through an ERISA plan.
3. *Independence HMO, Inc. v. Smith*, 733 F.Supp. 983 (E.D. Pa. 1990) The Eastern District of Pennsylvania has been one of the most active districts in holding that negligence claims against MCOs are not preempted.
4. *Miller v. Riddle Memorial Hospital*, No. Civ. A. 98-392, 1998 WL 272167 (E.D. Pa. May 28, 1998) Holding that negligence, agency, and ostensible agency claims for denial of skilled nursing care focused on the quality, not quantity of benefits and therefore did not "relate to" ERISA. The plaintiff did not plead that she was

entitled to the benefits under the plan and the complaint was otherwise devoid of mentioning the nature of the plan.

5. *Bauman v. U.S. HealthCare Inc.*, 1 F.Supp.2d 420 (D.N.J. 1998)  
The court applied the quality/quantity distinction in holding that claims for the negligent adoption of policies to discharge newborn infants and mothers within 24 hours of delivery, reckless indifference to the consequences of its policies, and negligently adopting policies that discourage re-admission of infants who develop complications are not preempted by ERISA.
6. *Ouellette v. Christ Hospital*, 942 F.Supp. 1160 (S.D. Ohio 1996)  
The court held that a claim based on limiting the hospital stay of subscribers, focused on the relationship between the hospital and the HMO, rather than the HMO and the patient, and is therefore distinct from a claim for benefits.

H. Examples of State Law Claims Held Preempted (note most ruling were before the Supreme Court's *Travelers* decision and hence may be less persuasive)

1. *Lancaster v. Kaiser Found. Health Plan*, 958 F.Supp. 1137 (E.D. Va. 1997) (widely cited case holding that the failure to establish appropriate guidelines is preempted as a claim for the denial of benefits).
2. *Corcoran v. United HealthCare, Inc.* 965 F.2d 1321 (5<sup>th</sup> Cir. 1992) (refusing to provide skilled nursing for high risk pregnancies is a suit for the denial of benefits and therefore preempted).
3. *Tolton v. American Biodyne, Inc.* 48 F.3d 937 (6<sup>th</sup> Cir. 1995) (denial of psychiatric treatment for suicidal patient who subsequently committed suicide preempted).
4. *Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8<sup>th</sup> Cir. 1993) (action alleging the negligent failure to pre-certify heart surgery is preempted as a suit for denial of benefits).
5. *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9<sup>th</sup> Cir. 1993) (applying an expansive interpretation of ERISA preemption).
6. *Cannon v. Group Health Services of Oklahoma, Inc.*, 77 F.3d 1270 (10<sup>th</sup> Cir. 1996) (claim for breach of contract and breach of fiduciary duties related to the improper processing of benefit claims for a bone marrow transplant).

7. *Danca v. Emerson Hospital*, 9 F.Supp.2d 27 (E. Mass. 1998)  
Without considering *Travelers* or *Dukes*, the court held that a claim for injuries arising from the denial of treatment at a psychiatric facility is a claim for the denial of benefits and is preempted by ERISA. Noting the tragic result of the case, the court in dicta expressed “[h]ad the Dancas sought the review of PHCS’s benefit determination before the injury occurred, alleging an imminent threat to life or health, this Court would have had the statutory authority to provide prospective relief for benefits allegedly due under the plan, perhaps averting this catastrophe.” *Id.* at 32.

#### I. Lessons Learned: Successful Approaches to Avoid Preemption

1. Allegations of Vicarious Liability: With very few exceptions, plaintiffs have consistently prevailed in motions to remand based on vicarious liability claims. Vicarious liability claims should include allegations of ostensible agency.
2. Quality v. Quantity Distinction: Ever since the *Dukes* decision, plaintiffs have been much more successful in actions against MCOs based on their direct negligence. The essence of the Motion for Judgment should challenge the appropriateness of medical decisions. The Motion for Judgment should not allege that the plan failed to pay for certain medical treatments but instead should focus on the poor quality of the medical decisions. *See Moscovitch v. Danbury Hospital*, 25 F.Supp.2d 74 (1998).
3. Claim does not “relate to” an ERISA plan. This approach is closely related to the quality v. quantity distinction. Following the path of the Supreme Court’s *Traveler’s* decision, the plaintiff should argue ERISA preemption should be construed narrowly, and as a rule of statutory construction, there is a presumption that Congress did not intend to preempt state laws. In successful cases the plaintiff drafted the claim with barely a mention of the ERISA plan.

#### IV. Exemptions from ERISA

##### A. Commerce Requirement:

1. In order for an employee benefit plan to be regulated by ERISA, the employer must be “engaged in commerce or in an industry or activity affecting commerce.” ERISA § 4(a)(1), 29 U.S.C. § 1003(a).

2. Commerce has been defined broadly and encompasses most every employee benefit plan.
- B. Government plans as defined in ERISA § 3(32), 29 U.S.C. § 1002(32):  
A plan is a government plan if the governmental agency has sufficient control over the employees. The IRS has issued a ruling that a retirement plan maintained by a volunteer fire department is not a governmental plan since the municipality does not have sufficient control over the company. Rev. Rul. 89-49, 1989-1 CB 117;
  - C. Church plans;
  - D. Plans maintained solely for the purpose of complying with applicable worker's compensation laws or unemployment compensation or disability insurance laws;
  - E. Plans maintained outside of the United States primarily for the benefit of non-resident aliens; and
  - F. Unfunded excess benefit plans - must be a separate plan in order to fall within the exception. *Farr v. U.S. West, Inc.* 15 Employee Benefits Cas. (BNA) 2322 (D. Or. 1992).

## V. Proceeding under ERISA

- A. Must exhaust remedies provided by the plan before filing a suit for benefits. *Coyne & Delaney v. BC/BS of Virginia*, 102 F.3d 712 (4<sup>th</sup> Cir. 1996).
- B. Available Remedies Under ERISA:
  1. Payment of benefits due. ERISA § 502(a)(1), 29 U.S.C. § 1132 (a)(1).
  2. Clarification of future rights and injunctions. ERISA § 502(a)(1), 29 U.S.C. § 1132 (a)(1). The court can issue a permanent injunction barring denial of future benefits, but the insured has the burden of demonstrating that her claim for benefits has merit and the denial of coverage was invalid. *Amoco Production Co. v. Village of Gambell*, 480 U.S. 531, 546 n.12 (1987).
  3. Breach of Fiduciary Duties: A fiduciary can be held liable for losses to the plan for breaching fiduciary duties. This provision allows for the plan, not individual beneficiaries to recover damages. ERISA § 409, 29 U.S.C. § 1109.

4. Other appropriate equitable remedies. ERISA § 502, 29 U.S.C. § 1132:
  - a) Compensatory damages are not available as equitable relief under ERISA. *LaFoy v. HMO Colorado*, 988 F.2d 97, 99 (10<sup>th</sup> Cir. 1993).
  
5. Attorney's Fees and Costs of Action
  - a) Discretionary with the court. ERISA § 502(g); 29 U.S.C. § 1132 (g).
  - b) Available to either party when services rendered by the attorney were beneficial and/or necessary to the administration of the fund. *Winpisinger v. Auror Corp.* 469 F.Supp. 782 (N.D. Ohio 1992).
  - c) Factors considered by the court: *Edmonds v. Hughes Aircraft Co.*, No. Civ. A 1:96-1368-A, 1998 WL 782016 (E.D. Va. 1998) (unpublished) *see Eaves v. Penn* 578 F.2d 453, 465 (10<sup>th</sup> Cir. 1978), *see also Salley v. DuPont de Nemours & Co*, 966 F.2d 1011 (5<sup>th</sup> Cir. 1992):
    - (1) Degree of culpability or bad faith
    - (2) Ability of opposing party to satisfy an award of attorney's fees
    - (3) Deterrent effect of awarding attorney's fees
    - (4) Merit of parties' positions
  - d) The quantum of attorney's fees awarded is controlled by factors including prevailing attorney's fees in the community, novelty of the matter, and time considerations. *Trimper v. City of Norfolk*, 58 F.3d 68, 73 (4<sup>th</sup> Cir. 1995) *cert. denied* 516 U.S. 997 (1995).
  
6. Right to a Jury Trial
  - a) ERISA does not provide a right to a trial by jury.
  - b) The Seventh Amendment guarantee to a right to jury trial does not for the equitable relief of recovering benefits. U.S. CONST. amend. VII.

C. Statute of Limitations

1. Action for breach of fiduciary duty: earlier of 6 years after the last action that constituted the breach or 3 years after plaintiff's knowledge of the breach.
2. Action not based on breach of fiduciary duty is controlled by the applicable state law.

D. Standards of Review - *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989).

1. "Arbitrary and Capricious:" applied when the plan reserves the discretion to construe and interpret benefits.
  - a) Court will uphold the plan's decision unless no reasonable basis existed at the time the decision was made or was made in bad faith.
  - b) Plan's decision will be upheld if the decision "is the result of a deliberate, principled reasoning process and if it is supported by substantial evidence." *Brogan v. Holland*, 105 F.3d 158 (4<sup>th</sup> Cir. 1997) (involving an action challenging pension plan trustees denial of disability retirement benefits).
  - c) The plan may give greater weight to its own consultants than the recommendations of the beneficiary's own doctors. *Sheppard & Enoch Pratt Hosp.*, 32 F.3d 120, 125 (4<sup>th</sup> Cir. 1994); *See also Marsteller v. Life Ins. Co. of North America*, 24 F.Supp.2d 593 (W.D. Va. 1998) (discussing the *Sheppard* decision).
  - d) Plan document must clearly articulate the reservation of discretion.
2. Sliding Scale Review: "The more incentive for the administrator or fiduciary to benefit itself by a certain interpretation of benefit eligibility or other plan terms, the more objectively reasonable the administrator or fiduciaries decision must be and the more substantial the evidence must be to support it." *Edmonds v. Hughes Aircraft Company*, No. Civ. A 1:96-1368-A, 1998 WL 782016 (E.D. Va. 1998) (unpublished), quoting *Ellis v. Metropolitan Life Insurance Co.*, 126 F.3d 228, 233 (4<sup>th</sup> Cir. 1997).

- a) *Doe v. Group Hospitalization & Medical Services*, 3 F.3d 80 (4<sup>th</sup> Cir. 1993) (less deference granted due to conflicts of interest).
  - b) In applying the “sliding scale,” the Fourth Circuit showed comparatively minimal deference to a medical report prepared at the request of the insurer in favor of the medical opinions prepared by treating physicians. *Edmonds v. Hughes Aircraft Co.*, No. 97-1431, 1998 WL 228200 (4<sup>th</sup> Cir. 1998) (unpublished).
  - c) A reviewing court considers the following factors in assessing the amount of discretion granted to the fiduciary or administrator. *Haley v. Paul Revere Life Insurance*, 77 F.3d 84, 89 (4<sup>th</sup> Cir. 1996); *see also*, RESTATEMENT (Second) TRUSTS § 187 cmt. d (1959).
    - (1) Scope of discretion granted by plan;
    - (2) Purpose of the plan provision in which discretion is granted;
    - (3) Any external standard relevant to the exercise of that discretion; and
    - (4) Any conflict of interest under which the administrator operates in making its decision.
3. “De novo” applied when there is no articulated standard within the plan and discretionary rights have not been expressly reserved.
4. Conflict of interest test analyzes the rights of the parties in light of common law conflict of interests and fiduciary duties:
- a) This test recognizes the inherent conflict of interest in the fiduciary decision making process.
  - b) If the insured can demonstrate a conflict of interest, the court should consider the conflict in evaluating whether there was an abuse of discretion. *Brown v. Blue Cross & Blue Shield of Alabama*, 898 F.2d 1556 (11<sup>th</sup> Cir. 1990) *cert. denied* 498 U.S. 1040 (1991); *Anderson v. Great White Life Insurance Co.* 942 F.2d 392 (6<sup>th</sup> Cir. 1991).

- c) Because insurance companies pay benefits out of their own assets, rather than the assets of a trust, it is in “perpetual conflict with its profit-making role as a business.” *Brown* at 1561.
  
- d) “[W]hen a plan beneficiary demonstrates a substantial conflict of interest on the part of the fiduciary responsible for benefits determinations, the burden shifts to the fiduciary to prove that its interpretation of the plan was not tainted by self-interest.” *Brown*, at 1566.