COMMENTARY

NEW HEALTH PLAN PROPOSALS DOOMED UNDER ERISA'S UMBRELLA

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HEALTH CARE
by Frank G. Lyle and J. Jeffrey Springer

When ABC's "Nightline" in September 1993 featured a discussion about President Clinton's proposed national health plan, one of the participants told the president about an experience she had with her insurance company after being admitted to a hospital. Although her doctor advised her to stay for several days, her insurance company informed her doctor that it would not pay for the future days recommended. The insurance company had determined that additional days were not "medically necessary."

The participant was appalled that her insurance company could tell her doctor how long she could be hospitalized. She asked the president who would be responsible for making this determination under his proposed health plan. To paraphrase the president's response, he indicated that the doctor would make this decision, not the insurance company.

This situation is not unique, however. The Employee Retirement Income Security Act of 1974 (ERISA) pre-empts state laws that would protect workers under their employee welfare benefit plans.

ERISA provides little deterrence to unfair claims practices, and in reality, encourages them. If ERISA is not modified or amended, and if most health insurance is provided to groups through employers, insurance companies will continue to have a license to deny claims that should be paid. Because the proposed national health plan is grounded on employer-sponsored insurance, unless changes are made, our national health care system as a whole will be void of any appropriate deterrence for the wrongful conduct so frequently encountered under the current system.

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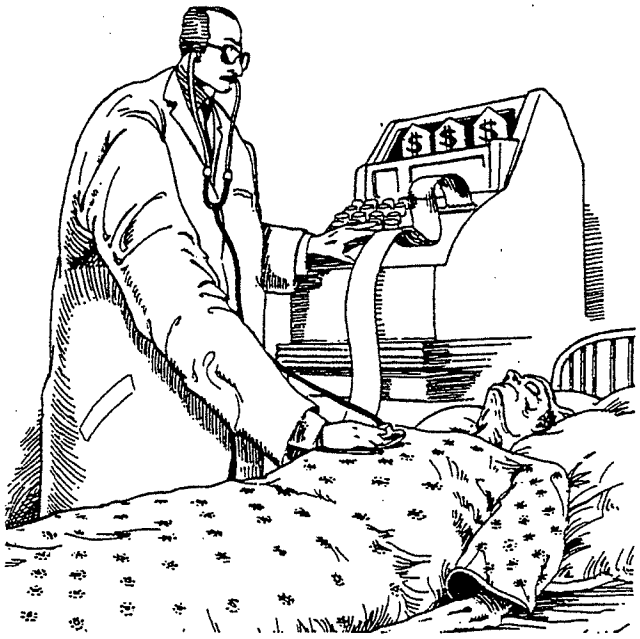
ERISA PRE-EMPTION

The Clinton administration is advocating a national health plan sponsored by employers. This is no secret. The significant question is whether this type of system will encourage quality medical care under existing federal law. A related question is what effect this system will have on each state's ability to regulate the practice of insurance.

Texas, for example, has at least four bodies of law that regulate the business of insurance: the Insurance Code, including a provision regulating Health Maintenance Organizations, the Administrative Code, the Business and Commerce Code and common law supported by Texas cases. These laws regulate all types of policies and practices, both at the marketing and claims levels. However, ERISA governs almost all claims for health insurance benefits arising under an employer-sponsored health plan.

The most notable exception to this general rule is ironic. Health plans that cover governmental employees are excluded from federal regulation. This means that employees of local, state and federal agencies can still seek the protection of state law. However, this is a relatively small class of individuals when compared to the entire national work force. Governmental employees constitute only 17 percent of the working population, according to July 1993 statistics from the U.S. Department of Labor.



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The issue of pre-emption is critical because it dramatically affects the type of action that an insured can bring against an insurance company. Under ERISA, an insured's cause of action is contractual in nature and is basically limited to seeking a recovery of benefits or enforcing rights under the terms of the health plan.

State law actions are usually more encompassing. For example, an insurance company in Texas would violate the Insurance Code if it failed to adopt and implement reasonable standards for prompt investigation of claims, or if it did not attempt in good faith to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. A plaintiff could bring a cause of action under the Business and Commerce Code if an insurance company represented that an insurance agreement conferred or involved rights, remedies or obligations that it did not. Under the Texas Health Maintenance Organization Act, a cause of action could be asserted against an insurance company that interfered with the practice of medicine. Under Texas common law, there exists a cause of action if an insurance company denies a claim or delays payment of a claim without a reasonable basis to do so.

Not only are fewer types of actions available under federal law, it is also much more difficult for an insured to prevail on the federal law claims.

In *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the Supreme Court held that plan administrators under ERISA are like trustees, whose discretionary actions are entitled to substantial deference in the courts. Under *Bruch*, so long as the plan provides the administrator with discretion, his actions are to be given deference in a suit to recover benefits or enforce rights under ERISA. Only non-discretionary decisions are reviewed de novo. The majority of courts also have agreed that no jury trial is available under ERISA.

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The most shocking example of how the federal system differs from most state systems concerns disputes over how an insurance policy should be interpreted. Under Texas law, ambiguous language in an insurance policy must be construed in favor of coverage.

On the other hand, under ERISA it is not even enough for the insured to go one step further and prove that his interpretation of the policy is correct. Instead, the insured must prove that the administrator abused his discretion or was arbitrary and capricious in interpreting the policy. The strictness of this burden of proof may easily result in a summary judgment for the insurance company. Therefore, given identical fact situations, a non-ERISA claimant may prevail as a matter of law in a state system, while the ERISA claimant could lose as a matter of law in the federal system.

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FEDERAL REMEDIES INADEQUATE

Why does it matter whether state laws can be used to regulate the insurance industry? If there is a remedy available under federal law, one would think that it would afford adequate protection to insureds under a health plan. Unfortunately, it is clear that ERISA was enacted with little concern for its effect on the insurance industry's treatment of insureds.

Remedies under ERISA are primarily limited to the cost of benefits wrongfully denied, plus discretionary attorneys' fees.

The federal statute does not provide remedies to plan participants for consequential damages such as lost wages or other out-of-pocket expenses, or extra-contractual damages such as physical pain and suffering, mental anguish and loss of earning capacity. And even when an insurance company's conduct is egregious or outrageous, there is no provision for exemplary damages.

Texas law, on the other hand, will afford a jury the opportunity to compensate an individual for all of the actual damages sustained when an insurance company wrongfully denies a claim for benefits. Texas law acknowledges the potential for exemplary damages when an insurance company knowingly commits a statutory violation, acts with malice, commits fraud or is consciously indifferent to the rights, safety or welfare of the persons affected.

The 5th Circuit case of *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), provides an example of the inadequacy of federal remedies. Florence Corcoran was an employee of South Central Bell Telephone Co. in Louisiana. She had health insurance through a self-funded plan provided by her employer. The plan itself was administered by Blue Cross and Blue Shield. The utilization review component of the plan was administered by United Healthcare Inc. Because Mrs. Corcoran did not work for a governmental agency, and because other exceptions to pre-emption did not apply, her health plan was governed by ERISA.

Mrs. Corcoran became pregnant while insured under the plan. Her obstetrician classified her condition as a high-risk pregnancy and recommended complete bed rest during the final months of her term. Her doctor eventually recommended hospitalization through delivery so the fetus could be monitored at all times.

United Healthcare refused to pre-certify the hospitalization. The dilemma posed was foreseeable: Mrs. Corcoran could follow her doctor's orders and be totally responsible for the medical costs, or she could trust that United's decision to furnish in-house nursing for part of the day would provide her with sufficient medical attention. Although Mrs. Corcoran had already entered the hospital, she left a few days later after learning of United's decision. A nurse was hired and Mrs. Corcoran remained at home. Unfortunately, her fetus went into distress and died while the nurse was off duty.

Louisiana law provides parents with a cause of action for the wrongful death of their unborn children. The law in this case however, was pre-empted by ERISA.

In addition to not having any remedy under state law, Mrs. Corcoran did not have an adequate remedy under federal law. The remedy provided by ERISA is essentially nothing more than recovery of policy benefits. Although she potentially had a viable claim for benefits, this claim was rendered meaningless with the loss of her child, as pointed out by the court. Because Mrs. Corcoran's claim for emotional distress was not a claim to recover benefits under the terms of her insurance policy, she could not be compensated under ERISA.

The *Corcoran* case presents a tragic fact situation that highlights a significant point. An employer-sponsored health plan triggers federal regulation that results in pre-emption. But for a plan that is established or maintained by an employer or employee organization, there is no federal regulation and there is no pre-emption. Had Mrs. Corcoran's policy been a private policy or one that fell within an exception to ERISA, Louisiana state law would have provided her with a meaningful remedy.

As is apparent, employer-sponsored health plans that are governed by ERISA do not encourage fair and reasonable claims-handling practices by the insurance industry. The *Corcoran* court concluded:

> 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 decision making. 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 . . . .
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> . . . While we are confident that the result we have reached is faithful to Congress's intent neither to allow state law causes of action that relate to employee benefit plans nor to provide beneficiaries in the Corcoran's 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.

UNFAIR CLAIMS PRACTICES

We are of the opinion that ERISA is used by the insurance industry as a tool to deny valid claims. In most instances, the worst that can happen to an insurance company is that it can eventually be made to pay the claim it denied. A recovery of attorneys' fees is discretionary, and the statute was not drafted to compensate individuals for other elements of actual damage.

Since limited relief for claimants is coupled with difficulty in prevailing under the federal statute, insurance companies are encouraged to write policies that will be governed by ERISA. In other words, it is advantageous to offer polices through employers rather than to individuals. By the same token, ERISA encourages companies to stop writing individual policies. In fact, Aetna stopped selling individual health insurance products in 1990.

In reviewing complaint files at the Texas State Board of Insurance, we discovered a letter written by an Aetna claims supervisor to a physician in Houston. The doctor's complaint addressed Aetna's refusal to pay for hospital days that the doctor believed were medically necessary. The portion of the letter quoted below indicates the insurance company's awareness of the pre-emption issue:

> In your letter you indicated you advised [the patient] to seek an attorney to sue Aetna. Your patient is covered by a self-funded medical plan that is administered by Aetna Insurance Company. Their right to appeal is explained in their document under ERISA Regulations. *A self-funded plan is not regulated by state legislation.* [Emphasis added.]

Although this letter was written by a claims supervisor with Aetna, we have experienced this sophistication of understanding at all employee levels with most insurance carriers. If an insurance company can argue that a health plan is governed by ERISA, it will. In the case of employer-sponsored group health plans, the argument will almost always prevail. And once ERISA comes into play, the insurance company has the upper hand in negotiating its members' health care. ■