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Holding an HMO Fully Accountable: ERISA Preemption and How to Avoid It
The potential client has just left your office, and you can hardly believe your good fortune.

He's asked you to file a lawsuit against an HMO that denied him medical care. The treatment he had sought was urgently needed, and clearly was covered under the terms of the benefit handbook issued by the HMO.

Your head is already dizzy with visions of a seven-figure judgment against a deep-pocket defendant that a jury is sure to despise. But then it hits you -- the prospective client's HMO coverage was provided by his employer. You're not certain, but you think that means that his damages could be severely limited by the Employee Retirement Income Security Act [29 USC § 1001 et seq.], commonly known as ERISA. In fact, ERISA could ultimately preclude recovery of any emotional distress or punitive damages, leaving your potential client with little to recover beyond the benefits the HMO should have paid.

So now what? Do you turn down the case? Or do you grudgingly accept it, even though it seems to have plummeted from a seven-figure case to a four or five-figure one? Or is there some way for you to circumvent ERISA and, in the process, protect your prospective client's right to recover all damages caused by the HMO's cavalier denial of medically necessary treatment?

The following highlights several approaches that may prove useful in your efforts to avoid the chilling effects of ERISA and preserve your client's right to recover civil damages from his HMO.

WHAT IS ERISA?

ERISA is a federal regulatory scheme enacted in 1974 in an effort to control fiduciary looting of company or union pension plans which left thousands of retired Americans stripped of the pension benefits they had accumulated after decades of work. [29 U.S.C. section 1001; *Massachusetts v. Morash* (1989) 490 U.S. 107, 115, 109 S.Ct. 1668, 1673]. Although originally enacted to prevent pension plan abuses, ERISA also applies to all employee benefit "plans", including health care coverage benefits, even when there is no formal "plan" established and even when the health care benefits are provided through the purchase of a group insurance policy [*Pilot Life Ins. Co. v. Dedeaux* (1987) 481 U.S. 41, 107 S.Ct. 1549].

WHAT REMEDIES ARE AVAILABLE IF ERISA APPLIES?

Determination of whether an action is subject to ERISA preemption is critical because of the limited remedies available under ERISA [29 U.S.C. 1132]. The courts almost universally conclude that remedies in connection with an ERISA-preempted insurance policy, healthcare plan or self-insured benefit plan are limited to the benefits owed and, in the court's discretion, reasonable attorney's fees. No matter how egregiously the insurer treated its insured, that insured cannot recover consequential damages, emotional distress damages or punitive damages if his suit is subject to ERISA [*Mass. Mut. Life Ins. Co. v. Russell* (1985) 473 U.S. 134, 142-144, 105 S.Ct. 3085, 3090; *Mertens v. Hewitt Assoc.* (1983) 508 U.S. 248, 113 S.Ct. 2063, 2069].¹

WHAT ARE SOME OF THE WAYS TO AVOID ERISA PREEMPTION?

To assess whether a policy is subject to ERISA preemption, it must first be determined whether there is "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 . . . benefits in the event of sickness, accident, disability, death or unemployment . . ." [29 U.S.C. section 1002(1)].

The insurer has the burden of proving the facts necessary to establish the existence of an ERISA "plan". *Kanne v. Connecticut General Life Insurance Co.* (9th Cir. 1988) 867 F.2d 489, 492, n. 2, cert. denied, 492 U.S. 906 (1989); see also *Zavora v. Paul Revere Life Ins. Co.* (9th Cir. 1998) 145 F.3d 1118, 1120, n.2. As a practical matter, though, most courts will determine that a benefit is part of an ERISA "plan" if the benefit is provided through employment.

That does not mean, however, that there are no potential ways to circumvent ERISA when suing an HMO. Here are a few:

California's New HMO Liability Statute

Effective January 1, 2001, California Civil Code section 3428 imposes liability against an HMO that fails to furnish covered benefits. Under the statute, an HMO owes its members a duty of ordinary care to arrange for the provision of "medically necessary" health care services as provided under the HMO plan [Civil Code § 3428(a)]. And an HMO is liable for "any and all harm" caused by its breach of that duty where (1) the breach results in the denial, delay or modification of care recommended for, or furnished to, a member² and (2) the member suffers "substantial harm"³ [Civil Code § 3428(a)]. Moreover, recoverable damages include, but are not limited to, the tort damages set forth in Civil Code § 3333 ("all detriment proximately caused" by the breach of duty), such that emotional distress damages and, presumably, punitive damages may be recovered [see Civil Code § 3428(j)].

But what about persons whose HMO plans are provided by their employers? Will they be able to impose statutory liability on their HMOs, or will such liability be preempted by ERISA? If the California Legislature has its way, ERISA will not bar employees from suing their HMOs under the new law or limit the damages they can recover in such a suit.

More specifically, the California Legislature has declared that, at least for purposes of statutory liability under Civil Code § 3428, HMOs "are engaged in the business of insurance . . . as that term is defined for purposes of the McCarron-Ferguson Act" [Statutory notes to Civil Code § 3428 (emphasis added)]. This is critical for purposes of ERISA, since ERISA preempts state laws related to employee benefit plans except those laws that "regulate insurance" [29 USC § 1144(B)(2)(A)] -- and a state law "regulates insurance" if it (1) is specifically directed toward the insurance industry and (2) fits within the "business of insurance" as that phrase is used in the McCarron-Ferguson Act [15 USC §1011 et seq.; see also *UNUM Life Insurance Co. of America v. Ward* (1999) 526 U.S. 358, 119 S.Ct. 1380, discussed *infra*].

Thus, the California Legislature's clear goal is to protect the new HMO liability statute from ERISA exemption. And to remove any doubt, the Legislature has declared that its intention is "to ensure that adequate state law remedies exist for all persons who are subject to the wrongful acts of those entities that contract to provide insurance for the life, health and disability of California citizens" [Statutory notes to Civil Code § 3428 (emphasis added)]. Nevertheless, it remains to be seen whether such legislative recitals will be enough to avoid ERISA preemption.

The U.S. Supreme Court's Decision in *UNUM v. Ward*

There is a recent indication by the United States Supreme Court that it will be receptive to arguments against ERISA preemption. In *UNUM Life Insurance Co. of America v. Ward* (1999) 526 U.S. 358, 119 S.Ct. 1380, 1390, n. 7, the Court noted that the Solicitor General of the United States -- on whose brief the Court had based its ruling in *Pilot Life*⁴ that ERISA is the exclusive remedy for state law causes of action for bad faith -- had changed its position on that issue. Although the Court concluded in *Ward* that it "need not address the Solicitor General's current argument" because *Ward* was suing under ERISA (for benefits due) rather than trying to circumvent it, the case at least suggests that the Court may be open to reconsidering its decision in *Pilot Life*.

And the federal district courts concur. In recent months, district court judges in Colorado⁵ and Oklahoma⁶ have relied on *Ward* in ruling that ERISA does not preempt a bad faith cause of action by an insured under a group insurance policy. In so holding, those courts distinguished *Pilot Life Ins. Co. v. Dedeaux* (1987) 481 U.S. 41, 107 S.Ct. 1549, wherein the U.S. Supreme Court had held that Mississippi's bad faith law was preempted by ERISA because it imposed liability against both insurance and non-insurance entities (and therefore did not "regulate insurance" within the meaning of ERISA's "savings clause" [29 USC § 1144(B)(2)(A)] so as to avoid preemption). Conversely, Colorado and Oklahoma limit the cause of action to the insurance industry⁷ -- and so does California.

More specifically, the California Supreme Court has repeatedly held that claims for tortious breach of the implied covenant of good faith and fair dealing (i.e., bad faith) can only be brought in cases involving insurance contracts. For example, the Court held in *Foley v. Interactive Data Corp.* (1988) 47 Cal.3d 654, 684, 254 Cal.Rptr. 211, 228 that it is only "in the context of insurance contracts where . . . breach of the implied covenant will provide the basis for an action in tort (emphasis added). And just last year, the Court reiterated that "compensation for [breach of the implied covenant] has almost always been limited to contract rather than tort remedies" and that "at present, this court recognizes only one exception to that general rule: tort remedies are available for a breach of the covenant in cases involving insurance policies [*Cates Construction Inc. v. Talbot Partners* (1999) 21 Cal.4th 28, 43, 86 Cal.Rptr.2d 855].

Thus, unlike the Mississippi law construed in *Pilot Life* (which allowed tortious bad faith claims in a variety of contexts and therefore did not "regulate insurance"), California's bad faith tort is only available in the insurance arena. For that reason, California's bad faith law should be found to "regulate insurance" and therefore be "saved" from ERISA preemption.

Vicarious Liability

Numerous courts have held that ERISA preempts vicarious liability claims that are based on denial of benefits under an ERISA plan. For example, in *Jass v. Prudential Health Care Plan, Inc.* (7th Cir. 1996) 88 F.3d 1482, 1489, the Court held that ERISA preempted a suit alleging that an ERISA plan administrator's employees or adjusters failed to properly investigate a claim and wrongfully denied benefits due.

But courts are split on whether ERISA preempts vicarious liability claims against a plan administrator based on the quality of care provided by affiliated health care providers (e.g., a claim that an HMO was negligent in selecting or supervising physicians rendering care to its members and therefore is liable for their malpractice). The leading case on this issue is *Dukes v. U.S. Healthcare* (3rd Cir. 1995) 57 F.3d 350, in which the court determined that an HMO was vicariously liable for the professional negligence of the medical providers it selected under the plan and that such liability was not preempted by ERISA. Other cases holding that malpractice claims against HMOs are not preempted by ERISA include:

Chaghervand v. Carefirst, 909 F.Supp. 304 (D. MD 1995)

Dearmas v. Hechavarria, 865 F.Supp. (S.D. FL 1994)

Dykema v. King, 959 F.Supp. 736 (D. S.C. 1997)

Edelen v. Osterman (D.C. 1996) 943 F.Supp. 75

Elsesser v. Hospital of the Philadelphia College, etc., et al. (E.D. Pa 1992) 802 F.Supp 1286

Haas v. Group Health Plan, Inc. (S.D. IL 1994) 875 F.Supp. 544

Independence HMO, Inc. v. Smith (E.D. Pa 1990) 733 F.Supp. 983

Jackson v. Roseman (D. Md 1995) 878 F.Supp. 820

Kearney v. U.S. Healthcare (E.D. Pa 1994) 859 F.Supp. 182

Ouellette v. Christ Hospital (S.D. Oh 1996) 942 F.Supp. 1160

Pacificare of Oklahoma, Inc. v. Burrage (10th Cir. 1995) 59 F.3d 151

Prihoda v. Shpritz (D. Md 1996) 914 F.Supp. 113 [ERISA does not "completely" preempt vicarious liability claim]

Rice v. Panchal (7th Cir. 1995) 65 F.3d 637

Roessert v. Health Net (N.D. Ca 1996) 929 F.Supp. 343

Sanitoro v. Evans (E.D.N.C. 1996) 935 F.Supp. 733

Smith v. HMO Great Lakes (N.D. IL 1994) 852 F.Supp. 669

Other Grounds for Circumventing ERISA

An independent contractor is not an "employee" and is therefore not subject to ERISA preemption [Nationwide Mut. Ins. Co. v. Darden, 503 U.S. 319, 327, 112 S.Ct. 1344, 1350 (1992); Barnhart v. New York Life (9th Cir. 1998) 141 F.3d 1310.8

A government employee or the employee of a public agency is exempt from ERISA [29 U.S.C. section 1003(b); 29 U.S.C. section 1002(32)].

Employees of churches or church-operated businesses are exempt from ERISA [29 U.S.C. section 1003(b)].

Sole proprietors, partners, and their spouses are exempt, so long as the business does not provide benefits under the policy to a common-law employee [See 29 C.F.R. sections 2510.3-3(b)(1) and (c)(1)]. In *Robertson v. Alexander Grant & Co.* (5th Cir. 1986) 798 F.2d 868, the Court relied on those regulations in "[f]inding ERISA inapplicable to plans covering only partners". Similarly, in *Meredith v. Time Insurance Co.* (5th Cir. 1993) 980 F.2d 352, the court held that "an insurance plan purchased by a sole proprietor, covering only herself and her spouse, [does not] constitute . . . an employee welfare benefit plan' as that term is defined in ERISA".⁹ Further, in *Fugarino v. Hartford Life & Acc. Ins. Co.* (6th Cir. 1992) 969 F.2d 178, the Court held that a business owner is exempt from ERISA, stating that "a plan whose sole beneficiaries are the company's owners cannot qualify as a plan under ERISA". And in *Slamen v. Paul Revere Life Insurance Co.* (11th Cir. 1999) 166 F.3d 1102, 1104, the Court stated that "in order to establish an ERISA employee welfare benefit plan, the plan must provide benefits to at least one employee,¹⁰ not including an employee who is also the owner of the business in question", and thus that ERISA does not apply where "the disability insurance policies at issue were for the sole interest and benefit of the plaintiff, and not his employees".

But even if the insured is a partner or other non-employee and the policy covers only him, the insurer may argue that his claims are nevertheless subject to ERISA because his policy is part of an overall company benefit plan that included other policies which did cover employees. This argument was made -- and soundly rejected -- in *Slamen v. Paul Revere Life Insurance Co.* (11th Cir. 1999) 166 F.3d 1102, wherein the Court was faced with a dentist who purchased a disability policy covering only himself and health and life insurance policies covering both himself and his employees. The Court held that the disability policy was not an ERISA plan because it only covered the dentist. Significantly, the Court was "not persuaded by Paul Revere's argument that ERISA . . . applies here because Slamen had in place other insurance for his employees Non-ERISA benefits do not fall within ERISA's reach merely because they are included in a multibenefit plan along with ERISA benefits". Similarly, in *Rand v. The Equitable Life Assur. Society of the U.S.* (E.D.N.Y. 1999) 49 F.Supp.2d 111, the plaintiff was a partner who purchased various disability policies, and his partnership provided a group health insurance policy for all its employees. The Court held that "the plaintiff's disability insurance policies, which are not covered by ERISA, are not converted into an ERISA plan merely because the plaintiff's employees received unrelated health insurance".¹¹

Some courts have suggested that a plan is not "established or maintained" by an employer [29 U.S.C. section 1002(1)] unless the employer intended to create an ERISA plan.¹² Other courts have indicated that an employer has "established or maintained" an ERISA plan only if it actively participated in the design and operation of the plan, directly controlled the day-to-day operation of the plan, exercised substantial discretion over the plan, and/or established a separate administrative scheme to manage the plan.¹³ Still others have found that the "established or maintained" requirement may not be met even if the employer was significantly involved in the administration of the plan.¹⁴ Certain others have indicated that an ERISA plan has not been "established" where the insurer failed to comply with ERISA's reporting and disclosure requirements and failed to mention ERISA in policy documents, brochures and letters.¹⁵ And a few others have held that the "is maintained" requirement implies that the plan must be in current operation,¹⁶ and thus that ERISA does not apply where the former employer has sold his business and stopped contributing to the plan¹⁷ or has gone bankrupt and ceased any involvement in the plan.¹⁸

Plans that fall under the Department of Labor's "safe harbor" regulations [29 C.F.R. 2510.3-1(j)] are exempt from ERISA. The regulations generally state that ERISA is inapplicable where (1) the employer does not "endorse" the program;¹⁹ (2) employee participation is completely voluntary; (3) premiums are paid entirely by the employee;²⁰(4) the employer's sole functions are to permit the insurer to publicize the program, collect the premiums through payroll deductions, and remit the premiums to the insurer; and (5) the employer

receives no consideration, except reasonable compensation for collecting and remitting the premiums. Significantly, however, some courts have found the "safe harbor" regulations applicable despite employer activities far beyond those permitted by the regulations. See Garrett and Johnson, supra.

CONCLUSION

It is hardly surprising that HMOs are aggressively denying claims subject to ERISA, since the most a member can recover in an ERISA action (assuming he prevails) is the benefits the HMO should have paid in the first place and -- if the court is feeling generous -- reasonable attorney's fees. Indeed, the courts are expressly recognizing that "it is entirely predictable that insurers will go overboard to minimize claims" that are preempted by ERISA, since they are "without any statutory or other legal deterrent"²¹ to act to the contrary.

Thus, it is imperative that consumer lawyers persist in their efforts to elude ERISA. Only if HMOs are faced with the prospect of bad faith liability and punitive damages will they have any deterrent against treating their members unfairly and inequitably. And only if attorneys continue to trumpet the inequities of ERISA will the courts conclude that preemption provides HMOs with the wrong incentive -- the incentive to minimize or deny valid claims by their members.

1. However, one line of cases has held that damages are properly recoverable under ERISA based on language in the U.S. Supreme Court's opinion in *Ingersoll-Rand Co. v. McLendon*, 498 U.S. 133, 139, 111 S.Ct. 478, 483. In that case, an employee sought compensatory and punitive damages for his employer's tortious termination of his employment just before his plan benefits would have vested [498 U.S. at 136, 111 S.Ct. at 481]. The Supreme Court stated that "[I]t is clear that the relief requested here is well within the power of federal courts to provide" [498 U.S. at 145, 111 S.Ct. at 486]. This language was authored by Justice O'Connor, the same Justice who only three years earlier penned the landmark decision in *Pilot Life Ins. Co. v. Dedeaux* (1987) 481 U.S. 41, 107 S.Ct. 1549. Based on *Ingersoll-Rand*, some courts have concluded that consequential and punitive damages are meant to be recoverable under ERISA [see., e.g., *Weems v. Jefferson-Pilot Life Ins. Co., Inc.* (Ala. 1995) 663 So.2d 905, 911, *Haywood v. Russell Corp.* (Ala. 1991) 584 So.2d 1291, *East v. Long* (N.D. Ala. 1992) 785 F.Supp. 941, 944; *International Union, United Auto., Aerospace & Agricultural Implement Workers v. Midland Steel Prods. Co.* (N.D. Ohio 1991) 771 F.Supp. 860, and *Lawrence v. Jackson Mack Sales, Inc.,* (S.D. Miss. 1992) 837 F.Supp. 771]. At present, however, that is far from the majority view.

2. The care need not have been recommended or furnished by one of the HMO's in-plan providers. It may have been recommended by any health care provider, as long as the recommendation was within the scope of the provider's practice [Civil Code § 3428(b)(2)].

3. "Substantial harm" means loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss [Civil Code § 3428(b)(1)].

4. *Pilot Life Ins. Co. v. Dedeaux* (1987) 481 U.S. 41, 107 S.Ct. 1549.

5. *Hall v. UNUM Life Ins. Co. of America*, U.S. District Court for the District of Colorado, Case No. 97-M-1828, November 1, 1999 Order by Chief Judge Richard S. Matsch Granting Motion For Leave To File Amended And Supplemental Complaint Adding Third Claim For Relief. Note that although the unpublished order did not expressly reference the Supreme Court's decision in *Ward*, the order was issued in response to a motion (for leave to file an amended and supplemental complaint) that had been based solely on *Ward*.

6. *Lewis v. Aetna U.S. Healthcare, Inc.* (N.D. Ok. 1999) 78 F.Supp.2d 1202.

7. For example, in Oklahoma the tort of bad faith is "specific to the insurance industry" [Lewis, 78 F.Supp.2d

at 1215], "applie[s] exclusively to contracts between insurance companies and their insureds" [Id. at 1212] and "has never been extended beyond the insurance area" [Id. at 1208].

8. But if the independent contractor obtains insurance benefits through the same group plan that covers employees of the company, the court may determine that he is a "participant" and that his claims are preempted [See *Harper v. American Chambers Life Ins. Co.* (9th Cir. 1990) 89 F.2d 1432, 1434].

9. And this result does not change simply because the sole proprietor is incorporated and pays the premiums through his professional corporation. In *Slamen v. Paul Revere Life Insurance Co.* (11th Cir. 1999) 166 F.3d 1102, 1106, n. 4, the court rejected the insurer's argument that the disability policy was preempted by ERISA because the premiums were paid by the dentist's professional corporation rather than the dentist as an individual. The Court reasoned that the professional corporation was wholly owned by the dentist, that he could not be considered an employee of the corporation he owned, and that the insurer would still "have to show that an employee other than [the dentist] received benefits under the disability insurance policy" in order to trigger ERISA. This holding was cited with approval in *Rand v. The Equitable Life Assur. Society of the U.S.* (E.D.N.Y. 1999) 49 F.Supp.2d 111.

10. Similarly, in *Donovan v. Dillingham* (11th Cir. 1982) 688 F.2d 1367, 1371, the court held that a "plan . . . falls within [the] ambit of ERISA only if the plan . . . covers ERISA participants because of their employee status in an employment relationship."

11. Similarly, in an unpublished memorandum opinion, the Ninth Circuit held in *Zeiger v. Zeiger* (9th Cir. 1997) 131 F.3d 150, that "a non-ERISA plan is not converted into an ERISA plan merely because an employer also sponsors a separate benefits plan subject to ERISA".

12. See *Kanne v. Connecticut General Life Ins. Co.* (9th Cir. 1988) 867 F.2d 489, 493; *Stanton v. Paul Revere Life Ins. Co.* (S.D. Cal. 1999) 37 F.Supp.2d 1159; *Hansen v. Continental Ins. Co.* (5th Cir. 1991) 940 F.2d 971, 978.

13. See *Hansen*, 940 F.2d at 978; *Johnson v. Watts Regulator Co.* (1st Cir. 1995) 63 F.3d 1129, 1134; *Elco Mechanical Contractors, Inc. v. Builders Supply Assoc. of West Virginia* (S.D. W. Va. 1993) 832 F.Supp. 1054, 1057-1058; *Taggart Corp. v. Life and Health Benefits Administration, Inc.* (5th Cir. 1980) 617 F.2d 1208, 1210; and *Sindelar v. Canada Transport, Inc.* (Neb. 1994) 520 N.W.2d 203, 207.

14. See *Zavora v. Paul Revere Life Ins. Co.* (9th Cir. 1998) 145 F.3d 1118, 1121; *du Mortier v. Massachusetts General Life Ins. Co.*, supra (C.D. Cal. 1992) 805 F.Supp. 816, 821; *Garrett v. Delta Air Lines, Inc.* (N.D. Ind. 1978) 1978 U.S. Dist. LEXIS 16460 and *Johnson*, supra, 63 F.3d 1129.

15. See *du Mortier and Johnson*, supra.

16. See *Stanton*, supra (S.D. Cal. 1999) 37 F.Supp.2d 1159.

17. *Loudermilch v. The New England Mutual Life Ins. Co.* (S.D. Ala. 1996) 942 F.Supp. 1434.

18. *Mizrahi v. Provident Life and Accident Ins. Co.* (S.D. Fla. 1998) 994 F.Supp. 1452.

19. "Endorsement of a program requires more than merely recommending it". *Johnson v. Watts Regulator Co.* (1st Cir. 1995) 63 F.3d 1129, 1136.

20. The mere fact that the employer gave employees the option of using a portion of their pre-tax salary to

purchase plan benefits does not mean that it contributed to the payment of plan premiums. See *Hrabe v. Paul Revere Life Insurance Company* (M.D. Ala. 1996) 951 F.Supp. 997, 1001.

21. *Dishman v. UNUM Life Ins. Co. of America* (C.D. Cal. 1997) 1997 WL 906146.