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HEALTH LAW

ERISA: A Close Look at Misguided Legislation

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The Employee Retirement Income and Security Act (ERISA) was enacted in 1974 primarily to address concerns about the solvency of pension funds and whether employees would get the retirement benefits their employers had promised [1]. There was an additional worry that those responsible for investing the funds did not always act in the best interests of employees and that state laws did not provide uniform remedies.

Although pension funds were ERISA's primary target, the legislation was broad and incorporated "employee *welfare* benefit plans" into its regulations, thereby including "medical surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment…" [2]. The reason for incorporating health benefits into the law was to ensure that these funds were also safeguarded and that employees had access to information about them.

The protection of employer-sponsored health benefits to ensure adequate coverage of medical expenses is a worthy aim. When ERISA was enacted, employers were routinely offering health benefits to entice employees. Regulation of insurers, however, differed from state to state, so one objective of the legislation was to place employer-sponsored benefit plans under a single regulatory scheme—and ERISA did that. The effect of the law, though, was to exclude these health benefit plans from much of the state law enforcement that would otherwise apply to them, and this exclusion turned out to have unintended consequences that I will explain shortly.

Preemption, Savings, and Deemer Clauses

ERISA is a complex law that uses somewhat ambiguous language to set up what is, essentially, a skeletal regulatory system for employer-sponsored health plans. There are three provisions that are most important in determining whether state law or the federal scheme regulates an insurer. The first states that "the provisions of [ERISA] shall supersede any and all State laws [that] relate to any employee benefit plan" [3]. The savings clause is next, and provides that "nothing in [ERISA] shall be construed to exempt or relieve any person from any law of any State which regulates insurance…." [4]. Finally, the "deemer" clause prevents an employee benefit plan covered by ERISA from being deemed an insurance company for the purposes of submitting that plan to governance by state laws that regulate insurance companies or contracts (note that laws that regulate insurance *companies* are different from laws that regulate insurance) [5].

What does all this mean? Most state contract and tort laws are superseded by ERISA. State laws that specifically regulate insurance, however, generally still apply to benefit plans covered by ERISA. For patients, this means that most meaningful redress for harms caused by decisions of a benefit plan are unavailable.

Congress intended for ERISA to help employees by protecting their benefits. Yet, discussion about ERISA provisions as they pertained to health benefits was sparse. Originally narrow in scope, the language of the legislation was broadened to preempt "state law relating to 'any employee benefit plan'" [6]. There is virtually no evidence of how Congress intended ERISA to relate to health benefits. Consequently, courts have had to provide their own interpretations about when ERISA supersedes state laws, and these interpretations have changed dramatically over the years.

ERISA and Managed Care Organizations

When ERISA was enacted, the health insurance system primarily reimbursed care that was delivered on a fee-for-service basis; that is, insurers paid physicians *retrospectively* for services that had been rendered at rates set by the physicians. In the ensuing decades, managed care organizations (MCOs) emerged as a reimbursement alternative to fee-for-service. Under managed care, physicians are paid *prospectively*, with insurers generally paying physicians a specified amount per *patient* per year, rather than by *service*. This system was designed to control costs by giving physicians an incentive to limit services to those that are truly necessary. The managed care system generated many disputes over which specific procedures the insurer would reimburse, and when these disputes went to court, ERISA was often invoked.

In early ERISA benefits decisions, courts took an expansive view of ERISA's preemption clause, deciding that Congress must have envisioned the broadest scope for the federal law in order to prevent health plans from having to deal with conflicting state laws. The seminal case of *Pilot Life Insurance Co. v. Dedeaux* in 1987, based on Pilot Life's decision to terminate disability benefits, provided the Supreme Court with an opportunity to examine the full extent of the ERISA preemption clause [7]. Mr. Dedeaux claimed that Pilot Life breached its contract by improperly denying coverage. Breach of contract is a state common law claim. The court decided that the common law breach of contract claim, because it applied to all contracts and not just insurance, was not a law "which regulates insurance" [8], hence Dedeaux could not seek redress under state laws. The result of the ruling was that lawsuits related to improper processing of benefits claims (benefits decisions) fell entirely within the scope of ERISA preemption and were subject only to the civil remedies ERISA provided, and not to state law remedies [9].

The real effect of *Dedeaux* when applied to MCOs is that they are liable only for the cost of the denied treatment and, possibly, for attorney fees. Even if the insurer denies coverage for a procedure or service that is explicitly covered and the insured is injured because of the denial, there can be no damages for pain and suffering, and no wrongful death claims if the insured dies while waiting for treatment.

The immunity from state law claims still stands for employer-funded health plans that wrongfully deny benefits. Some court decisions, however, have created a subtle distinction between wrongful denial of benefits and treatment decisions. If an *insurer* denies benefits on grounds that a particular treatment is not appropriate, claims filed by the insured are still primarily subject to state laws. If the decision to deny coverage is made by a *treating physician* employed by an MCO, the Supreme Court has ruled that these are "mixed benefit-treatment decisions" and are covered under ERISA [10].

The exact scope of MCO liability under ERISA is still in flux. A 2002 Supreme Court decision upheld an Illinois statute that required independent medical review of a denial by an insurer [11]. According to the court, this law regulated insurance and therefore was not preempted by ERISA. Two years later, however, the Supreme Court found that claims filed under the Texas Health Care Liability Act alleging that MCOs improperly refused to cover a specific drug in one case and additional days of hospitalization in another were entirely superseded by ERISA [12].

Clearly the law on MCO liability is not settled. One judgment held that certain decisions made by insurers could be litigated under state law [11], but lawsuits based on that decision were overridden 2 years later [12]. Overall, judicial decisions holding that MCO liability is limited to remedies provided in ERISA protects insurers substantially, but at some potential risk to physicians.

ERISA and Physicians

ERISA does not protect physicians from state law liability for malpractice or other claims related to medical care. ERISA applies only to health plans and not to the basic decision maker in the patient-physician relationship. This may be because physicians were generally independent of insurers at the time the law was passed.

Today, however, the financial structure of physician-insurer relationships greatly limits the autonomy of physicians. MCOs are much more involved in treatment decisions than were fee-for-service insurers. The Supreme Court has recognized that financial incentives may play a role in physicians' decisions, but it has chosen not to expand the scope of ERISA health plan liability on this basis [10]. Even if the incentives tempt physicians to limit care, the Court has reasoned that, "the check on this influence…is the professional obligation to provide covered services with a reasonable degree of skill and judgment in the patient's interest" [13].

What this means for physicians is that they may be the only truly liable party in a claim for malpractice if a health plan covered under ERISA denies coverage. As stated earlier, if a patient is injured because of a denial of a claim for benefits, the remedy from the MCO is to pay the insured what the procedure would have cost if it had been approved. In malpractice, however, damages can be both compensatory (such as economic loss) and punitive, and physicians may have to bear the costs of litigating and paying these claims.

Conclusion

The Employee Retirement Income Security Act has an innocuous title; for those in fear of loss of retirement benefits, the law has provided some reassurances that benefit managers will be held to account. But the limited language concerning health benefits has had far-reaching, broad effects on medical liability—and on the health care system—that are not as beneficial as the title of the act makes it seem.

One objective of the medical malpractice system, whether or not one believes it works, is to ensure that those who make poor decisions are accountable for their mistakes. In the past, physicians were the primary decision makers in medicine and generally faced sole responsibility for any injury to their patients. In the world of managed care, plan administrators infringe upon the traditional autonomy of physicians by reviewing and determining whether the care a physician recommends is covered by the plan and whether it is necessary. Under ERISA, though, liability risk for MCOs and physicians may not be proportional to their respective roles in determining care.

ERISA has the effect of diminishing liability expertise for health plans and, along with it, the responsible decision making that medical malpractice is intended to encourage. This in turn may affect how physicians make decisions (for example, electing more conservative treatments or only those deemed permissible by the insurer) and permit insurers to act less conscientiously and less in the interest of patient care.

It will be up to the courts to define further how ERISA impacts traditional remedies and up to Congress to provide more specific guidelines. In an industry as heavily regulated as health care, it takes more than the basic standards provided in ERISA to ensure the safe and effective care of patients.

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