

Hot ERISA Topics

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The ADA and ERISA

The Americans with Disabilities Act, 42 USC section 12101 et seq, protects disabled individuals against discrimination both in employment and access to public accommodations, including access to goods and services. Thus, although there may be no ERISA violation in a given plan decision, the ADA might require a different outcome.

For example, while ERISA does not mandate how a benefit plan is designed, discrimination based on a disabling condition might violate the ADA. Then again, disability-based distinctions might be permissible because the ADA contains a "safe harbor" for such distinctions if they're based on actuary data or claims experience.

Mental v physical disorders. Some recent decisions, however, suggest that the courts are struggling with these issues. For example, courts have generally ruled that distinctions between mental and physical disability claims are lawful. Typically, benefits for mental disorders are limited to two years unless the claimant is confined to an institution at the end of that period. The mind/body issue is also confounding to psychiatry, as this excerpt from the *Diagnostic and Statistical Manual of Mental Disorders IV* reveals:

Although this volume is titled the *Diagnostic and Statistical Manual of Mental Disorders*, the term *mental disorder* unfortunately implies a distinction between "mental" disorders and "physical" disorders that is a reductionistic anachronism of mind/body dualism. A compelling literature documents that there is much "physical" in "mental" disorders and much "mental" in physical disorders. The problem raised by the term "mental" disorders has been much clearer than its solution, and, unfortunately, the term persists in the title of DSM-IV because we have not found an appropriate substitute.

A challenge to the two-year limitation for mental disorders was brought by the Equal Employment Opportunity Commission in *EEOC v CNA Insurance Companies*, 96 F3d 1039 (7th Cir 1996). The EEOC contended that the distinction violated the employment discrimination provisions of the ADA (Title I). The court disagreed and ruled that because the disabled employee could no longer perform her job duties she was not a "qualified individual with a disability" subject to protection by the employment provisions of the ADA. The court limited its holding to Title I of the ADA (discrimination in employment).

That holding was expanded to claims under Title III of the ADA (discrimination in the provision of goods and services) in *Parker v Metropolitan Life Insurance Company*, 121 F3d 1006 (6th Cir 1997). In *Parker*, the court reversed on rehearing an earlier decision holding that such limitations violated the ADA.

A look at some cutting-edge ERISA issues and how courts are resolving them.

Although there are still some decisions finding that policy distinctions between mental and physical disabilities violate the ADA, the courts of appeal have been unanimous in finding no violation, the most recent example being *Lewis v Kmart*, 180 F3d 166 (4th Cir 1999).

Disability v employment discrimination. Does a claim for disability benefits estop a claim for employ-

ment discrimination under the ADA? In some early cases, courts of appeal ruled that applicants for Social Security disability who claim total disability on statements submitted with their applications are barred from claiming disability discrimination in employment.

To qualify for protection under the ADA, the reasoning goes, an employee must be a "qualified individual with a disability," defined in the statute as an "individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires." Several courts, refusing to allow employees to claim total disability in one forum and ability to work in another, have applied the doctrine of judicial estoppel to bar the discrimination claims. (Judicial estoppel applies to a party assuming inconsistent positions in different judicial tribunals.)

Taking the opposite view in *Overton v Reilly*, 977 F2d 1190 (7th Cir 1992), the seventh circuit explained that "disability" has differing definitions in the Social Security Act and the ADA and thus a claim for Social Security disability is not necessarily inconsistent with a discrimination claim under the ADA or the Rehabilitation Act. More recently, the seventh circuit reaffirmed its view that receiving Social Security disability benefits does not necessarily preclude ADA relief because the two Acts have different standards, procedures, and objectives. However, where the allegations made to Social Security or a disability insurer are completely inconsistent with the ability to work, the court will apply judicial estoppel. *Haschmann v Time Warner Entertainment Co.*, 151 F3d 591 (7th Cir 1998). That position was accepted by the EEOC in its Notice 915.002, 2/12/97.

The Supreme Court also accepted a case-by-case approach in *Cleveland v Policy Management Systems*, 119 S Ct 1597 (1999), which held that an application for Social Security disability benefits does not automatically preclude a claim for disability discrimination. However, the Court cautioned, allegations in the disability claim application may show a severe enough disability to lead to summary judgment for the employer if the condition clearly cannot be accommodated.

AIDS, infertility. The ADA has also been invoked to prohibit insurers from discriminating against victims of AIDS or other discrete conditions. The court in *World*

Insurance Co. v Branch, 966 F Supp 1203 (ND Ga 1997), ruled that an insurer could not cap benefits for AIDS treatment, finding that such disparate treatment violated the ADA provisions protecting against discrimination in providing goods and services. However, on appeal the court vacated that portion of the ruling (156 F3d 1142 (1998)); thus, the only remaining decision on point found no ADA violation. In *Doe v Mutual of Omaha Insurance Co.*, 179 F3d 557 (7th Cir 1999). In *Doe*, the court held that the ADA only requires that a benefit be provided; the benefit amount could not be regulated even if below the actual cost of treatment.

Infertility treatments have also enjoyed ADA protection. In Illinois, for example, state law mandates that group insurance plans cover treatment for infertility. However, that requirement is not binding on self-funded plans, which are not governed by state insurance laws. Nonetheless, the ADA may preclude an insurer from refusing infertility-treatment coverage. Last term, the U.S. Supreme Court in *Bragdon v Abbott*, 118 S Ct 2196 (1998), ruled that the inability to have children is a protected disability under the ADA. Thus, it may be impermissible to deny infertility treatment. A federal district court in Chicago ruled that a self-funded insurance plan might violate ERISA if it excludes such treatment. *Bielicki v City of Chicago*, 1997 WL 260595 (ND Ill 1997). Expect further litigation on this subject.

Coverage for experimental medical treatments

There has also been much litigation over coverage for experimental treatments deemed by the claimant's physicians to be lifesaving. Most cases have involved high dosage chemotherapy in connection with autologous bone marrow transplant or peripheral stem cell rescue.

The outcome in such cases often turns on the specific language of the insurance plans. The more specific the definition of "experimental," the more likely it is that the insurance plan will prevail in its interpretation. Further, if the insurance plan confers discretion on the plan administrator to issue determinations and benefit plan interpretations, the plan is more likely to prevail. *Smith v CHAMPUS*, 97 F3d 950 (7th Cir 1996). In *Smith*, the court ruled that it was reasonable for the plan to have based its decision on several medical studies and that the plaintiff failed to present authoritative medical authority in support of her position.

Another approach to these cases is to challenge the benefit denial under the ADA. In *Henderson v Bodine Aluminum, Inc.*, 70 F3d 958 (8th Cir 1995), the ADA was used to challenge an insurer's approval of high dosage chemotherapy for some conditions while rejecting it for other forms of cancer.

An illustration of the tragedy of limiting treatment in these cases is *Bushman v State Mutual Life Assurance Company*, 915 F Supp 945 (ND Ill 1996). There, a man suffering from terminal cancer was denied treatment with high dosage chemotherapy on the grounds that the treatment was being administered as part of a research protocol. The court regretfully held that the terms of the insurance plan allowed the insurance company to deny payment, commenting with irony that the plan would have paid indefinitely for conventional chemotherapy, which failed to remediate plaintiff's condition.

Medical necessity

In an era of managed care, review of claims for medical necessity has become a contentious issue among insureds, providers, and health-plan administrators. Some recent rulings have limited plan administrators' discretion to make such decisions.

For example, *Crocco v Xerox Corp.*, 956 F Supp 129 (D Conn 1997), aff'd in part, rev'd in part, 137 F3d 105 (1998), involved Xerox's use of a third-party administrator for mental health claims. A plan participant's treating doctor had recommended a course of treatment, which the administrator refused to authorize. When challenged in court, the plan administrator defended itself by arguing that it relied on the expertise of the third-party administrator.

This defense was rejected by the district court and affirmed by the court of appeals. The court ruled that Xerox's plan administrator erred by blindly accepting the opinions of its consultant without weighing the evidence on both sides. Under ERISA, it is an improper delegation of fiduciary responsibility to abdicate decision-making responsibility to an organization without such fiduciary liability.

Similarly, in *Bedrick v Travelers Insurance Company*, 93 F3d 149, 154 (4th Cir 1996), the court overturned a plan's denial of physical and occupational therapy to a developmentally disabled child on grounds of lack of medical necessity. The court found that the insurer had a conflict of interest in that it stood to gain financially by refusing treatment and questioned the expertise of the physicians who reviewed the claim. Under a statutory requirement that the plan must act "solely in the interest of [plan] participants and beneficiaries and for the exclusive purpose of providing benefits...." 29 USC section 1104(a)(1)(A), the court found the plan's failure to properly consider the medical necessity of the treatment was an abuse of discretion.

Another such case is *Booton v Lockheed Medical Benefit Plan*, 110 F3d 1461 (9th Cir 1997), where a plan administrator refused to pay for dental implants for a patient who had been kicked in the mouth by a horse. In addition to noting the plan's failure to properly communicate with the claimant, the court held that denying a claim without explanation and relevant supporting information is an abuse of discretion, since overwhelming evidence from the treating doctors established the medical necessity for the procedure.

Judge Kozinski concluded his opinion with a strong warning to insurers and plan administrators: "If ERISA plan administrators want to enjoy the deference to which they are statutorily entitled, they must comply with these simple, common-sense requirements embodied in the regulations and our caselaw." *Id.* at 1465.

"Reasonable and customary" charges

Related to medical necessity is the limitation on payment of benefits that exceed reasonable, usual, and customary charges. Recently, in *Fallick v Nationwide Mutual Ins. Co.*, 162 F3d 410 (6th Cir 1998), the court ruled that a class action could be used to challenge an insurer's methodology of calculating reasonable and customary charges. The U.S. Department of Labor also mandates that insurers disclose such methodology when a challenge is raised to its calculations. ERISA Opinion Letter 96-14A (US Dept Labor 7/31/96).

Also, in *Humana, Inc. v Forsyth*, 119 S Ct 710 (1999), the Supreme Court ruled that a RICO claim could be brought against an insurer that was overcharging its insureds on medical co-payments. Under the insurance plan, the insureds were to have paid a percentage of hospital bills; however, the insurer had negotiated a substantial reduction of the charges but was still insisting on co-payment of the "retail" charge.

Managed care – breach of fiduciary duty

Two recent decisions from the seventh and eighth circuits have caused great consternation among health insurers. In *Shea v Esenstein*, 107 F3d 625 (8th Cir 1997), the court found that an HMO's failure to disclose financial incentives not to refer a patient to a specialist gave rise to a cause of action for breach of fiduciary duty. The claimant was suffering from chest pains and asked his primary care physician to refer him to a specialist. The physician refused, and the patient died. Although the type of damages recoverable was not spelled out, this case provides an example of the backlash against managed care plans.

A similar ruling was issued even more recently by the seventh circuit in a case that the Supreme Court has decided to hear. In *Herdrich v Pegram*, 154 F3d 362 (7th Cir 1998), cert granted 120 S Ct 10 (1999), the court ruled that a managed care plan that rewards participating physicians with bonuses based on savings achieved each year breached its fiduciary duty when it refused necessary treatment to a patient. The court issued a strongly worded diatribe against the evils of managed care, relying more on newspaper editorials than on legal precedent.

Further — although not in the ERISA context — the Wisconsin Supreme Court ruled in *McEvoy v Group Health Co-Op of Eau Claire*, 570 NW2d 397 (Wisc 1997), that an HMO was not immune from suit for failing to refer a patient outside its network. The court found that the insurer let its financial interest outweigh its duty to the plan subscriber, and its actions were therefore in bad faith.

The public's dissatisfaction with managed care also resulted in a massive jury award against Aetna U.S. Healthcare in early 1999. In *Goodrich v Aetna*, 1999 WL 181418 (March 29, 1999), the jury awarded over \$120 million against an HMO for its failure to pay for a cancer treatment recommended by the health plan doctors. Had the case fallen under ERISA, though, the verdict would have been \$0. (*Goodrich* was a government employee and thus ERISA did not apply).

Another possible means of attack is the RICO statute. In *Humana, Inc. v Forsyth*, 119 S Ct 710, the Supreme Court opened the door to RICO suits in managed care situations that appear fraudulent. Given the current hostile climate against HMOs, other comparable decisions are anticipated.

Complete preemption and malpractice claims

Another hot question is whether ERISA preempts medical negligence claims. In the typical case, a claimant suffers some unfortunate result because of a decision made by a managed care entity/utilization reviewer employed by a health insurer. The cases in this area have not clearly resolved this issue, and Congress is currently considering

legislation to allow patients to sue for injuries caused by managed care decisions. The proposed Patient's Bill of Rights may give patients the right to seek third-party review of medical benefits decisions.

The proposed legislation is a direct result of cases such as *Corcoran v United Healthcare, Inc.*, 965 F2d 1321 (5th Cir 1992), which insulated an HMO from malpractice liability when a utilization reviewer prohibited a pregnant patient from being hospitalized, allegedly leading to the death of her fetus. Suit was subsequently brought against the insurer for malpractice; however, the court ruled that the claim was preempted by ERISA and that ERISA had no mechanism for an award of damages for malpractice.

More recent decisions have followed *Corcoran*. For example, in *Jass v Prudential Health Care Plan, Inc.*, 88 F3d 1482 (7th Cir 1996), a case involving a claimant dissatisfied with a knee replacement operation, the court ruled that a vicarious liability claim against an insurer was preempted by ERISA.

In these cases, insurers have successfully argued to the courts that they are not providing medical care; only the physicians and medical staff can do that. Further, although the health plan may be immune from suit, if medical negligence has been committed, the physician may still be held liable.

However, the backlash against managed care is apparent in cases such as *Herdrich*, discussed in the previous section, and *Bauman v U.S. Healthcare*, 193 F3d 151 (3d Cir 1999), which recently partially removed a health care provider's ERISA shield and subjected the provider to potential malpractice liability after the plaintiff's newborn child died of meningitis due to an early hospital discharge. The Illinois Appellate Court recently reached a similar conclusion in *Hinterlong v Baldwin*, No 2-98-1194 (2d D Nov. 4, 1999).

Subrogation and assignment

Health plans typically contain provisions allowing them to recover benefits when a third party is responsible for causing the condition for which medical expense has been incurred (subrogation). A recent seventh circuit decision tempers a health plan's subrogation right by subjecting it to an equitable principle known as the "common fund doctrine."

In *Blackburn v Sundstrand Corporation*, 115 F3d 493 (7th Cir 1997), the court ruled that ERISA does not preempt the common fund doctrine and that an insurer subrogating benefits is required to reduce its claim to pay the fees and expenses of the attorney who has created the fund from which the health plan is being reinsured. *Sundstrand* adopted the reasoning of the Illinois Supreme Court in *Scholtens v Schneider*, 173 Ill 2d 375, 671 NE2d 657 (1996), that ERISA does not preempt the common fund doctrine.

However, the seventh circuit has also enforced the rights of plans to obtain full subrogation, recently ruling in *Administrative Committee v Gauf*, 188 F3d 767 (7th Cir 1999), that even if a state court is seeking to adjudicate liens, the insurer can file its claim in the federal court and obtain reimbursement out of the tort recovery. Likewise, reimbursement can also be obtained from an uninsured motorist insurance recovery, *Health Cost Controls v Washington*, 187 F3d 703 (7th Cir 1999). ▀