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# HIGH-DEDUCTIBLE HEALTH PLANS: LITIGATION HAZARDS FOR HEALTH INSURERS

*E. Haavi Morreim*<sup>†</sup>

## INTRODUCTION

### A. The Rise of HDHPs

Recent decades have witnessed enormous and ongoing change in the American health care scene.<sup>1</sup> The "Artesian Well of Money"<sup>2</sup> that followed World War II--lavish funding that paid health care providers virtually anything they asked, for virtually any service they rendered--spawned roaring inflation in health care that, in turn, triggered a near-violent reversal: managed care.<sup>3</sup> Though temporarily successful in

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<sup>1</sup> For more extensive discussion of this history, see E. Haavi Morreim, *High-Deductible Health Plans: New Twists on Old Challenges from Tort and Contract*, 59 VAND. L.REV. 1207, 1208-1217 (2006) (hereinafter *Morreim, New Twists*); Richard L. Kaplan, *Who's Afraid of Personal Responsibility? Health Savings Accounts and the Future of American Health Care*, 36 MCGEORGE L. REV. 535, 545-48 (2005).

<sup>2</sup> E. Haavi Morreim, *Redefining Quality by Reassigning Responsibility*, 20 Am. J.L. & Med. 79, 80 (1994).

<sup>3</sup> As described by Prof. Rodwin:

Managed care refers to health insurance combined with . . . controls over the delivery of health services. Managed care organizations (MCOs) exercise control over the kind, volume, and manner in which services are provided by choosing providers, or by controlling their behavior through financial incentives, rules, and organizational controls.

Under traditional indemnity insurance and fee-for-service medical practices, the insurers enter into a contract with the insured party and reimburse the individual for certain medical expenses that are incurred. The individual receives medical services from any provider he or she chooses and usually

restraining costs, harsh tactics<sup>4</sup> earned a public enmity that eventuated in attenuation, if not abdication, of the major techniques by which costs were controlled.<sup>5</sup>

If managed care began to fade, the cost of health care did not. In 2005, for the first time, the average premium for family health care coverage in the United States reached the equivalent of a minimum-wage worker's annual wage-- \$10,880 versus \$11,000, respectively.<sup>6</sup> Spending that year increased nearly 7 percent,<sup>7</sup> far ahead of general inflation. Although that increase was somewhat smaller than the two

pays a fee for each service rendered, with the insurer having no control over the choice of provider or provision of services

Managed care changes this relationship either (1) by directly providing the contracted-for services; or (2) by exercising control over the services provided. . . .

Many indemnity insurers now provide managed care in that they exercise control over their beneficiaries' use of medical services. They require pre-authorization for . . . expensive referrals or procedures. They do not reimburse claims from medical providers for services rendered if the organization decides they were not necessary.

Mark A. Rodwin, *Managed Care and Consumer Protection: What are the Issues?*, 26 SETON HALL L. REV. 1007, 1009 n.1 (1996).

The Texas Civil Practices and Remedies code defines a managed care entity as "any entity which delivers, administers, or assumes risk for health care services with systems or techniques to control or influence the quality, accessibility, utilization, or costs and prices of such services to a defined enrollee population . . ." TEX. CIV. PRAC. & REM. CODE ANN. § 88.001(8) (Vernon 2005 & Supp. 2006).

<sup>4</sup> These tactics included, *inter alia*, close utilization management with stringent preauthorization requirements and ready denial of payment for services either proposed or rendered, tight fee schedules or capitation arrangements for providers, and gate-keeping arrangements requiring patients to visit their primary care physicians to secure permission for specialist visits. Robert F. Rich & Christopher T. Erb, *The Two Faces of Managed Care Regulation & Policymaking*, 16 STAN. L. & POL'Y REV. 233, 236-37 (2005). Overall, managed care involved "(1) contractual arrangements with selected providers to furnish a comprehensive set of health care services to members; (2) significant financial incentives to direct patients to providers and procedures *within* the plan; and (3) ongoing accountability of providers for their clinical and financial performance through formal quality assurance and utilization review." *Id.* at 236. See generally E. HAIVI MORREIM, *HOLDING HEALTH CARE ACCOUNTABLE: LAW AND THE NEW MEDICAL MARKETPLACE*, 19-20, 60-61 (Oxford Univ. Press 2001) (hereinafter MORREIM, *HOLDING HEALTH CARE*).

<sup>5</sup> Thomas M. Burton, *United Health to End Ruling on Treatments*, WALL ST. J., Nov. 9, 1999, at A-3; James C. Robinson, *Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design*, W2 HEALTH AFFAIRS W139, W143 (Mar. 20, 2002).

<sup>6</sup> David Blumenthal, *Employer-Sponsored Health Insurance in the United States--Origins and Implications*, 355 New Eng. J. Med. 82, 85 (2006).

<sup>7</sup> Aaron Catlin et al., *National Health Spending in 2005: The Slowdown Continues*, 26 HEALTH AFFAIRS 142, 142 (2007).

prior years, health care spending nevertheless represented 16 percent of the gross domestic product<sup>8</sup>

Since many Americans receive health insurance through their employers,<sup>9</sup> the business community is among the first to face rising premiums, necessitating decisions about how much more expense they can absorb, how much they must pass along to workers, and indeed whether they will continue to provide this benefit at all. Although one option is to ask employees to share the increased cost of premiums, many corporations are turning to an alternative: increased cost-sharing at the time of service.<sup>10</sup>

Greater cost sharing became a more viable option with the Medicare Modernization Act of 2003 (MMA).<sup>11</sup> This statute permits citizens who have a high-deductible health plan (HDHP) for catastrophic coverage--also known as a Consumer-Defined Health Plan (CDHP)--to establish a tax-free health savings account (HSA). As of 2007, a qualifying HDHP required a deductible<sup>12</sup> of at least \$1100 for an indi-

<sup>8</sup> *Id.* See also Blumenthal, *supra* note 6, at 85.

<sup>9</sup> In 2005, 59.5 percent of Americans received health care coverage from their employers; down from 59.8 percent in 2004. Victoria Colliver, *More in U.S. Lack Health Insurance: Employers, Workers Feel Financial Pinch*, *U.S. Census Reports*, S.F. CHRON., Aug. 30, 2006, at A7.

<sup>10</sup> Catlin, et al., *supra* note 7, at 149.

Current developments were foreshadowed by the recent past. From 1993 to 2004, workers' average deductible rose from \$222 to \$414 for an individual, and from \$495 to \$861 for a family plan. Devon M. Herrick, *Consumer Driven Health Care: The Changing Role of the Patient*, NAT'L CTR. POL'Y ANALYSIS, Rep. No. 276, at 10 (May 2005), [www.ncpa.org/pub/st/st276](http://www.ncpa.org/pub/st/st276).

<sup>11</sup> Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1201, 117 Stat. 2066, 2469 (2003).

<sup>12</sup> A "deductible" should be distinguished from related terms like "coinsurance" and "copayment." James Robinson captures the differences well:

Conventional indemnity insurance imposed a deductible, which makes the enrollee responsible for all costs up to a defined threshold, and then a coinsurance rate, which makes the enrollee responsible for a percentage of costs between the deductible threshold and an annual out-of-pocket maximum. As insurers shifted their indemnity enrollment to PPO products to compete with HMOs, they often restructured the cost sharing from coinsurance to fixed-dollar copayments for office visits, hospital admissions, and other services. Copayments offer enrollees the advantage of specifying in advance the amount for which they are responsible; the offer providers the advantage of ease of collection (copayments typically are paid prior to service, while coinsurance typically is paid afterward). ... Copayments suffer from the salient limitation, as a cost-control instrument, of not varying according to which physician or hospital is chosen, despite the often considerable differences among providers in rates charged to the insurance plan. In contrast, percentage coinsurance provisions expose enrollees to at least part of the financial consequences of their choice.

vidual and \$2200 for a family, with maximums reaching \$5500 for individuals and \$10,500 for families.<sup>13</sup> HSAs can then be used to pay for medical expenses within the deductible as well as health-related expenses not covered by insurance.<sup>14</sup>

The MMA amended the Internal Revenue Code,<sup>15</sup> designating all money placed into or earned in an HSA tax-free, so long as it is spent on eligible health care expenses. Money spent on non-health care expenses is subject to taxation and a 10 percent penalty, although that penalty is removed for non-health care expenses if the individual is 65 or older.<sup>16</sup> Since their inception, HDHPs with HSAs have gained considerable acceptance, and are expected to become a standard feature of the health insurance landscape.<sup>17</sup>

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James C. Robinson, Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design, March 20, 2002, W-139, at 141-42.

<sup>13</sup> I.R.C. §§ 62(a)(19), 106(d), 223(a)-(b), 3231(e)(11), 3306(b)(18) (West 2005). See also Timothy S. Jost & Mark A. Hall, *The Role of State Regulation in Consumer-Driven Health Care*, 31 AM. J.L. & MED. 395, 395-97 (2005); Kaplan, *supra* note 1, at 548-559 (explaining MMA and its provisions). As of March 2005, the average deductible for individuals was \$2790 and for families was \$5230. James C. Robinson, *Health Savings Accounts—The Ownership Society in Health Care*, 353 NEW ENG. J. MED. 1199, 1200 (2005) (citation omitted).

<sup>14</sup> HSAs are similar to, but more broadly available than three other options permitting the use of tax-sheltered funds for health care. While the worker owns his HSA funds, Health Reimbursement Accounts (“HRAs”) are, and remain, the property of the employer. Medical Savings Accounts, created by the Health Insurance Portability and Accountability Act of 1996, are largely identical to HSAs, but are only available in limited settings. A Flexible Spending Account (“FSA”) also enjoys tax subsidies, but the employee must designate at the beginning of the year how much he wants placed in his FSA, and at the end of the year, whatever he does not use, he will lose. See David Blumenthal, *Employer-Sponsored Insurance—Riding the Health Care Tiger*, 355 NEW ENG. J. MED. 195, 197 (2006); see DEVON M. HERRICK, NAT’L CTR FOR POLICY ANALYSIS, BRIEF ANALYSIS NO. 496, FLEXIBLE SPENDING ACCOUNTS: MAKING A GOOD DEAL BETTER 1 (2004), available at <http://www.npcpa.org/pub/ba/ba496/>; see also Morreim, *New Twists*, *supra* note 1, at 1213-14.

<sup>15</sup> I.R.C. § 223(f)(1)-(2), 223(f)(4)(A) (West 2005).

<sup>16</sup> I.R.C. § 223(f)(2), 223(f)(4)(A)-(C).

<sup>17</sup> As of March 2005, total combined enrollment in HRAs and HSAs totaled about 2.6 million. Robinson, *supra* note 13. The largest vendor was UnitedHealth (865,000 members), followed by Aetna (370,000), and various Blue Cross/Blue Shield plans (400,000). *Id.* (citations omitted). Much of the enrollment in HSAs is from “outside the employment context.” *Id.* Over the same time-frame, the average deductible was \$2790 for individuals and \$5230 for families. *Id.*

The next year “there were 3.6 million HSA accounts at the end of 2006 with \$5.1 billion in deposits, up from 1.1 million accounts with \$1.2 billion in deposits at the end of 2005.” Eileen A. Powell, *New Rules over Health Savings Accounts Making Them More Attractive*, SUN-SENTINEL, Mar. 28, 2007, available at <http://www.sun-sentinel.com/business/sfl-328healthsavings,0,2899909.story?coll=sfl->

### B. HDHP-Associated Litigation

Innovations in health plan design will doubtless inspire innovations in litigation. As explored elsewhere,<sup>18</sup> physicians could face several fairly distinctive litigation issues from HDHPs. This article, in parallel, examines the litigation challenges that may arise specifically for health plans. But the focus will be narrow. In the range of catastrophic coverage--the high-dollar claims exceeding the deductible threshold--we can expect fairly familiar issues, such as whether the insurer should cover costly new treatments.<sup>19</sup> Rather than focus on those, this article targets the issues that may crop up within the deductible, where the patient is paying out of pocket or HSA. Although it may seem odd to suppose health plans will be sued over decisions patients pay for, a variety of challenging issues could arise.

Importantly, in any given year the great majority of people with HDHPs will pay for all their health care out of pocket, or HSA. This

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yourmoney.

Many employers have been eager to steer employees into these plans, often via added financial incentives such as up-front coverage for preventive services, and special drug coverage for people with chronic illnesses. Vanessa Fuhrmans, *Decoding New Health Plans: Despite Sky-High Deductibles, They Yield Savings—Sometimes; Bargain-Hunting for Care*, WALL ST. J., Oct. 22, 2005, at B1; see also Michael E. Chernew, Allison B. Rosen & A. Mark Fendrick, *Value-Based Insurance Design*, 26 HEALTH AFF. W195, W197 (2007); see also *HSAs Will Grow Significantly in 2007 Despite Congressional Doubts*, MARKET WIRE, Mar. 26, 2007, <http://www.marketwire.com/mw/release.do?id=719862&k=hsa>; East Bay Bus. Times, *Survey: HSA Plan Enrollment Increases*, SACRAMENTO BUS. J., April 2, 2007, available at

[http://sacramento.bizjournals.com/sacramento/stories/2007/04/02/daily9.html?jst=b\\_1n\\_hl](http://sacramento.bizjournals.com/sacramento/stories/2007/04/02/daily9.html?jst=b_1n_hl) (highlighting the increased enrollment in high-deductible health plans in the group insurance market).

<sup>18</sup> See Morreim, *New Twists*, *supra* note 1, at 1216-17.

<sup>19</sup> During the 1990s, for instance, there was a plethora of claims that demanded insurers cover new treatments such as high-dose chemotherapy, with autologous bone marrow transplant or stem cell transplant for diseases such as advanced breast cancer. See generally *Turner v. Fallon Cmty. Health Plan, Inc.*, 127 F.3d 196 (1st Cir. 1997); *Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003 (9th Cir. 1998); *Harris v. Blue Cross Blue Shield, of Mo.*, 995 F.2d 877 (8th Cir. 1993); *Harris v. Mut. of Omaha Cos.*, 992 F.2d 706 (7th Cir. 1993); *Fuja v. Benefit Trust Life Ins. Co.*, 18 F.3d 1405 (7th Cir. 1994); *Henderson v. Bodine Aluminum, Inc.*, 70 F.3d 958 (8th Cir. 1995); *Bechtold v Physicians Health Plan*, 19 F.3d 322 (7th Cir. 1994); *Dahl-Eimers v. Mutual of Omaha Life Ins. Co.*, 986 F.2d 1379 (11th Cir. 1993); *Wilson v. Office of Civilian Health & Med. Programs of the Uniformed Servs.*, 65 F.3d 361 (4th Cir. 1995); *Graham v. Med. Mut. of Ohio*, 130 F.3d 293 (7th Cir. 1997); *Schwartz v. FHP Int'l Corp.*, 947 F. Supp. 1354 (D. Ariz. 1996); *Foster v. Blue Cross & Blue Shield of Mich.*, 969 F. Supp. 1020 (E.D. Mich. 1997); *Michelle M. Mello & Troyen A. Brennan, The Controversy over High-Dose Chemotherapy with Autologous Bone Marrow Transplant for Breast Cancer*, HEALTH AFF., Sept.-Oct. 2001, at 101.

is because, while the great majority of health care *dollars* are spent on relatively few people with catastrophic or chronic illnesses, the great majority of *people* use relatively few resources in a given year. As of the mid-1990s, "85% of Americans spen[t] less than \$3000 a year on medical care, and 73% ha[d] less than \$500 a year in claims."<sup>20</sup> By the same token, as of 1996, the top 10 percent of patients accounted for nearly 70 percent of total health expenditures, while the top 30 percent consumed 90 percent of resources. This picture has remained largely constant over several decades.<sup>21</sup>

This means that, for the first time in many years--perhaps ever<sup>22</sup>--large numbers of relatively affluent, well-educated people will directly pay significant amounts for their health care. Those with modest health care needs will now be paying the entire tab, not just the first few hundred dollars in a low deductible plan. They will not be indifferent to the cost of care, as they might comfortably be where an insurer is paying. Many will want to know, before they make health care spending decisions, just how much the bill will be, and what they can expect to get for their money.

This article explores anticipated litigation tussles between patients and health insurers where it is the patient's, not the insurer's money, directly at stake. Some issues will be explored only briefly, because they will not differ significantly from familiar complaints that arise

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<sup>20</sup> Editorial, *Consumer-First Health Care*, WALL ST. J., July 21, 1994, at A14.

<sup>21</sup> Marc L. Berk & Alan C. Monheit, *The Concentration of Health Care Expenditures, Revisited*, HEALTH AFF., Mar.-Apr. 2001, at 9, 12. Similarly, Luft observed that 1 percent of the population consumes 30 percent of all medical care costs, while the bottom 50 percent accounts for only 3 percent of expenditures. Harold S. Luft, *Modifying Managed Competition to Address Cost and Quality*, HEALTH AFF., Spring 1996, at 23, 26 (citation omitted). One factor appears to have changed since 1996, however. Health care spending has become somewhat more diffuse due to the rapid growth in prescription drug spending, which has spread across much of the population, while spending for inpatient care has slowed. By 2002 the top 1 percent of patients accounted for 22 percent of spending, down 6 percent from the 1998 figure of 28 percent. Nevertheless, the top 5 percent of patients still accounted for nearly half of all health care spending. See Samuel H. Zuvekas and Joel W. Cohen, *Prescription Drugs and the Changing Concentration of Health Care Expenditures*, 26 HEALTH AFF. 249, 249-51 (2007).

<sup>22</sup> Prior to the mid-twentieth century, medicine had relatively little to offer patients. During and especially after World War II, the rapid rise and proliferation of medical science and technology were accompanied by a commensurate expansion of generous health insurance in the workplace and then, in 1965, to the elderly and indigent via Medicare and Medicaid. Hence, in earlier times when most people paid out of pocket, there was little to buy; when there was much to buy, most people enjoyed ample third-party payment. See generally E. HAAVI MORREIM, *BALANCING ACT: THE NEW MEDICAL ETHICS OF MEDICINE'S NEW ECONOMICS* 8-11 (1995).

where the insurer pays, or refuses to pay, for care. Rather, this article focuses on the more distinctive claims arising from cost-conscious patients.

Part I sets the stage by outlining some of the new services many plans now provide as they adapt to a more consumer-driven marketplace.

Part II examines several avenues for tort litigation. After briefly reviewing familiar concepts of direct corporate liability in health care, this article explores two plausibly emerging scenarios. The first line of claims could spring from some of the new health advisory services many HDHPs now offer, such as disease management and telephone triage. Insurers that undertake to provide direct medical counseling could be subject to traditional medical malpractice claims. Second is potential liability for "economic informed consent" claims, because patients now need to know about costs as a key side-effect of care. Health plans could potentially incur liability either by interfering with physicians' financial disclosures or by breaching new economic disclosure duties arguably owed by health plans themselves.

Part III discusses contract issues. First, many insurers are helping enrollees keep track of their expenditures; indeed, some plans directly manage enrollees' HSA funds. Where they do, accounting mishaps could spawn contract quarrels. Second, some insurers, in an effort to ensure that patients actually pay providers within this deductible range, are establishing financing mechanisms that feature payroll deductions. These mechanisms might adversely affect patients' ability to contest the amounts and reasonableness of providers' charges.

Part IV explores a special area that may prove particularly interesting. Patients paying out of pocket will want to know, not just the immediate cost of a test or treatment, but whether and how much that expenditure will count toward the deductible, bringing them closer to the point where the health plan pays the bills. Health plans have an incentive to count as little as possible, because the slower patients meet the deductible threshold, the less the plan must pay. Cumulatively, health plans could save substantial sums. At the same time, plans may be tempted to suppose they have little to fear from litigation. The amounts at stake--a few hundred dollars toward someone's deductible--are individually so small that attorneys are unlikely to accept these claims on a contingency basis, while patients may be reluctant to pay more in attorney fees than the deductible itself is worth. On the other hand, angry patients could directly file myriad suits in small-claims courts and, if the denials on which those suits are based exhibit a sinister pattern, class action could loom.



As with any other discussion about litigation against health plans, the Employee Retirement Income Security Act of 1974 ("ERISA")<sup>23</sup> is the proverbial "800-pound gorilla." Part V discusses which sorts of claims ERISA likely will preempt, causing removal to federal courts, with their limited panoply of claims for relief, and even more limited remedies. It also shows how ERISA may force plans to produce at least some kinds of information, such as determining, in advance, whether and how much of a test or treatment will count toward the deductible.

Finally, the conclusion discusses some practical realities of litigation in this realm.

Overall, this article argues that HDHPs can open a variety of fairly distinctive avenues for litigation against health plans, even within the deductible range where patients spend their own money.

## I. NEW SERVICES FROM HDHPS

Discussion of incipient sources of litigation must begin with a brief overview of how HDHPs are constructed, particularly the diverse benefit packages and the new kinds of financial and health advisory services that these plans are beginning to offer.<sup>24</sup> In any given HDHP, actual coverage may be comprehensive, encompassing prescription drugs, a large network of providers, a panoply of services such as physical therapy, and the like; or it may be very narrow, a bare-bones policy covering little aside from major hospitalization; or it may be something in between. Actual financial coverage for each covered service can vary widely, often depending on whether the provider is in- or out-of-network, or even on the provider's quality rating.<sup>25</sup> Although every patient has a high deductible in these plans,

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<sup>23</sup> See generally 29 U.S.C. §§ 1001-1461 (2000).

<sup>24</sup> As noted by James Robinson, "Health insurance is evolving from comprehensive coverage for a restricted set of choices to limited coverage for a broader set of choices. Diverse benefit designs and increased consumer cost sharing challenge conventional policy wisdom but may counteract some of the pernicious features of the health care status quo." Robinson, *supra* note 12, at W139; see generally Jon R. Gabel, Anthony T. Lo Sasso & Thomas Rice, *Consumer-Driven Health Plans: Are They More Than Talk Now?*, HEALTH AFF., Nov. 20, 2002, at W395; Wendy K. Mariner, *Can Consumer-Choice Plans Satisfy Patients? Problems with Theory and Practice in Health Insurance Contracts*, 69 BROOK. L. REV. 485, 503 (2004) (illustrating the options available to consumers).

<sup>25</sup> "Employees with customized benefits, at their most elaborate, can choose among as many as five deductibles, five co-insurance levels, broad or narrow doctor and hospital networks and several prescription-drug options." Sarah Rubenstein, *Buying Health Insurance, Cafeteria Style*, WALL ST. J., Oct. 19, 2004, at D4. See generally Robinson, *supra* note 12.

such differences loom large once that deductible has been met, and can also influence how soon the patient reaches the deductible threshold.<sup>26</sup>

#### A. Financial Assistance

Many plans provide financial services, such as website tools with which enrollees can keep track of their expenditures, including checking their claims history online, and making decisions about how to invest the funds in their HSAs.<sup>27</sup> To make it easier for members to pay at the time of service, some HDHPs provide debit cards that directly deduct the costs from the patient's HSA.<sup>28</sup>

A number of insurers and even provider groups also have begun helping patients find out, in advance, the cost of a proposed test or treatment and its reasonable alternatives. After all, a major goal of high-deductible health care is to encourage patients to consider the economic as well as the medical wisdom of their choices. As discussed elsewhere,<sup>29</sup> pricing information has traditionally been proprietary and convoluted, hence difficult for anyone to learn. Nonetheless, many health plans have undertaken major efforts to bring pricing information to their enrollees,<sup>30</sup> even including the cheapest places to buy medications.<sup>31</sup>

Many plans also provide "discount networks" of providers who offer services to plan enrollees for a discount. Often these networks include services that are not covered by the plan, such as massages or

<sup>26</sup> See *infra*, Part IV.A.

<sup>27</sup> Zack Martin, *The Plan: Drive Consumers Online*, HEALTH DATA MGNT., June 2006, available at <http://www.healthdatamanagement.com/issues/20060601/13482-1.html>.

<sup>28</sup> Sarah Rubenstein, *What Do You Owe the Doctor? Swipe a Card to Find Out*, WALL ST. J., July 26, 2005, [http://online.wsj.com/article\\_print/0,,SB112203619672493328,00.html](http://online.wsj.com/article_print/0,,SB112203619672493328,00.html).

<sup>29</sup> Morreim, *New Twists*, *supra* note 1 at 1250, 1258 & n.244.

<sup>30</sup> Damon Darlin, *You Think 401(k)'s Are Hard to Manage? Try Health Accounts*, N.Y. TIMES, Feb. 18, 2006, at C5, available at <http://www.nytimes.com/2006/02/18/business/yourmoney/18money.html>; Vanessa Fuhrmans, *WellPoint Aims To Get Consumers To Compare Medical-Care Costs*, WALL ST. J., Sept. 25, 2006, at A12; Bob Mook, *Colo. Health Insurers Quick to Embrace Transparency*, DENVER BUS. J., July 6, 2007, <http://www.bizjournals.com/denver/stories/2007/07/09/story7.html?b=1183953600%5e1487201>; Carol Gentry, *Humana Tool Helps Users Shop Health Care*, TAMPA TRIB., July 7, 2007, at C1, available at <http://www.tbo.com/news/money/MGBE5J1DT3F.html>; Lisa Girion, *Doctors' List Puts a Price on Care: A Decision by a Major Medical Group to Post Rates Could Push Rivals to Do the Same, Letting Californians Shop*, L.A. TIMES, May 28, 2007.

<sup>31</sup> Darlin, *supra* note 30.

fitness club memberships. The discounts render those services more affordable and thereby make the plan itself more attractive.<sup>32</sup>

### B. Provider Information and Medical Assistance

Aside from such financial assistance, HDHPs also provide tools to help enrollees make medically informed decisions. Provider selection, for instance, can be aided by quality and satisfaction ratings for various hospitals and physicians.

Plans also help patients make specific health care decisions. Telephone triage services are typically staffed by registered nurses who can, through a series of questions, help the caller decide whether his current symptoms warrant visiting a physician or perhaps even the emergency room.<sup>33</sup> In some cases a physician may be the one at the other end of the line.<sup>34</sup>

Many health plans provide disease management services to help people with chronic illnesses such as diabetes, heart failure, or asthma, to cope effectively with their illness. Some insurers have a system for reminding enrollees about flu shots, mammograms, and other preventive care,<sup>35</sup> or even offering tips on how to cut costs, such as by splitting pills.<sup>36</sup>

<sup>32</sup> These services include weight-loss programs, vision care, and alternative medicine. Michelle Andrews, *Does It Pay to Manage Your Own Care?* N.Y. TIMES, Jan. 18, 2004, § 3, at 7, available at <http://www.nytimes.com/2004/01/18/business/yourmoney/18heal.html>; Robinson, *supra* note 12, at W146; Jost & Hall, *supra* note 13, at 401; Gerard Britton, *Discount Medical Plans and the Consumer: Health Care in a Regulatory Blindspot*, 16 LOY. CONSUMER L. REV. 97, 97-98 & n.2 (2004).

<sup>33</sup> Herrick, *supra* note 10, at 13; Annette M. O'Connor, Hilary A. Llewellyn-Thomas & Ann Barry Flood, *Modifying Unwarranted Variations in Health Care: Shared Decision Making Using Patient Decision Aids*, HEALTH AFF., Oct. 7, 2004, at VAR-63, VAR-69.

<sup>34</sup> John Wasson et al., *Telephone Care as a Substitute for Routine Clinic Follow-Up*, 267 JAMA 1788 (1992) ("a clinician typically has at least 10 telephone consultations a day.").

<sup>35</sup> Tom Anderson, *Insurers Use Personalized Statements to Improve Employee Health and Lower Costs*, EMP. BENEFIT NEWS, November 2005, at 24, available at <http://www.benefitnews.com/asset/article/239688/insurers-use-personalized-statements-improve-employee.html>.

<sup>36</sup> For example:

A new cost-cutting push by one of the nation's largest insurance companies is encouraging patients to engage in a controversial tactic: cutting their drug bills by cutting their pills in half.

UnitedHealth Group's is now offering patients a chance to lower their copayments by buying a pill for twice the dose they need and cutting it in half. The program is voluntary and gives patients the opportunity to save as much as \$300 annually in copayment costs per prescription.

Beyond that, patient decision aids can provide detailed information and decision-trees for people facing an important choice, such as whether to have surgery for benign prostate enlargement or which kind of therapy to choose for cancer.<sup>37</sup> Unlike generic health information for a general audience, these decision aids focus on defined groups of people and aim to assist with specific decisions.<sup>38</sup>

From this diversity of services emerge several sources of tort and contract litigation.

## II. TORT CLAIMS

Although health plans can be indirectly liable for providers' quality of care via *respondeat superior* or ostensible agency,<sup>39</sup> such liabil-

Tara Parker-Pope, *Health Insurers Push Pill Splitting As a Way To Save Money on Drugs*, WALL ST. J., Nov. 22, 2005, at D1.

<sup>37</sup> See Sarah Rubenstein, *Health Insurers Show Employees Graphic Surgery Videos*, WALL ST. J., Nov. 30, 2005, at B1. Such decision aids attempt to present "high-quality, up-to-date information about the condition or disease stimulating the need for a decision, the available health care options, the likely outcomes for each option, the probabilities associated with those outcomes, and the level of scientific uncertainty." O'Connor et al., *supra* note 33, at VAR-64-65. The aids also promote values clarification discussions and guidance, helping patients better to communicate their questions and values to providers. *Id.* at VAR-65.

<sup>38</sup> These aids can also enhance physician-patient communication by providing patients with a better information base from which to ask more enlightened questions and thus, it might be hoped, help them arrive at solutions that better fit their individual needs. Such questions might, for instance, result in inquiries of whether or not there is a generic alternative to a costly medication. See Sarah Rubenstein, *Is Your Doctor Really Right? Insurers' Tools Help Patients Question Doctors*, WALL ST. J. ONLINE, Jan. 26, 2006, [http://online.wsj.com/article/SB113742469884447596.html?mod=health\\_hs\\_health\\_providers\\_insurance](http://online.wsj.com/article/SB113742469884447596.html?mod=health_hs_health_providers_insurance).

<sup>39</sup> Ordinarily, neither a hospital nor an insurer will be liable for the actions of independent contractors, such as physicians who typically practice in their own offices and may have contracts with a variety of insurers and MCOs. However, as the *respondeat superior* doctrine developed for hospitals, when the plaintiff has been induced to believe and then relies on the belief that the physician actually is an employee of the hospital, the hospital may be liable as though it were an employer. See *Insinga v. LaBella*, 543 So. 2d 209, 214 (Fla. 1989); *Clark v. Southview Hosp. & Family Health Ctr.*, 628 N.E.2d 46, 48 (Ohio 1994); *Baptist Mem'l Hosp. Sys. v. Sampson*, 969 S.W.2d 945, 949 (Tex. 1998); *James v. Ingalls Mem'l Hosp.*, 701 N.E.2d 207, 209 (Ill. App. Ct. 1998); *Sword v. NKC Hosps., Inc.*, 714 N.E.2d 142, 152-53 (Ind. 1999); *Pamperin v. Trinity Mem'l Hosp.*, 423 N.W.2d 848, 855 (Wis. 1988); *Kashishian v. Port*, 481 N.W.2d 277 (Wis. 1992).

The doctrine was then extended to health plans, applicable when the plan: (1) held itself out as the provider of health care, without informing the patient that the care is given by independent contractors, and (2) . . . the patient justifiably relied upon the conduct of the HMO by looking to the HMO to provide health care services, rather than to a specific physician.

ity will not be spotlighted here, because the issues are likely to be the same whether they crop up above, or below, the deductible. That is, if a network physician performs poorly, the health plan could potentially be vicariously liable regardless of whether the faulty service was paid for out of pocket or covered by insurance. Accordingly, this article will focus instead on direct liability, or corporate negligence, as it may emerge where patients are paying out of pocket.

As applied to health plans, direct liability analysis largely emerged from the duties ascribed to hospitals.<sup>40</sup> In the seminal case

Petrovich v. Share Health Plan of Ill., Inc., 719 N.E.2d 756, 766 (Ill. 1999).

A number of courts have been willing to find health plans liable under ostensible agency. *See, e.g.*, Kearney v. U.S. Healthcare, Inc., 859 F. Supp. 182, 188 (E.D. Pa. 1994); Boyd v. Albert Einstein Med. Ctr., 547 A.2d 1229, 1232 (Pa. Super. Ct. 1988); Villazon v. Prudential Health Care Plan, Inc., 843 So. 2d 842, 855 (Fla. 2003); Schleier v. Kaiser Found. Health Plan of Mid-Atl. States, Inc., 876 F.2d 174, 177-78 (D.C. Cir. 1989); Independence HMO, Inc., v. Smith, 733 F. Supp. 983, 987-89 (E.D. Pa. 1990) (recognizing vitality of ostensible agency theory, but not ruling on the underlying claim's merits); Albain v. Flower Hosp., 553 N.E.2d 1038, 1040, 1044 (Ohio 1990); Elsesser v. Hosp. of Philadelphia Coll. of Osteopathic Med., 802 F. Supp. 1286 (E.D. Pa. 1992); DeGenova v. Ansel, 555 A.2d 147, 149-50 (Pa. Super. Ct. 1988) (against an insurer); Paterno v. Albuerno, 855 F. Supp. 1263, 1263 (S.D. Fla. 1994); DeArmas v. Av-Med, Inc., 865 F. Supp. 816 (S.D. Fla. 1994); Jackson v. Roseman, 878 F.Supp. 820, 822 (D. Md. 1995); Prihoda v. Shpritz, 914 F. Supp. 113 (D. Md. 1996); Dunn v. Praiss, 606 A.2d 862 (N.J. Super. Ct. App. Div. 1992), *rev'd*, 656 A.2d 413 (N.J. 1995); McClellan v. HMO of Pa., 604 A.2d 1053, 1056-58 (Pa. Super. Ct. 1992), *aff'd*, 686 A.2d 801 (Pa. 1996); Petrovich v. Share Health Plan of Ill., Inc., 696 N.E.2d 356 (Ill. App. Ct. 1998), *aff'd*, 719 N.E.2d 756 (Ill. 1999); Jones v. Chicago HMO Ltd. of Ill., 703 N.E.2d 502, 504 (Ill. App. Ct. 1998), *aff'd in part & rev'd in part*, 730 N.E.2d 1119 (Ill. 2000); Negron v. Patel, 6 F. Supp. 2d 366, 371-72 (E.D. Pa. 1998); Clark v. Southview Hosp. & Family Health Ctr., 628 N.E.2d 46, 54 (Ohio 1994); Sloan v. Metro. Health Council of Indianapolis, Inc., 516 N.E.2d 1104, 1109 (Ind. Ct. App. 1987).

*But see* Raglin v. HMO Illinois, Inc., 595 N.E.2d 153 (Ill. App. Ct. 1992) (denying claim for vicarious liability on ground that HMO did not control physicians); Chase v. Indep. Practice Ass'n, 583 N.E.2d 251, 255 (Mass. App. Ct. 1991) (finding no vicarious liability in IPA-type HMO); Ricci v. Gooberman, 840 F. Supp. 316, 317-18 (D.N.J. 1993) (holding that ERISA preempts state tort claims based on vicarious liability); Ramos v. Preferred Med. Plan, Inc., 842 So. 2d 1006, 1007-08 (Fla. Dist. Ct. App. 2003) (holding that the issue of apparent agency is a question of material fact); *See also* William A. Chittenden III, *Malpractice Liability and Managed Health Care: History and Prognosis*, 26 Tort & Insur. L.J. 451, 458-64 (1991).

<sup>40</sup> William E. Milks, Annotation, *Liability of Health Maintenance Organizations (HMOs) for Negligence of Member Physicians*, 51 A.L.R.5TH 271, 280-81 (1997) ("As a general proposition, physician malpractice claims against HMOs are based on the same theories which support physician malpractice claims against hospitals. They include direct negligence claims (for example, negligent hiring, retention, or supervision), vicarious liability, ostensible or apparent agency, and respondeat superior. Such claims are typically included in complaints naming one or more individual physicians as defendants, as well."). *See, e.g.*, Darling v. Charleston Cmty.

*Thompson v. Nason Hospital*,<sup>41</sup> the Pennsylvania Supreme Court identified several duties hospitals directly owe patients, including a duty to "select and retain only competent physicians," and to "formulate, adopt and enforce adequate rules and policies to ensure quality care for the patients."<sup>42</sup> Thereafter, in *Shannon v. McNulty*,<sup>43</sup> a Pennsylvania Superior Court extended direct duties to health plans wherever they perform functions similar to those of hospitals.<sup>44</sup> It has now become quite widely accepted that health plans directly owe certain duties to enrollees, such as to exercise due care in selecting, monitoring, and retaining their physician staff.<sup>45</sup> Courts have also identified addi-

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Mem'l Hosp., 211 N.E.2d 253, 257 (Ill. 1965), *cert. denied*, 383 U.S. 946 (1966); *Thompson v. Nason Hosp.*, 591 A.2d 703 (Pa. 1991); *McClellan v. HMO of Pa.*, 686 A.2d 801 (Pa. 1996); *Shannon v. McNulty*, 718 A.2d 828 (Pa. Super. Ct. 1998).

<sup>41</sup> 591 A.2d 703 (Pa. 1991).

<sup>42</sup> *Id.* at 707. The four duties *Thompson* identified are: "(1) a duty to use reasonable care in the maintenance of safe and adequate facilities and equipment . . . ; (2) a duty to select and retain only competent physicians . . . ; (3) a duty to oversee all persons who practice medicine within its walls as to patient care . . . ; and (4) a duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for the patients." *Id.* at 707; *see also* *Insinga v. LaBella*, 543 So. 2d 209, 214 (Fla. 1989).

<sup>43</sup> 718 A.2d 828 (Pa. Super. Ct. 1998).

<sup>44</sup> *Id.* at 835-36.

Where the HMO is providing health care services rather than merely providing money to pay for services their conduct should be subject to scrutiny. We see no reason why the duties applicable to hospitals should not be equally applied to an HMO when that HMO is performing the same or similar functions as a hospital.

*Id.*

<sup>45</sup> *See generally* Allen D. Allred & Don L. Daniel, *Upon Further Review: Rush Prudential HMO, Inc. v. Moran and a New Era of Managed Care Organization Liability*, 47 ST. LOUIS U. L.J. 309, 323-330 (2003); Chittenden, *supra* note 39, at 455-57, 468; William M. Sage, *Enterprise Liability and the Emerging Managed Health Care System*, LAW & CONTEMP. PROBS., Spring 1997, at 159, 166, 173-74; Allen D. Allred, Terry O. Tottenham, *Liability and Indemnity Issues for Integrated Delivery Systems*, 40 ST. LOUIS U. L.J. 457, 458-59 (1996); Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431 (1988); David L. Trueman, *Managed Care Liability Today: Laws, Cases, Theories, and Current Issues*, 33 J. Health L. 191 (2000); Peter D. Jacobson & Scott D. Pomfret, *Form, Function, and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence*, 35 HOUS. L. REV. 985, 1067-68 (1998).

For cases featuring hospital and/or health plan liability, see *Shannon v. McNulty*, 718 A.2d 828 (Pa. Super. Ct. 1998); *Dunn v. Praiss*, 656 A.2d 413, 415 (N.J. 1995); *McClellan v. HMO Pa.*, 686 A.2d 801 (Pa. 1996); *Negron v. Patel*, 6 F. Supp. 2d 366, 370-71 (E.D. Pa. 1998); *Petrovich v. Share Health Plan of Ill., Inc.*, 719 N.E.2d 756 (Ill. 1999); *Jones v. Chicago HMO Ltd. of Ill.*, 730 N.E.2d 1119 (Ill. 2000); *Johnson v. Misericordia Cmty. Hosp.*, 301 N.W.2d 156 (Wis. 1981); *Simmons v. Tuomey Reg'l Med. Ctr.*, 533 S.E.2d 312, 322-23 (S.C. 2000); *Kampmeier v. Sa-*

tional duties, such as to avoid defective design and implementation of utilization management programs.<sup>46</sup>

Within this realm, several possibilities arise for litigation against health plans where the enrollee is spending his own money below the deductible.

### A. Decision Advisory and Related Health Services

Where a health plan undertakes to provide health care services, that assistance should comport with a reasonable standard of care. As noted above,<sup>47</sup> those services can include direct health advice such as telephone triage or decision aids<sup>48</sup> to help patients make major decisions. And they can include quality ratings of doctors and hospitals in an effort to guide patients toward better providers.

*Shannon*<sup>49</sup> concerned telephone triage. A pregnant woman who believed she was in pre-term labor was unable to obtain help from her

cred Heart Hosp., No. CIV. A. 95-7816, 1996 WL 220979 (E.D. Pa. May 2, 1996). *But see* *Gafner v. Down E. Cmty. Hosp.*, 735 A.2d 969 (Me. 1999).

<sup>46</sup> See *Wilson v. Blue Cross of S. Cal.*, 271 Cal. Rptr. 876, 878-80 (Cal. Ct. App. 1990); *Wickline v. State*, 228 Cal. Rptr. 661, 670-71 (Ct. App. 1986); *Long v. Great W. Life & Annuity Ins. Co.*, 957 P.2d 823, 826-28 (Wyo. 1998); *Dunn v. Praiss*, 656 A.2d 413 (N.J. 1995); *McClellan v. HMO of Pa.*, 686 A.2d 801 (Pa. 1996); *Steineke v. Share Health Plan of Neb., Inc.*, 518 N.W.2d 904 (Nev. 1994) (Caporale, J., dissenting); *Foster v. Blue Cross & Blue Shield of Mich.*, 969 F. Supp. 1020, 1024-25 (E.D. Mich. 1997); *Jones v. Chicago HMO Ltd. of Ill.*, 730 N.E.2d 1119 (Ill. 2000). *But see* *St. Luke's Episcopal Hosp. v. Agbor*, 952 S.W.2d 503 (Tex. 1997) (hospital found not liable for negligent credentialing based on explicit state statute; because this case predated Texas' more recent statute holding health plans potentially liable for their medical decisions, it is unclear whether this case has any precedential value).

See also *Allred & Daniel*, *supra* note 45, at 359-61; *Hall*, *supra* note 46, at 458-59 (discussing *Darling v. Charleston Community Memorial Hospital*, 211 N.E.2d 253 (Ill. 1965)); *Clark C. Havighurst, Making Health Plans Accountable for the Quality of Care*, 31 GA. L. REV. 587, 601-03 (1997); *Chittenden*, *supra* note 39, at 468-73; *Sage*, *supra* note 45, at 173-75.

In some of these cases, ERISA preempts claims for direct negligence that might otherwise go forward (*see infra* Part V). See, e.g., *Lancaster v. Kaiser Found. Health Plan*, 958 F. Supp. 1137 (E.D. Va. 1997); *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 54-56, 62-64 (D. Mass. 1997); *DeArmas v. Av-Med, Inc.*, 865 F. Supp. 816, 817-18 (S.D. Fla. 1994); *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182, 186 (E.D. Pa. 1994); *Elsesser v. Hosp. of Philadelphia Coll. of Osteopathic Med.*, 802 F. Supp. 1286, 1290-92 (E.D. Pa. 1992) (holding that ERISA preempts claims for misrepresentation but not for ostensible agency); *Altieri v. Cigna Dental Health, Inc.*, 753 F. Supp. 61, 64 (D. Conn. 1990); *Pacificare of Okla., Inc. v. Burage*, 59 F.3d 151, 155 (10th Cir. 1995).

<sup>47</sup> See *supra* Part I.B.

<sup>48</sup> *Rubenstein*, *supra* note 38; *O'Connor et al.*, *supra* note 33, at VAR-69.

<sup>49</sup> 718 A.2d 828 (Pa. Super. Ct. 1998).

physician, despite multiple attempts. The only help provided by the plan's phone triage service was to recommend that she try, again, to contact the unresponsive physician. The situation spiraled downward, and when Mrs. Shannon finally received care, the baby was delivered prematurely and died two days later.<sup>50</sup> The court held that the plaintiff had stated various causes of action, including direct corporate liability.<sup>51</sup> There could be liability for medically substandard advice, or failure to mention important options.<sup>52</sup>

Similarly, decision aids need to be well-constructed. Ideally, the patient should receive "high-quality, up-to-date information about the condition or disease stimulating the need for a decision, the available health care options, the likely outcomes for each option, the probabilities associated with those outcomes, and the level of scientific uncertainty."<sup>53</sup> Given the constant changes in medical science, maintaining this level of quality could pose serious challenges, as the aids would need to be regularly updated.<sup>54</sup> Equally importantly, the information

<sup>50</sup> *Id.* at 832.

<sup>51</sup> As the court described:

Where the HMO is providing health care services rather than merely providing money to pay for services their conduct should be subject to scrutiny. We see no reason why the duties applicable to hospitals should not be equally applied to an HMO when that HMO is performing the same or similar functions as a hospital. . . . Here, HealthAmerica provided a phone service for emergent care staffed by triage nurses. Hence, it was under a duty to oversee that the dispensing of advice by those nurses would be performed in a medically reasonable manner. Accordingly, we now make explicit that which was implicit in *McClellan* and find that HMOs may, under the right circumstances, be held corporately liable for a breach of any of the *Thompson* duties which causes harm to its subscribers.

*Id.* at 835-36.

<sup>52</sup> For instance, in *Smith v. Karen S. Reisig, M.D., Inc.*, a patient injured during a hysterectomy later learned that acceptable therapeutic alternatives might have permitted her to avoid the hysterectomy entirely. 686 P.2d 285, 288 (Okla. 1984). The Supreme Court of Oklahoma held that when the physician fails to disclose medically viable alternatives, the damages can include the cost of the treatment itself as well as any complications arising there from. *Id.*

<sup>53</sup> O'Connor et al., *supra* note 33, at VAR-64-65.

<sup>54</sup> *Id.* at VAR-67-68. O'Connor et al. note one effort to enhance the quality of these aids. *Id.* at VAR-68.

[T]he Cochrane Collaboration on Decision Aids has used six basic criteria (called 'CREDIBLE') to rate the quality of PtDAs: C = competent developers and development; R = recent; E = evidence-based; DI = disclosure of conflicts of interest; BL = balanced presentation of options, benefits, harms; and E = efficacious. A second generation of quality standards is being developed, using an international consensus process and key stakeholders such as developers, producers, users, and payers.

*Id.*



must not be biased, for instance, by inducing patients to choose less costly treatments. Where efforts fall short and a patient is injured by erroneous, outdated, biased, or incomplete information, liability could ensue for the health plan.<sup>55</sup> Although the undertaking may be gratuitous--an extra service the plan provides beyond those required under the contract--once the patient is invited to rely on this information, it should be provided with a reasonable level of competence. The Restatement (Second) of Torts cautions:

One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if

- (a) his failure to exercise such care increases the risk of harm, or
- (b) the harm is suffered because of the other's reliance upon the undertaking.<sup>56</sup>

Analogously, where plans purport to provide quality ratings of doctors, hospitals, or other providers in an effort to steer patients toward "better" care, those ratings should be founded on solid criteria and data.<sup>57</sup> Of interest, in July of 2007 "the New York State attorney general's office asked a health insurance company . . . to halt its planned introduction of a method for ranking doctors by quality of care and cost of service, warning of legal action if it did not comply."<sup>58</sup> The request was largely based on physician groups' concerns that the rankings were based more on cost than quality.<sup>59</sup>

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<sup>55</sup> For an excellent discussion of the arguments on behalf of holding health plans potentially liable for their medical information and advice, even in ERISA plans, see Kristin Madison, *ERISA and Liability for Provision of Medical Information*, 84 N.C. L. Rev. 471 (2006).

<sup>56</sup> RESTATEMENT (SECOND) OF TORTS § 323 (1965).

<sup>57</sup> See Gabel et al., *supra* note 24, at W401. Many observers believe that "the most important type of information – the quality of available providers – is not yet adequate to meet consumer needs." *Id.*

<sup>58</sup> Anthony Ramirez, *Attorney General Objects to Insurer's Ranking of Doctors by Cost and Quality*, N.Y. TIMES, July 14, 2007, at B3.

Generally, physicians express concern that the quality ratings that allegedly reflect their performance may be peppered with errors, and difficult to correct. Ellen Nakashima, *Doctors Rated but Can't Get a Second Opinion: Inaccurate Data About Physicians' Performance Can Harm Reputations*, WASH. POST, July 25, 2007, at A01; available at <http://www.washingtonpost.com/wp->

In a related scenario, at least one jury found a health plan liable for failing to provide the case management services they promised. As with telephone triage and other advisories, such services may be gratuitous in the sense that they go beyond the financial support that a health plan is first and foremost expected to provide. However, once offered, the plan generally has a duty to deliver. In *Smelik v. Mann*, when a woman died from problems associated with kidney failure, her husband sued his wife's physicians and HMO, arguing that the HMO did not provide the disease management programs they had promised, and which her condition warranted.<sup>60</sup> The case did not allege any failure to pay for medical care, but rather a failure to provide the close coordination and supervision of care that would be provided in a case management program.<sup>61</sup> Ultimately the federal district court awarded the plaintiff \$9 million in damages, 35 percent of which the jury assigned to Humana.<sup>62</sup>

To be sure, such jury verdicts do not create binding precedent. However, they may foreshadow future possibilities. Though health plans may not be obligated to provide ancillary advisory and case management services, once again a gratuitous undertaking must measure up to a reasonable standard of care.

#### B. Economic Informed Consent: Tort Injuries

Aside from the quality of their health advice, health plans might also incur liability related to economic informed consent. There are two scenarios: one in which the plan obstructs patients' access to pric-

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[dyn/content/article/2007/07/24/AR2007072402545\\_pf.html](http://online.wsj.com/article/2007/07/24/AR2007072402545_pf.html).

<sup>59</sup> *Id.* By the end of 2007 New York's Attorney General Andrew Cuomo had reached an agreement with major health plans regarding how they would construct and promulgate their physician rating systems. Jilian Mincer, Doctor Ratings Revised, *Wall St. J.*, December 16, 2007; available at <http://online.wsj.com/article/SB119776597524732041.html.html>

<sup>60</sup> *Jury Finds Humana Negligent in Care of Enrollee: HMO to Pay \$4.2 Million in Damages*, MEALEY'S MANAGED CARE LIABILITY REP., July 20, 2005, at 2 [hereinafter *Humana*] (reporting on the jury verdict in *Smelik v. Mann*, No. 2003-CI-06936 (Tex. Dist. Ct. June 28, 2005)). The plaintiff and physicians reached a confidential settlement prior to trial, but the suit against the HMO, Humana, proceeded. *Id.* at 1.

<sup>61</sup> For further discussion of *Smelik*, see Cameron Krier, *One Step Forward, Two Steps Back: The Impact of Aetna Health Inc. v. Davila on ERISA and Patients' Rights*, 38 *TEX. TECH L. REV.* 127, 151-52 (2005); Linda P. McKenzie, *Eligibility, Treatment, or Something In-Between? Plaintiffs Get Creative to Get past ERISA Preemption*, 23 *J. CONTEMP. HEALTH L. & POL'Y* 272 (2007).

<sup>62</sup> *Jury Finds Humana Negligent*, *supra* note 60, at 2.

ing information, and another in which the plan provides prices, but the numbers are inaccurate.

### 1. Health Plan Obstructs Economic Information

Hazards under the first scenario are real but, fortunately, fading. Elsewhere it has been argued that, under HDHPs, physicians could potentially encounter tort liability if they fail to make certain kinds of pricing information available.<sup>63</sup> In the applicable scenario the patient has, let us assume non-negligently, been injured by undergoing an intervention that he would have refused, had the physician explained its high financial cost.<sup>64</sup> Where the physician's failure to disclose the cost proximately causes the patient to accept the ill-fated procedure, tort liability for a failure of economic informed consent is plausible, even if not yet black-letter law.<sup>65</sup>

Assuming that this hypothetical breach of economic informed consent presents a viable claim for relief against a physician, health plans might incur a similar liability by forbidding physicians to disclose the pricing information that patients want and need.

Historically, insurers have done just that, largely to preserve their bargaining power with various physician groups.<sup>66</sup> Physicians too have been loath to forfeit the bargaining leverage that financial secrecy provides.<sup>67</sup> Thus, when patients try to find out costs, many have

<sup>63</sup> See Morreim, *New Twists*, *supra* note 1, at 1217-25. This particularly applies to the physician's own fees, as distinct from fees set by other providers, such as hospitals. See *id.* at 1219-20.

<sup>64</sup> See *id.*

<sup>65</sup> See *id.* at 1219-22.

<sup>66</sup> For example:

Insurers typically put confidentiality agreements into their contracts with medical providers, with the goal of keeping providers from getting information that could boost their bargaining power . . . .

Insurers also don't want rival insurers to know about the deals they strike with doctors, as the insurers compete with each other for business. Hospitals and doctors, who may accept less from one insurer than another, also have a stake in keeping the amounts they'll accept secret . . . .

Sarah Rubenstein, *Patients Paying for Medical Care Struggle to Divine the Costs*, WALL ST. J., Feb. 16, 2005, [http://online.wsj.com/article\\_print/0,,SB110780138521747816,00.html](http://online.wsj.com/article_print/0,,SB110780138521747816,00.html).

<sup>67</sup> "Medical providers and insurers consider [the price insurance companies pay for procedures] to be highly sensitive competitive information, and their contracts require that it remain secret." Judith Graham, *Pricing Health Care? It's Not That Easy*, CHI. TRIB., Aug. 10, 2006, at A1.

Beyond this, physicians who discuss fees with each other could trigger antitrust scrutiny directed toward possible price-fixing.

Doctors also cite federal and state laws that say competing insurers and doctors can't band together with their rivals to set the same prices across the

found their efforts blocked by doctors and health plans alike.<sup>68</sup> Where the health plan erects the block, then the plan may share in the liability.<sup>69</sup>

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board. Though the Federal Trade Commission doesn't say a doctor can't tell an individual patient their negotiated rates, sharing those rates with other physicians can sometimes lead to government scrutiny, making doctors hesitant to talk about them with anybody, says William Jessee, a doctor and chief executive of the Medical Group Management Association, an organization of people who manage and lead group medical practices.

Rubenstein, *supra* note 66.

<sup>68</sup> Patients "are running into a roadblock: Their insurers and doctors don't tell them the price tag for care in advance--when they can make a decision about it." Rubenstein, *supra* note 66.

<sup>69</sup> One potential legal theory on which liability might be founded is "tortious interference with the physician-patient relationship." The concept is largely theoretical, introduced by legal scholars in response to the rising impingement by managed care organizations (MCOs) on physicians' professional autonomy and medical judgment. As noted by Professor Hall:

A novel approach to these issues is to view them through the lens of tortious interference with advantageous relationships. This broadly articulated private law doctrine protects against "improper" interference with any type of existing or prospective contractual relationship. The doctrine is fully capable of activating the law's inchoate protection of individual patient/physician relationships from interference because the tort applies to any source of interference, lay or professional, and its highly malleable character allows it to adjust to varying degrees of interference. If a physician's judgment is dictated by orders from fellow professionals or if economic sanctions tied to treatment regimens are too severe, "impropriety" is the only concept the court must invoke to strike the arrangement. Thus, a hospital or HMO that restrained a physician's medical judgment in any manner not considered appropriate by the law could be subject to liability. Indeed, several courts have sustained tortious interference as a legitimate theory under which to challenge exclusions from a hospital medical staff. Also, in non-tort contexts, courts have relied on interference principles to police the validity of medical staff regulations such as mandatory consultation.

Hall, *supra* note 45, at 470-71 (citations omitted); see also Annotation, *Liability in Tort for Interference with Attorney-Client or Physician-Patient Relationship*, 26 A.L.R.3d 679, 683 (1969) (stating that third parties who interfere with the physician/patient "relationship will be held liable under the general principles of the tort of interference" (citation omitted)); David L. Trueman, *Managed Care Liability Today: Laws, Cases, Theories, and Current Issues*, 33 J. HEALTH L. 191, 220, 230-31 (2000).

Notwithstanding fairly sparse case law, there are at least some suggestive opinions. In *Drolet v. Healthsource, Inc.*, a health maintenance organization (HMO) promised members that "[t]he physician has a contractual relationship with Healthsource which does not interfere with the exercise of the physician's independent medical judgment . . ." 968 F.Supp. 757, 758 (D.N.H. 1997) (emphasis omitted).

In *Hammonds v. Aetna Casualty & Surety Co.*, a federal district court found that the plaintiff had stated a cause of action against the physician's malpractice insurer for allegedly inducing an interruption of the physician-patient relationship, for

Fortunately, this litigation scenario is becoming increasingly unlikely. Not only are most insurers backing away from their former insistence on secrecy, many are now taking the lead in providing cost information.<sup>70</sup> If the driving rationale for HDHPs is to inspire cost-consciousness in health care consumers, empowering patients with economic information is imperative.<sup>71</sup>

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allegedly inducing the physician to divulge confidential information gained through that relationship, and beyond that, severing the relationship under inappropriate pressure from that insurer. 237 F. Supp. 96, 98 (N.D. Ohio 1965).

<sup>70</sup> Some insurers, including Harvard Pilgrim and Tufts Health Plan, now publish on their websites the amounts they pay to doctors and hospitals for various outpatient tests and procedures. Liz Kowalczyk, *Insurers Post Prices for Medical Care*, BOSTON GLOBE, May 29, 2004, available at [http://www.boston.com/news/nation/articles/2004/05/29/insurers\\_post\\_prices\\_for\\_medical\\_care](http://www.boston.com/news/nation/articles/2004/05/29/insurers_post_prices_for_medical_care).

Some essentially provide the same service by providing price information, at the time of service, as the HSA debit card is swiped. Rubenstein, *supra* note 28.

Several insurers provide online tools to estimate the costs patients will pay, based on their particular insurance package, for selected procedures at various local hospitals. These insurers include Humana, Aetna, Lumenos, and WellPoint. Rubenstein, *supra* note 66; Fuhrmans, *supra* note 30.

Cigna now provides typical prices for certain types of doctor visits, and lists specific price ranges for hospitals nationwide for several common admissions, including child birth, angioplasty, and coronary bypass surgery, in addition to the quality and efficiency rankings it already provides for these admissions. Rubenstein, *supra* note 38; see Lewis Krauskopf, *Cigna to Publicize Prices for Medical Procedures*, REUTERS, Nov. 29, 2005, available at <http://gahealthplans.org/index.php?module=pagesetter&func=viewpub&tid=3&pid=238>.

In perhaps the most striking departure from the confidentiality about fees, Aetna is making available the exact prices it pays physicians for a wide variety of tests and procedures. It now provides this information for several cities, with plans to do the same elsewhere in the country. Vanessa Fuhrmans, *Insurer Reveals What Doctors Really Charge*, WALL ST. J., Aug. 18, 2005, at D1; Sarah Rubenstein, *Patients Get New Tools To Price Health Care*, WALL ST. J., June 13, 2006, at D1, available at [http://online.wsj.com/article/SB115016291772778539.html?mod=health\\_home\\_insider\\_today\\_left\\_column](http://online.wsj.com/article/SB115016291772778539.html?mod=health_home_insider_today_left_column).

In another instance, a private corporation plans to collect and make pricing information available in exchange for a modest fee. Jon Sarche, *Company Details True Cost of Health Care*, INT'L BUS. TIMES, Mar. 20, 2006, available at <http://in.ibtimes.com/articles/20060320/personal-insurance-health-savings.htm>.

<sup>71</sup> Like health plans, some governmental entities now provide or mandate certain price disclosures. Medicare, for instance, now places on its website price comparisons for similar brand name drugs used to treat such conditions as high blood pressure, arthritis, high cholesterol, and the like, and publishes the common prices it pays for certain medical procedures. See Robert Pear, *Price Comparison for Drugs is Put on Federal Web Site*, N.Y. TIMES, Sept. 16, 2004, at A18; Sarah Lueck, *Prices U.S. Pays Hospitals, Doctors To Be Publicized*, WALL ST. J., Mar. 14, 2006, at D4, available at [http://online.wsj.com/article/SB114230937938997488.html?mod=health\\_home\\_stories](http://online.wsj.com/article/SB114230937938997488.html?mod=health_home_stories); Ceci Connolly,

## 2. Health Plan Provides Inaccurate Economic Information

If the first litigation scenario is fading, a second might arise from the converse situation, in which the plan actively provides information about how much a proposed intervention might cost. Two kinds of effort must be distinguished.

On one hand, the plan might simply offer a rough approximation of, for instance, the average cost of a particular surgical procedure within an enrollee's geographic area.<sup>72</sup> Actual costs could vary widely among providers, and could change even more if a particular patient needs more or different services from those initially anticipated.<sup>73</sup> If the information is provided with appropriate caveats reminding patients of such variability, liability is doubtful because the plan has not created expectations of precision.

On the other hand, health plans may bear considerably greater accountability where they purport to provide exact information. Most commonly this might be the actual fee the plan negotiated with a particular provider for a given procedure. Importantly, this information should not be confused with telling the patient the prices each provider charges. The provider's charge may be considerably higher than what the health plan pays the provider, and unless that provider has agreed to accept the health plan's reimbursement as payment in full, the patient may be expected to pay the difference. In either event, whether the plan purports to tell what providers charge, or more narrowly what it will pay providers, the plan needs to be accurate and

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*Medicare Rates to Be Posted*, WASH. POST, Mar. 17, 2006, at A17, available at <http://www.washingtonpost.com/wp-dyn/content/article/2006/03/16/AR2006031601785.html>.

California and a number of other states now mandate that hospitals make public the "charge masters" that track list prices for all the services and products the hospital provides. See Lucette Lagnado, *Medical Markup: California Hospitals Open Books, Showing Huge Price Differences*, WALL ST. J., Dec. 27, 2004, at A1; Sarah Rubenstein, *Patients Get New Tools To Price Health Care: To Enable Comparison Shopping, More Insurers and States Reveal The Costs of Many Procedures*, WALL ST J, June 13, 2006, at D1, available at [http://online.wsj.com/article/SB115016291772778539.html?mod=health\\_home\\_inside\\_today\\_left\\_column](http://online.wsj.com/article/SB115016291772778539.html?mod=health_home_inside_today_left_column); Graham, *supra* note 67.

Some states are beginning to require that hospitals and surgery centers report costs of various outpatient procedures, as well as their success rates. Christi Parsons, *State Will Post Surgery Prices: Outpatient Data to Go Online in January '07*, CHI. TRIB., June 15, 2005, at Metro 1; Graham, *supra* note 67.

<sup>72</sup> Rubenstein, *supra* note 66; Paul B. Ginsburg & Joy M. Grossman, *When The Price Isn't Right: How Inadvertent Payment Incentives Drive Medical Care*, W5 Health Affairs 376, 380 Aug. 9, 2005, <http://content.healthaffairs.org/webexclusives/index.dtl?year=2005>

<sup>73</sup> See Martin, *supra* note 27.

specific<sup>74</sup> so that the patient can, if he wishes, choose providers or treatments according to affordability.

In this scenario, liability could follow an error that causes harm. If the plan provides a price figure that is too high, the patient might forego an intervention, thinking it to be too costly, thereby incurring harm. Conversely, if the number is significantly lower than the reality, the patient might accept an intervention that harms him, one he would not have accepted had he known the real cost.

This scenario is essentially equivalent to physicians' litigation risk.<sup>75</sup> The health plan may not have a duty to provide pricing information, but any such service must be provided with reasonable care.<sup>76</sup> If the patient is injured, and if a jury finds that a reasonable person would have chosen differently with accurate information, then the plan might indeed be liable in tort.<sup>77</sup> As discussed below, an analogous issue could arise where the question concerns the patient's progress toward meeting the deductible.<sup>78</sup>

Overall,

[a]lthough insurers are not likely to be guarantors of the information provided, courts will carefully scrutinize patients' decisions based on reasonable reliance on the accuracy and currency of the data. . . . If patients are expected to make choices about the value of treatment options relative to costs, including choosing high-quality providers, the institutions providing data will face litigation for any harm resulting from deficient information. Patients will have a strong claim that they justifiably and detrimentally relied on the insurer's information.<sup>79</sup>

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<sup>74</sup> See Fuhrmans, *supra* note 70 (arguing that simple pricing information is merely "a first step in bolstering healthcare consumerism").

<sup>75</sup> See Morreim, *New Twists*, *supra* note 1 at 1217-25.

<sup>76</sup> As the *Thompson* court quoted the Restatement 2d of Torts § 323:

One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if (a) his failure to exercise such care increases the risk of such harm, or (b) the harm is suffered because of the other's reliance upon the undertaking.

*Thompson*, 591 A.2d at 708.

<sup>77</sup> Morreim, *New Twists*, *supra* note 1, at 1225.

<sup>78</sup> See *infra* Sec. III.

<sup>79</sup> Peter D. Jacobson & Michael R. Tunick, *Consumer-Directed Health Care and the Courts: Let the Buyer (and Seller) Beware*, 26 HEALTH AFF. 704, 710 (2007).

### III. CONTRACT CLAIMS

#### A. Errors in Financial Management

As noted above,<sup>80</sup> insurers offering HDHPs and HSAs often accompany these products with a number of financial services, such as online tools to help members keep track of their health care bills, claims experience, and the financial activity in their HSA accounts, including current balance, contributions from the employer or employee to the HSA, any interest or dividends earned by the invested HSA funds, HSA maintenance fees, and any debts to providers that exceed available HSA funds.<sup>81</sup> Many insurers offering HDHPs do not actually manage the HSA money themselves, but rather contract with major banks.<sup>82</sup> Other HDHPs do administer their own HSAs, and UnitedHealth acquired a bank, Exante, which will manage its HSAs.<sup>83</sup>

As health insurers become increasingly enmeshed with their members' finances, opportunities for error arise. Some are purely accounting errors, while others may influence patients' provider choices, and still others carry broader financial implications.

##### 1. Accounting Errors

A variety of accounting errors could arise in these complex financial relationships. The health plan could deduct the wrong amount from the member's HSA, for instance, then make a refund that is wrongly cast as a contribution to the HSA.<sup>84</sup> This, in turn, could af-

<sup>80</sup> See *supra* Part I.

<sup>81</sup> Some of the plans that provide such services include: Definity Health, <http://www.definityhealth.com> (last visited Oct. 20, 2007); Lumenos, <http://www.lumenos.com> (last visited Oct. 29, 2007); The Chesapeake Life Ins. Co., <http://www.healthmarket.com> (last visited Nov. 4, 2007); and HealthAllies, <http://www.healthallies.com> (last visited Nov. 6, 2007).

<sup>82</sup> Aetna, for instance, partners with J.P. Morgan, while the Blue Cross and Blue Shield plans have linked with other banks. Jost & Hall, *supra* note 13, at 407.

<sup>83</sup> *Id.*; Jonathan G. Bethely, *United Offer: We'll Pay Doctors Up Front for Patients' Share*, AM. MED. NEWS, Apr. 10, 2006, <http://www.ama-assn.org/amednews/2006/04/10/bisb0410.htm>.

<sup>84</sup> Sarah Rubenstein, *Savings Accounts for Health Care Cause Confusion*, WALL ST. J. ONLINE, Nov. 30, 2004, [http://online.wsj.com/article\\_print/](http://online.wsj.com/article_print/). Richard Kaplan offers a useful discussion of the ins and outs of HSA contributions and management:

HSA contributions are subject, however, to an overall limitation, whether they come from the employer or from the employee. [I.R.C. § 223(b)(4)(B) (West 2004).] This limitation is the *lesser* [I.R.C. § 223(b)(2)(A), (B)] of: (1) the annual deductible of the 'high deductible health plan' that is associated with the HSA, [I.R.C. § 223(b)(2)(A)(i), (B)(i)] or (2) a limit that



fect the member's allowable contributions in the future. Disagreements could arise over whose job it is to correct which records. Myriad problems could arise, some of them quite serious. As noted by Professors Jost and Hall:

Because funds in HSAs can be carried over from year to year, insurers that administer HSAs could potentially accumulate large sums of money for which they are responsible. Most insurers, however, have little experience functioning as banks. The process of managing and investing assets, receiving deposits, processing checks and debit card transactions, and providing account statements may be new to them.<sup>85</sup>

Moreover, they point out, it is not clear that the usual governmental banking regulations will actually apply to a health insurer offering such financial services.<sup>86</sup> The only real requirement seems to be that "the funds must be maintained in a separate account and must not be commingled with insurer funds that are at risk. If these funds are kept separate from the insurer's other funds, then they are not subject to, and do not affect, the insurer's solvency and reserve requirements."<sup>87</sup>

Clearly, the opportunities for financial error in this new setting are abundant. And equally clearly, mismanagement could lead to litigation, whether as breach of contract, breach of warranty,<sup>88</sup> or even breach of fiduciary duty.<sup>89</sup>

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is adjusted annually for inflation. [I.R.C. § 223(b)(2)(A)(ii), (B)(ii), (g)(1)(B)(i).] In 2004, that limit is \$2,600 for self-only coverage and \$5,150 for family coverage. [I.R.S. Notice 2004-2, 2004-2 I.R.B. 269, 270 (Q&A 12).]

Kaplan, *supra* note 1, at 554.

<sup>85</sup> Jost & Hall, *supra* note 13, at 407.

<sup>86</sup> *Id.* at 408.

<sup>87</sup> *Id.*

<sup>88</sup> In *Dunn v. Praiss* the New Jersey Supreme court held, in a case concerning the concurrent duties of physicians and health plans to provide medical care, that the HMO could be liable for contribution to the physician, based on (alleged) breach of contract by HMO in its duty to provide care to its subscribers. 656 A.2d 413, 415-16 (N.J. 1995). The court went on to note that "[c]ontract law might also be utilized to hold HMOs liable for malpractice based on breach of contract or breach of warranty." *Id.* (citing David J. Oakley & Eileen M. Kelley, *HMO Liability for Malpractice of Member Physicians: The Case of IPA Model HMOs*, 23 TORT & INS. L.J. 624, 626 (1988)). In this case, the physician who had already been found liable for medical malpractice could rightly demand "contribution from his HMO on the basis of its independent breach of contractual duty to a patient-subscriber of the HMO." *Id.* at 416.

<sup>89</sup> In *Brosted v. Unum Life Ins. Co. Am.*, 421 F.3d 459 (7th Cir. 2005), for instance, the plaintiff had qualified for disability insurance benefits and began receiv-

Presumably, health plans will anticipate such eventualities with caveats and warnings. From one website: "[t]he program and its administrators have no liability for providing or guaranteeing service or the quality of service rendered. . . ."<sup>90</sup> However, it remains to be seen whether courts will agree that such warnings are sufficient to exonerate plans from liability where their accounting procedures are clearly inadequate, particularly where those warnings are inconsistent with glowing advertisements aiming to lure subscribers to purchase this plan with its putatively magnificent financial services.

To be sure, many of the accounting problems that arise when health plans venture to keep track of patients' HSAs and other financial issues within these high deductible plans will be correctible, and limited in their impact. Nevertheless, substantial sums of money are now in the hands of insurers who, as Jost and Hall observe, may be relatively inexperienced in these matters.<sup>91</sup> It remains to be seen whether the problems will remain small and limited.

## 2. Economic Informed Consent: Contract Damages

Whereas Part II identified physical harms that might result from inadequate economic informed consent, a different group of cases arises where the harm is only financial. Consider where a health plan says that Hospital A charges \$882 for a computed tomography (CT) scan of the head, whereas Hospital B charges \$4,038.<sup>92</sup> The patient

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ing payments. However, due to a clerical miscalculation, Brosted received higher reimbursement than he was entitled to. When the insurer subsequently reduced his benefits to make up for prior overages, Brosted sued, *inter alia*, alleging breach of fiduciary duty. Upholding the district court's summary judgment for defendant, the Seventh Circuit held that "a breach of fiduciary duty claim premised on a misstatement requires an intent to deceive." *Id.* at 466. In this ERISA case, the court also observed that, "while there is a duty to provide accurate information under ERISA, negligence in fulfilling that duty is not actionable." *Id.* (quoting *Vallone v. CNA Fin. Corp.*, 375 F.3d 623, 642 (7th Cir. 2004)); *See also* *Schmidt v. Sheet Metal Workers' Nat'l Pension Fund*, 128 F.3d 541 (7th Cir. 1997) (explaining that a claim for breach of fiduciary duty can only be valid against an individual or entity that qualifies as an ERISA "fiduciary" and showing an unwillingness to hold fiduciaries responsible where they provided adequate written disclosures, and did not participate in the communication of misleading information).

<sup>90</sup> HealthAllies, <http://www.healthallies.com/>. Health Allies is not an insurer, but rather is a network of discount providers. As of October 2003, HealthAllies became part of Uniprise, which is a division of UnitedHealth Group. <http://www.healthallies.com/public/about/index.jhtml>

<sup>91</sup> Jost & Hall, *supra* note 13, at 407.

<sup>92</sup> These numbers are real. When California required hospitals publicly to disclose their "chargemaster" rates for various procedures, it revealed the striking differences among various hospitals' charges for common tests and treatments. A

gets the test at A, learning too late that the price-tags were inadvertently reversed. Hospital A bills him \$4,038. He dearly wishes he had gone to Hospital B.

Or analogously, the health plan simply underestimates the cost of a procedure, telling the patient it will cost \$500 when in fact it is \$1500. The patient is not medically harmed by the test, but there was no urgent need for it, as his doctor had said "watch-and-wait" would have been medically acceptable. Had the patient known the true cost, he would have saved his money.

In contrast to the tort discussion in Part II, in which inaccurate price information causes the patient to select medical care that leads to physical injury,<sup>93</sup> here the injury is purely economic. The patient alleges he paid more than he would or should have, had he received an accurate, up-front estimate. In this setting, tort claims will have no viable foothold. The "economic loss rule," fundamental to the boundary between contract and tort, holds that where injuries are purely economic, unaccompanied by any personal injury, then the remedies must be purely financial, and pursuant to the law of contract.<sup>94</sup>

At that point the patient's opportunity to prevail under contract law will depend largely on the language surrounding the plan's offer to provide pricing information. If the plan padded its offer with caveats that it does not guarantee accuracy, the patient may have a thin reed on which to protest, particularly where he could have directly verified the prices on his own.

On a different tack, patients may wish to dispute whether the price was reasonable, e.g., whether Hospital B's bill for \$4038 was reasonable for a CT scan. However, these issues must generally be pursued against the provider who actually made the charge.<sup>95</sup>

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basic chest x-ray with two views ranged from \$120 to \$1,519; a comprehensive metabolic panel ranged from \$97 to \$1,733; CT scan of the head (without contrast) went from \$882 to \$4,038; a single tablet of Tylenol could be no charge or \$7; leeches ranged from \$19 to \$81 each. Lagnado, *supra* note 71.

<sup>93</sup> See *supra* Part II.B.2.

<sup>94</sup> *Alejandro v. Bull*, 153 P.3d 864, 868 (Wash. 2007) (noting that "the purpose of the economic loss rule is to bar recovery for alleged breach of tort duties where a contractual relationship exists and the losses are economic losses. If the economic loss rule applies, the party will be held to contract remedies, regardless of how the plaintiff characterizes the claims"); see also *Lloyd v. Gen. Motors Corp.*, 916 A.2d 257, 265-66 (Md. 2007); *Stop Loss Ins. Brokers, Inc. v. Brown & Toland Med. Group*, 49 Cal. Rptr. 3d 609, 612-13 (Ct. App. 2006) (explaining that absent social policy requiring resort to tort remedies, breach of contract claims cannot be recast in tort).

<sup>95</sup> See Morreim, *New Twists*, *supra* note 1, at 1251-59.

Nevertheless, in cases where the patient encounters serious difficulties trying to get the information on his own, or where the health plan advertises its service to help patients learn costs ahead of making decisions, the plan itself could potentially be liable for breach of contract when it provides inaccurate pricing information that causes the patient financial loss.

If a court finds a breach of contract, the question will then of course center on damages. If the patient actually received a service that was medically useful, the doctrine of unjust enrichment, or *quantum meruit*, will block any claim that the patient should pay nothing. Rather, the court would require that the patient pay a "reasonable" fee for the service.<sup>96</sup> To determine reasonableness, a court might look to what is charged by other providers in the community, plus any factors relevant to that particular hospital.<sup>97</sup> In contrast, if the patient successfully argues that the service was completely superfluous, or worthless, arguably his complaint will be against the provider who recommended and/or provided it, rather than against the insurer, who simply provided an incorrect pricing estimate.

If it is found that the patient paid too much for an otherwise medically acceptable service, the further question would address who owes the patient the difference between the actual price and the reasonable price. The plan will, of course, argue that the provider should be responsible for the difference, since the provider has demanded the excessive price. On the other hand, the provider can argue that it is the plan's error that induced the patient to seek out this particular provider and to accept this specific service. Had the plan not misled the patient, he would more likely have directly discussed prices with the provider and either negotiated an acceptable price or foregone the service.

While such questions are beyond the scope of this article, it should be noted that practical realities may play a significant role.

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<sup>96</sup> In *Doe v. HCA Health Services of Tennessee*, 46 S.W.3d 191, 198 (Tenn. 2001), the Tennessee Supreme Court held that, although the absence of a clearly set price term between a patient and hospital rendered the contract for service void for vagueness, the patient must pay a reasonable sum for services received. The court identified the elements of unjust enrichment: (1) no enforceable contract; (2) the party seeking recovery did provide goods or services; (3) the other party received them; (4) the parties should have reasonably understood that the party providing goods/services expected compensation; and (5) it would be unjust for a party to retain goods or services without paying. *Id.*

<sup>97</sup> *Id.* (citing *Galloway v. Methodist Hosp., Inc.*, 658 N.E.2d 611, 614 (Ind. Ct. App. 1995); *Heartland Health Sys., Inc. v. Chamberlin*, 871 S.W.2d 8, 11 (Mo. Ct. App. 1993)). For further discussion on questions about reasonableness of health care charges, see Morreim, *New Twists*, at 1251-59.

Patients may have a difficult time verifying pricing information, and health plans may be reluctant to annoy too many of their customers by abdicating responsibility when their advisories prove wrong. Moreover, as discussed below, a plethora of small claims suits may inspire plans either to take considerable care to ensure the accuracy of their information, or to provide some sort of informal guarantee that they will absorb the extra cost if they misinform the patient. Alternatively, plans might refrain entirely from providing price information. The latter would indeed be unfortunate, if plans' efforts to protect themselves served, in the end, to remove a valuable economic information service from the marketplace.

Yet another contract issue is likely to surface via HDHPs. To be sure, some patients will have ample funds available, particularly if they contribute generously to their HSAs, use few health care services, and then watch their HSA funds roll over from year to year to accumulate a tidy sum. However, many people with HDHPs will not have an HSA at all, and not everyone with an HSA will be able to fill the pot.<sup>98</sup> As a result, providers may find that, where their services must be paid for within the patient's deductible, they have trouble collecting.<sup>99</sup> One insurer, United Healthcare, has developed an answer that raises distinctive issues.

### B. Automatic Deductions

Historically, when patients are directly responsible for health care bills, they often pay physicians and hospitals slowly, taking an aver-

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<sup>98</sup> "In looking at total employer contributions to HSA qualified HDHPs, we note that 37% of employers offering HSA qualified HDHPs (covering 30% of workers enrolled in these plans) do not make contributions towards the HSAs that their workers establish. The averages that we show include the large portion of covered workers whose employer contribution to the HSA is zero." GARY CLAXTON ET AL., THE HENRY J. KAISER FAMILY FOUNDATION & HEADQUARTERS HEALTH RESEARCH AND EDUCATION TRUST, 2006 ANNUAL SURVEY OF EMPLOYER-SPONSORED HEALTH BENEFITS, at 105, available at <http://www.kff.org/insurance/7527/upload/7527.pdf>.

"According to a report last year by the U.S. Government Accountability Office, only about 55% of people who have such accounts put any money in them." Daniel Yi, *High Deductibles a Pain for Some Insured: Cash-Strapped Consumers Can End Up Forgoing Needed Medical Treatment or Falling into Debt*, L.A. TIMES, June 3, 2007, at C1.

<sup>99</sup> "Physicians may end up being unpleasantly surprised. Collecting from HSAs may prove more difficult than they might expect. Some patients will not pay their bills on time, even from their HSAs. Moreover, once HSAs are exhausted but deductibles have not yet been reached, patients are on their own. Most bankruptcies are currently driven in part by medical debt, and most persons bankrupted by medical debt are insured." Jost & Hall, *supra* note 13, at 417.

age of seven months,<sup>100</sup> or do not pay at all. According to the American Hospital Association, hospitals incurred nearly \$27 billion in uncompensated care in 2004.<sup>101</sup> In light of this pattern many providers are concerned that, when patients must personally pay even more of the bill than most do today, these shortfalls will grow worse, and with them, the costs of collection and its attendant animosity.

Patients, for their part, are commonly bewildered by the flurry of bills they receive, often multiple times from multiple providers, with no clear indication how much they owe, or how many of these notices are simply a statement of what has been, or might be, paid on their behalf.<sup>102</sup>

Banks and financial institutions are responding rapidly to the emerging need for financial services as HDHPs and HSAs gain in market share. Whereas only seven served the HSA market two years ago, more than 600 are in the business today, including financial giants like Bank of America and J.P. Morgan Chase.<sup>103</sup> In some cases, health plans link up with existing banks,<sup>104</sup> while in other cases the health plan literally creates its own bank.<sup>105</sup> First among the latter, UnitedHealth Group opened a bank, Exante, and is testing a novel, far-reaching financial service.<sup>106</sup>

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<sup>100</sup> Tracey Walker, *UnitedHealth Pilot Explores Credit Line/Paycheck Deduction*, MANAGED HEALTHCARE EXECUTIVE, June 2006, at 17, 17; *One Bill, One Pay: Pilot Program Simplifies Billing for Consumers and Physicians*, HUB MAGAZINE, Summer 2006, available at <http://www.hubmagazine.net/articles.php?ID=106>.

<sup>101</sup> While some of this deficit is for care of the medically indigent, insured patients incur a significant portion. Walker, *supra* note 100; *One Bill, One Pay*, *supra* note 100; see also Kim Dixon, *Hospitals Struggle over Who Can Afford to Pay*, REUTERS, Aug. 6, 2007, <http://www.reuters.com/article/ousiv/idUSN0333186320070806>.

<sup>102</sup> See *One Bill, One Pay*, *supra* note 100.

<sup>103</sup> This includes over 200 credit unions and more than 400 banks that provide HSA management. John Carroll, *Banks Give Insurers an Offer Most of Them Cannot Refuse*, MANAGED CARE MAG., July 2006, available at <http://www.managedcaremag.com/archives/0607/0607.banks.html>.

<sup>104</sup> BlueCross & BlueShield of Tennessee, for instance, has teamed up with Wells Fargo and First Horizon Bank. *Id.*

<sup>105</sup> Blue Cross & Blue Shield Association expected to open its own bank, Blue Healthcare Bank, in January 2007. *Id.*; see also Rob Roberts, *Blue Cross Association Enters Health Care Banking*, KANSAS CITY BUS. J., Feb. 13, 2007, available at <http://kansascity.bizjournals.com/kansascity/stories/2007/02/12/daily17.html> (noting the approval of a federal savings bank charter for Blue Healthcare Bank and detailing the bank's plans).

<sup>106</sup> UnitedHealth Group, About Exante Financial Services (January, 2007), [http://www.unitedhealthgroup.com/assets/shared/Exante\\_Fact\\_Sheet.pdf](http://www.unitedhealthgroup.com/assets/shared/Exante_Fact_Sheet.pdf); *One Bill, One Pay*, *supra* note 100; Pamela Babcock, *Medical Expenses Deducted From Checks: Workers Out of 'Blizzard of Paperwork'*, H.R. MAGAZINE, June 1, 2006, available at <http://www.allbusiness.com/>

The plan, called OnePay, is completely voluntary for employers, patients, and providers. When the patient incurs a bill, she offers her OnePay card, whereupon the entire bill is processed, and once adjudicated and approved by the insurer, is immediately paid in full, both the insurer's and the patient's portions. Thereafter the patient receives a monthly statement, much like a credit card statement, detailing the charges paid and the patient's share of the bill. As with a credit card, the patient then has 20 days to review and dispute the charges. "If a dispute is filed, the charges are put on hold; no payment is taken or interest charged until the dispute is resolved."<sup>107</sup> Once the individual's charges are clear, she has the option of paying out of pocket, drawing on her HSA, HRA, FSA, MSA or other health spending account,<sup>108</sup> or if available funds are insufficient, drawing on a line of credit that comes with the OnePay plan. At that point, the debt will be paid by a moderate monthly deduction from the patient's paycheck, no more than \$60 per pay period, with interest charged at the prime rate, 7.5 percent as of the program's inception in April, 2006.

For patients who might otherwise have charged their health care on a credit card with a much higher interest rate, this sort of arrangement may be very attractive. Providers who enter the program agree to give an additional discount, which is then split between the patient and the employer.<sup>109</sup> However, notwithstanding the potential advantages for providers, for the banks who reap fees for such services, and even for patients who may be able to reduce the confusion of multiple bills or high interest rates from credit cards, several contract-related issues could arise under this arrangement.

One potential problem is that, although patients will have a 20-day grace period in which to dispute any charges, health care and its bills are often highly complex. Some people may not be able to understand the bill well enough to know what needs to be challenged.<sup>110</sup> In any event, challenges could take several forms. Most simple is a

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sector-92-public-administration/administration-human/1181868-1.html; Bethely, *supra* note 83; see Carroll, *supra* note 103.

<sup>107</sup> Walker, *supra* note 100.

<sup>108</sup> See Blumenthal, *supra* note 14, at 197-98.

<sup>109</sup> Sarah Rubenstein, *In New Health Plan, Patients Pay Their Share -- Or Else*, WALL ST. J., Mar. 13, 2006, at B1, available at [http://online.wsj.com/article/SB114221304342196190.html?mod=health\\_home\\_inside\\_today\\_left\\_column](http://online.wsj.com/article/SB114221304342196190.html?mod=health_home_inside_today_left_column); *One Bill, One Pay*, *supra* note 100; Babcock, *supra* note 106; Bethely, *supra* note 83.

<sup>110</sup> At this time, it is unclear when patients will lose their right to challenge, whether it will expire in those first twenty days or at some later point. Presumably, this problem could be addressed in the same manner as credit card disputes, in which problems discovered after this period are rectified with appropriate credits to patients' accounts, where warranted.

complete error, as where the patient did not receive the service in question. Presumably these could be solved relatively easily by reconciling bills with patient records.

More interestingly, the patient may acknowledge that she received the service, but may want to dispute the reasonableness of the provider's prices. As noted elsewhere, this has already become a keen focus in litigation against health care providers.<sup>111</sup> Most pertinently here, once the bill has been paid, the patient's right to contest prices may be foreclosed. In fact, courts are divided over whether the patient must have already paid the bill, or conversely must not have paid, to have standing to sue over allegedly unreasonable prices.

On one side, in *Hall v Humana Hosp. Daytona Beach*<sup>112</sup> the court ruled that because plaintiffs had already paid the bill, they could no longer contest the reasonableness of providers' charges.<sup>113</sup> Even if there may have been elements of compulsion when patients were still hospitalized, the plaintiffs paid the bill after the need for care ended, hence any potential for duress no longer existed.<sup>114</sup>

On the opposite side, in *Burton v. William Beaumont Hospital*<sup>115</sup> a federal district court ruled that the plaintiffs, who refused to pay all charges in full, could not maintain a claim for relief against the hospital for excessive and unreasonable charges. "The rule in Michigan is that one who first breaches a contract cannot maintain an action against the other contracting party for his subsequent breach or failure to perform."<sup>116</sup>

Thus, these diverging trends illustrate the lack of clarity on whether the patient whose bill is already paid via a system such as OnePay would have standing to oppose providers' charges. Under *Burton* they could not raise their issue unless they have paid, but un-

<sup>111</sup> See Morreim, *New Twists*, *supra* note 1, at 1243-51.

<sup>112</sup> *Hall v Humana Hosp. Daytona Beach*, 686 So. 2d 653 (Fla. Dist. Ct. App. 1996).

<sup>113</sup> In this case a group of patients filed a class action demanding partial refunds for items such as pharmaceuticals, medical supplies, and lab services, which they argued were excessive, unreasonable, and disproportionate to the market prices for those same items. *Id.* at 655. Examples included \$11.50 for one tablet of Zantac, \$52 for one Tylenol with codeine, and \$20.50 for one tablet of Cipro. *Id.* The Florida appellate court affirmed summary judgment on this issue. *Id.* at 658.

<sup>114</sup> "By voluntarily making payment of these alleged overcharges once the alleged coercion practiced by Humana had ceased, Plaintiffs ratified or affirmed their prior agreement to pay these charges." *Id.* at 657. Two years later another Florida appellate court applied the same reasoning to similar circumstances. *Greene v. Alachua Gen. Hosp., Inc.*, 705 So. 2d 953, 953 (Fla. Dist. Ct. App.-1st 1998).

<sup>115</sup> 373 F. Supp. 2d 707 (E.D. Mich. 2005).

<sup>116</sup> *Id.* at 719 (quoting *Flamm v. Scherer*, 198 N.W.2d 702 (Mich. Ct. App. 1972)).



der *Hall* they could not do so unless they have *not* paid. Clearly, the latter scenario raises a particularly serious question for people in a system like OnePay. Courts could find that once the patient allows the bill to be paid, by not disputing it during the 20-day grace period, or indeed perhaps by voluntarily signing up for the program in the first place,<sup>117</sup> then the patient voluntarily paid the provider's charges, precisely as she agreed to in her contract with that provider.<sup>118</sup> Under *Hall* she would have lost her standing to contest the prices.

Of note, that putative voluntariness might itself be challenged. Even at an early pilot-testing stage, one officer from UnitedHealth Group indicated that "[w]e've had some employers ask us if we could force it on an entire population."<sup>119</sup> Providers, too, could pressure patients to accept the automatic bill-paying mechanism, simply by closing their practices to anyone who does not accept it. If patients' enlistment in automatic bill-paying was not genuinely voluntary, *Hall's* reasoning may be less applicable.

Moreover, patients could argue that the sheer size and complexity of their bills,<sup>120</sup> particularly for hospitalization or other complicated care, precludes virtually anyone but the most educated from being able to discern the accuracy, let alone reasonableness, of the charges within a 20-day grace period, or other limited timeframe.

If indeed litigation emerges under the theory that a OnePay type system has precluded the patient from challenging any charges not promptly contested, a different problem may develop. If patients become locked into accepting a charge simply by not disputing it, patients may be incentivized to keep charges under dispute, just to make sure they do not foreclose their options, or just to delay the day they must pay. Here, contract claims may be brought by providers against patients rather than vice versa. The prospect of such scenarios thus highlights the point that, when payment plans such as OnePay are brought into the market, their contractual terms must be both fair in light of patients' marked bargaining disadvantages, and clearly disclosed.

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<sup>117</sup> According to the terms of the pilot program, OnePay is voluntary for patients, employers, and providers. Walker, *supra* note 100; *One Bill, OnePay*, *supra* note 100; Babcock, *supra* note 106.

<sup>118</sup> *Hall*, 686 So. 2d at 656-57.

<sup>119</sup> Quoted comment is from Tom Policelli, senior vice president of health care financial solutions for Uniprise, a subsidiary of UnitedHealth Group. Babcock, *supra* note 106.

<sup>120</sup> See Lee Gomes, *A Technology Writer Confronts Wizardry in Today's Hospitals*, WALL ST. J., Mar. 7, 2007, at B1 (describing complex technology involved in his twelve-day hospitalization for pneumonia, and appending to the article to a copy of his fifteen-page hospital bill).

One way or another, the well-known difficulties of collecting from patients can be expected to generate significant controversy where, for the first time, a substantial number of patients must pay virtually all of their care out of pocket or HSA, where the amounts at stake are considerably larger than at any time in the past, and where patients will likely be scrutinizing the value, cost, and quality of their care ever more intensely.

#### IV. COUNTING TOWARD THE DEDUCTIBLE

##### A. The Basics About Deductibles Under HDHPs

With the foregoing discussion of general tort and contract issues, it is now possible to focus on a narrower, quite distinctive area. Where patients are still spending out of their own pockets or HSAs, many will want to know whether a particular expenditure will count toward their deductibles.<sup>121</sup>

The question is important because patients need to know, not just the initial price of a test or treatment, but the "bottom line" cost. Suppose, for example, that Lasik eye surgery costs \$3500 and the patient's deductible is \$5000. If all \$3500 counts toward his deductible, then he is only \$1500 away from the point at which insurance will cover additional health expenses. Indeed, many health plan members make a host of such calculations toward the end of each benefits-year. Those who have already meet the deductible for the current year may try to fit in a variety of health care services, since those services will be covered. Those who have not met the deductible may opt to delay certain kinds of care, since the cost will be out of pocket.<sup>122</sup> The ostensibly simple question of whether and how much an intervention will count toward the deductible is thus fraught with complexities.

First, the expenditure must be a covered service under the policy. The fact that it may be an "eligible" or "qualified" medical expense under the HSA--meaning that one can pay for it with tax-free funds--says nothing about whether it will count toward the insurer's deducti-

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<sup>121</sup> "Consumer-directed care also raises questions about the cost of various clinical options and whether insurers will accept medical expenses as meeting the insurance deductible." Jacobson & Tunick, *supra* note 79, at 706. "[A] patient may sue if the insurer subsequently rejects the deductible expense as not medically necessary." *Id.* at 707.

<sup>122</sup> Alice Dembner, *High Deductibles a Healthcare Worry: The Newly Insured May Shun Doctors*, BOSTON GLOBE, Mar. 5, 2007, at A1, available at [http://www.boston.com/news/local/articles/2007/03/05/high\\_deductibles\\_a\\_healthcare\\_worry/](http://www.boston.com/news/local/articles/2007/03/05/high_deductibles_a_healthcare_worry/).

ble.<sup>123</sup> If Lasik is not a covered service under an individual's health plan, no part of the fee will count toward the deductible, and the patient will still have to meet her \$5000 deductible before catastrophic coverage kicks in.<sup>124</sup>

Discount networks introduce comparable potential for confusion. As noted above,<sup>125</sup> one of the benefits many plans now offer is the opportunity to save on a host of health care services that are, themselves, outside the plan. For instance, plans may incentivize members to use fitness facilities by providing discounts at local health clubs.<sup>126</sup> It would be easy, but mistaken, for patients to suppose that because their insurer provides such opportunities, they are part of the plan's covered benefits and that their costs will chip away at the deductible.<sup>127</sup>

Second, even if a particular kind of service such as a diagnostic CT scan generally qualifies as a covered benefit, it does not mean that every CT scan of every patient will be covered. Preauthorization requirements for proposed interventions, and retrospective review after receipt of care,<sup>128</sup> will still figure prominently. Medical necessity

<sup>123</sup> Kaplan, *supra* note 1, at 560; Jost & Hall, *supra* note 13, at 401.

<sup>124</sup> Sarah Rubenstein describes a specific example:

Plans with high deductibles can leave some benefits out. In Ms. Stacey's region, for example, one \$2,500-deductible plan from LifeWise Health Plan of Washington includes coverage for three visits to the doctor a year, even before meeting the deductible, but it provides no coverage for prescription drugs, preventive-care exams, maternity care or mental-health care. It also has a separate, \$5,000 deductible for services a customer gets from an out-of-network medical provider.

Sarah Rubenstein, *As Health Deductibles Increase, So Does Consumers' Confusion*, WALL ST. J. ONLINE, Jan. 28, 2005, [http://online.wsj.com/article/0,,SB110633529596332769,00.html?mod=health\\_home\\_inside\\_today\\_left\\_column](http://online.wsj.com/article/0,,SB110633529596332769,00.html?mod=health_home_inside_today_left_column).

<sup>125</sup> See *supra* Part I.A.

<sup>126</sup> Robinson, *supra* note 5, at 146.

<sup>127</sup> Jost & Hall, *supra* note 13, at 410; see generally Britton, *supra* note 32. Another source of confusion within these discount networks concerns which providers are actually in the network and thus, which providers are obligated to provide a discount. See Britton, *supra* note 32, at 109-10 (noting that providers are often "ignorant" about their status as a "network provider"); *McPherson v. Shea Ear Clinic*, No. W2006-01936-COA-R3-CV, 2007 WL 1237718, at \*1-\*2 (Tenn. Ct. App. Apr. 27, 2007) (highlighting an instance in which a consumer was presented with an unexpected fee from providers who were part of a discount plan).

<sup>128</sup> It is useful to distinguish between prospective, concurrent, and retrospective utilization review. In prospective review, physicians are expected to obtain the health plan's pre-certification to ensure payment for contemplated hospitalizations, surgeries, or other costly interventions. In concurrent review, the health plan or review entity contacts physicians caring for its hospitalized members on a regular basis to ensure that the patient does not remain in the hospital longer than necessary, and

"serves almost universally as the contractual touchstone of plan coverage,"<sup>129</sup> and even in HDHPs, health plans will review claims to determine whether a service is "medically necessary"<sup>130</sup> and thereby covered.

Plans are . . . concerned that deductibles not be exhausted too quickly, and they continue to impose pre-approval or other utilization review requirements in determining whether expenses are covered and count against the deductible and the out-of-pocket maximum. Therefore, providers still need to ensure that patients receive needed approvals before services are rendered.<sup>131</sup>

Indeed, the Medicare Modernization Act that created HSAs<sup>132</sup> expressly "permits HDHPs to impose penalties for the failure of insured's to seek precertification of services and these penalties do not count against the HDHP out-of-pocket maximum, or, presumably, against the deductible."<sup>133</sup> As a result, if the patient failed to obtain

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receives appropriate types and levels of care. In retrospective review, a payor (or an independent reviewer with which it has contracted) decides, after care has been rendered, whether it will reimburse providers. MORREIM, *supra* note 22, at 32.

<sup>129</sup> CLARK C. HAVIGHURST, *HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM* 15 (1995); *see also* Mark A. Hall et al., *Judicial Protection of Managed Care Consumers: An Empirical Study of Insurance Coverage Disputes*, 26 SETON HALL L. REV. 1055, 1055 (1996).

<sup>130</sup> As Professor Hall summarizes the point, the bare fact that the health plan has a higher deductible will not likely change the basic contractual bases for coverage. The same "medical necessity" reviews that ordinarily govern adjudication of benefits will still be in place. "If the basic contractual standards of medical necessity did not materially change under managed-care insurance, this change is certainly not likely to happen under consumer-driven health insurance, particularly as managed-care restrictions are loosened." Mark A. Hall, *Paying for What You Get and Getting What You Pay for: Legal Responses to Consumer-Driven Health Care*, LAW & CONTEMP. PROBS., Autumn 2006, at 159, 172. Professor Hall further notes:

Insurers will sometimes deny medical necessity for expenditures that are entirely subject to the deductible even though the insurer is not obligated in any event. This is because medical necessity still determines whether these initial expenditures count toward the deductible each year, and the deductible determines insurers' responsibility for costs above the deductible; therefore, insurers retain some stake in reviewing medical necessity below the deductible.

*Id.* at 173 (citations omitted).

<sup>131</sup> Jost & Hall, *supra* note 13, at 417.

<sup>132</sup> *See* I.R.S. Notice 2004-50, 2004-33 I.R.B. 196, available at <http://www.irs.gov/pub/irs-irbs/irb04-33.pdf> (discussing expenses and HDHPs in Q&A 16, 18, and 19); I.R.S. Notice 2004-2, 2004-2 I.R.B. 269, available at <http://www.irs.gov/pub/irs-irbs/irb04-02.pdf> (addressing HDHPs in Q&A 4).

<sup>133</sup> Jost & Hall, *supra* note 13, at 409.

required pre-approval, an otherwise covered type of service may not be deductible in a given instance.

Third, even if the service is covered and approved, this does not mean that the full amount the patient paid will count toward his deductible. In some cases a service may be covered only up to a certain amount. If a plan covers \$500 of physical therapy per year, for instance, then even if the patient paid for \$800 of physical therapy, only \$500 will count toward the deductible.<sup>134</sup> By the same token, plans will not simply pay whatever a particular provider wants to charge. If a surgeon charges \$3000 for a service that the plan only considers worth \$1500, then only \$1500 counts toward the deductible. Generally, if the patient's provider is within the network of preferred providers with whom the plan has contractual fee arrangements, the amount deducted will be the contracted amount. However, if the provider is out-of-network, the plan will pay whatever it deems reasonable for the service.<sup>135</sup> That amount could be substantially less than the patient expects.

In the final analysis, patients may be headed for ugly surprises if they do not understand the complex details of these new health plans. "It is easy to imagine some consumers exhausting their HSAs on miscellaneous expenses that do not count toward the deductible at all and then facing the rude surprise of 'catastrophic' medical expenses once a serious accident or illness strikes and learning that insurance coverage is still a long way off."<sup>136</sup>

### B. Possibilities for Tort Litigation

Parallel to the discussion above,<sup>137</sup> one opportunity for tort litigation concerns economic informed consent. Here, the plan might erroneously say a service is not deductible, prompting the patient to forego a test or treatment. She thereby suffers harm that could have

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<sup>134</sup> Rubenstein, *supra* note 124.

<sup>135</sup> *Id.*

If your doctor is in the network, you'll get a discounted rate that's been negotiated by your insurer. For out-of-network doctors, your insurer will likely have an amount that it's defined as 'reasonable and customary' for your doctor to charge. Your doctor can bill you for more than what's 'reasonable,' but generally only the 'reasonable' amount will count toward your deductible.

*Id.*

<sup>136</sup> Jost & Hall, *supra* note 13, at 409-10; see also Sarah Rubenstein, *Savings Accounts for Health Care Cause Confusion*, WALL ST. J., Nov. 30, 2004, at D3 (explaining the potential issues associated with HSAs, including determining how much money is in the account, what the patient ought to pay, and avoiding tax errors).

<sup>137</sup> See *supra* Parts II, III.B.

been averted, had the plan correctly noted that the intervention was indeed deductible. The same basic sequence could happen if, for instance, the plan substantially over- or understates the deductible amount, likewise prompting the misinformed patient to accept or forego an intervention, to his medical detriment.

Informed consent scenarios go well beyond purely economic misstatements. Suppose, for instance, that a physician recommends an MRI to evaluate lower back pain. The patient, somewhat uncertain about whether he wants to spend the \$800, asks his insurer whether this expenditure will count toward his deductible. A plan representative reviews the patient's records and declares the scan "not medically necessary,"<sup>138</sup> hence no part of the charge would count toward the deductible. The patient is caught in an ugly cross-fire in which his physician says "you must" while his insurer says "it's needless." Nevertheless, relieved at the prospect of saving money, the patient relies on the plan's medical judgment and foregoes the scan. Unfortunately, it turns out he should have gotten the MRI. He is thereby harmed as the delay in diagnosing his problem leads to a serious deterioration in his condition.

Obviously this scenario invites claims against the physician. Perhaps she did not sufficiently emphasize the importance of the MRI,<sup>139</sup> or perhaps she should have helped the patient fight the denial.<sup>140</sup> And

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<sup>138</sup> Indeed, many plans now require prospective utilization review of radiologic diagnostics such as magnetic resonance imaging (MRI) or computed tomography (CT) scans, as these procedures are among the biggest current contributors to the rise in health care costs.

The number of imaging procedures, including traditional X-rays, is rising by 20 percent a year, according to National Imaging Associates, a New Jersey firm that provides imaging services for many health plans, including Harvard Pilgrim and Tufts. But costs for advanced imaging techniques are increasing by as much as 35 percent annually, according to the company.

Even though they account for a small percentage of the number of overall imaging procedures, they account for most of the spending increase.

Jeffrey Krasner, *Blue Cross to Require Preapproval for Scans: MRI, Other Imaging Costs Up 20% in Year*, BOSTON GLOBE, Sept. 6, 2005, at C1, available at [http://www.boston.com/business/healthcare/articles/2005/09/06/blue\\_cross\\_to\\_require\\_preapproval\\_for\\_scans/](http://www.boston.com/business/healthcare/articles/2005/09/06/blue_cross_to_require_preapproval_for_scans/).

See also David Phelps, *Insurers Want 2nd Opinion Before MRI, CT Scans*, STAR TRIBUNE, January 3, 2007, <http://www.startribune.com/535/story/914071.html>; Linda A. Johnson, *Health Insurers Limit Advanced Scans*, SEATTLE TIMES, March 24, 2008, [http://seattletimes.nwsource.com/html/business/technology/2004300975\\_aplimitingmedicalscans.html](http://seattletimes.nwsource.com/html/business/technology/2004300975_aplimitingmedicalscans.html).

<sup>139</sup> Morreim, *New Twists*, *supra* note 1, at 1222-23.

<sup>140</sup> See *id.* at 1220.

there may be room to blame the patient: it was his choice to forego a recommended intervention to save money.<sup>141</sup>

But there might also be claims against the health plan. Where plans undertake the medical judgments implicit in utilization review, they may be expected to do so in a medically credible way. Some courts note that, even where health plans ostensibly make only a determination of benefits, sometimes they cannot do so without also making medical judgments.<sup>142</sup> And as opined by other courts, health plans' utilization review mechanisms must be medically sound.<sup>143</sup> Other cases have considered whether physicians, acting as utilization reviewers or medical directors for health plans, are acting as physicians subject to review by state licensing boards,<sup>144</sup> and whether they can be said to have a physician-patient relationship with the person whose care they are reviewing.<sup>145</sup> Moreover, at least fourteen states

<sup>141</sup> See *id.* at 1226-1230.

<sup>142</sup> *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1331 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992).

<sup>143</sup> See *Wickline v. State*, 228 Cal. Rptr. 661, 670 (Ct. App. 1986) (holding that "[t]hird party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms"); *Wilson v. Blue Cross Southern. Calof.*, 271 Cal. Rptr. 876, 884 (Cal. Ct. App. 1990).

<sup>144</sup> In *Murphy v. Bd. Med.Exam'rs Ariz.*, 949 P.2d 530 (Ariz. Ct. App. 1 1997), a physician engaging in utilization review ("UR") on behalf of a managed care organization declined to authorize gallbladder surgery, pointing to the patient's prior history of irritable bowel syndrome, her normal laboratory blood values, and the absence of evidence for stones on ultrasound examination. The state's Board of Medical Examiners ("BOMEX") noted that in cases like this, UR physicians' "decisions could adversely affect the health of a patient", *Id.* at 535, and concluded that because this UR physician had indeed practiced medicine, the Board had jurisdiction over the quality of his practice. The Arizona appellate court agreed.

Although Dr. Murphy is not engaged in the traditional practice of medicine, to the extent that he renders medical decisions his conduct is reviewable by BOMEX. Here, Dr. Murphy evaluated information provided by both the patient's primary physician and her surgeon. He disagreed with their decision that gallbladder surgery would alleviate her ongoing symptoms. S.B.'s doctors diagnosed a medical condition and proposed a non-experimental course of treatment. Dr. Murphy substituted his medical judgment for theirs and determined that the surgery was 'not medically necessary.' There is no other way to characterize Dr. Murphy's decision: it was a 'medical' decision.

*Id.* at 536. *But see* *Morris v. D.C. Bd. of Med.*, 701 A.2d 364 (D.C. 1997).

<sup>145</sup> A Texas appellate court held that the physician on call to authorize admissions for a health plan did indeed have a physician-patient relationship with a man for whom he refused to authorize hospitalization:

[T]he contracts . . . show that the Humana plan brought Hand and Tavera together just as surely as though they had met directly and entered the physician-patient relationship. . . . In effect, Hand had paid in advance for the

have statutes governing liability of managed care organizations.<sup>146</sup> One important component in many of these, as seen for instance in the Texas Health Care Liability Act, requires that health plans must exercise ordinary care when making medical judgments.<sup>147</sup> Case law likewise supports the notion that, where a health plan provides concrete medical information or advice as part of its benefits determination process, the plan should be susceptible to liability where its information and reasoning are medically unsound.<sup>148</sup>

In the MRI hypothetical, then, the injured patient might be able to show duty and breach in a tort claim against the health plan, if it turns out that the plan used medically substandard judgment in its decision that the imaging procedure was not medically warranted, hence not deductible. The patient would also, of course, have to prove causation, typically that had the plan made a medically credible decision, the reasonable person would have decided differently and avoided the injury.<sup>149</sup> If the denial was particularly egregious, he might additionally allege bad faith breach of contract.<sup>150</sup>

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services of the Humana plan doctor on duty that night, who happened to be Tavera, and the physician-patient relationship existed. We hold that when the health-care plan's insured shows up at a participating hospital emergency room, and the plan's doctor on call is consulted about treatment or admission, there is a physician-patient relationship between the doctor and the insured.

Hand v. Tavera, 864 S.W.2d 678, 679 (Tex. Ct. App. 1993).

<sup>146</sup> Rich & Erb, *supra* note 4, at 271.

<sup>147</sup> Texas Health Care Liability Act (THCLA), TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-003 (Vernon 2005 & Supp. 2006); *see, e.g.*, Corporate Health Ins., Inc. v. Texas Dep't of Ins., 220 F.3d 641 (5th Cir. 2000).

<sup>148</sup> For an excellent discussion of this liability, see Madison, *supra* note 55.

<sup>149</sup> For discussion of the causality element in such cases see Morreim, *New Twists*, *supra* note 1, at 1225.

<sup>150</sup> Mariner, *supra* note 24, at 527; *see also* Kenneth S. Abraham, *Judge-Made Law and Judge-Made Insurance: Honoring the Reasonable Expectations of the Insured*, 67 VA. L. REV. 1151 (1981); Allred & Daniel, *supra* note 45, at 330-32.

At the extreme, deficiencies that spring from malice, oppression, or reckless indifference to the rights of subscribers may constitute bad faith. *See* Weatherly v. Blue Cross Blue Shield Ins. Co., 513 N.W.2d 347, 354 (Neb. Ct. App. 1994). The bad faith doctrine first arose in insurance law, though it has also seen limited expansion into other areas. It is predicated on the fact that in certain kinds of contracts:

[The] plaintiff seeks something more than commercial advantage or profit from the defendant. When dealing with an inn-keeper, a common carrier, a lawyer, a doctor or an insurer, the client/customer seeks service, security, peace of mind, protection or some other intangible. These types of contracts create special, partly noncommercial relationships, and when the provider of the service fails to provide the very item which was the implicit objective of the making of the contract, then contract damages are seldom ade-



In one fairly predictable response to this prospect, health plans may be reluctant to make firm determinations about deductibility, whether by a broad caveat stating that any advance utilization review decision is tentative, or by simply refusing to give any advance determinations or opinions about which expenditures will count toward the deductible until after the care is rendered and the plan has all pertinent medical information at hand.<sup>151</sup> If the plan refuses to provide firm advance determinations, it can then simply point out that if the patient decided to forego an intervention because it *might* not count, that was clearly the patient's own decision.<sup>152</sup>

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quate, and the cases have generally permitted the plaintiff to maintain an action in tort as well as in contract.

*Id.* at 353 (quoting *Braesch v. Union Ins. Co.*, 464 N.W.2d 769, 774-75 (Neb. 1991)). This description applies especially well to health care coverage:

[I]t is difficult to imagine a policy of insurance that is more important, where the insured seeks maximum security and protection, than the case of a major medical insurance policy to be used in paying for needed medical care that is usually beyond the economic ability of most people to cover without insurance. It is also difficult to imagine anyone who is in a weaker bargaining position than a person in need of major medical care as compared to his or her medical insurance company that has the power to deny benefits.

*Id.*

Whereas litigation in contract will mainly concern substantive questions of whether the patient was owed a particular resource and whether that resource was received, bad faith tort questions will mainly concern the procedures by which these decisions were made. Health plans must have considerable leeway in exercising the judgment that adjudication of benefits inevitably involves. To show bad faith, that is, to have a cause of action for tortious failure of a health plan's expertise, a plaintiff must not just show that an alternate decision might have been justified, but that the denial of resources was without any reasonable basis, and that the health plan knew, or recklessly disregarded, this lack of a reasonable basis for denying benefits. . . . Although bad faith claims originated in third-party insurance, in which the insured is exposed to great vulnerability by depending on the insurer to defend him against outside claims, arguably at least as much vulnerability characterizes the patient needing health care benefits. By the time illness or injury arises, it is too late to shop for another health plan; the plan determines what level of care will be provided, and the patient suffers potentially major and long-lasting detriments if the plan makes the wrong decision.

E. Haavi Morreim, *Medicine Meets Resource Limits: Restructuring the Legal Standard of Care*, 59 U. PITT. L. REV. 37 n.121 (1997).

<sup>151</sup> "It is likely . . . that such reviews will be done retrospectively, after treatment, rather than requiring patients to obtain permission first. In addition, patients will be paying for these services regardless of the outcome of the dispute, so the dispute affects only the insurer's future contingent financial liability." Hall, *supra* note 133, at 173 (citations omitted)."

<sup>152</sup> However, in an important twist discussed below, ERISA plans may be compelled to provide deductible information in advance, albeit with the saving grace

### C. Possibilities for Contract Litigation

Whereas tort litigation may arise mainly where advance determinations about deductibility influence medical decisions, contract litigation would contest decisions made after care has been rendered. The plan says "that wasn't a covered benefit," "that service was not medically necessary," or "the out-of-network provider's fee was not reasonable, and we will only deduct the amount we deem reasonable."

Thereafter, the patient may dispute the plan's decision as a breach of contract.<sup>153</sup> The initial step may be to seek an independent review. At least forty-two states and the District of Columbia have provisions for independent review of medical necessity determinations, although exact provisions vary considerably.<sup>154</sup> Some states regard the independent reviewer's opinion as merely advisory; many states require enrollees first to exhaust the plan's internal appeals processes; while other states refuse to review coverage denials after treatment has been provided.<sup>155</sup>

If independent review is unavailable, impractical, or unsatisfactory the patient may then turn to contract litigation. In these types of actions health plans should ordinarily be able to defend a clear contractual exclusion quite easily, as where the plan simply does not cover dental care, or covers physical therapy services only up to \$500. In general, where benefits determinations are made according to clear criteria, courts tend to honor their terms. In *Loyola University of Chi-*

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for the plan, that any errors it makes will be litigated under limited federal remedies. See *infra* Part V.

<sup>153</sup> In a similar kind of action, the plaintiff in *Williams v. Tyco Electronics Corp.*, No. 6:06-CV-00024, 2006 WL 2645170 (W.D.Va. Sept. 14, 2006), deposited \$1200 into a health reimbursement account, thinking he could use his 2006 contributions to cover expenses incurred in 2005. When told that 2006 money could not count toward 2005 expenses, he asked the company to rescind his request to participate in the plan for 2006, and to have his money refunded. The court granted summary judgment to the defendant employer. *Id.* See also Tyco Electronics' Memorandum in Support of Motion for Summary Judgment, *Williams v. Tyco Elec. Corp.*, 2006 WL 2645170 (No. 6:06-cv-00024), WL 2780029 (arguing that the plaintiff's attempt to rescind his participation fails as a matter of law, and that the terms of the plan preclude plaintiff from seeking reimbursement).

<sup>154</sup> Linda Greenhouse, *Court, 5-4, Upholds Authority of States to Protect Patients*. N.Y. TIMES, June 21, 2002, at A1, available at <http://www.nytimes.com/2002/06/21/national/21HEAL.html>.

<sup>155</sup> See Wendy K. Mariner, *Independent External Review of Health Maintenance Organizations' Medical-Necessity Decisions*, 347 NEW ENG. J. MED. 2178, 2178 (2002); Michelle Andrews, *Health Care Appeals Are No Snap*, N.Y. TIMES, July 21, 2002, at B11. Of note, the Supreme Court has held that even plans subject to ERISA do not foreclose the option of seeking external review. *Rush Prudential, Inc. v. Moran*, 536 U.S. 355 (2002).

*cago v. Humana Ins. Co.*,<sup>156</sup> for example, the patient failed to secure advance approval for a heart transplant. The Seventh Circuit held: "This is a contract case and the language of the benefit plan controls. Again, Loyola and Mr. Via were certainly free to attempt these life-saving procedures, but the benefits plan does not require Humana to pay for them."<sup>157</sup> The court noted that "[a]s the plan unambiguously states, no benefits are payable without prior approval."<sup>158</sup>

In contrast, plans may be particularly vulnerable where their denial of deductibility turns on medical necessity, the cornerstone of most health insurance contracts.<sup>159</sup> Unfortunately for plans, the vagueness of medical necessity provides a very weak foundation for defending benefits decisions. The doctrine of *contra proferentem* is based on the fairness principle that, since the party writing the agreement had the opportunity to make the wording clear, then its failure to do so should not work against the party who lacked this opportunity.<sup>160</sup> A number of courts have utilized this doctrine to favor plaintiffs where the denial of benefits was based on medical necessity.<sup>161</sup>

<sup>156</sup> 996 F.2d 895, 897 (7th Cir 1993).

<sup>157</sup> *Id.* at 903.

<sup>158</sup> *Id.* Similarly, in *McGee v. Equicor-Equitable HCA Corp.*, 953 F.2d 1192, 1210 (10th Cir. 1992), the Tenth Circuit upheld an HMO's refusal to pay for nursing home care for which prior UM approval had not been sought as required. "While it is readily apparent Mr. McGee sought the best possible care for his daughter, he was still obligated to work within the defined contractual borders of the HMO he elected to participate in." *Id.* at 1207; *see also* *Nazay v. Miller*, 949 F.2d 1323, 1336 (3rd Cir. 1991); *Fuja v. Benefit Trust Life Ins. Co.*, 18 F.3d 1405 (7th Cir. 1994); *Gee v. Utah State Ret. Bd.*, 842 P.2d 919, 920-21 (Utah Ct. App. 1992); *Harris v. Mut. of Omaha Cos.*, 992 F.2d 706, 713 (7th Cir. 1993); *Arrington v. Group Hospitalization & Med. Servs., Inc.*, 806 F. Supp. 287, 290 (D.D.C. 1992); *Free v. Travelers Ins. Co.*, 551 F. Supp. 554, 560 (D. Md. 1982); *McLeroy v. Blue Cross/Blue Shield of Or., Inc.*, 825 F. Supp. 1064, 1071 (N.D. Ga. 1993); *see generally* E. Haavi Morreim, *Playing Doctor: Corporate Medical Practice and Medical Malpractice*, 32 U. MICH. J.L. REFORM 939, 1017 (1999).

<sup>159</sup> *See supra* III.A.

<sup>160</sup> MORREIM, HOLDING HEALTH CARE, *supra* note 4, at 47-49; HAVIGHURST, *supra* note 129, at 182; Mariner, *supra* note 24, at 523.

<sup>161</sup> In *Van Vactor v. Blue Cross Ass'n*, 365 N.E. 2d 638, 643 (Ill. App. Ct. 1977), for instance, the Illinois Supreme Court held that because "medically necessary" was ambiguous, and contract disputes must be construed in favor of the insured, the patient should receive coverage for inpatient removal of impacted wisdom teeth. In *McLaughlin v. Connecticut General Life Ins. Co.*, 565 F. Supp. 434 (N.D. Cal. 1983), the California Supreme Court likewise cited *contra proferentem* to hold that, in view of the ambiguities inherent in "medical necessity," immunoaugmentive therapy for terminal lung cancer should be covered. In *ex parte Blue Cross-Blue Shield of Ala.*, 401 So. 2d 783 (Ala. 1981), the Alabama Supreme Court relied on the same reasoning to award coverage for inpatient care of osteoporosis-related fractures, while in *Group Hospitalization, Inc. v. Levin*, 305 A.2d 248, 249-50 (D.C. 1973), the

Admittedly, even where the text of the contract is clear, courts may still look to the "reasonable expectations" of the insured, which in turn may be based on concepts about the purpose and processes of health care insurance.<sup>162</sup> Nevertheless, given that the patient already received care (hence is not medically desperate), that the amounts at stake within the deductible are relatively small, and that courts are generally willing to honor a clear contract,<sup>163</sup> it is reasonable to suppose that judges may not strain to grant patients an effusive benefit of doubt.<sup>164</sup>

## V. ERISA

### A. ERISA Basics

No discussion about health plan litigation is complete without attention to ERISA,<sup>165</sup> the proverbial "800-pound gorilla." Here, the "gorilla's" reach is currently somewhat limited. ERISA covers the great majority of health plans provided through the workplace. However, as of 2005 "[m]ost enrollment in HSAs [came] from persons purchasing coverage outside the employment context"--from private individuals buying their own insurance--and hence would not be sub-

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District of Columbia appellate court awarded inpatient care for back pain. Similarly, a California appellate court held in *Hughes v. Blue Cross of N. Cal.*, 245 Cal. Rptr. 273 (Cal. Dist. Ct. App. 1988), that when an insurer implemented a standard of medical necessity significantly different from prevailing community standards and did not properly investigate a claim, it stood to incur liability for bad faith.

<sup>162</sup> Mariner, *supra* note 24, at 529.

<sup>163</sup> See *McGee v. Equicor-Equitable HCA Corp.*, 953 F.2d 1192, 1202 (10th Cir. 1992) (stating that "the objective in construing a health care agreement . . . is to ascertain and carry out the true intention of the parties"); see also cases cited *supra* note 161.

<sup>164</sup> For example:

Although courts no longer apply rotely the principle that an insured is bound by everything in the policy regardless of whether she read it, that remains the presumption unless mistake or fraud can be shown. However, within the particular context of health plans, more scrutiny of adhesionary terms may be necessary to determine what can reasonably be expected, both of patients and insurers.

Mariner, *supra* note 24, at 526-27.

Professor Mark Hall argues that courts may defer to insurers' medical necessity decisions in these cases because conflicts of interest are ameliorated where their denials of deductibility do not directly impinge on the plan's resources. Hall, *supra* note 133, at 173-74.

<sup>165</sup> Employee Retirement Income Security Act of 1974. See generally 29 U.S.C. §§ 1001-1461 (2000).

ject to ERISA.<sup>166</sup> Still, as more employers embrace the idea, we can expect the proportion of HDHPs subject to ERISA to rise.<sup>167</sup>

Congress passed ERISA during a prolonged economic downturn in which employers became increasingly unable to meet their obligations to employees, particularly for pensions. Congress became deeply “concerned that the Social Security system, itself strained by the increasing demands made on it by retired workers, could not be relied upon to provide adequate retirement benefits for the vast majority of covered employees”<sup>168</sup> if large numbers of employers simply failed to keep their promises to fund pension plans.

Accordingly, Congress created a *quid pro quo*: in exchange for requiring that pension plans be funded and vested under federal specifications, all benefit plans, welfare benefits as well as pensions,<sup>169</sup> were placed under a uniform set of federal rules that would ease their administration and minimize unanticipated expenses. Companies would no longer need to tailor their benefits to fifty different sets of

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<sup>166</sup> See Robinson, *supra* note 12.

<sup>167</sup> “Despite recent entry into the market, these plans are gaining popularity. Drawing on information from major insurance carriers, William Boyles, publisher of the Consumer Driven Market Report, estimates that enrollment in HSA-type plans or HRAs (a forerunner to health savings accounts) more than doubled since January 2006, to 13.4 million Americans.” David Gratzner, *A Health-Care Bargain*, WALL ST. J., Jan. 31, 2007 at A12.

“Since HSAs first became available in 2004, more employers have begun shifting health care costs to workers, leading to a surge in the accounts’ popularity. In late 2004, about 500,000 individuals had them; currently more than 3 million use them.” Karla Dial, *New Tax Law Expands and Improves HSAs*, HEALTH CARE NEWS, Feb. 1, 2007, available at <http://www.heartland.org/Article.cfm?artId=20485>. Nevertheless, the rate of increase may be difficult to predict.

The numbers of U.S. workers enrolled in such plans through their jobs (excluding dependents and those in firms with fewer than three workers) grew only slightly, to 2.7 million in 2006 from 2.4 million in 2005, according to the Kaiser Family Foundation. Most do it because either their companies give them no choice or the premiums are the cheapest. Enrollment is growing faster on the individual market and among sole proprietors, but that may be because the plans are often the only affordable option.

Vanessa Fuhrmans, *Health Savings Plans Start to Falter*, WALL ST. J., June 12, 2007, at D1.

<sup>168</sup> *Holmes v. Pac. Mut. Life Ins. Co.*, 706 F. Supp. 733, 735 (C.D. Cal. 1989).

<sup>169</sup> “Welfare benefits such as medical insurance . . . are not subject to the rather strict vesting, accrual, participation, and minimum funding requirements that ERISA imposes on pension plans.” *Pitman v. Blue Cross & Blue Shield of Okla.*, 24 F.3d 118, 121 (10th Cir. 1994) (quoting *Wise v. El Paso Natural Gas Co.*, 986 F.2d 929, 935 (5th Cir. 1993), *modified*, 217 F.3d 1291 (10th Cir. 2000); see also 29 U.S.C. § 1001 (2000).

state laws,<sup>170</sup> and they would not be required to provide any particular set of benefits. But in return, a promise made must be a promise kept.

ERISA applies only to businesses engaged in interstate commerce,<sup>171</sup> hence does not cover government workers or church employees. Aside from these limited exceptions, however, nearly all employment-based benefit plans are governed by ERISA.

The statute has three major structural features. First, it preempts state laws in favor of federal causes of action and remedies. ERISA shall "supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . ."<sup>172</sup> Thus, in health care ERISA has largely shielded employment-based health plans from accountability for malpractice, wrongful death, fraud, breach of contract, and the panoply of state-based causes of action for which those plans might otherwise have been liable.<sup>173</sup>

Second, the "savings clause" permits states to continue to regulate the business of insurance.<sup>174</sup> That is, nothing in ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . ."<sup>175</sup> Thus, for instance, a state can require all commercial insurers to provide mental health care benefits.<sup>176</sup>

<sup>170</sup> See, e.g., *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137 (1990) (noting that in passing ERISA, Congress set various uniform standards); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 44 (1987); Rich & Erb, *supra* note 4, at 242.

<sup>171</sup> *Settles v. Golden Rule Ins. Co.*, 927 F.2d 505, 507-08 (10th Cir. 1991) (citing 29 U.S.C. § 1003(a)(1)).

<sup>172</sup> 29 U.S.C. § 1144(a) (2000); see, e.g., *Pilot Life Ins. Co.*, 481 U.S. at 45.

<sup>173</sup> See, e.g., 29 U.S.C. § 1144(a) (2000); *Pilot Life Ins. Co.*, 481 U.S. at 45; *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1339 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992); see also *Pomeroy v. Johns Hopkins Med. Servs., Inc.*, 868 F. Supp. 110, 111, 116 (D. Md. 1994) (preempting state claims against an HMO for failure to cover treatments for diplopia, chronic back pain, facial tic, severe depression, and addiction to prescription pain medications); *Hemphill v. Unisys Corp.*, 855 F. Supp. 1225, 1229, 1232 (D. Utah 1994) (preempting various tort claims related to insurer's failure to cover certain benefits after auto accident); *Rollo v. Maxicare of La., Inc.*, 695 F. Supp. 245, 246-47 (E.D. La. 1988) (citing *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987)) (preempting claim against HMO for poor care after an auto accident).

<sup>174</sup> "ERISA explicitly 'saves' from preemption state laws that regulate insurance, assuring that most issues affecting insured employee benefit plans are governed by state rather than federal law. Recent Supreme Court decisions interpreting ERISA have emphasized the expansive state regulatory authority over insured ERISA plans." *Jost & Hall, supra* note 13, at 398 (citing 29 U.S.C. § 1144(b)(2)(A)).

<sup>175</sup> 29 U.S.C. § 1144(b)(2)(A) (2000).

<sup>176</sup> See *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1984) (holding that a Massachusetts statute requiring insurance companies to provide mental health care benefits is not preempted by federal law).

Third, ERISA's "deemer" clause provides that companies' self-funded benefit plans shall not "be deemed to be an insurance company or any other insurer . . ."<sup>177</sup> The Supreme Court has read the deemer clause as preempting all state laws that relate to self-insured employee benefit plans.<sup>178</sup>

As a result, employers can provide health care--or not--as they see fit, and can modify, including to downsize or eliminate, their benefit plans at will.<sup>179</sup> The only requirement is that, if a benefit has been promised, it must be delivered. Moreover, the ERISA fiduciaries who

<sup>177</sup> 29 U.S.C. § 1144(b)(2)(B).

<sup>178</sup> *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990). For this reason, many larger corporations self-fund their health plans rather than buying insurance products from the open market. By avoiding plans encumbered with costly state-mandated benefits, these companies can save considerably as they provide workers' health care. See *Am. Med. Sec., Inc. v. Bartlett*, 111 F.3d 358 (4th Cir. 1997) (overturning a Maryland law that required all benefit plans, including self-funded ones, to carry stop-loss coverage because such law was a violation of ERISA).

In 2007 the Fourth Circuit held that ERISA preempted the Maryland "Fair Share Health Care Fund Act, which requires employers with 10,000 or more Maryland employees to spend at least 8% of their total payrolls on employees' health insurance costs or pay the amount their spending falls short to the State of Maryland." *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 183 (4th Cir. 2007). The court noted that ERISA "does not mandate that employers provide specific employee benefits but leaves them free, "for any reason at any time, to adopt, modify, or terminate welfare plans." *Id.* at 190 (quoting *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995)).

One exception is Hawaii, which enacted legislation mandating employers provide health insurance in 1974. See Sylvia A. Law, *Health Care in Hawaii: An Agenda for Research and Reform*, 26 AMER. J.L. & MED. 205, 206-15 (2000) (discussing a program that has an exemption from ERISA); John C. Lewin and Peter A. Sybinsky, HAWAII'S EMPLOYER MANDATE AND ITS CONTRIBUTION TO UNIVERSAL ACCESS, 269 JAMA 2538 (1993).

<sup>179</sup> Employers can design their welfare benefit plans, including health care, however they wish, and can change them virtually at will so long as they satisfy certain requirements, such as notification. Indeed, the ERISA statute and case law are quite emphatic that employers must not be required to provide any particular level or kind of benefits. "Nothing in ERISA requires employers to establish employee benefit plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan." *Pegram v. Herdrich*, 530 U.S. 211, 226-27 (2000) (citing *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996)). "ERISA does not mandate that employers provide any particular benefits . . ." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983). "In general, welfare benefits are not subject to vesting requirements under ERISA, 29 U.S.C. § 1501 (1). Employers may adopt, modify or terminate welfare benefit plans." *Pisciotta v. Teledyne Indus., Inc.*, 91 F.3d 1326, 1330 (9th Cir. 1996) (citing *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995)). See also *McGann v. H & H Music Co.*, 946 F.2d 401, (5th Cir. 1991) *cert. denied* 506 U.S. 981 (1992) (holding that employers can change benefits at will, so long as the change does not intentionally discriminate against any particular group).

administer these plans are accorded considerable discretion as they engage in the difficult balancing between the interests of any individual, versus those of the plan members as a whole.<sup>180</sup> ERISA provides that so long as an ERISA fiduciary's benefits decisions are not arbitrary and capricious, or an abuse of discretion, they should generally be enforced, even when the decision may not be the most reasonable interpretation of the plan.<sup>181</sup>

As a consequence, most litigation surrounding ERISA plans focuses on the way the plan and its benefits are being administered, and on whether the issue is preempted to federal courts.<sup>182</sup>

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<sup>180</sup> The statute and the Supreme Court define the ERISA fiduciary functionally, "as one who 'exercises any discretionary authority or discretionary control respecting management of [a] plan or exercises any authority or control respecting management or disposition of its assets.'" *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) (citing 29 U.S.C. § 1002(21)(A)(i)); *See also* *Mertens v. Hewitt Assocs.*, 508 U.S.248, 262 (1993); *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 220 (2004).

More particularly, "a person is a fiduciary with respect to a plan to the extent [(1)] he exercises any discretionary authority or discretionary control respecting management of such plan . . . [or (2)] he has any discretionary authority or discretionary responsibility in the administration of such plan." 29 U.S.C. § 1002(21)(A) (2000).

The fiduciary has the difficult task of balancing the interests of all the beneficiaries who depend on him to administer the plan in their interests. And when he errs, he is "personally liable for damages . . . , for restitution . . . , and for . . . [equitable relief as the court sees fit]." *Mertens v. Hewitt Assocs.*, 113 S.Ct. 2063, 2066 (1993); *see also* *Varity Corp. v. Howe*, 516 U.S. 489, 516-20 (1996) (Thomas, J., dissenting).

For further discussion *see generally* E. Haavi Morreim, *Benefits Decisions in ERISA Plans: Diminishing Deference to Fiduciaries, and an Emerging Problem for Provider-Sponsored Organizations*, 65 *Tenn. L. Rev.* 511 (1998) (hereinafter *Morreim, Benefits Decisions in ERISA*); E. Haavi Morreim, *Another ERISA Twist: The Mysterious Case of Pegram and the Missing Fiduciary*, 63 *U. PITT. L. REV.* 235 (2002) [hereinafter *Morreim, Another ERISA Twist*].

<sup>181</sup> For example:

It must be remembered that the decisions of plan administrators are entitled to deference because the plan administrators are *fiduciaries* charged with the responsibility to make decisions critical to the lives of individual citizens. To a very real degree they are on the front line in determining the extent and the quality of health care being delivered in this country. They have the duty to assure that the financial integrity of health plans is preserved by denying improper claims, however difficult such decisions may be. In doing so they assist in placing restraints upon health care providers who, if left to their own devices, might well permit health care costs to continue to spiral upward. However, that said, plan administrators have a duty to assure that valid claims of beneficiaries who are in need of medical care are not denied simply because of the cost of such care.

*Adelson v. GTE Corp.*, 790 F. Supp. 1265, 1270 (D. Md. 1992).

<sup>182</sup> ERISA jurisprudence represents a formidable body of work. *See generally*



Causes of action and remedies for breaches of duty are strictly limited under federal law. Per ERISA § 502(a)(1)(B), a participant or beneficiary may bring civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan . . . ." <sup>183</sup> Remedies include the monetary value of the wrongly denied benefit, attorney fees when warranted, and certain forms of injunctive and other equitable relief. <sup>184</sup> Thus, in health care cases, the patient can win an injunction requiring the plan to cover a treatment, or retrospectively, the monetary value of the health services denied, but not much more. The plaintiff cannot claim damages even for very

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Rich & Erb, *supra* note 4, at 250-61 (explaining the varied legal interpretations of ERISA since its enactment); Jost & Hall, *supra* note 13; F. Christopher Wethly, *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.: Vicarious Liability Malpractice Claims Against Managed Care Organizations Escaping ERISA's Grasp*, 37 B.C. L. REV. 813 (1996); Jacobson & Pomfret, *supra* note 45; Milks, *supra* note 40, at 279-96 (explaining that most claims against HMOs are subject to a pre-emption challenge under ERISA); Jeffrey A. Brauch, *ERISA at 25-and Its Most Persistent Problem*, 48 U. Kan. L. Rev. 285, 289-90 (2000); Kathy L. Cerninara, *Protecting Participants in and Beneficiaries of ERISA-Governed Managed Health Care Plans*, 29 U. MEM. L. REV. 317 (1999); Catherine L. Fisk, *The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 HARV. J. ON LEGIS. 35 (1996); George L. Flint, Jr., *ERISA: Extracontractual Damages Mandated for Benefit Claims Actions*, 36 ARIZ. L. REV. 611 (1994); Russell Korobkin, *The Battle over Self-Insured Health Plans, or "One Good Loophole Deserves Another"*, 5 YALE J. HEALTH POL'Y L. & ETHICS 89 (2005); Thomas R. McLean & Edward P. Richards, *Managed Care Liability for Breach of Fiduciary Duty After Pegram v. Herdrich: The End of ERISA Preemption for State Law Liability for Medical Care Decision Making*, 53 FLA. L. REV. 1 (2001); Dana M. Muir, *Fiduciary Status As an Employer's Shield: The Perversity of ERISA Fiduciary Law*, 2 U. PA. J. LAB. & EMP. L. 391 (2000); Scott D. Pomfret, *Emerging Theories of Liability for Utilization Review Under ERISA Health Plans*, 34 TORT & INS. L.J. 131 (1998); Jeffrey Shuren, *Legal Accountability for Utilization Review in ERISA Health Plans*, 77 N.C. L. REV. 731 (1999); Jeffrey W. Stempel & Nadia von Magdenko, *Doctors, HMOs, ERISA, and the Public Interest After Pegram v. Herdrich*, 36 TORT & INS. L.J. 687 (2001); Jana K. Strain & Eleanor D. Kinney, *The Road Paved with Good Intentions: Problems and Potential for Employer-Sponsored Health Insurance Under ERISA*, 31 LOY. U. CHI. L.J. 29 (1999); Morriem, *Benefits Decisions in ERISA*, *supra* note 180; Morreim, *Another ERISA Twist*, *supra* note 180; E. Haavi Morreim, *ERISA Takes a Drubbing: Rush Prudential and Its Implications for Health Care*, 38 TORT TRIAL & INS. PRAC. L.J. 933 (2003); MORREIM, *HOLDING HEALTH CARE*, *supra* note 4, at 160-83.

<sup>183</sup> 29 U.S.C. § 1132(a)(1)(B) (2000).

<sup>184</sup> *Mertens v. Hewitt Associates*, 113 S.Ct. 2063 (1993); *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985); *Novak v. Andersen Corp.*, 962 F.2d 757, 760 (8th Cir. 1992).

grave medical consequences of a wrongful denial, for pain and suffering, or any other state-based remedy.<sup>185</sup>

<sup>185</sup> Indeed, some courts have openly lamented ERISA's dearth of remedies for serious harms. As expressed by the Fifth Circuit:

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 to the plans that rely on these companies to contain medical costs. ERISA plans, in turn, will have one less incentive to seek out the companies that can deliver both high quality services and reasonable prices.

*Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1338 (5th Cir. 1992) (footnote omitted), *cert. denied*, 506 U.S. 1033 (1992).

Other courts have echoed the point.

The Court is not unmindful this holding leaves plaintiff with no remedy under ERISA for the needless and tragic loss she has suffered. ... Nevertheless, the Court must respect Congress' intent to have the civil enforcement mechanism of ERISA be the exclusive remedy for such claims. ... "There is sound reason to alter ERISA in order to provide relief to plaintiffs who present claims like this one; however, amending ERISA to accommodate those causes of action is for Congress, not the courts.

*Huss v. Green Spring Health Servs., Inc.*, 18 F.Supp.2d 400, 408 (D.Del. 1998).

"This case, thus, becomes yet another illustration of the glaring need for Congress to amend ERISA to account for the changing realities of the modern health care system." *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 53 (D. Mass. 1997) (citation omitted).

Although ERISA provides a remedy for the improper denial of benefits—it is not the remedy that plaintiffs desire. Plaintiffs misconstrue the nature of ERISA preemption. That ERISA does not provide the full range of remedies available under state law in no way undermines ERISA preemption. "The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA."

*Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 943 (6th Cir. 1995) (footnotes omitted) (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987)).

"Although forcing the Basts to assert their claims only under ERISA may leave them without a viable remedy, this is an unfortunate consequence of the compromise Congress made in drafting ERISA." *Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1010 (9th Cir. 1998).

"ERISA preempts all causes of action that attempt to recover for a denial of benefits. This may seem [a] harsh result in this case, but it is an unfortunate consequence of the breadth of ERISA's preemption clause." *Foster v. Blue Cross & Blue Shield of Mich.*, 969 F. Supp. 1020, 1024 (E.D. Mich. 1997).

See also *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1495 (7th

One other recent development should be noted. With the emergence of HSAs under the MMA,<sup>186</sup> the Department of Labor has indicated that an HSA--the tax-protected fund that can be used for qualified health care expenses--is not, itself, an ERISA plan, so long as it is completely voluntary and the employer exerts no control over it.<sup>187</sup> The ruling makes sense since, after all, an HSA isn't a "plan" at all, but simply a pot of money.<sup>188</sup> The plan, in this case, is the HDHP to which the HSA is attached.<sup>189</sup>

With this background it is possible to review the assorted potential claims in tort and contract, discussed above, to discern what impact ERISA might have on each.

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Cir. 1996); *Turner v. Fallon Cmty. Health Plan, Inc.*, 953 F. Supp 419, 424 (D. Mass 1997), *aff'd*, 127 F.3d 196 (1st Cir. 1997); *Cannon v. Group Health Serv. of Okla.*, 77 F.3d 1270, 1272-74 (10th Cir. 1996) *cert. denied*, 519 U.S. 816 (1996); *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966, 974 (S.D.N.Y. 1994); *Olson v. Gen. Dynamics Corp.*, 960 F.2d 1418, 1423-24 (9th Cir. 1991) (Reinhardt, J., concurring).

<sup>186</sup> Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1201, 117 Stat. 2066, 2469 (2003).

<sup>187</sup> Robert J. Doyle, U.S. Dept. of Labor, *Field Assistance Bulletin 2004-1* (Apr. 7, (2004), [http://www.dol.gov/ebsa/regs/fab\\_2004-1.html](http://www.dol.gov/ebsa/regs/fab_2004-1.html)); *see also* U.S. Dept. of Labor, Employee Benefits Security Administration, *Field Assistance Bulletin No. 2006-02*; *Health Savings Accounts - ERISA Qs & As* (Oct. 27, 2006); *Jost & Hall, supra* note 13, at 402. *See also* *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 196 (4th Cir. 2007).

<sup>188</sup> As noted by the Supreme Court, a benefit plan is "a scheme decided upon in advance." *Pegram v. Herdrich*, 530 U.S. 211, 223 (2000). The Court explained, "Here the scheme comprises a set of rules that define the rights of a beneficiary and provide for their enforcement. Rules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a plan." *Id.* It is an "agreement between an HMO and an employer who pays the premiums [that] may, as here, provide elements of a plan by setting out rules under which beneficiaries will be entitled to care." *Id.*

<sup>189</sup> The ERISA statute defines a benefit plan broadly as:

[A]ny plan, fund, or program which . . . 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, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services . . . .

29 U.S.C. § 1002(1) (2000).

## B. Tort Claims

### 1. Direct Liability

The foregoing discussion<sup>190</sup> identified two particularly likely areas of direct liability for HDHPs, namely, direct health care services, such as phone triage and disease management, and economic informed consent.

#### a. Direct Health Care Services

In *Pegram v. Herdrich*,<sup>191</sup> the Supreme Court held that whereas "pure eligibility" determinations<sup>192</sup> will be preempted, "treatment decisions"<sup>193</sup> are not. Arguably, when plans provide direct medical advice, such as telephone triage, disease management, or patient decision aids that simply help patients to make better-informed medical decisions, state-based tort claims will likely go forward. These services do not involve decisions about which benefits the plan will provide or pay for, and indeed in some cases they may not strictly be a part of the formal plan at all, but simply some helpful lagniappes the plan offers to attract buyers.<sup>194</sup> Moreover, they most closely resemble the "treatment decisions" that *Pegram* indicated are not subject to ERISA.<sup>195</sup>

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<sup>190</sup> See *supra* Part II.A-B.

<sup>191</sup> 530 U.S. 211 (2000).

<sup>192</sup> These are decisions that "turn on the plan's coverage of a particular condition or medical procedure for its treatment." *Id.* at 228. The Court also described "mixed" decisions, found where the treating physician, acting on behalf of the HMO, essentially makes benefit determinations via medical decisions about which care (not) to provide for the patient-enrollee. *Id.* at 228-30. As discussed below, in *Davila* the Court emphasized that "mixed" decisions are only found in this very narrow context. See *infra* Part V.C-D.

<sup>193</sup> The Court defines "treatment decisions" as "choices about how to go about diagnosing and treating a patient's condition." *Pegram*, 530 U.S. at 228.

<sup>194</sup> As noted above, the "plan" is a set of rules defining the benefits to which an enrollee is entitled, plus procedures for submitting claims, etc. *Id.* at 223; see *supra* notes 191-92.

<sup>195</sup> More broadly, Professor Kristin Madison proposes distinguishing between benefits decisions and the medical information on which they are based. Madison, *supra* note 55, at 502-31. While the benefits should remain preempted, Madison argues that deficiencies in the quality of the information should not. *Id.* Patients, after all, increasingly utilize a variety of sources of medical information, beyond their physicians, to make health care decisions. *Id.* And where plans' misinformation causes harm, it should be subject to liability. *Id.* at 522.

In reply it might be argued that, in cases where benefits have been denied on the basis of ill-informed medical necessity judgments, it may be difficult to tease

The issue rises to the next level--from medical information and advisory to actual health care services--in *Smelik v Mann*.<sup>196</sup> Here, the plaintiff's wife allegedly died because the health plan failed to provide its promised case management. The federal district court determined that ERISA did not preempt the case because, per the plaintiff's attorney, "[t]his [was] not a denial-of-benefits case. This [was] a mismanagement-of-managed care [case].'<sup>197</sup> In *Smelik*, the plaintiff did not allege that Humana failed to pay for his wife's medical treatment, but instead argued the [sic] Humana was negligent in the coordination and supervision of her care."<sup>197</sup>

However, the validity of such reasoning is debatable. Although providing substandard medical information is not a denial of benefits, here we find a failure to provide a promised service. If the insurer expressly stipulates that it will provide case management services as one of its enumerated benefits, then fails to deliver, appellate courts may deem this a failure to provide the benefits due, and find that ERISA preempts the case. A health plan's failure to provide its own direct service is just as much a denial of benefits as is a failure to authorize, or to pay for a physician or hospital to provide a service.

On this reasoning, if an HDHP wishes to maximize its ERISA protection, it will enumerate services like case management as a part of its benefit plan. ERISA defines a "benefit plan" as

a scheme decided upon in advance. . . . a set of rules that define the rights of a beneficiary and provide for their enforcement. Rules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a plan.<sup>198</sup>

Where a service is encompassed in the plan, litigation over any failure to deliver that service will be preempted.

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out the harms caused by the denial from the harms caused by the patient's reliance on the (mis)information underlying the denial. Nevertheless, surely there are clear cases in which a health plan's medical information directly causes harm. As illustrated above, a plan's determination that an MRI is not deductible because it is not medically necessary can place the patient in the difficult position of deciding whether to believe his doctor or his health plan. See *supra* Part IV.B. Yet here, the denial of deductibility does not directly deny the medical service at all, or even financial access to it. Accordingly, it would appear to be a prime example of liability for substandard information, quite outside the ambit of ERISA.

<sup>196</sup> See *supra* Part II.A; *Humana*, *supra* note 60, at 1-2.

<sup>197</sup> Krier, *supra* note 61, at 152 (citation omitted).

<sup>198</sup> *Pegram v. Herdrich*, 530 U.S. 211, 223 (2000).

In contrast, where a health plan is purchased by an individual on the open market, hence not operating under ERISA, that plan might wish to contract in the opposite direction. If a direct service such as case management is expressly promised, then not delivered, breach of contract would be an obvious claim. If it was never contractually promised, but rather provided only as a gratuitous extra, then it is more difficult to complain of breach. Thus, ERISA introduces distinct quirks into the health care market, in that "name every benefit" appears preferable for an insurer's ERISA plans, while limiting express promises may be better for the insurer in the individual market.

#### b. Economic Informed Consent

As discussed,<sup>199</sup> tort claims for breach of economic informed consent could arise either when a health plan forbids physicians to provide pricing information, or when the plan itself provides inaccurate information, proximately causing an injury. ERISA may well affect these two scenarios rather differently.

ERISA is likely to preempt cases where the health plan forbids physicians from providing pricing information. Such policy decisions are arguably a function of health plan administration, as the plan oversees the delivery of benefits to enrollees. ERISA generally preempts health plan administration issues.<sup>200</sup>

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<sup>199</sup> See *supra* Part II.B.

<sup>200</sup> *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 273 (3d Cir. 2001); *Roessert v. Health Net*, 929 F. Supp. 343, 348 (N.D. Cal. 1996) (finding state law claims that directly or indirectly concern the *administration* of the benefit plan are preempted); *In re Estate of Frappier*, 678 So. 2d 884, 887 (Fla. Dist. Ct. App. 1996); *Santitoro v. Evans*, 935 F.Supp. 733, 736 (E.D.N.C. 1996); *Haas v. Group Health Plan, Inc.*, 875 F.Supp. 544, 548 (S.D.Ill. 1994); *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182, 184-85 (E.D. Pa. 1994); *Jackson v. Roseman*, 878 F.Supp 820, 821/825 (D.Md. 1995); *DeArmas v. Av-Med, Inc.*, 865 F. Supp. 816, 818 (S.D. Fla. 1994); *Lancaster v. Kaiser Found. Health Plan*, 958 F. Supp. 1137, 1145 (E.D. Va. 1997); *United Healthcare Ins. Co. v. Levy*, 114 F. Supp. 2d 559, 564 (N.D. Tex. 2000); *Kuhl v. Lincoln Nat'l Health Plan*, 999 F.2d 298, 303 (8th Cir. 1993), *reh'g denied*, 1993 U.S. App. LEXIS 20677 (8th Cir. Aug. 13, 1993), *cert. denied*, 510 U.S. 1045 (1994).

See also *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656-58 (1995) (noting that ERISA pre-empts "state laws that mandated employee benefit structures or their administration"). Different states could apply different standards for what constitutes a negligent precertification training or supervisory practice. This in turn could affect how defendants carry out their claims assessment duties, by requiring different administrative procedures in different jurisdictions. The preemption clause was designed to avoid precisely such a result. See *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990) (holding that preemption is used to avoid "patchwork" regulation and inefficient benefit programs).

See also *Hinterlong v. Baldwin*, 720 N.E.2d 315, 321-22 (Ill. App. Ct. 1999):

The latter scenario, in which the plan provides inaccurate pricing information, poses more interesting questions. On one hand, although providing price information is not an adjudication of benefits, courts might deem it an administrative service provided by the plan, hence preempted. If the plan actually makes this information an express plan benefit, it will again probably be preempted by the federal law.

On the other hand, if pricing estimates are not a listed plan benefit, but rather an ancillary service,<sup>201</sup> the plan may well be subject to state-based tort claims. Given this possibility, ERISA-governed health plans might be well-advised to describe pricing information as an explicit service of the plan, thereby bringing it within the scope of ERISA preemption. Note that here, too, just as above, this recommendation would not necessarily apply to a non-ERISA plan. For plans outside ERISA's reach, tort liability for pricing errors remains a real possibility. If the tort risks of inaccurate information loom too large, plans may opt to avoid providing that service--an unfortunate outcome, given patients' fairly urgent need for this information.<sup>202</sup>

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In enacting ERISA, Congress found that 'the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered' (29 U.S.C. § 1001(a) (1994)) due to a lack of uniformity in the regulations of such plans....

Congress's intent in engrafting section 514(a) on ERISA was to establish regulation of the *administration* of employee benefit plans as an exclusively federal concern. . . . In *Travelers*, the Court noted that the purpose of section 514(a) is to ensure that benefit plans are subjected to a uniform body of law that minimizes the administrative and financial burden of complying with conflicting directives among states or between states and the federal government. (citing *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656-57 (1995)).

*Pryzbowski v. U.S. Healthcare, Inc.*, 64 F. Supp. 2d 361, 367 (D.N.J. 1999):

It is axiomatic that if a participant in a plan subject to ERISA is suing an HMO based upon the improper processing of a claim under that plan, the claim is completely preempted by federal law. . . . It follows, therefore, that a claim for negligent delay in the utilization review, or pre-authorization process, even if alleged as a state law violation against the physician, would, at the very least, 'relate to' an ERISA plan and, thus, be preempted.

If a participant is challenging the quality of care he or she received from the physician, however, that claim is not preempted. (citation omitted)

*aff'd in part & vacated in part*, *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001).

<sup>201</sup> See *supra* Part V.B.1.a.

<sup>202</sup> While the "safer" option for the plan may be to abjure such a service, it would do so at the cost of denying patients important information. Hence, contracts with enrollees will need clear and explicit caveats about the possibility that final costs may differ significantly from advance estimates.

## 2. Indirect Liability

Courts differ widely as to whether ERISA preempts tort suits to hold health plans liable for providers' malpractice, whether via *respondeat superior* for the plan's own employees or via ostensible agency for independent contractors.<sup>203</sup> Some federal courts have found that plans can indeed be liable under state law for physicians' quality of care,<sup>204</sup> while others hold that ERISA preempts such suits.<sup>205</sup> Extensive exploration will be foregone here, as that has been done by others.<sup>206</sup>

The Supreme Court's most recent ruling in this general area reinforced the power and reach of ERISA's preemption. As the Court observed in *Aetna Health, Inc. v. Davila*, "Congress' intent to make the ERISA civil enforcement mechanism exclusive would be undermined if state causes of action that supplement the ERISA § 502(a) remedies were permitted, even if the elements of the state cause of action did not precisely duplicate the elements of an ERISA claim."<sup>207</sup> Accordingly, unless the plaintiff can clearly show that the claim he makes has no connection with a benefits determination or with administration of the plan, the claim is likely to be preempted.

## C. Contract Claims

ERISA preempts state-based contract as well as tort claims. Contract claims might address whether the enrollee has been granted the right kind and amount of benefits, or whether the plan has been properly administered.<sup>208</sup> Where the cause of action concerns decision

<sup>203</sup> See *supra* at Part II; see also *supra* note 39.

<sup>204</sup> See *Dukes v. United States Healthcare Inc.*, 57 F.3d 350 (3d Cir. 1995); *Corporate Health Ins., Inc. v. Tex. Dep't of Ins.*, 215 F.3d 526 (5th Cir. 2000), *overruled in part by* *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002); *Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151, 155 (10th Cir. 1995); *Villazon v. Prudential Health Care Plan, Inc.*, 843 So. 2d 842, 851 (Fla. 2003); see *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182, 185 (E.D. Pa. 1994) (noting that courts are split on whether a claim based on ostensible agency is preempted by ERISA, which implies that such a claim exists).

<sup>205</sup> See *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1495 (7th Cir. 1996); *Baxter v. C.A. Muer Corp.*, 941 F.2d 451, 453 (6th Cir. 1991).

<sup>206</sup> See generally *Wethly*, *supra* note 182; *Rich & Erb*, *supra* note 4, at 250-61; *Milks*, *supra* note 40; *Clark C. Havighurst, Vicarious Liability: Reallocating Responsibility for the Quality of Medical Care*, 26 AM. J.L. & MED. 7, 20 (2000) (discussing the implications of assigning vicarious liability to MCOs).

<sup>207</sup> *Davila*, 542 U.S. at 216.

<sup>208</sup> See *DeArmas v. Av-Med, Inc.*, 865 F. Supp. 816, 818 (S.D. Fla. 1994); *Kuhl v. Lincoln Nat'l Health Plan*, 999 F.2d 298, 302 (8th Cir. 1993).



about whether or not to cover a particular benefit, it will fit squarely within the "benefits determinations" shielded by ERISA.

A much more interesting question concerns cases in which the insurer provides financial services for the patient's HSA. If there are financial errors in managing the HSA, an inaccurate posting of the patient's expenses, or bungling of an automatic deduction from the worker's payroll, the pivotal question will be whether these services are expressly part of the benefit plan, or simply "extra" services the plan provides. If the former, they will likely be preempted.

However, where such financial services are not expressly part of the benefit plan, as with the OnePay pilot project that arranges for extra financing to pay for care,<sup>209</sup> errors might well be addressed in state courts. Because ERISA's goal is to foster uniform administration of health plans,<sup>210</sup> and because *ex hypothesi* this service is not an intrinsic part of the plan, the implication may be that errors in this realm lie beyond ERISA's reach. Once again, plans that are ERISA-governed may find it attractive to preserve the shield by expressly making these services part of the plan.

#### D. Counting Toward the Deductible

##### 1. Possibilities for Tort Litigation

###### a. "No, That Won't Be Deductible"

As noted,<sup>211</sup> tort claims regarding deductibility are most likely where the plan announces in advance that a particular product or service will not be deductible because it is not medically necessary. At first blush such claims might seem to escape preemption on the ground that determinations of medical necessity appear to be medical rather than benefits decisions, hence subject to state-based tort litigation. However, a closer look reveals otherwise.

Courts have wrestled with the issue. *Corcoran v. United Healthcare, Inc.*<sup>212</sup> concerned a case in which the health plan determined that

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<sup>209</sup> See *supra* Part III.B.

<sup>210</sup> "The basic thrust of the pre-emption clause was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans. Thus, ERISA pre-empts state laws that mandate employee benefit structures or their administration as well as those that provide alternate enforcement mechanisms." *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 646 (1995).

<sup>211</sup> See *supra* Part IV.B.

<sup>212</sup> *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), *cert.*

hospital care was not medically necessary for a high-risk pregnancy, opting instead to approve limited home nursing services. The Fifth Circuit held:

Ultimately, we conclude that United makes medical decisions—indeed, United gives medical advice—but it does so in the context of making a determination about the availability of benefits under the plan. Accordingly, we hold that the Louisiana tort action asserted by the Corcorans for the wrongful death of their child allegedly resulting from United's erroneous medical decision is pre-empted by ERISA.<sup>213</sup>

The Supreme Court subsequently endorsed this view in *Davila*, finding that "a benefit determination is part and parcel of the ordinary fiduciary responsibilities connected to the administration of a plan. . . . The fact that a benefits determination is infused with medical judgments does not alter this result."<sup>214</sup> Thus, where a plan appeals to medical necessity to deny the deductibility of a proposed intervention, the health plan's decision will likely be preempted to federal courts, even if the decision causes harm to the patient.

Some observers might point out that, particularly for such a costly thing as health care, a denial of assured payment often means the pa-

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*denied*, 506 U.S. 1033 (1992).

<sup>213</sup> *Id.* at 1331. See *Cicio v. John Does 1-8*, 385 F.3d 156 (2d Cir. N.Y. 2004). *But see Pappas v. Asbel*, 724 A.2d 889, 893 (Pa. 1998).

<sup>214</sup> *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 219 (2004). In reaching this conclusion the Court clarified important misconceptions about its earlier opinion in *Pegram v. Herdrich*, 530 U.S. 211 (2000). In that case the Court distinguished among pure eligibility decisions, treatment decisions, and "mixed" decisions that rely on "medical judgments in order to make plan coverage determinations." *Pegram v. Herdrich*, 530 U.S. 211, 212 (2000). The Court ruled that where the plan is comprised of physician-owners who make benefits decisions in the context of providing medical care, such mixed decisions are not the decisions of an ERISA fiduciary, hence not subject to allegations of breach of fiduciary duty. *Id.* at 231-32.

From this it may be tempting to conclude that, where a health plan makes a "mixed" decision that invokes "medical necessity" to determine whether a medical intervention will count toward the patient's deductible, the decision will not count as a benefits determination. If so, then it seems any injuries caused by a medically unsound decision, as where someone foregoes care because the plan has said the intervention is not medically necessary, would not be preempted. Indeed, this is precisely what the Fifth Circuit—the same court as in *Corcoran*—found it must conclude in *Davila's* case. *Davila*, 542 U.S. at 221.

The Supreme Court, however, said that "*Pegram* cannot be read so broadly" because that case featured a health plan in which the physicians actually owned the plan, even as they directly treated patients. *Id.* at 218. "The plaintiff's treating physician was also the very person charged with administering plaintiff's benefits; it was she who decided whether certain treatments were covered." *Id.*

tient will not receive care.<sup>215</sup> The Court, unmoved, emphasized in *Davila* that "[u]pon the denial of benefits, [the patients] could have paid for the treatment themselves and then sought reimbursement through a § 502(a)(1)(B) action, or sought a preliminary injunction."<sup>216</sup>

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<sup>215</sup> Several courts have acknowledged the close connection between funding and the availability of care. One court took "judicial notice that, due to the high cost of major medical treatment, individuals who obtain such treatment typically depend upon insurance of some kind to cover much if not most of the bill. In the current health-care market, absent pre-claim verification of insurance coverage, patients may be forced to leave a hospital without receiving medical treatment—even though they are insured for the medical services they seek to obtain—because they lack other sufficient financial resources to pay the costs of treatment." *Mimbs v. Commercial Life Ins. Co.*, 832 F. Supp. 354, 358 (S.D. Ga. 1993) (citation omitted) (holding a health plan had incorrectly stated, in prospective UR, that the proposed care would not be covered).

In *Long v. Great West Life & Annuity Insurance Co.*, 957 P.2d 823, 827 (Wyo. 1998), the Wyoming Supreme Court noted:

Although the attending physician is the ultimate decision-maker regarding a patient's treatment, it is, as commentators note, naive to assume that a provider's determination that recommended care is not medically necessary, and therefore not covered by insurance or the health plan, will not affect the treatment ultimately received by the patient.

Other courts have likewise "recognized the 'commercial realities' facing third-party providers of health care services, noting that in situations in which it is not clear whether a patient is covered by a health insurance plan, 'the provider wants to know if payment reasonably can be expected. Thus, one of the first steps in accepting a patient for treatment is to determine a financial source for the cost of care to be provided.'" *Cypress Fairbanks Med. Ctr. v. Pan-American Life Ins. Co.*, 110 F.3d 280, 283 (5th Cir. 1997) (citing *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d at 246 (5th Cir '90)).

In *Varol v. Blue Cross & Blue Shield*, 708 F. Supp. 826, 831 (E.D. Mich. 1989), the court noted that psychiatrists agreed to a utilization review program that gave an insurer "the right to have significant and, perhaps, dominant influence in deciding what shall be accepted as the correct diagnosis and the proper treatment." The court disagreed with the psychiatrists, however, that this constituted unlicensed practice of medicine.

"Because lack of coverage frequently translates, at least as a practical matter, to lack of access to care, prospective and concurrent utilization review can expose a health plan to liability claims of a kind from which indemnity plans are largely insulated." Robert J. Conrad, Jr., & Patrick D. Seiter, *Health Plan Liability in the Age of Managed Care*, 62 DEF. COUNS. J. 191, 191 (1995); see also *Morris v. D.C. Bd. of Med.*, 701 A.2d 364, 367 (D.C. 1997) (quoting the Board of Medicine, "[I]f health insurance is not available, a procedure very well might not be performed.").

<sup>216</sup> 542 U.S. at 211; see also *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 53-54 (1987).

Courts have been willing to grant preliminary injunctions in a number of cases. See, e.g., *DiDomenico v. Employers Coop. Indus. Trust*, 676 F.Supp. 903, 908 (N.D. Ind. 1987); *Bailey v. Blue Cross & Blue Shield Va.*, 866 F.Supp. 277, 283 (E.D.Va. 1994); *Calhoun v. Complete Health Care, Inc.*, 860 F. Supp. 1494, 1501

In sum, whether the patient chooses to accept or to forego care on the basis of an advance estimate of costs, or a declaration that the cost will not count toward the deductible, the consequences apparently are his own. In either case, ERISA preempts.

b. "We Won't Tell You Whether It's Deductible"

Health plans may be reluctant to declare, up front, whether a particular service will be deductible and, if so, how much of the cost will count toward the deductible. After all, adequate information may not be readily available, and if they err, the patient may sue for the resulting harms. It may be far easier simply to refuse to make any advance determinations.

ERISA could override such reluctance. ERISA expressly permits any plan participant or beneficiary "to clarify his rights to future benefits under the terms of the plan."<sup>217</sup> Accordingly, if the plan refuses to say whether or what amount of the care will count toward deductible, the patient can take the question to federal court and demand a clarification of his rights.

Below the deductible threshold, the dollar awards would be relatively small, but ERISA plan enrollees still have the right to know this information. Although it is unlikely that many patients would actually sue for an answer, just a few determined people could pursue the matter vigorously enough to get health plans' attention. Plans would then find themselves forced to assemble a considerably more effective apparatus than many presently have in order to answer those questions in a timely fashion. Given that ERISA plans can avoid facing tort claims where their estimates err, such added accounting responsibilities may be a relatively small price to pay, to help patients make economically informed decisions.

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(S.D. Ala. 1994), *aff'd*, 61 F.3d 31 (11th Cir. 1995); *Leonhardt v. Holden Bus. Forms Co.*, 828 F. Supp. 657, 672 (D. Minn. 1993); *McLaughlin v. Williams*, 801 F. Supp. 633, 640, 644 (S.D. Fla. 1992); *Pittman ex rel. Pope v. Secretary, Fla. Dept. Health & Rehab. Servs.*, 998 F.2d 887 (11th Cir. 1993) (no ERISA); *Henderson v. Bodine Aluminum, Inc.*, 70 F.3d 958, 962 (8th Cir. 1995); *Graham v. Med. Mut. of Ohio*, 130 F.3d 293, 295-97 (7th Cir. 1997).

*But see Maltz v. Aetna Health Plans of N.Y., Inc.*, 114 F.3d 9 (2nd Cir. 1997); *McLeroy v. Blue Cross/Blue Shield of Or., Inc.*, 825 F. Supp. 1064, 1070 (N.D. Ga. 1993).

<sup>217</sup> ERISA provides that a plan beneficiary can bring suit "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan . . ." 29 U.S.C. § 1132(a)(1)(B) (2000).

## 2. Possibilities for Contract Litigation

As the plan determines whether and how much an intervention will count toward the patient's deductible, the process will be an eligibility decision. Although ERISA preempts state-based contract claims, it does permit suits resembling contract litigation, because the beneficiary can file suit to recover benefits due and to enforce his rights under the plan.<sup>218</sup>

In these suits, parallel to the discussion above,<sup>219</sup> plans are likely to prevail where their decisions flow from contractual clarity, as *Davila*<sup>220</sup> illustrates. In *Davila's* two consolidated cases, health plans in both instances had denied benefits on the basis of fairly explicit criteria. In the first case Juan Davila requested the drug Vioxx. The health plan refused, referring to its "step-therapy" program in which the patient must try less costly medications before the plan will approve costlier ones.<sup>221</sup> Davila did not appeal or contest the decision, whereupon the health plan refused to approve the Vioxx.<sup>222</sup> In the other case Ruby Calad underwent surgery, and although her physician recommended a longer stay, "a CIGNA discharge nurse determined that Calad did not meet the plan's criteria for a continued hospital stay."<sup>223</sup> In both cases the Court refers to fairly explicit procedures and criteria that the plans required as prerequisites to the requested treatment.

Reciprocally, patients may fare better where the plan bases its determinations on vague concepts like medical necessity.<sup>224</sup> However,

<sup>218</sup> *See id.*

<sup>219</sup> *See supra* Part IV.C.

<sup>220</sup> 542 U.S. 200.

<sup>221</sup> Brief for Petitioner-Appellant at 8-9, *Aetna Health, Inc. v. Davila*, 542 U.S. 200 (2004) (No. 02-1845), *microformed on* U.S. Supreme Court Records and Briefs (Cong. Info. Serv.).

<sup>222</sup> *Davila*, 542 U.S. at 205.

<sup>223</sup> *Id.*

<sup>224</sup> *See supra* Part IV.C.

A case in point concerns a welter of ERISA suits brought during the 1990s after health plans denied prospective approval for treatments such as high-dose chemotherapy ("HDC") with autologous bone marrow transplant ("ABMT") or peripheral stem-cell transplant ("PSCT"). Courts were deeply divided. Some courts readily latched onto any ambiguity they could find to authorize the treatment. *See, e.g.*, *Bailey v. Blue Cross/Blue Shield*, 866 F. Supp. 277 (E.D. Va. 1994), *aff'd*, 67 F.3d 53 (4th Cir. 1995). Other courts pointed to health plan terms such as "experimental" and found that because there was little or no scientific evidence favoring the treatment, the plan's denial was not an abuse of discretion.

*See also* *Harris v. Blue Cross Blue Shield, of Mo.*, 995 F.2d 877 (8th Cir. 1993); *Nesseim v. Mail Handlers Benefit Plan*, 995 F.2d 804, 807-08 (8th Cir. 1993); *Calhoun v. Complete Health Care, Inc.*, 860 F. Supp. 1494 (S.D. Ala. 1994), *aff'd*, 61

any such advantage is limited under ERISA. Courts must generally treat the decisions of ERISA fiduciaries with deference. They recognize that the fiduciary has the difficult task of balancing the interests of all the beneficiaries who depend on him to administer the plan in their interests. "Accordingly, '[a] trustee may be given power to construe disputed or doubtful terms, and in such circumstances the trustee's interpretation will not be disturbed if reasonable.'"<sup>225</sup> Generally, courts will only second-guess the fiduciary if a denial of benefits is arbitrary and capricious, an abuse of discretion, or fraught with conflict of interest.

## CONCLUSIONS

Several summary points emerge from the foregoing discussion. In non-ERISA plans, where patients are spending under the deductible, health plans could be subject to several potentially high-dollar litigation in several scenarios, such as:

- \*the plan provides medically inept advice through phone triage, decision aids, or other such services;

- \*the plan has a medically unsound basis for determining in advance that a proposed intervention would not be medically necessary, hence not deductible, and the patient then foregoes care to his detriment;

- \*the plan provides inaccurate price estimates that, in turn, prompt the patient to make a medically untoward treatment choice;

- \*the plan errs while directly managing patients' HSA funds, or while providing collection services on behalf of providers.

The opportunities for such suits are significantly larger than elsewhere in health insurance, simply because the majority of HDHPs currently are purchased by individuals outside the employment context,<sup>226</sup> and hence beyond the reach of ERISA.

Within ERISA, health plans will enjoy their usual shield from state-based litigation. However, even these plans may experience some surprises. They may be forced to determine, in advance and with specificity, whether a variety of proposed services will be de-

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F.3d 31 (11th Cir. 1995); *Wilson v. Group Hospitalization & Med. Servs., Inc.*, 791 F. Supp. 309 (D.D.C. 1992), *appeal dismissed*, 995 F.2d 306 (D.C. Cir. 1993); *Pirozzi v. Blue Cross-Blue Shield of Va.*, 741 F. Supp. 586 (E.D. Va. 1990).

By the same token, various courts affirm that clear contractual language will prevail. See, e.g., *Fuja v. Benefit Trust Life Ins. Co.*, 18 F.3d 1405 (7th Cir. 1994); *Harris v. Mut. of Omaha Cos.*, 992 F.2d 706, 713 (7th Cir. 1993); *Arrington v. Group Hospitalization & Med. Servs., Inc.*, 806 F. Supp. 287 (D.D.C. 1992).

<sup>225</sup> *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111 (1989).

<sup>226</sup> *Robinson*, *supra* note 13; see *supra* Part IV.A.

ductible. And it is unclear whether errors in pricing information will enjoy the protection of preemption.

Although HDHPs will likely pose some significant challenges for health plans within patients' deductible range, the story is not finished. Perhaps the most striking feature of these suits will be that most will involve such small sums. Except for torts claims that follow breaches of economic informed consent or medically inept advice, these suits will all focus on out-of-pocket expenses, the maximum of which would be around \$10,000 in a family plan.<sup>227</sup> For an ordinary person's budget this is, of course, a substantial sum. But in the greater scheme of health care, such figures are minute. More importantly for patients who wish to bring a claim, the sums are so small that few attorneys are likely to be willing to take such suits on a contingency payment basis.

Nevertheless, some litigation can be expected. In *Williams v. Tyco Electronics Corp.*,<sup>228</sup> the plaintiff deposited \$1200 into a health reimbursement account, thinking he could use his 2006 contributions to cover expenses incurred in 2005. When he was told that 2006 money could not count toward 2005 expenses, Williams requested rescission of his enrollment in the plan for 2006 and a refund of his money.<sup>229</sup> Williams initially brought the suit in state court but, invoking ERISA, Tyco promptly removed it to federal court<sup>230</sup> where they moved for and received summary judgment.<sup>231</sup>

Just as this \$1200 suit ultimately had its day in federal court, it is possible to imagine many such suits.<sup>232</sup> Though the amounts are small in the broader scheme of societal health care costs, they loom large for individuals. And just as this was filed in the plaintiff's local trial

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<sup>227</sup> I.R.C. §§ 62(a)(19), 106(d), 223(a)-(b), 3231(e)(11), 3306(b)(18) (West 2005).

<sup>228</sup> No. 6:06-CV-00024, 2006 WL 2645170 (W.D.Va. Sept. 14, 2006).

<sup>229</sup> *Id.* See also Tyco Electronics' Memorandum in Support of Motion for Summary Judgment, *supra* note 153, at 2.

<sup>230</sup> *Williams*, 2006 WL 2645170, at \*1.

<sup>231</sup> *Id.* at \*3. The court found that the Summary Plan Description clearly stated that the funds could not be used for expenses incurred during the year prior to the effective date of the plan. *Id.* at \*2-\*3.

<sup>232</sup> Another example of a small-damages suit is *McPherson v. Shea Ear Clinic*, No. W2006-01936-COA-R3-CV - Filed April 27, 2007 (Tenn. App. 2007). The plaintiff was uninsured, but had joined "Care Entree," a discount network. When McPherson sought care for his hearing impairment he consulted network administrators and concluded that his physician was part of the network. When the physician billed a considerably higher charge than the fee McPherson expected, he sued. By the time Shea Clinic won summary judgment because the pro se plaintiff presented little or no evidence to support his claims, the case nevertheless had gone to the Tennessee appeals court twice. *Id.* at \*2.

court,<sup>233</sup> other such plaintiffs can likewise begin in the most convenient, least costly place, even if they must then move to federal court.<sup>234</sup> Indeed, Williams appeared *pro se* in his suit.<sup>235</sup> When people are highly conscious of how much they spend, we can expect to see considerably more of this small litigation than heretofore.

Of somewhat greater concern to health plans is the potential for class action litigation. It is one thing for a health plan to determine that some particular health care expense will not count toward this or that patient's deductible. However, if a pattern of unfair denials surfaces, to the detriment of enrollees and the financial advantage of the plan, a collective action could ensue.

Admittedly, in 2005 Congress curtailed opportunities for such suits via the Class Action Fairness Act of 2005.<sup>236</sup> Per that legislation, "class-action suits seeking more than \$5 million would move to federal court if fewer than a third of the plaintiffs were from the same state as the primary defendant. If the primary defendant and more than a third of the plaintiffs were from the same state, the case could still be heard in state court."<sup>237</sup> Nevertheless, determined groups of plaintiffs could still bring such suits either by heading for federal court, or by bringing several suits that apportion plaintiffs to keep the suits in state courts. Such actions have already been filed on behalf of indigent patients who are billed high charges for hospital and emergency room care.<sup>238</sup> By analogy, a class action against HDHPs might try to

<sup>233</sup> *Williams v. Tyco Electronics Corp.*, No. 6:06-CV-00024, 2006 WL 2645170, at \*1 (W.D.Va. Sept. 14, 2006).

<sup>234</sup> In *Majid v. Stubblefield*, 589 N.E.2d 1045, 1046 (Ill. App. Ct. 1992), for instance, a physician sought payment of \$250 by filing a small claims complaint. The patient responded by arguing that the physician's fees were "excessive and unreasonable." *Id.*

<sup>235</sup> *Williams v. Tyco Electronics Corp.*, No. 6:06-CV-00024, 2006 WL 2645170, at \*1 (W.D.Va. Sept. 14, 2006).

<sup>236</sup> Class Action Fairness Act of 2005, Pub.L. 109-2, 119 Stat. 4 (codified in scattered sections of 28 U.S.C.).

<sup>237</sup> William Branigin, *Congress Changes Class Action Rules*, WASH. POST, Feb. 17, 2005, <http://www.washingtonpost.com/wp-dyn/articles/A32674-2005Feb17.html>.

<sup>238</sup> A broad series of class action suits has been filed on behalf of indigent patients, alleging *inter alia* that hospitals charge unreasonable prices. These suits have not seen resounding success. See, e.g., *Kolari v. New York-Presbyterian Hosp.*, 382 F. Supp. 2d 562, 566-67 (S.D.N.Y. 2005), *vacated in part*, 455 F.3d 118 (2d Cir. 2006); *In re Not-For-Profit Hospitals/Uninsured Patients*, 341 F. Supp. 2d 1354 (J.P.M.L. 2004); *Kizzire v. Baptist Health Sys., Inc.*, 343 F.Supp. 2d 1074 (N.D. Ala. 2004); *DiCarlo v. St. Mary's Hosp.*, No. CV-05-1665 (DRD-SDW), 2006 U.S. Dist. LEXIS 49000 (D.N.J. July 19, 2006); *Rockford Mem'l Hosp. v. Havrilesko*, 858 N.E.2d 56 (Ill. App. Ct. 2006); *Hudson v. Cent. Ga. Health Servs.*, No. 5:04CV301 (DF), 2005 U.S. Dist. LEXIS 2613 (M.D. Ga. Jan. 13, 2005); *Morreil v. Wellstar*



allege, for instance, that one or more health plans systematically denied deductible expenses in order to minimize the extent of catastrophic coverage their plans' must cover.

Assuredly it is important for health plans to be accountable for the quality of what they do. However, if health plans find too much litigation snapping at their efforts to help patients make medically and economically informed decisions, they may simply stop providing important services such as phone triage, decision aids, price information, and the other assistance that patients truly need as they try to make intelligent decisions while paying substantial amounts out of their own pockets. It is thus to be hoped that the ideal does not become the enemy of the good.

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Health Sys., Inc., 633 S.E.2d 68 (Ga.App. 2006); *Harrison v. Christus St. Patrick Hosp.*, 432 F. Supp. 2d 648 (W.D. La. 2006); *Woodrum v. Integris Health, Inc.*, No. CIV-05-1224-HE, 2007 U.S. Dist. LEXIS 5189 (W.D. Okla. Jan. 24, 2007).

The litigation has not been completely unsuccessful, however. At least one court has found that identifying "reasonable charges" for a hospital requires more than just reference to the hospital's standard billing rates. *Colomar v. Mercy Hosp. Inc.*, 461 F. Supp. 2d 1265 (S.D. Fla. 2006); *see also* *Urquhart v. Manatee Mem'l Hosp.*, No. 8:06-cv-1418-T-17-EAJ, 2007 U.S. Dist. LEXIS 17531 (M.D. Fla. Mar. 13, 2007).

Additionally, a number of these suits have settled privately. *See, e.g.,* David Phelps, *Uninsured Patients May Get Discounts*, NIGHT RIDDER TRIBUNE BUSINESS NEWS, Mar. 17, 2007,

[http://www.romingerlegal.com/newsviewer.php?ppa=8oplo\\_\[lqmnsrmRVgb!6%3C"bfem^!](http://www.romingerlegal.com/newsviewer.php?ppa=8oplo_[lqmnsrmRVgb!6%3C); Victoria Colliver, *Settlement Reached in Sutter Lawsuit*, S.F. CHRON., Aug. 4, 2006, at C1; Julie Appleby, *'Hospital-Based' Clinics Can Charge More*, USA TODAY, Nov. 16, 2006, at B3.