

S. HRG. 105-859

**ERISA PREEMPTION: REMEDIES FOR DENIED  
OR DELAYED HEALTH CLAIMS**

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**HEARING**  
BEFORE A  
SUBCOMMITTEE OF THE  
COMMITTEE ON APPROPRIATIONS  
UNITED STATES SENATE  
ONE HUNDRED FIFTH CONGRESS  
SECOND SESSION  
**SPECIAL HEARING**

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## **ERISA PREEMPTION: REMEDIES FOR DENIED OR DELAYED HEALTH CLAIMS**

**THURSDAY, MAY 14, 1998**

U.S. SENATE,  
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN  
SERVICES, AND EDUCATION, AND RELATED AGENCIES,  
COMMITTEE ON APPROPRIATIONS,  
*Washington, DC.*

The subcommittee met at 12:35 p.m., in room SD-138, Dirksen Senate Office Building, Hon. Arlen Specter (chairman) presiding.  
Present: Senators Specter and Faircloth.  
Also present: Senators Kennedy and Durbin.

DEPARTMENT OF LABOR

PENSION AND WELFARE BENEFITS ADMINISTRATION

**STATEMENT OF OLENA BERG, ASSISTANT SECRETARY**

OPENING STATEMENT OF SENATOR SPECTER

Senator SPECTER. The subcommittee on Labor, Health and Human Services, and Education, will now proceed with this hearing concerning the ERISA preemption of remedies on health care claims. We hear a lot about ERISA. It is the Employee Retirement Income Security Act of 1974, which has created a comprehensive Federal approach, dealing with the rights of employees in welfare benefit plans offered by employers.

The Congress has preempted all State laws that, quote, "relate to any employee benefit plan." And as a consequence of that provision, patients are prevented from suing employer-sponsored health insurance plans if injury occurs as a result of any improperly denied or delayed health coverage. The issue has created quite a lot of controversy. It is a matter which is frequently raised in the open-house town meetings that I conduct in my State. There is a real concern that if there is a modification of this provision, the costs will rise very substantially for health care premiums—some estimates being as high as 8 or 9 percent.

The use of the managed care plans has risen tremendously. In 1984, only 5 percent of the employees were covered by managed care. More recently, that figure has increased to as much as 80 percent of the employees in the United States.

The Congress has moved ahead with a number of measures on the so-called micromanagement. When the issue of drive-by deliveries came up, the Congress acted, to require that patients stay in

the hospital for at least 48 hours. There are provisions up for drive-by mastectomies. Once one of these provisions reaches the floor of the U.S. Senate or the U.S. House, it is very hard to see those measures voted against. But it is obviously undesirable to have micromanagement by the Congress.

We have seen areas of major concern on the so-called gag rule. We have seen major concern on capitation on the issue of referral by the general practitioner to specialists. There are issues of more disclosure being necessary, appellate rights and these are issues which are very much in the forefront in the Congress today, with several health care plans being pending.

We have a very distinguished panel today. And let me yield for a brief opening statement by Senator Kennedy, who has asked for leave to sit with the subcommittee today. He has been a leader in health care over the years.

Senator Kennedy, welcome.

OPENING REMARKS OF SENATOR EDWARD M. KENNEDY

Senator KENNEDY. Thank you, Mr. Chairman. And I just want to thank Senator Specter for having the hearings. I hope we are able to hear the hearings as we go on through the course of this hearing. But I do want to express appreciation, because this is an issue of enormous importance.

And no matter where different parties come out on the questions of a Patients' Bill of Rights or other kinds of related issues, this one is something that is of enormous importance and consequence in and of itself. And we have panelists here to help us. And we have not had really the kinds of hearings that we are having there that can really benefit us in the Senate.

So, I thank the Senator for extending the courtesy. I basically had indicated that I just welcome the chance to listen to our witnesses here this morning, and I am grateful to him. He has outlined the basic challenges that we are faced with. We have really, as he pointed out, a changed situation in our Nation. And we have 123 million Americans that are covered by some employer kind of related coverage and health insurance programs, and they are treated one way. We have State and local employees—millions of those—almost 20 million—that are treated a different way. We have individuals who have individual plans, and they are treated differently.

And the real kind of question is, how are we going to best protect the consumer? And how are we going to, with these changed conditions, in terms of the managed care, how are we best going to protect the consumer?

PREPARED STATEMENT

And we are looking forward to hearing from our panelists here today on their observations and their recommendations.

I am very grateful to the chair. I would like to put my full statement in the record.

Senator SPECTER. Without objection, it will be placed in the record.

[The statement follows:]

## STATEMENT OF SENATOR EDWARD M. KENNEDY

I commend Senator Specter for holding this hearing and for his leadership on this important issue, and I'm grateful for the opportunity to participate in this hearing.

Too often today, because of ERISA preemption, unscrupulous health insurance plans have a license to maim and kill.

Under the Employee Retirement and Income Security Act, patients whose lives have been devastated or destroyed by the reckless behavior of their health plan are denied the right to go to court to obtain reasonable remedies under state law. ERISA "preempts" all state actions.

Patients are limited to the narrow Federal remedy, which covers only the cost of the procedure that the plan refused to pay for. Some remedy! You can be crippled for life because your health plan refused to authorize a test costing a few hundred dollars—and all you can recover is the cost of the test.

The denial of fair remedies is indefensible. It's an incentive for unscrupulous plans to deny payment for costly services, knowing they can't be held liable for the serious injuries that result.

Persons who are injured by such willful or negligent acts deserve a remedy. If they are seriously injured, they may have no other way to obtain the financial help they need to care for themselves or provide for their families for the rest of their lives.

ERISA preemption applies to millions of Americans who obtain their health insurance coverage through a private employer. But it does not apply to 23 million State and local employees and their families. It does not apply to people who buy insurance on their own, rather than through an employer. It does not apply to Medicaid patients. It does not apply to Medicare patients enrolled in private health plans. These patients already have appropriate remedies under current law, and so should every other patient.

If state and local government employees have the right to hold their taxpayer-financed health plans accountable, equally hard-working Americans employed by private companies should have the same basic right.

Every other industry in America can be held responsible for its actions. Health plan decisions can truly mean life or death, and they do not deserve immunity.

The Patients' Bill of Rights legislation that many of us support will guarantee this right as well as provide a number of other critically important protections for patients against abusive behavior by health plans. It has been endorsed by more than 100 organizations representing doctors, nurses, and patients, and it deserves to be endorsed by the Senate. This hearing is an important step toward doing so, and I look forward to the comments of our witnesses.

## SOURCE OF COVERAGE

Senator SPECTER. Before turning to Senator Faircloth for an opening statement, I would call attention to the two charts which our very able staff has prepared, showing the source of coverage. On average, there is about 125 million people who receive their health insurance coverage through employers' base plans. As I stated earlier, 5 percent of those who received health insurance in 1984 were on these plans. But by 1997, more than 80 percent of employees had shifted to the HMO, away from fee-for-service medicine, into managed care.

There is always some competitive force around here, and we are going to try to get the drilling stopped. But, in the interim, we want to proceed with the very distinguished panel which we have today. The lights will be for 5 minutes, with the yellow signifying 1 minute.

Before doing that, I turn to my very distinguished colleague from North Carolina, Senator Faircloth.

## OPENING REMARKS OF SENATOR LAUCH FAIRCLOTH

Senator FAIRCLOTH. Thank you, Mr. Chairman.

I'm pleased to be here to address the very serious problem people are facing today regarding the denial or delay of health benefits.

Health insurance plans are supposed to provide security to workers and their families in the event of illness or injury. But as more companies become self-insured or adopt managed care, I've been hearing from more people, constituents in North Carolina, who are unhappy with their care.

This seems to be caused by the different ways traditional fee-for-service and managed care plans provide care. Under fee-for-service, treatment is provided up front and payment issues are dealt with later. Most managed care plans require coverage decisions to be made before care is given. The focus becomes cost, not care.

I can understand the concern when people feel they or a loved one needs care and faces a delay as the HMO decides to respond—well, I'd be upset too. I feel deeply for people who are denied basic rights, like access to specialists and emergency room care. I support the consumer protection and quality provision in the patients' bill of rights. I also agree with doctors who say they should not be held accountable for medical decisions they have not made which have been imposed by a plan. But I cannot in good conscience, support any approach that results in more litigation which drives up health costs.

I see that one of our witnesses today is a trial lawyer, and well versed in this dynamic. In his testimony, he will talk about the chilling effect of litigation. He lays it all out—expanded lawsuits cause increased costs to the insurance and managed care company and employers. They pass this cost along, and my constituents pay more for health insurance. They pay enough already, I don't want to see them have to pay more.

After careful consideration, I decided to cosponsor a bill known as QUEST, which meets 7 of the 11 elements the AMA say they need. QUEST enhances protection for patients by improving internal claims and appeals review, and requiring external reviews. But QUEST does not reach self-insured companies, which cover many of these lives. So, I am pleased to hear that the administration will now use a similar approach to better provide patient protection for ERISA plans. And I am delighted that they have decided to make these improvements in the name of decreased litigation.

Thank you, Mr. Chairman.

Senator SPECTER. Thank you very much, Senator Faircloth.

PREPARED STATEMENT OF SENATOR TOM HARKIN

We have received a prepared statement from Senator Harkin, it will be inserted into the record at this point.

[The statement follows:]

PREPARED STATEMENT OF SENATOR TOM HARKIN

Thank you, Mr. Chairman, for holding this important hearing on federal law regarding ERISA self-insured health plans and its effect on consumers' ability to seek redress for denied or delayed health claims. And I am happy to welcome Senator Kennedy here with us this afternoon. He has shown tremendous leadership on this subject.

This is an issue of increasing concern to millions of Americans throughout our country; 146 million Americans get their insurance through their employer. Of that number, 123 million people—roughly half the nation—are in self insured plans regulated by ERISA, and have very limited legal remedy if their treatment is denied by their HMO.

As increasing numbers of employers are turning to managed care as a cost-efficient way to provide health benefits to their employees, it is vital that Congress examine the possible problems presented by ERISA.

I am pleased to say that I have cosponsored Senator Daschle and Senator Kennedy's bill, "The Patients' Bill of Rights." This consumer protection bill would provide Americans with a fundamental set of health care rights. It is a good, fair bill and I believe the Senate should take it up for consideration without delay.

Included in this bill is a provision that amends ERISA so that the States are allowed to determine whether or not a beneficiary can bring a state cause of action against health plan administrators who cause harm through their decisions.

Our legal system is based on the principle that individuals and companies are responsible for the decisions they make or the actions they take. If a health maintenance organization makes a decision to improperly delay or deny care that results in harm to a patient, that organization ought to be held accountable for their decision. Today, too often that is not happening.

In my own State of Iowa, Randy and Nancy Davis brought suit against their employer and their group health plan on behalf of their daughter Wendy, a child with Down's Syndrome. Randy Davis was employed by the Ottumwa YMCA. One of the benefits of the job was group health insurance, which was critical to the Davis family because of Wendy's condition. When Wendy needed medical treatment, their health plan denied their coverage on the grounds that the YMCA had allowed their policy to lapse. This left the Davis family without any coverage. The Davises sued, but the court would not hear their case—their claim was preempted because of ERISA.

But if the Davises had been State or local employees covered by their employer, or if they had purchased individual insurance directly from the insurer, they could have sued under State law and the court would have considered the case. But the Davises are among a fast growing majority—approximately 80 percent of Americans—that do not have such an option.

This case and numerous others demonstrate the need for us to re-examine certain aspects of ERISA. Twenty-four years ago, ERISA was enacted to protect the pension and welfare benefits of employees, while at the same time helping employers avoid costly regulatory requirements and legal impediments. But 24 years ago, the vast majority of Americans were covered through traditional fee-for-service plans. When a patient sought care, he or she usually received it, and then was reimbursed by the insurer. Today, however, managed care has fundamentally changed the delivery of health care in this country. Patients are too often not assured they will get the care they need because of cost cutting efforts.

When a company is in the business of deciding what medical treatment is necessary, I believe they are making medical decisions. And they should be held accountable for those decisions. ERISA should reflect that.

A judge from Massachusetts, after dismissing a case because ERISA preempted the claim, states, "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. Enacted to safeguard the interests of employees and their beneficiaries, ERISA has evolved into a shield of immunity that protects health insurers, utilization review providers, and other managed care entities from potential liability for the consequences of their wrongful denial of health benefits."

I think we all would do well to heed this judge's advice.

Thank you.

#### SUMMARY STATEMENT OF HON. OLENA BERG

Senator SPECTER. Our first witness is Ms. Olena Berg, now serving in her fifth year as Assistant Secretary for the United States Department of Labor's Pension and Welfare Benefits Administration. She had been chief deputy treasurer in California, and had been executive vice president of Lowe Associates in Los Angeles.

We are still trying to stop the noise, Ms. Berg, but if you would proceed at this time as best you can.

Ms. BERG. Well, thank you, Chairman Specter and members. I appreciate your inviting me here today to speak to you about ERISA preemption. The administration is absolutely committed to improving consumer protections by making real the Presidential Commission's Consumer Bill of Rights, and ensuring that its pro-

tections are enforced. Bipartisan legislation has been introduced in this Congress to implement the bill of rights. These bills have momentum, and Congress should act now to put these protections in place.

As you know, many of these bills do address the issue of remedies. It is crucial that consumers be able to obtain adequate redress when they are injured by the wrongful delay or denial of a health benefit claim. But ERISA currently only provides for the benefit the individual should have received to begin with. No additional medical costs, no other compensation is available. Consumers in ERISA plans do not have adequate protections.

And this is a problem. Because as you have already pointed out, ERISA covers approximately 125 million Americans.

This law was enacted in 1974, primarily to address abuses in the private sector pension plans. And as a result, it included only limited protections for participants in health plans. In addition, two key changes have occurred since ERISA was enacted that have resulted in the statute not providing for adequate remedies.

The first, again, has already been pointed out, the immense growth in managed care arrangements. In traditional fee-for-service medicine, you got the treatment up front and people argued afterward how the payment would be divided. Now, in managed care arrangements, coverage decisions are made before the medical treatment is provided. And so today, the improper denial of a claim to which someone is entitled means they will not get the treatment to which they are entitled.

Second, ERISA preemption has blocked the application of State protections in health care claims involving ERISA plans. In 1987, the Supreme Court held that ERISA occupied the entire field of remedies for its participants, precluding the States from providing any different or additional protections. The limited remedies in ERISA applied both to self-insured plans and to the fully-insured plans that would otherwise be subject to State regulation.

This is why legislation is now needed to ensure that ERISA serves the purpose for which it was enacted in the first place. And that is to protect promised benefits.

It is also important to note that participants in many health care plans not governed by ERISA have stronger protections. Consumers who purchase individual insurance policies directly from an insurer or an HMO, State and local government employees, participants in Medicare and Medicaid all can sue under State law for wrongful denial of a benefit. Unlike ERISA participants, not only can they receive the benefit and attorney's fees, but also the cost of additional care, lost wages, and other damages, as well.

The protections we have should not depend on the type of plan we have.

Let me briefly illustrate the problem with ERISA with an example. Let us assume an ERISA plan participant goes to her HMO doctor complaining of severe and persistent headaches, and the doctor determines that she needs a CAT scan. But that test has to be approved by a utilization review panel. And let us assume that they wrongfully deny her that test. And as a result, a treatable condition that she has goes undiagnosed and untreated. That condition causes her to become permanently disabled.

If she goes to court under ERISA and if she is successful, her remedy will be the cost of the test that she should have had in the first place.

Now, as I point out in my written testimony, we believe that a solution to the problem of wrongful claims denial has three components. First, strengthening internal claims reviews. Second, requiring independent external review. And, finally, remedies.

Some would argue that only the first two are necessary. We disagree. First, a strengthened grievance procedure will not be effective 100 percent of the time, no matter how good it is, and wrong decisions will still cause damage. In those cases, individuals should be able to be compensated.

Second, plans can comply with procedural requirements, they can meet all of those, and still arbitrarily deny claims. Now, external review might take care of a large part of that, but many participants, we know, never question that initial determination. They never go into the appeals process. They just assume that that determination was properly made.

And if at the end of the day the only consequence for plans that engage in this kind of practice, just arbitrarily denying things, is paying the benefit that they would have had to pay in the first place, they have no reason to do the right thing and strong economic reasons for denying valid claims. Only in combination will internal reviews, external reviews and improved remedies secure consumers' rights to their benefits.

These reforms provide plans with both the mechanisms and the incentives to treat consumers fairly from the start. There are a number of ways to provide remedies and accountability. In the interest of time, I will not outline them for you, but I refer you to my written testimony.

#### PREPARED STATEMENT

We look forward to working with you, to sign into law bipartisan legislation that will improve consumer protections and provide remedies under ERISA. I applaud your willingness to look at this issue, and thank you for the opportunity to be here today. I am happy to answer any questions you may have. Thank you.

Senator SPECTER. Thank you very much, Ms. Berg, for your testimony. All written statements will, as customary, be made part of the record.

[The statement follows:]

#### PREPARED STATEMENT OF OLENA BERG

##### INTRODUCTION

Chairman Specter and Members of the Subcommittee, thank you for inviting me to speak with you this morning about ERISA preemption and its impact on consumer remedies for improper delay and denial of health benefit claims. We appreciate the leadership of the Chairman, Ranking Member, and other Committee members in holding this hearing to address ways to restore the public's confidence in America's health care system by implementing enforceable consumer protections.

As Assistant Secretary of the Pension and Welfare Benefits Administration (PWBA), I direct the agency that administers the Employee Retirement Income Security Act (ERISA), the primary federal statute governing employment-based health plans. As you know, the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, co-chaired by the Secretaries of Labor and

Health and Human Services, last fall issued a Consumer Bill of Rights and Responsibilities. This approach recognizes that consumer protections and health care quality are each essential to the other. The President embraced the Bill of Rights and called on Congress to pass bipartisan legislation this session.

The Administration is strongly committed to improving consumer protections and the quality of health care in the employment-based system, including improved internal claims review procedures and external review. We are also committed to ensuring that these protections are enforceable. We recognize the fundamental problem regarding ERISA remedies best characterized by Judge Young in his opinion in *Andrews-Clarke v. Travelers Insurance Company*. Judge Young stated that, although ERISA was “[e]nacted to safeguard the interests of employees and their beneficiaries, [it] has evolved into a shield of immunity that protects health insurers, utilization review providers and other managed care entities from potential liability for the consequences of their wrongful denial of health benefits.” Judge Young noted the, “glaring need for Congress to amend ERISA to account for the changing realities of the modern health care system.”

At the heart of the opinion in the *Andrews-Clarke* case is the matter before us today. When an individual suffers harm due to the wrongful delay or denial of a claim for promised health benefits, ERISA only provides for the benefit that the individual should have received to begin with; no additional medical costs or other compensation is available.

#### OVERVIEW OF ERISA

This issue is so important because of the simple fact that most workers and their families receive their health care through ERISA-covered plans. ERISA covers over 2.5 million private sector health plans which provide health benefits to 125 million people. These plans are either provided by employers, or are jointly trustee “Taft-Hartley” plans negotiated by unions with groups of employers.

The employment-based health care system regulated by ERISA is a voluntary system. While we in PWBA enforce ERISA’s provisions, we do not certify, accredit, or approve plans. ERISA represents an effort to adequately protect the health benefits promised to individuals while avoiding overly burdensome or costly requirements that might discourage employers from offering, or employees from enrolling in, plans.

In providing health benefits, employers and employees can either contribute to the purchase of third party insurance or provide health benefits directly themselves. Thus, “fully-insured plans” are plans that pay a premium or per capita payment to a third party to insure the health benefits offered to employees. “Self-insured plans,” also called “self-funded” plans, are ones in which the plan sponsor agrees to be primarily liable for the provision of promised health benefits to employees.

#### THE ERISA FRAMEWORK

In order to understand the purpose and operation of ERISA, it may be helpful to briefly review the history of this legislation. ERISA was enacted in 1974 primarily to address abuses in private sector pension plans. Hearings in the 1960’s and 1970’s revealed that large numbers of working people were losing their pension benefits because of: underfunding, long vesting periods, and plain “garden variety” pension fraud and mismanagement. These problems were compounded by a lack of adequate reporting and disclosure either to the government or to participants of the status of their pension benefits. These problems were serious enough that many States had either passed, or were considering passing, statutes regulating pension plans. This posed an additional problem: plan sponsors that wished to offer their participants uniform benefits but that operated in more than one State would have to cope with myriad and possibly conflicting State regulations.

ERISA dealt with these problems with respect to pension plans by providing detailed minimum standards for participation, vesting and funding of the plans, and uniform reporting, disclosure and fiduciary requirements. ERISA also provided uniformity by preempting all State laws relating to any ERISA-covered employee benefit plan.

However, while ERISA provides uniform reporting, disclosure and fiduciary standards for health plans, there is no substantive regulation of health plans under ERISA that is comparable to the participation, vesting, and funding requirements for pension plans.

When ERISA was enacted in 1974, most people received health insurance coverage through insurance contracts which were regulated by States. Since there was a general consensus that States could and should regulate insurance contracts, they were carved out of ERISA’s general preemption of State law by the so-called “sav-

ings clause.” Because of this structure, insurance contracts purchased by employment-based health plans are generally regulated by States, while self-insured plans are not. That may not have been much of an issue in 1976, when only 4 percent of health benefits were paid under self-insured plans. Today, however, for a variety of reasons, about 40 percent of workers with private employment-based health benefits are covered under self-insured plans.

It may appear that I have drawn a simple line to help you understand the ERISA framework: self-insured plans are generally regulated federally by ERISA while plans that purchase insured products accept the State regulations that apply to the product they purchase. Unfortunately, because of the scope of ERISA’s preemption clause and a series of court decisions, things are not quite that simple.

#### SCOPE OF ERISA PREEMPTION

I have to qualify my comments by noting that the extent and the limits of ERISA preemption are far from clear. To date, the U.S. Supreme Court has issued 16 decisions on how preemption should be applied. Other issues are confused by conflicting decisions by the lower courts. Nevertheless, I will venture toward some tentative conclusions that I hope will help.

One, States laws governing the solvency of insurers or mandating that health insurance policies cover certain types of care are not preempted, because of the savings clause, as laws regulating insurance are not preempted. However, these same laws may not be applied to self-funded plans.

Two, State laws that allow participants to sue plans for failing to follow certain procedures in denying and reviewing benefit claims, and providing that a participant may obtain compensatory damages for abusive processing of such claims are preempted, even if the claimed defect is a violation of a State law regulating insurance. The Supreme Court, in the *Pilot Life* decision, held that ERISA preempts an employee’s State common law breach of contract and tort action against an insurance company for improper claims processing. Although the court ruled that the employee’s action was not saved from preemption by ERISA’s “insurance savings clause,” it also noted that ERISA’s remedies for plan participants to enforce claims for benefits displaced State laws conferring similar causes of action. The Supreme Court said, in effect, that ERISA occupied the entire field of remedies for ERISA plans, precluding the States from providing any different or additional remedies. State laws that provide for external review of claims denials may also be preempted by ERISA. This issue has never been decided by the courts. To the extent that State insurance laws prohibiting insurance companies from engaging in unfair claims practices are enforced by State agencies, such claims may survive ERISA preemption as applied to fully-insured plans. However, the courts have never addressed this issue.

Three, there have been cases where a Health Maintenance Organization (HMO) will attempt to use ERISA preemption to protect itself from such liability. The Department has successfully argued in a number of amicus briefs that State laws holding physicians and those that contract for their services liable for medical malpractice in connection with treatment decisions are not preempted, even if the physician provides services to ERISA plan participants. We have opined that State medical malpractice laws do not relate to ERISA plans. Instead, State malpractice laws, regulate medical treatment without regard to how it is paid for. On the other hand, if treatment is denied or delayed through wrong or slow decisions, based solely on what is or is not covered by the plan, State laws cannot address this problem. If a State attempts to regulate the payment of claims, including refusals to preauthorize medically necessary care, such a law will likely be preempted with respect to ERISA plans, whether insured or self-insured.

As a result of ERISA’s remedial framework and the interpretation of its preemption provisions, the States are limited in their ability to protect the rights of participants in all ERISA-covered plans.

In addition, the absence of more stringent accountability for ERISA plans has become especially problematic for ERISA plan participants in the past decade due to the dramatic increase of managed care arrangements. According to various data sources, enrollment in managed care grew from approximately 1 percent to 81 percent of total health plan enrollment among medium to large size employers between 1980 and 1997. Most smaller businesses have embraced managed care as well. Managed care plans raise questions of regulation and legal remedies that were not anticipated when ERISA was enacted in 1974. Unlike the traditional fee-for-service environment where treatment is provided up front and payment issues are dealt with later, most managed care arrangements require coverage decisions to be made before most medical services are provided. Today, denying a request for medical cov-

erage can do more than force the patient to pay for the care herself. In all too many cases, delay or denial of plan benefits can even lead to a failure to obtain necessary treatment. This makes the timeliness and accuracy of these decisions more significant, and the availability of adequate procedural protections and remedies even more important.

The consequence of all of these developments is that ERISA does not adequately provide for the essential consumer protections listed in the Commission's Consumer Bill of Rights. As a result, legislation is needed to implement these protections in ERISA-covered plans and provide a mechanism for the enforcement of these protections.

#### BROADER REMEDIES ARE AVAILABLE ELSEWHERE

In its final report, the President's Commission noted that, "consumers can be injured as a result of an inappropriate decision to deny insurance coverage for services that are medically necessary and covered by the plan. In some cases such decisions can lead to a delay in care or to a decision to forgo care entirely." Plainly, ERISA's current enforcement mechanism has proved insufficient to safeguard consumers' health care benefits. Participants in many health care plans not governed by ERISA enjoy stronger protections. To illustrate this point more clearly, consider the experiences of two hypothetical individuals: "Bob" and "Mary."

If Bob bought an individual policy directly from an insurer or HMO, or if he is a State or local government employee covered by his employer's plan, chances are he can sue the insurer, HMO, or plan under State law for wrongful denial of a promised benefit. The State court will examine the dispute anew, considering all available facts. If Bob wins, remedies are available which, depending on Bob's losses and the laws in his State, can include the benefit that should have been paid, the cost of otherwise uncovered additional care, attorney's fees and other legal costs, lost wages and other financial losses, compensation for injury or wrongful death, compensation for pain and suffering, and, possibly, punitive damages.

If Mary, Bob's neighbor, is insured as a private sector employee, her remedy for wrongful delay or denial of a promised benefit is determined not by State law, but by ERISA, which preempts State remedies. Mary generally can sue only in federal court. The court will likely consider only facts considered already by the person who denied coverage, and will defer to that person's judgment unless it is shown to be unreasonable. What's more, if she wins, she can recover only the benefit that should have been paid and, at the court's discretion, possibly attorney's fees.

The inability of consumers to recover additional remedies is best illustrated by the real life story of Madison Scott as reported by NBC Nightly News. When Madison Scott was born prematurely with correctable retinopathy, her parents allege that the HMO delayed a key test 8 weeks. Today the two-year-old is blind. Unfortunately, under ERISA, her HMO is not liable for the harm that occurred if the coverage was delayed. Moreover, Mr. and Mrs. Scott cannot recover the additional costs they will need to provide special care for Madison. We believe that the Madison Scott's of this world deserve their day in court, with a court determining the facts of the case, and with remedies adequate to address the injury, if any, that was suffered as a result of the alleged delay.

Today in America, there are 125 million people who are enrolled in ERISA-covered health plans and, like Madison and our hypothetical Mary, are, therefore, unprotected by adequate remedies. There are roughly 60 million individuals, like our hypothetical Bob who are protected by stronger State law remedies. This varied treatment depending upon which law governs your particular health benefit plan is unjustifiable.

There is growing evidence of the consequences of ERISA's limited remedies. In fact, delay or denial of coverage is the most commonly stated health insurance problem, reported by 11 percent of managed care enrollees in a survey for the Kaiser Family Foundation and others. Delays and denials suffered by Kaiser survey respondents resulted in claims of serious harm:

- 24 percent said they were physically injured;
- 3 percent were permanently disabled;
- 26 percent lost school or work time, while 9 percent lost more than 10 days; and
- 41 percent suffered financial losses.

Furthermore, our legal system is premised on the basic principle that individuals and organizations must be responsible and accountable for actions that cause injury to others. Where an entity fails to deliver what it promises, or negligently provides a service or product, and this failure results in injury to a consumer, that consumer must be compensated for the injury.

Ironically, I have more consumer protections and remedies available when I buy a car, a toy for my child, or use my credit card. If I walk into my neighborhood grocery store, and due to a dangerous condition inadvertently created by store employees, I slip, fall, and injure myself, our legal system allows me to have legal recourse against the store to seek compensation for my injuries. If my pharmacist mistakenly gives me the wrong medication, and I am injured as a result, I also can seek to obtain relief from the pharmacist or the company that employs her. If I buy a car or any other product, I rely on the expertise of the manufacturer to make sure that the product is safe and free of defects. If I am injured due to a defect in the product, the product manufacturer can be held accountable for damages under our legal system to reasonably compensate me for my injury. By the same token, when I receive health care benefits, I rely on the expertise of plan administrators to make the correct coverage decision in a timely manner. Under ERISA, however, if I am injured because such decisions are not made correctly or are unreasonably delayed, our legal system does not hold the plan accountable. I cannot receive any damages beyond the benefit itself. There is no reason why we should treat health care differently than we treat other consumer products or services.

#### REMEDIES AS PROCEDURAL PROTECTION

Several health care consumer protection bills pending in this Congress would enact strong procedural protections to protect participant health benefits. Some of the bills include improved internal plan claims review, impartial external review, and enhanced remedies. The theory behind this arrangement is that these three elements working together can assure accountability, better health care delivery, and may result in less, not more, litigation of these issues.

ERISA's current provisions regarding internal claims review have become inadequate to protect the rights of ERISA plan participants in today's managed care environment. For this reason, the Department will be proposing amendments to the current claims review regulation in the near future to require fairer and more expeditious handling of benefit claims and appeals through plans' internal claims procedures. The Department will propose faster processing of routine and urgent benefit claims and appeals, require consultation with medical professionals in deciding appeals involving medical judgments, and require that appeal decisions consider all relevant information and be rendered by a party other than the party who made the original claims determination, among other provisions. Clearly, effective and appropriate regulation in this area should not lock in yesterday's standards, but should be part of a framework in which plans can adapt to future needs. Consumer protections tailored to accommodate group plans' variety can advance patients' rights while nurturing innovations that improve quality, choice, and affordability for group plan enrollees.

Independent external review is also an important component to provide accountability. ERISA currently provides no authority for requiring an independent system of external review. As a result, legislation is needed to amend ERISA and provide for this requirement. An impartial, speedy, expert review by an entity external to the health plan is essential to securing participants' right to covered benefits. The more claims that can be resolved at an earlier stage of the process through internal or external review the less likely it will be that participants will be injured by the wrongful delay or denial of health claims. An improved internal claims review coupled with an independent system of external review will go a long way toward resolving improper delay or denial of claims before an injury occurs, reducing the need for litigation.

However, adding these enhanced procedural protections on the front end do not eliminate the need for improved remedies. Procedural rights, even when honored, cannot eliminate negligent or self-interested decision making by those determining whether claimed coverage has been promised by the plan. Some cases will involve only disputes about the availability of a benefit, and, if promptly resolved, no consequential harm will result. However, other wrongful decisions, even if ultimately corrected by some newly created administrative tribunal or by the courts will, some percentage of the time, cause injury before they are corrected. In some cases, the relief necessary to repair the injury will be easily defined and relatively minimal. For these cases, we should be looking for speedy, economical, and fair means of dispute resolution. As the seriousness of the health and economic harm increases, more substantial remedies should be available from traditional court proceedings.

In other contexts throughout our legal system, foreseeable injuries caused by a failure to deliver what has been promised must be compensated. Under ERISA, however, working men and women give their labor in exchange for the promise of benefits, but are not compensated for injuries when benefits are wrongly withheld.

Under this system, an insurance company or HMO may stubbornly refuse to provide what is promised in the hope that the worker will not finance a court battle, and even if she does, years of litigation will produce no more than an order to provide the withheld benefits.

How else to explain *Bedrick v. Travelers Ins. Co.*? There the Fourth Circuit Court of Appeals determined that Travelers had withheld desperately needed physical therapy from a severely handicapped child on the grounds that the therapy was not medically necessary since it would only prevent further deterioration in the child's condition, but could not cure him. Would Travelers have engaged in a long and costly court battle to oppose the therapy, if it knew that it might be responsible for the consequences of the delayed treatment? Under our present system, the litigation, premised on a defense that the court found "revolting," made economic sense for Travelers. If the child's family could not finance the physical therapy while the litigation remained pending, every week spent in court was a week during which Travelers did not have to pay for on-going therapy. While the discussion about what types of remedies are needed is a legitimate one, without additional remedies, our system produces perverse results.

The absence of remedies produces another perverse result that additional procedural protections cannot prevent. As our system is currently constituted there is no disincentive to applying harsh and arbitrary guidelines for the initial denial of care. To litigate a claim's denial requires significant resources, and some percentage of claimants can be counted on to give up without pursuing their claim. While we are aware of no studies, advocates for claimants have reported to us an astonishing rate of success in getting decisions overturned prior to, or immediately after, filing litigation. Attorney's fees for pre-suit work are borne by the claimant. The current system lacks incentives to assure that the initial claims determination is fair, since the wrongly denied claimant who is injured can never seek compensation for injury while his case is pending, and the discouraged participant with a meritorious claim represents pure savings to the managed care entity. A system which delays justice until an internal appeal or even a threat of litigation saves the managed care entity money. Thus, under our current system, there is a strong financial incentive to delay providing costly medical treatment.

In the end, better internal review, and independent external review are necessary elements to consumer protection, but we must make sure that these procedural protections are properly enforced.

#### COST ISSUES

The cost implications of providing for additional remedies must be carefully evaluated. We are sensitive to this issue, and we realize that estimating the cost of additional remedies is difficult.

We are aware that there are studies with conflicting results on the cost impact of additional remedies. The studies on the issue have focused on measuring the cost of an approach that would narrow ERISA preemption to allow consumers to sue a plan that wrongfully delayed or denied a promised health benefit under State law. Some of these studies have concluded that this State approach to providing additional remedies will increase premiums only marginally.

The best evidence regarding cost impact exists in those markets where expanded remedies already exist. There is nothing in these markets to show that these remedies result in larger premium costs. For example, participants in group health plans covering State and local employees are outside ERISA and often have access to full State law remedies for injuries that result from improper delay and denial of benefit claims. Yet insurers and HMO's compete aggressively for State and local group business, and there is no evidence that insurers charge higher prices to these groups because of the greater liability exposure associated with them. Thus, it seems highly unlikely that the availability of additional remedies would force employers to retreat from offering health coverage.

It is also important to note that we have yet to see any studies on the cost impact of simply adding additional remedies to ERISA, or any approach other than narrowing ERISA preemption to allow actions in State court. The State approach may be a good, viable option, but it is not the only one. As I will discuss later, there are several possible alternatives for providing additional remedies.

We ask that you consider the two following points when faced with pessimistic assumptions about the cost implications of added remedies:

First, as I stated previously, the cost of expanded remedies will be mitigated by the existence of better internal review as well as external review procedures. External review, particularly, should lessen the number and degree of injuries resulting from wrongful benefit determinations, by providing a means for benefit disputes to

be resolved before an injury occurs. External review could also decrease the number of claims brought by individuals by ensuring access to a more inexpensive and timely means of resolving these disputes than litigation, and by increasing enrollee confidence generally.

Second, this new incentive to make proper and timely claims decisions up front may reduce total health care costs by preventing the wrongful conduct and any resulting injury in the first place. For example, if a plan wrongfully denies an individual coverage for a mammogram, and that denial results in breast cancer going undetected, eventually someone, probably the plan, will have to pay for the additional costs associated with the resulting cancer treatment. The plan could have prevented this extra cost in the first place with the proper claims review decision.

#### PERSPECTIVES ON A SOLUTION

In addition to evaluating the cost and coverage implications of additional legal remedies, Congress must decide how best to ensure that these additional remedies are available. There are several ways that Congress could provide additional remedies to fairly compensate injured consumers and hold plans accountable for their actions. Various pieces of bipartisan legislation have been introduced in this Congress suggesting alternative mechanisms to expand remedies for ERISA plan participants.

One approach would be to narrow ERISA preemption to permit States to apply their existing substantive laws and remedies, as well as any newly enacted laws and remedies, to address the improper denial and delay of health benefit claims. This approach has been set out in varying forms in the following bills: the "Patients' Bill of Rights Act of 1998" (S. 1890/H.R. 3605) introduced by Senator Daschle and Representative Dingell; the "Responsibility in Managed Care Act" (H.R. 2960) intended to replace section 4 of the "Patient Access to Responsible Care Act" (S. 644/H.R. 1415) introduced by Senator D'Amato and Representative Norwood; and the "Employee Health Insurance Accountability Act of 1997" (S. 1136) introduced by Senator Durbin.

The advantage of this approach is that it returns to the States the traditional role of overseeing health insurance issues. The States would be able to impose their standards for awarding damages under this approach. They would be able to award any type of damages, including compensatory damages, or limit damages. Another benefit of the State approach is that it would give ERISA plan participants the same opportunities for relief that are currently held by individual purchasers of insurance and employers of State and local government employees.

A second approach, a form of which is applied by Representative Stark in his bill, the "Managed Care Accountability Act of 1997," (H.R. 1749) would be to amend ERISA to incorporate additional remedies and other procedural protections for consumers. One possible option would be to make damages available for economic losses, such as the cost of care and lost wages, when an improper denial or delay in deciding health benefit claims. Non-economic damages such as pain and suffering, as well as punitive damages, could also be made available under specified circumstances.

This approach could be combined with well-crafted other procedural protections that could also be added to ERISA such as changing the standard of review for claims review decisions. Currently, when courts review ERISA claims denials they are required to apply a standard of review that gives deference to the denial made at the plan level, unless it can be shown that the plan's decision was arbitrary and capricious. Often the review is limited to the information and documents considered in the initial claims denial. Under what is called a "de novo" standard of review, a court would be able to assess both the plaintiffs' and defendants' side equally and can evaluate evidence that was not before the internal claims review. Other procedural changes to the statute could include restrictions on the ability of plans to remove cases to federal court, and awarding reasonable attorney and expert fees to successful claimants.

There are several advantages to this federal approach of adding enhanced remedies and procedural protections to ERISA. It would establish a uniform standard applicable to all ERISA plans as well as result in uniform federal precedent regarding claims denial cases. Also, it would not alter ERISA's present preemption scheme.

These are just two of the many approaches that can be taken to address the remedies problem. Yet another approach would be to apply a standard that would overturn the decision in the *Pilot Life* case. Under this approach, a federal standard could be applied to self-insured plans, permitting State laws to apply to fully-insured plans. This approach would allow the States to fully enforce their laws, but

would not subject self-funded plans to the diversity of State remedies. We are certain that there are other approaches to providing additional remedies. We are open to other ideas, and are eager to work with Congress to find a bi-partisan solution to this problem.

Each of the approaches that we have discussed has its own set of advantages. One advantage common to all of these options is that they may ultimately lessen the need for increased government regulation of health benefit plans. The Department of Labor will never have the resources to effectively police the hundreds of millions of claims determinations made within ERISA plans. With additional remedies, participants are empowered to seek legal redress when appropriate without government involvement.

CONCLUSION

The provision of health care benefits is an important tool that employers use to attract employees. Health insurance plans are designed to provide security to workers in the event of illness. There is no security, however, when plans can deny or delay covered benefits with impunity. This is, in fact, not a benefit at all but a burden on workers who are under the mistaken belief that their covered health benefits are assured.

The implementation of the Commission's Consumer Bill of Rights will provide necessary protections for all Americans. We look forward to working with you to develop legislation to both pass a Consumer Bill of Rights, and to ensure that these protections are available under ERISA.

*Managed care growth—percent of employer plan enrollment*

| <i>Fiscal year</i> | <i>Percent</i> | <i>Fiscal year</i> | <i>Percent</i> |
|--------------------|----------------|--------------------|----------------|
| 1980 .....         | 2              | 1989 .....         | 35             |
| 1981 .....         | 3              | 1990 .....         | 41             |
| 1982 .....         | 4              | 1991 .....         | 47             |
| 1983 .....         | 5              | 1992 .....         | 56             |
| 1984 .....         | 5              | 1993 .....         | 58             |
| 1985 .....         | 10             | 1994 .....         | 65             |
| 1986 .....         | 14             | 1995 .....         | 69             |
| 1987 .....         | 22             | 1996 .....         | 74             |
| 1988 .....         | 29             | 1997 .....         | 81             |

Notes: Includes, HMO, PPO, POS plans. Data for 1988-97 from KPMG Peat Marwick survey of employers with 200 plus employees. Data for 1980, 1982, 1984, and 1986 from U.S. Bureau of Labor Statistics survey of medium and large private establishments. Data for 1981, 1983, 1985, and 1987 interpolated.

*Source of coverage*

|   | <i>Millions</i> |
|---|-----------------|
| Medicaid .....                                  | 37              |
| Medicare .....                                  | 37              |
| State-regulated (individual market) .....       | 16              |
| Federal employee plan .....                     | 9               |
| State and local government employee plans ..... | 23              |
| ERISA-regulated (private employee plans) .....  | 123             |

Source: President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

**STATEMENT OF ROBERT GALLAGHER, PRINCIPAL, GROOM & NORDBERG, CHARTERED, ON BEHALF OF THE ASSOCIATION OF PRIVATE PENSION AND WELFARE PLANS [APPWP] THE BENEFITS ASSOCIATION**

Senator SPECTER. We turn now to Mr. Robert Gallagher, Executive at Groom & Nordberg, a Washington, DC, firm which specializes in employee benefits laws. He had served as Counsel for ERISA from 1976 through 1982. And while working at the Department of Labor, tried the first case by the Department under ERISA.

Welcome, Mr. Gallagher, and we look forward to your testimony. Mr. GALLAGHER. Thank you, Chairman Specter, Senators.

I have been practicing exclusively in the ERISA for 22 years. I have brought cases on behalf of participants and beneficiaries, employees, on behalf of benefit plans themselves, employer sponsors of plans, and companies engaged in providing services to health benefit plans. So, I have seen these issues from a number of perspectives.

In my view, the proposals to limit ERISA preemption would be disastrous for health benefit plans. The proposals would be a major step backward in a national effort to provide the highest degree of quality health care for the largest number of people at a reasonable cost. The current system has made steady progress toward that goal. Under the current system, the labor market, and sometimes negotiations between employers and employee representatives, determine how much employees will be paid and what part of that compensation will go towards health care.

Under the current system, the plan sponsor, sometimes in negotiations with employee representatives, determine the plan design of the health benefit plan, what benefits will be covered. Every benefit cannot be covered.

The typical restrictions for care, that it is not medically necessary or care that is experimental, are a result of that process of trying to put the dollars to the highest use; the greatest good for the greatest number.

Repeal of preemption would turn the authority to make those plan design decisions—what benefits will be covered—take it away from the traditional employer or employee representatives—and turn it over to the State courts and to juries.

The results of that would be several. There would be a lack of uniformity in decisions, where plans would have to apply the same rule and give it a different meaning in different jurisdictions. The same plan term could be interpreted differently in a dozen or more different States. That would defeat the principal objective of the preemption provisions of ERISA, enacted back in 1974—to provide uniformity in plan administration, for efficient plan administration.

It would also introduce a far higher level of uncertainty among employees, employers, payors, of what benefits would be covered under plans.

What it would do really is turn what is now a system for the rational allocation of available resources into basically a lottery, where a few people—principally plaintiffs' lawyers—would get large judgments and attorneys' fees, and that much money would be taken out of the system available to provide benefits to others.

For example, in a recent case in California, involving a bone marrow transplant, a common controversy—is this a medically necessary or an experimental procedure, is it covered, and there is great professional debate on all sides of that issue—in this case, the employer lost; \$77 million in punitive damages were awarded, \$12.3 million in compensatory damages. That is almost \$90 million. That \$90 million could have provided hundreds, if not thousands, bone marrow transplants to people who were covered for that procedure.

The repeal of preemption would significantly increase the cost of coverage for many employers and for employees. It does that by making plan administration less efficient, with diverse rules that

have to be followed, and defending these cases that will be brought. Cases are very expensive to defend. Most of them cost tens of thousands of dollars to defend. Some of them cost hundreds of thousands of dollars to defend.

And it would also change the design of employee big plans, so that most employers would probably have to eliminate the limitations for services that are not necessary or that are experimental. So that would basically change the mechanism of who designs employee benefit plans.

Small employers would probably eliminate plans altogether, many of them would. Larger employers would have to reduce their coverage or pass on more of the costs to employees. And studies show that even a small increase in cost to employees results in electing to drop coverage or to elect less coverage.

And private pension plans covered by ERISA—the 120 million people that we have talked about—there are hundreds of millions of claims processed every year. Very few of them result in the kinds of problems that have raised this committee's attention. Most employers work hard to fix procedures, make claims processing more efficient so there are fewer errors. And I think that is the way to do it. Work on the so-called front-end problems rather than the so-called back-end problems.

#### PREPARED STATEMENT

If you are convinced that something must be done to improve the system, the Department of Labor has told us that they do have authority and they are working on regulations to help improve the front-end system. And all the employers that I know of and all the members of the Association would be happy to work with the Department of Labor to do that.

We think that is the right approach.

Thank you, Senator.

Senator SPECTER. Thank you very much, Mr. Gallagher.

[The statement follows:]

#### PREPARED STATEMENT OF ROBERT GALLAGHER

Chairman Specter and members of the Subcommittee, my name is Robert Gallagher, and I am executive principal in the Washington, D.C. based law firm of Groom and Nordberg. I have specialized exclusively in the field of employee benefits law for 22 years. Prior to joining Groom and Nordberg, I served as counsel for ERISA litigation at the U.S. Department of Labor where I tried the first case brought by the Department under ERISA as well as many other cases seeking to protect the interests of employer benefit plans and their participants and beneficiaries. At Groom and Nordberg, I routinely counsel employers that sponsor health benefits plans on fiduciary duty issues arising under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). I also routinely advise companies in connection with the scope of ERISA's preemption clause, including application of ERISA preemption to state laws affecting the health care industry, and I have been involved in litigation of ERISA preemption issues on behalf of both employers and service providers to health plans.

I am appearing before you today on behalf of the Association of Private Pension and Welfare Plans (APPWP—The Benefits Association), a national trade association of companies concerned about the employee benefits system. APPWP's members include many Fortune 1000 companies offering health benefits to their employees, as well as organizations that provide benefit services to employees. Collectively, APPWP's members either sponsor or administer health and retirement plans covering more than 100 million Americans.

I would like to share my perspectives with you on the current state of the law of ERISA preemption, the existing remedies for improper denial of health benefits claims in connection with ERISA-regulated health plans, and the possible consequences to employers if ERISA were amended to expand the available remedies when ERISA plans deny claims.

#### I. THE CURRENT STATE OF THE ERISA PREEMPTION DOCTRINE

When ERISA was enacted in 1974, Representative John Dent, a leading sponsor of the legislation, noted that “to many, the crowning achievement of this legislation” was its preemption clause. See 120 Cong. Rec. 29,197 (Aug. 13, 1974) (remarks of Rep. Dent).

ERISA’s preemption rules were designed, in the words of the late Senator Jacob Javits, to “eliminate the threat of conflicting or inconsistent state and local regulation, \* \* \* laws hastily contrived to deal with some particular aspect of private welfare and pension plans.” Congress intended, instead, “that a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under welfare and pension plans.” See 120 Cong. Rec. 29933 (Aug. 22, 1974) (remarks of Senator Javits). For more than 20 years ERISA’s preemption clause has successfully worked to eliminate potential regulatory disincentives for employers to offer health benefits to employees, and has helped make employer-paid health care an expected benefit routinely provided to American workers.

The preemption rules of ERISA are found in section 514 of the statute. Section 514 requires a three-step analysis to determine whether a particular state law is preempted. Section 514(a) provides generally that ERISA “supersedes any and all state laws insofar as they may now or hereafter relate to any employee benefit plan,” and therefore the first step is to determine whether the law “relate[s] to” an ERISA-regulated employee benefit plan. If so, the second step is to determine whether one of the enumerated exceptions to preemption applies, because under section 514(b) of ERISA, even if a state law “relates to” an employee benefit plan it will be saved from preemption if it is a law that regulates insurance, banking, or securities. The final step is to determine whether the exception to preemption for insurance laws is inapplicable because of the so-called “deemer” clause. Under section 514(c) of ERISA, a state law regulating insurance will nonetheless be preempted if it has the effect of deeming an ERISA plan to be an insurance company or engaged in the business of insurance.

Over the years, a dichotomy has developed in the treatment of health benefits plans in which the employer provides benefits through purchase of a health insurance policy, and those health benefit plans in which an employer chooses to self-insure the risk. Many states mandate that group health insurance policies sold in such state contain certain benefits, such as coverage for mental health or drug or alcohol abuse treatment. In 1985, the Supreme Court analyzed whether states may use these laws to regulate the content of insured and self-insured health plans in light of the savings clause. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

The Court found that ERISA preemption does not prevent states from regulating the content of insurance policies purchased by an employer for a health plan. However, the Court concluded that state laws that regulate the content of self-insured plans were preempted because they would not be “saved” as laws regulating insurance. Therefore, when employers purchase group health insurance policies to fund the health benefits programs offered to their employees, these state mandates effectively dictate the design of the benefits program, because the policies funding these plans must meet state benefit mandates. See *Metropolitan Life Ins. Co. v. Massachusetts; FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

The Supreme Court has adopted a two-step approach to determine whether a state law falls within the insurance law exceptions to ERISA preemption. *Metropolitan Life Ins. Co. v. Massachusetts*, *supra*. First, a court must resolve whether the law satisfies a “common sense” definition of insurance regulation. Second, a court must look at three factors drawn from cases analyzing the McCarran-Ferguson Act’s reference to the “business of insurance”: (1) whether the state law has the effect of transferring or spreading a policyholder’s risk; (2) whether the statute concerns an integral part of the policy relationship between the insurer and the insured; and (3) whether the state law is limited to entities within the insurance industry.

Probably the most fundamental service undertaken in the administration of an employer-provided health benefits plan is the processing of benefit claims—the decision, made by either an insurance company or a claims administrator, as to whether the health benefits plan will pay for a particular medical service. Liability under ERISA in connection with benefits claims does not turn on whether a plan is in-

sured or self-insured. Accordingly, the courts uniformly hold that state-based contract or tort actions asserting the improper processing by an insurance company or claims administrator of a claim for benefits under an ERISA-regulated plan, whether insured or self-insured, "relate[s] to" a benefit plan, and is preempted. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

In my experience, it is customary for health benefits plans to include specific language clearly communicating to covered employees that the plan will not cover services or treatments that are experimental in nature, or are not medically necessary. As you know, the gate-keeping and other review protocols that are a key element of the managed-care approach to health care often involve determinations by claims administrators whether a treatment or service is medically appropriate. Consequently, persons injured by managed-care decisions often bring state-based causes of action seeking tort remedies for allegedly negligent medical professional determinations, and there is a substantial body of case law addressing the effect of ERISA preemption on those claims.

The majority of courts agree that ERISA preempts wrongful death, medical malpractice, loss of consortium, and other state-based claims based on medical judgment decisions made in the context of a benefits plan coverage determination. See, e.g. *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142 (2d Cir.), cert. denied, 493 U.S. 811 (1991) (wrongful death, loss consortium, misrepresentation all preempted in connection with delay in authorization of coverage); *Corcoran v. United Healthcare*, 965 F.2d 1321 (5th Cir. 1993) (Louisiana wrongful death statute preempted in action arising from utilization review provider's refusal to authorize hospitalization); *Kuhl v. Lincoln National*, 999 F.2d 298 (8th Cir. 1993) (medical malpractice, tortious interference claims based on HMO's delay in authorizing heart surgery preempted).

Moreover, state tort claims for negligence, fraud, or misrepresentation in connection with how HMOs or insurance carriers have structured provider networks, or the quality of the physicians included in the network, are routinely found to be preempted, as are claims relating to statements that HMOs and carriers have made about the quality of care to be provided by the network. See *Kearney v. U.S. Healthcare*, 18 Empl. Ben. Cases (BNA) 1886 (E.D. Pa. 1995); *Stroker v. Rubin*, 1994 WL 719694 (E.D. Pa. 1994); *Elesser v. Philadelphia College Osteopathic Medicine*, 16 Empl. Ben. Cases (BNA) 1063 (E.D. Pa. 1992). Similarly, to the extent a challenged communication about the structure of the network or the quality of network care is made in a benefit plan document, that communication is deemed an ERISA plan benefit communication, and the challenge must be ERISA-based.

On the other hand, in instances in which medical judgment are not made in the context of determining whether the benefits plan will cover a service or treatment, and thus the judgment is disengaged from a plan coverage decision, courts are unlikely to find state-based challenges to the propriety of such judgments preempted. See *Dukes v. U.S. Healthcare*, 57 F.3d 350, 19 EBC 1473 (3d Cir.), cert. denied, 116 S. Ct. 564 (1995) (no allegation participants denied benefits they were due under plan; rather, participants contested the quality of HMOs medical care provided through plan; no preemption); *Fritts v. Khoury*, 933 F. Supp. 668 (E.D. Mich. 1996); *Howard v. Sasson*, 19 Empl. Ben. Cases (BNA) 2091 (E.D. Pa. 1995). In these cases, there is no allegation that medical treatment was wrongfully delayed or denied, or that the challenged acts by the medical organization were undertaken in its utilization review role, refusing to authorize and/or pay for treatment. Rather, the issue centers on the quality of the medical care actually delivered and covered, whether by a primary care physician or other provider.

Furthermore, courts are increasingly foreclosing the use of ERISA preemption as a means of shielding HMOs and insurance carriers from vicarious liability claims under state law in connection with allegedly negligent treatment provided by a physician or other health care provider. These claims are based on apparent or ostensible agency theory, with the claimants asserting that even if the allegedly negligent provider was not the employee of the HMO or carrier, the objectively reasonable impression formed by the patient was that such provider acted as an agent, and thus the HMO or carrier is liable as a quasi-principal. In cases like *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151 (10 Cir. 1995) and *Jass v. Prudential Health Care Plan*, 88 F.3d 1482 (7th Cir. 1996) the courts held that ERISA does not preempt a state law claim against an HMO or claims administrator to hold it vicariously liable for the alleged malpractice of one of its contracting physicians or utilization review personnel. Lower courts are increasingly making it clear that ERISA does not preempt vicarious liability claims against HMOs, carriers, or administrators, even in instances in which the medical judgment at issue was made in the context of a benefits determination. See *Kearney v. U.S. Healthcare, Inc.*, 18 Empl. Ben. Cases (BOA) 1886 (E.D. Pa. 1994).

I also believe it is most important to recognize that the trend in ERISA preemption is to narrow its boundaries, not extend them. The narrowing of ERISA preemption is due to a decision of the Supreme Court I will now discuss. The effect of the decision on state efforts to regulate managed care is still very much in flux and it is far from settled how the ERISA preemption curbs state efforts to regulate managed care in the future.

Until 1995, the Supreme Court applied a plain meaning test in construing the "relate to" clause in section 514(a) of ERISA, and construed the language quite expansively to preempt all state action that bore some connection to ERISA plans. See, e.g., *Shaw v. Delta Air Lines*, 463 U.S. 85, 97-98 (1983) (term relate to "was to be given its broad common sense meaning"); *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125 (1992).

Yet in *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers' Inc. Co.*, 115 S. Ct. 167 (1995) the Court effectively abandoned the "plain meaning" test and narrowed the boundaries of ERISA preemption. In *Travelers*, the Court unanimously ruled that laws which have only an indirect economic effect on benefits plans do not "relate to" such plans, and are not preempted. The Supreme Court noted that despite the broad language in ERISA's preemption clause, state action in fields of traditional state regulation, such as health care, are nonetheless assumed not to be preempted, unless preemption was the "clear and manifest" purpose of Congress. Under the *Travelers* framework, a state law will be deemed to "relate to" ERISA benefit plans only if it makes specific reference to a plan, or mandates an employee benefit structure or administration, or precludes administrative uniformity or uniform interstate benefits.

Lower courts are just beginning to apply this new preemption framework to the efforts by states to regulate the managed care process. While *Travelers* and its progeny are unlikely to be construed, and should not be construed, as overruling prior cases like *Pilot Life*, it is also clear that the ERISA bar to states regulating in the health care area is lower than it was prior to *Travelers*.

## II. REMEDIES FOR ERISA FIDUCIARY MISCONDUCT AND IMPROPER CLAIMS DETERMINATIONS

Under ERISA, the persons with the ultimate responsibility to determine whether a benefits plan will cover a claim are cloaked with fiduciary status. Such fiduciaries, when deciding claims, are required to exercise prudent judgment in determining claims, and are to act solely in the interests of the benefit plan and its participants and beneficiaries. See ERISA § 404(a)(1). If a person is aggrieved by a wrongful denial of health benefits, he or she can sue to recover payment of the benefit. See ERISA § 502(a)(1)(B). Fiduciaries who act inconsistently with their duties of prudence and loyalty also may be sued by aggrieved health benefit plan participants, and the Supreme Court has recognized that ERISA plan participants may recover directly from fiduciaries for the latter's misconduct. See *Howe v. Parity Corp.*, 116 S. Ct. 1065 (1996).

Although punitive damages and other forms of extra-contractual relief may not be imposed upon ERISA fiduciaries, see *Massachusetts Life Ins. Co. v. Russell*, 473 U.S. 134 (1985), courts otherwise have the authority to award a broad array of equitable relief against fiduciaries. See *Mertens v. Hewitt Associates*, 113 S. Ct. 2063 (1993). Fiduciaries may be forced to make restitution against injured participants, and can be required to specifically perform. Moreover, fiduciaries can be removed from office. In addition, courts have the discretion to award attorneys' fees to the victorious party in actions against fiduciaries. See ERISA § 502(g). In instances in which a suit is brought by the Department of Labor against a fiduciary for breach of duty, ERISA does provide for extra-contractual damages in the nature of civil penalties. See ERISA § 502(1).

Thus, for example, if a health benefits plan denies coverage for a medical service and as a consequence the treatment is unavailable to the plan participant, that participant can sue the fiduciary and obtain an order requiring the fiduciary, on behalf of the benefits plan, to provide coverage. If a claims administrator is shown to systematically engage in imprudent and sloppy claims processing techniques, a participant has standing to sue to remove such party. More specifically, if a utilization review manager were shown to have engaged in a pattern of systematic denials of medical coverage involving care that a court otherwise finds necessary, such court would have the power under ERISA to remove the fiduciary from its claims administrative office. In fact, if the charges were sufficiently serious, a court has the authority to ban the entity from performing any fiduciary services to ERISA plans for a period of years. See generally *Marshall v. Snyder*, 572 F.2d 894 (2d Cir. 1978).

The particular forms of relief and remedies that may be obtained against ERISA fiduciaries reflect a careful balancing of competing interests. When enacting ERISA, the 92nd Congress recognized that it needed both to protect ERISA plan participants in their benefits and also to avoid creating liability rules that would discourage employers either from establishing benefits plans, or offering benefits that are stingy and of little value. By eliminating the threat of extra-contractual damages against fiduciaries, but allowing courts to award improperly denied benefits, to issue injunctions requiring coverage, and to remove fiduciaries who are not sufficiently competent or loyal to warrant positions of authority, ERISA grants participants a broad array of rights against managed care benefit decision-makers without imposing liabilities that will chill the business community's continued willingness to provide generous health benefit plans.

### III. THE CONSEQUENCES OF EXPANDING LIABILITY

The decision by an employer to provide health care benefits, and the design of such benefits plans, are by and large left to the discretion of the employer. In my experience, when employers are faced with significant increases in the cost of health benefits they react in one of two ways. They either eliminate coverage for categories of medical treatment that previously were covered, or they increase the cost-sharing elements of the health plan by raising contributions, deductibles or copayments. In the case of benefits employers provide through HMOs, employers pass through costs typically by asking employees to pay a higher portion of the monthly HMO premiums via salary withholding.

I believe that if punitive damages and other extracontractual tort remedies available under state law were expanded to cover ERISA health benefit claims administration, a number of adverse consequences will occur. The most fundamental will be (1) that the cost of benefits will increase, (2) each constituency (insurers/HMOs, employers) will in fact pass through such costs, and (3) employees will end up paying considerably more for health insurance.

If punitive damages and other extracontractual tort remedies were expanded to include employers that perform claims administration, employers simply would abandon involvement in that process and contract the complete authority for claims processing to insurance carriers and other third parties. Many companies, particularly self-insured companies, currently reserve to themselves the right to make final claims determinations. Furthermore, in many jointly sponsored union-management plans, otherwise known as Taft-Hartley plans, a joint group of union-management trustees retain final authority to decide claims. This practice of reserving final authority is often desired because it allows intervention in tough cases and improves employee relations.

But I have little doubt such companies and Taft-Hartley plan trustees would abandon such efforts if liability were expanded. Given that claims processing is not part of the core effort of the business community (except for insurance carriers and third party administrators), those not in the primary business of claims administration are unlikely to be willing to accept the cost of malpractice insurance and the adverse publicity surrounding claims litigation, and would cede all authority to outsiders.

Even if liability were not extended to employers, and even if insurance carriers, HMOs, or third party administrators were prohibited by law from obtaining indemnification from employers for expanded liability, the economic result would still be the same. This would be true whether or not awards of significant punitive damages in benefits disputes involving medical necessity actually increase. Insurance companies, HMOs and third party administrators would adjust to the prospect of increased economic exposure by routinely granting coverage in close cases, or even worse, routinely granting coverage in instances in which the medical necessity is doubtful but the prospect of jury litigation were high. Insurance companies, HMOs and third party administrators will make the economic trade-off of avoiding the risk of punitive damages litigation for more expensive claims experience.

Why? Because the increased cost in higher claims experience can more easily be passed back to the business community, either in higher premiums or, for self-insured plans, higher plan costs. Why should claims administrators risk the adverse publicity and expense of jury litigation when it can easily avoid such risk simply by granting coverage, even for treatment that the weight of medical authority deems experimental, or which the medical community by and large believes serves cosmetic needs. Why should a claims administrator risk that the determination of whether a treatment is experimental, or medically appropriate, be significantly influenced by the understandable emotions of a jury instead of sound scientific evidence or outcomes research? Expanding claims administration remedies to include

extracontractual and punitive damages will simply shift the pendulum sharply to an environment in which expensive and controversial treatments are routinely granted, regardless of whether they are objectively necessary.

Ironically, if a claims administrator were to be materially influenced in its fiduciary decision-making by the threat of punitive damages, such conduct would itself be a fiduciary breach of its duty to conserve plan assets for the benefit of other plan participants. But the practical ability of the business community to prove such an influence when it occurs will be difficult and expensive. In most instances, the choice that I believe health care administrators will make—to err on the side of granting coverage—will be made with impunity. And, in an ever competitive business environment, employers will not have to look far to identify the constituency to whom they can pass on these higher costs. The price will be passed through to employees, in some instances by abandoning the health benefits plan altogether, in most other instances, through cost-sharing.

Furthermore, the cost of actual plan administration also will increase. Exposure of ERISA plan claims administrators to state-based punitive and extra-contractual damages also means exposure to state-based substantive standards of conduct. Punitive damages are merely a remedy. Such damages cannot be imposed unless there is a violation of the concomitant substantive duty whose violation carries with it such penalty. This means that in every state a body of law will develop governing the conduct of ERISA-plan claims administrators whenever such decisions involve a medical judgment. Those laws will undoubtedly vary by state, with different standards of conduct and different burdens of proof in the event of litigation. This will further increase the cost of plan administration by creating exactly the kind of inconsistent patchwork of benefits law that the designers of ERISA preemption hoped to avoid.

Indeed, the current proposals for managed care reform would, by their terms, cede to state law the regulation of only those health benefits decisions involving the exercise of medical judgments. But the legal determination as to when a benefits claims decision involves a medical judgment will be difficult and the results will, in my view, undoubtedly be inconsistent. In some jurisdictions, the line between claims administration decisions that are governed exclusively by ERISA and those governed by state tort law will be different than in others.

In conclusion, it is clear from past experience that any legislation limiting the scope of ERISA preemption will increase the cost of providing a given level of benefits. That will, in turn, result in higher costs and an increase in the complexity of plan administration. This increase in cost and complexity will cause some plan sponsors—particularly smaller employers—to simply drop health benefit plans altogether, resulting in a larger uninsured population. Larger employers will likely respond by altering their health benefit plans to provide more limited coverage at higher costs, though the possibility exists that these employers will forego providing coverage at all. Ultimately, limiting the scope of ERISA preemption will result in lower benefits for the great majority of plan participants and more money spent on attorneys' fees that would otherwise go to provide needed benefits.

**STATEMENT OF RONALD F. POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA**

Senator SPECTER. We now turn to Mr. Ron Pollack, executive director of Families USA, an national organization for health care consumers. In 1997, Mr. Pollack was appointed the sole consumer organization representative of the Presidential Advisory Commission on Consumer Protection and Quality in the health care industry. Mr. Pollack had been dean of the Antioch University School of Law.

Welcome, Mr. Pollack, and we look forward to your testimony.

Mr. POLLACK. Thank you so much, Mr. Chairman, and distinguished members of the panel.

I would like to make five quick points in the short time we have.

First, following up on what Mr. Gallagher said, I think consumers are interested in the front-end protection, as well, not just the back-end. And that is why I think a Patients' Bill of Rights, which established modest procedural protections, such as the independent right of appeals, is very important. And it is my hope that if such

a patient right of appeals is established, then we are likely to see less litigation, although we are still going to see abuses and problems that do need to be addressed.

Second, the issue with respect to ERISA is not merely a preemption issue. That is a part of the issue. But what is also a part of the issue is that the Federal remedy that is established under ERISA is essentially a nonremedy remedy. The only thing that is available to a person after that person succeeds in the litigation process is that person can only receive the service that was originally denied, which may come at a point where it is absolutely too late.

And if I may, let me cite a very brief example that I think illustrates this. Take the case of Frank Wurzbacher, a plaintiff in Kentucky, who unfortunately had prostate cancer. He was receiving injections that cost \$500 per injection. And he was getting those until his employer changed carriers to administer his plan, to Prudential. Prudential said: "You are going to have to pay \$180 for each injection." And Mr. Wurzbacher simply could not afford to pay for those injections.

So, he sought alternatives. And he asked his physician. And the only alternative that his physician said was available to him, given the progression of his cancer, was that he should be castrated. He went to Prudential and Prudential said: "We will pay for your castration." And, indeed, Mr. Wurzbacher was castrated.

The day Mr. Wurzbacher returned from the hospital, he received a notice from Prudential saying: "We made a mistake; you did not have to pay the \$180 in copayments."

Now, if Mr. Wurzbacher goes to court under Federal law, the only remedy afforded to him is that he can now get his injections for free. Now, how anyone can say that that is a reasonable remedy, I find that absolutely extraordinary. This is the only area where, irrespective of indifference, callousness, willfulness, or just negligence, there is simply no accountability.

The third point I want to make is that the judiciary has been handling numerous such cases—and I brought with me, if you would like for the court record, but it is certainly available to the distinguished members of this panel—a series of cases, all across the country, which represent the kind of situations that Mr. Wurzbacher himself represents. But what is interesting about this is what the judges themselves are saying. The judges are adhering to what the ERISA statute requires.

But if you take a look at my testimony—and I have cited some of the quotes from some of those judges—you will see what the judges are saying—is this is a travesty of justice, this is absolutely wrong, but we are powerless to change this. The only way this can be changed is through congressional statute.

And, by the way, Florence Corcoran, who was cited as one of those cases, which I suggest is well worth reading, is sitting behind me. And if you would like to talk to her, cited the facts in her case, I think you would find it illustrative of what I am saying.

The fourth point I want to make is that ERISA made sense when Congress adopted it in 1974. We were in a totally different world in 1974. We were in a fee-for-service world. And so the controversy in litigation was after the service was provided and the insurance

company was denying payment of that claim. And so if you then required the insurance company to pay for that service, that person was made whole. But at that point, less than 5 percent of the plans in this country were HMO's or managed care plans.

Today it is totally different. When there is a controversy between a plaintiff and a plan, that controversy is whether you are going to receive that service in the first place. And people change their course of conduct, as unfortunately Mr. Wurzbacher did, and we need to find a different remedy.

To say that you now need to provide this service that you originally should have provided merely says to a plan: You can keep on delaying and delaying and delaying and delaying, and the only thing that you are going to ultimately be accountable for is that you are going to have to, at the end of that road, you are going to have to pay for the service you originally denied. And by that point, it is likely, in many cases, to be too late.

#### PREPARED STATEMENT

The last point I want to make is that there really are two alternative remedies. And seeing that the red light has gone on, I would just conclude with a sentence. S. 1890 and S. 644 adopt one approach, which I think makes a great deal of sense: to allow the States to establish remedies. Another alternative is not to change the ERISA structure, but to change the ERISA remedy.

Thank you.

Senator SPECTER. Thank you very much, Mr. Pollack.

[The statement follows:]

#### PREPARED STATEMENT OF RONALD F. POLLACK

Mr. Chairman and members of the committee: Thank you for inviting me to testify today on an issue of growing significance to people in managed care plans. I am Ron Pollack, Executive Director of Families USA, the national organization for health care consumers. I had the privilege of serving on the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. As you know, the Commission received extensive testimony and analysis about the role of ERISA in establishing a remedial system for people aggrieved by denials or delays of care by their health plans.

At the outset of my testimony, I should emphasize that consumers are most interested in preventing wrongful denials and delays of care, not simply seeking remedies after the fact. At the point that someone goes to court to seek a remedy, the harm has already occurred. Enlightened policy must focus on the front end of health decision-making, not just the back end after harm has been caused. Public policy, therefore, should take effective steps to ensure that appropriate health care is not withheld and that quality of care is provided to America's health care consumers. It is for this reason that consumer organizations across the country are very supportive of a Patients' Bill of Rights—such as the Bill of Rights proposed by the President's Commission and in bills pending in Congress. These proposals offer modest steps designed to empower consumers with information and procedural rights so that they get the health care that was promised to them when they procured health coverage.

I should hasten to add that one of the key features of a Bill of Rights is the establishment of an independent and prompt right to appeal denials or delays of health care services. The President's Commission unanimously recommended such a right, and that right is incorporated into each of the major bills now pending in the Congress. I believe that the establishment of such a right would not only be very welcomed by health care consumers but would significantly reduce the likelihood of subsequent litigation. This right to an independent appeal, according to the analysis prepared for the President's Commission, would cost merely 0.3 to 7 cents per health plan enrollee per month.

The remedy issues raised by existing ERISA legislation are important in promoting high-quality care, not simply because they deal with specific grievances by enrollees of health plans but because they help to deter plans from being cavalier about denials of needed care. Without a meaningful remedy at the end of a grievance process, health plans will always have an incentive to deny care because they know there will never be a penalty for improperly doing so. The creation of an effective remedy, therefore, must be part and parcel of a system that encourages high-quality care.

Unfortunately, ERISA—which was intended to protect employees in pensions and health plans—has become a protective shield for managed care plans even when they wrongfully deny care, either through negligence or malicious indifference. Central to ERISA's failure is its preemption of state remedies for wrongful denials of care and its failure to establish a meaningful federal remedy. Today, approximately 123 million people in working families are denied reasonable relief if their health plans improperly withhold care.

Under ERISA, consumers whose benefits are wrongfully denied are entitled only to equitable relief and not monetary damages. In practical terms, this means that a worker who is improperly denied health care can only recover the value of the denied service or the service itself—which, in some tragic cases, comes far too late. The worker, however, is not allowed to receive any compensation to make him or her whole from the benefit denial, even in the event of loss of life because of the health plan's improper denial. Neither compensatory nor punitive damages are available under ERISA. As a result, workers and their families are very much at risk of arbitrary benefits denials, and this risk is most substantial when the treatment sought is costly.

Health plans have no accountability for their decisions to deny needed care and treatment. This lack of meaningful remedies invites abuse. Regardless of a managed care company's indifference, callousness, willfulness or negligence in refusing to authorize medically necessary treatment, the only punishment made available by ERISA, if a plaintiff ultimately prevails, is the provision (or payment for) the initially denied treatment. In other words, a managed care company has every financial incentive to deny or delay care—knowing full well that, even after years of litigation, the worst that can happen is that the plan will only have to pay for the services originally denied. This clearly invites, and creates financial incentives for, abuse.

A recent case emanating from Kentucky illustrates the absurdity of the ERISA remedial system. Frank Wurzbacher had the misfortune of contracting prostate cancer. To deal with his condition, Mr. Wurzbacher received periodic injections of leupron. Under his health plan, these treatments—costing \$500 per injection—were supposed to be fully covered. When Prudential took over as the plan administrator, Mr. Wurzbacher was told that he would have to pay \$180 per injection—an amount he could not afford. As a result, Mr. Wurzbacher asked his physician for health care alternatives. In light of the aggressiveness of his cancer, Wurzbacher's doctor said that his only alternative was castration.

Prudential approved the castration operation and Mr. Wurzbacher was castrated. When Wurzbacher returned home from the hospital, he found a letter from Prudential notifying him that it had made a mistake and that the plan would pay the full \$500 for the leupron injections.

When Mr. Wurzbacher brought suit under state law, his claim was denied due to ERISA preemption. More significantly, if Mr. Wurzbacher brought suit under the provisions of ERISA, his only available "remedy" would be the provision of leupron injections at no cost. Obviously, this "remedy" constitutes a nonremedy and is entirely useless for Mr. Wurzbacher. ERISA, in this and many other cases, constitutes a cruel and unusual joke for someone who experienced tragic harm due to the health plan administrator's negligence.

The ERISA-caused injustice experienced by Mr. Wurzbacher is occurring in many other situations and courts across the country. I have brought with me a notebook full of cases decided in the last full years that are replete with the types of injustices exemplified by the Wurzbacher case. Notably, in some of these cases, judges—as they implement the strictures of ERISA—are commenting about the resulting injustices being caused and are admonishing Congress to take corrective action. Permit me to cite two such cases.

The first case, *Andrews-Clarke v. Travelers Insurance Co.*, was decided last year in the Federal District Court for the District of Massachusetts. [See 21 EBC 2137, 1997 WL 677932.] The facts of the case are as follows. Richard Clarke's health plan—that covered him, his wife, and their four young children—provided, under its terms, for one 30-day inpatient rehabilitation program per year. When Mr. Clarke drank to excess, his physician admitted him to a hospital for alcohol detoxification

and medical evaluation. Travelers Insurance, through its utilization review provider (Greenspring of Eastern Pennsylvania), refused to approve Clarke's enrollment in a 30-day inpatient alcohol rehabilitation program. Instead it approved two separate brief (five and eight days, respectively) hospital stays. Within 24 after the second hospital stay, Clarke attempted suicide in the garage with the car engine running while he consumed a combination of alcohol, cocaine, and prescription drugs. His wife discovered him by breaking through the garage door. Clarke was taken to the hospital where he was treated for carbon monoxide poisoning.

At his mental commitment proceeding, the court ordered Mr. Clarke to participate in a 30-day detoxification and rehabilitation program following his release from the hospital. "By now," according to the Federal District Court, "it was tragically apparent to everyone but Travelers and its agent, Greenspring, that Clarke was a danger to himself and perhaps others." However, Travelers (in the words of the Court) "incredibly refused" to authorize admission under the plan. Instead, Clarke was sent to a correctional center where he was forcibly raped and sodomized by another inmate. He received little therapy or treatment at the correction center. Following his release, he went on a prolonged drinking binge that resulted in his hospitalization due to respiratory failure. After his release from the hospital, he began drinking again and was found the following morning dead in his car, with a garden hose running from the tailpipe into the passenger compartment.

The Federal District Court dismissed the suit brought by Clarke's widow and four children. The Court held that the ERISA statute preempted the claim. The Court held that, even though the "insurer and utilization reviewer repeatedly and arbitrarily refused to authorize medical and psychiatric treatment that was expressly provided by the plan and that was prescribed not only by doctors at several hospitals, but by state courts as well, and where participant's death was [a] direct and foreseeable result of such refusal," ERISA compelled dismissal of the claim. The Court, however, underscored the resulting injustice. In relevant part, the Court said:

"Under traditional notions of justice, the harms alleged—if true—should entitle Diane Andrews-Clarke to some legal remedy on behalf of herself and her children against Travelers and Greenspring. Consider just one of her claims—breach of contract. This cause of action—that contractual promises can be enforced in the courts—pre-dates Magna Carta. It is the very bedrock of our notion of individual autonomy and property rights. It was among the first precepts of the common law to be recognized in the courts of the Commonwealth and has been zealously guarded by the state judiciary from that day to this. Our entire capitalist structure depends on it.

"Nevertheless, this Court had no choice but to pluck Diane Andrews-Clarke's case out of the state court in which she sought redress (and where relief to other litigants is available) and then, at the behest of Travelers and Greenspring, to slam the courthouse doors in her face and leave her without any remedy.

"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. Enacted to safeguard the interests of employees and their beneficiaries, ERISA has evolved into a shield of immunity that protects health insurers, utilization review providers, and other managed care entities from potential liability for the consequences of their wrongful denial of health benefits."

The Court concluded that: "[a]lthough the alleged conduct of Travelers and Greenspring in this case is extraordinarily troubling, even more disturbing to this Court is the failure of Congress to amend a statute that, due to the changing realities of the modern health care system, has gone conspicuously awry from its original intent."

Another example also illustrates the frustration experienced by the courts in reviewing ERISA cases and how members of the judiciary are calling upon Congress to amend ERISA. In *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), the plaintiff, Florence Corcoran, was in an employer-sponsored health plan using Blue Cross as administrator and United HealthCare as the utilization reviewing agency. Mrs. Corcoran was pregnant and had a history of pregnancy-related problems and was viewed as a high-risk pregnancy. Although her doctor recommended hospitalization so that the fetus could be monitored as the due date approached, and another obstetrician (who was contacted for a second opinion) concurred, United HealthCare denied that hospitalization was medically necessary and refused to certify a hospital stay. Instead, ten hours of daily in-home nursing care were authorized. When the nurse was not on duty, the fetus developed problems and died.

The Court found that, under ERISA, the Corcorans had no remedy for damages. The Court found that the Corcorans' claim for damages under state law were preempted. In so ruling, the Court decried the obvious injustice perpetrated under

ERISA and called for Congressional action to amend ERISA. In its applicable part, the Court stated:

"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. 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 decisionmaking. 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.

"Second, in any plan benefit determination, there is always some tension between the interest of the beneficiary in obtaining quality medical care and the interest of the plan in preserving the pool of funds available to compensate all beneficiaries. In a prospective review context, with its greatly increased ability to deter the beneficiary (correctly or not) from embarking on a course of treatment recommended by the beneficiary's physician, the tension between interest of the beneficiary and that of the plan is exacerbated. A system which would, at least in some circumstances, compensate the beneficiary who changes course based upon a wrong call for the costs of that call might ease the tension between the conflicting interests of the beneficiary and the plan.

"Finally, cost containment features such as the one at issue in this case did not exist when Congress passed ERISA. While we are confident that the result we have reached is faithful to Congress's intent neither to allow state-law causes of action that relate to employee benefit plans nor to provide beneficiaries in the Corcorans' position with a remedy under ERISA, the world of employee benefit plans has hardly remained static since 1974. Fundamental changes such as the widespread institution of utilization review would seem to warrant a reevaluation of ERISA so that it can continue to serve its noble purpose of safeguarding the interests of employees. Our system, of course, allocates this task to Congress, not the courts, and we acknowledge our role today by interpreting ERISA in a manner consistent with the expressed intentions of its creators."

Across the country there are approximately 146 million people who have employer-based coverage. Of this number, more than four out of five—approximately 84 percent, or 123 million people—are in ERISA plans and are governed by ERISA's non-remedial regimen and are preempted from receiving protection under state law. (Public employees are the largest group who may receive employer-based coverage but are not subject to ERISA provisions.) In Pennsylvania, approximately 89 percent of the people with employer-based coverage, or approximately 6.4 million Pennsylvanians, are in ERISA plans. All of these people are vulnerable to the same legal frailties of ERISA that were experienced by Frank Wurzbacher, the Andrews-Clarke family, and Florence Corcoran.

Congress should reconsider the remedial restrictions currently contemplated by the 1974 ERISA statute. In the old world of fee-for-service health care, the ERISA statute made rational sense. At that time, people routinely received the care they sought and the dispute centered on whether the claim for reimbursement of costs incurred should be honored. This dispute was a narrow one, albeit important for the party litigants. The remedy available—namely, payment for the service received—had the potential of making a plaintiff "whole." This, however, is no longer true in today's world of managed care.

Today, the dispute usually does not relate to reimbursement for services already rendered. With managed care and utilization review, the service at issue is normally withheld and consumer-patients are usually forced either to forego necessary medical treatment or seek other care. As a result, the stakes are much higher than they were when ERISA was enacted. If, during the pendency of litigation—a period which may be quite considerable—the service needed for good health or survival is being withheld, a remedy limited to the ultimate provision of the withheld service may be, and often is, illusory. Moreover, this non-remedy remedy provides a powerful added incentive for managed care organizations to deny care. At worst, they will face a slap on the wrist and be required to provide the service that was originally denied.

Congress can respond to this problem through two alternative approaches. First, the civil enforcement provisions of ERISA can be remedied by establishing a system that makes aggrieved consumers and their families whole. Such a system can include one or a combination of compensatory, consequential and punitive damages. Such a system would not alter the ERISA framework but would establish meaning-

ful remedies within that framework. Rep. Pete Stark has introduced H.R. 1749, the Managed Care Plan Accountability Act of 1997, which takes this approach.

Alternatively, Congress can amend ERISA by explicitly removing the state pre-emption remedial bar that currently limits states' abilities to establish causes of action for wrongful denials of care. Both the Patients' Bill of Rights Act (S.1890/H.R. 3605) and the Patients' Access to Responsible Care Act (PARCA) (S. 644/H.R. 1415), comprehensive consumer protection bills now pending in Congress, adopt this approach.

We believe that either approach is vastly preferable to the current ERISA scheme. Although there is, as yet, no independent economic analysis of these approaches, we believe that these alternatives are inexpensive and cost-effective. As experience in other health care contexts demonstrate, few people avail themselves of the opportunity to litigate. Indeed, few people even apply for external administrative hearings when given the opportunity to do so—as is currently available for people in the Medicare program. Moreover, the provision of punitive damages, even when theoretically available, is virtually never invoked. Thus, while these alternative remedies will undoubtedly induce improved behavior on the part of managed care plans, the direct costs of making a meaningful remedy available are likely to be less than 1 percent, and undoubtedly less than 2 percent, of insurance premiums—as is the case with malpractice insurance premiums today.

Such a cost-effective deterrent to improper denials of care is clearly warranted in the new world of managed health care.

**STATEMENT OF MARK A. SMITH, EMPLOYEE BENEFITS COMPLIANCE  
MANAGER, AMP INC., ON BEHALF OF THE NATIONAL ASSOCIATION  
OF MANUFACTURERS**

Senator SPECTER. We now turn to Mr. Mark Smith, employee benefits compliance manager for AMP Inc., with headquarters in Harrisburg, PA. Mr. Smith also serves as an adjunct professor of law at Dickinson School of Law. Among several prior positions, Mr. Smith served as employee benefits manager for a Big 6 accounting firm in Central Pennsylvania.

Welcome, Mr. Smith. We look forward to your testimony.

Mr. SMITH. Thank you, Chairman Specter and Senators.

As you indicated, I am employed at AMP Inc. Our CEO and president, William Hudson, is currently the vice chairman of the National Association of Manufacturers Board. We are speaking here today on behalf of the NAM, the Nation's oldest and largest broad-based industrial trade association.

As you have indicated, AMP's headquarters are located in Harrisburg, PA, where we employ in excess of 9,500 employees, and are the world's leading manufacturer of electric connectors and interconnection systems. We have over 46,000 employees worldwide, in over 300 facilities, in 53 different countries. Suffice it to say that if something turns off and on, there is likely an AMP product involved.

We are pleased to have this opportunity to discuss with you proposed changes to the current system of ERISA remedies. Like you and the other Members of Congress, we believe that policymakers, business owners, health care providers, consumers, and managed care organizations need to work together to continue to ensure and improve the quality of care Americans receive.

At AMP, we believe that providing quality health care benefits to our employees is a civic responsibility, the right thing to do at a moral level; but besides that, it makes good business sense. A high-quality health care program can be a key retention and recruitment tool for employees.

We strongly believe that both ERISA and the advent of managed care has been essential to our ability to offer quality, cost-effective

benefits to our employees. In fact, at AMP, we are very careful about who we do business with in the health care arena. And we work very hard to ensure that the HMO's that we work with are accredited.

ERISA requires all plans to have claim procedures for solving benefit disputes. Plans are now liable for medical malpractice when they are involved in treatment. Suing plans over coverage of specific procedures or therapies will force them to pay for high-risk or minimally effective treatments. Advocates of liability are wrong to think that they can protect the employers.

If the employee is suing as a result of coverage received under a benefit program, both sponsored and designed by the employer and administered by a vendor under a contract with the employer, it would be very difficult for the employer to escape liability under that scenario. To escape liability under the bills currently before Congress, an employer would have to abandon any responsibility for processing claims or reviewing claim decisions made by their health plans.

At AMP, we have a dedicated individual who works with our employees when they have problems getting claims paid through our various health care providers. And if you could have an opportunity to sit with that gentleman during the day, I think you would see that AMP, as an employer, is highly committed to making sure that our employees get the coverage they are entitled to.

And for each of these very unfortunate stories that we hear, I could bring in many, many, many success stories that would counter the notion that managed care is not being effective.

The NAM opposes the changes in the law which would lead employers to face punitive and economic damages for health benefit decisions. Creating plan liability for benefit decisions would force plans who wish to avoid liability for coverage decisions to be more restrictive in defining covered benefits. We have heard references to the recent polls that talks about the general support for consumer protection in this area. However, that support erodes very quickly when the notion of increased health care premiums is brought into the story.

And I can tell you, at AMP, our employees are highly sensitive to any change in their health care programs. We have very, very competitive programs. We do have employee cost sharing, and they pay attention. And we have many employees who voluntarily elect to go into managed care because of what they deem to be a more reasonable premium opportunity and, in many cases, a more expensive premium option but a richer package of benefits.

We have over 50 percent of our employees participating in managed care. And out of 40,000-some claims processed a year, we see very, very few formal appeals. And many times, these appeals are resolved in favor of the employee. And at AMP, we have not had any major appeals that involved excessive claim denial or managed care vendors acting in an irrational manner.

#### PREPARED STATEMENT

We also believe that it is unfair to allow private employers to be sued when the Federal Government programs remain protected from these lawsuits. Congress should reject this attempt to redefine

ERISA remedies. It will only harm your constituents and our employees.

Thank you. I will take questions.

Senator SPECTER. Thank you very much, Mr. Smith.

[The statement follows:]

PREPARED STATEMENT OF MARK A. SMITH

I am Mark Smith, employee benefits compliance manager at AMP Incorporated. Our CEO and President, William J. Hudson, is currently the vice chairman of the NAM's Board of Directors. We at AMP share your commitment and interest in ensuring access to quality health care. Thank you for this opportunity to speak about the importance we place on quality health care for our employees and their families.

AMP employs more than 9,500 Pennsylvanians and is the world's leading manufacturer of electronic connectors and interconnection systems. Headquartered in Harrisburg, PA, we have more than 46,500 employees in more than 300 facilities in 53 countries. We serve customers in the automotive, computer, communications, consumer, industrial and power industries.

The NAM is the nation's oldest and largest broad-based industrial trade association. The association's nearly 14,000 member companies and subsidiaries, including approximately 10,000 small manufacturers, are in every state and produce about 85 percent of U.S. manufactured goods. Through its member companies and affiliated associations, the NAM represents every industrial sector and more than 18 million employees.

We are pleased to have the opportunity to discuss with you our opposition to proposed changes to the current system of ERISA remedies. Like you and the other members of Congress, we believe that policy-makers, business owners, health care providers, consumers and managed care organizations need to work together to continue to ensure and improve the quality of care Americans receive.

Our testimony makes two key points: First, we will outline the contribution of the Employee Retirement Income Security Act of 1974 (ERISA) and managed care in improving the voluntary private employer-provided health care system in this country. Second, we will show that changing ERISA remedies to allow patients to sue their HMOs or employers for benefits decisions would impede employers' ability to continue to provide high-quality, cost-effective health care benefits to employees and their families.

THE VALUE OF THE EMPLOYER-BASED SYSTEM

*Virtually all NAM members offer health benefits to their employees*

Perhaps the biggest challenge facing manufacturers in today's fiercely competitive environment is recruitment and retention of the highly skilled workers needed in today's modern, high-tech workplaces. Health benefits are a key recruitment and retention tool. Nearly all NAM members offer health benefits to their full-time employees, a success record found in few other sectors of the economy. According to a survey of NAM members in April and May of last year, 99.4 percent offer health benefits to their full-time employees; 97.6 percent offer dependent coverage to their full-time employees; and equally, impressive, 98.2 percent of NAM members with fewer than 26 employees provide health benefits to their employees. (The NAM has more than 2,000 member companies with fewer than 26 employees.)

*Value-purchasing*

Before the widespread adoption of managed care, liberal insurance payments encouraged hospital stays and high-cost tests and procedures. Few incentives existed to reduce costs and most employers were merely passive bill payers, not active purchasers.

During the late 1980's and early 1990's, the medical-care inflation rate was approximately twice the general inflation rate. As late as 1992, when national health expenditures increased 9.1 percent, fee-for-service indemnity plans enrolled the majority of employees (52 percent). Business coped with this cost onslaught by turning increasingly to managed care, which slowed the growth in health care costs, and, by 1997, indemnity plans covered only 15 percent of employees.

In 1997, AMP U.S. spent approximately \$45 million on health care for its employees. After experiencing double-digit increases for a number of years, the company's net health care costs have increased at less than 4 percent. Because our costs have been well controlled recently, we have been able to implement important benefit improvements to some of the plans. In addition, employee contributions for many of

the health options are either remaining the same during 1998 or increasing only modestly.

In the 1980's, American manufacturers adopted Total Quality Management techniques to satisfy their customers and compete in the world economy. They expected no less from their suppliers. Many companies now set performance standards for health plans the same way that they do for vendors of other goods and services. This value-based purchasing approach involves evaluating the quality delivered for the dollar paid. Through managed care techniques, employers try to control the quality of health care and expenses, so that their health plans can achieve the greatest good for the greatest number of employees.

The managed care delivery system evolved from an effort to eliminate the excessive, unnecessary and inappropriate care that the financial incentives of the fee-for-service delivery system created. Research has documented a huge geographic variation in medical practice; often it is not clear that those geographic areas with higher intensity of use of particular services have better health outcomes. In fact, the Rand Corporation has estimated that one-third of all medical treatment is unnecessary or inappropriate.

Many employers are collecting HEDIS (Health Plan and Employer Data Information Set) data<sup>1</sup> and accreditation status information and developing "report cards" to incorporate quality, patient-satisfaction measures and cost. These efforts provide the basis for employer decisions about selecting, retaining and modifying their relationships with managed care vendors. Many large employers incorporate the results of this report-card approach in the pricing of the various plans offered employees and incorporate quality performance standards into their vendor contracts.

#### THE VALUE OF MANAGED CARE

Managed care has been key to the value-based purchasing strategy because it creates provider accountability, emphasizes preventive care and spurs the development of data systems that allow meaningful plan-to-plan comparisons. It also has helped to control health care costs, reduce the number of uninsured and increase worker wages. While it may not be perfect, managed care has served a valuable role in the improvement of health care delivery in the United States.

Workers have benefited financially from the advent of managed care. According to the Lewin Group, in 1996, Americans workers with health insurance reaped wage gains of between 0.7 and 1.0 percent as a result of managed care. For workers earning less than \$6 per hour, these wage gains were 4.0 percent. For workers earning more than \$15 per hour, the gains were approximately 0.8 percent. Managed care saved private insurance in 1996 somewhere between \$130 million and \$205 million, which translates into a 2.7-4.3 percent premium savings and an annual savings per family of \$107.

Managed care has had a positive effect on health care quality. Most studies show that health indicators are about the same when HMO and fee-for-services patients are compared.

Ninety-two percent of American workers who receive health coverage through their employers are offered at least one plan that covers care provided by out-of-network physicians and hospitals. Two-thirds of workers offered health coverage are offered more than one health plan. The issue of choice has been at the center of the congressional debate over health care. We suggest that as you continue to debate this issue, you ensure that managed care remains an option for those employees who choose it and those employers who decide to offer it.

CHOICES is the employee benefit delivery system at AMP. Our program strategy includes offering high-quality managed care choices, self-insuring plan options where appropriate, overall plan design changes, and effective employee contribution strategies.

Instead of providing everyone with the same benefits package, CHOICES gives employees the power to design their own benefits program to meet their own unique needs. CHOICES offers four medical options with each option covering essentially the same eligible medical services. Each option promotes effective use of health care and results in cost savings. In general, plans that provide an overall higher level of benefits may have a higher price tag, while plans that incorporate a higher employee co-pay and co-insurance generally have lower price tags. The CHOICES pro-

<sup>1</sup> HEDIS is a set of standard performance measures to help employers request comparable data about quality from health plans. An example of HEDIS data would be the Cesarean section rate by the HMO population, since we know that C-sections are often performed when they are not medically necessary, leading to an increase rate of surgical complications.

gram offers several different indemnity options with an opportunity to elect coverage under several HMOs available in our geographic area.

*ERISA ensures delivery of promised health benefits and allows for plan-sponsor flexibility*

The innovation and value-based purchasing described here would not have been possible without ERISA, the 1974 law that governs all privately provided benefits and currently covers more than 160 million Americans. The crafters of ERISA struck a careful balance: The law does not require that employers offer benefits to their employees or specify the exact benefits to be offered, but instead ensures that participants get the benefits they are promised. If an employer does offer benefits, ERISA requires him or her to meet certain standards. By not dictating plan design, ERISA avoids overly burdensome or costly requirements that might discourage employers from offering, or employees from enrolling in, plans offered under our voluntary health system.

In avoiding such micro-management and over-regulation, ERISA has provided businesses with the flexibility to tailor the content of health plans to meet the unique needs of their employees, and the freedom to operate under uniform federal regulation instead of under a patchwork of varying state laws. This flexibility is crucial not only to large multi-state employers such as AMP, but also to small employers, since they frequently operate in more than one state and recruit workers from multiple states. ERISA has also enabled many of the quality innovations that have been made in the marketplace.

ERISA's pre-emption of conflicting state laws promotes consistent treatment of similarly situated participants and enables employers to administer their plans uniformly. Further, allowing individual states to regulate such benefit plans would substantially increase the costs and complexity of plan administration. It would be difficult or impossible to offer the same or comparable benefits to employees of the same company who are located in different states.

Contrary to popular belief, ERISA plans are subject to substantive requirements. These include: reporting and disclosure requirements, which were tightened by last year's Health Insurance Portability and Accountability Act (HIPAA); non-discrimination requirements; the fiduciary obligation to deliver promised benefits; continuation of benefits required under the Consolidated Budget Reconciliation Act (COBRA) of 1985; and the portability and non-discrimination requirements in HIPAA. The Americans With Disabilities Act also applies to ERISA plans.

The vast majority of HMOs offered to employees are offered on a fully insured basis and are monitored on quality issues and the grievance process by state health and insurance departments, the Federal HMO Act and the Health Care Financing Administration, as well as by various private accreditation agencies.

*The fiduciary's duty to deliver promised benefits under ERISA provides superior consumer protection*

ERISA requires fiduciaries to act in the sole interest of the beneficiaries of the plan. If a fiduciary does not, he or she can be held personally liable. The plan cannot reimburse the fiduciary for any liability the court may levy against him or her, although the fiduciary's employer could choose to do so. Additionally, if the fiduciary is found to have breached those rules, he or she can be removed from the job. In fact, the Department of Labor (DOL) has brought numerous cases to assure that the fiduciaries of health plans comply with this ERISA provision. The statute also authorizes injunctive relief against conduct by plans and the removal of plan fiduciaries or service providers who engage in systematic patterns of abuse.

In a February informational letter, the DOL concluded that ERISA plan fiduciaries must consider service quality and provider qualifications when selecting a health care service provider, or risk possible violations of these ERISA fiduciary rules. We at AMP have long selected providers based on both quality and cost considerations. We believe this new guidance from the DOL is appropriate and it will lead other employers or Taft-Hartley plans to factor quality into their plan selection.

*Dispute resolution under ERISA*

Issues of coverage arise as a matter of course in health plans because no plan can afford to cover everything. Benefits and benefit limits in employer-sponsored health plans are described in plan documents and applied, on a case-by-case basis, by plan administrators. ERISA requires health benefit plans to have procedures to provide a "full and fair review" of disputed claims.

*Coverage decisions in managed care plans*

Under the old indemnity system, the chief issue was whether a payment would be made by the plan for a service that had already been provided. The old indemnity

plans also had very specific limits on the amount of treatment they would pay for. Studies showed that patients sometimes got the procedure that their physicians were trained in rather than the most appropriate treatment.

In contrast to the old indemnity plans, in managed care plans, the health care provider and the patient often know the plan's decision before the service has actually been provided. Care is coordinated and purchasers are learning to measure a health plan's success in improving the health of their patients. This means that everyone involved—the patient, the provider, the plan and the employer—has a stake in making sure that the right decisions are made in the first place, and that the decisions are made consistently and fairly.

Plan sponsors shifted from indemnity type coverage (everything specifically spelled out and limited) to comprehensive benefits in order to provide greater flexibility in meeting patient needs. Rather than pay for only what was listed in the plan document, the plan would pay for whatever was "medically necessary" and "appropriate" for the patient. The plan had the responsibility to determine what that was.

Employers have encouraged plans to base their medical decisions on available medical evidence, to adopt guidelines from medical societies or with medical teams and to revise them based on evidence from treatment and medical literature. Managed care has provided structure to bringing individual treating physicians' judgments in line with the state of the art medical practices. The treating physician is not always the last word on the most suitable treatment for the patient.

#### *Advantages of the current system*

In the 1987 *Pilot Life versus Dedaueux* decision, the Supreme Court determined that ERISA provides the "exclusive remedies" for insured and self-insured ERISA plans. ERISA permits recovery for the costs of the benefit due, plus prejudgment interest, plus attorney's fees. Injunctive relief is available to employees in cases where an immediate coverage decision or other resolution is required. The advantage of the current system is that it provides simplified judicial relief to plan beneficiaries who do not need to get conflicting state laws or jurisdictional questions resolved. They can go straight to federal court. ERISA thereby assures that an employee's legal rights, remedies and obligations do not depend on where he or she happens to reside.

#### *Benefits decisions are not medical decisions*

It is important to understand the distinction between malpractice liability and plan administration liability. When a treatment decision has harmed a patient's health, the question is one of medical malpractice and is litigated under state tort law. Medical practitioners must be specifically licensed to make medical-treatment decisions. In fact, many states specifically ban the "corporate practice of medicine": Medical decision-making by a plan administrator or an employer of physicians who is not a licensed physician. As a result, only physicians can be liable under state law for medical malpractice. In fact, the DOL has argued successfully in a number of cases that state laws holding physicians, and those that contract for their services, liable for medical malpractice in connection with treatment decisions, are not pre-empted even if the physician provides services to ERISA plan participants.

Managed care plans are often included in suits brought over the issue of provider negligence or the quality of care provided as they can sometimes be found to be "vicariously liable" for the actions of the network providers to the extent that providers are viewed as employees or agents of the health plan. Such suits are usually most successful against staff or group model HMOs, which can be assumed to have more control over the providers in their plan than can a more loosely integrated managed care plan.

Suits over benefits decisions are different. There is also an important difference between medical decision-making and coverage decisions. Physicians choose from a wide range of diagnoses and treatment options, not all of which may be covered under the terms of the plan.

#### *Needed care is provided*

Some consumer advocates allege that utilization review personnel routinely overrule a doctor's decision on necessary treatment or that physicians are forced to spend a tremendous amount of time and energy justifying treatment decisions to clerks in distant offices. The reality is quite different. A recent study of more than 2,000 physicians caring for patients in plans that utilize managed care found that the final coverage denial rate for physician recommendations within eight categories of care was at most 3 percent and much less for other categories of care. The majority of physicians reported no coverage denials whatsoever for any form of care surveyed. Moreover, physicians are spending more time with patients than they did a few years ago; they spend just 3 percent of their time on insurance paperwork.

Under current ERISA law, the plan participant or beneficiary has a right to internal plan review and can appeal the plan decision in federal court to receive benefits. Further, while the current rule may allow up to a year for claims to be resolved, anecdotal evidence from NAM member companies, including our own, suggests that claims resolution rarely ever takes that long. We understand that in September, the DOL issued a request for information on claims procedures for employee welfare-benefit plans and already has the statutory authority to shorten these time frames.

As is the case with any employee benefit program, not all employees are completely satisfied with their health care coverage. Accordingly, as required under ERISA, AMP employees have the right to appeal claim denials. AMP is committed to ensuring that its employees receive the coverage to which they are entitled. Indeed, AMP is diligent in its efforts to resolve claim disputes in a timely fashion. Over the past three years less than 1 percent of claims processed have resulted in formal appeal proceedings. A vast majority of the claim appeals involve amounts in controversy of less than \$200. Of the claims appealed, many are ultimately resolved in favor of the plan participants. To the extent that the original claim denial is deemed appropriate, the plan participant is given a full and complete explanation.

In one case, a plan participant had incurred ambulance costs in excess of plan limits. Nonetheless, rather than simply deny the claim, AMP personnel contacted the ambulance provider and negotiated a 20 percent discount on behalf of the plan participant. This commitment to customer service is but one example of AMP's dedication to providing high-quality health care to its employees.

#### HOW WILL CHANGES TO ERISA REMEDIES AFFECT THE PROVISION OF HEALTH CARE BENEFITS BY PRIVATE-SECTOR EMPLOYERS?

The fundamental issue before the Congress is: Should health plans and plan sponsors be liable under state tort law (with jury trials and punitive damages) for coverage decisions and denials of benefits? Bills such as the Patient Access to Responsible Care Act (S. 644) and the Patient Bill of Rights Act (S. 1890) would allow lawsuits to be brought against employers, insurers, third-party administrators and others under state law causes of action in personal injury and wrongful death cases.

Changing the current system could create more adversarial relationships that are unresponsive to the needs of both employees and employers. Administrative expenses, such as the costs of claim review and litigation, consume funds that otherwise would be available for benefits. In addition, turning plan disputes over to the vagaries of state courts and juries would take from employers the opportunity to intervene early before formal procedures were triggered, increasing time and monetary costs to both employees and employers.

Congress must recognize that we have a voluntary health care system. Plan sponsors provide the package of benefits they can afford. The benefit package is an agreement between the employer and employee. It is understood from the beginning that everything a provider might do will not necessarily be paid for by the employer plan.

#### *ERISA and malpractice reform*

S. 644 includes a provision that would eliminate ERISA pre-emption of "any state cause of action to recover damages for personal injury or wrongful death against any person that provides insurance or administrative services to or for an employee welfare benefit plan maintained to provide health care benefits." This provision would open up liability for employers who administer their own plans, and, depending on the interpretation of the regulatory agencies and courts, could also directly affect self-insured employers who purchase administrative services.

The Patient Bill of Rights Act would impose liability against those that "arrange" for medical and administrative services for health coverage. To some extent, all plan sponsors "arrange for medical services," therefore this provision could result in potential exposure of plan sponsors to state causes of action.

#### *The threat of increased litigation would cause many employers to drop or scale back their health benefits*

The NAM strenuously and vigorously objects to this provision. Exposing plans to damages beyond the scope or value of the benefits provided through the plan would fundamentally alter the nature of the benefit contract between employers and employees. Such remedies also would create perverse incentives for costly and unnecessary litigation at the expense of the dispute resolution methods currently in ERISA. The threat of increased litigation would discourage employers from offering health care plans. This liability burden would pose one more hurdle—and a very large one at that—for the small employer just on the cusp of offering health benefits to his or her employees. Further, employers would significantly reduce or eliminate health

care coverage in order to insulate themselves from liability in an area that is not their core business activity.

The NAM conducted a survey of more than 2,000 manufacturers in March at National Manufacturing Week. The survey found that 51 percent of companies would cut back benefits to offset the costs of potential lawsuits and 14 percent would stop offering health benefits altogether if faced with increased liability for health benefits. According to another survey conducted by the polling firm Public Opinion Strategies for the Health Benefits Coalition (of which the NAM is a member): 57 percent of very small employers (between 5 and 50 employees) would likely drop coverage if exposed to malpractice lawsuits. Almost 4 out of 10 (39 percent) say they would be “very likely” to stop providing coverage.

*Removing the ERISA shield for State causes of action would be costly and would depress wages’ job growth and other benefits*

A recent study by the Barents Group found that expanding liability under ERISA for benefits decisions would increase health care premiums by as much as 8.6 percent. This premium increase would be hardest to bear for small businesses and low-wage workers. This cost increase could force as many as 1.8 million more Americans to lose their coverage in 1999. (In 1996, 64 percent of Americans received health care coverage through employers.) Some would lose their coverage as a result of their employers dropping coverage entirely. Other consumers would decide they could not afford the increased cost sharing that would be passed on to them as a result of this proposal. In fact, a study conducted by researchers in the Department of Health and Human Services and published in the health-policy journal *Health Affairs* (Nov.-Dec. 1997) found that while employers are increasingly offering health benefits to their employees, employees, particularly those who are young or earn low-wages, are increasingly turning that offer down. Most likely these employees decline this coverage because they cannot afford the cost-sharing requirements. At a time when policy-makers continue to struggle with the ever-increasing problem of the uninsured, why would Congress want to do anything to aggravate the problem?

Over the next five years, such a cost increase could result in as much as \$94 billion in additional health care costs for American business. Such an increase could depress worker wages as well by a loss of as much as \$1,512 in take-home pay per household. As total compensation (benefits plus wages is fixed), this increase in health insurance costs would force wages down as well as create job losses. Indeed, according to Barents, as many as 240,000 jobs could be lost in 2003 as rising health care costs forced employers to cut their payrolls.

More important than this average cost increase across the board is what would happen to an employer, particularly a small one, faced with an expensive malpractice suit. Such a suit could wipe out an employer. Even if liability insurance were available for employers in these cases, this insurance is likely to be experience-rated and thus prohibitively expensive for employers who have experienced any adverse action.

*Expanded remedies benefit only the trial bar and would not improve health care quality*

Increased lawsuits would channel scarce health benefit dollars to the trial lawyers’ bar and away from the care for employees and their families and efforts to improve the quality of care. If health plans and employers could be sued for medical malpractice over their benefits decision, most of the money would go to trial lawyers—not injured patients. According to the Rand Corporation, only 43 cents of every dollar awarded in medical liability litigation goes to patients. Access to a jury trial also does nothing for the patient. Issues affecting the patient would be resolved years after the patient needed a treatment decision.

The NAM has long recognized that malpractice liability is a significant problem for physicians, but increasing malpractice liability—for plans—is not a panacea. Instead, this attempt emphasizes a reactive approach to health care quality and interferes with proactive approaches that emphasize continuing quality improvement and greater accountability of physicians.

Judgments about the most appropriate treatment are best made in a medical context, not in a courtroom. Taking these issues before a jury would put science-based decisions on trial after the fact. The issue before the jury would be whether the choice of treatment, in retrospect, could have contributed to a poor outcome for the patient (which can never be known for sure), not whether the choice of treatment was the best choice at that time for the patient.

Throwing medical decision-making before juries creates substantial liability for doing the very things that we want plans to do to improve quality. Any effort by an employer or health plan to review physician decisions or provide evidence-based

guidelines creates a potential for liability. State tort liability for benefit denials would also give the treating physician a weapon against the medical director and the medical committee in the plan. Treating physicians would be able to force plans to pay for outdated or unproven treatments.

Applying malpractice liability to coverage decisions would make the patient's health outcome a sufficient condition for liability, regardless of whether proper procedures and practices were employed. Unfortunately, sometimes despite the best possible treatment and the correct decisions on coverage, patients die or their conditions worsen.

*Imposing expanded liability on private plans is fundamentally unfair*

Such an increased liability essentially punishes those private employers who try to do the right thing by their employees by providing them with benefits. More unjust is the fact that none of the bills under consideration by Congress would expose public programs such as Medicare, Medicaid or the CHAMPUS program operated by the Department of Defense to such liability. This double-standard is completely inconsistent with the spirit of the Congressional Accountability Act and Unfunded Mandates Act.

It is also unfair to impose such an increased liability threat on private-sector employers when neither the Federal Employees Health Benefits Program (FEHBP) nor the Medicare program permits the award of punitive or compensatory damages beyond the scope of the covered benefits.

*Expanded liability will decrease provider flexibility*

Creating plan liability for treatment may bring the very result that physicians are trying to avoid: an increased role for administrators and lawyers in medical decision-making. The best way for plan sponsors to avoid liability is to pick specific treatments, perhaps only those benefits that are determined to be medically necessary by the courts, and provide an explicit statement in the plan that those are all the treatments the plan will pay for. Enrollees cannot sue to get benefits the plan clearly does not provide. This would remove any discretion from the treating physician or the plan's medical director. It would also substantially reduce the quality of medical decision-making. Plan participants will have very limited coverage that would not keep pace with innovations in medical treatment or account for unique individual needs.

*Employers cannot be shielded from liabilities for benefits decisions under congressional proposals*

Many in Congress seek to draft legislation that would somehow allow only health plans and not employers to be sued for malpractice for benefit decisions. For example, Representative Charles Norwood, the chief House sponsor of PARCA, has stated that it was not his intent for employers to be held liable under H.R. 1415. Therefore, in November, he introduced H.R. 2960, The Responsibility in Managed Care Act. H.R. 2960 states that the liability provisions shall not apply to any cause of action against an employer or other health plan sponsor unless, "The employer or other plan sponsor exercised discretionary authority to review and make decisions on claims for plan benefits, and the exercise by such employer or other plan sponsor of such authority resulted in personal or financial injury or death." S. 1891 also allows state causes of action against an employer or other plan sponsor if "such action is based on the employer's or other plan sponsor's exercise of discretionary authority to make a decision on a claim for benefits covered under the plan or health insurance coverage in the case at issues; and the exercise by such employer or other plan sponsor of such authority resulted in personal injury or wrongful death."

We believe that trying to somehow isolate employer liability from the liability of a managed care organization's liability for a benefits decision is bad policy. First, it is almost impossible to write legislation that would make managed care organizations, but not employers, liable for benefit decisions. In part this difficulty is due to the fact that employer sponsors of health benefits plans are not passive buyers of health care services. Instead, they exercise discretionary authority on a daily basis to determine what benefits are covered under the terms of the plan. In fact, such authority is part of an employer plan sponsor's fiduciary duty under ERISA. In other words, to escape liability under bills currently before the Congress, an employer would have to abandon any responsibility for processing claims or reviewing claims decisions made by their health plans. This puts employers in the untenable position of having to give up control over their health plans or risk lawsuits. Given that many NAM members intervene with the health plans they contract on behalf of their employees to ensure that they get better care, such a policy will only hurt workers and their families.

Second, even if it were possible to limit such liability to managed care organizations, the NAM would oppose such liability as it would hamper medical innovation and efforts to improve health care quality and decrease health care costs. Employers and their workers would ultimately pay for expanded liability for HMOs and other health plans.

*Medical necessity decisions*

Just last week, Representative Norwood unveiled a revised version of PARCA (PARCA 98) with new ERISA remedies provisions. PARCA 1998 would "not apply to any cause of action to recover damages for personal or financial injury or wrongful death against any person that provides insurance or administrative services to or for a group health plan," unless an employer denied a benefit on the grounds that the benefit was not medically necessary." (PARCA 1998 also prohibits punitive damages in cases that have gone through an external review process.)

As explained previously, employers working with their health plans do not make medical judgments; they make coverage decisions. Nonetheless, they cannot afford to pay for every treatment a patient may desire or a provider may wish to prescribe or undertake. They, therefore, must sometimes decide—while consulting with properly trained utilization management teams or other experts—that a treatment does not meet best-practice standards. While there is much hype that non-medical personnel supposedly make medical decisions, the NAM sits on the board of the American Accreditation Health Care Commission/URAC, which accredits utilization review organizations and network-based managed care plans. I can tell you that non-medical personnel have no medical discretion to deny a claim in an accredited plan. If they turn down a treatment based on the scripts, they are required in any accredited plan to turn the case over almost immediately to a medical professional.

Expanding malpractice liability to cover benefits decisions would allow external review parties and the courts to have wide latitude to override internal procedures defining the terms of what constitutes plan benefits (i.e., medically necessary services). Every plan would then have to provide whatever benefits a district or circuit court may find "medically necessary" in a particular case. Certainly, providers would use this window to introduce every other provider service imaginable into HMOs and self-insured plans, whether or not given scarce benefit dollars such services were truly in the best interest of the majority of the plan's beneficiaries. To have either federal regulatory agencies or the courts determine what is and is not "medically necessary" was the essence of the President's failed Health Security Act and would result in the destruction of the private health care market.

*Conclusion*

Even the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry failed to recommend expanded liability in its final report. Your former colleague, Florida Governor Lawton Chiles has also rejected such an approach. In his 1996 veto letter over just such a proposal in Florida, Governor Chiles wrote, "Throwing these cases into our already overly crowded and overly litigious tort system is also troubling. The tendency in most cases would be to require the HMO to pay for the services regardless of cost. \* \* \* The key to any dispute resolution system for health care claims is that it be fast, fair and efficient. The tort system is none of those."

In fact, while the American Medical Association as a whole has sought out other deep pockets to pay for medical malpractice and embraced these ERISA-liability expansions, the president of the New Hampshire Medical Society in a February letter to the New Hampshire legislature wrote, "We believe that ready access to information at the time the denial was made is critical to taking the appropriate next step in a patient's care. An explanation, today, on why a service has been denied, will help me and my patient decide whether or not to continue on a course of treatment, change direction or pursue an appeal with the HMO. Health insurer liability in a court case 3 years down the road does little to help my patient here and now."

We urge Congress, too, to reject expanded liability for health plans and employers. Such an expansion would only decrease health care quality, increase health care costs and the number of uninsured, harm small businesses, jeopardize the very existence of the employer-based system and enrich the trial bar. Instead, we support private-sector efforts to encourage better medical and benefits-decision-making at the front-end. Thank you for letting us share our views with you on this important subject.

## EXECUTIVE SUMMARY

Health benefits are a key recruitment and retention tool for employers. It is therefore, in an employer's self-interest to provide quality health care benefits to attract new employees and keep these employees productive.

The Employee Income Security Act of 1974 (ERISA) has encouraged employers to provide health benefits to their employees by leaving up to employers the types and amounts of benefits they can provide. It simply requires that employers fulfill the benefit promises they have made. ERISA also contains strict fiduciary standards, which require employer plan sponsors and other plan administrators to act in the sole interest of the beneficiaries covered under the plan. Fiduciaries who fail to do so can be severely penalized. Recently, the Department of Labor has determined that fiduciaries must take quality as well as cost into account when purchasing health benefits.

ERISA requires all plans to have claims procedures for solving benefit disputes and provides the sole remedy for self-insured and fully insured ERISA plans in disputes. The case is heard in federal court and the remedy is limited to the costs of the benefit due plus pre-judgment interest and attorney's fees. Current law distinguishes between treatment decisions—where individuals can sue for medical malpractice—and decisions over plan administration which are coverage decisions—and are generally pre-empted by ERISA. The NAM believes strongly that this distinction should be maintained.

Legislation, such as the Patient Access to Responsible Care Act (S. 644) and the Patient Bill of Rights Act (S. 1890), would destroy the employer-based health care system by allowing lawsuits to be brought in state courts against employers and health plans in personal injury and wrongful death cases.

The NAM opposes this change in the law, which may lead employers to face punitive and economic damages for health benefits decisions for the following reasons:

(1) The threat of increased litigation would lead many employers to drop or scale back their health benefits.

(2) Expanding liability under ERISA for benefits decisions would harm employers and employees by increasing health care premiums by as much as 8.6 percent, leading to less health care coverage, fewer jobs and lower overall employee compensation.

(3) Allowing such suits would take money away from efforts toward increasing health care quality and towards our malfunctioning tort system. Only 43 cents in medical liability litigation goes to patients.

(4) Allowing private employers to be sued when federal government programs would remain protected from these lawsuits is unfair.

(5) Creating plan liability for benefits decisions would force plans—which wished to avoid liability for coverage decisions—to be more restrictive in defining covered benefits. The resulting rigidity in benefit design would hurt patients.

(6) Despite various congressional attempts to do so, employers cannot be insulated from liability for benefits decisions without ceding all control over the benefit plans they pay for. Even if employers could be isolated, they and their employees—if they were fortunate enough to continue to have health benefits—would still pay the increasing health care costs that resulted from this new liability.

(7) Expanding malpractice liability to penalize employers or health plans that denied in good faith a benefit for lack of medical necessity would allow the courts or regulatory agencies to define medical necessity. Private-sector health plans would then have to cover almost all benefits.

Congress should reject—as did Governor Lawton Chiles of Florida, the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry and the New Hampshire Medical Society—this misbegotten attempt to redefine ERISA remedies. It will only harm constituents.

## COMMON LAW RIGHTS OF ACTION

Senator SPECTER. Before proceeding to the 5-minute rounds of questioning, I would state the facts of the case involving Mrs. Corcoran. As reported in the Federal reports, she was pregnant but had a history of pregnancy-related complications. Her treating doctor recommended hospitalization. The HMO determined that hospitalization was not medically necessary, instead authorizing 10 hours of in-home nursing care per day. According to the facts presented to me, the fetus became distressed while the nurse was not

on duty, and the fetus died. The Federal courts denied liability under the ERISA statute.

Coming right to the core, Ms. Berg, of the administration's proposal, are you contending that ERISA should be changed so that Mrs. Corcoran would have a common law right to sue the HMO?

Ms. BERG. Yes, we are. We are saying that these remedies should be available to participants in health plans. As Mr. Pollack already noted, there are a couple of ways to do that. We note that in our testimony, as well.

One approach, again, is to put these issues back into State court. Another is to change the ERISA remedy. There are variations of these approaches. And we would be happy to work with you in developing any of them. But the goal here is to make sure these remedies are available.

Senator SPECTER. Ms. Berg, the contention is raised by many that there would be an enormous increase in health care costs, estimated by the National Federation of Independent Businesses, to be \$94 billion, contending that there would be a loss of some 1.8 million Americans on their coverage. Does the administration have an analysis as to what increased costs would arise and what coverage would be limited if the common law rights of action were available, as you have recommended?

Ms. BERG. Well, first, before I talk about the estimates, let me point out whenever we are talking about a change like this, you will find different sorts of estimates. In this case, we have actual experience going on out there: the millions of participants in health care plans that are not covered by ERISA and have these remedies available to them. And, indeed—and let us use State and local government employees as an example—State and local government employees generally are covered in higher numbers than private sector employees. We do not see their employers running away from providing health insurance because of these liabilities.

Senator SPECTER. What liabilities do you find in those plans where there is a common law right of action?

Ms. BERG. They are able to go into State court, under contract or tort law, and sue for the benefit they should have gotten, and obtain attorneys' fees. They can get expert witnesses' fees if necessary. They can get compensation for other monetary harm that has been done to them. They can get damages for pain and suffering.

Senator SPECTER. Economic damages and punitive damages?

Ms. BERG. Economic damages and punitive damages.

Senator SPECTER. And what are those costs? What do they aggregate?

Ms. BERG. Again, we do not see a difference in the premiums for State and local government employees. In fact, many of them are in the same HMO's that also cover ERISA employees.

Senator SPECTER. Mr. Gallagher, do you disagree with that?

Mr. GALLAGHER. I do not have the answer to that, Senator. I know that in the case of individuals who buy private coverage, their costs are substantially higher. I have seen studies that indicate it is 25 percent higher.

Senator SPECTER. Well, Mr. Gallagher, we really need the specifics as to what the comparison in costs are. Now, this is obviously

a big factor. If there are greater rights attaching, there obviously will be increased costs. And there ought to be an evidentiary base, since there are alternative plans, which would provide an answer to it.

Mr. Pollack, you had your hand up.

Mr. POLLACK. Mr. Chairman, yes. The one State that has actually adopted a specific provision akin to what we are talking about is the State of Texas. They adopted legislation last year. And an analysis was made for the Legislature and the Governor concerning the cost. And that cost—and I have the estimate here; I am happy to share it with you—was 34 cents per enrollee, per month. And the reason it is so low is the same experience that we have in a whole bunch of other health situations. And that is very few people make claims.

And so in terms of any State that has tried this so far and has gone to the trouble to develop estimates, the State of Texas, I submit to you, has done that. And it comes out to less than \$4 per enrollee, per year.

Senator SPECTER. How long has Texas had this legislative plan?

Mr. POLLACK. It has been in effect for approximately a year. And I will say that this was a prospective analysis.

Senator SPECTER. Is there litigation as to whether Texas may make that provision, in light of the ERISA preemption?

Mr. POLLACK. Yes; there is litigation pending in Federal district court. And it is our belief that there will be a judgment rendered in that case within the month.

Senator SPECTER. To what extent, Mr. Pollack, as an expert in this field, do you think there would be a reduction in complaints if you had the independent right of appeal as a mandatory provision?

Mr. Smith, you say you do have that right of appeal in AMP's plan?

Mr. SMITH. Internally, yes, we do.

Senator SPECTER. Internally. OK.

Mr. POLLACK. And I have to say, Senator, when we were in the President's Commission, one of the things is when we suggested an external right of appeal—and we voted on this unanimously, health plans, insurance companies, employers—one of the things I think that all of us felt was these different systems of internal, external and ultimately the right to judicial remedies, it helps get the problems solved at an earlier point. Because if you know you have got an external right of appeal, you are more likely to deal with this successfully in the internal right of appeal.

Senator SPECTER. How would you propose the external right of appeal work?

Mr. POLLACK. Well, we have some experience with that in a few States, and we have experience with that in the Medicare program. After an internal review has taken place and the plan has had an opportunity to make a judgment in the internal review, there would be a panel that would be selected. That panel would be independent of the plan. And they would conduct a de novo hearing. And that de novo hearing would then make a determination as to whether the denial was inappropriate.

I want to be clear, however, that panel would not have the right to redesign a benefit package. They would have to render their decision based on the benefit package that was established by the employer. And this would not be a pretext for opening that up.

Senator SPECTER. Senator Faircloth.

Senator FAIRCLOTH. Yes; I had a question for Ms. Berg. The growth of managed care did not happen overnight. While it has gone from 4 percent to 40 percent of health benefits paid under self-insurance, you have had many years of complaints I am sure. Why has it taken the administration so long to decide to issue regulations to protect health benefits?

Ms. BERG. Well, Senator, I cannot speak to the 15 or more years before I got here since the passage of the original reg, but I can speak to the last 5 years.

Senator FAIRCLOTH. You have been there 5 years?

Ms. BERG. Yes, I have been here 5 years.

I will say we recognized the problem right from the beginning. But at the time that I got here, there were some—I like to think many—who hoped that universal health care reform was in sight. And it did not seem to be a productive use of time to work on amending a regulation, with all the work that that takes, that might immediately be irrelevant.

By the time it became apparent that it was more likely there were going to be incremental approaches to health care reform, we picked the issue right back up. In fact, during deliberations on the Kennedy-Kassebaum bill, we wrote, requesting that these issues of protections be included in that legislation, because we knew, to some extent, our regulatory authority was limited and there could be a more comprehensive addressing of the issue through legislation.

Unfortunately, that did not happen. And our immediate responsibility, after the passage of HIPAA, was to get regulations in place, implementing that legislation in an extremely short timeframe. We did that. I am very proud of the way that we did that.

And immediately after that, we turned back to this issue yet again, and put out a request for information, modeled on work that was already being done by HCFA and others. Because we said, why reinvent the wheel; let us pick up on that. The question we went out with is, why will these kinds of standards not work in the private sector? We asked any number of questions.

And I have to tell you, I am a little bit amused, because the employer group representatives who are now saying if the Department would change the regulation we would not be here talking—I mean, I can quote to you from their response to our request for information on our current regulation, the APPWP: “We believe the existing minimum claims procedure standard, supported by ERISA’s strict fiduciary rules, have resulted in timely, fair and cost-effective resolutions for health plan claims.”

Don’t do anything, they are telling us. Similarly, the ERIC testified, as well.

So it has only been since the bills that we are talking about, the bills with real protections that we need to add on to the internal claims process, have the momentum that they have that suddenly

people are saying, well, gee, improvements to our claims process is all that is needed here.

Senator FAIRCLOTH. When do you plan to issue the regulations?

Ms. BERG. Within 60 days.

Senator FAIRCLOTH. Within 60 days you will be issuing them.

You propose that legislation be passed to amend ERISA, to require self-insured plans to have independent systems for external review of claims. You justify this on the basis that it will reduce the need for litigation. What is the connection?

Ms. BERG. Well, again, as I was explaining, our position is that all three pieces are needed: a strong internal claims review process, where we would hope that most of these problems would be picked up in the first place—but as I pointed out—and, again, this is the problem with remedies at the end of the day—if a health plan knows that if they deny a benefit, even though it ought to be covered under the plan, at the end of the process, all they will have to do is pay that benefit, if they are trying to improve their financial situation for whatever reason, there is no disincentive for them to deny claims.

They can be in perfect procedural compliance. They can deny every single one of those claims within 72 hours, or whatever. But the problem is those claims should not have been denied in the first place. So you need to know there is going to be a review of that kind of practice so these things will not happen. And ultimately, remedies as well, so that there is financial incentives that make people do the things that they should be doing in the first place.

Senator FAIRCLOTH. What would be the administration's response to laws to put a limit on what claims could be—a specific limit on what any claim could be?

Ms. BERG. Well, again, as we point this out in our testimony, there are different approaches that can be taken with this. Many of the States have limitations on claims already, as well. We are open to different approaches. We are not saying there is any one that is absolutely right and perfect.

Senator FAIRCLOTH. Mr. Pollack, what would be yours?

Mr. POLLACK. Well, in response to the question you asked the Assistant Secretary, I would say, first of all, the external right of appeal is going to be very important.

Senator FAIRCLOTH. Well, I asked for a specific monetary limit on what any claim could amount to. What would your response to that be?

Mr. POLLACK. I am not sure I would establish one across-the-board monetary limit. I am not sure that that would be appropriate.

If that approach was adopted, there might be different classifications of cases, where there would be some range established, as we have in our penal system.

Senator FAIRCLOTH. Is there some way to put a compensation limit to what it could be?

Mr. POLLACK. I understand what you are driving at.

Senator FAIRCLOTH. For simplification, I think it would save attorney's fees. It would save time. The injured person would get paid quicker. Is it possible to do what I am talking about?

Mr. POLLACK. I think it is possible. It is very difficult to do it. I think it is possible to do it. I do not think I am going to be able to respond directly, as you are asking me to, to give you a precise fee for each and every kind of situation.

I think it is possible to do it. It is very difficult to do it. But it is achievable.

Senator FAIRCLOTH. Well, lawsuits are out of hand is the thing I believe you mentioned. Somebody gets \$90 million.

Mr. POLLACK. Yes; that was my colleague on my left, Mr. Gallagher, said that.

Senator FAIRCLOTH. Was that Mr. Gallagher? OK. Well, litigation is out of hand, and in some way it has got to be brought under control.

Thank you, Mr. Chairman.

Senator SPECTER. Thank you, Senator Faircloth.

Senator Kennedy.

Senator KENNEDY. Thank you.

And I thank the panel. It has been enormously interesting.

As I understand, there are two different ways of doing the remedies. There is one, either to have a Federal remedy, or otherwise leave it to the States. And I think many of us have felt that we could leave this to the States and let the States make these decisions about where they are going to come out in terms of the remedy itself. That certainly would be the approach that I would take.

I know there are some—Congressman Stark and others—who want the Federal. Then I think the question is about what you do along the lines in setting limits that may be an issue. But that, I suppose, could be another time.

I think, for the most part, I do not know particularly in the Senate, about the Federal remedies. It is basically to let the States make these judgments.

Could I ask, just coming back to the point about the questions about the costs. Because this has been sort of the way that many of those that are opposed to both having the appeals—and I thought that was an enormously important issue to raise, because it really is part of this whole process to have the appeals procedures, as Mr. Pollack has mentioned, as well as the remedies. And tying those together are very, very important, so that we have the preventive aspect to try and get this done.

And as I understand, Mr. Pollack and others, we do have that under the Medicare and it works pretty well. Maybe we ought to be finding ways to make it better, but we do have those external appeals. We are not trying to take a whole new concept, as I understand it. We are trying to build on something that we do know that works.

Mr. POLLACK. And is inexpensive. And I want to be clear about this, because this is a point that should be discussed, and it is very relevant. Every one of us are talking about it in some way.

We did get estimates from the—when we made the recommendation for an external right of appeal, independently, from the Lewin Group. And what we heard was as follows. We got a range. And the range provided to us by the Lewin Group was that the cost of an external right of appeals—and I am giving you the exact figures—was 0.3 cents per enrollee, per month, up to 7 cents per en-

rollee, per month. You take the maximum end of that, and you are talking about 84 cents per enrollee, per month, for an external right of appeals.

Senator KENNEDY. So this is a small factor.

Now, let me just ask about the differential, in terms of the cost of the remedies. You mentioned the Texas situation. We also have the example of CALPERS, California, 1.2 million. Their State and local employees, their premiums are competitive and in many instances are less because they have a better bargaining position. And as I understand, they have the complete right of remedies that you are recommending under the Bill of Rights. Am I correct?

Mr. POLLACK. That is correct.

Senator KENNEDY. So, you know, there is speculation about what the costs are going to be. And Mr. Gallagher was unable, as I understand it, and I will give him a chance to respond, but unable to respond to the point that, in reality, what is happening in terms of the State and county employees, and local employees, we have not seen any evidence, or it has not been submitted, evidence, about any real difference in terms of premiums, nor for individuals who are outside, who purchase—I guess there may be some difference there, but I did not see there was very much of a difference, even in terms of the premiums, outside of individual—the marketing reasons for individual purchasers.

Is that your understanding?

Mr. POLLACK. Yes.

Senator KENNEDY. Now, what we are really talking about here—and this is just the end, Olena Berg—let us take your case about your CAT scan. If a person has the CAT scan, if the doctor, if the groups says, the package says, you can have the CAT scan, and the doctor says, I am not going to do the CAT scan because I do not think that it is worthwhile in this case, the person then gets a health implication of this, at the present time, they can sue the doctor for malpractice, is that correct?

Ms. BERG. That is correct.

Senator KENNEDY. OK. Now, if they say that the doctor wants to do the CAT scan but the package does not provide the CAT scan, and so the plan says, no, you cannot do that CAT scan, then what is the remedy if the person gets additional medical complications? What happens now?

Ms. BERG. In that case, it is a benefit determination, and it would be subject to ERISA. So, arguably, the only benefit that would be available is the original test, if the person were damaged. But I have to point out that we actually have three situations here. One is the plan clearly says we are not going to cover this, and there is no question about that.

Senator KENNEDY. OK.

Ms. BERG. The issues that we are mostly talking about today is kind of the intermediary. The plan has a set of benefits, but there is a determination by someone, not the doctor. The doctor says, my patient needs this test, and someone in the process—a utilization review committee or something like that—even though, under the plan, the person is covered for what is determined to be medically necessary, someone wrongfully says, this test is not necessary, and the person does not get it.

And we are saying that situation should be treated exactly as the malpractice situation is. Someone has done something that was wrong that harmed the patient.

Senator SPECTER. Senator Kennedy, we are under tight time constraints. After this hearing was set, the Appropriations Committee set a meeting with Prime Minister Netanyahu at 2 o'clock. So we are going to turn to Senator Durbin for a round of questioning.

Senator DURBIN. Thank you, Senator Specter. I apologize for being late. And I want to applaud you for holding this hearing. This is a timely issue, and one that I have tried to address by introducing legislation on the matter.

And I frankly come to this issue with two life experiences that give me great interest. One is, before I was elected to Congress, I was a medical malpractice attorney. And I represented both sides. I defended doctors and I sued them. So I have been on both sides of this issue. I think I understand better than some that we are talking about real-life experience and real-life tragedies.

The second experience relates to a program in my hometown of Springfield, IL, that invited Members of Congress to spend a day with the doctor. So I went on rounds in a hospital with a doctor. I spent 1 hour of that day standing at a nurse's station while this doctor, on the telephone, argued with a clerk from an insurance company in Omaha, Nebraska, about whether a woman would be admitted. And, finally, the doctor, in desperation, said I cannot in good conscience, send this woman home. I am going to admit her and fight the insurance company myself.

I think this issue is about accountability. Who should be held accountable? If a doctor makes a medical decision in the best interest of his patient, and then is overridden by the insurance company, who should be held accountable?

Let me just say, before I offer Mr. Pollack an opportunity here, those who argue that this is going to shift a burden on employers who choose these managed care plans, I beg them to read the legislation that I have introduced. We clearly indemnify all employers. This is a question about the managed care company. It is also a question of a doctor's advice. And it is a question of accountability.

Mr. Pollack.

Mr. POLLACK. Mr. Durbin, if I may just build on your comment, and Mr. Specter's elaboration of Mrs. Corcoran's case, you have got a perfect example of that situation. Her doctor said that she needed—she had an at-risk pregnancy. Her doctor said she needed to be in the hospital as she was approaching term. And the doctor was clear that she needed that care.

Unbeknownst to Mrs. Corcoran, that HMO had gotten a second opinion. And that second opinion also said she should be in the hospital and that she should be under constant doctor's care. Notwithstanding that, the HMO said no, she should not be in a hospital; that she should be getting 10 hours a day of nurse's care. And as a result of that, her child died.

There is no question that plans are practicing medicine. And what the plans, in effect, are saying to us is: We can practice medicine except when we make a mistake. Then you should not treat us as if we are practicing medicine.

But Mrs. Corcoran is a clear example of how the plans have overridden professional decisions about what was good for herself and for her fetus. And unfortunately, the plan overrode it and she has no remedy today.

Senator DURBIN. I would like to ask Mr. Smith and Mr. Gallagher a question—it is not a hypothetical, it is a real case of a woman in Chicago, who went on vacation in Hawaii, and had a severe reaction. And the doctor in Hawaii recommended a bone marrow transplant immediately to save her life. She called her HMO. They said no, you have to come back to Chicago. We will not do it in Hawaii. And her doctor in Hawaii warned her: Do not get on that plane. She said: I have no choice; I cannot pay for this. She got on the plane, suffered a stroke, and died 9 days later.

Should the HMO and insurance company get off the hook in this situation? Should they be limited to the cost of the procedure only if they have overridden a doctor's medical decision about what is in the best interest of a patient, and the patient dies as a result of that insurance company decision?

Mr. Smith.

Mr. SMITH. As it stands now, if a plan is involved in practicing medicine, they are subject to liability. And in terms of indemnifying employers, you can indemnify all you want, but the costs will come back to us. And so far, all we have heard about these costs are examples of State and local governments. I have heard examples of Medicare being held up as an example.

To the extent that you want to start comparing State and local government management to what a private employer can do, that makes me very uncomfortable. And this notion that we have no incentive to, other than financial controls, is ludicrous. We care about our employees and we want them to get top-quality care.

And I will repeat this again. We can cite example after example of some very horrific situations, but for every one of those there are many, many, many success stories. And I am as sorry as I can be about this woman who died on her way back from Chicago. It is a terrible thing. And any employer would feel very compassionate toward their employee for that. But to the extent that we try to fix those individual situations with a broad-based piece of legislation, then you are going to impact the lives of—

Senator DURBIN. Mr. Smith—

Senator SPECTER. Senator Durbin, we are going to have to give Mr. Gallagher a chance.

Senator DURBIN. Well, I would like to respond to this first. Let me tell you, this is not about compassion. This is about justice. This is about justice. This is a decision made by a company, not by a doctor. The company overrode the doctor. And you are saying, oh, there is liability. But it is a limited liability. And I think your response was not totally responsive to the question.

Mr. SMITH. If they practiced medicine, then they could be subject to State malpractice.

Senator DURBIN. Mr. Gallagher?

Mr. SMITH. So there is more liability than you are suggesting.

Senator SPECTER. Mr. Gallagher, would you care to reply?

Mr. GALLAGHER. Thank you. Briefly.

I know all the members of the committee here are lawyers, and you know the phrase “bad facts make bad law,” and that applies to legislation, too.

But you should not deprive employees of this country of the benefits that they have gotten from the managed care system, which is better care, wellness benefits, all the things that we did not have in the fee-for-service system, by focusing on penalizing employers and managed care companies when mistakes are made. The focus should be on making sure those mistakes do not happen again.

Senator SPECTER. Mr. Smith and Mr. Gallagher, would you care to reply on this issue of internal and external rights of appeal? You have not been given an opportunity to comment on that. Do you think that there ought to be internal right of appeal?

Mr. Smith, you commented within your own company. Do you think that that would be an appropriate remedy, for a mandatory internal right of appeal?

Mr. SMITH. I cannot speak on behalf of NAM, but at AMP we have been involved in developing policy statements, where, as an alternative to changing some of these ERISA remedies, we would certainly favor some type of an appeal process to help resolve some of these issues.

Senator SPECTER. How about external appeal?

Mr. SMITH. Under the right circumstances. That is fraught with certain difficulties, as well. But it is something we would certainly prefer to some of the ERISA remedy changes.

Senator SPECTER. Mr. Gallagher, would you care to answer that question?

Mr. GALLAGHER. I know, Senator, that many companies and many managed care companies, are considering doing that on a voluntary basis merely because of the perception that consumers and others have that they are not going to get a fair shake when you go back to the—

Senator SPECTER. The question goes to whether you would think it appropriate for Congress to make that a requirement, internal and external rights of appeal.

Mr. GALLAGHER. I would prefer that it be voluntary, that the decision be left to the company.

Senator SPECTER. Senator, do you have one more comment to make here? I am sorry to limit—this is a vast subject, but we do have, as I said, the Prime Minister coming in very shortly.

Senator DURBIN. Senator, you have been kind enough to hold this hearing. I am glad you did. And I will not hold it up. Thank you very much.

Senator SPECTER. All right.

Do you want to make another comment, Ms. Berg?

Ms. BERG. Just one final comment on the issue of cost, because it is important that there be a weighing of that. There are a couple of studies on the PARCA bill, one by Muse and Associates, which estimates the additional costs due to these remedies at two-tenths of a percent of premium. There are two studies by industry groups who oppose the bill.

Now, one of these two studies I will not discuss with you in detail because I can best describe it as using assumptions that have little basis in fact. I could go assumption by assumption with you

and go through that. I would be happy to provide information on that. The other study—now, this is a group that is opposed to this provision—estimated the additional costs of these provisions at just under a billion dollars in the context of total health care premiums. That is three-tenths of 1 percent. They came in right where Muse and Associates did—very little difference.

So that, too, supports our contention that these are important protections, with very little additional cost.

Senator SPECTER. Well, we thank you all. The subcommittee would be interested in any additional data that you could provide on how many people will fall out of plans and will not have any coverage at all, so that they do not get some care, what the factor is there. We have to make a public policy judgment as to what ought to be required.

The cases of Mrs. Corcoran and others are very heart-rendering and very compelling. We want to know what the incidence is of such cases which are like Mrs. Corcoran's. And we also want to know what the cost would be as to how many people would drop out of plans and not have any care at all, the other side of the coin, of lack of care.

This is a very complex question, and we have obviously only scratched the surface. But I think that it is important to proceed, to find out what we can about the hard facts, which will enable the Congress to make an informed judgment.

#### CONCLUSION OF HEARING

Thank you all very much for being here, that concludes our hearing. The subcommittee will stand in recess subject to the call of the Chair.

[Whereupon, at 1:40 p.m., Thursday, May 14, the hearing was concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]

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