Texas Jury Verdict Suggests Way for Plaintiffs to Get Around ERISA Preemption

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On July 1, 2005, a Texas jury awarded the husband and children of a San Antonio woman $7.4 million in their wrongful death suit against her physician, his practice group, and Humana Health Plan of Texas, Inc. Humana was the health maintenance organization (“HMO”) that administered the health plan provided to Joan Smelik through her husband’s employer, Southwest Forklift, Inc. This is an important fact because individuals who sue an employer-sponsored plan are frequently frustrated by a federal law, the Employee Retirement Income Security Act of 1974 (“ERISA”).1 Here, the jury found Humana to be responsible for 35 percent of the actual damages. In addition, Humana must pay punitive damages of $1.6 million, bringing the HMO’s total obligation to the plaintiffs to more than $4 million. While it is not unusual for the family of a deceased patient to win a judgment against the treating physician, ERISA has made a judgment against an HMO far less common.

The Smelik family contended that Humana failed to properly supervise the physicians with whom they contracted, resulting in the provision of substandard care to Mrs. Smelik. In addition, they charged Humana with negligence and fraud based on several theories of liability, including failure to identify Mrs. Smelik as a candidate for case management, negligent provision of case management, negligent pharmacy management, negligent discharge planning, and negligence in keeping accurate medical records.

Case management is a service that HMOs and other managed care organizations frequently make available to patients with multiple or complicated medical problems.2 Typically, the HMO identifies candidates for case management through a review of members’ utilization of medical services.3 The Smeliks maintained that Humana’s own policy of identifying members with complex, “chronic or potentially catastrophic” diseases should have ensured that Mrs. Smelik received case management.4 To support

2 The Commission for Case Manager Certification certifies candidates who meet specified education and licensing requirements and who pass an examination. To be eligible for case manager certification a candidate must have completed, at a minimum, “a post-secondary degree program in a field that promotes the physical, psychosocial, or vocational well-being of the persons served.” Case managers are responsible for patient education, advocacy, coordination of medical care, and assisting in procurement of community services. For a description of case management, see the Commission for Case Manager Certification Glossary of Terms and Reference List, available at [http://www.cmcertification.org/index.html](http://www.cmcertification.org/index.html) (last visited May 6, 2006).
4 News Reports, Jury Awards $7.4 Million in Wrongful Death Lawsuit Against Humana HMO, PRNEWSWIRE, July 21, 2005, available at
their assertion, the Smeliks’ attorneys introduced testimony that Mrs. Smelik had “emphysema, kidney disease, and a circulatory condition that affected [her] kidneys.”

In fact, her case actually received the attention of a case manager for a short period of time. Humana had a contract with Alamo City Medical Corp. to provide case management services to Humana enrollees, and Alamo identified Mrs. Smelik as needing this service. Humana, however, did not renew its contract with Alamo, instead bringing management of complicated cases “in house.” It was at this point, the family alleged, that Humana failed to provide the necessary oversight. Specifically, Humana approved prescription drugs contraindicated in a patient with kidney disease. As a result, Mrs. Smelik died from complications of renal failure in May 2001. This is the precise type of outcome that case management is designed to guard against.

The Smelik case is important because, if upheld on appeal, it may identify a new set of circumstances that gives rise to a state law cause of action against an HMO that is not preempted by ERISA. As one of the family’s attorneys, Renee F. McElhaney, stated, “This case sends a clear message that when an HMO promises to manage care, then they have to do it. And when HMOs fail to do that, the court system will hold them responsible.” On the other hand, the Smelik case may merely stand for established ERISA law, which holds that a medical malpractice action is not preempted by ERISA.

The question becomes whether an appellate court will view the Smeliks’ allegations as negligent performance of case management, the equivalent to malpractice, or a claim


6 According to the Smeliks’ attorney, “Mrs. Joan Smelik was a complex patient who according to Humana never hit the ‘triggers’ to qualify for case management. Humana’s own computer records for Mrs. Smelik showed that Humana knew of her diseases even down to the size of each of her small kidneys, which were indicative of ‘chronic’ kidney disease. Ms. Smelik had a documented episode of acute renal failure attributed in part to the effects on her kidneys of a combination of three drugs, specifically a NSAID agent [non-steroidal anti-inflammatory drug], a diuretic, and an ACE inhibitor in September 2000. Then, Humana approved Vioxx, an NSAID type drug, in January 2001, and later approved the purchases of the exact same three-drug toxic cocktail of prescription drugs that had put Joan Smelik into renal failure five months earlier.”

7 ERISA’s preemptive power is exceptional. ERISA Section 514(a) pre-empts “any and all State laws insofar as they may now or hereafter relate to any employee benefit plan” governed by ERISA. 29 U.S.C. § 1144(a) (2006). In addition to § 514(a) express pre-emption, the U.S. Supreme Court has held that ERISA pre-empts state law claims that could have been brought under ERISA § 502. Pilot Life v. Dedeaux, 481 U.S. 41 (1985).

8 Id.

9 Dukes v. U.S. Healthcare, Inc., 57 F.3d 350 (3rd Cir. 1995) (finding “that a claim about the quality of a benefit received is not a claim under § 502(a)(1)(B) to ‘recover benefits due ... under the terms of [the] plan.’ ”) Id. at 357; see also Furstonberg v. Mintz, 170 F.Supp.2d 695 (N.D.Tex. 2001) (holding that plaintiffs’ claims against their doctors and the related insurance companies and hospitals [do not] challenge the administration of or eligibility for benefits, which are completely preempted under § 502. The state law claims “challenge the quality of the medical treatment performed, which may be the subject of the state action.”) Id. at 698.

10 Dukes, 57 F.3d at 357.
for denial of the case management benefit altogether, a benefit determination. If it is the former, then Humana cannot prevail, as the appellate courts have carved out an exception to ERISA preemption for medical malpractice claims.12 If the latter, however, it seems reasonable to assume that Humana will succeed in having the verdict overturned on appeal on the ground that the state court lacked jurisdiction to hear the case.13

The most intriguing possibility would arise if the appellate courts characterize the allegations as something other than denial of a benefit or negligent provision of a benefit. The Smeliks argued that Humana had a duty not only to provide case management but also to identify Joan Smelik as a candidate for this benefit based on Humana’s own case management criteria. There is no prior case law analyzing ERISA preemption in light of an HMO’s failure to identify a potential beneficiary of case management. In its most recent opinion on ERISA preemption, the U.S. Supreme Court held that the claim brought by a patient who was injured when plan administrators refused to cover a prescribed medication was merely a denial of benefit claim, preempted by ERISA.14 The Supreme Court stressed the fact that Mr. Davila could have purchased the medication himself and brought a suit under ERISA to recover the cost.15 Applying this analysis, Mrs. Smelik could be just another plaintiff who was denied a benefit. Up to this point, however, the Supreme Court has considered only cases where a benefit was affirmatively denied and where the injured party knew a benefit was denied. In Mrs. Smelik’s case, it is uncertain that she knew or could have known that she fit Humana’s criteria and was thus entitled to case management services. Further, it is unclear whether she could have purchased the service herself.16

Another interesting question raised by this case is why Humana never removed to federal court. A common strategy for health plan defendants in ERISA cases is to remove to federal court and invoke ERISA preemption of state law. Failure to remove becomes especially confusing given that counsel for Humana was very familiar with ERISA law based on its representation of one of the HMOs involved in Roark v. Humana,17 a Fifth Circuit case that the U.S. Supreme Court later decided under the name Aetna v. Davila.

11 Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (holding that suits involving improper processing of claims for benefits are “regarded as arising under the laws of the United States,” and subject to jurisdiction of the federal courts); Aetna v. Davila, 542 U.S. 200 (2004) (holding that claims for denial of benefits are preempted by ERISA’s 502(a)).
12 Dukes, 57 F.3d at 357; Mintz, 170 F.Supp.2d at 697-98.
13 Metropolitan Life v. Taylor, 481 U.S. 58 (1987) Under ERISA’s complete preemption doctrine, a claim that could have been brought under 502(a)(1)(B) is a claim arising under federal law, regardless of how it is plead and defendant can remove a claim filed in a state court to federal court. The rationale for complete preemption is that Congress so completely preempted an area of law that any claim within in it must be brought under federal law. Id. at 66-67.
15 Id.
16 Complex Case Management Available, supra note 3 (advising that “physicians cannot refer patients to the [case management] program (patients will be identified by case managers depending on their condition/diagnosis/need for post-discharge services”).
17 Roark v. Humana, Inc., 307 F.3d 298 (5th Cir. 2002). Counsel for Humana in the Smelik case, Steven R. Shaver of Wilson, Elser, Moskowitz, Edelman & Dicker, Dallas, TX, also represented CIGNA Healthcare of Texas Inc. in Roark.
One reason might be that Humana’s counsel genuinely believed that the case was purely a claim for malpractice and legitimately belonged in state court. This is contradicted, however, by Humana’s post-judgment motion asking the court to disregard the verdict based on ERISA preemption. At the outset of the Smelik case Humana may have been relying on the Fifth Circuit’s December 2002 decision in Roark, which held that a claim alleging denial of benefits is a malpractice claim and that, because ERISA does not provide a tort remedy against managed care plans, it does not block states from doing so. Under Roark, the case may have looked like a malpractice claim that would not fall under ERISA at all. Was Humana simply a victim of bad timing, relying on a case that had not been overturned when the litigation began? This raises yet another question. Why did Humana not remove in June 2004 when the Supreme Court reversed Roark with its Davila opinion? The Smelik jury trial did not even begin until the summer of 2005.

Smelik v. Mann, at least at this stage of the litigation, leaves many unanswered questions. Some of these questions may be easier to answer as the facts become available. Others may require the analysis of appellate courts, possibly the Supreme Court, to place Smelik in its rightful place in the ERISA scheme. Attorneys, legislators, and others interested in health law and policy will most definitely be watching as this case progresses through the appeals process.

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18 Id.
19 Id.