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Education and the Constitution: Shaping Each Other & the Next Century

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MANAGED CARE ORGANIZATIONS MANAGE TO ESCAPE LIABILITY: WHY ISSUES OF QUANTITY VS. QUALITY LEAD TO ERISA'S INEQUITABLE PREEMPTION OF CLAIMS

I. INTRODUCTION

Not long ago the notion of managed care was an unfamiliar concept for most Americans. Today, however, phrases such as "primary care physician," "health maintenance organization," and "provider network" are part of the healthcare vernacular.[1] In corporate takeover fashion, the traditional fee-for-service delivery of medicine in the United States has been dismantled, giving way to imposing health care giants in the shape of managed care organizations ("MCOs").[2] Marketed as a cost-effective means of delivering healthcare services, MCOs have revolutionized the medical industry in the form of health maintenance organizations ("HMOs"), preferred-provider organizations ("PPOs"), and other variations of networked group health plans.

This paradigm shift to providing cost-effective "corporate" healthcare leads many to question the price patients pay when third-party review boards determine the scope of their

[1] Heather Hutchinson, Note, *The Managed Care Plan Accountability Act*, 32 IND. L. REV. 1383, 1384 (1999). Managed care is experiencing widespread growth across the United States with more than 45 million Americans enrolled in managed care organizations [hereinafter MCOs] *Id.* at 1385. An escalating number of Americans are affected by MCOs and their administration of healthcare as more than 70 percent of American workers and their families are covered by managed care health plans. *Id. See also* Phyllis C. Borzi, *The Evolving Role of ERISA Preemption and Managed Care: Current Issues of Importance to Employers, Fiduciaries and Providers*, Q286 A.L.I.-A.B.A. 17, 19 (1999) (noting that U.S. Department of Labor statistics reveal that 72 percent of the workforce, nearly two-thirds of the entire non-elderly population, is covered under group health plans subject to ERISA).

[2] For purposes of this comment, the term "MCOs" refers to group health plans such as health maintenance organizations (HMOs) or preferred-provider organizations (PPOs), which offer a wide-range of healthcare services at a fixed price by employing cost-containment mechanisms such as capitation, utilization reviews, and referral restrictions. *See* Joan H. Krause, *The Role of the States in Combating Managed Care Fraud and Abuse*, 8 ANNALS HEALTH L. 179, n.11

medical treatment in place of their personal physicians. Issues surrounding medical accountability and liability have also arisen with the emergence of MCOs, as unwary patients find themselves without a legal cure for injuries wrought by their health benefit plans.

In evaluating patients' potential legal remedies, this Comment explores 1) the emergence of managed care organizations in the United States; 2) the creation of the Employee Retirement Income Security Act of 1974 ("ERISA") and how it impacts patients' claims against their MCOs; 3) the question of "quantity" versus "quality" in evaluating whether ERISA preemption exists; 4) three theories (direct liability, breach of fiduciary duty, and vicarious liability) used to hold MCOs liable for injuries resulting from malpractice or the wrongful denial of benefits; 5) state legislative attempts to circumvent ERISA's inequitable preemption of claims; and 6) why, given ERISA's failure to safeguard employees, new federal legislation is necessary to protect participants in managed care organizations.

II. The Emergence of Managed Care Organizations

A. Traditional Fee-For-Service Healthcare

Until the late 1980s, the concept of managed care was relatively obscure in the United States.[3] The predominant form of healthcare for Americans was the fee-for-service model.[4]

(1999).

[3] Borzi, *supra* note 1, at 20 (1999) ("Although some staff model HMOs existed (particularly in California where Kaiser was popular), the wide variety of managed care organizations available in the marketplace today, including provider-owned networks, were not in existence or were not readily accessible to most Americans.") *See also* Corrine Parver & Kimberly Alyson Martinez, *Holding Decision Makers Liable:*

Under this traditional plan, a patient would go to whichever physician she chose, and the insurance company would pay for the patient's healthcare services, regardless of the physician she selected.[5] Without influence exerted by the patient's insurance company, the physician determined the type and extent of his patient's treatment, and the insurance company paid him an amount based upon the physician's individual fee structure.[6]

The fee-for-service plan opened itself up for abuse, however, because physicians' income levels rose in direct proportion with the number of services they provided.[7] Critics of the fee-for-service concept accused physicians of "overtreating" patients by providing unneeded services and subjecting patients to extraneous tests simply to make more money.[8] As the prevalence of medical malpractice suits grew in the late 1970s and 1980s, the fee-for-

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Assessing Liability Under a Managed Health Care System, 51 ADMIN. L. REV. 199, 204 (1999) (noting that the Kaiser Foundation offered its first health care plans in the mid-1930s, but the rapid expansion of HMOs did not occur until 1973 when Congress passed the Health Maintenance Organization Act, which permitted many HMOs to obtain federal grants and loans).

[4] *See* Ryan Steven Johnson, Note, *ERISA Doctor in the House? The Duty to Disclose Physician Incentives to Limit Health Care*, 82 MINN. L. REV. 1631, 1635 (1998). *See also* Jack K. Kilcullen, *Groping for the Reins: ERISA, HMO Malpractice, and Enterprise Liability*, 22 AM. J.L. & MED. 7, 15-16 (1996) (noting that until the 1920s, patients paid their physicians directly for medical services rendered, and that private insurance companies emerged after the Great Depression when the American Hospital Association established service-benefit plans under which subscribers were reimbursed by a third-party payor for hospital care costs).

[5] Hutchinson, *supra* note 1, at 1384 (1999). *See also* Parver *supra* note 3, at 201-202 (noting third-party payors' increasing importance in the 1970s as health insurance companies evolved and began paying doctors on a "fee-for-service" basis for services rendered).

[6] Stephen R. Latham, *Regulation of Managed Care Incentive Payments to Physicians*, 22 AM. J.L. & MED. 399, 400 (1996). *See also* E. Haavi Morreim, *Redefining Quality by Reassigning Responsibility*, 20 AM. J.L. & MED. 79, 81 (1994) (stating that under the traditional fee-for-service system, physicians were unhindered by outside influence, and they determined their patients' needs without considering the costs of those services). *But see* Marcia Angell, *Cost Containment and the Physician*, 254 JAMA 1203, 1205 (1985) (noting that physicians' widespread use of unnecessary tests contributed to increasing healthcare costs).

[7] Johnson, *supra* note 4, at 1635. *See also* Kenneth R. Pedroza, *Cutting Fat or Cutting Corners, Health Care Delivery and Its Respondent Effect on Liability*, 38 ARIZ. L.REV. 399, 404 (1996) (noting that healthcare costs skyrocketed largely because of the fee-for-service reimbursement system, physicians' practice of overtreating patients to avoid lawsuits, and the emergence of new technologies in the medical industry).

[8] Krause, *supra* note 2, at 181-82 (discussing physicians' financial incentives to overtreat their patients in an

service plan was also criticized for encouraging "defensive" medicine, a practice used to thwart malpractice lawsuits by providing superfluous medical services.[9]

B. Making Way for Managed Care

Concerns about physicians "overtreating" patients for profit grew. Amidst widespread allegations of insurance abuse in fee-for-service medical practices, managed care organizations moved in, vowing to eradicate high-priced medicine.[10] Tired of the astronomical expense of traditional healthcare plans, employers welcomed MCOs with open arms, eager to believe promises to reduce the cost of providing health care benefits to their employees.[11]

Today, according to the U.S. Department of Labor, more than 125 million Americans rely on more than 2.5 million group health plans for medical coverage.[12] With more than 70 percent of the American workforce and their families enrolled in MCOs, issues concerning patients' rights and the quality of care received under managed care plans affect the majority of the U.S. population.[13]

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attempt to boost their own incomes). *See also* Jason Mark, *HMO Liability: Medical Decisions Made in the Corporate Boardroom*, MASS. LAW. WKLY., June 30, 1997, at B25.

[9] Parver, *supra* note 3, at 202 (noting that critics of the fee-for-service system also accused physicians of practicing "defensive" medicine, i.e. providing unnecessary medical services to avoid malpractice suits). *See also* Pedroza, *supra* note 7, at 402 n.21 (stating that in the United States defensive medicine may cost $25 billion each year). *But see* Peter A. Glassman et al., *Physicians' Personal Malpractice Experiences Are Not Related to Defensive Clinical Practices*, 21 J. HEALTH POL. POL'Y & L. 219, 233-34 (1996) (suggesting that defensive medical practices may not be as common as previously thought).

[10] Hutchinson, *supra* note 1, at 1384. *See also* Parver, *supra* note 3, at 202 ("With health care costs threatening to bankrupt the county, managed care has become a reality.").

[11] *See* Julie K. Locke, *The ERISA Amendment: A Prescription to Sue MCOs for Wrongful Treatment Decisions*, 83 MINN. L. REV. 1027, 1031 & n.21 (1999). By the late 1980s, national medical spending accounted for nearly 12 percent of the Gross National Product, totaling $604 billion. *See also* Krause, *supra* note 2, at 181 (stating that "[w]hile health care made up only five percent of the Gross National Product in 1950, it reached twelve percent in the early 1990s, and is predicted to grow to fifteen percent by the year 2000.").

[12] Borzi, *supra* note 1, at 19.

[13] Hutchinson, *supra* note 1, at 1385.

C. How Managed Care Works

While MCOs may provide employers with less expensive health care benefit plans, the cost-cutting methods employed by MCOs have garnered tremendous criticism.[14] MCOs reduce costs by limiting *who* can provide medical services (establishing a provider network); by monitoring *what* type of services are available (requiring pre-certification processes, utilization reviews, and "gag clauses"); and by restructuring *how* healthcare providers make money (employing capitation, risk-sharing arrangements, and other incentives for reduced specialist referrals).[15]

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[14] *See, e.g.,* Jane M. Mulcahy, *The ERISA Preemption Question: Why Some HMO Members are Dying for Congress to Amend ERISA*, 82 MARQ. L. REV. 877, 898 (1999) (stating that Americans are in favor of allowing patients to sue HMOs for malpractice because they believe economic incentives created by HMOs are responsible for decreased patient care); Eleanor D. Kinney, *Behind the Veil Where the Action is: Private Policy Making and American Health Care*, 51 ADMIN. L. REV. 145, 156 (1999) (discussing the concern generated by MCOs because they encourage physicians to limit care); Debra S. Wood, *Risky Business: Lending to Health Maintenance Organizations and Physician Practice Management Companies*, 1 N.C. BANKING INST. 322, 350 (1997) (noting the common perception that HMOs' cost-containment mechanisms result in decreased quality of care for HMO patients); Julie A. Martin & Lisa K. Bjerknes, *The Legal and Ethical Implications of Gag Clauses in Physician Contracts*, 22 AM. J.L. & MED. 433, 439 (1996) (arguing a decline in patient care due to HMO-created conflicts between a physician's desire to treat patients and the economic incentives offered for limiting treatment); David Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155, 158-59 (1996) (discussing the limitations MCOs place on physicians' abilities to thoroughly treat patients); Susan R. Martyn & Henry J. Bourguignon, *Physician-Assisted Suicide: The Legal Flaws of the Ninth and Second Circuit Decisions*, 85 CAL. L. REV. 371, 424 (1997) (studies reveal patients are less satisfied with HMO-provided care than with care provided in fee-for-service arrangements). *But see* Maxwell J. Mehlman, *Medical Advocates: A Call for a New Profession*, 1 WIDENER L. SYMP. J. 299, 301 (1996) (asserting that patients enrolled in MCOs receive the same care or better quality care than patients enrolled in fee-for-service programs).

[15] As discussed *supra* at note 2, MCOs in this Comment refer to group health plans which offer a wide-range of health care services at a fixed price by employing capitation, utilization reviews and specialist referral restrictions as cost containment mechanisms. The terms HMO and PPO are specific breeds of MCOs, but there are variations amidst even these species that can be confusing. There are three different HMO models: the staff model, the independent practice association model (IPA), and the group model. The staff model includes providers who are salaried employees of the HMO. The IPA model consists of physicians who contract with an HMO to provide services to the HMO's members, although IPA physicians may treat other non-HMO affiliated patients as well. Under the IPA model, the physicians are paid a fee based on the services rendered or by capitation, a method by which a physician is paid a fixed amount per HMO patient irrespective of the quantity of services they provide. The group model usually includes a contract between the employer and a medical group affiliated with the HMO to provide medical services to its employees.

Under the group model, the medical group receives compensation from the HMO on a capitation basis, i.e. a fixed amount per plan member regardless of the amount of services the physician provides. It should be noted that these types of HMOs are not set in stone, and some HMOs have varying characteristics of all three. In addition to the HMO varieties of MCOs, a PPO is another type of managed care entity. Under the PPO model, physicians, hospitals, and other healthcare providers join together to provide services to enrollees who usually pay a premium to the PPO. The PPO, in turn, compensates the health care providers for the treatment they provide PPO enrollees. Christine E. Brasel, *Managed Care Liability: State Legislation May Arm Angry members with Legal Ammo to Fire at Their MCOs for Cost Containment Tactics¼But Could it Backfire?*, 27 CAP. U. L. REV. 449, 451-52 (1999).

The majority of managed care plans seeking to "manage" healthcare costs begin by establishing a limited network of providers.[16] These MCOs contract with specific doctors and hospitals to provide healthcare services for plan participants.[17] This is the MCO's first layer of insulation, as providers are directly responsible for supplying healthcare to plan members as agreed upon in their contract with the MCO.[18] Physicians are not reimbursed for any costs or services provided above and beyond those expenses authorized by the MCO.[19] This tactic shifts the risk of excess costs and medical services to those providers, thereby furnishing physicians with a financial incentive to limit treatment to those procedures deemed "strictly medically necessary."[20]

After establishing *who* may provide medical services, MCOs then limit *what* types of healthcare services are covered.[21] This next step involves multiple levels of monitoring the

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[16] Frank Cummings, *ERISA Litigation: An Overview of Major Claims and Defenses*, SD89 A.L.I.-A.B.A. 1, 53 (1999). An HMO offers plan participants a list of "primary care physicians" from which the enrollee must select a physician who will provide his or her healthcare services and make all determinations regarding referrals to other specialists in the plan's network.

[17] *Id*. In typical employer offered group health plans, the employer pays premiums to an HMO for "coverage" of employees and their eligible dependents.

[18] *See* Jeffrey E. Shuren, *Legal Accountability for Utilization Review in ERISA Health Plans*, 77 N.C. L. REV. 731, 739-40 (1999).

[19] Krause, *supra* note 2, at 181. ("The primary cost containment strategy has been to replace providers' traditional incentives to maximize the volume of services provided with incentives designed to do the opposite—generally by putting physicians at 'financial risk' for the costs of services they provide or initiate.").

[20] Shuren, *supra* note 18, at 739-40 & n.92. "Medically necessary" and "medically appropriate" refer to an MCO's particular utilization review guidelines and not to what the medical community considers necessary or appropriate care for that patient. *Id.* Retrospective utilization review typically makes "medically necessity" determinations as to whether a proposed treatment is necessary for a medical reason, but not whether the particular treatment is the most appropriate. *Id.* Prospective utilization review, on the other hand, usually determines whether the proposed therapy is both necessary and appropriate. *Id.* Because prospective utilization reviews are a key MCO cost-containment technique, they are the type of utilization review focused on in this comment.

[21] Hutchinson, *supra* note 1, 1386 & n.9 (noting that MCOs are usurping physicians' determinations regarding treatment). *See also* Gregg Easterbrook, *Healing the Great Divide: How Come Doctors and Patients End Up on Opposite Sides?*, U.S. NEWS & WORLD REP., Oct. 13, 1997, at 64. "You can't do

treatment that a patient receives. MCOs often require their participants to obtain pre-certification or pre-authorization *before* undergoing certain procedures.[22] The MCO may then conduct utilization reviews,[23] or external evaluations of medical decisions, to ascertain whether the proposed treatment is "medically necessary."[24] The end result of these reviews can be devastating if a MCO determines that a physician's recommended treatment is unnecessary or "experimental," or if these external reviews recommend less expensive treatment and there is disagreement over whether such treatment would accomplish the same purpose as the

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anything anymore without first calling an 800 number where someone with a high-school education asks you to spell out the diagnosis," according to Quentin Young, a Chicago physician and president-elect of the American Public Health Association. *Id.*

[22] Parver, *supra* note 3, at 205 (noting that whereas retrospective utilization review assesses a claim after medical treatment has been given, not significantly altering the quality of care a patient receives; prospective review occurs prior to rendering treatment, and plays a pivotal role in the level of care a patient receives because treatment is denied until questions of payment are settled). *See also* Brasel, *supra* note 15, at 452-53 (discussing the departure from past practices where treatment was reviewed after it had been rendered); *and* Carla Jensen Hamborg, *Medical Utilization: The New Frontier for Medical Malpractice Claims?*, 41 DRAKE L. REV. 113, 138 (1992) (stating that the review of proposed treatments before they are administered plays an important role in the cost containment function of HMOs).

[23] Parver, *supra* note 3, at 205 (stating that utilization reviews refer to "external evaluations that are based on established clinical criteria and are conducted by third-party payors, purchasers, or health care organizers to evaluate the appropriateness of an episode, or series of episodes, of medical care."). Utilization management entails three principal elements: benefit design, quality control, and health services delivery. *See* Susan J. Stayn, *Securing Access to Care in Health Maintenance Organizations: Toward a Uniform Model of Grievance and Appeal Procedures*, 94 COLUM. L. REV. 1674, 1679 (1994). By designing a benefits package that covers only medically necessary care, monitoring the plan's resources and providers, and assessing physicians' performance through a quality assurance program, utilization management controls costs prospectively. *Id. See also* Cheralyn E. Schessler, Comment, *Liability Implications of Utilization Review as a Cost Containment Mechanism*, 8 J. CONTEMP. HEALTH L. & POL'Y 379, 391 (1992) (noting that in general utilization review organizations seek to combine quality control and cost containment to create guidelines for appropriate care while eliminating over utilization of medical services).

[24] Mulcahy, *supra* note 14, at 890-91. Despite the fact that these utilization review procedures often override a physician's medical recommendation in an effort to cut costs, these reviews are spun to plan participants as measures that improve the "quality of care by eliminating medically unnecessary treatment." *Id. See also* Shuren, *supra* note 18, at 744-45 (discussing how utilization reviews infringe on what was previously the physician's sole domain); Parver, *supra* note 3, at 205-06 (noting that prospective utilization reviews are divided into pre-admission reviews and concurrent reviews: the standard for reviewing medical treatments under a pre-admission review is whether the procedure is "medically necessary"; under concurrent reviews third-party payors are allowed to assess a patient's progress and evaluate the need for additional treatment while the patient receives ongoing care).

physician's prescribed care.[25]

In addition to rampant dissatisfaction with the purpose and effect of prospective utilization reviews, patients and physicians alike also consider "gag clauses" to be among MCOs' most offensive limitations on available medical services.[26] These provisions restrict a physician from discussing forms of available treatments with patients until *after* the MCO has approved the medical services.[27] If a particular course of treatment is not covered under an MCO plan that employs such "gag clauses," the physician is forbidden from counseling the patient on options outside the MCO's scope of coverage.

After limiting access to specific providers and curtailing the types of medical treatment available, the final -- and seemingly most effective -- cost-cutting mechanism employed by MCOs involves fee structures designed to reward physicians for restricting medical services to

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[25] Brasel, *supra* note 15, at 453. *See also* O. Mark Zamora, *Medical Malpractice and Health Maintenance Organizations: Evolving Theories and ERISA's Impact*, 19 NOVA L. REV. 1047, 1055 (1995) (noting contentious disagreement about what types of treatment MCOs consider as accomplishing the same purpose); *and* Mark A. Hall & Gerald F. Anderson, *Models of Rationing: Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637 (1992) (concluding that courts look at the following three factors in evaluating "medical necessity": 1) if a doctor orders the treatment; 2) if the treatment is recognized as appropriate according to the common custom; and 3) if the treatment is not experimental, educational or primarily research-oriented).

[26] David Trueman, *As Managed Care Plans Increase, How can Patients Hold HMOs Liable for Their Actions?*, 71-FEB N.Y. ST. B.J. 6, 27 (1999). In *Weiss v. CIGNA Healthcare, Inc.*, the U.S. District Court for the Southern District of New York permitted a claim against an HMO alleging breach of fiduciary duty arising from its "gag order" clause. 972 F. Supp. 748 (S.D. N.Y. 1997). The court ruled that the plaintiff could proceed on her claim that the gag clause was a breach of the plan's fiduciary duty, finding that "CIGNA's alleged policy of restricting the disclosure of non-covered treatment options would, if true, directly undermine the ability of plan participants to have unfettered access to all relevant information relating to their physical or mental condition and treatment options." The court, however, dismissed plaintiff's claims for both breach of fiduciary duty and breach of good faith and fair dealing relating to the allegation that the financial arrangement pressured physicians to forego medical treatment in order to increase profits. *Id.*

[27] *See* Trueman, *supra* note 26, at 27 (discussing the *Weiss* court's commentary cautioning that risk-sharing arrangements are not inherently illegal, and that the HMO's cost-cutting motive did not make it inevitable that physicians would undertreat patients to maximize profits).

"no-frills" health care.[28] Through common capitation plans, MCOs pay a physician, or a practice group, a flat rate for each plan participant regardless of the amount of care or services provided in a particular month.[29] MCOs detach themselves from financial jeopardy even further by implementing risk-sharing arrangements that allow them to withhold a percentage of the physician's monthly capitation payment, pool it with that of other providers, and use it to pay for specialist referrals, lengthy hospital stays, expensive medical tests or procedures, and other unanticipated expenses.[30] The underlying rationale of these cost-containment efforts is to furnish providers with economic incentives to act as gatekeepers for the MCOs.[31]

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[28] Alison Farber Walsh, Comment, *The Attack on Cost Containment: The Expansion of Liability for Physicians and Managed Care Organizations*, 31 J. MARSHALL L. REV. 207, 216-18 (1997). *See also* Laura H. Harshbarger, Note, *ERISA Preemption Meets the Age of Managed Care: Toward a Comprehensive Social Policy*, 47 SYRACUSE L. REV. 191, 221 (1996) (stating that of 2,000 physicians surveyed, 83.6 percent of those physicians who are MCO members and 92 percent of those who are not MCO members indicated that financial incentives diminish the quality of care patients receive). *See also* Parver, *supra* note 3, at 206. Because of the influence exerted by managed care organizations, third-party payors are increasingly paying physicians and other health-care providers either a set salary, a fixed fee for certain services or a capitation fee. *Id.* Utilization reviews are also employed by managed care organizations to keep health care costs down. *Id.* These payment mechanisms or utilization review procedures limit a physician's ability to exercise independent professional judgment and potentially expose the physician and the paying entity to tort liability, because these cost-containment procedures diminish the physician's control over the patient's care. *Id.*

[29] *See* Walsh, *supra* note 28, at 218 (noting the financial incentive for physicians to limit the amount of medical services they provide to their patients). *See also* Vernellia R. Randall, *Managed Care, Utilization Review, and Financial Shift Risking: Compensating Patients for Health Care Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1, 31-32 (1993) (stating that because capitation forces the provider to shoulder personal loss, it produces the greatest risk of undertreatment because the provider receives no reimbursement for providing additional services, but is instead responsible for covering costs in excess of the capitation fee).

[30] Locke, *supra* note 11, at 1032 & n.25. *See also* Walsh, *supra* note 28, at 219-20 (discussing the "payment incentives" that MCOs use to encourage limiting medical services, especially specialist referrals, that physicians provide patients); *and* Randall, *supra* note 29, at 30 (noting that MCOs induce financial risk shifting through an assortment of arrangements such as ownership interest, joint venture, bonus arrangements, rewards, penalties, or a combination thereof).

[31] Randall, *supra* note 29, at 31-32 (concluding that providers will offer services to patients in accordance with payer guidelines or else risk incurring financial losses). *See also* Parver, *supra* note 3, at 206-07 (noting that when a doctor's judgment regarding appropriate medical treatment is artificially controlled by a third party, such as an MCO, by means of cost-containment procedures it is patently unfair to hold only the doctor liable).

III. ERISA PREVENTS PLAINTIFFS FROM RECOVERING AGAINST MCOS

A. ERISA's Noble Purpose

Generally, patients injured by medical malpractice can sue their doctors, hospitals, or other alleged wrongdoers under state law.[32] But a person's lawsuit will be barred if the individual's malpractice claim depends upon the terms of a health benefit plan that is covered by the Employee Retirement Income Security Act of 1974 ("ERISA").[33] Congress originally enacted ERISA as a protective measure for American workers.[34] Although primarily intended to safeguard workers' pension plan assets from corporate and union misappropriation, the legislative provisions encompassed *all* employer-sponsored health benefit plans, except where the employer is a government or church entity.[35]

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[32] Armond Budish, *You and the Law: Do You Have the Right to Take an HMO to Court?*, THE PLAIN DEALER, October 24, 1999, at K8.

[33] 29 U.S.C.S. § 1001 (1994). *See also* Budish, *supra* note 32, at K8 (noting that ERISA was adopted to provide a uniform set of rules to govern employee benefit plans, including health plans. "To avoid a patchwork of state regulations, ERISA supersedes all state laws and bars lawsuits that relate to employee benefit plans.") "Patients enrolled in ERISA-regulated MCOs have no remedy and no adequate right of recourse when their MCOs negligently provide care, because ERISA preempts the patients' causes of action. ERISA enrollees can only recover the value of the benefit denied, an inadequate remedy for a patient who has been seriously injured or has died due to the negligence of an MCO." Parver, *supra* note 3, at 207.

[34] Budish, *supra* note 32, at K8 (stating that "ERISA allows lawsuits 'to recover benefits' or to 'enforce rights under the terms of the plan.' But recovering benefits is very different from recovering damages for medical malpractice."). *See also* Blaine Hummel, *The Duty of Ordinary Care for HMOs: Can Texas Senate Bill 386 Weather the Storm of ERISA Preemption?*, 18 REV. LITIG. 649, 651 (1999). Discussion of the rapid growth of employee benefit plans that prompted the legislative enactment. ERISA's purpose was "to protect interstate commerce and the interests of participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to Federal Courts." *Id.*

[35] 29 U.S.C.S. §§ 1002(1)(3) (1994). An employee welfare benefit plan is defined by ERISA as any plan, fund, or program established or maintained by an employer or an employee organization for the purpose of providing "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services: to its participants or their beneficiaries. *Id.* §1002(1). An employee pension benefit plan is similar to a welfare plan except that the pension plan, fund, or program "provides retirement income to employees, or results in a deferral of income by employees for

Intending to establish uniform standards for regulating the administration of benefit plans, Congress also included a broad preemption clause so that ERISA would supersede "conflicting or inconsistent state and local regulations."[36] By enacting ERISA, Congress sought to safeguard employees from unfair benefit plan practices while federally protecting the plans from inappropriate remedies.[37] Rather than living up to its intended protections, however, the legislation's inclusive language has had the practical effect of creating loopholes through which MCOs have largely avoided liability.[38]

B. The Question of Preemption and the "Relate to" Language in ERISA

For more than two decades, courts have scrutinized the language of ERISA's preemption clause.[39] Central to the issue of preemption is whether or not a state law "relates to" an employee benefit plan.[40] Until 1995, it appeared well established by the courts that ERISA

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periods extending to the termination of covered employment or beyond." *Id.* §§ 1002(2)(A). ERISA defines an "employee benefit plan" as "an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan." *Id.* § 1002(3). *See also* Kathy L. Cerminara*, Protecting Participants In and Beneficiaries of ERISA-Governed Managed Health Care Plans*, 29 U. MEM. L. REV. 317, 323 (1999).

[36] 120 Cong. Rec. 29, 197 & 29, 933 (1974) (quoting Senator Williams). *See also* Mulcahy, *supra* note 14, at 878-79.

[37] Mulcahy, *supra* note 14, at 878.

[38] Trueman, *supra* note 26, at 7. *See also* Parver, *supra* note 3, at 200 & n. 5 (concluding that the ERISA loophole denies patients injured by the negligent decisions of ERISA-regulated MCOs the right to hold these MCOs legally accountable for their decisions):

> The cost impact of closing the ERISA loophole on insurance premiums is very low. PricewaterhouseCoopers (PWC) (formerly Coopers & Lybrand) has surveyed the major cost studies concerning the cost of closing the ERISA loophole. All cost studies, including those released by the insurance and business lobbies, agree that closing the loophole will not substantially impact health insurance premiums. PWC determined that the range of estimates for the health insurance premium costs of litigation for the provision is 0.14 to 1.4%.

Id.

[39] Borzi, *supra* note 1, at 21 (discussing the uncertainty surrounding ERISA preemption).

[40] 29 U.S.C.S. § 1144(a). The statute states its provisions "shall supersede any and all State laws insofar as they many now or hereafter *relate to* any employee benefit plan." *Id.* (emphasis added). Section 1003(a)(3) defines employee benefit plans as "any plan, fund, or program" established or maintained by an employer,

preemption was expansive, and that any state statute that impacted employee benefit plans, whether directly or indirectly, would be powerless against its reach.[41] Recent U.S. Supreme Court decisions have chipped away at this wall of judicial precedent, however, and the once overly broad presumption of ERISA preemption appears to be narrowing.[42]

In *Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, Justice Souter reformulated the "relate to" analysis of *Shaw v. Delta Air Lines, Inc.*[43] In the *Shaw* opinion,

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an employee organization, or both, to provide participants and beneficiaries with certain specified benefits. *Id.* Section 1003(a)(1) defines employee welfare benefit plans as plans in which employers provide: "through the purchase of insurance or otherwise, … medical, surgical or hospital care or benefits, or benefits in the event of sickness, accident [or] disability, death, unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services . . . ." *Id.*

[41] Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504 (1981). The claim involved employee pension plans subject to federal regulation under ERISA providing that an employee's retirement benefits shall be reduced or offset by an amount equal to any workers' compensation awards for which the individual was eligible. The plaintiff brought suit contending that the plans, maintained by the defendants, directly conflicted with the provisions in the New Jersey Worker's Compensation Act (NJWCA). The Supreme Court determined that the state law was preempted under 29 U.S.C. § 1144(a) of ERISA, holding that "even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern" and therefore fall within the "relate to" provision of ERISA. *Id.* at 525. *See also* Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97 (1983) (". . . a state law 'relates to' a benefit plan in the normal sense of the phrase, if it has a connection with or reference to such a plan"); Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724 (1985) (relying on the broad scope of preemption from *Shaw* and the indirect effect of *Alessi* to find that minimum mental-health benefits requirement "related to" plan. State law was, however, saved from preemption because of ERISA's insurance savings clause); Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41 (1987) (finding common law tort and contracts causes of action were "related to" employee benefit claim and therefore preempted. Claim was also distinguished from *Metropolitan Life* and not exempt under savings clause); FMC Corporation v. Holliday, 498 U.S. 52 (1990) (finding that state antisubrogation law which interfered with plan design and calculation of benefit levels "related to" plan and was preempted) Ingersoll-Rand v. McClendon, 498 U.S. 133 (1990) (state wrongful discharge claim based on allegation that employer wrongfully discharged employee to avoid contributions under pension plan was preempted because it "relates to" a plan).

[42] *See generally* New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995); California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc., 519 U.S. 316 (1997); DeBuono v. NYSA-ILA Medical and Clinical Serv. Fund, 520 U.S. 806 (1997). *See also* Borzi, *supra* note 1, at 22 ("After *Travelers*, state laws of general application operating in areas of traditional state regulation that do not single out ERISA plans, nor interfere with their administration, are more likely to survive preemption challenges. Importantly the Supreme Court has sent out a strong signal that in evaluating questions of preemption, the necessary analysis involves not only legal principles but factual determinations.")

[43] *See Shaw*, 463 U.S. at 96-97 (". . . a state law 'relates to' a benefit plan in the normal sense of the phrase, if it has a connection with or reference to such a plan").

the Court had determined that a state law "relates to" an ERISA-regulated employee benefit plan "if it has a connection with or reference to such a plan."[44] However, in the unanimous opinion in *Travelers*, Justice Souter retained the "reference to" prong from the twelve-year-old *Shaw* decision, but he substantially altered the analysis involving the "connection with" prong.[45] Justice Souter explicitly narrowed the effect of the Court's earlier *Alessi* decision, which found an ERISA connection where state laws even *indirectly* affected employee benefit plans.[46] In the *Travelers* decision, Justice Souter backed away from the previous judicial interpretation, reasoning that infinite connections would stretch preemption in ways unintended by Congress, and that such limitless "indeterminacy" could not be the measure of preemption.[47]

Because a textual analysis of the ERISA statute provides little guidance, as does the "relate to" provision, the *Travelers* Court expressed the need to "look instead to the objectives of the ERISA statute as a guide to the scope of state law that Congress understood would survive."[48] The Court specifically enumerated as a key ERISA objective the establishment of a "nationally uniform administration of employee benefit plans," heralding that goal as the "basic thrust of the preemption clause."[49]

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[44] *Id.*
[45] Hummel, *supra* note 34, at 659 (noting that through its discussion of "reference to" up until the "connection with" analysis in *Travelers,* the Court remained faithful to the *Shaw* analysis of which state laws might "relate to" an employee benefit plan).
[46] *Alessi*, 451 U.S. at 525 ("even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern" and therefore fall within the "relate to" provision of ERISA).
[47] *Travelers*, 514 U.S. at 655 ("[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for '[r]eally, universally, relations stop nowhere"). *But see Alessi,* 451 U.S. at 525 (holding that "even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern" and therefore fall within the "relate to" provision of ERISA).
[48] Hummel, *supra* note 34, at 659-60. *See also Travelers*, 514 U.S. at 656.
[49] Hummel, *supra* note 34, at 660. *See also Travelers*, 514 U.S. at 657.

After *Travelers*, courts determining whether a state law "relates to" an employee benefit plan must consider a factual analysis that had previously been overlooked during the era of sweeping judicial interpretations of ERISA's preemptive power.[50] If the state law does not specifically refer to an employee plan and if it does not impede a "nationally uniform administration of employee benefit plans," it may be saved from ERISA preemption.[51]

C. Statutory Exemptions from Preemption: ERISA's "Savings" Clause

Like most things in life, ERISA has an exception that "proves" the rule. Although Congress enacted the legislation to protect all employee benefit plans from state interference, the "savings" clause of the statute explicitly saves from preemption any state law regulating insurance, banking, or securities.[52] This exception is responsible for the legislative flurry within states seeking to establish "preemption-proof" insurance laws in response to the current upheaval over issues of health services and managed care.[53]

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[50] Borzi, *supra* note 1, at 22 ("After *Travelers*, state laws of general application operating in areas of traditional state regulation that do not single out ERISA plans, nor interfere with their administration, are more likely to survive preemption challenges. Importantly the Supreme Court has sent out a strong signal that in evaluating questions of preemption, the necessary analysis involves not only legal principles but factual determinations.").

[51] *Id. See also Travelers*, 514 U.S. at 649-56. The Supreme Court's analysis of whether a New York statute imposing surcharges on patients covered by "a commercial insurer but not from patients insured by a Blue Cross/Blue Shield plan" related to an employee benefit plan found the statute was not preempted by ERISA because it did not make any specific reference to ERISA plans and because its connection with employee benefit plans was not such that would disrupt a uniform federally administrated employee benefit plan. *Id.* at 649-60.

[52] 29 U.S.C.S. § 1144(b)(2)(A) ("[N]othing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."). *See also* Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724 (1985). This was the first case in which the Supreme Court determined which laws would be considered the type regulating insurance. The state statute in question required insurers to offer Massachusetts residents, as part of their general insurance policies, minimum levels of mental health benefits. The Court concluded that the statute escaped preemption by virtue of the savings clause. *Id.* at 730-44.

[53] Borzi, *supra* note 1, at 23 ("As states have moved to broaden access to health insurance for the uninsured and to respond to the consumer backlash against managed care, state insurance regulation, including

In addition to insurance, banking, and securities laws, the ERISA "savings" provision also provides statutory exemption for pre-ERISA acts (causes of action which arose prior to January 1, 1975); generally applicable criminal laws; other laws of the United States (i.e., federal laws); the Hawaii Prepaid Health Care Act (under certain circumstances); some state laws concerning multiple employer welfare arrangements; and qualified domestic relations orders.[54]

D. ERISA's "Deemer" Clause

In order to thwart states' efforts to statutorily circumvent ERISA's preemption of state laws relating to employee benefit plans, Congress included within the legislation a "deemer" clause.[55] Designed to prevent states from disguising their regulation of employee benefit plans as mere regulation of insurance, this provision states that:

> [n]either an employee benefit plan, nor a trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust, company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any state purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.[56]

In other words, this ERISA provision prohibits a state law from deeming an employee

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activity involving providers and a new generation of risk-bearing entities, has become a lightening rod for legal challenges based on preemption.").

[54] *Id.* at 23-24.

[55] *Id.* at 24. *See also* Pilot Life Insurance Co. v. Dedeaux, 481 U. S. 41 (1987). In this case, the Supreme Court struck down a state law proving state tort and contracts protections for consumers who had been subject to unfair claims practices by insurers. In finding that this was not a state law regulating insurance, the Court distinguished the facts from those in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985), by taking a literal reading of the term "regulates insurance." The Court found that to be a law regulates insurance it must "not just have an impact on the insurance industry, but must be specifically directed toward that industry." The state statute at issue was therefore preempted under ERISA. 481 U.S. at 50.

[56] 29 U.S.C.S. § 1144(b)(2)(B).

benefit plan to be an insurance company by purporting to regulate the business of insurance.[57] However, the U.S. Supreme Court has permitted state insurance laws to regulate insured plans, just not self-insured plans under the "deemer" clause, thereby affording self-insured plans greater protection from the reach of state laws under ERISA.[58]

E. But Does It "Relate to" an ERISA Plan?

Although many individuals are enrolled in managed care organizations as part of their employer-sponsored health plans, it is important to distinguish the notion of general health plans from the type of employee benefit plan specifically regulated by ERISA.[59] Because only state laws that "relate to" ERISA plans are preempted, it is important to accurately differentiate between the employer-sponsored health benefit plan itself and the MCO as a service provider to the ERISA plan.[60] Courts that fail to closely inspect the facts of claims may falsely categorize state laws regulating MCOs as laws regulating ERISA plans, thereby subjecting the state laws

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[57] Shuren, *supra* note 18, at 754 (discussing the restrictions the "deemer" clause places on state law).
[58] *Id. See also* Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. at 747 (holding that ERISA did not preempt a Massachusetts statute requiring all group health insurance plans and employee health care plans to provide certain minimum mental health care benefits, *except* as the statute pertained to self-insured health plans).
[59] Borzi, *supra* note 1, at n.2 (discussing the confusion between generic health plans and the term of art employer-sponsored benefit plans legislated by ERISA):

> Despite the similarity of terminology, various types of "health plans" such as health maintenance organizations, preferred provider organizations, physician sponsored organizations, and other types of managed care organizations (MCOs) are not "group health plans" under ERISA, but rather vendors to an employer-sponsored group health plan. Rather, under ERISA, these entities are commonly referred to as "health insurance issuers," a term coined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to distinguish them from ERISA-covered employee health benefit plans. HIPAA § 101(a), adding new ERISA §706(b)(2) defines "health insurance issuer" to mean an insurance company, insurance services, or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in a state and which is subject to state law regulating insurance (within the meaning of ERISA section 514(b)(2)). This term does not include a group health plan.

Id.

to wrongful preemption.[61] Prior to preempting state laws, courts must also determine that the law relates to the employee benefit plan rather than simply to an employee benefit.[62]

F. The Ramifications of ERISA Preemption

Despite congressional intent to enact ERISA as a sword for aggrieved workers, ERISA preemption harms individuals by largely shielding MCOs from negligence liability.[63] After plan participants -- or their beneficiaries -- bring state claims against their managed care plans, MCOs generally argue preemption by asserting that the state law "relates to" them as employee benefit plans under ERISA.[64] MCOs then initiate removal of the state claims to federal court under the federal question doctrine.[65]

Plan participants are usually opposed to ERISA preemption because of the statute's limited remedies.[66] Individuals whose claims have been preempted by ERISA cannot recover for all of the injuries caused by their MCOs' refusal of treatment or substandard medical care;

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[60] *Id.* at 27-28.

[61] *Id.* at 28 & n.3 ("In examining a health insurance issuer's claim to ERISA preemption protection, the court must examine the facts and circumstances of each case carefully to determine whether the state law is aimed at regulating the health insurance issuer's business or in regulating the activities of an ERISA plan."). *See also* American Drug Stores v. Harvard Pilgrim Health Care, Inc., 473 F. Supp. 60 (D.Mass. 1997) and Washington Physicians Serv. Ass'n. v. Gregoire, 147 F.3d 1039 (9th Cir. 1998), *amended on reh'g denied*, No. 97-35536, 1998 WL 525583 (9th Cir. Aug. 24, 1998), *and cert. denied*, 525 U.S. 1131 (1999).

[62] Fort Halifax Packing Co. v. Coyne, 482 U.S. 1 (1987). The Supreme Court found a Maine statute requiring employers to provide a one-time severance payment to employees after a plant closing was saved from ERISA preemption because the law regulated the benefit but not the benefit plan. *Id.* at 6-16.

[63] Suzanne Carter, *Health Care and ERISA*, 36 HARV. J. ON LEGIS. 561, 561 (1999) (noting that current law generally exempts HMOs from the legal rules of negligence).

[64] *See supra* note 40 for ERISA-governed employee benefit plans.

[65] Carter, *supra* note 63, at 562 & n.10 ("While a claim of federal preemption is not usually sufficient to furnish removal jurisdiction on a federal court, where federal law has 'completely preempted' state law, removal is proper.").

[66] Mulcahy, *supra* note 14, at 881. *See also* Greg Otterson, Comment, *Medical Malpractice for Texas HMOs: The End of a "Charmed Life?"*, 39 S. TEX. L. REV. 799, 809-10 (1998).

rather, they may seek only injunctive or declaratory relief provided under ERISA.[67] Because the statutory language in ERISA's provisions is unclear, courts are split over which forms of relief Congress intended to include under ERISA's "equitable" remedies. Five circuits of the United States Courts of Appeals have held that § 1132 precludes ERISA plaintiffs from recovering either punitive damages or compensatory damages.[68] The practical effect of these decisions is to deny many plaintiffs a legal cure for the injuries they have suffered.[69]

In addition to leaving many *patients* without adequate legal remedies, courts have also denied a plan participant's *survivors* from enforcing a claim if the participant dies as a result of an MCO's refusal of treatment or of substandard medical care.[70] This judicial determination that a deceased plan participant's rights against her MCO are no longer viable after death has created a system in which ERISA's "equitable" remedies are anything but equitable.[71]

G. Well-pleaded Complaints May Escape Preemption

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[67] 29 U.S.C.S. § 1132(a)(3). *See also* Carter, *supra* note 63, at 562 (noting that once a judge determines the state claim to be preempted by ERISA, the plaintiff loses her right to consequential and punitive damages) ("All that will be recoverable will be the cost of a procedure, no matter how severe a patient's injury or how evident her pain and suffering.").

[68] Corcoran v. United HealthCare, Inc., 965 F.2d 1321, 1336 n.18 (5th Cir. 1992) (citing Drinkwater v. Metropolitan Life Ins. Co., 846 F.2d 821 (1st Cir. 1988), *cert. denied* 488 U.S. 909 (1988); Harsch v. Eisenberg, 956 F.2d 651 (7th Cir. 1992), *cert. denied* 514 U.S. 1051 (1995) *and* 506 U.S. 818 (1992); Novak v. Andersen Corp., 962 F.2d 757 (8th Cir. 1992), *cert. denied* 508 U.S. 959 (1993); Bishop v. Osborn Transp., Inc., 838 F.2d 1173 (11th Cir. 1988), *cert. denied* 488 U.S. 832 (1988); Sokol v. Bernstein, 803 F.2d 532 (9th Cir. 1986)).

[69] Mulcahy, *supra* note 14, at 881 (noting that if a MCO refuses to cover medically necessary treatment, the damages will be limited to the cost of that treatment) ("[I]f a woman dies because a mammogram was refused and her breast cancer was not detected, the damages are limited to $99—or whatever the cost of the mammogram. The fact that a plaintiff will have no remedy does not affect whether ERISA will supersede state law."). *See also* Cerminara, *supra* note 35, at 327 ("The lack of substantive regulation in ERISA, however, permits many plaintiffs . . . to sue only for benefits due rather than for a full range of compensatory damages. Put simply, some patients lack effective remedy merely because of the source of their health care benefits.").

[70] Mulcahy, *supra* note 14, at 883 (stating that a deceased plan participant's survivors cannot enforce her rights under the terms of the employee benefit plan).

A plaintiff bringing a claim against her MCO can avoid immediate preemption under ERISA by carefully drafting her complaint in accordance with the "well-pleaded complaint rule."[72] The Supreme Court's explanation of this rule provides that a civil action will arise under federal law when a federal question appears on the face of the complaint.[73] Because a defendant cannot automatically convert a state claim into a federal question by asserting a federal defense, a plaintiff who pleads only state law issues may successfully avoid preemption.[74] An exception to the well-pleaded complaint rule exists, however, in the form of "complete preemption."[75] If Congress "so completely pre-empts a particular area" such that any claim invoking it necessarily becomes federal in question, a defendant may convert a plaintiff's state claim into a federal question merely by raising the defense.[76]

The ERISA provision preempting state statutes that "relate to" an employee benefit plan involves § 1144 and is separate from the "complete preemption" analysis that occurs under §

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[71] *Id. See also* Turner v. Fallon Community Health Plan Inc., 953 F. Supp. 419 (D. Mass. 1997), *cert. denied* 523 U.S. 1072 (1988); and Mertens v. Hewitt Assoc., 508 U.S. 248 (1993).

[72] 28 U.S.C.S. § 1441(b) (to find that a cause of action arises under federal law, a plaintiff's well-pleaded complaint must on its face raise issue of federal law). *See also* Mulcahy, *supra* note 14, at 883-84 ("The first barrier to overcome in successfully avoiding ERISA preemption is meeting the 'well pleaded complaint rule.'").

[73] Franchise Tax Bd. of Cal. v. Construction Laborers Vacation Trust for S. Cal., 463 U.S. 1, 9-12 (1983); Louisville & Nashville R. Co. v. Mottley, 211 U.S. 149, 152 (1908). *See also* 28 U.S.C. § 1441(b) (only when an area of law is completely preempted does preemption lead to federal question jurisdiction; on the other hand, federal preemption that serves only as a defense to a state law claim (often referred to as "conflict preemption" or "defensive preemption") does not confer federal question jurisdiction).

[74] Mulcahy, *supra* note 14, at 883.

[75] 29 U.S.C.S. § 1132 (ERISA's civil enforcement provision impliedly preempts actions brought in state court that could have been brought under its provisions). *See also* Mulcahy, *supra* note 14, at 884.

[76] 29 U.S.C.S. § 1132. Two prerequisites to "complete preemption" under ERISA's civil enforcement provision are that 1) the plaintiff must be able to bring the action, i.e., the plaintiff must be the participant or beneficiary of an employee benefit plan; and 2) the claim must come within the scope of that provision, i.e., it must be a claim to recover benefits or to enforce rights under the terms of the plan. *See also* Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 63-64 (1987) ("Congress may so completely pre-empt a particular area that any civil complaint raising this select group of claims is necessarily federal in character.").

1132.[77] For purposes of clarification, if a state law relates to an employee benefit plan, either by making reference to it or by having a connection with it, the law will be preempted under § 1144 of ERISA.[78] If this "relate to" analysis reveals that preemption is proper, the federal court is without removal jurisdiction and the state court must resolve the ERISA preemption dispute.[79] Conversely, if the same analysis concludes that the state law does not relate to an employee benefit plan, then the plaintiff is saved from preemption and she may proceed with her state law claims.

This is different than if the claim is categorically preempted under § 1132 of ERISA by way of complete preemption, such as a claim arising under an area that is necessarily federal in question.[80] Claims against MCOs that fit in this § 1132 "complete preemption" category include

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[77] Rice v. Panchal, 65 F.3d 637, 639 (7th Cir. 1995) *amended, reh'g en banc denied sub. nom* Rice v. Kanu, 1995 U.S. App. Lexis 31419 (7th Cir. 1995) (concluding that § 1132(a) provides a basis for complete preemption, whereas § 1144 (a) provides the basis for conflict preemption). The Seventh Circuit summarized the distinction between conflict and complete preemption as applied under ERISA:

> The difference between complete preemption under [§ 1132(a)] and conflict preemption under [§ 1144(a)] is important because complete preemption is an exception to the well-pleaded complaint rule that has jurisdictional consequences. If a state law claim has been "displaced," and therefore completely preempted by [§ 1132(a)], then a plaintiff's state law claim is properly "recharacterized" as one arising under federal law. But state law claims that are merely subject to "conflict preemption" under [§ 1144(a)] are not recharacterized as claims arising under federal law; in such a situation, the federal law serves as a defense to the state law claim, and therefore, under the well-pleaded complaint rule the state law claims do not confer federal jurisdiction. Thus, complete preemption under [§ 1132(a)] creates federal question jurisdiction whereas conflict preemption under [§ 1144(a)] does not.

Id. at 640.

[78] *Travelers*, 514 U.S. at 649-56. The Supreme Court's analysis of whether a New York statute imposing surcharges on patients covered by "a commercial insurer but not from patients insured by a Blue Cross/Blue Shield plan" related to an employee benefit plan found the statute was not preempted by ERISA because it did not make any specific reference to ERISA plans and because its connection with employee benefit plans was not such that would disrupt a uniform federally administrated employee benefit plan. *Id.*

[79] Mulcahy, *supra* note 14, at 885 (stating that this is termed "ERISA preemption."). *See also* Schmid v. Kaiser Found. Health Plan, 963 F. Supp. 942, 944 (D. Or. 1997).

[80] Mulcahy, *supra* note 14, at 886 (discussing the differences between ERISA preemption under § 1144 and complete preemption under § 1132). *See also* Metropolitan Life Ins. Co. v. Taylor, 481 U.S. at 66.

those to recover benefits due or claims enforcing or clarifying a plan participant's rights.[81] Such claims are completely preempted because they raise a federal question that must be addressed in federal court.[82] A plaintiff is generally disadvantaged by federal jurisdiction under a completely preempted ERISA claim because of the severely limited remedies available under the statute.[83]

IV. The Question of Quantity Versus Quality

A. Preemption Under § 1144: A Quantity Versus Quality Determination

It is clear that a claim alleging that a MCO wrongfully failed to authorize treatment is barred under ERISA's complete preemption provision (§ 1132), but that does not mean that all suits against managed care are doomed.[84] In evaluating whether claims "relate to" an employee benefit plan under § 1144 of ERISA, courts are increasingly distinguishing between claims involving the "quantity" of benefits provided and those concerning the "quality" of care received. However, this is not a straightforward determination.[85] The following review of two claims

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[81] *Id.*

[82] *Id. See also* 28 U.S.C.S. § 1441(b) (to find that a cause of action arises under federal law, a plaintiff's well-pleaded complaint must raise issue of federal law on its face).

[83] 29 U.S.C.S. § 1132(a)(3). *See also* Carter, *supra* note 63, at 562 (noting that once a judge determines the state claim to be preempted by ERISA, the plaintiff loses her right to consequential and punitive damages) ("All that will be recoverable will be the cost of a procedure, no matter how severe a patient's injury or how evident her pain and suffering.").

[84] *See* Budish, *supra* note 32, at K8 (noting that courts initially threw out practically all cases against HMOs, but growing numbers of courts are determining claims with a quantity of care vs. quality of care analysis).

[85] *Id.* (stating that "Trying to distinguish between quality and quantity of benefits is not easy. Two courts can look at similar sets of facts and come to different results."). *See also* Bauman v. U.S. Healthcare, Inc., 193 F.3d 151 162 (3rd Cir. 1999) (reiterating that the court has "embraced a distinction between claims pertaining to the quality of the medical benefits provided to a plan participant and claims that the plan participant was entitled to, but did not receive, a certain quantum of benefits under his or her plan." The Third Circuit restated, however, that "[t]here are some cases in which it may be difficult to distinguish between claims challenging the quality of benefits rather than their quantity"). *See also* Ouellette v. Christ Hospital, 942 F.Supp. 1160, 1164 (S.D. Ohio 1996) (stating that because the Sixth Circuit has not developed a test to

involving pregnant women demonstrates how, in the absence of a "bright line" Supreme Court ruling, courts' blurred interpretations of ERISA can lead to disparate results.

During Linda Visconti's third trimester of pregnancy, she developed symptoms typical of preeclampsia.[86] Her obstetrician ignored these symptoms, and Ms. Visconti's fully developed baby girl was stillborn.[87] The Viscontis sued U.S. Healthcare, their HMO, alleging medical malpractice, and the Third Circuit Court of Appeals held that their claim against their HMO could proceed in state court, where a viable remedy existed.[88]

Florence Corcoran's pregnancy was different than Linda Visconti's because Ms. Corcoran's obstetrician correctly diagnosed hers as a high-risk pregnancy.[89] He admitted Ms.

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determine when a claim falls within § 1132(a), they would adopt a test used by the Seventh Circuit in analyzing the preemptive effect of § 301 of the Labor Management Relations Act, which the legislative history of § 1132(a) expresses an intent to mirror). This case is discussed in depth *infra* at note 94. In *Rice*, 65 F.3d at 644, the Seventh Circuit found that "[t]he common thread running through [the] cases [interpreting § 301] is that complete preemption is required where a state law claim cannot be resolved without interpretation of the contract governed by federal law." *Id.* The Seventh Circuit concluded that similar analysis was appropriate under § 1132(a) because the ERISA provision concerns claims to recover benefits or enforce rights "under the terms of the plan." *Id.* Thus, "a suit brought by an ERISA plan participant is an action to 'enforce his rights under the term of a plan' within the scope of [§ 1132(a)] where the claim rests upon the terms of the plan or the 'resolution of the [plaintiff's] state law claim … require[s] construing [the ERISA plan].' " *Id.* at 644-45 (quoting Lingle v. Norge Div. of Magic Chef, Inc., 486 U.S. 399, 407 (1988)).

[86] Dukes v. U.S. Healthcare, Inc., 57 F.3d 350, 353 (3d Cir. 1995), *cert. denied* 516 U.S. 1009 (1995). Preeclampsia is a serious disorder that occurs in the second half of pregnancy, in which a woman experiences high blood pressure, fluid retention, nausea, and headaches. If it is not treated, it can lead to eclampsia, a serious condition characterized by seizures. *The American Medical Association Medical Glossary,* (visited Nov. 15, 1999), <http://www.ama-assn.org/insight/gen_hlth/glossary/index.htm>.

[87] Dukes v. U.S. Healthcare, Inc., 848 F.Supp. 39 (E.D. Pa. 1994), *rev'd* 57 F.3d 350 (3d Cir. 1995).

[88] *Dukes*, 57 F.3d at 360-61 ("plaintiffs' claims . . . merely attack the quality of benefits they received: The plaintiffs here simply do not claim that the plan erroneously withheld benefits due."). The *Dukes* court held that § 1132 of ERISA, providing complete preemption of the recovery of benefits due under an employee benefit plan, is "concerned exclusively with whether or not the benefits due under the plan were actually provided. The statute simply says nothing about the quality of benefits received." *Id.* at 357. In *Dukes*, the Third Circuit observed that "patients enjoy the right to be free from medical malpractice regardless of whether . . . care is provided through an ERISA plan. *Id.* at 358. The *Dukes* court also provided as plain dictum a recognition that in some cases the quality of care may be "so low that the treatment received simply will not qualify as health care at all. In such a case, it well may be appropriate to conclude that the plan participant or beneficiary has been denied benefits due under the plan." *Id.*

[89] Corcoran v. United HealthCare, Inc., 965 F.2d 1321, 1322 (5th Cir. 1992). In this case, Florence Corcoran,

Corcoran to a hospital and prescribed a course of treatment for her that included complete bed rest during her final months of pregnancy.[90] Despite her doctor's medical recommendation, Ms. Corcoran's HMO, United HealthCare, determined that hospitalization was not necessary and instead authorized home nursing care for ten hours per day.[91] While no nurse was on duty, Ms. Corcoran's baby went into distress and died in utero.[92] The Corcorans sued their HMO for wrongful death, but the Fifth Circuit Court of Appeals held that their claim was preempted by ERISA, leaving the Corcorans without any remedy for the alleged wrongful death of their baby.[93]

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a long-time employee of South Central Bell Telephone Company, became pregnant in early 1989. In July, her obstetrician recommended that she have complete bed rest during the remainder of her pregnancy, but the benefits were denied. Ms. Corcoran's physician wrote to the medical consultant for Bell explaining that she had a "high risk pregnancy," but the consultant denied disability benefits. Unbeknownst to Ms. Corcoran or her physician, the consultant solicited a second opinion on her condition from another obstetrician who suggested that "the company would be at considerable risk denying [Ms. Corcoran's] doctor's recommendation." Despite this information, the Bell medical consultant did not initiate providing disability benefits. *Id.* As Ms. Corcoran neared her delivery date, her physician ordered her hospitalized so that he could monitor the fetus around the clock. Because Ms. Corcoran was a member of Bell's Medical Assistance Plan, a self-funded welfare benefit plan which provides medical benefits to eligible Bell employees, her doctor sought pre-certification for Ms. Corcoran's hospital play in accordance with her plan's requirements. Despite her doctor's recommendation, United HealthCare, as administrator for a portion of Bell's medical plan pursuant to its agreement with Bell, determined that hospitalization was not necessary. *Id.* Instead, United HealthCare authorized ten hours per day of home nursing care. Ms. Corcoran entered the hospital on October 3, 1989, but because United had not pre-certified her stay, she returned home on October 12th. On October 25th, during a period of time when no nurse was on duty, the fetus went into distress and died. *Id.*

[90] *Id.* at 1322-23.

[91] *Id.* at 1324. In *Corcoran*, the Fifth Circuit held that, although the conclusion that Ms. Corcoran did not need to be hospitalized was erroneous "medical advice," it did so in the context of making a determination about the availability of benefits under an employee disability plan, and the claim was therefore preempted under § 1144 of ERISA because it "related to" an employee benefit plan.

[92] *Id.*

[93] *Corcoran*, 965 F.2d at 1338. As its defense, United HealthCare argued that the Corcorans' cause of action sought damages for improper handling of a claim from those responsible for simply administering benefits under an ERISA-governed plan. *Id.* at 1325. They contended that, because their relationship with Ms. Corcoran came into existence solely as a result of an ERISA plan, it was defined entirely by the plan. *Id.* United HealthCare therefore argued that the Corcorans' claims "related to" an ERISA plan and was within the broad scope of state law claims preempted by the statute. *Id.* The Corcorans argued, however, that their cause of action should be treated as a state law of general application which involves an exercise of

The disparate outcomes of these two cases illustrate ERISA's inequitable preemption of claims.[94] Federal courts have consistently found that the ultimate determination of whether a claim is completely preempted by ERISA to be revealed by a *quantity* of benefits versus *quality* of benefits analysis.[95] Unfortunately, this analysis yields inconsistent results.[96]

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traditional state authority and affects principal ERISA entities in their individual capacities. *Id.* Furthermore, they contended that preemption would contravene the purposes of ERISA by leaving them without a remedy. *Id.* The Fifth Circuit concluded that, based on the specific facts, United HealthCare's medical decisions were incidental to its benefit determinations. *Id.* at 1331. The court noted that "United makes medical decisions as part and parcel of its mandate to decide what benefits are available under the Bell plan." *Corcoran*, 965 F.2d at 1332. Because the Corcorans were attempting to recover for a tort allegedly committed in the course of handling a benefit determination, the court held their claim was preempted under ERISA: "Moreover, allowing the Corcorans' suit to go forward would contravene Congress's goals of 'ensur[ing] that plans and plan sponsors would be subject to a uniform body of benefit law' and 'minimiz[ing] the administrative and financial burdens of complying with conflicting directives among States or between States and the Federal Government.' " *Id.*

[94] It is important to note, however, that *Corcoran* was decided before the Supreme Court's *Travelers* decision. Central to the *Corcoran* decision was an expansive interpretation of ERISA preemption, which was narrowed somewhat by the *Travelers* opinion. That is not to say that recent court decisions find the issue of "quality" versus "quantity" any more precise, as the following cases demonstrate. *See, e.g.,* Ouellette v. Christ Hospital, 942 F.Supp. 1160 (S.D. Ohio 1996). In this case, Victoria Ouellette had her ovaries removed, and despite complications that arose following the procedure, she was discharged from the hospital because her HMO, ChoiceCare, had a policy limiting hospital stays for ovary removal to two days. Once at home, Ouellette's condition deteriorated further, so she sued the hospital and ChoiceCare for medical malpractice by the hospital staff, allegedly caused by the hospital's financial relationship with the HMO. ChoiceCare argued that federal law barred the claim because it was a complaint about the number of days Ouellette was allowed to be in the hospital, i.e. a claim over "quantity" of care. The U.S. District Court for the Southern District of Ohio rejected their argument and instead determined: "Ms. Ouellette is not challenging the amount of benefits but the quality of the service she received. She asserts that ChoiceCare maintains financial incentives with its providers, the effect of which undermines the quality of care provided by the providers. Such a claim is separate and distinct from a claim for benefits under a plan." *Id.* at 1165. Accordingly, the court held Ouellette's claim was not completely preempted by ERISA, noting, however, that whether Ouellette's claims are ultimately preempted (under § 1144) will be a matter for the state court to decide. *Id. See also* Bauman v. U.S. Healthcare, Inc., 193 F.3d 151 (3rd Cir. 1999). In *Bauman*, the Third Circuit Court of Appeals similarly distinguished between the roles of an HMO as an insurance company making administrative decisions and as a health provider actually making medical decisions. Specifically, Michelle Bauman's newborn daughter was released from the hospital 24 hours after her birth in 1995. She died the next day of meningitis. The Baumans sued their HMO, claiming it was negligent in discharging their daughter too quickly. The court held that their lawsuit was not barred by ERISA because their claim concerned a "medical determination of the appropriate level of care." *Id.* at 163. It was "not a claim that a certain benefit was requested and denied." *Id.* The court concluded that the lawsuit did "not involve an attempt to recover benefits due" but instead sought "recovery under the quality standard" based on state law. *Id.* at 163-64.

[95] Mulcahy, *supra* note 14, at 886. *See also Dukes*, 57 F.3d at 357 (citing to *Travelers* to support its conclusion that Congress intended that the quality of health care benefits remain "a field traditionally

A "quantity" claim seeks benefits allegedly due to a participant of an ERISA regulated plan.[97] Such benefit recovery claims fall under §1132 of ERISA and are completely preempted.[98] Conversely, claims alleging that the health benefits received were of inferior "quality" escape complete preemption, at least temporarily.[99] In these situations, because a plan participant's complaint is not exclusively federal in nature, it does not implicate § 1132 of ERISA and thus it is not immediately preempted.[100] The claim will remain in state court long enough for the judge to evaluate whether the state law at issue "relates to" the employee benefit plan.[101] If so, the claim will be preempted under § 1144 of ERISA, and the plaintiff's available remedies will be limited to injunctive or declaratory relief.[102] If, however, the state law does not have a "connection with" or a "reference to" an employee benefit plan under the *Travelers*

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occupied by state regulation").

[96] *Dukes*, 57 F.3d at 357-58 ("We recognize that the distinction between the quantity of benefits due under a welfare plan and the quality of those benefits will not always be clear . . . .").

[97] *Id.* at 356-57. The *Dukes* court determined that plaintiffs' complaints did not fall within the scope of ERISA's civil enforcement scheme because there was nothing raised regarding a failure "to provide benefits due under the plan." *Id.* The plaintiffs did not allege the failure to perform tests arose in any way from a denial of benefits under the ERISA plan involved, rather the complaints asserted claims regarding the quality of care received. *Id.*

[98] Mulcahy, *supra* note 14, at 886.

[99] *Id. See also Dukes*, 57 F.3d at 355-57.

[100] *Dukes*, 57 F.3d at 357 (concluding that nothing in ERISA's legislative history suggested that quality claims, as opposed to quantity claims, would be completely preempted).

[101] *Rice*, 65 F.3d at 640 (noting that "state law claims that are merely subject to 'conflict preemption' under [§ 1144(a)] are not recharacterized as claims arising under federal law . . . and therefore, under the well-pleaded complaint rule the state law claims do not confer federal jurisdiction.").

[102] 29 U.S.C.S. § 1132(a)(3). *See also* Carter, *supra* note 63, at 562 (noting that once a judge determines the state claim to be preempted by ERISA, the plaintiff loses her right to consequential and punitive damages) ("All that will be recoverable will be the cost of a procedure, no matter how severe a patient's injury or how evident her pain and suffering."). "[I]f a woman dies because a mammogram was refused and her breast cancer was not detected, the damages are limited to $99—or whatever the cost of the mammogram. The fact that a plaintiff will have no remedy does not affect whether ERISA will supersede state law." Mulcahy, *supra* note 14, at 881. "The lack of substantive regulation in ERISA, however, permits many plaintiffs…to sue only for benefits due rather than for a full range of compensatory damages. Put simply, some patients lack effective remedy merely because of the source of their health care benefits." Cerminara, *supra* note 35, at 327.

standard, the claim will escape preemption and will be adjudicated in light of the available state law remedies.[103]

Despite the relatively clear distinctions between a "quality" analysis under § 1144 and a "quantity" analysis under § 1132, courts remain troubled by imprecise definitions of what actions fall under which category, if and when a claim finally makes its way to state court. What one court views as a denial of some quantifiable benefit, another court deems to be substandard care or a "quality" of care question.

V. ALTERNATIVE MEANS OF ACHIEVING MCO ACCOUNTABILITY

A. Direct Liability

The status of direct negligence claims against managed care entities remains unclear under current law.[104] In the wake of the uncertain judicial interpretation of liability, many states, including Texas, have attempted to use legislation to impose both direct and vicarious liability on MCOs for injuries sustained in the course of medical treatment; however, the scope of an MCO's potential responsibility has not been fully resolved.[105] It is clear though that MCO

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[103] *Travelers*, 514 U.S. at 649-56. The Supreme Court's analysis in *Travelers* determined that a state law was not related to an employee benefit plan because it did not make any specific *reference to* ERISA plans and because its *connection with* employee benefit plans was not such that would disrupt a uniform federally administrated employee benefit plan. *Id.*

[104] Claimants alleging direct negligence liability for benefit denials have not fared well under judicial scrutiny. *See* Corcoran v. United HealthCare, Inc., 965 F.2d 1321 (5th Cir. 1992); Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482 (7th Cir. 1996); Tolton v. American Biodyne, Inc., 48 F.3d 937 (6th Cir. 1995). The *Corcoran* case is discussed *supra* at notes 89-94 and accompanying text. *But see* In re U.S. Healthcare, Inc., 193 F.3d 151 (3rd Cir. 1999) (succeeding on direct tort and vicarious liability claims due to the quality of benefits received); Dukes v. U.S. Healthcare, Inc., 57 F.3d 350, 357 (3rd Cir. 1995) (succeeding on a claim for vicarious liability for medical malpractice due to the quality of benefits received). The *Dukes* case is discussed *supra* at notes 86-88 and accompanying text.

[105] TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001—002 (West 1998). *See also* Parver, *supra* note 3, at 204 ("The legal liability of an HMO for the health care it manages for enrollees depends upon the amount and level of control exerted by the managed care organizations over providers.").

liability is lessened in independent practice association models where the control over physicians and other healthcare providers is limited.[106] In these instances, it is more difficult to establish a clear agency relationship because of the administrative layers that separate the MCO and the health care providers.[107] Fortunately, however, the judicial trend appears to favor increased MCO accountability, and courts are currently considering a variety of direct liability claims against MCOs.[108]

These claims can take a variety of forms, including negligence in the utilization review process; breach of contract; negligent selection or supervision of physicians; breach of warranty; misrepresentation; bad faith; and breach of fiduciary duty.[109] Patients bringing negligence claims against MCOs must establish four elements: 1) the MCO owed a duty to the patient; 2) the MCO breached that duty; 3) an injury resulted from the breach; and 4) the

[106] *See supra* note 15 for a discussion of the various types of MCOs.
[107] Parver, *supra* note 3, at 205 (discussing the difficulties of demonstrating an employer-employee relationship between an HMO and a physician when a patient goes to her doctor's office for treatment instead of to the HMO office directly).
[108] *Id.* at 207 ("[C]ourts today are becoming increasingly wary of letting third party payors go entirely 'scott-free,' and are devising new techniques to hold payors liable either through traditional agency principles or more direct routes.").
[109] *Id*. at 207-08. *See, e.g.,* Wickline v. California, 192 Cal. App.3d 1630 (1986) (holding third-party payor "legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms"); Steineke v. Share Health Plan of Nebraska, 518 N.W.2d 904 (Neb. 1994) (claiming breach of contract based on the HMO's representations); Harrell v. Total Health Care Inc., 781 S.W.2d 58 (Mo. 1989) (ultimately rejecting a negligent supervision of physicians claim because of a state immunity statute); Cirafici v. Goffen, 407 N.E.2d 633 (Ill. App. 1980) (noting that under some circumstances health care providers could be liable for breach of warranty); McClellan v. Health Maintenance Org., 604 A.2d 1053 (Pa. Super. 1992) (holding that to establish misrepresentation in an HMO claim a plaintiff must show "(1) a misrepresentation of past or existing facts; (2) utterances that were fraudulent; (3) an intent to induce detrimental reliance; [and] (4) damages proximately caused by the fraudulent conduct"); Hughes v. Blue Cross of Northern California, 215 Cal. App.3d 832 (1989) (addressing an alleged breach of implied covenant of good faith and fair dealing for an early hospital release); Weiss v. Cigna Healthcare, Inc., 972 F. Supp. 748 (S.D.N.Y. 1997) (recognizing a breach of fiduciary duty based on a "gag order" restricting a plan physician's ability to discuss treatment options not covered by the plan).

existence of a causal relation between the breach and the injury.[110] In order for a duty to arise, a person must reasonably foresee that his actions could cause injury to another.[111] Critics of MCO utilization reviews contend that such cost-containment practices trigger foreseeable injuries when patients are denied medically necessary treatment as a result of prospective reviews.[112] In circumstances where a duty exists, courts must evaluate whether MCOs breached that duty by falling below the required standard of care.[113] Although patients can easily demonstrate their injuries, it is more difficult to establish the two-step causal connection required for negligence claims, namely cause-in-fact and proximate cause.[114] Once patients cross this evidentiary threshold, however, and providing ERISA doesn't preempt the claim, MCOs have good reason to worry because, when given the chance, juries have awarded massive monetary damages against the managed care industry.[115]

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[110] RESTATEMENT (SECOND) OF TORTS § 281 (1965). *See also* Parver, *supra* note 3, at 208 (discussing the difficulties that plaintiffs in utilization review negligence claims have in demonstrating the existence of a duty and the causal relationship between the breach of the duty and injury to the plaintiff).

[111] WILLIAM L. PROSSER ET AL., TORTS 390 (8th ed. 1988).

[112] Parver, *supra* note 3, at 208 (stating that where a patient is denied medically necessary treatment through a utilization review decision, the injury becomes foreseeable).

[113] *Id.* at 208-209. Case law suggests the existence of two different standards of care: 1) a "procedural standard" requiring MCOs that conduct utilization reviews to follow a specified procedure to ensure quality control and prevent undue liability; and 2) a "substantive standard," similar to a medical standard of care in malpractice cases, under which utilization review decisions would be evaluated based on the reasonableness of the course of treatment, given the prevailing medical knowledge and skill commonly held by health care professionals in good standing.

[114] *Id.* To prove cause-in-fact, a plaintiff must demonstrate that the injury would have been prevented had the medical treatment not been wrongfully denied. *Id.* The plaintiff must then prove that the denial of treatment under utilization review was the proximate cause of the patient's harm. *Id.* "Clearly, proving causation becomes difficult when a patient already has a low chance of survival and experimental treatment options are the only remaining hope." Parver, *supra* note 3, at 208-09.

[115] *Id.* at 211 (noting that insurers and HMOs have grown "increasingly uneasy about liability resulting from decisions under utilization reviews"). *See also* Fox v. Healthnet, 1993 WL 794305 (Cal. Super. Ct. 1993). In this case, after being diagnosed with breast cancer, Mrs. Fox underwent traditional forms of treatment, including two radical mastectomies and chemotherapy. Because these were not completely effective, Mrs. Fox's physicians recommended a bone marrow transplant as her last chance of survival. However, her HMO denied coverage of the procedure as experimental. The Foxes sued their HMO for breach of contract, breach

Although the majority of cases against MCOs assert some form of a breach-of-contract claim, these suits have had limited success because of ERISA preemption.[116] Increasingly, breach of fiduciary duty claims are taking center stage in direct negligence actions against MCOs.[117] For that reason, and because of their specific ERISA implications, those claims are discussed separately below.

B. Breach Of Fiduciary Duty

Suits alleging that doctors or health plans breached their fiduciary duties have a good chance of weathering ERISA preemption challenges in today's judicial climate.[118] As part of ERISA's intent to establish the uniform administration of employee benefit plans, the statute

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of the covenant of good faith and fair dealing, and intentional infliction of emotional distress, winning a jury award of $89 million, including $77 million in punitive damages. Distressed over how the verdict would affect future claims, the HMO settled for an undisclosed amount prior to the entry of final judgment. *But see* Martin v. Blue Cross & Blue Shield of Virginia, Inc., 115 F.3d 1201 (4th Cir. 1997) (holding that the defendants provided sufficient evidence that the proposed treatment was experimental so as to satisfy the substantive standard of care required to ward off the negligence claim).

[116] Parver, *supra* note 3, at 213. *See also* Steineke v. Share Health Plan of Nebraska, 518 N.W.2d 904 (Neb. 1994). In *Steineke*, the plaintiff had an ectopic pregnancy and was seen by a physician outside of Share's health network. That non-Share physician scheduled the plaintiff's necessary surgery with a Share physician located at the same hospital. The two physicians sought to save plaintiff's left fallopian tube, which concerned her because a previous ectopic pregnancy had resulted in the loss of her right fallopian tube. The plaintiff's HMO, Share, sought to transfer her to the hospital where her primary care physician was located even though the patient's condition worsened and the procedure to save her fallopian tube wasn't available at that facility. Although it recognized the potential claim for breach of contract, the court held that the plaintiff had not sufficiently proven causation.

[117] Parver, *supra* note 3, at 217 ("With increased publicity regarding managed care companies' imposition of so-called 'gag orders,' courts are beginning to recognize a cause of action based on the insured's breach of its fiduciary duty under ERISA for restrictions on the details that participating physicians can give about treatment options not covered by the HMO.").

[118] Shea v. Esenten, 107 F.3d 625 (8th Cir. 1997) (holding that the widow of a deceased health plan participant had stated an ERISA claim against her HMO for failing to disclose the terms of a financial incentive arrangement designed to minimize referrals); Drolet v. Healthsource, Inc., 968 F. Supp. 757 (D.N.H. 1997) (noting that the broad applicability of ERISA's fiduciary duty provisions, permitting the plaintiff to proceed on allegations that both her plan administrator and her plan's coverage provider failed to disclose material facts regarding physician payment arrangements to plan beneficiaries. *But see* Weiss v. Cigna Healthcare, Inc., 972 F. Supp 748, 755 n. 6 (S.D.N.Y. 1997) (declining to follow *Shea* and *Drolet*). *See generally* Clifford A. Cantor, *Fiduciary Liability in Emerging Health Care*, 9 DEPAUL BUS. L.J. 189 (1997) (discussing claims for breach of fiduciary duty).

includes rules relating to "reporting, disclosure, and fiduciary responsibility."[119] In order for a patient alleging breach of fiduciary duty to succeed in a suit again her physician and MCO, she must establish the following elements: 1) that both are plan fiduciaries; 2) that they breached their fiduciary duties; and 3) that a cognizable injury resulted.[120]

Congress enacted ERISA with the intent that the statute's definition of "fiduciary" be broadly interpreted.[121] The statute further mandates that an ERISA-qualifying fiduciary must perform his duties in accordance with the following standards:

> [A] fiduciary shall discharge his duties with respect to a plan solely in the interest the participants and beneficiaries and—
> (A) for the exclusive purpose of:
> (i) providing benefits to participants and their beneficiaries; and
> (ii) defraying reasonable expenses of administering the plan;
>
> (B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like

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[119] *See* Herdrich v. Pegram, 154 F.3d 362, 369 (7th Cir. 1998), *reh'g en banc denied*, 170 F.3d 683 (7th Cir. 1999), *cert granted*, 1999 U.S. LEXIS 4742 (September 28, 1999), *citing to* Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 137 (1990).

[120] *Herdrich*, 154 F.3d at 369-370. ERISA defines the term "fiduciary" in 29 U.S.C.S. § 1002(21)(A), which reads, in relevant part:

> Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority of control respecting management of such plan or exercises any authority of control respecting management or disposition of its assets … or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

Id.

[121] *Herdrich*, 154 F.3d at 370. The court cites to a statement by the Chairman of the House Committee on Education and Labor, 120 Cong. Rec. 3977, 3983 (February 25, 1974) *reprinted at*, 2 Legislative History of the Employee Retirement Income Security Act of 1974, at 3293:

> The Committee has adopted the view that the definition of fiduciary is of necessity broad . . . . A fiduciary need not be a person with direct access to the assets of the plan . . . . Conduct alone may in an appropriate circumstance impose fiduciary obligations. It is the clear intention of the Committee that any person with a specific duty imposed upon him by this statute be deemed to be a fiduciary . . . .

aims . . . .[122]

Because a doctor would be breaching his fiduciary duty under ERISA by benefiting his own financial interests, the Seventh Circuit Court of Appeals recently held that patients may bring suit for breach of fiduciary duty when physicians withhold or delay treatment because they have a pecuniary stake in limiting the amount of services provided.[123] In 1998, the Seventh Circuit held that doctors who have profit motives in reducing their patients' access to specialists or diagnostic testing are in direct conflict with their ERISA-imposed duty to act in the best interest of their patients.[124] Because cost-containment mechanisms are at the very heart of managed care organizations' success, this ruling has enormous implications for the healthcare

[122] 29 U.S.C.S. § 1104(a)(1). *See also Herdrich*, 154 F.3d at 371 (citing to James F. Forden et al., *Handbook on ERISA Litigation § 3.03[A]*, at 3-53 (1994), stating that "*[a] fiduciary breaches its duty of care under section 1104(a)(1)(A) whenever it acts to benefit its own interests*.") (emphasis in original).

[123] Herdrich v. Pegram, 154 F.3d 362 (7th Cir. 1998), *reh'g en banc denied*, 170 F.3d 683 (7th Cir. 1999), *cert granted*, 1999 U.S. LEXIS 4742 (September 28, 1999). In *Herdrich*, a patient complained to her doctor of abdominal pain. Her doctor discovered an inflamed mass, but allegedly delayed a referral for an ultrasound test for eight days. While waiting for the test, Cynthia Herdrich's appendix ruptured, allegedly resulting in peritonitis (an inflammation of the abdominal wall). Her HMO required Herdrich to go to a hospital 50 miles from her home for treatment. Herdrich sued her doctor under Illinois' medical malpractice law and recovered $35,000 in compensatory damages. Herdrich also alleged that her doctor and health plan had breached their fiduciary duty under the plan's structure that awarded bonuses to doctors who limited patient access to specialists and expensive diagnostic testing. However, a federal district court dismissed the portion of her suit that, based on ERISA, claimed the HMO had breached its fiduciary duty. The Seventh Circuit reinstated Herdrich's fiduciary duty claim however, reversing the district court's decision. Herdrich's health plan, Health Alliance Medical Plans, Inc., appealed the case, and the U.S. Supreme Court granted certiorari in September of 1999.

In June of 2000, the Supreme Court reversed the Court of Appeals. Pegram v. Herdrich, 120 S.Ct. 2143 (2000). In its unanimous decision, the Supreme Court ruled that Ms. Herdrich could not sue her HMO for allegedly putting profits ahead of the quality of medical care provided to her. *Id.* The Court opined that patients can sue their doctors for malpractice in state court, but they cannot attack the HMO itself for being too cost-conscious. *Id.* at Syllabus,¶ (a). According to Justice Souter, the very purpose of an HMO is to hold down costs by "rationing" medical care. *Id.* If patients can sue and win damages merely by showing that the HMO's administrators were driven by a profit incentive, Justice Souter reasoned it would mean "nothing less than the elimination of the for-profit HMO." *Id.*at Syllabus, ¶ (d). Justice Souter noted that, in 1973, Congress encouraged the formation of HMOs, and that just a year later, it enacted ERISA to protect the benefits that employees were promised. *Cf. id.*

[124] *Id. See also* Linda Greenhouse, *Managed Care Challenge To Be Heard by High Court*, N.Y. TIMES, September 28, 1999, at A22.

industry.[125]

During the fall of 1999, the heated debate grew even more intense when the Supreme Court granted certiorari in *Pegram v. Herdrich* to determine if these financial conflicts of interest are unlawful.[126] Although its review of *Herdrich* provides an opportunity for the Supreme Court to champion patients' rights, even if the Court upholds a patient's right to sue her physician and MCO for breach of fiduciary duty, the patient will not be awarded big money damages because of ERISA's limited remedies, unless the Court drastically rethinks its interpretation of the statute's damages provision.[127]

C. Vicarious Liability

Some federal courts have held MCOs vicariously liable for a physician's negligence under the doctrines of *respondeat superior* and ostensible agency.[128] These legal theories require a showing that the physician was negligent because a vicarious liability daim is

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[125] Alissa J. Rubin, *Justices to Hear Challenge to HMO Shield: Health Case is One of Several Involving Responsibility for Injuries to Patients*, N.Y. TIMES, September 29, 1999, at A14 ("[Managed Care Organizations] viewed the lower court's ruling as potentially harmful to the industry because it could undermine many plans' arrangements for controlling costs and providing standard patient care. It is common, according to health care lawyers, for managed care companies to withhold part of doctors' salaries and put it into a pool used to give bonuses to physicians who provide the most economical care.").

[126] *Id.* ("'We've got California passing a bill holding HMOs liable and Congress debating the same kind of measure. And now the Supreme Court is going to open the question of whether these financial conflicts of interest violate the letter and spirit of the law and whether patients should have remedies,' said Jamie Court, of the Foundation for Taxpayer and Consumer Rights (Santa Monica)"). *See also*, Budish, *supra* note 32, at K8 (noting that the U.S. Supreme Court's decision to review a case involving claims against an HMO may clarify the scope of protection for HMOs under ERISA). *See supra* note 123 for a discussion of the Supreme Court's decision in *Pegram v. Herdrich.*

[127] Rubin, *supra* note 125, at A14 ("However, even if the patient prevails in this case, she is unlikely to win much in the way of damages. Under [ERISA] . . . the most a patient can receive if wrongly denied care is the cost of the benefit that was denied. Thus, a woman whose plan refused to pay for a colonoscopy and who later was diagnosed with colon cancer and had to have her colon removed could recoup only the cost of the colonoscopy.").

[128] Carter, *supra* note 63, at 562 (noting that, because of their "expanded decision-making capacity," medical malpractice claims against MCOs are rapidly increasing in the United States).

predicated on the notion that the physician is an agent of the MCO, and the MCO is therefore liable for his medical malpractice.[129] Under the doctrine of *respondeat superior*, an employer will be liable for an employee's negligent acts as long as the employee is acting within the scope of his employment.[130] Similarly, an HMO model that directly employs physicians, nurses, and other healthcare workers will be liable for its employees' negligence in treating patients.[131] Realizing the detrimental effect of this direct employment relationship, many MCOs quickly restructured and entered into "independent contractor" relationships with physicians in an attempt to dodge vicarious liability.[132]

Tenacious patients and their lawyers have, however, attempted to combat the "independent contractor" defense by holding MCOs accountable for physicians' negligence under the theory of ostensible agency.[133] The doctrine of ostensible agency provides that, where

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[129] Parver, *supra* note 3, at 218 (noting that establishing a physician's negligence can be difficult because often the MCO acted negligently without the physician's involvement).

[130] Carter, *supra* note 63, at 562. *See also* Parver, *supra* note 3, at 220. Under traditional agency principles, a relationship exists when two factors are present: 1) the agent is subject to the principal's control with respect to the work to be performed and the manner of performance; and 2) the agent's work is performed for the principal's benefit or in the principal's business. *Id.* Once these elements are established, the principal (the MCO) has the burden of proving that the agent (the physician) acted outside the scope of his authority or employment. *Id.* A principal's control over an agent is determinative of the agency relationship. *Id.* The right to control the methods or the manner of providing health care is indicative of an employment relationship, whereas the absence of this right indicates an independent contractor relationship. *Id.* In evaluating agency claims related to medical professionals, courts traditionally focus on those areas of medical service that can be supervised and controlled. *Id.* Because of the prevalence of managed care in today's society, the focus should widen to permit inspection into the level of control exerted by MCOs over the medical judgment of physicians through utilization review restrictions on treatment. Parver, *supra* note 3, at 221.

[131] *Id*. at 221. *See also supra* note 15 for a discussion of various MCO structures.

[132] Carter, *supra* note 63, at 563 ("Under the respondeat superior theory of tort, however, a health care provider using independent contractors can escape liability. HMOs and hospitals have therefore had an incentive to hire independent contractors rather than permanent employees."). *See also* Jennifer Anderson, Comment, *All True Histories Contain Instruction: Why HMOs Cannot Avoid Malpractice Liability Through Independent Contracting With Physicians*, 29 MCGEORGE L. REV. 323, 333 (1998) (noting the policy reasons for preventing MCOs from escaping liability via independent contractors).

[133] Carter, *supra* note 63, at 563. *See also* L. Frank Coan, Jr., Note, *You Can't There From Here—*

an organization represents that a physician is its agent or employee, and causes a patient to rely on that representation in submitting to care, an organization will be vicariously liable for the negligence of the purported agent, regardless of the existence of an independent contractor relationship.[134]

Travelers opened the door for successful vicarious liability claims that allege inferior medical care, notwithstanding ERISA. Under the preemption analysis framework provided by the *Travelers* Court, "quality" standards of the type embodied in medical malpractice law do not "relate to" an ERISA plan. Thus, medical malpractice law does not have a "connection with" an employee benefit plan because such claims neither impose a benefits structure on plans nor interfere with the uniform administration of plan benefits.[135] Furthermore, medical malpractice law is simply one component of broader negligence tort laws, and it does not specifically "refer to" any ERISA plan.

Relying upon the holding in *Shaw*, the *Travelers* Court determined that such "quality" issues would have merely an indirect economic influence on a plan's cost.[136] The Court reasoned that claims accusing MCOs of delivering poor "quality" care do not directly affect the uniform administration of employee benefits plans, because such claims have only a "tenuous, remote, or peripheral" connection with employee benefits plans.[137] Rather than being concerned with the structure or substance of an employee benefits plan, a medical malpractice

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Questioning the Erosion of ERISA Pre-emption in Medical Malpractice Actions Against HMOs, 30 GA. L. REV. 1023, 1030-36 (1996).

[134] John R. Penhallegon, *Emerging Physician and Organization Liabilities Under Managed Health Care*, 64 DEF. COUNS. J. 347, 353 (1997) (referring to RESTATEMENT (SECOND) OF AGENCY § 267 (1958)).

[135] *Travelers*, 514 U.S. at 658-68.

plaintiff brings suit based on substandard medical care, not the regulation of care specific to any ERISA health benefits plan.[138]

VI. STATES MOVE FORWARD WITH LEGISLATION

A. Circumventing ERISA at the State Level

On the state level, Texas was the first to impose both direct and vicarious liability on MCOs for injuries that patients received as a result of substandard health care.[139] Under the Texas Senate Bill 386 [hereinafter SB 386], health insurance carriers,[140] health maintenance organizations,[141] and other managed care entities[142] have a "duty to exercise ordinary care when making health care treatment decisions."[143] Ordinary care is essentially the care that a reasonable and prudent MCO would offer patients under similar circumstances.[144] SB 386

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[136] *Shaw*, 463 U.S. at 100 n.21.
[137] *Id.* at 100 n.21.
[138] Lancaster v. Kaiser Found. Health Plan of Mid-Atlantic States, Inc., 958 F. Supp. 1137, 1146 (E.D. Va. 1997) (stating that because "medical malpractice plaintiffs need only show that a deviation from the standard medical care occurred . . . [not] why it occurred," vicarious liability claims were not preempted despite allegations that a HMO's financial incentives prompted the malpractice at issue).
[139] TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001—002 (West 1998). *See also* S. 977, 1997-98 Leg., Reg. Sess. (CAL. 1997); S. 984, 19th Leg. (HAW. 1997); S. 1904, 90th Leg. (ILL. 1997); H.R. 78, 1998 Leg., Reg. Sess. (MD. 1998); S. 1400, 222d Leg., Reg. Sess. (N.Y. 1999); H.R. 641, 122d Leg. (OHIO 1997); H.R. 677, 122d Leg. (OHIO 1997); H.R. 685, 122d Leg. (1997); S. 100, 182d Leg. (PA. 1997); H.R. 2530, 100th Leg. (TENN. 1997); S. 2986, 100th Leg. (TENN. 1997); H.R. 2530, 100th Leg. (TENN. 1997) (state legislative provisions that subject managed care organizations to liability).
[140] § 88.001(6) defining a "health insurance carrier" as "an authorized insurance company that issues policies of accident and sickness insurance under Section 1, Chapter 397, Acts of the Legislature, 1955 *(Articles 3.70-1, Vernon's Texas Insurance Code*)." TEX. CIV. PRAC. & REM. CODE ANN. § 88.001(6) (West 1998).
[141] § 88.001(7) defining "health maintenance organization" as "an organization licensed under the Texas Health Maintenance Organization Act *(Chapter 20A, Vernon's Texas Insurance Code*)." TEX. CIV. PRAC. & REM. CODE ANN. § 88.001(7) (West 1998).
[142] *See* § 88.001(8) defining a "managed care entity" as one that "delivers, administers, or assumes risk for health care services with systems or techniques to control or influence the quality, accessibility, utilization, or costs and prices of such services to a defined enrollee population, but does not include an employer purchasing coverage or acting on behalf of its employees" or other exceptions. TEX. CIV. PRAC. & REM. CODE ANN. § 88.001(8) (West 1998).
[143] *Id.* § 88.002(a).
[144] *See id.* § 88.001(10). *See also* Douglas H. Ustick, *Texas: The New Accountability*, HEALTH SYSTEMS

extends this duty of ordinary care to MCOs' "employees, agents, ostensible agents, or other representatives."[145] "[H]ealth care treatment decisions" are defined under Texas law as "determination(s) made when medical services are actually provided by the health care plan . . . decisions which affect the *quality* of the diagnosis, care, or treatment provided to the plan's insureds or enrollees."[146]

Under SB 386, patients insured by or enrolled in MCOs may not maintain claims against such organizations without going through an extensive utilization review process.[147] Prior to initiating cause of action, the patient must give written notice of her claim and submit the claim to independent review in compliance with the state's Insurance Code.[148] Texas law also permits courts to mandate independent review, mediation, or other nonbinding alternative dispute resolution.[149]

Additionally, the Texas statute establishes several affirmative defenses for MCOs.[150] An MCO cannot be held liable unless it controlled, influenced or participated in the healthcare treatment decision.[151] Furthermore, unless the MCO denied or delayed payment for any treatment prescribed by the insured's physician, it cannot be held liable for a patient's medical

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REVIEWS, Nov./Dec. 1997, at 30.

[145] TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(b).

[146] *Id.* § 88.001(5) (emphasis added). *See also* Carol Marie Cropper, *In Texas, a Laboratory Test on the Effects of Suing H.M.O.s*, N.Y. TIMES, September 13, 1998, at C3 (noting that the Texas law, intended to remedy cases in which utilization reviewers overruled physicians' or patients' requests for treatment).

[147] *See* TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.003(a)(1) ("A person may not maintain a cause of action … unless the affected insured, enrollee, or the insured's or enrollee's representative has exhausted the appeals and review applicable under the utilization review requirements.").

[148] *Id.* at § 88.003(a)(2)(A), (B).

[149] *Id.* at § 88.003(d).

[150] Hummel, *supra* note 34, at 661.

[151] TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.002(c)(1).

injuries.[152] This provision was designed to focus legislative scrutiny on prospective or current utilization reviews, not on retrospective reviews regarding payment.[153] No defense exists, however, under the common law corporate practice doctrine.[154]

The Texas legislation has already been attacked by MCOs challenging the new state law under ERISA preemption.[155] Plaintiffs Corporate Health Insurance Inc., Aetna Health Plans of North Texas Inc., and Aetna Life Insurance Co., brought suit asserting in a summary judgment motion that SB 386 "impermissibly interferes with the purpose, structure, and balance of ERISA, thereby injecting state law into an area exclusively reserved for Congress."[156] The Texas Department of Insurance filed a motion to dismiss for failure to state a claim, arguing that the statute simply creates a quality-of-care tort that is within the traditional realm of state tort law.[157]

Looking to *Travelers* for guidance, the Texas court upheld many provisions of SB 386, including those holding managed care entities liable for substandard healthcare treatment.[158] However, the court held that several other provisions were preempted by ERISA, such as the statute's independent review process for adverse benefit determinations.[159]

In its "relate to" analysis under *Travelers*, the Texas court found little support for

[152] *Id*. at § 88.002(c)(2).
[153] Ustick, *supra* note 144, at 31.
[154] TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.002(h) (denying use of state law prohibiting the practice of medicine or being licensed to practice medicine as a defense to claims brought under this section or any other law). *See also* Hummel, *supra* note 34, at 662 n.97 ("The corporate practice doctrine permits only organizations run by physicians to practice medicine and had been interpreted to bar medical malpractice claims against HMOs because they are not licensed to practice medicine.").
[155] Corporate Health Ins., Inc. v. Texas Dep't of Ins., 12 F. Supp. 2d 597 (S.D. Tex. 1998).
[156] *Id.* at 603.
[157] *Id*. at 603.

plaintiffs' claim that the law interfered with the uniform administration of employee benefit plans. Given that "[t]he historic powers of the State include the regulation of matters of health and safety," the court found that the MCOs failed to meet their "considerable burden of overcoming 'the presumption that Congress did not intend to supplant state law.'"[160]

Because "the existence of an ERISA plan is not essential to the operation of the Act," the court held that SB 386 does not "refer to" an employee benefit plan.[161] The court, however, held that the legislation had several "connections with" ERISA plans, namely that "the Act improperly imposes state law liability on ERISA entities, impermissibly mandates the structure of plan benefits and their administration, unlawfully binds plan administrators to particular choices, and wrongfully creates an alternate enforcement mechanism."[162]

In upholding a patient's right to sue under SB 386, the court particularly stressed the legislation's focus on the *quality* of benefits a patient receives.[163] The court made a key distinction between a claim for wrongly denying benefits ("quantity") and a claim alleging the medical care provided was substandard ("quality").[164] The court noted that "[c]laims

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[158] *Id.* at 597.
[159] *Id.*
[160] *Corporate Health Ins., Inc.*, 12 F. Supp. 2d at 611. The court noted that it began with the "assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Id.*
[161] *Id.* at 614. Relying upon the framework established in *Travelers*, the court held that because "the Act imposes a standard of ordinary care directly upon health insurance carriers and health maintenance organizations when making health care treatment decisions, regardless of whether the commercial coverage or membership therein is ultimately secured by an ERISA plan," SB 386 did not make reference to ERISA plans. *Id.* at 612.
[162] *Id.* at 614.
[163] *Id.* at 616-17. The court noted that any claim brought under SB 386 "would relate to the quality of benefits received from a managed care entity when benefits are actually provided, not denied." *Corporate Health Ins., Inc.,* 12 F.Supp. 2d at 616-17.
[164] *Id.* at 620.

challenging the quality of a benefit . . . are not preempted by ERISA. Claims based upon a failure to treat where the failure was a result of a determination that the requested treatment wasn't covered by the plan, however, are preempted by ERISA."[165]

VII. CONGRESS MUST ACT TO AMEND ERISA

A. A Patients' Bill of Rights or a Worthless Bill of Goods?

State legislators must consider the fate of SB 386 in Texas when they draft legislation designed to hold MCOs accountable for life or death decisions. However, Congress, as a *federal* body, can create new legislation or amend ERISA without fear of such judicial limitations. Unfortunately, partisan bickering has stalled the enactment of federal legislation to resolve ERISA's inequitable preemption of claims.

Heated debate in the House of Representatives surrounded the passage of a Patients' Bill of Rights, which, unlike its toothless Senate counterpart, provided patients with a right to sue their MCOs for malpractice.[166] Supporters hoped that a Patients' Bill of Rights would amend ERISA, thereby forcing MCOs to take responsibility for their actions while, at the same time, enabling malpractice victims to recover completely for their injuries.[167]

In 1999, however, Congress failed to reconcile the House version with its weaker

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[165] *Id. But see* Brenda T. Strama & Elizabeth Rogers, *Splitting the Baby*, TEX. LAW., November 30, 1998, at 17 (arguing the court's decision effectively killed most of the reforms in SB 386 because utilization reviews – the most commonly cited form of managed care abuse – continue to be unrestricted and preempted by ERISA).

[166] *See* H.R. 2723. Sponsored by U.S. Rep. Charlie Norwood, the bill would amend Title I of the Employee Retirement Income Security Act of 1974, Title XXVII of the Public Health Service Act, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage.

[167] Carter, *supra* note 63, at 570 (noting that a Patients' Bill of Rights would hold HMOs accountable, contain legal and medical costs, and allow malpractice victims to be duly compensated).

counterpart in the Senate.[168] Although some view this delay as a sign that the Patients' Bill of Rights will "die in committee," others speculate that managed care reform will be high on the political agenda when legislators reconvene in January of 2000.[169]

VIII. CONCLUSION

Tragically, while Congress takes its time in legislating protections for patients in MCOs, many Americans will die waiting. Even with state legislative efforts in progress to arm patients with the right to sue their MCOs for medical malpractice, the disparity is still great between recovery on claims alleging substandard *quality* of health care and the limited ERISA remedies for claims alleging the wrongful denial of some *quantity* of benefits.

ERISA was intended to serve as a legislative sword in the hands of workers battling for their rights, yet the same statute now makes a mockery of justice by shielding managed care organizations from liability. Congress must heed the call from its constituents to take action by enacting effective relief for those who have been injured by their health benefit plans. Only then can ERISA fully protect those plan participants and beneficiaries it was intended to safeguard.

The current status of claims against MCOs remains unclear as a result of judicial inconsistencies with respect to available ERISA remedies, as well as imprecise judicial

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[168] Helen Dewar & Juliet Eilperin, *Congress Leaves Behind Much Unfinished Business*, AKRON BEACON JOURNAL, Nov. 21, 1999, at A15 (stating that the 106th Congress' first year "was notable more for what it did not do than for what it did," and noting that legislating protections for patients in health maintenance organizations is among the pile of unfinished business facing the 106th Congress when it returns in January).

[169] *Id.* (stating that Congress' agenda for early 2000 is a daunting one, and that "only the most popular of initiatives, such as HMO reform, are likely to be approved in the take-no-risks climate of an election year"). Despite high expectations for its 2000 term, Congress again failed to deliver a "Patient's Bill of Rights" that amended ERISA and that offered citizens the protection necessary to sue MCOs. Furthermore, such reform does not seem imminent, given the political landscape after the 2000 election.

interpretations of "quantity" versus "quality." Congressional legislation that amends ERISA or creates new statutory protections for managed care patients would be the most effective means of resolving the inequities that plague plaintiffs in MCO litigation.[170] When Congress reconvenes in the new year, managed care reform must be its first priority. Failure to legislate adequate protections will wreak havoc on millions of American lives throughout the next millennium.

Patricia Mullen Ochmann

[170] Corcoran v. United HealthCare, Inc., 965 F.2d 1321, 1338, *cert. denied* 506 U.S. 1033 (1992) (the Fifth Circuit found it "troubling" that ERISA compelled it to reach a decision leaving the Corcorans without any remedy for what may have been a serious mistake). The court noted that:

> [C]ost 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 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 intention of its creators.

Id.