ERISA Preemption, HMOs, and Denial of Benefit Claims

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I. INTRODUCTION

A forty-six year old woman suffering from leukemia is denied a bone marrow transplant; a sixteen year old child with cystic fibrosis is denied access to medical specialists; and a fifty-two year old man with a brain tumor is misdiagnosed for two years before being declared a hopeless case and denied treatment. In each of these cases, the proposed treatment that might have prolonged or saved these individuals' lives was denied by their respective health maintenance organizations (HMOs). The woman and child died, and the man elected to go outside his health plan to receive chemotherapy, but was forced to pay out-of-pocket for the treatment. Is there a remedy available to these individuals for the neglect or malpractice of their HMOs in denying the necessary treatment? Under the Employment Retirement Income Security Act of 1974 (ERISA), these patients' claims of malpractice against their HMOs for injuries resulting from denial of benefits will likely be preempted, leaving them with little or no available remedy.

Theories of liability and remedies typically available to patients for traditional medical malpractice are generally not available for malpractice by the HMO, because HMOs are immune from liability by virtue of the express preemption clause of ERISA. This clause provides for preemption of all state laws that "relate to" ERISA qualified benefit plans. The provision has allowed for a broad interpretation by the courts of ERISA preemption which has resulted in the creation of a gap in an area of the law that states cannot regulate and that Congress has not regulated: ERISA-qualified employee health plans or HMOs. This gap has served as a shield of immunity for HMOs against traditional medical malpractice claims. The effect of this shield is that HMOs are protected from legal attack and HMO patients are prevented from recovering for lost wages, death or disability, pain and suffering, emotional distress or other harm that a patient suffers as a result of improper denial of care. Preemption of state

Copyright 1999, by LOUISIANA LAW REVIEW.
2. Id.
3. Id.
5. 29 U.S.C. § 1144(a) (1998). "Except as provided in subsection (b) of this section, the provision of this subchapter and subchapter III of this chapter shall supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."
6. Though both ERISA-qualified HMOs and non-ERISA HMOs exist, for the purposes of this paper, "HMO" will refer only to ERISA-qualified plans.
7. Ronald Brown, ERISA-Employees Receive Insurance Shaft Again, "Recent HMO News" (visited Oct. 6, 1998) <http://www.hmopage.org/index.html>; see also 29 U.S.C. § 1132(a)(1) (1998) under which a plan participant may only recover benefits due to him under the plan. See also
law medical malpractice claims effectively eliminates the HMO patient’s ability to recover for personal injury because damages under ERISA are limited to the actual cost of medical services and attorney fees.\(^8\)

However, there is a current trend to abrogate the immunity enjoyed by HMOs. The question of whether patients should be able to sue their HMOs if they are wrongly denied treatment is the tip of a large health care reform iceberg. Currently, ERISA governs HMOs covering approximately 125 million Americans.\(^9\) A June 1998 survey by the Pew Research Center indicated that the potential regulation of HMOs was the most important issue to respondents and the country at large.\(^10\) A poll by Harvard University revealed that “78% [of those polled favored] laws that would provide more consumer protections for people enrolled in managed care plans.”\(^11\)

In response to rising consumer complaints, several bills were proposed in Congress in 1998 supporting increased consumer protections in health care. However, there is a clear split along party lines regarding the issue of HMO liability. Democratic party leaders and consumer groups support amending ERISA in order to make HMOs accountable for the quality of care provided and to act as a deterrent against making benefit decisions based on cost-containment strategies.\(^12\) Republican leaders and business groups claim that allowing malpractice suits against HMOs would defeat the purpose of HMOs by increasing the cost of health care.\(^13\)

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Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49 (D. Mass. 1997) (plaintiff’s claim preempted by ERISA, therefore no recovery for wrongful death of husband related to denial of benefits). Note, however, the strong language used by the court: “This [result], of course, is ridiculous. The tragic events set forth in [the] complaint cry out for relief . . . . Under traditional notions of justice, the harms alleged—if true—should entitle [the plaintiff] to some legal remedy . . . . Nevertheless, this Court has no choice but to pluck [the plaintiff’s] case out of state court in which she sought redress . . . and then, at the behest of [the defendants], to slam the courthouse doors in her face and leave her without a remedy.” \(\text{Id. at 52-53.}\)


12. David Espo, GOP Muscles HMO Bill Through House, The Advocate, July 25, 1998 at 2A. \(\text{See also Welch, supra note 1.}\)

13. \(\text{Id. See also Welch, supra note 1 and Neus, supra note 11.}\) (Republicans and their supporters have claimed that the proponents of the amending ERISA have waged a “casualty of the day” war, greatly exaggerating the seriousness of the effect of benefit denial, but 77% of those polled said their views of HMOs were shaped by their own experiences of friends and family. Only 17% said their views resulted from media horror stories. In addition, 66% of those polled for Kaiser Family Foundation believed politicians to be using the issue of managed care reform for political advantage.).
This controversy has also been considered by numerous state legislatures that have passed laws providing more consumer protections. For example, in 1997, Texas became the first state to enact a law expressly providing the right to sue HMOs. In addition, Missouri’s governor has signed a bill into law that eliminates the liability exemption that HMOs have relied on and allows medical malpractice claims to be brought against HMOs. The question remains, however, whether these state laws can withstand ERISA preemption.

The trend in moving away from HMO immunity has also been apparent in recent Supreme Court decisions. The Court has moved from its broad and expansive interpretation of ERISA preemption to a narrower construction of the "relates to" terminology in the preemption clause. This interpretation has served to narrow the gap, and it has opened the door for state and federal courts to recognize theories of liability against HMOs, including those for claims of denial of benefits.

II. THE RELATIONSHIP BETWEEN HMOs AND ERISA

A. What is Managed Care?

An HMO is a type of managed care organization (MCO). Managed care was pioneered during World War II, but its growth was confined over the next forty years by state legislation that restricted the practice of corporate medicine. In the 1970s, the realization that the current fee-for-service health

16. If these new state laws are deemed to "relate to" an ERISA benefit plan under 29 U.S.C. § 1144(a) in a way that is not "too tenuous," the laws will be preempted by ERISA. See Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 99 n.21, 103 S. Ct. 2890, 2901 n.21 (1983).
18. Corey J. Ayling, Comment, New Developments in ERISA Preemption and Judicial Oversight of Managed Care, 31 Creighton L. Rev. 403, 404 (1998). Private health insurance was first offered as a fringe benefit of employment in the 1920s. Employers in Oklahoma and Los Angeles offered a managed care type of health insurance as a way of providing low cost medical care to impoverished employees. During World War II, Kaiser Permanente pioneered managed care for employees of shipyards and steel mills. Like modern managed care organizations (MCOs), Kaiser owned its own hospitals, clinics and employed its own physicians. After World War II, health insurance became a standard benefit of employment. Id. at 434.
19. Alan D. Lieberson, Healthcare Enterprise Liability 804 (1997). During the next forty years, the growth of MCOs was limited by strong opposition from the American Medical Association (AMA). The AMA has historically been opposed to the practice of "corporate medicine." Only a physician who is licensed can practice medicine. Corporations are not natural persons, so they cannot be licensed to practice medicine; therefore, a corporation that gives physicians direction or instructions in how to practice medicine is practicing medicine. A commission to study the ethics of managed care in 1927 suggested the expansion of contract style practice, but the AMA adopted the minority opinion that was against this type of expansion. In 1930, the AMA said it was unethical
care system contributed to cost inflation opened the doors to rapid acceptance and growth of managed care systems.\(^{20}\) With the passage of the Health Maintenance Act of 1973, the federal government encouraged the development of HMOs.\(^{21}\) The intent of this act was to encourage development of new programs that promoted preventive care and created incentives to physicians to keep people well, rather than only providing care after illness had begun.\(^{22}\) The federal government further supported this growth when, in 1979, an order was issued to the American Medical Association to cease its ethical restraints on the manner in which physicians contracted with entities that offered medical services to the public.\(^{23}\) Corporate medicine is now accepted as a legitimate means for delivering health care, and the federal government supports cost-containment measures in both in-patient and out-patient settings.\(^{24}\) Managed care organizations have taken advantage of corporate medicine laws to avoid liability by claiming that since corporations cannot practice medicine under these state laws, then they, as corporations, are not practicing medicine, and therefore cannot be held liable for medical malpractice.\(^{25}\)

B. What are HMOs?

The catalyst for the modern explosion of growth of HMOs was the uncontrollable increase in the costs of health care.\(^{26}\) The primary goal of HMOs is health care cost containment, with a second and separate goal of making health care more available and more affordable to more Ameri-

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\(^{20}\) Id. at 804.

\(^{21}\) Id. at 804-05. The HMO Act of 1973 encouraged the growth of HMOs by: (1) providing seed money for the start up of non-profit HMOs, (2) requiring employers with 25 or more employees to offer an HMO as an option if one was available in the geographical area (mandatory dual choice requirement), and (3) ending many of the state prohibitions against corporate medicine.


\(^{23}\) Lieberson, *supra* note 19, at 807. The Federal Trade Commission (FTC) issued this Final Order to the AMA. The FTC said that the AMA's restrictions on contract arrangements for physicians had the following anti-competitive effects: (1) they limit price competition between physicians by restricting them to fee-for-service and (2) they prevent creation of more economical business structures by restricting contracts between physicians and non-physicians.

\(^{24}\) Id. at 808-09. Many states still have laws prohibiting the practice of corporate medicine.

\(^{25}\) Id. at 808-09.

An HMO is a type of MCO that provides comprehensive health care to an enrolled membership for a fixed per capita fee. The common goal of MCOs is to provide health care services at a reduced cost through consumer competition. Arguably, HMOs can provide cost savings, and these cost savings are attributed to the incentives created by per capita fixed fees. Costs are controlled through cost-containment strategies such as: incentives to physicians to decrease the patient’s initial use of services; fixed fees for identified procedures; predetermined annual payment for comprehensive care (capitation payments); and decreased physician involvement if over-utilization of services by the plan participants can be demonstrated. Any or all of these may require the physician to act as a gatekeeper by denying or restricting health care measures requested by the patient.

MCOs create a new relationship among payors, participants and providers. The participant pays a fixed fee to the payor (MCO) in exchange for limits on his choice of provider. The payor accepts some of the financial risk from the provider (physician) in exchange for some control over the way the physician practices medicine. This is in contrast to the traditional relationship that existed directly between the physician and the patient. When malpractice

27. Id. See also Andy Miller, Managed Care Savings Noted, Atlanta J., June 5, 1997, at E3 (noting prediction that HMOs will save Americans up to $383 billion this decade).
28. See Thomas W. Malone and Deborah H. Thaler, Managed Health Care: A Plaintiff’s Perspective, 32 Tort & Ins. L.J. 123 (1996) (quoting John K. Inglehart, Health Care Policy Report—Physicians and the Growth of Managed Care, 331 New England J. Med. 1167 (1994)) (An MCO is “a system that, in varying degrees, integrates the financing and delivery of health care through contracts with selected physicians and hospitals that provide comprehensive health care services to enrolled members for a predetermined . . . premium.” (alteration in original)). See also Scheutzow, supra note 22 (quoting from the National Association of Insurance Commissioners—Draft Paper on the Regulations of Risk Bearing Entities, 1996, at 1 n.3) (A managed care organization is defined by the National Association of Insurance Commissioners as a risk bearing entity of one or more persons that contracts with individuals, employers or other groups to arrange for or provide health care benefits on a basis that involves the assumption of insurance risk by the risk bearing entity.).
29. Furrow, supra note 17, at 478.
30. American College of Legal Medicine, Legal Medicine 164 (3d ed. 1995). Common features of MCOs are: (1) they select restricted groups of health care professionals who provide services to program participants; (2) the programs accept fixed payments by the participants in exchange for arranging for the provision of health care (this pressures the MCO to find ways to cut costs); and (3) they use strategies to ensure cost-effective care such as utilization review techniques, incentives, and creating health care gatekeepers.
31. Furrow, supra note 17, at 480.
32. Legal Medicine, supra note 30.
33. Furrow, supra note 17, at 480.
34. Wayne Blackmon, The Emerging Convergence of the Doctrine of Informed Consent and Judicial Reinterpretation of the Employee Retirement Income Security Act, 19 J. Legal Med. 377 (1998). In the traditional patient-physician relationship, an independent fiduciary relationship existed between the two parties. Under a managed care system, the HMO acts as a middleman between the participant/patient and the network physicians. The HMO has the ability to control the physician’s access to patients and vice versa. See also Deborah W. Larios, Barbarians at the Gate? An Essay
occurs in a traditional patient-physician relationship, direct liability exists between the patient and the physician. In a patient-HMO-physician relationship, however, theories of liability have become complex.

There are several kinds of HMOs, the most prevalent being staff models, group models and network HMOs. The classification of the HMO is relevant in suits in which the plaintiff claims the HMO was vicariously liable for the malpractice of its employer-physician or established a relationship of ostensible or apparent agency with its physicians. In a staff model HMO, the parent company owns the health care facility, and the physicians are direct employees who provide care to plan enrollees. In a group model HMO, the parent company contracts with a medical group which, in turn, contracts with the physicians who are paid a fixed monthly fee. Finally, in a network model, the parent company contracts with several medical groups who collectively own the health care facility. The physicians provide care to plan enrollees as well as to patients outside the HMO plan.

C. What is ERISA?

ERISA was passed in 1974 in response to public outcry over the lack of fairness and soundness of private retirement programs, and it was designed to remedy certain defects in the private retirement system. The government had been bombarded for years with stories of employees losing their pensions, and the desire to protect these workers from such pension plan abuses prompted

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36. Id.
37. Id.
38. Id.
39. Id. There are also independent practice associations (IPAs) which are usually formed by a physician's organization which contracts with an MCO to provide services to a group of enrollees, but does not work only for the HMO. Preferred provider organizations (PPOs) are the fastest growing type of MCO. A panel of health care providers agrees to provide services at cost in return for the marketing advantage of being "preferred providers." The PPO enrollees' choice is not limited to PPO physicians. There is less incentive for physicians to cut costs because the physicians do not agree to fixed payments and they maintain their independence. Id. at 814. In a POS (point of service) plan, the enrollee can get services from the preferred organization or from an outside provider. A managed indemnity plan is a traditional fee-for-service plan and is not an MCO. Id.
Congress to enact ERISA. ERISA was proposed to establish minimum standards of benefit insurance to protect the security of pension rights so that an employee covered by a pension plan became entitled to protection of his future retirement benefits in case of termination of his employment. The primary purpose of ERISA is to:

- protect . . . the interests of participants in employee benefit plans . . .
- by requiring the disclosure and reporting to participants . . . of financial and other information . . .
- 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 the Federal courts.

In this way, ERISA serves to protect employers from multiple and conflicting state regulations. ERISA does not mandate that employers provide benefit plans, so it is up to employers to voluntarily create them for their employees. To encourage this development of plans, ERISA establishes uniform regulations and imposes federal oversight of this area. Essentially, ERISA holds employers to their promises when they offer employees fringe benefits and mandates that fringe benefits, such as pension plans or medical benefits, have to be adequately funded. ERISA also requires that eligibility for benefits be fairly decided, reports be filed and benefits be managed by fiduciaries answerable to employees and to the United States Department of Labor.

When a dispute involves an employee benefit plan, ERISA is implicated. Employee benefit plans include both welfare benefit plans and pension benefit plans. Welfare benefit plans provide employees with “medical, surgical, or hospital care benefits, or benefits in the event of sickness, accident, disability, death or unemployment.” HMOs typically contract to provide these types of health benefits through the plan offered to employees; therefore, HMOs have been accepted by the courts as benefit plans. So

43. 29 U.S.C. § 1001(b) (1998). This statute also applies to participants’ beneficiaries.
44. L. Frank Coan, Jr., You Can’t Get There From Here—Questioning the Erosion of ERISA Preemption in Medical Malpractice Actions against HMOs, 30 Ga. L. Rev. 1023, 1038 (1996).
45. Id.
46. Id.
47. Ayling, supra note 18, at 406.
48. Id. For a discussion of the transformation of ERISA’s protection of employees to protection of employers, see supra note 33 to infra note 65 and accompanying text.
49. Coan, supra note 44, at 1039.
52. Coan, supra note 44, at 1039. See also 29 U.S.C. § 1003(a) (1998). ERISA applies to:

any employee benefit plan if it is established or maintained (1) by any employer engaged in
what does ERISA have to do with claims by patients for malpractice and denial of coverage of HMOs?

D. Preemption

The recognition by federal judges that HMOs can qualify as ERISA plans has created a loophole through which HMOs can avoid liability. Though ERISA does provide employers with protection by creating uniform regulation of benefit plans, courts and commentators have noted that the intent when ERISA was enacted was to provide protection to employees, not to employers. As commerce or actively affecting commerce; or (2) by any employee organization representing employees engaged in commerce or in any industry or activity affecting commerce; or (3) both. See also Kanne v. Connecticut Gen. Life Ins. Co., 867 F.2d 489, 492 (9th Cir. 1988), cert. denied, 492 U.S. 906, 109 S. Ct. 3216 (1989) (The question of whether an ERISA plan exists is “a question of fact, to be answered in light of all the surrounding facts and circumstances from the point of view of a reasonable person.”). See also Donovan v. Dillingham, 688 F.2d 1367, 1370 (11th Cir. 1982) (en banc) (A welfare benefit plan under ERISA requires five essential elements: (1) a plan, fund, or program (2) established or maintained (3) by an employer or by an employee organization, or by both (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, unemployment or vacation benefits, apprenticeship or other training program, day care centers, scholarship funds, prepaid legal services or severance packages (5) to participants or their beneficiaries). See, e.g., Page v. Heeman, No. L-93-372, 1993 WL 818743 (D. Md. Oct. 1, 1993) (the HMO was not an ERISA plan because it had not been "established or maintained") and Wickline v. Northwestern Nat'l Ins. Co., 908 F.2d 1077 (1st Cir. 1990) (the insurance plan was "established and maintained" so as to be a qualified ERISA plan). See also Byard v. Qualmed Plans for Health, Inc., 966 F. Supp. 354, 357 (E.D. Pa. 1997) (The United States Department of Labor, as authorized by 29 U.S.C. § 1135, has promulgated regulations clarifying what “employee welfare benefit plans” and “welfare plans” are by describing activities that do not involve employee benefit plans. These regulations are found in 29 C.F.R. 2510.3-1(i) and state that group health insurance programs which do all of the following are not employee welfare benefit plans under ERISA: (1) no contributions are made by the employer or employee organization; (2) participation in the program is completely voluntary for employees or members; (3) the sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs dues and to submit them to the insurer; and (4) the employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.). See also Kanne, 867 F.2d at 492 (if any of these elements is missing, an employee benefit plan is subject to ERISA as a matter of law). See, e.g., Pacificare v. Martin 34 F.3d 834 (9th Cir. 1994) (for an example of application of the United States Department of Labor’s regulations). Also consider that some HMOs are federally qualified under 42 U.S.C. § 300e and federal jurisdiction may apply to these HMOs pursuant to 29 U.S.C. § 1132(e)(1) & (f) (1998).

53. Lieberson, supra note 19, at 810.

54. See Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 103 S. Ct. 2890 (1983) (the United States Supreme Court observed that ERISA was enacted as a “comprehensive statute designed to promote the interests of employees and their beneficiaries in employees benefit plans.” Id. at 90, 103 S. Ct. at 2896.). See also Larry J. Pittman, ERISA’s Preemption Clause and the Health Care Industry: An Abdication of Judicial Law Creating Authority, 46 Fla. L. Rev. 355, 359 (1994) (the primary purpose
one commentator has suggested, "[i]t is difficult to discern in ERISA's goals any congressional purpose to protect health insurers," but that has been the effect of ERISA.55

The McCarran-Ferguson Act granted states total control of the insurance industry, but if the insurer is regulated by ERISA, state law is preempted by ERISA.56 Therefore, if an HMO is a qualified ERISA plan, state law claims against it may be preempted under the express preemption provisions of ERISA.57 Since medical responsibility is governed by state malpractice laws, claims of medical malpractice by an HMO have typically been preempted by ERISA.58

ERISA provides HMOs with two strong defenses against liability: complete preemption59 and conflict preemption.60 These are two entirely different concepts, but are easily confused. To avoid confusion, some courts use terms focused on removability rather than complete preemption.61 Conflict, or ordinary, preemption however, does not confer removal jurisdiction.62 The distinction between ordinary preemption and complete preemption is important.63 If a state law claim falls outside the scope of ERISA's civil enforcement of ERISA is to provide protection to employees, not to employers. See also 120 Cong. Rec. 29,935 (1975) (Sen. Javits) (at the time of its passage, ERISA was heralded as "nothing less than a pension 'bill of rights' to which every worker . . . is entitled"). See also 120 Cong. Rec. 29,193 (Sen Biaggi) (it was called an employee's "emancipation proclamation"). See also Pittman, supra, at 360 (citing savings clause and Shaw) ("There is no indication in the language of ERISA's preemption clause, or in ERISA's legislative history, that employers and benefit plans were to obtain some self-promoting protection for state law obligations.").

55. Ayling, supra note 18, at 407.
56. Id. The McCarran-Ferguson Act of 1945 gave the power to regulate insurance to the states. Id. at 806. This included such regulations as controlling allowable premiums. Id. The ERISA statute has a savings clause and a deemer clause (29 U.S.C. § 1144(b)(2)(A) & (B) (1998)) which work together to protect state laws that cover the "business of insurance" under the McCarran-Ferguson Act and indirectly regulate insured, not self-funded, plans. Terese M. Connerton, Suits by Beneficiaries Against Plans or Employers to Recover Benefits, CA23 ALI-ABA 207, 238 (1996). However, if an ERISA plan exists and there is a claim under state law for denial of benefits or fiduciary representations related to the ERISA plan, the claims are preempted by ERISA despite the savings and deemer clauses.

57. Ayling, supra note 18, at 410.
58. Lieberson, supra note 19, at 810.
59. 29 U.S.C. § 1132(a)(1)(B) (1994) (also known as ERISA § 502(a)). "A civil action may be brought by a participant or a beneficiary . . . to recover benefits due him under the terms of the plan, to enforce his rights under the terms of his plan, or to clarify his right to future benefits under the plan."
60. 29 U.S.C. § 1144(a) (1998) (also known as ERISA § 514(a)). "Except as provided in subsection (b) of this section, the provision of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."
63. Id. Typically, a plaintiff files his state law claims against his HMO in state court, usually with no allegations concerning ERISA. The defendant/HMO removes to federal court under ERISA.
provision, the claim is not completely preemted, and federal courts are without removal jurisdiction and cannot resolve the question of whether the claim falls under the conflict preemption provision of ERISA. The significance of these defenses is that if a plaintiff's claims are preemted by ERISA, his recovery is severely limited by the civil enforcement provisions enumerated in ERISA.

1. Complete Preemption

ERISA provides a civil enforcement provision which allows civil actions to be brought against ERISA plans to: (1) recover benefits due under the plan, (2) enforce rights under a plan, or (3) clarify rights to future benefits. If the plaintiff's claims fit within one of these categories, the suit can be removed to federal court, and all state claims can be preemted. This provision provides a basis for federal subject matter jurisdiction. However, under the well-pleaded complaint rule, removal on the grounds of federal question jurisdiction requires that a federal question be present on the face of the plaintiff's complaint, so a plaintiff may avoid removal by alleging only common law causes of action. Theoretically, this rule makes the plaintiff the master of the claim: the plaintiff may avoid federal jurisdiction by exclusive reliance on state law. If the defendants assert preemption as a defense when only state law claims have been alleged, removal should not be permitted.

However, HMOs have traditionally been able to take advantage of an exception to the well-pleaded complaint rule. This exception exists where there is complete preemption of the state claim by congressional intent for federal legislation to occupy an area, leaving no place for state law. If there is congressional intent to replace state law with federal law, then state law will be completely preemted even if there is no federal claim on the face of the complaint. The exception requires a clearly manifested congressional intent to make causes of action removable to federal court. Once an area of state

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64. Id.
66. Id.
67. Dukes, 57 F.3d at 355.
68. Id.
70. Id. at 393, 107 S. Ct. at 2430.
71. Id.
72. Id.
74. Id. See also Cyr v. Kaiser Found. Health Plan of Texas, 12 F. Supp. 2d 556 (N.D. Tex. 1998).
law has been completely preempted, any claim purportedly based on that preempted state law is considered, from its inception, a federal claim, and therefore arises under federal law.”

There is complete preemption, and thus federal removal jurisdiction, over state claims when they fall within the three categories of ERISA’s civil enforcement provision. The Supreme Court has ruled that ERISA meets the requirements for this exception. The effect of complete preemption is that state claims are removed to federal court where the plaintiff is generally denied a jury trial and is limited to recovering the cost of the treatment denied because ERISA provides the exclusive remedy. The plaintiff cannot collect damages for health problems resulting from not receiving the treatment.

2. Conflict Preemption

If the state claim is not completely preempted under the civil enforcement provision and is, therefore, not removed to federal court, the claim may still be preempted by what is known as “conflict preemption.” This is a second line of defense for HMOs. This provision states that ERISA “shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan.” The Supreme Court has decided several cases involving ERISA preemption. Most of the ERISA cases decided by the Supreme Court

75. Caterpillar, 482 U.S. at 393, 107 S. Ct. at 2430.

82. Id. (emphasis added).
involved the scope of the term "relates to" and "the Court has struggled... with the inherent vagueness of that key statutory phrase." The Supreme Court has variously described the ERISA preemption clause as having a "broad scope, and an expansive sweep, and [as being] broadly worded, deliberately expansive, and conspicuous for its breadth." Under the Court's early test, developed in Shaw v. Delta Air Lines, Inc., ERISA conflict preemption hinged on whether the state law related to an ERISA plan—that is, did the state law have a connection with or a reference to an ERISA plan? This test was later expanded to include preemption of all state laws that indirectly affected benefit plans.

Under this early analysis of "relates to," federal courts found that most state law claims against ERISA plans fell within one of the three categories of claims in the civil enforcement statute which resulted in removal and complete preemption of the state law claims. Even if the state claims were found not to be completely preempted and were remanded to state court, the breadth of the meaning of the "relates to" clause allowed the state courts to find that the HMOs were immune from liability under the concept of conflict preemption.

Although ERISA preemption was expansive under this early Shaw analysis, it was recognized that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' a plan," and some claims against HMOs have succeeded. HMOs have been found liable under principles of agency, vicarious liability, corporate negligence and claims of breach of contract and unfair trade practices. Claims

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85. Dillingham, 519 U.S. at 321, 117 S. Ct. at 837 (internal citations omitted).
89. Barry B. Cepelewics et al., Recent Developments in Medicine and Law, 33 Tort & Ins. L.J. 583 (1998). See also Jass v. Prudential Health Care Plan, 88 F.3d 1482 (7th Cir. 1996) (the court held that a vicarious liability claim against the health plan was not completely preempted, but "related to" an ERISA plan so was preempted under conflict preemption).
90. Corcoran, 965 F.2d at 1329 (quoting Shaw, 463 U.S. at 100, 103 S. Ct. at 2901 n.21.
for denial of benefits and breach of fiduciary duty, though, have traditionally been found to be preempted by ERISA.91

III. THEORIES OF RECOVERY AGAINST HMOs

A. Vicarious Liability and Ostensible/Apparent Agency Claims

The theory behind vicarious liability, or respondeat superior, is that the employer is liable for the acts of his employees if committed within the course and scope of employment.92 The test for determining if there is an employer-employee relationship focuses on the amount of control the employer exercises over the employee.93 In a health care setting, if the health care institution has substantial control over the physician's choice of patients or furnishes the physician with equipment, an employer-employee relationship exists.94 "Courts look at the operation of the HMO and determine if it conducts itself in a fashion akin to a health care provider," and if the answer is yes, the HMO is subject to the same liability as a hospital.95 For example, in Robbins v. HIP of New Jersey,96 Lorraine Robbins died after being diagnosed and treated for breast cancer. Her husband sued the HMO for professional negligence.97 The court stated there was no policy against holding an HMO liable under respondeat superior if the actual health care provider was directly employed by the HMO.98

If there is no direct control, and thus no vicarious liability, the court may find that an agency relationship exists.99 If a plan sponsor/employer has created an expectation on the part of the patient that the plan will make available high-quality providers of care, then there may be ostensible or apparent agency.100

91. See, e.g., Corcoran, 965 F.2d 1321 (a denial of benefits claim is preempted by ERISA). See also infra notes 150-160 and accompanying text for discussion of breach of fiduciary duty claims.


93. Id.

94. Furrow, supra note 17, at 483. See also Sloan v. Metropolitan Health Council of Indianapolis, Inc., 516 N.E.2d 1104, 1109 (Ind. App. Ct. 1987) (HMO may be held vicariously liable for the acts of employee physicians when the usual requisites of agency or employer-employee relationship exist); Raglin v. HMO Illinois, Inc., 595 N.E.2d 153 (Ill. App. Ct. 1992) (HMO not vicariously liable because no right of control over physician's professional conduct); Williams v. Good Health Plus, Inc., 743 S.W.2d 373 (Tex. App. 1988) (no liability for agency or respondent superior where the physicians were independent contractors); Schlier v. Kaiser Found. Health Plan of the Mid-Atlantic States, Inc., 876 F.2d 174 (D.C. Cir. 1989) (HMO was vicariously liable for its consulting physician even though physician was an independent contractor because HMO had some ability to control physician's actions).

95. Furrow, supra note 17, at 484.


97. Id.

98. Id.

99. Prosser, supra note 92, at 508.

100. Furrow, supra note 17, at 483.
Likewise, if the plan restricts the choice of providers, the providers may look like agents.  

In *Boyd v. Albert Einstein Medical Center*, the decedent, Mrs. Boyd, and her husband were participants in an HMO as provided by his employer. The Boyds, restricted to physicians listed as participating in the HMO, selected primary care physicians from the list. Mrs. Boyd subsequently became ill and required a surgical biopsy after which she was sent home. Once home, Mrs. Boyd experienced chest pain. She was examined in the emergency room and was again sent home where she later expired after suffering a heart attack. Mr. Boyd sued the HMO on theories of vicarious liability and ostensible agency. He alleged that the HMO had advertised that its physicians and health care providers were competent and had been evaluated prior to being selected to participate in the HMO. The trial court granted a motion for summary judgement for the HMO based on the plaintiff’s failure to establish an agency relationship. The Superior Court of Pennsylvania, however, after describing the relationship between the HMO and its physicians, held that an issue of material fact did exist, reversed the trial court’s order and remanded the case. The court noted that to determine if a treating physician is an ostensible agent, the court must consider whether the patient looks to the institution, rather than to the individual physician for care and whether the HMO holds the physician out as its employee.

**B. Corporate Negligence Claims**

Corporations, such as health care organizations, can also be held liable for the negligent selection, retention and supervision of their employees. A health care organization has a duty to its patients to ensure the competency of its medical staff and the quality of medical care provided through prudent selection, review and continuing evaluation of the physicians granted staff privileges. This duty extends to HMOs, which owe their plan participants a duty to select competent health care providers. This is a strong duty because the patient

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101. *Id.* at 486.
102. 547 A.2d 1229 (Pa. 1988).
103. *Id.*
104. *Id.*
105. *Id.*
106. *Id.*
108. *Id.*
109. *Id.*
110. *Id.*
111. *Id.*
113. *Id.* at 486.
114. *Id.* at 491.
has selected the HMO, but not the physicians, and the patient relies on the HMO for the selection of the physicians who will provide care as part of the HMO’s services. In addition, a failure to implement proper procedures to detect problems with physicians could lead to direct liability.

In McClellan v. HMO of Pennsylvania, Mrs. McClellan, as a member of the defendant HMO, selected her primary care physician from the provided list. The physician removed a mole from Mrs. McClellan’s back and discarded it without further testing despite reports that the mole had recently changed in size and color. Mrs. McClellan subsequently died from malignant melanoma that was not timely diagnosed or treated. Her husband sued the HMO under a theory of corporate negligence. The trial court dismissed the claim, but on appeal, this decision was reversed and remanded. The appellate court found the plaintiff’s allegations were sufficient to state a cause of action for negligence in the selection, retention and/or evaluation of the primary care physician. The court relied on Section 323 of the Restatement (Second) of Torts and found that a complaint sufficiently sets out a cause of action if it establishes that: (1) an HMO has undertaken to provide services to the patient; (2) the HMO should recognize the services are necessary for the protection of the patient; (3) the HMO failed to exercise reasonable care in selecting, retaining and/or evaluating the primary care physician; and (4) the failure resulted in an increased risk of harm to the patient.

C. Breach of Contract and Unfair Trade Practices Claims

Claims for recovery for breach of contract or claims that allege unfair trade practices are non-negligence claims. Under the early, broad interpretation

115. *Id.* See also Harrell v. Total Health Care, Inc., 781 S.W.2d 58 (Mo. 1989) (claim of malpractice that HMO was negligent in its selection of the surgeon who was incompetent and treated patient was exempt).

116. *Id.* See also Lupo v. Human Affairs Int’l, Inc., 28 F.3d 269 (2d Cir. 1994) (plaintiffs claim of negligence against the benefit plan for negligent hiring and negligent supervision of physician who engaged in negligent treatment and misuse of privileged information not preempted by ERISA).


118. *Id.*

119. *Id.*

120. *Id.* Mr. McClellan also sued the defendant HMO on theories of ostensible agency and misrepresentation. These claims were also dismissed by the trial court which was reversed on appeal.

121. *Id.*

122. *Id.*

123. Restatement (Second) of Torts § 323 provides: “One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other’s person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if (a) his failure to exercise such care increased the risk of such harm, or (b) the harm is suffered because of the other’s reliance upon the undertaking.”

of ERISA, some courts found that these claims were not related to ERISA plans. For instance, the court in *Smith v. HMO Great Lakes* found that the plaintiffs’ state law negligence claims were based on a contractual relationship between the HMO and the physicians and this did not “relate to” an ERISA plan, so the claims were therefore not preempted. In this case, the Smiths were participants in HMO Great Lakes. The HMO contracted with the community hospital to provide services to the plan participants. Mrs. Smith delivered a child by caesarean birth at the hospital after the infant suffered from fetal distress. The Smiths alleged this distress resulted in severe disabilities in the child. The Smiths sued the HMO based on a breach of contract between the HMO and the hospital for failure to provide reasonable care.

In *Memorial Hospital System v. Northbrook Life Insurance Co.*, the Fifth Circuit recognized that claims of deceptive and unfair trade practices are not preempted by ERISA. In this case, Mr. Echols and his family were participants in the HMO provided by his employer. The agreement was that there would be no coverage by the health plan until the employee had worked for the employer for thirty days. Mrs. Echols began receiving medical treatment from Memorial Hospital before Mr. Echols had worked the required amount of time. However, prior to providing treatment, Memorial Hospital had telephoned the HMO to verify coverage and was assured that Mrs. Echols was covered by the HMO. Relying on this representation, the hospital provided approximately $110,000 worth of medical services. The Echols assigned their rights to Memorial, but when the hospital requested payment from the HMO, the request was denied based on lack of coverage. The hospital sued the HMO on theories of negligent misrepresentation, breach of contract and deceptive and unfair trade practices. The trial court dismissed the breach of contract and unfair trade practice claims as preempted by ERISA, but stated the negligent misrepresentation claim was not “related to” an ERISA plan. On appeal, the Fifth Circuit affirmed the dismissal of the breach of contract claim, but

125. See also *Memorial Hosp. System v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990) (claim by a hospital against HMO for unfair trade practices not preempted by ERISA, but claims based on breach of contract, fraud or misrepresentations are preempted).
127. *Id.*
128. *Id.*
129. *Id.*
130. *Id.*
131. *Id.*
132. 904 F.2d 236 (5th Cir. 1990).
133. *Id.*
134. *Id.*
135. *Id.*
136. *Id.*
137. *Id.*
138. *Id.*
reversed the dismissal of the unfair trade practices claim as not preempted by ERISA.139

In addition to breach of contract claims and unfair trade practices claims, breach of warranty claims may arise from the language of an HMO brochure if there is a promise of quality care.140 For example, in a concurring opinion in Boyd v. Albert Einstein Medical Center,141 the judge noted the literature distributed by the HMO to its participants "guaranteed" and "assured" the quality of care that would be provided. Based on this language, the judge noted that the plaintiff's complaint supported a breach of warranty claim against the HMO.

D. Utilization Review and Denial of Benefits Claims

Since the passage of ERISA, the health care delivery system has evolved from a fee-for-service system to one of managed care.142 In managed care, the health care services considered for a patient are reviewed prospectively or concurrently in order to determine if the medical treatment is necessary.143 This is known as utilization review, and the purpose is to contain health care costs by limiting or rationing the amount of health care available to plan participants.144 If it is deemed to be unnecessary, the service or payment for the service may be denied, and this denial of health care services can result in injury or death to the patient/participant.145 It is this review process that has led to the question of whether HMOs are providing medical care when they make medical-necessity decisions for which they can be held liable for medical malpractice.146

139. Id.
141. Id.
142. Suzanne M. Grosso, Rethinking Malpractice Liability and ERISA Preemption in the Age of Managed Care, 9 Stan. L. & Pol'y Rev. 433, 434 (1998). When ERISA was enacted, health plans did not act as providers of care. Health care was delivered on a fee-for-service system in which the patient received services and the health plan retrospectively reviewed and paid for those services. With retrospective review, treatment could not be denied since it had already been provided, so the patient's health was not endangered.
143. J. Scott Andresen, Comment, Is Utilization Review the Practice of Medicine?, 19 J. Legal Med. 431 (1998). Concurrent review is an ongoing review of the cost and quality of care for a particular patient. Id. at 434. Prospective review requires preauthorization before a physician may deliver medical care. Id. See also Vandall, supra note 26, at 1654 (citing Institute of Medicine, Controlling Costs and Changing Patient Care? The Role of Utilization Management 3, 17-18 (Bradford H. Gray & Marilyn J. Fields eds. 1989)) (noting the overall percentage of denied requests under a prospective review system is only one to two percent and that, often, medical necessity reviews are performed by insurance clerks with no formal medical training).
144. Andresen, supra note 143, at 432.
145. Id. at 435. Under ERISA, the patient and/or his survivors are left without an adequate remedy against the health plan because they are limited to recovering the actual cost of the benefit denied. 29 U.S.C. § 1132(a)(1) (1994).
146. Vandall, supra note 26, at 301. HMOs have rigorously argued against the idea that they are practicing medicine and are adamantly opposed to judicial review of their utilization review decisions. Id. If a medical malpractice claim is removed to federal court, there is no judicial review
The confusion giving rise to this question results from the dual roles that HMOs play. Initially, newly created ERISA-qualified health plans only acted to coordinate health care services, but gradually, dual roles were created by HMOs: as providers of health care and as administrators of benefit plans. These roles developed when HMOs contracted with employers to provide health insurance to the employees, then offered to administer these plans for the employers. Traditionally, courts did not distinguish between these two roles, and under the Supreme Court's broad interpretation of what "related to" an ERISA plan, most state claims against ERISA plans were found to be preempted. However, courts are now beginning to carefully delineate the boundaries of these two roles.

As administrators, the health plans have become ERISA fiduciaries. ERISA protects fiduciaries from negligence actions, but does not afford protection for "providers." Physicians, hospitals, and other direct providers of medical care have typically not been deemed fiduciaries whose standards of conduct are defined and liability limited by federal law. "Fiduciary," as used in ERISA, is construed broadly. If a person or entity is deemed a fiduciary under ERISA, claims of breach of fiduciary duty will be preempted and recovery will be limited by ERISA. A fiduciary's conduct, alone, may be of the decision, but if it is remanded to state court, decisions to deny health care will be reviewed by the courts. Id. at 310. The function of judicial review through a tort suit is to encourage the HMO to make a reasonable decision on patient treatment by considering factors other than profit. Id. at 301. One of the arguments against judicial review is that the courts are not technically trained to understand complex medical issues, but courts deal with complex medical, scientific and technological issues every day. Id. at 307.

147. Ayling, supra note 18, at 407.
148. Id.
149. See supra notes 53-91 and accompanying text for a discussion of the Supreme Court's analysis of ERISA's preemption clause.
152. Stephen D. Kinnard, Judicial Refusal to Apply ERISA Preemption to Tort Actions Against Health Care Providers, The Brief, Vol. 26, No. 2 (1997) at 26. See also 29 U.S.C. § 1002(21)(a) (1998) (A person is a fiduciary with respect to a plan "to the extent [that] he exercises any discretionary authority or control respecting management of [the] plan or . . . respecting management or disposition of its assets . . . or he has any discretionary authority or discretionary responsibility in the administration of such plan.").
153. See Herdrich v. Pegram, 154 F.3d 362 (7th Cir. 1998) (quoting from a statement by the Chairman of the House Comm. on Education and Labor, 120 Cong. Rec. 3977, 3983 (Feb. 25, 1974)).
154. 29 U.S.C. § 1104(a) (1998). See also Pegram, 154 F.3d at 371 (To properly state a claim for breach of fiduciary duty under ERISA, a plaintiff must allege that: (1) the defendants are plan fiduciaries; (2) the defendants breached their fiduciary duties; and (3) a cognizable loss resulted.).
enough to impose a fiduciary duty. These duties are breached if the fiduciary acts to benefit his own interests. A fiduciary who breaches his duty can be held liable to the plan for losses caused by the breach or for equitable or remedial relief. ERISA allows any plan beneficiary to sue any plan fiduciary for breach of fiduciary duty. A plan participant may bring an action for breach of fiduciary duty on behalf of the plan itself, but any recovery inures to the plan. An action may also be brought on behalf of the participant who is limited to recovering equitable relief.

Claims against HMOs in their second role as providers of care, such as injuries resulting from denial of benefits, have traditionally been found to be preempted under ERISA. However, recent Supreme Court and federal courts of appeals decisions have demonstrated a trend in allowing state claims to survive ERISA preemption.

IV. WINDS OF CHANGE

Under the Supreme Court’s broad interpretation of the “relates to” provision, claims of negligence for injuries resulting from denial of benefits, or improper utilization review, have almost always been completely preempted under the civil enforcement provision. These claims were typically found by the courts to

155.  Id. See also 29 U.S.C. § 1104(a)(1)(A) (1998) (Under ERISA, a “fiduciary shall discharge his duties with respect to a plan solely in the interests of the participants and beneficiaries and for the exclusive purpose of providing benefits to [them] and defraying the reasonable expenses of administering the plan.”).

156.  Pegram, 154 F.3d at 371. See also 29 U.S.C. § 1104(B) (1998) (These duties will be discharged by the fiduciary “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.”).

157.  29 U.S.C. § 1109(a) (1998) (“Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.”).

158.  29 U.S.C. § 1132(a)(3)(A) (1998) provides that a plan participant, beneficiary or fiduciary may bring a civil action to “enjoin any act or practice which violates any provision of [ERISA] or the terms of the plan, or to obtain other appropriate relief to redress such violations or to enforce any provision of [ERISA] or the terms of the plan.”


160.  See 29 U.S.C. § 1132(a)(3) (1998). See also Allinder v. Inter-City Products Corp., 152 F.3d 544 (6th Cir. 1998) (stating that equitable relief does not include punitive or compensatory damages, but is instead similar to injunctions or restitution).

161.  See also Memorial Hosp. System v. Northbrook Life Ins. Co., 904 F.2d 236 (5th Cir. 1990) (claims by plan participant alleging improper processing of a claim for plan benefits is preempted by ERISA); but see Wickline v. State, 239 Cal. Rptr. 810 (Cal. 1987) (third party payors can be held accountable when medically inappropriate decisions result from defects in the design or implementa-
be for "recover[y] [of] benefits due under the plan, to enforce rights under a plan, or to clarify rights to future benefits,"162 or they were claims for negligence resulting from a breach of fiduciary duty in administering the plan.163 Thus, once preempted, the plaintiff could only recover the cost of the benefit denied.164 However, recent Supreme Court decisions have limited the scope of the "relates to" provision.165 As a result, more suits alleging state claims of negligence or malpractice by HMOs are surviving complete preemption and are being remanded to state court.166 "Commentators and case law show that when cases are remanded to state courts, even though conflict preemption may be available as a defense, state courts are disinclined to offer immunity to HMOs."167

A. Judicial Changes

1. United States Supreme Court

In New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.168 in 1995, the Supreme Court noted that the phrase "relates to" had previously been given a broad, textual meaning. Justice Souter concluded that the text of the ERISA preemption clause "could not be read to extend to the furthest stretch of its indeterminacy, [or] for all practical purposes, preemption would never run its course for [r]eally, universally, relations stop nowhere."169 Since its decisions in Travelers and subsequent cases, the Supreme Court has provided more concrete guidelines regarding the scope of "relates to" preemption.170 The two-prong test formulated in Shaw v. Delta remains intact—a state law relates to ERISA if it: (1) has a reference to or (2) a connection with an ERISA plan, unless the relation is "too tenuous, remote, or peripheral."171 However, in Travelers and subsequent cases, the Supreme Court has put limitations on what references and connections are sufficient to find that the state

169. Id. (quoting H. James, Roderick Hudson xli (New York ed.) World Classics 1980).
170. Id.
law actually "relates to" an ERISA plan.\textsuperscript{172} Thus, under the first prong of the \textit{Shaw} test, there is no "reference to" an ERISA plan if the state law does not act immediately or exclusively on an ERISA plan, or where the existence of an ERISA plan is not essential to the state law's operation.\textsuperscript{173} Under this new analysis, state laws that have only an indirect economic impact on ERISA plans will not necessarily be preempted.\textsuperscript{174}

Under the second prong of \textit{Shaw}, to determine if a state law has the forbidden connection with an ERISA plan, the Supreme Court has looked beyond the text of ERISA.\textsuperscript{175} Courts must now consider "the objectives of the ERISA statute as a guide to the scope of state law that Congress understood would survive" and the nature of the effect of the state law on ERISA plans.\textsuperscript{176} State laws that expressly refer to ERISA will still be superseded by ERISA.\textsuperscript{177}

To support this new analysis, the Supreme Court has described the purpose of ERISA as being to "avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans."\textsuperscript{178} This is accomplished through "reporting, disclosure, fiduciary responsibility, and the like."\textsuperscript{179} Furthermore, the Supreme Court noted that in cases where federal law is said to bar state action in fields of traditional state regulation, there is an "assumption that the historic police powers of the states [are] not to be superseded by the federal act unless that was the clear and manifest purpose of Congress."\textsuperscript{180} If it is a field traditionally occupied by the states, there is a considerable burden in overcoming the presumption that Congress does not intend to supplant state law.\textsuperscript{181}

The historic police powers of a state include the regulation of matters of health and safety.\textsuperscript{182} The Court has noted that the preemptive reach of ERISA and the words "relate to" would limit nothing if ERISA were concerned with any state action potentially affecting the choices made by ERISA plans, such as standards for medical care quality or hospital workplace regulations that would increase costs of providing certain benefits.\textsuperscript{183} If ERISA were read as preempt-
ing all state laws even indirectly related to ERISA plans, this would effectively read the limiting language out of the statute. This "conclusion... would violate basic principles of statutory interpretation and could not be squared with [the Supreme Court's] prior pronouncement that "[p]reemption does not occur... if the state law has only a tenuous... connection with covered plans, as is the case with many laws of general applicability.""

The Supreme Court's most recent action regarding the issue of ERISA preemption was to grant certiorari in Unum Life Insurance Co. of America v. Ward. In this case, the plaintiff, John Ward, became disabled in 1992 and notified his company's human resources department. Mr. Ward claimed his company failed to tell him he qualified for disability insurance through Unum, the defendant. After the deadline had passed for applying for benefits, Mr. Ward discovered a brochure from which he learned he qualified for benefits. He then applied for benefits, but was denied. The basis of Mr. Ward's claim was a California law that said if an insurer does not have an agent in the workplace, then the company's personnel department acts as the insurer's agent. Under this law, Mr. Ward's original notification to his company's human resources department was timely. The lower court found these claims were preempted by ERISA. The Ninth Circuit reversed and remanded on the basis of another California law which states that insurers may not deny a claim that is not timely without reviewing the merits of the case. In addition, the insurer must prove that the insurance company was prejudiced by the claimant missing the deadline. The Supreme Court has granted certiorari to determine if ERISA should override state laws.

2. Federal Circuit Courts

Following the Supreme Court's lead, some federal circuits have developed their own tests for determining the reach of preemption under ERISA.

185. Id. (citation omitted).
186. 135 F.3d 1276 (9th Cir.), cert. granted, 119 S. Ct. 334 (1998).
187. Id. at 1279.
188. Id.
189. Id.
190. Id.
191. Unum, 135 F.3d at 1279.
192. Id.
193. Id.
194. Id. at 1280.
195. Id.
a. Third Circuit: Quality v. Quantity Test

Shortly after the Travelers ruling by the Supreme Court, the Third Circuit decided Dukes v. U.S. Healthcare in which two HMOs were sued for malpractice. Because the plaintiffs' complaints did not attack the erroneous withholding of benefits by the HMOs, the court, on appeal, held the state claims were not completely preempted and remanded the cases to state court.

In both suits, the plaintiffs alleged the HMOs were negligent under theories of ostensible agency and for the negligent selection, retention and supervision of the medical personnel who provided the negligent health care. The Third Circuit distinguished allegations regarding the quantity of service from allegations about the quality of service. The court ruled that to be completely preempted, the complaint, on its face, must be for claims "to recover benefits due him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." The plaintiffs, and the United States Department of Labor as amicus curiae, viewed these claims as simply attacks on the behavior of the HMOs which was separate from the administration of the ERISA plan. The defendant HMOs argued that the claims of negligence and agency only related to the quality of the plan benefits and the HMOs' roles in arranging those benefits. The court assumed that if the complaints had alleged that the HMOs refused to provide the services to which membership in the plans entitled the plaintiffs, the claims would be preempted. However, the court agreed with the plaintiffs and the Department of Labor, stating "the plaintiffs here simply do not claim that the plans erroneously withheld benefits due. Nor do they ask the state courts to enforce their rights under the terms of their respective plans or to clarify their rights to future benefits." Rather, the plaintiffs complained about the low quality of the medical treatment that they actually received.

The Third Circuit then applied the rules of statutory construction and determined that Section 1132(a)(1)(B) of ERISA said nothing about the quality of benefits received, but was concerned exclusively with whether or not the

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197. 57 F.3d 350 (3d Cir.), cert. denied, 516 U.S. 1009, 116 S. Ct. 564 (1995). Two cases were consolidated and were heard on an appeal of the district courts' dismissals of motions to remand to state court. The district courts had found the plaintiffs' claims were completely preempted by ERISA.

198. Id.


200. Dukes, 57 F.3d at 356.

201. Id.

202. Id.

203. Id.

204. Id.
benefits due under the plan were actually provided. The court also concluded that nothing in the legislative history, structure, or purpose of ERISA suggested that Congress intended this complete preemption provision to create a remedy for a plan participant injured by medical malpractice. Quality control is a field traditionally occupied by state regulation, and the Third Circuit interpreted congressional silence as reflecting an intent that it remain as such.

The Third Circuit also recognized that HMOs play two roles: as utilization reviewers and as arrangers of medical treatment. It is only in the role as utilization reviewer that an entity is in a position to deny benefits under an ERISA plan. In these cases, the plaintiffs were attempting to hold the HMOs liable for their roles as arrangers of medical treatment, and not in the roles of utilization reviewers. Furthermore, the court said, “[P]atients enjoy the right to be free from medical malpractice regardless of whether or not their medical care is provided through an ERISA plan.”

This “quality versus quantity” test has been followed in recent Third Circuit cases to determine if state claims against ERISA plans are completely preempted. For example, in Eaccarino v. Canlas, the plaintiff alleged that the treating physicians were negligent in failing to order appropriate testing and that these physicians were ostensible agents of the HMO. The case was removed to federal court, but was remanded. The court found these claims were not completely preempted because there was no allegation that the HMO was liable because of refusal to provide a benefit due under the plan or that the HMO had any role in directing the plaintiff’s medical treatment. The court noted that, “under well settled precedent, such garden variety medical malpractice claims do not implicate complete preemption doctrine.”

b. Fifth Circuit: Sommers Test

The Fifth Circuit has created its own two-part test for determining when a relationship to an ERISA plan is “too tenuous.” This test was established in

205. Id. at 357.
206. Id.
207. Id.
208. Id. at 361.
209. Id. at 360.
210. Id.
211. Id. at 358.
213. Id. at *4.
214. Id.
Sommers Drug Stores Co. v. Corrigan Enterprises, Inc. In this case, the plaintiff, an employee profit-sharing trust, sued the defendants for breach of fiduciary duties under ERISA. At trial, the jury found the defendants had breached their fiduciary duties and awarded the plaintiffs punitive damages. On appeal, the Fifth Circuit reversed and remanded because ERISA does not provide for these types of damages for breach of fiduciary duty. To guide the lower court, the Fifth Circuit carefully described a two-pronged test to be used for determining if a state law "relates to" an ERISA plan in "too tenuous" a way. If the relationship is found to be "too tenuous," the state law will not be preempted by ERISA.

The elements of the Sommers test are: (1) if a state law does not fall within an area of exclusive federal concern or the state law involves an exercise of traditional state authority, it is less likely the state law will be found to be related to an ERISA plan; and/or (2) if the state law directly affects the relationship between the principal entities (the employer, the plan, the fiduciary, and the participant and beneficiaries), then it is more likely to relate to an ERISA plan. To determine whether a claim falls within an area of exclusive federal concern or is an exercise of traditional state authority, the Fifth Circuit recognized that Congress’ intent in enacting ERISA was the “ultimate touchstone.” The court clarified the purpose of ERISA as being to “promote the welfare of employees and their beneficiaries by protecting their contract defined benefits” and noted that a party’s recovery is limited under the civil enforcement provision of ERISA. Therefore, under the first prong of the Sommers test, claims which allege that an ERISA plan denied a participant benefits may more likely be preempted by ERISA.

Under the second prong of the test, a court must identify under what capacity the claim affects the parties. A state claim may affect the relations of parties who are principal entities, but in capacities that are not governed by ERISA, such as a patient-provider relationship. Under part two of the Sommers test, the question, then, is not whether the state law nominally affects

217. Id. at 1457.
218. Id.
219. Id. at 1459.
220. Id. at 1465.
221. Id.
223. Id.
225. Id.
226. Sommers, 793 F.2d at 1467-68.
the relationship between parties who happen to be principal entities, but whether the state claim affects the duties of the principal entities which arose from the terms of the benefit plan.\textsuperscript{228}

This test has been applied by lower courts in recent negligence suits against HMOs.\textsuperscript{229} For example, in \textit{Blum v. Harris Methodist Health Plan, Inc.},\textsuperscript{230} the plaintiffs alleged claims that related to the quality of the medical services provided by the HMO. The plaintiffs claimed that the HMO had a duty as a provider of medical care, and this duty was breached.\textsuperscript{231} The court applied the \textit{Sommers} test and found that this duty arose independently of the terms of the plan, so this was not an area of exclusive federal control and part one of the \textit{Sommers} test was not met.\textsuperscript{232} To meet the second prong of the test, the court examined whether the plaintiff’s claims affected the relationship between the parties in their capacities as principal entities.\textsuperscript{233} The court found that the plaintiffs’ claims of negligence and medical malpractice only affected the patient-provider relationship and not the fiduciary-participant relationship, so part two of the test was also not met.\textsuperscript{234} Because the plaintiffs’ claims were too tenuous to be related to an ERISA plan and were, therefore, not preempted by ERISA, the court granted the motion to remand to state court.\textsuperscript{235}

\textsuperscript{228} Id.


\textsuperscript{230} No. 3:97-CV-0374P, 1997 WL 452750 (N.D. Tex. July 31, 1997). See also Cyr v. Kaiser Found. Health Plan of Texas, 12 F. Supp 2d 556 (N.D. Tex. 1998) (Plaintiffs alleged the HMOs, while providing medical care, were negligent in failing to properly diagnose and treat serious physical ailments. Neither plaintiff alleged a claim based on improper denial of benefits. The court applied the \textit{Sommers} test and found: (1) that because the plaintiffs’ claims of medical malpractice alleged that the HMOs had a duty as providers of care that arose outside the terms of the plan, these claims did not involve an area of exclusive federal concern; and (2) the plaintiffs’ claims of negligence and medical malpractice did not directly affect the relationship between the principal entities, but only affected the relationship between the parties as provider of care and patient. Because neither prong of the \textit{Sommers} test was met, the claims were “too tenuous” to relate to an ERISA plan and were, therefore, not preempted.).

\textsuperscript{231} \textit{Blum}, 1997 WL 452750 at *3.

\textsuperscript{232} Id.

\textsuperscript{233} Id.

\textsuperscript{234} Id.

\textsuperscript{235} Id. at *4.
The Fifth Circuit and lower courts, however, have applied this test inconsistently. In Sommers, for example, the Fifth Circuit based its decision solely on the second prong of the Sommers test after reasoning that the first factor was unsupported by the broad language of ERISA. However, in Memorial Hospital System v. Northbrook Life Insurance Co., the same court relied on both prongs of the Sommers test to determine that a state law was not related to an ERISA plan. In addition, there are cases in which the Fifth Circuit has decided preemption issues without relying on the Sommers test at all. Finally, the Fifth Circuit's oft-cited decision in Corcoran v. United Healthcare, Inc. has placed limits on the usefulness of the Sommers test in denial of benefits cases. In Corcoran, a claim alleging injuries resulting from a denial of benefits was found to "relate to" an ERISA plan and was preempted. The district court reasoned that under the Sommers test "but for the ERISA plan, the defendants would have played no role . . . [and] the ERISA plan was the source of the relationship between the [plaintiff] and the defendants;" therefore, the plaintiff's claim directly affected a relationship between ERISA entities and was preempted. The Fifth Circuit, however, distinguished the relationship between the parties in Corcoran from the relationship between the parties in Sommers and therefore found that Sommers did not mitigate ERISA preemption in this case.

c. Ninth Circuit: Relationship Test

The Ninth Circuit has developed its own "relationship" test for determining the limits of ERISA preemption. In General American Life Insurance Co. v. Castonguay, the Ninth Circuit first stated that a state law claim is preempted if it "encroaches on the relationships regulated by ERISA." The key issue under this test is whether the parties' relationships are ERISA-governed

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237. 904 F.2d 236, 245 (5th Cir. 1990).

238. See, e.g., Cefalu v. B. F. Goodrich Co., 871 F.2d 1290 (5th Cir. 1989).

239. 965 F.2d 1321 (5th Cir.), cert. denied, 506 U.S. 1033, 113 S. Ct. 812 (1992) (Mrs. Corcoran brought a claim of malpractice for denial of benefits against her HMO after losing her unborn child. Her physician had requested that Mrs. Corcoran be put on bedrest in the hospital because of a high-risk pregnancy. Her health plan, however, refused to authorize hospitalization, but agreed to pay for home health nurse visits. At a time when no nurse was present, Mrs. Corcoran went into premature labor and subsequently lost her child.).

240. Id. at 1325.

241. Id.

242. Id. at 1334.


244. 984 F.2d 1518, 1522 (9th Cir. 1993).
relationships. This test was applied in Geweke Ford v. St. Joseph's Omni Preferred Care Inc. The Ninth Circuit reiterated the three areas the Supreme Court has recognized in which ERISA was intended to preempt state law claims. State laws are preempted if they: (1) mandate employee benefit structures or their administration; (2) bind employers or plan administrators to particular choices or preclude uniform administrative practices thereby functioning as regulations of an ERISA plan themselves; or (3) provide alternate enforcement mechanisms for employees to obtain ERISA benefits. If the state claim falls outside these three areas, arises from state laws of general applicability, or does not depend on ERISA or affect the relationship between principal ERISA participants, the state claim is not preempted. This test more clearly delineates the "connection with" test from Shaw v. Delta Air Lines, Inc., but the "reference to" test remains unchanged. The Ninth Circuit has said:

The key to distinguishing between what ERISA preempts and what it does not lies ... in recognizing that the statute comprehensively regulates certain relationships. [F]or instance, the relationship between plan and plan member, between plan and employer, between employer and employee ... and between plan and trustee. ... But, ERISA doesn't purport to regulate those relationships where a plan operates just like any other commercial entity—for instance, the relationship between the plan and its own employees, or the plan and its insurers or creditors. ... The Ninth Circuit has also clarified what is not meant by "administering" a plan; the performance of ministerial, non-discretionary functions is not administration of a plan, and a person without authority to grant, deny, or review denial claims is not a fiduciary.

This test was applied in Moreno v. Health Partners Health Plan. The plaintiff in this case brought a medical malpractice action against his HMO and

245. Id.
246. 130 F.3d 1355 (9th Cir. 1997).
247. Geweke, 130 F.3d at 1360.
249. Arizona State Carpenters Pension Fund v. Citibank, 125 F.3d 715, 724 (9th Cir. 1997).
251. Arizona, 125 F.3d at 724 & n.4.
252. Id. (citing General American Life Ins. Co. v. Castonguay, 984 F.2d 1518, 1521-22 (9th Cir. 1993)).
physician alleging negligence in the creation of a substandard care plan. The court held that medical malpractice is a state common law claim that is not preempted by ERISA. The court applied the Ninth Circuit’s “relationship” test and found that the ability to sue on a medical malpractice claim does not fit within the three areas of exclusive federal control. Furthermore, medical malpractice claims are grounded in state common laws of general application to any medical practitioner whether or not the medical care was arranged for, paid for, or the physician was engaged by an employer benefit plan. Lastly, the possibility of a medical malpractice claim does not affect the relationship between principal ERISA entities. The court found that the medical malpractice claim was not completely preempted by ERISA and remanded the case to state court.

d. Effects

Each of these tests seems to recognize the dual nature of HMOs—as providers of care and as administrators of health plans. Under early ERISA analysis, these roles were not considered separately because they were so closely related to each other as to give rise to complete preemption of the plaintiffs’ state law claims against HMOs. With the Supreme Court’s step back from reading the “relates to” clause to the “limits of its indeterminacy,” however, lower courts have begun to differentiate the functions of these two roles.

Clearly, state laws affecting the administration of ERISA plans are expressly preempted under the civil enforcement statute. But, in considering the congressional intent for enacting ERISA and following the assumption that Congress has no intent to supplant state law, lower courts have been able to determine that claims against HMOs acting in the role as providers of care were not intended to be completely preempted. This is supported by the fact that, at the time ERISA was passed, health care was delivered on a fee-for-service basis and not through managed care. It is doubtful that Congress could have foreseen the impact of the tremendous growth of HMOs; nor could legislators foretell this dual role of HMOs which has resulted in a judicially created immunity for HMOs.

Under the Third Circuit’s “quality v. quantity” test, attacks on the quality of care provided reflect the HMO’s behavior in its “provider of medical care” role. This implies that a patient-provider relationship is not protected by ERISA. This

255. Id. at 892.
256. Id.
257. Id.
258. Id.
259. Moreno, 4 F. Supp. 2d at 893.
260. Id. The court did recognize that Arizona state law regarding corporate practice of medicine might serve as a defense at the state court level, but did not decide this issue because the court was without subject matter jurisdiction. Id.
is stated more clearly in the Ninth Circuit's test. The result of this test is that, if a plaintiff's complaint alleges the HMO acted negligently in the "provider of care" role, the claim is less likely to be completely preempted in federal court. However, if the plaintiff, on the face of his complaint, alleges that injury resulted from a denial of benefits by the HMO, the claim will be completely preempted because it is based on the role of the HMO as administrator of the plan. If the claims are remanded to state court, the possibility exists that the claims may still be preempted by ERISA's conflict preemption clause. At this level, however, the plaintiff has a better chance of recovering for damages because (1) he is not limited only to recovery of the cost of denied benefit, and (2) he may invoke his right to a trial by jury.

B. Legislative and Regulatory Changes

1. Congress

Though changes are apparent in the judicial interpretation of ERISA, there is still no consistent result. A claim that one circuit court finds preempted may not be preempted in another circuit. Typically, the defendant HMOs' first defense is to have a negligence or medical malpractice action immediately removed to federal court and have the federal court determine that the claims are completely preempted. Under the old "everything relates to" analysis, the federal courts' jurisdiction was easy to satisfy, and state law claims were quickly preempted. Under the newer analysis, federal courts must carefully scrutinize the records and make a determination of federal jurisdiction on a case-by-case basis. These determinations can tie the federal courts up for months, and under the new tests, many of these cases will ultimately be remanded to state court. To level the playing field between parties and eliminate judicial inefficiency, Congress should amend ERISA so that medical malpractice suits will be expressly allowed against ERISA-qualified HMOs.

As the result of consumer complaints, this issue was a "hot topic" in the 105th congressional session. The political parties are sharply divided on the issue of HMO liability. Republicans claim allowing liability will result in increased costs and a flood of litigation; Democrats deny this. Several bills were proposed to afford patients with more protections against their HMOs, but none of these bills was enacted.\textsuperscript{261}

The first bill\textsuperscript{262} was passed in the House of Representatives and was known as the "Patient Protection Act." This was the Republican House Bill, and it would not have removed the immunity from liability that HMOs enjoy. This bill left the right to make decisions regarding "medical necessity" in the hands of the insurance companies rather than with physicians. There was no requirement that

\textsuperscript{261} The President Clinton/Monica Lewinsky scandal derailed these legislative efforts.

\textsuperscript{262} H.R. 4250, proposed by Representative Newt Gingrich and supported by business groups.
grievance and appeals processes be conducted by health professionals, and patients would have been required to pay for any external review. This bill even went so far as to create new federal preemption of state protection laws for associations’ health plans and would have overridden patient protections currently enacted in several states. Furthermore, it did not hold health plans properly accountable for treatment decisions resulting in injury or death. This bill met with a tremendous amount of criticism, voiced most succinctly by Donna E. Shalala, Secretary of Health and Human Services:

I’m extremely disappointed in th[is] bill . . . While it may protect HMO profits, it certainly won’t protect patients’ rights. Americans need a Patients’ Bill of Rights that delivers real reforms. Th[is] bill simply gives lip service to those reforms, without really accomplishing them . . . The House bill leaves millions of Americans in the individual insurance market out in the cold, offering them no protections at all . . . It sets up an appeals process that has no teeth, and leaves crucial decisions about health care in the hands of the HMO bureaucrats, instead of doctors and their patients. It leaves patients and their families with no right to just compensation when injury or death result from a health care plan’s wrongful action.263

The second major proposal, known as the “Patient’s Bill of Rights,”264 was supported by the American Medical Association and numerous other consumer advocacy groups and medical groups. It provided a grievance and appeals process for protesting benefit denial decisions which must be reviewed for a timely resolution. If the patient utilized an external source to review the decision, the plan would be required to pay.265 In addition, utilization review must be done by qualified personnel, there can be no incentives that reward denials and decisions must be based on a “medically necessary standard.” Also, this proposal would have allowed individuals to sue under state causes of action for personal injury or wrongful death actions against the health plan. Employers would be protected from suits unless they made a decision to deny care that caused injury or death. This bill expressly eliminated ERISA preemption. A major criticism

264. H.R. 3605/S. 1890, known as the "Daschle/Dingell" bill, the "Democratic bill" and, because it was also supported by Republican Representative Ganske, also called the "bipartisan bill."
265. Id. The bill provided that: "Appeals and grievances must have a process for timely resolution and procedures for follow-up; a 72 hour limit for expedited internal review, 15 days for others-internal appeals may be oral and can be bypassed if plan misses deadlines; and external review if internal appeals were exhausted if life or health was in jeopardy with the following time limits—72 hours for expedited and up to 60 days for others—to be paid for the plan."
of this proposal was that allowing suits against HMOs would drastically increase
the cost of health care. However, a study by the Congressional Budget
Office indicated that this health care reform would raise insurance costs four
percent, which would be approximately $6.50 per month per employee. Other studies indicated costs would only increase between three to thirteen cents per month per plan enrollee or between 2.6% to 8.6% a year.

The third major proposal was the Senate Republican bill, known as the
“Patient Access to Responsible Care Act” (PARCA). This proposal was also
supported by consumer groups and provided many of the same protections as the
Patient Bill of Rights. For grievances and appeals, the bill provided that patients
must have the ability to appeal adverse decisions for denial of claims or
reimbursement. Internal review was to be done by appropriate clinical peers in
a timely manner. Utilization review, based on “sound medical evidence,”
was to be applied by health professionals, and there could be no incentives to
compensate for denials of care. Furthermore, patients could hold managed care
decision makers legally responsible for injuries suffered as a direct result of their
decisions. This permitted state liability laws to apply to ERISA plans in cases
of wrongful death or injury and did not specifically exempt employers from
being sued. One study by the Health Benefits Coalition called this proposal the
“Billion Dollar Bill” because ERISA plans would be exposed to three new types
of legal liability that would add almost one billion dollars to the annual cost of
the health care delivery system. Proponents of this bill, however, claimed
this study was greatly exaggerated and the costs would actually be about one
dollar per month per person.

The final major proposal was the Republicans’ “Patient Bill of Rights.” This proposal basically maintained the status quo and was allegedly full of
“poison pills.” This bill did not allow physicians the right to make final
treatment decisions, nor did it hold managed care plans accountable when their
decisions to withhold or limit care injured patients. Additionally, this bill did not
provide patients the right to obtain external review of benefit decisions.

267. Id.
268. Insurance Regulation: New Analysis of Health Plan Liability Puts Cost at Three to 13
Cents per Month, BNA’s Health Care Daily Report, July 9, 1998.
269. H.R. 1415/S. 644 sponsored by Representative Norwood and Senator D’Amato.
270. “Timely manner” would be within 1 hour for urgent cases and 24 hours for all others.
271. Study Calls PARCA the Billion-Dollar Bill, 2 No. 6 Mealey’s Litigation Reports: Managed
272. Id.
273. S. 2330 sponsored by Senators Lott and Nickles and known as the Senate Republican Bill
or the Republican Patient’s Bill of Rights.
274. These “poison pills” were items included in the bill to guarantee that if it were passed, it
would ultimately be vetoed.
Each of these bills died in the 105th Congress, subordinated to the Monica Lewinsky scandal which thwarted any attempt by Congress to support reform efforts. Representative Norwood was the first to introduce a health care reform bill in the 106th Congress. This new proposal, H.R. 216, was introduced January 8, 1999 and is known as the “Access to Quality Care Act” (AQCA). It is essentially a revised version of the 1998 PARCA bill, but also incorporates components of the Patient Protection Act (H.R. 4250). Opponents to this new proposal have called it “little more than last year’s Democratic bill in Republican clothing.” Representative Norwood has stated he will not support a partisan bill in 1999 and claims this proposal is bipartisan.

AQCA’s most notable provisions include: (1) amending ERISA to remove immunity from liability for HMOs, and (2) adopting an appeals process that allows patients to seek redress from health plans that have denied treatment coverage, despite recommendations from medical specialists. The language of this bill explicitly removes the right to ERISA preemption under 29 U.S.C. § 1144 from HMOs. It states:

Nothing in this title shall be construed to invalidate, impair, or supercede any cause of action under State law to recover damages resulting from personal injury or for wrongful death against any person in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health plan, or that arises out of the arrangement by such person for the provision of such insurance, administrative services or medical services by other persons.

However, the bill does exclude causes of action against employers or plan sponsors who maintain the group health plan. A provision for an appeals

276. Id.
278. Id.
280. Plan Regulation, supra note 277. See supra notes 266 and 271 and accompanying text noting that both the Democratic bill and PARCA supported removal of the ERISA clause which has granted HMOs immunity from liability.
281. Id.
process allows for “fast track” access to the courts for patients who are too ill to go through the usual, lengthy appeals process. It also requires health plans to create external review boards with authority to make binding decisions on appeals brought by patients who have been denied services. Failure to comply with this provision could result in the health plans being subject to fines of $750 per day up to $250,000, owed to the patient. This bill has been met with the same criticisms as the 1998 proposals, primarily the threat of increased health care costs and the potential for poorer quality of care because HMOs will be forced to spend financial resources on litigation rather than health care.

2. United States Department of Labor

Also in response to consumer complaints, the United States Department of Labor (DOL) proposed rules on September 9, 1998, to strengthen the rights of workers in health benefit plans. These regulatory rules had not been updated since 1977. The DOL has the authority to administer and enforce ERISA. These proposals are part of the Department’s commitment to implementing the recommendations of the President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry. These rules would guarantee participants prompt and fair consideration of their claims for health and other benefits. The provisions include: (1) shortening the time limits for making health benefit claim decisions; (2) requiring plans to provide better information about appeal rights and why benefits were denied; and (3) a requirement that decisions be based on medical judgements in consultation with an independent health care professional. Opponents to these proposed rules argue that the DOL has exceeded its authority and the rules will increase costs and place a heavy burden on employee benefit plans. One opponent stated these regulations indicated the DOL’s lack of faith in the legislative process as many of the DOL’s regulations had also been proposed in the health care reform

287. Id.
288. Plan Regulation, supra note 277.
292. Id. See also Rooney, supra note 275 (During his 1996 Presidential campaign, President Clinton established the Advisory Commission on Consumer Protection and Quality in the Health Care Industry. This Commission recommended a “Patient Bill of Rights” and the President instructed federal programs to implement as many of the Commission’s recommendations as possible.).
293. PWBA, supra note 289.
294. Employee Benefits, supra note 290.
legislation of 1998.\textsuperscript{295} In retrospect, this lack of faith seems to have been well-placed. Because these proposed regulations have generated loud protests from opponents to health care reform, the Senate Labor and Human Resources Committee is planning a hearing to review these new rules.\textsuperscript{296}

The DOL has long supported finding against ERISA preemption in many amici briefs filed through the years.\textsuperscript{297} Most recently, the DOL filed an amicus brief in \textit{Unum Life Insurance Co. of America v. Ward,}\textsuperscript{298} the ERISA case in which the Supreme Court has recently granted certiorari. The DOL, in its brief, argues that patients should not be precluded from suing for damages under state insurance laws for denials of benefits.\textsuperscript{299} The DOL wanted a "common-sense" approach applied to the question of HMO liability.\textsuperscript{300} This filing concerns "insured" plans in which employers buy health insurance policies for their employees.\textsuperscript{301} This new position taken by the DOL could have a major impact on court decisions as well as on making it easier for states to pass laws allowing for suits against health plans for denial of benefits.\textsuperscript{302}

3. \textit{Changes at the State Level}

Many state legislatures have passed their own patient protections acts in 1997 and 1998. Some states have eliminated their "corporate medicine" statutes which have been used as a defense by HMOs. In 1997, Texas passed a bill expressly allowing HMOs to be sued for liability.\textsuperscript{303} The bill went into effect
September 1, 1997 and allows consumers the right to sue HMOs and to collect damages if the HMOs' treatment decisions result in harm to the consumer. 304 Under this bill, an HMO may be held liable for breaching a duty to exercise ordinary care or for decisions made by employees or agents acting on behalf of the HMO. 305

Immediately after passage, this law was challenged by several subsidiary HMOs of Aetna on the grounds that its provisions were preempted by ERISA. 306 United States District Judge, Vanessa Gilmore, upheld the portion of the law allowing suits against HMOs, but struck down the law's independent review provisions as being preempted by ERISA. 307 In issuing this decision, Judge Gilmore invited Congress to redefine ERISA: "If Congress wants the American citizens to have access to adequate health care, then Congress must accept its responsibility to define the scope of ERISA preemption and to enact legislation that will ensure every patient has access to that care." 308 The effects of this decision are, as yet, unknown. Proponents of the law claim that this ruling will allow suits against HMOs for injuries resulting from denial of care or for failure to exercise ordinary care. 309 However, opponents of the law also claim the decision as a victory based on Judge Gilmore's language restricting suits against HMOs to "cases in which an HMO actually delivers poor care, not disputes over HMO treatment decisions." 310 As a result, opponents claim, an injured plaintiff in Texas would be unable to obtain relief on the basis that an HMO's negligent decision to deny benefits resulted in patient harm. 311 Despite these contradictory opinions, Judge Gilmore's rulings do suggest an increasing willingness on the part of courts to recognize the distinction between the quality and quantity of benefits under an employee benefit plan. 312 Appeals have been


305. "Id.


307. Id. See also Deborah W. Larrios, Barbarians at the Gate? An Essay on Payor Liability in an Era of Managed Care, 65 Tenn. L. Rev. 445, 453 (1998). See also Charles Ornstein, Judge Upholds State Law that Lets Patients Sue Over HMO Denials but Ruling Strikes Down Much of Independent Review Process, The Dallas Morning News, Sept. 19, 1998 (1998 WL 13103652) (The loss of the independent review process has disappointed parties on both sides of the issue. This process has been used by more then 200 Texans to resolve their benefit disputes. Now, patients must actually sue after being harmed to attempt to resolve any disputes. This decision is also harmful for the insurance companies because it invalidates a process designed to prevent litigation and the insurance companies must now bear the risk of litigation.

308. Corporate Health, 12 F. Supp. 2d at 616 n.7.


312. Rooney, supra note 275, at 100.
filed by both parties in a scramble to save the review process, but legal experts claim Aetna's appeal will also enable the company to challenge the right-to-sue provision.\(^{313}\) Those who disfavor Judge Gilmore's ruling say it is likely the Fifth Circuit will overturn the right-to-sue provision as preempted by ERISA.\(^{314}\) Others, however, are confident the law, which was written with the Fifth Circuit's prior decisions and language in mind, will survive the challenge.\(^{315}\)

In addition to Aetna's challenge, one month after Judge Gilmore's decision, the first state court suit was filed under this new law.\(^{316}\) In this case, the plaintiff, Kathryn Plocica, filed suit against her health plan for the wrongful death of her husband who died after drinking antifreeze.\(^{317}\) She sought actual and punitive damages.\(^{318}\) Mr. Plocica was being treated for severe depression, but his HMO ordered him discharged over his physician's objections.\(^{319}\) He committed suicide within hours of being discharged from the hospital.\(^{320}\) The suit alleged that the causes of action arose under the Texas Act because the health plan "controlled or influenced the quality of the medical diagnosis, care, and treatment of Mr. Plocica."\(^{321}\) The defendants removed the case to federal court, but the court agreed with the plaintiff that there was no basis for federal subject matter jurisdiction because the defendant failed to carry its burden that at least one of the causes of action was subject to complete preemption.\(^{322}\) The case was remanded to state court.\(^{323}\) The plaintiff's petition was couched in terms of "quality of care" rather than "denial of benefits" and the defendant was a non-ERISA health plan, so it is unclear whether the decision in this case will answer whether the Texas law will survive ERISA preemption.\(^{324}\)

V. RECOMMENDATIONS AND CONCLUSION

Congress' intent in enacting ERISA in 1974 was to provide protection to employees with regard to their pension plans. ERISA was meant to protect employees' pension funds from mismanagement and end the problem of employees relying on pension plans that were unavailable at retirement because


\(^{314}\) Id.

\(^{315}\) Id.

\(^{316}\) Plocica v. NYLCare of Texas Inc., Case No. 141-175780-98 (141st JDC TX 1998).


\(^{318}\) Id.

\(^{319}\) Id.

\(^{320}\) Id.

\(^{321}\) Strama & Rogers, supra note 311.

\(^{322}\) Plocica v. NYLCare of Texas Inc., 43 F. Supp. 2d 658 (N.D. Tex. 1999).

\(^{323}\) Id.

\(^{324}\) Id.
of poor investments or lack of any investments at all. Instead, ERISA provides equitable remedies for those actions it sought to protect against and preempts state laws so that pension plans can be administered by the states in a uniform way. Additionally, ERISA serves to foreclose recovery of punitive and compensatory damages.

In considering the original intent behind ERISA, it is also important to remember the basic purposes of tort law. These are to preserve the peace by acting as a substitute for vengeance, to find fault for wrongdoing and to provide for compensation for injury caused by that wrongdoing, and to discourage future wrongdoing. A basic premise of tort law is that the wrongdoer owes some duty to the injured party which was breached in some manner resulting in harm or injury.

At the time ERISA was enacted, the nation's health care was primarily delivered in the traditional fee-for-service or pay-as-you-go method that had existed for generations. Under this traditional system, relationships between the patient and the doctor were direct, and defining what was meant by the delivery of medical care was simple. If the doctor breached some duty to his patient, the patient had causes of action in tort against the doctor and could be compensated for any wrongdoing by the doctor which resulted in harm to the patient. This is the main principle underlying medical malpractice which fits the basic purposes of tort law. Through the years, this principle of liability has been applied to other health care providers such as nurses and hospitals.

The managed health care system as it exists today was not contemplated by Congress in 1974. Under this modern health care delivery system, the relationships between a patient and those providing him with medical care are increasingly complex and the definition of "provision of care" has become blurred. Though traditional medical malpractice claims still exist, it has become more difficult to map out what duties are owed and by whom they are owed, given these newly intricate provider-patient relationships. Statutory and case law has been relied on to characterize these relationships.

Initially, managed care organizations, or HMOs, avoided liability for claims of medical malpractice by asserting they were not practicing medicine, either on the basis of state statutory prohibition of corporate medicine or on the grounds that treatment decisions were merely methods of administering a "pension plan." As the number of managed care organizations grew, they became characterized under ERISA as welfare benefit plans. This has allowed these organizations to use ERISA as a defense against traditional tort claims of medical malpractice. This, in turn, has led to the current debate of whether HMOs actually provide medical care for which they can be held accountable or whether they only act to administer the plans. Allowing HMOs to rely on ERISA as a defense, however, goes against the intent of Congress in enacting ERISA to protect employees. Permitting managed care organizations to avoid liability actually serves to protect the employers and the plans themselves. This immunity from liability is also contrary to traditional tort theories which have served to grant some recompense to victims of wrongdoing.
First, the patient, who becomes a participant in the HMO by virtue of some employee-employer relationship, is often limited financially or through his employment in his choice of health care providers. This places the patient in a vulnerable and dependent position with respect to the HMO who may be responsible for making crucial health care decisions. Despite this vulnerability and dependency, however, HMOs under ERISA have no need to worry about being held accountable to patients for the effects of their decisions. Without the restraint of accountability, HMOs have been able to utilize methods to ostensibly contain health care costs which translate into profits for the organization at the risk of quality health care. This plays havoc with the deterrent role of basic tort theory.

Additionally, HMOs claim to have no duty to patients in regard to health care. A typical argument is that although a doctor, employed by an HMO, must comply with the policies and procedures of that HMO, it ultimately remains the doctor's duty to decide medical issues. So, for example, in a situation in which a doctor recommends a life-saving procedure that is denied by the HMO, the doctor must disregard the HMO's regulations and perform the surgery anyway. This puts the doctor at risk for sanctions for not working within his employer's mandates and puts the patient at risk for out-of-pocket expenses that the patient expected to be paid by his health plan. If the physician chooses to follow the decision made by the HMO, he could be directly liable to the patient for failing to perform the surgery. This system places doctors in a difficult position, forcing them to choose between their own livelihood and their duty to the patient. With no duty owed to the patient, the HMO cannot be found at fault for any wrongdoing, and again, reliance on tort law fails.

Congress did not intend to place traditional tort theories beyond the reach of those most in need of their protections. Congress never meant for tort law and ERISA to become mutually exclusive such that if a patient receives benefits under an ERISA plan, then he gives up the protections afforded him under tort theory. To read ERISA in this way has led to unfair and unjust results. To return to the original intent behind ERISA, statutory law must be amended to remove this unintentional immunity from liability for ERISA plans, or the judiciary must exercise its role in interpreting ERISA in light of Congress' intent to protect employees.

In order to honor the primary objective of ERISA to protect employees, and the secondary goal of uniform state regulation, the most effective means for change would be for Congress to expressly amend ERISA so that state law claims will no longer be preempted. Because federal law preempts state law by virtue of the Supremacy Clause of the Constitution, a congressional amendment would easily accomplish the goal of uniformity underlying ERISA.

The strongest argument against amending ERISA is that doing so will drastically increase the cost of health care and make affordable health insurance less available to the public. This concern can easily be addressed in new legislation. For example, Congress could amend ERISA to create a federal cause of action against ERISA plans, but could place caps on medical malpractice
damages to address the concern of increased cost. But a more favorable solution could be for Congress simply to amend ERISA to remove preemption of medical malpractice claims. This would allow state courts to hear medical malpractice claims which fall within a field traditionally occupied by the states: regulation of matters of health and safety. This would be consistent with ERISA’s goal of uniformity by eliminating the conflicting interpretations of ERISA among the federal circuit courts. Because most states already have damage caps in place, it would also provide HMOs with protection against unlimited damage awards.

Though many attempts to change the existing law were made in the 105th Congress, none of those measures came to fruition. Representative Norwood’s newest proposal, H.R. 216, appears to be a viable attempt to accomplish ERISA’s goals. The proposed language expressly eliminates ERISA preemption for decisions to provide or deny care which result in harm to the participant. This bill would protect participants as well as maintain the requirement of uniformity. Participants would be protected because the doors would be opened to tort law remedies for compensation by the wrongdoer for injuries. Uniformity would be met by allowing states to apply their own state law.

Currently, the split in the federal circuits demonstrates that state law applies in some jurisdictions but not in others, so that ERISA is currently not acting to regulate the states in a uniform way. Under H.R. 216, HMOs would become accountable for treatment decisions under state law. Additionally, the proposal mandates external appeals procedures that would result in binding decisions. Failure to comply with this mandate could result in fines to the HMOs, but only up to a cap of $250,000. This bill would protect the participants’ interest in being compensated for their injuries and would protect the HMOs’ interest in cost-containment strategies through the appeals process cap as well as through state law caps. HMOs should take into account the cost of litigation when evaluating the costs of doing business, and application of state law damages caps would assist them in projecting future expenses. Congress should also clarify what is meant by “employers” and “plan sponsors” where the bill excludes such persons from available causes of action. Clarifying these terms will help avoid the same problem of broad judicial interpretation encountered under ERISA. Without clarification, a court may deem HMOs to fall within one of these excepted categories and participants would, once again, be left without any meaningful remedy.

Absent congressional action to expressly amend ERISA, the DOL’s regulations should be adopted. These regulations would provide uniformity in the appeals procedures available to participants. However, these proposed regulations do nothing to address the preemption problem because this issue is outside the scope of the DOL’s authority.

If Congress fails to act, it will continue to be the job of the courts to interpret ERISA. The Supreme Court has begun to narrow and clarify the meaning of the "relates to" preemption provision of ERISA, beginning with the Travelers case and continued in subsequent cases. Furthermore, the Court has stated that there is a considerable burden to overcome the presumption that
Congress had no intention of supplanting state law in fields traditionally occupied by the states such as public health and safety. However, these prior pronouncements of the Supreme Court have not gone far enough in explaining the extent to which ERISA preemption should be limited. Rather, lower courts have interpreted these decisions almost as broadly as the Supreme Court’s early, expansive “relates to” analysis.

From the unanimous opinion in Travelers to the majority opinions in Dillingham and De Buono, the Supreme Court has demonstrated its willingness to be the instrument of change regarding this complex and controversial preemption issue. But, it is time for the Court to stop testing the waters and to dive fully into this controversy. As Justice Scalia wrote in his concurring opinion in Dillingham, joined by Justice Ginsburg:

[The] opinion [in Dillingham] is no more likely than our earlier ones, to bring clarity to this field... I think it would greatly assist our function of clarifying the law if we simply acknowledged that our first take on [ERISA] was wrong: that the “relate to” clause of the preemption provision is meant, not to set forth a test of preemption, but rather to identify the field in which ordinary field preemption applies—namely, the field of laws regulating “employee benefit plan[s].”¹²²⁵

Adopting this solution would eliminate the difficult task faced by the courts in attempting to determine what Congress meant by “relating to” an ERISA plan. In addition, the Supreme Court should formulate a test to aid the courts in distinguishing between the administrator and provider roles played by HMOs. Or, the Court could simply adopt a test developed by one of the Circuits such as the Third Circuit’s “quality v. quantity” test.²²⁶ Formulating a new test or adopting an existing one would accomplish the goals of Congress in enacting this statute. Participants would be protected because they would have a cause of action against the HMOs in cases of wrongdoing. Additional protection would come from the deterrent affect on HMOs in knowing they will be held accountable for decisions that affect the care provided to their participants. A test adopted by the Supreme Court would also lend itself to a uniform application of ERISA by resolving the split in the Circuits, acting as a guide for the lower courts, and eliminating the disparate results for injured parties in different jurisdictions.

Patients/participants must be afforded some protection against wrongful acts by their health plans that result in harm or injury. Congress should expressly amend ERISA to remove the immunity enjoyed by HMOs and to allow for some causes of action to proceed against HMOs in state court. Congress should adopt

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326. See supra text accompanying notes 197-215.
a version of a bill similar to Representative Norwood's proposal in the 106th Congress which would provide protection to consumers as well as expressly give patients the right to sue their health plans when benefit decisions result in injury. Until such a bill is enacted, the DOL's recommendations should be adopted so that participants have a universal appeals procedure in place. If the Texas right-to-sue law survives ERISA preemption in early court decisions, other states should follow Texas' lead. Absent state or federal legislative action, the liability of HMOs will only be established by jurisprudence. The Supreme Court should adopt a test clearly defining the scope of ERISA preemption such as the Third Circuit's "quality v. quantity" test. Congress and the courts should listen to the complaints about HMOs and carefully heed the grumbles of dissatisfaction with the current state of affairs.

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