

1-1-2000

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### Recommended Citation

Joshua Michael Kaye, *Closing the Lid on Pandora's Box: ERISA Preemption of Tort Actions Against Managed Care Organizations in State Courts*, 54 U. Miami L. Rev. 373 (2000)

Available at: <https://repository.law.miami.edu/umlr/vol54/iss2/7>

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# COMMENTS

## Closing the Lid on Pandora's Box: ERISA Preemption of Tort Actions Against Managed Care Organizations in State Courts

### INTRODUCTION

The Employee Retirement Income Security Act of 1974<sup>1</sup> (ERISA) was promulgated by Congress in order to standardize employee benefit laws and to protect workers receiving employer-provided benefits from administrative and funding abuses.<sup>2</sup> Due to the skyrocketing costs of health care, employers are increasingly shifting toward securing employees' health benefits through managed care organizations (MCOs). This shift has resulted in a public perception that MCOs are placing profits and cost savings above patient welfare.<sup>3</sup> Tragic stories of denied health care benefits, causing otherwise curable diseases or ailments to result in death, have fueled public demand to hold managed care organizations liable to enrollees, who are perceived to be victimized by a flawed health care system.<sup>4</sup>

Critics of MCOs urge courts to narrow the scope of ERISA and thereby permit state regulation of MCOs.<sup>5</sup> These critics advocate that holding an MCO liable for its decisions is a state matter. Furthermore, only the states can ensure a balance between attention to patient well-being and an MCO's pressure to reduce health care costs.<sup>6</sup>

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1. 29 U.S.C. §§ 1001-1461 (1994).

2. See generally Deborah S. Davidson, *Balancing the Interests of State Health Care Reform and Uniform Employee Benefit Laws Under ERISA: A "Uniform Patient Protection Act,"* 53 WASH. U. J. URB. & CONTEMP. L. 203, 206 (1998).

3. See, e.g., Ezekiel J. Emanuel & Lee Goldman, *Protecting Patient Welfare in Managed Care: Six Safeguards*, 23 J. HEALTH POL. POL'Y & L. 635 (1998).

4. See *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1323-24 (5th Cir. 1992). In *Corcoran*, would-be parents sued their MCO and its utilization review company for the wrongful death of their unborn child, alleging that the MCO negligently provided utilization review services. The Fifth Circuit affirmed a district court finding that ERISA preempted their claims because "generally applicable negligence-based [claims] may have an effect on an ERISA-governed plan," and "[b]ut for the ERISA plan, the defendants would have played no role in Mrs. Corcoran's pregnancy.

5. 29 U.S.C. §§ 1001-1461 (1994). Section 1144(a) of ERISA provides, in relevant part, that ERISA "shall supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . ."

6. See Emanuel & Goldman, *supra* note 3, at 635-36.

Such critics, however, promote a resolution that ignores Congress's intent in enacting ERISA. Moreover, these critics offer few suggestions on how to precisely mitigate the actual problem – fairly and expeditiously distributing medical care and health services to the American public.<sup>7</sup> ERISA expressly preempts any state law that “relates to” the administration of employee benefit plans.<sup>8</sup> Moreover, Congress furnished ERISA with a civil enforcement clause intending for complete preemption and exclusive federal jurisdiction, thereby providing for the enforcement of remedies for denied employee benefits.<sup>9</sup> By virtue of ERISA's civil enforcement provision, enrollees are provided with a cause of action to either obtain the actual benefit, payment for the benefit, or a decree granting the administration of future benefits.<sup>10</sup> MCOs are not in the business of medicine, which would be governed by state law. Rather, MCOs act within the scope of ERISA by making decisions regarding the administration of employee benefits. Consequently, a healthcare benefit decision that is administered by an MCO, in the context of an employee benefit plan, should not be regulated by individual states because Congress has expressly preempted such laws or claims in favor of federal regulation.

This article argues that Congress intended for ERISA to preempt all state laws effecting the administration of employee benefit plans. In furthering the congressional aim, courts must prevent state laws and claims from imposing liability upon MCOs in their role as plan administrators. The proper response when Congress has enacted a publicly criticized law is not for states to ignore the law, but rather for Congress to reform the law. Consequently, if critics are not pleased with ERISA, they must seek aid from the federal legislature.

Part I of this article explains the purpose and function of MCOs. Part II sets forth the scope of ERISA's preemption clause and explains why state regulation of MCOs is unconstitutional. Part III analyzes the Supreme Court's interpretation of ERISA's preemption clause. Part IV discusses recent Supreme Court decisions that endorse the quality/quantity distinction – the test many courts have relied on to determine whether an MCO should be held liable under state laws or for state claims. Part V examines how the Supreme Court would rule if asked to

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7. See generally, Michael D. Reagan, D.M., *Physicians as Gatekeepers: A Complex Challenge*, 317(27) *NEW ENG. J. MED.* 1731 (1987).

8. 29 U.S.C. § 1144(a).

9. 29 U.S.C. § 1132 provides a remedy “to recover benefits due . . . under the terms of [the] plan, to enforce . . . rights under the terms of the plan, or to clarify . . . rights to future benefits under the terms of the plan . . .”. See also Barbara Williams, *ERISA and State Common Law Causes of Action*, 192 *AUG. N.J. L. MAG.* 29 (August 1998).

10. See 29 U.S.C. § 1132.

consider whether ERISA preempts statutory or common law claims against managed care entities. This section focuses on a recently enacted Texas statute providing for a malpractice claim against MCOs. Part VI analogizes how Coase's economic theorem of Social Cost<sup>11</sup> supports the view that Congress' interest in employee-benefit plans is so pervasive that it precludes any state regulation of employee-benefit plans. Applying Coase's theorem to the managed care industry demonstrates that MCOs should not be held liable at the state level for denying benefits after properly utilizing cost containment mechanisms. Finally, Part VII endorses that ERISA reform, if any, should be based upon Congress amending ERISA to provide for methods of alternative dispute resolution. This reform should eliminate the tragic stories of denied benefits, rather than open the floodgates of litigation at the state court level.

#### I. THE PURPOSE AND FUNCTION OF MANAGED HEALTH CARE ORGANIZATIONS

"Managed care" is a comprehensive term used to describe the implementation of techniques offering quality health care at a low cost.<sup>12</sup> Under the traditional health care system, a patient and a doctor contract for the doctor to render services to the patient for a fixed fee that the patient's insurer agrees to pay to the doctor.<sup>13</sup> The burden of the cost in this system falls squarely on the insurer and not the party receiving the healthcare.<sup>14</sup> For this reason, the patient is insulated from the actual cost of the doctor's services.<sup>15</sup> This traditional system provides an incentive for the patient and physician to over-consume health care resources.<sup>16</sup>

MCOs intervene between the doctor and the patient.<sup>17</sup> The MCO must authorize the doctor's treatment prior to the patient receiving health care.<sup>18</sup> Through cost containment devices, such as utilization review and risk-shifting processes, the managed care system aims to

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11. See generally R.H. Coase, *The Problem of Social Cost*, 3 J. Law & Econ. 1 (1960). Coase's theorem postulates that in choosing between social arrangements, a change in the existing system, which will lead to an improvement in one problem, may lead to the worsening of other problems.

12. See Carla Jensen Hamborg, *Medical Utilization Review: The New Frontier for Medical Malpractice Claims?*, 41 DRAKE L. REV. 113, 117 (1992).

13. See Daniel N. Burton & Michael S. Popok, *Managed Care 101*, 72 FLA. B.J. 26, 28 (April 1998).

14. See *id.*

15. See *id.*

16. See *id.*

17. See generally Ila S. Rothschild, et al., *Recent Developments in Managed Care*, 32 TORT & INS. L.J. 463, 464 (Winter 1997).

18. See *id.*

provide health care that is high in quality and low in cost.<sup>19</sup> The result is that unnecessary medical services are limited, and the exorbitant fees sought by health care providers are lowered.<sup>20</sup>

MCOs are primarily comprised of two entities: Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO).<sup>21</sup> The HMO is a pre-paid health service plan, which divides the risk of patient misuse of the health-care system between the HMO and the health provider.<sup>22</sup> The enrollee pays a fixed premium to the HMO that entitles the enrollee to designated health services from a list of contracted health care providers.<sup>23</sup> HMOs guarantee access to medical services within the network's resources<sup>24</sup> by contracting with medical practitioners for a share of enrollees and charging enrollees on either a capitated<sup>25</sup> or fee-for-service basis.<sup>26</sup> HMOs often control costs and determine what services are medically necessary by utilizing a "gate-keeper," primary care physician, or nurse.<sup>27</sup> Other uncovered and "nonmedically" necessary procedures are excluded. As a result, HMOs must utilize cost containment measures in order to provide quality health care at a lower cost and simultaneously determine what is medically necessary.<sup>28</sup>

PPOs contract with a group of health care providers to service members on a discounted fee-for-service basis or other payment mechanism.<sup>29</sup> A PPO is an MCO that utilizes the economic leverage achieved from "a high volume patient base to secure favorable rate and payment

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19. *See id.* at 464.

20. *See* Charles S. DeRousie, *It's All in There in Black and White, Figuring Out the Various Managed Care Plans: What Should the Employer's Contract Cover*, 6 BUS. L. TODAY 38 (August 1997).

21. *See* Rothschild, *supra* note 17, at 464.

22. *See* Dominick C. DiCicco, Jr., *Liability of the HMO for the Medical Negligence of its Providers*, ANDREWS HEALTH L. LITIG. REP. 22 (Nov. 1996).

23. *See id.*

24. *See* Robert A. Blum & William F. Brossman, *Basic Legal Issues for Employers in Managed Care*, C799 A.L.I.-A.B.A. 509, 514-15 (1993).

25. *See* Rothschild, *supra* note 17, at 466. The term "capitated" is derived from the per capita payment to providers from the MCO on a flat monthly "per enrollee, per month basis." Generally, the amount is based on an actuarial formula which factors in the health of the MCO's enrollees, as well as the frequency and expense of the health care services predicted to be used by the MCO's particular population. *See id.*

26. *See id.* at 466-67. MCO establishes a menu of discounted set fees, which are designated to each specific health care service.

27. *See id.*

28. *See* Robert Vilensky, *The Liability of Health Maintenance Organizations*, 69 N.Y. ST. B.J. 20 (1997) (explaining that cost containment procedures include having doctors contact the HMO for approval prior to rendering treatment to a patient so that the HMO's medical review board can recommend alternative less costly treatments).

29. *See* Cathy L. Burgess, Comment, *Preferred Provider Organizations: Balancing Quality Assurance and Utilization Review*, 4 J. CONTEMP. HEALTH L. & POL'Y 275, 276 (1988).

formulas with select providers.”<sup>30</sup> The enrollee may choose from a panel of physicians and hospitals.<sup>31</sup> The distinction between a PPO and an HMO is that PPOs generally provide members with more choices in care and treatment by permitting enrollees to seek care from practitioners outside of the network via “any willing provider” clauses.<sup>32</sup> Moreover, PPOs exert less authoritative power over the services that enrollees may receive because they operate more frequently on a fee-for-service basis rather than a fixed premium.<sup>33</sup>

Due to advances in medical technology, overall healthcare expenditures continue to increase as patients seek and practitioners prescribe unnecessary tests and procedures.<sup>34</sup> Even where doctors perform a life-saving operation, complications may lead to exorbitant costs.<sup>35</sup> To complicate issues, the human life expectancy is longer than it has ever been. The steady increase in the cost of health care during the last few months of one’s life has resulted in soaring insurance premiums and Medicare expenditures.<sup>36</sup>

The advent of managed care should at least be credited with reducing medical care costs for subscribers.<sup>37</sup> As health care costs escalate, MCOs present a means to provide quality and affordable health care to employees and their families. By implementing a utilization review, managed care provides a logical system for rationing scarce medical resources that otherwise may simply go to the highest bidder. “The medical profession now has professional norms concerning what constitutes bad medical practice. These norms have expanded to include cases in which high costs are not justified by minor expected benefits.”<sup>38</sup> Evidently, managed care has contributed to eradicating unnecessary procedures and services, increasing efficiency, and focusing attention on providing care to patients in the appropriate setting.<sup>39</sup>

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30. See Burton & Popok, *supra* note 13, at 29.

31. See *id.*

32. See Note, *ERISA Preemption of “Any Willing Provider” Laws – An Essential Step Toward National Health Care Reform*, 73 WASH. U. L.Q. 227, 229 n.8 (1995) (discussing basic features of HMOs and PPOs).

33. See *id.*

34. See Alan L., Hillman, et al., *How Do Financial Incentives Affect Physicians’ Clinical Decisions and the Financial Performance of Health Maintenance Organizations?*, 321(2) NEW ENG. J. OF MED. 86, 86-92 (1987).

35. See Barrett Seaman, *TIME*, Oct. 12, 1998, at 93, 94 (“[liver transplant] could cost anywhere from \$80,000, if procedure went smoothly, to perhaps \$1 million if complications arose”).

36. See Rashi Fein, *Health Care Reform, in the Sociology of Health & Illness*, 275, 276-77 (Peter Conrad & Rochelle Kern eds. 4th ed. 1994).

37. See *id.*

38. L.C. Thurow, *Learning to Say “No,”* 329(8) NEW ENG. J. MED. 573, 573-576 (1984).

39. See Emanuel & Goldman, *supra* note 3, at 637.

To remain economically viable, MCOs must operate under an efficiency-driven strategy employing cost-saving tactics, such as utilization review,<sup>40</sup> gatekeepers, capitation, pre-admission certification, and co-payments.<sup>41</sup>

The continued expansion of managed health care will precipitate an increase in the implementation of these techniques.<sup>42</sup> In 1994, more than fifty million Americans utilized MCOs.<sup>43</sup> By 1997, approximately one hundred fifty million people in the United States participated in some form of managed-care plan.<sup>44</sup> Moreover, a recent survey reported that seventy-five percent of insured working Americans are covered by a managed-care benefit plan.<sup>45</sup> Forty percent of the one trillion dollars exhausted annually on healthcare is spent by enrollees of managed care plans, suggesting that the public is seeking ways to decrease the exorbitant cost of health care.<sup>46</sup> This proportion will swell in the twenty-first century with the expected explosive growth in managed Medicare and Medicaid.<sup>47</sup> Any form of managed care or health provider inevitably must adopt similar cost-efficient techniques in order to remain solvent.<sup>48</sup> To be blunt, managed care is here to stay.

The public, frustrated with perceived limits on freedom of choice inherent in the managed care industry, may view utilization review as a profit-driven system whose sole objective is to deny substantial coverage and care to patients. Empirical evidence, however, indicates that utilization review does not adversely affect the quality of care provided to patients.<sup>49</sup> When properly administered, managed care represents an appropriate solution to spiraling health care costs.<sup>50</sup>

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40. See Amy Stoeckl, *Refusing to Follow Doctor's Orders: Texas Takes First Step in Holding HMOs Liable for Bad Medical Decisions*, 18 N. ILL. U. L. REV. 387, 390-91 (1998).

41. See Burgess, *supra* note 29, at 278.

42. See Emanuel & Goldman, *supra* note 3, at 637.

43. See GROUP HEALTH ASSOCIATION OF AMERICA (GHAA), PATTERNS IN HMO ENROLLMENT, 6-7 (4th ed. 1994).

44. See Earl Ubell, *You Can Get Quality Care in an HMO World*, PARADE MAGAZINE, Sept. 14, 1997, at 10.

45. See Jensen, G.A., M.A. Morrisey, S. Gaffney and D. Liston, *The New Dominance of Managed Care: Insurance Trends in the 1990s*, HEALTH AFFAIRS (16)(1): 125-136 (1997).

46. Ubell, *supra*, note 44, at 10. Managed care plans are unique because they are formulated to reduce health care costs by restricting choices of doctors and hospitals and covering solely the cost of treatment that is "medically necessary."

47. See Emanuel & Goldman, *supra* note 3, at 637.

48. *Id.*

49. See Deven C. McGraw, *Financial Incentives to Limit Services: Should Physicians be Required to Disclose These to Patients*, 83 GA. L.J. 1821, 1832-1833 (1995).

50. Gov. Lawton Chiles, *Introduction to the Review of Legislation Health Care Reform in Florida: Promoting Improved Access, Cost and Quality*, 23 FLA. ST. U.L. REV. 7 (1995).

## II. THE SCOPE OF ERISA PREEMPTION

State law may be preempted by express provision, implication, or a conflict with federal law.<sup>51</sup> The Supremacy and Commerce clauses of the United States Constitution may be distinguished from express Congressional action for purposes of determining federal preemption of state law.<sup>52</sup> The Supremacy Clause of the Constitution requires preemption of state law whenever state law conflicts or is inconsistent with federal legislation.<sup>53</sup> Additionally, when Congress has not acted, the “dormant commerce clause” invalidates state laws that unduly burden interstate commerce, an area that Article I of the Constitution authorizes Congress to regulate.<sup>54</sup> In cases implicating ERISA, the federal interest in establishing a uniform national market outweighs the states’ interests.<sup>55</sup>

Preemption may also result from legislative action. Congress may expressly invalidate state regulation in areas that the Constitution has authorized Congress to legislate such as interstate commerce.<sup>56</sup> Alternatively, Congress may impliedly preempt state law by indicating an intention to exclusively occupy a field although no particular federal law conflicts with the state law in question.<sup>57</sup>

ERISA preemption is legislative preemption and can manifest in two ways: (1) § 502’s “complete” preemption or (2) § 514’s broad “relate to” preemption.<sup>58</sup>

Section 502(a) authorizes a claimant to recover benefits, enforce rights, or clarify future benefits under the terms of an employee benefit plan.<sup>59</sup> Courts must therefore determine whether a claim challenges a

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51. See *Pacific Gas and Elec. Co. v. State Energy Resources Conservation and Devp. Comm.*, 461 U.S. 190, 203-204 (1983); see also *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947).

52. See Margaret G. Farrell, *ERISA Preemption and Regulation of Managed Health Care: The Case for Managed Federalism*, 23 AM. J.L. & MED. 251, 253 (1998).

53. See U.S. CONST. art. VI.

54. See U.S. CONST. art. I, 8; see generally *Pike v. Bruce Church*, 397 U.S. 137 (1970) (invalidating a state official’s order regarding the cantaloupe packaging industry as unduly burdensome on interstate commerce).

55. In *Kassel v. Consolidated Freightways Corp.*, 450 U.S. 662, 670 (1981), J. Powell noted: [T]he incantation of a purpose to promote the public health and safety does not insulate a state law from Commerce Clause [preemption]. Regulations designed for that salutary purpose nevertheless may further the purpose so marginally, and interfere with commerce so substantially, as to be invalid under the Commerce Clause.

56. See Farrell, *supra* note 52, at 254.

57. See *City of Burbank v. Lockheed Air Terminal, Inc.*, 411 U.S. 624, 633 (1973) (invalidating local noise abatement ordinance as preempted by Federal Aviation Act).

58. See Farrell, *supra* note 52, at 254.

59. See 29 U.S.C. § 1132(a) (1994). This section further provides that a civil action may be brought for five alternative reasons: (1) for an administrator’s refusal to supply information; (2) to recover benefits due a plan or to enforce rights under a plan; (3) to clarify rights to future benefits



denial of benefits due under the terms of the plan, and hence is preempted, or whether the claim attacks a managed care entity outside of its role as the plan's administrator.<sup>60</sup> If the state suit pertains to the terms of the managed care plan, it is subject to exclusive federal jurisdiction and ERISA remedies.<sup>61</sup> Once a state law or claim is subject to complete preemption, it is also "related to" ERISA and therefore preempted under § 514.<sup>62</sup> Consequently, an MCO that successfully removes a state claim based upon complete preemption should also succeed in preempting a state claim under § 514.

A state law or claim against an MCO that does not arise under the civil enforcement section may still be preempted by § 514(a) of ERISA.<sup>63</sup> Pursuant to this section, ERISA "supersedes any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." This inquiry is wider in scope than § 502 because it encompasses the recent Supreme Court decisions interpreting the broadly worded preemption clause.

Had Congress enacted ERISA without the express preemption provision, the Supremacy Clause would still require courts to invalidate any state laws affecting employer-provided health care benefits that conflicted with ERISA.<sup>64</sup> Additionally, the Dormant Commerce Clause would negate state health care laws if a court determined that on balance the federal interest in the free flow of commerce and nondiscriminatory representative regulation outweighed the individual state's interests in protecting local health and safety.<sup>65</sup> Because the Supremacy Clause negates state laws that conflict with federal laws, even when Congress is silent about their preemptive effect, the express preemption of §514's "relate to" provision in ERISA has been deciphered to be as broad as its meaning in the normal sense of the phrase.

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under a plan; (4) to sue for breach of fiduciary duty; or (5) to enjoin an act in violation of ERISA or the plan terms and to redress violations. *See also* Rice v. Panchal, 65 F.3d 637, 644 (7th Cir. 1995). Three factors are relevant in determining whether a claim is within the scope of section 502(a): (1) whether the plaintiff is a participant or a beneficiary; (2) whether the plaintiff's cause of action falls within the scope of ERISA and can be enforced through section 502(a); and (3) whether the plaintiff's claim can be resolved without interpreting the plan governed by ERISA. *See id.* at 644.

60. *See* Dukes v. United Healthcare Inc., 57 F.3d 350, 356 (3d Cir. 1995).

61. *See id.* at 354 (citing Metropolitan Life Ins. Co v. Taylor, 481 U.S. 58, 66 (1987)); *see also* James Walker Smith, *ERISA Preemption: No Longer a Sure Thing for HMOs*, 14 No. 5 Med. Malpractice L. & Strategy 1 (Mar. 1997).

62. *See* Dukes, 57 F.3d at 356.

63. *See* 29 U.S.C. § 1144 (1991).

64. *See* U.S. CONST. art. VI; *see generally* LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW*, §§ 6-13, at 436 (2d ed. 1988).

65. *See* Southern Pac. Co. v. Arizona ex rel. Sullivan, 325 U.S. 761, 766 (1945); Jones v. Rath Packing Co., 430 U.S. 519, 526, 543 (1977).

### III. SUPREME COURT'S INTERPRETATION OF ERISA PREEMPTION

In an effort to guard against exorbitant costs, MCOs occasionally limit an enrollee's treatment to only medically necessary procedures.<sup>66</sup> Unfortunately, at times this results in tragedy,<sup>67</sup> and these disquieting incidents culminate in state claims to which MCOs raise an ERISA preemption defense.<sup>68</sup>

The Supreme Court has historically ruled that Congress intended for the ERISA preemption clause to be given broad construction.<sup>69</sup> Under the Supreme Court's analysis, a law relates to an ERISA plan if it "has a connection with or reference to" ERISA in the "normal sense of the phrase."<sup>70</sup> To determine whether a state law has the forbidden connection, courts look to the objectives of the ERISA statute for guidance to decide which scope of state laws should survive preemption.

The Supreme Court originally interpreted ERISA's preemption clause in *Alessi v. Raybestos-Manhattan, Inc.*<sup>71</sup> In *Alessi*, retired employees challenged the legitimacy of clauses in their pension plans that diminished the worth of their benefits by a sum equal to what they received for workers' compensation prior to retirement.<sup>72</sup> The employees alleged that a New Jersey law prohibiting such a reduction rendered the clauses invalid.<sup>73</sup> The Court found § 514 of ERISA to be an explicit congressional statement about the scope of ERISA's preemption clause,<sup>74</sup> thereby establishing pension plan regulation to be exclusively a matter of federal concern.<sup>75</sup> Although the state statute referred only to workers' compensation benefits and did not directly relate to pension plans, the Court reasoned that the law related to an ERISA plan because it applied directly to the formulation of pension benefits and eliminated

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66. See William A. Chittenden III, *MALPRACTICE LIABILITY AND MANAGED HEALTH CARE: HISTORY AND PROGNOSIS*, 26 *TORT & INS. L.J.* 451 n. 1 (1991).

67. See, e.g., *De Buono v. NYSA-ILA Med. and Clinical Servs.*, 117 S.Ct. 1747 (1997); *Dukes v. United States Healthcare, Inc.*, 57 F.3d 350 (3d Cir.), cert. denied, 516 U.S. 1009 (1995); *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985).

68. See Denise Chan, *ERISA Preemption: Immunity for HMOs*, 98 *U. ILL. L. REV.* 199 (1998).

69. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (holding that common law causes of action asserting improper processing of a claim for benefits under an employment-benefit plan is subject to ERISA preemption).

70. *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 138-39 (1990) (finding that under the applicable broad common sense meaning of the word, a state law may relate to a benefit plan and be preempted even if the law is not specifically designed to affect such plans or the effect is indirect).

71. 451 U.S. 504 (1981).

72. See *Alessi*, 451 U.S. at 507.

73. See *id.*

74. See *id.* at 509, 522.

75. See *id.* at 523, 525.

a method of calculation that was permitted by federal law.<sup>76</sup> In holding that ERISA preempted the statute, the Court reasoned that it made no difference whether the state law indirectly impacted the plans because Congress intended to preclude state laws from “avoiding through form” the substance of ERISA’s preemption clause.<sup>77</sup>

In *Shaw v. Delta Airlines, Inc.*,<sup>78</sup> the Court continued its expansive approach and established the basis of its current preemption analysis. The Supreme Court configured a two-prong analysis of ERISA’s “relate to” clause by looking at whether the state law or claim was “in connection with” or “in reference to” a health benefit plan.<sup>79</sup> In *Shaw*, New York established laws prohibiting employee benefit plans from discriminating against employees on account of pregnancy. New York also required employee benefit plans to grant benefits for sick leave to employees incapable of working because of a non-work related disability.<sup>80</sup> In determining whether ERISA preempted the state law, the Court explained that “[p]re-emption may be either express or implied, and is compelled [whenever] Congress . . . explicitly [declares it] in the statute . . . or implicitly contain[s it] in the statute’s structure and purpose.”<sup>81</sup> The Court then held that a statute relates to an employee benefit plan whenever that law is in “connection with” or “in reference to” such a plan.<sup>82</sup> Applying this broad definition, the Court determined that both statutes related to benefit plans and therefore were preempted by ERISA.<sup>83</sup>

Drawing from Congress’ intent, the Court inferred that Congress used the language “relate to” in the “normal sense of the phrase.”<sup>84</sup> Thus, interpreting § 514(a) to preempt only state laws precisely designed to affect employee benefit plans would ignore the remainder of § 514.<sup>85</sup> Moreover, limiting the preemption clause to only state regulations dealing with the issues covered by ERISA would contradict the statute’s legislative history.<sup>86</sup> When ERISA was initially drafted, the scope of its preemption was limited to those state laws that regulated

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76. *See id.* at 524.

77. *Id.* at 525.

78. 463 U.S. 85 (1983).

79. *Shaw*, 463 U.S. at 96-97.

80. *See id.* at 88 (regarding New York’s Human Rights Law and Disability Benefit Law).

81. *Id.* at 95 (quoting *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977)).

82. *Id.* at 96-97.

83. *See id.* at 97. The Court noted that *Alessi* is distinguishable, because here the Court relied on “the State law’s frustration of congressional intent,” rather than the legislative history of § 514. *Id.* at 96, n.15.

84. *Id.* at 96-97.

85. *See id.* at 98.

86. *See id.* at 98-99. ERISA’s subject matter is confined to duties of reporting, disclosure, and fiduciary responsibility.

specific areas delegated exclusively to ERISA.<sup>87</sup> The ERISA Conference Committee, however, rejected this restrictive approach and instead, adopted the liberal “relate to” language.<sup>88</sup> Congress ascertained that this broad application was essential to advance the federal interest of a national common market in regulating the field of employee benefit plans, thus “eliminating the threat of conflicting or inconsistent State and local regulation.”<sup>89</sup>

Relying on its two-prong analysis of ERISA’s “relate to” criterion enunciated in *Shaw*, the Supreme Court reemphasized the broad scope of the “in connection with” or “in reference to” standard in *Metropolitan Life Insurance Co. v. Massachusetts*.<sup>90</sup> A Massachusetts law mandated mental health care benefits to be provided to all residents insured within the state due to the rising costs accompanying health care for mental illness.<sup>91</sup> The Court held that even though the state’s law was not labeled as a law affecting the administration of plan benefits, the statute affected benefit plans “indirectly, but substantially” by compelling all plans to provide benefits for mental health services.<sup>92</sup> The Court reiterated that a state law relates to a benefit plan “if it has a connection with or reference to such a plan” and that even indirect state action may encroach upon areas exclusively confined to federal concern.<sup>93</sup>

The Court next applied its expansive view of ERISA in a preemption analysis of state common law claims. In *Pilot Life Insurance Co. v. Dedeaux*,<sup>94</sup> an employee brought a diversity action against his employer’s insurance company.<sup>95</sup> The employee asserted various state common law causes of action for improperly terminating and processing his employee health care benefits.<sup>96</sup> Relying on its expansive sweep of the preemption clause in *Shaw* and *Metropolitan Life*, the unanimous Court stated, “There is no dispute that the common law causes of action asserted in Dedeaux’s complaint ‘relate to’ an employee benefit plan . . . .”<sup>97</sup> The Court emphasized that Congress intended a broad interpretation of the ERISA preemption clause.<sup>98</sup> The Court therefore held that

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87. *See id.* at 98.

88. *See id.* (citing H.R. Rep. No. 93-1280, at 383 (1974); S. Rep. No. 93-1090, at 383 (1974)).

89. *See id.* at 99. (quoting 120 Cong. Rec. 29,197 at 29,933 (1974)).

90. 471 U.S. 724 (1985).

91. *See id.* at 727.

92. *Id.* at 739. ERISA did not completely preempt the Massachusetts statute because it fell within the savings clause exception of ERISA. *See id.* at 744. The savings clause prevented ERISA preemption, because the Massachusetts statute was deemed to regulate insurance. *See id.*

93. *Id.* at 739.

94. 481 U.S. 41 (1987).

95. *Pilot Life Ins. Co.*, 481 U.S. at 41.

96. *See id.* (claiming breach of fiduciary duties, tortious breach of contract, and fraud).

97. *Id.* at 47.

98. *See id.* at 47-48.

an action asserting improper processing of a claim for benefits covered by an employee benefit plan is preempted by § 514 of that ERISA.<sup>99</sup> The Court reasoned that the expansive scope of ERISA's preemption was not "[confined to] state laws [particularly] designed to affect employee benefit plans."<sup>100</sup> Although this analysis added little in substance, it confirmed the Court's commitment to a broad interpretation of ERISA preemption.

In the Supreme Court's next two cases involving ERISA, the Court significantly broadened ERISA's interpretation of the "relate to" phrase. The first case, *FMC Corp. v. Holliday*,<sup>101</sup> involved a Pennsylvania anti-subrogation statute.<sup>102</sup> The Court held that a Pennsylvania law was preempted, because it contained a "reference to" a self-insured welfare benefit plan.<sup>103</sup> In determining whether preemption is appropriate, the Court based its holding on the risk of "subjecting plan administrators to conflicting state regulations."<sup>104</sup> The Pennsylvania law would frustrate an administrator's burden to formulate nationwide uniform benefits.<sup>105</sup> The Court confirmed its view that the scope of § 514 is "as broad as its language."<sup>106</sup>

The broadest interpretation of § 514 by the Supreme Court arose in *District of Columbia v. Greater Washington Board of Trade*.<sup>107</sup> The District of Columbia mandated that employers who provide health insurance for their employees must also provide comparable health insurance coverage for injured employees who were eligible for workers' compensation benefits.<sup>108</sup> Justice Thomas, writing for the Supreme Court, emphasized that the "relate to" language should be given its ordinary meaning, thereby giving "effect to the 'deliberately expansive' language chosen by Congress."<sup>109</sup> The Court pointed out that its prior judgments held that a state law relates to an ERISA plan "even if the law is not . . . designed to affect such plans, or the effect is only indirect."<sup>110</sup> Hence, ERISA preempted the state statute because the law referred to welfare benefit plans, which falls within the area of ERISA's exclusive

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99. *See id.*

100. *Id.* (quoting *Shaw v. Delta Air Lines*, 463 U.S. 85, 97 (1983)).

101. 498 U.S. 52 (1990).

102. *See FMC Corp.*, 498 U.S. at 54 (Pennsylvania statute prohibited "employee welfare benefit plans from exercising subrogation rights on a claimant's tort recovery").

103. *Id.*

104. *Id.* at 59-60.

105. *See id.* at 60.

106. *Id.* at 59 (quoting *Shaw v. Delta Air Lines*, 463 U.S. 85, 98 (1983)).

107. 506 U.S. 125 (1992).

108. *See Greater Wash. Bd. of Trade*, 506 U.S. at 126-27.

109. *Id.* at 129.

110. *Id.* at 130 (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990)).

control.<sup>111</sup>

In its 1995 benchmark decision on ERISA preemption, *New York Conference of Blue Cross v. Travelers Insurance*,<sup>112</sup> the Supreme Court expanded its interpretation of ERISA preemption to embrace ERISA's underlying purpose of achieving uniform national administration of health care benefits. In *Travelers*, a New York statute imposed surcharges on insurance companies and HMOs.<sup>113</sup> The Court restated its presumption that Congress did not intend for ERISA to supplant state law.<sup>114</sup> Justice Souter, writing for the Court, began his analysis of ERISA preemption by stating that in areas traditionally regulated by the states, the historic police powers of the states may not be superseded by the federal act unless this was the clear and manifest intent of Congress.<sup>115</sup> In interpreting Congress' intent, Justice Souter configured a three-pronged analysis consisting of examining the text of the provision at issue, the law's structure, and the purpose of the Act.<sup>116</sup>

Beginning with the text of ERISA, the Court stated "that [a] law 'relates to' an employee benefit plan . . . if it has a connection with or reference to such a plan."<sup>117</sup> The Court excluded the "in reference to" requirement, rationalizing that the surcharges were mandated on patients and HMOs regardless of whether their insurance was secured by an ERISA plan, and therefore, cannot be solely in reference to an ERISA plan.<sup>118</sup> The Court, however, scrutinized whether the "in connection" requirement was implicated. The Court noted that if the words "relate to" were taken "to extend to the furthest stretch of . . . indeterminacy, then for all practical purposes preemption would never run its course."<sup>119</sup> The critical term "relates to" has no fixed meaning, but, as Justice Souter discerned, is inconclusive, referring to infinitely expansive causal relationships.<sup>120</sup>

Looking to ERISA's legislative history, the Court noted that Congress' aim "was to avoid a multiplicity of regulation in order to permit

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111. *See id.*

112. 514 U.S. 645 (1995).

113. *See id.* at 649-50. The statute required "patients to be charged not for the cost of their individual treatment but for the average cost of treating [the] medical problem." *Id.* at 649. The surcharge was to be adjusted for each specific hospital to reflect that individual entity's "operating costs, capital investments, bad debts . . . and the like." *Id.* at 650.

114. *See id.* The Court emphasized the judicial presumption against federal preemption in areas of local concern, such as health care, but postulated the possibility of preemption when state law had an effect on health plans.

115. *See id.* at 655.

116. *See id.*

117. *Id.* at 656.

118. *See id.*

119. *Id.* at 655 (quoting HENRY JAMES, RODERICK HUDSON at xli, *World's Classics* 1980).

120. *See id.* at 655.

the nationally uniform administration of employee benefit plans.”<sup>121</sup> The Court found the words “insofar as they . . . relate” to express a limitation.<sup>122</sup> Therefore, the preemption provision did not displace all state laws having an indirect economic effect on employee-benefit plans.<sup>123</sup> Examining New York’s law, the Court found that the statute did not impede multi-state employers from administering their employee health plans consistently.<sup>124</sup> The New York law was not promulgated to compel ERISA employers to encumber specified plan benefits.<sup>125</sup> Consequently, the Supreme Court held that New York’s law was not preempted, because it did not “relate to” ERISA administration.<sup>126</sup>

Since the decision in *Travelers*, the Supreme Court has continued to apply Justice Souter’s framework in determining ERISA preemption. In *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*,<sup>127</sup> a California law required public works’ contractors to compensate their employees based on the prevailing wage rate in the area where the public works’ project was located.<sup>128</sup> The statute, however, carved out an exception that permitted a reduced wage to be paid to workers who participated in the State’s apprenticeship program.<sup>129</sup> Dillingham hired apprentices from a non-approved program. The California Division of Apprenticeship delivered a notice of non-compliance to Dillingham for paying apprentice wages to an employee from an unapproved program.<sup>130</sup> Dillingham defended on the grounds that the state law was preempted by ERISA.<sup>131</sup>

The Supreme Court began its analysis with the assumption that “the historic police powers” of a state were not to be preempted by federal law “unless that was the clear and manifest purpose of Congress.”<sup>132</sup> Relying on *Travelers*, the Court looked to “ERISA’s objectives as a guide to the scope of the state law that Congress understood would survive, and to the nature of the law’s effect on ERISA plans . . . .”<sup>133</sup> The Court then applied the two-tier inquiry of the “relate to” requirement to the plan.

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121. *Id.* at 659.

122. *Id.*

123. *See id.*

124. *See id.* at 657-68.

125. *See id.* at 659.

126. *Id.* at 668.

127. 519 U.S. 316 (1997).

128. *See Dillingham Constr., N.A., Inc.*, 519 U.S. at 319.

129. *See id.*

130. *See id.* at 322.

131. *See id.*

132. *Id.* at 325 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

133. *Id.* at 320 (citing *Travelers*, 514 U.S. at 646, 654).

The Court first noted that to meet the “in reference to” requirement, a state law must act “immediately and exclusively upon ERISA plans” or “the existence of ERISA plans [must be] essential to the law’s operation.”<sup>134</sup> It then enunciated three examples in which it found preemption on the basis of the “in reference to” requirement: “[ (1) ] a law that impose[s] requirements by reference to covered programs . . . ; [ (2) ] a law that specifically exempted ERISA plans . . . ; and [ (3) ] a common-law cause of action premised on the existence of an ERISA plan.”<sup>135</sup> Applying California’s statute to ERISA’s “in reference to” requirement, the Court determined that the law was not in reference to an ERISA plan because the state law affected not only employee benefit programs, but also included programs that may not constitute an ERISA plan.<sup>136</sup>

Having ruled out the “in reference to” requirement, the Court next applied the “in connection with component” of the analysis. The Court acknowledged the parallel between California’s wage law and the rate-setting provisions at issue in *Travelers*, noting that apprenticeship programs have long been regulated concurrently by states and other federal legislation.<sup>137</sup> This alone would not insulate the statute from ERISA preemption.<sup>138</sup> Conversely, California’s wage statute only impacted the incentives, rather than prescribing the choices of ERISA plans. The Court therefore held that the statute was not subject to preemption.<sup>139</sup> As a result, the Supreme Court did not alter the presumption that the police powers of the state were not superseded.<sup>140</sup>

The Supreme Court recently narrowed the scope of ERISA’s preemption power as to not disturb state police power to regulate health care.<sup>141</sup> In *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, the Court examined New York’s Health Facility Assessment (HFA), which imposed a tax on gross receipts for patient services at health care centers.<sup>142</sup> The Court concluded that the hospital tax imposed by the state was of general applicability.<sup>143</sup> Based on ERISA’s legislative history, the Court held that this was not the type of law that Congress intended to preempt when it enacted ERISA.<sup>144</sup>

These recent Supreme Court cases demonstrate the evolving inter-

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134. *Id.* at 325.

135. *Id.* at 324.

136. *See id.* at 326.

137. *See id.* at 328-29.

138. *See id.*

139. *See id.* at 324.

140. *See id.* at 331.

141. *See DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997).

142. *See id.* at 809.

143. *See id.*

144. *See id.* at 814.



pretation of ERISA preemption and provide the framework that other courts should utilize when confronted with an ERISA issue. A court should first ascertain whether the state law or issue in question affects an ERISA plan.<sup>145</sup> There will be no federal preemption where an ERISA plan is not implicated. If the law or claim implicates an ERISA plan, the court should shift its focus to the "relate to" analysis delineated in *Travelers*. The two disjunctive components used to determine whether a state law or claim satisfies the "relate to" qualification are: (1) in reference to, or (2) in connection with.<sup>146</sup> In order for a state law or claim to be preempted, it need only satisfy one of the prongs.<sup>147</sup> The "in reference to" prong is satisfied whenever a state law or claim immediately and primarily impacts an ERISA plan or when the emergence of an ERISA plan is fundamental to the law's operation.<sup>148</sup> The Court's application of the "in connection with" prong should address the purposes of the ERISA statute. ERISA's legislative history should guide a determination of the scope of the state law that Congress understood would survive and the nature of the effect of the state law on the ERISA plan.<sup>149</sup> Particularly, a court should decide whether the state law requires specific benefit structures or their administration.<sup>150</sup> Such a determination has resulted in courts applying the quality versus quantity test.

#### IV. THE AFTERMATH: DISTINGUISHING BETWEEN THE QUALITY AND QUANTITY DISTINCTION

The Supreme Court stated in *Ingersoll-Rand Co. v. McClendon*<sup>151</sup> that:

[S]ection 514(a) was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefit law; the goal was to minimize the administrative and financial burden of complying with conflicting directions among or between States and Federal Government.<sup>152</sup>

The Supreme Court observed that Congress intended for ERISA to preempt state laws pertaining to the administration of employee-benefit plans while acquiescing to state regulation pertaining to the quality of

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145. See 29 U.S.C. §§ 1002(1), 1144(a) (1994).

146. See *New York Conf. of Blue Cross v. Travelers Ins.*, 514 U.S. 645, 656 (1995).

147. See *California Div. of Labor Standards Ent. v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997).

148. See *id.*

149. See *id.*

150. See *id.* at 329.

151. 498 U.S. 133 (1990).

152. *Ingersoll-Rand Co.*, 498 U.S. at 142.

care that the benefits provided.<sup>153</sup> Consequently, cases addressing the scope of ERISA preemption fall within two distinct categories: (1) claims for denial of benefits due to negligent utilization review decisions, and (2) claims attacking the quality of care received. On the basis of this distinction, preemption is applied in the former but not the latter case.<sup>154</sup>

Applying this analytical framework to issues concerning ERISA preemption raises the question of whether an MCO should be held directly liable for state tort claims alleging negligent quality of care such as suits for medical malpractice. The logical conclusion initially suggests "yes." This is because upon first impression there does not appear to be any term in the language of ERISA's text or legislative history indicating that "Congress chose to displace health care regulation, which has historically been a matter of local concern."<sup>155</sup> On the other hand, an MCO utilizes claim-review committees and other cost-efficient driven strategies in order to offer strictly a pragmatic business decision.<sup>156</sup> The inquiry boils down to whether the plaintiff challenges the quality of the benefits received, rather than challenging actual benefit determinations.<sup>157</sup> Only the latter is preempted by ERISA.

Another layer to this distinction is whether the benefits are depicted as the actual medical care or as "part and parcel" of a benefit determination.<sup>158</sup> This distinction has led courts to categorize claims into two forms: vicarious liability and direct liability.<sup>159</sup> If an MCO can demonstrate a correlation between the medical decisions and the administrative services (i.e., as "part and parcel" of the benefit determination), then any claim relating to a medical decision is preempted by ERISA because it is actually a direct claim against the MCO for denial of benefits.<sup>160</sup>

Alternatively, plaintiffs have successfully defeated ERISA preemption by asserting claims based upon a theory of vicarious liability. The most common vicarious liability claims asserted against MCOs are based on the doctrine of respondeat superior or the theory of ostensible-

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153. See Williams, *supra* note 9, at 29.

154. Compare Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992) (addressing a claim for denial of benefits), with *Dukes v. United States Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995) (ruling on claims regarding the quality of care received).

155. *New York Conf. of Blue Cross v. Travelers Ins.*, 514 U.S. 645, 661 (1995).

156. See Denise Chan, *ERISA Preemption: Immunity for HMOS*, 1998 U. ILL. L. REV. 199 (1998).

157. See *id.*

158. See Corcoran, 965 F.2d at 1332.

159. See generally O. Mark Zamora, *Medical Malpractice and Health Maintenance Organizations: Evolving Theories and ERISA's Impact*, 19 NOVA L. REV. 1047, 1048 (1997).

160. See Corcoran, 965 F.2d. at 1322.

apparent agency.<sup>161</sup>

Respondent superior claims allege that the MCO held itself out as a provider of medical services rather than as merely an administrator. The nexus to these claims depends on whether an actual employer-employee relationship existed and whether the negligent conduct resulted from within the physician's scope of employment.<sup>162</sup> Courts determine whether an employer-employee relationship existed by focusing on the MCO's right to control a health practitioner, rather than the actual control that was exerted.<sup>163</sup> If a doctor is found to be an employee of the MCO, courts have consistently held MCOs vicariously liable for the negligent medical care of its agent, the physician.<sup>164</sup>

Plaintiff-attorneys have asserted claims of apparent-ostensible agency as an alternative theory of liability where an employer-employee relationship cannot be established.<sup>165</sup> Apparent agency claims are more often asserted against a PPO, because PPOs do not directly employ physicians.<sup>166</sup> The Sixth Circuit, in *Decker v. Saini*,<sup>167</sup> may have become the catalyst for extending ostensible agency liability to MCOs when it declared, "it would be against public policy to allow [MCOs] . . . to escape liability for their members' treatment."<sup>168</sup> Under this theory, two elements need to be established: (1) a representation by the principal that an agency relationship exists, and (2) reliance on this representation by a

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161. See Chittenden, *supra* note 66, at 458.

162. See *Hill v. St. Claire's Hospital*, 490 N.E.2d 823 (N.Y. 1986) (holding medical facility liable for the negligence of its employees, but will not be held liable if its providers are independent contractors). Compare *Schleier v. Kaiser Found. Health Plan of the Mid-Atlantic States, Inc.*, 876 F.2d 174, 178 (D.C. Cir. 1989) (per curiam) (applying respondeat superior theory in federal court), with *Raglin v. HMO Ill., Inc.*, 595 N.E.2d 153, 156 (Ind. Ct. App. 1992) (holding that no master-servant relationship exists where an IPA does not directly employ its own physicians).

163. See *Sloan v. Metropolitan Health Council*, 516 N.E.2d 1104 (Ind. Ct. App. 1987) (holding HMO liable for physician's failure to diagnose); see also *Chase v. Independent Practice Ass'n, Inc.*, 583 N.E.2d 251, 254 (Mass. App. Ct. 1991).

164. See, e.g., *Haas v. Group Health Plan, Inc.*, 875 F.Supp. 544, 548 (S.D. Ill. 1994); *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182 (E.D. Pa. 1994) (distinguishing a claim that a person was denied a promised benefit, which is preempted, from a claim that a person received promised service from a provider who performed that service negligently, which is not preempted); *Smith v. HMO Great Lakes*, 852 F.Supp. 669 (N.D. Ill. 1994) (taking a circumspect view of the scope of ERISA preemption, and holding that professional malpractice claims have nothing to do with a denial of plaintiffs' rights under such plans); *Dunn v. Praiss*, 139 N.J. 564, 565 (N.J. 1995) (holding physician liable for medical malpractice may state a claim for contribution from an HMO under the theory that the HMO breached an independent contractual duty to the plaintiff).

165. See *Zamora*, *supra* note 159, at 1050.

166. See Helene L. Parise, Comment, *The Proper Extension of Tort Liability Principles in the Managed Care Industry*, 64 TEMP. L. REV. 977, 996-97 (1991).

167. No. 88-361768 NH 1991, WL 277590, at \*4-5 (Mich. Cir. Ct. Sept. 17, 1991) (ostensible agency applies when an MCO holds physician out as its employee).

168. *Id.* at 5.

third party.<sup>169</sup> The first element of this test requires courts to determine whether the MCO "holds out" the doctor or health practitioner as its employee.<sup>170</sup> Satisfaction of the second element depends on whether the patient relied on the MCO rather than on the individual physician for care.<sup>171</sup> Courts are likely to continue to extend ostensible agency MCOs because members often look to the MCO for a list of approved providers rather than autonomously selecting a physician.<sup>172</sup>

Courts have also extended direct liability to MCOs pursuant to a theory of corporate negligence.<sup>173</sup> Under the corporate negligence doctrine, MCOs are held liable for the negligent selection or control of physicians.<sup>174</sup> The focus to this type of lawsuit is whether the MCO negligently retained a physician with a tendency to commit malpractice.<sup>175</sup> In *Harrel v. Total Healthcare, Inc.*, the Missouri Supreme Court first addressed what duties MCOs owe to their members.<sup>176</sup> The court held that an MCO's restriction on available practitioners for its enrollees manifested a duty of care in the selection and retention of its participating providers.<sup>177</sup>

MCOs have also been subjected to direct liability via claims of negligent implementation of cost-containment systems.<sup>178</sup> MCOs employ quality assurance and cost-containment procedures to authorize or deny health care services to their members.<sup>179</sup> Two decisions from California Courts of Appeals indicate that an MCO may owe a duty of care in forming medical decisions based on utilization review. In *Wickline v.*

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169. See RESTATEMENT (SECOND) OF AGENCY § 267 (1958). One who represents that another is his servant or other agent and thereby causes a third [person] justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such. See *id.*

170. See *Boyd v. Albert Einstein Medical Center*, 547 A.2d 1229, 1234 (Pa. Super. Ct. 1988) (first court to expand the ostensible agency theory from the hospital-employee setting to the MCO-physician setting).

171. See *id.*

172. See Torin A. Dorros & T. Howard Stone, *Implications of Negligent Selection and Retention of Physician in the Age of ERISA*, 21 AM. J.L. & MED. 383, 393 (1995).

173. See Chittenden, *supra* note 66, at 468-85.

174. See *id.*

175. See Zamora, *supra* note 159, at 1055.

176. 781 S.W.2d 58, 59-60 (Mo. 1989); see also *Insinga v. LaBella*, 543 So. 2d 209 (Fla. 1989) (finding HMO liable on corporate negligence theory). Although the Missouri Supreme Court denied recovery to the plaintiff, it is significant that the Missouri Court of Appeals declared that MCOs have a duty of care in selecting its physicians. See Dorros & Stone, *supra*, note 159, at 397.

177. See *Harrel*, 781 S.W.2d at 60.

178. See Zamora, *supra* note 159, at 1055.

179. See Robert C. Macaulay, Jr., *Health Care Cost Containment and Medical Malpractice: On a Collision Course*, 21 SUFFOLK U. L. REV. 91, 91 (1987) (cost-containment measures impact medical services).

*State*,<sup>180</sup> the court held that the state's Medicaid program did not owe a duty of care in implementing its utilization review because it was following statutory requirements for cost containment. However, the court stated in dicta that "[t]hird party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms . . . ."<sup>181</sup> Additionally, the court in *Wilson v. Blue Cross*<sup>182</sup> determined that a private insurer or utilization review entity may be liable for injuries resulting from the negligent design or implementation of cost containment mechanisms.<sup>183</sup> Under this theory, MCOs may be held liable for negligent decisions that directly caused the patient's injury or death.<sup>184</sup>

On the other hand, federal courts have consistently held that ERISA preempts direct liability claims against MCOs for the denial of benefits because such suits delve beyond the quality threshold of the provided health care benefits.<sup>185</sup> These suits assert that an MCO negligently implemented its cost-efficient formula. These claims are flawed because cost-efficient formulas, by their nature and function, are necessary to the sustenance of affordable health-care. Utilization review decisions are administrative choices relating to the plan's benefit. Because "uniform administration of employee benefit plans" is a goal of ERISA, the Supreme Court requires preemption whenever state laws mandate employee-benefit structures or administration, or provide alternate enforcement mechanisms that do not exist in ERISA.

## V. WHETHER THE SUPREME COURT WILL DETERMINE THAT ERISA PREEMPTS TEXAS'S LEGISLATION ON MCO LIABILITY?

### A. *Senate Bill 386*

When Texas enacted Senate Bill 386 on May 22, 1997, it became the first state to permit medical malpractice claims to be brought directly against MCOs.<sup>186</sup> By virtue of a prior statute, corporations were prevented from practicing medicine.<sup>187</sup> Senate Bill 386 was passed in

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180. 228 Cal. Rptr. 661 (Ct. App. 1986).

181. *Wickline*, 228 Cal. Rptr. at 670.

182. 271 Cal. Rptr. 876 (Cal. Ct. App. 1990).

183. *Wilson*, 271 Cal. Rptr. at 882-83.

184. *See id.*

185. *See Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1331 (5th Cir. 1992) (holding that ERISA preempts claims based on negligent administration of the availability of benefits).

186. Act of May 22, 1997 Tex. Gen. Laws 317. *See also* George Parker Young, *Don't Preempt the HMO Liability Bill*, TEX. LAW., Sep. 22, 1997, at 26.

187. *See* Jim M. Perdue, *Causes of Action and Practice Tips Under the New HMO Liability Law*, EIGHTH ANNUAL MEDICAL MALPRACTICE CONFERENCE 357, 361 (1997). Prior to 1997, doctors in Texas could be sued for medical malpractice while MCOs were protected from liability

response to concerns that MCOs could not be held legally accountable for negligent medical decisions. The new Texas law imposes two forms of liability on MCOs. First, MCOs may be liable for a breach of a "duty to exercise ordinary care when making health care treatment decisions."<sup>188</sup> Failure to exercise such care subjects the MCOs to claims of medical malpractice.<sup>189</sup> The standard of care required of such entities is that which a managed care entity of "ordinary prudence would use under the same or similar circumstances."<sup>190</sup> A significant ramification of the bill is that its coverage is confined to those health care decisions made "when medical services are [actually] provided by the health care plan . . ."<sup>191</sup> This language limits the scope of the medical services which must be considered because an MCO is not required to use ordinary care for services not provided for in the patient's health care plan.<sup>192</sup>

MCOs may also be liable for decisions made by employees or agents acting on the MCO's behalf.<sup>193</sup> This second cause of action looks as though it merely mirrors responsibility under the auspices of vicarious liability.<sup>194</sup> However, this second cause of action does more than merely create another agency theory. This law may be the impetus for bringing malpractice claims against MCOs that require an employee or agent to give approval for medical treatment prior to a doctor providing care to the patient. If payment for treatment is denied due to a utilization review, patients usually forego the treatment because they cannot afford to pay for it themselves. In such situations, utilization review appears to control both the quality and quantity of care a doctor offers to a patient, because the treatment is solely based on what will be paid for. It follows then where such treatment or omission of treatment causes injury, the MCO could be held liable.<sup>195</sup> Under the Texas bill, determi-

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pursuant to the Texas Medical Malpractice Act and the Texas HMO Act on the grounds that because corporations could not practice medicine, they could not be held liable for medical decisions. See *Williams v. Good Health Plus, Inc.*, 743 S.W.2d 373, 375, 378 (Tex. App. 1987) (holding HMO could not be held liable for negligence because it was incapable of practicing medicine according to the statute).

188. See TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (West 1998).

189. See *id.*

190. *Id.* at § 88.001(10).

191. *Id.* at § 88.001(5).

192. See Greg Otterson, *Medical Malpractice For Texas HMOs: The End of A "Charmed Life,"* 39 S. TEX. L. REV. 799, 823 (1998).

193. See TEX. CIV. PRAC. & REM. CODE ANN (West 1998). The statute holds managed care entities "liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by its (1) employees; (2) agents; (3) ostensible agents; or (4) representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control which result in the failure to exercise ordinary care." *Id.*

194. See Stoeckl, *supra* note 40, at 403.

195. See *id.*

nations as to whether to provide medical treatment or how much medical treatment to provide are now subject to malpractice actions if the denied benefit proximately caused the patient's injury.<sup>196</sup>

B. *Applying the ERISA Analysis to Senate Bill 386*

1. *CORPORATE HEALTH INSURANCE, INC. V. TEXAS DEPT. OF INSURANCE*

The potential effects of Senate Bill 386 induced Aetna Health Plans of Texas to file for a permanent injunction against the bill's enactment, arguing on the grounds that federal preemption precluded its adoption.<sup>197</sup> Aetna asserted that Senate Bill 386 is preempted by ERISA and is an improper expansion of state law into an area regulated by Congress and the Supremacy Clause of the United States Constitution.<sup>198</sup> Aetna contended, *inter alia*, that Senate Bill 386 "related" to employer-provided benefit plans covered by ERISA and it was intended to:

1. impose state law liability on managed care entities in connection with the administration of employee benefit plans;
2. modify the standard of review for benefit decisions under ERISA plans;
3. modify the terms of plans by substituting a statutory definition of "medically necessary" for those already in plans; and
4. eliminate a method of structuring benefits under plans by purporting to change the contractual relationships between the MCO and their respective contracting physicians from independent contractors to agents or ostensible agents.<sup>199</sup>

Senate Bill 386 should be preempted according to the Supreme Court's position regarding ERISA. The first step in addressing an ERISA claim is applying the presumption against preemption.<sup>200</sup> As Justice Souter noted in *Travelers*, a Federal Act should supersede the historic police powers of the State only where it was Congress' clear and manifest purpose to do so.<sup>201</sup> Additionally, the Court noted in *De Buono* that "the fact that a statute targets only the health care industry does not in itself warrant preemption," but rather calls for the "application of the

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196. *See id.*

197. *See* Plaintiff's Complaint for Declaratory Judgment and Permanent Injunction at 2-5, *Corporate Health Ins., Inc. v. Texas Dept. of Ins.*, No. H-97-2072 (S.D. Tex. June 16, 1997).

198. *See id.* at 2-3.

199. *See id.* at 8-9. Aetna additionally claimed that Senate Bill 386 is preempted by FEHBA, a federal program providing health care benefits to federal employees. *See id.* at 8.

200. *See* *California Div. of Labor Standards v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316 (1996); *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 519 U.S. 316 (1996); *New York State Conference of Blue Cross & Blue Shield v. Travelers Ins. Co.*, 514 U.S. 645, 654 (1995).

201. *See Travelers*, 514 U.S. at 655.

'starting presumption' against preemption."<sup>202</sup> It follows then if Senate Bill 386 solely addresses the healthcare industry's quality of care, the Supreme Court would apply its initial presumption against preemption. This starting presumption alone, however, is in no way indicative of whether state law is immunized from preemption.<sup>203</sup> Alternatively, the Court will evaluate whether ERISA is expressly concerned with any of the areas that the state law tends to regulate.<sup>204</sup>

In *Dillingham*, the Court identified the "areas with which ERISA is expressly concerned — 'reporting, disclosure, fiduciary responsibility, and the like.'"<sup>205</sup> Because the California statute in *Dillingham* regulated wage rates for a particular class of employees, the Court held that the law had too remote of an effect on ERISA, and therefore would not be preempted.<sup>206</sup> In that regard, Senate Bill 386 seems to pass preemption muster because it addresses the quality of care that managed care entities should give to their enrollees. Quality of care issues are not an area that is expressly governed by ERISA.

On the other hand, the distinction between quality and quantity is not always clear.<sup>207</sup> Because there is no bright line distinction, a claim that is based solely on the quality of care may still be subject to ERISA preemption if the quality of "care will be so low that the treatment received simply will not qualify as health care at all."<sup>208</sup> ERISA would compel such a claim to be brought under § 502(a).<sup>209</sup> Consequently, the claim would be subject to complete preemption because a denial of benefits falls within the civil enforcement section governed solely by ERISA.<sup>210</sup> Decisions regarding the denial of benefits might be preempted depending on how one characterizes the complaint. It appears that the only form of claims that would be immunized from preemption are claims regarding the quality of care a person received when medical service was actually provided. Because a finding of preemption is fact-sensitive, the Supreme Court would have to decide on a case-by-case basis whether the area of law Senate Bill 386 regulates affects areas expressly reserved to ERISA governance.

If the law passes muster after the presumption against preemption has been applied, the next step is to determine whether the state law or

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202. *De Buono*, 520 U.S. at 180.

203. *See Dillingham*, 519 U.S. at 330.

204. *See id.*

205. *Id.* at 330 (quoting *Travelers*, 514 U.S. at 661).

206. *See id.*

207. *See Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 358 (3d Cir. 1995).

208. *Id.*

209. *See* 29 U.S.C. § 1144(b)(2)(A) (1994).

210. *See Pilot Life Ins. Co. v. Massachusetts*, 481 U.S. 41, 44-45 (1987).



claim involves an employer-provided benefit plan. ERISA's scope is confined exclusively to the administration of employer-provided benefit plans.<sup>211</sup> Therefore, if a claim is brought under an employer health plan, ERISA governs and the "relate to" analysis will commence. ERISA will not apply if the claim does not concern a health care plan provided by an employer.<sup>212</sup>

If the claim satisfies the plan qualification, the Court will apply the "relate to" criteria of ERISA. A state law relates to an employee benefit plan if it is "in reference to" or "in connection with" such a plan.<sup>213</sup> A state law or claim has to meet only one of the prongs to be preempted.

If asked to analyze Bill 386, the Court would probably dispose of the "in reference to" requirement first because it is detected more easily.<sup>214</sup> The Court in *Dillingham* noted that "where the existence of ERISA plans is essential to the law's operation" then that law satisfies the "in reference to" requirement and results in preemption.<sup>215</sup> Thus, the critical issue that arises is whether Senate Bill 386 makes any reference to an ERISA plan.<sup>216</sup> The bill defines a health care plan as "any plan whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services."<sup>217</sup> The plain language of the bill appears to not rely on ERISA plans for its existence. Additionally, the broad definition of health care plan covers plans provided by employers as well as plans not provided by employers, because of the general phrases relating to "any plan" provided by "any person." Even though the statute embraces ERISA plans, the connection may not be sufficient to warrant preemption of the Texas law.<sup>218</sup> By employing the *Dillingham* analysis, it appears that claims against plans not expressly or impliedly covered by ERISA may be entitled to relief under Senate Bill 386 without being preempted.<sup>219</sup>

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211. See 29 U.S.C. 1002(1)(a) (1994). A welfare benefit plan under ERISA provides employees with "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment. . . ." *Id.*

212. See *id.*

213. See *New York Conference of Blue Cross v. Travelers Ins.*, 574 U.S. 645, 656 (1995).

214. See, e.g., *California Div. of Labor Standards v. Dillingham Constr., N.A.*, 519 U.S. 316, 324-25 (1997).

215. *Id.* at 325.

216. See *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990). Pursuant to the Texas law, recovery is provided where the plaintiff proves the primary reason for termination was the employer's desire to avoid contributing to benefits under the employee's pension fund. See *id.* at 140. Because pensions are specifically governed by ERISA and there is no claim without the existence of a pension plan, the plaintiff's claim was in reference to an ERISA plan. See *id.*

217. TEX. CIV. PRAC. & REM. CODE ANN. § 88.001(3) (West 1998).

218. See *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 130 n.1 (1992).

219. See *Tex. Civ. Prac. & Rem. Code Ann. § 88.001(3)* (West 1998) (applying broadly to any health care plan, rather than just ERISA plans); see also *Dillingham*, 519 U.S. at 324. The Court

Assuming the Court does not preempt the claim pursuant to the “in reference to” requirement, the Texas law must also hurdle the “in connection with” component of ERISA’s preemption clause. In looking at ERISA’s legislative history, the Court in *Travelers* found that the aim of ERISA preemption “was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.”<sup>220</sup> Senate Bill 386 does not appear to overcome the “in connection with” component, because the bill places restraints on the administration of plans.<sup>221</sup> First, the bill subjects MCOs to state tort liability for making an administrative decision — a determination that is surely within the scope of ERISA. Second, the law prohibits an MCO from removing a doctor from its plan or refusing to renew a physician for advocating “appropriate and medically necessary health care for the enrollee.”<sup>222</sup> Third, Senate Bill 386 does not permit managed care entities to contract with others for indemnification clauses.<sup>223</sup> All of these prohibitions are “in connection with” benefit plans, because they affect the administration of such plans.

These limitations strike a direct blow against ERISA’s statutory objective — promoting uniformity in the regulation of health care providers and the uniform administration of employer-provided benefit plans. ERISA, on its face, preempts any state law that relates to an employee-benefit plan. Where an MCO provides health care benefits to an employee as part of an employer-provided benefit plan, ERISA requires exclusive federal jurisdiction. If the Supreme Court chooses to ignore the broad language of the preemption clause, it would defy well-established rules of statutory interpretation in favor of judicial policy. Instead, the Supreme Court should follow Congress’ objective and reform, if any, should be implemented by the states’ representatives in Congress.

Critics of managed care argue that MCOs influence, sometimes even make, medical decisions and should be held liable for injuries resulting from such decisions. Senator David Sibley, a major proponent of the Texas bill, defined the core of the bill: “If the HMOs choose to make medical decisions – stand in the shoes of the doctor, as it were – they ought to stand in the shoes of the doctor in court too.”<sup>224</sup> However,

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held that because it appeared that the state law affected employee benefit plans, which need not be ERISA plans, the law was not in reference to ERISA. *See id.*

220. *Travelers*, 514 U.S. at 657.

221. TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.002(f)-(g) (West 1998).

222. *Id.* § 88.002(f).

223. *Id.* § 88.002(g).

224. Debate on Tex. S.B. 386 on the Floor of the Senate, 75th Leg., R.S. 3 (March 17, 1997) (statement of Senator Sibley).

if benefits are to be provided to an employee, those benefits are to be governed by ERISA. Congress intended for any state law that relates to an employee benefit plan to be preempted by ERISA, because the need for uniform regulation of health care providers outweighs the state's concern for employees who were denied benefits on the grounds that they were medically unnecessary. The next section of this article further endorses the public policy providing for MCOs to be insulated from state regulation.

#### VI. COASE'S THEOREM: THE ECONOMIC POLICY FOR PREEMPTION

The Problem of Social Cost, commonly known as Coase's theorem, is concerned with those actions of businesses that cause harm to others.<sup>225</sup> Coase contends that harms caused by businesses are reciprocal in nature.<sup>226</sup> The analogy between Coase's theorem and an MCO's practice suggests that the aim of both is to avoid the more serious harm. MCOs achieve this aim by applying a risk/benefit analysis to their decisions of whether to authorize treatment to the enrollee. This principle can be illustrated by way of an example of a contamination of a stream.<sup>227</sup> If the harmful effect of the contamination is that it kills fish, the issue is whether the value of the lost fish is greater or less than the value of the product that causes the contamination of the stream.<sup>228</sup> For example, if a business created a vaccine for AIDS that would save human lives, one cannot easily conclude that the harm produced as part of the creating process (i.e., contamination of the stream kills fish) should be eliminated. Consequently, a comparison between the benefit and the harm is a factor in determining whether a harmful effect should be abated.<sup>229</sup>

Most economists would agree that the aim of statutes is to extend the scope of the law by prohibiting certain activities.<sup>230</sup> Conversely, governmental interests may actually protect businesses from the claims of those that have been harmed by their actions.<sup>231</sup> While there is a misconception that statutes always concern the activities that the public would like to see stopped or curtailed, those activities may well be socially justified.<sup>232</sup> In dealing with actions that have harmful effects, the gain from preventing the present harm must be measured against the

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225. See R.H. Coase, *The Problem of Social Cost*, 3 J. L. & ECON. 1 (1960).

226. See *id.* at 2.

227. See *id.*

228. See *id.*

229. See *id.*

230. See *id.* at 24.

231. See *id.*

232. See *id.* at 26.

loss that would be suffered elsewhere as a result of stopping the action that produces the harm.<sup>233</sup>

Applying Coase's theorem to managed care entities shows the necessity for federal regulation over state regulation. Congress enacted ERISA to encourage employers to provide employee benefit plans by establishing uniform guidelines for their administration.<sup>234</sup> By drafting a broad preemption clause, Congress exhibited its intent to insulate employers from the burden of discordant state law standards. Additional proof of Congress' intentions is reflected in ERISA's civil enforcement clause. ERISA's civil enforcement clause establishes a federal cause of action to receive a denied benefit, reimbursement for the benefit or a decree as to future benefits.<sup>235</sup> By providing for a federal remedy, this clause reflects Congress' understanding of the wide scope of ERISA's preemption language.

Due to fiscal demands, MCOs must endeavor to contain costs of health care to only medically necessary procedures. In doing so, the managed care entities have created cost containment mechanisms such as utilization review.<sup>236</sup> Prior to authorizing a health practitioner to treat the enrollee, the doctor or nurse contacts the MCO to ensure that the MCO will pay for the cost of the procedure. If such a cost containment procedure is constructed and operated in a proper manner, it should not be adjudged to be negligent. Accordingly, enrollees who are denied benefits under their employee benefit plans may suffer injuries and inconveniences. However, there is no negligent determination when these injuries result from the ordinary and necessary, therefore proper, use and operation of a cost containment mechanism. These injuries and inconveniences are not due to negligent determinations, but are the necessary concomitants of the managed care entity's aim. The ultimate result is an administrative decision for the greater good of the American public, which confines health costs so that quality care can be provided to more patients.

An enrollee who feels abused by such an administrative determination has recourse through the federal court system. Subjecting MCOs to state tort liability would eradicate the very purpose and scope of ERISA – uniform administration of employee benefit plans as well as a federal remedy for denied benefits. Summarizing Coase's theorem, “[I]n the absence of negligence it seems that a [business] exercising statutory powers will not be liable to an action merely because it might, by acting

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233. *See id.*

234. *See* 29 U.S.C. § 1001(a)-(b) (1994).

235. *See* 29 U.S.C. § 1132 (1994).

236. *See* Coase, *supra* note 225.

in a different way, have minimi[z]ed an injury."<sup>237</sup> Hence, the kind of situation which the public is prone to consider as requiring corrective government action is, in fact, often the result of government action.<sup>238</sup> If a remedy is to be sought for an MCO's decision, it should be brought within the scope of ERISA's framework; and if reform is to be advocated, it must be promoted at its source, which is Congress.

## VII. A REAL SOLUTION: GUIDELINE REVIEW BOARDS AND EXPEDITED HEARINGS

The difficulties posed by utilization reviews and financial incentives like capitation do not arise from an MCO's negligence, but from conflicts of interest. The physician's chief responsibility is the health and care of the patient.<sup>239</sup> This professional standard implies that physicians' financial interests should not influence physicians' decisions about how to care for patients.<sup>240</sup> However, prior to managed care, substantial data confirms that many abuses occurred in the fee-for-service reimbursement system.<sup>241</sup> The ramifications of overuse and inappropriate use motivated by physicians' investments in and financial returns for utilization of their own surgicenters, facilities, and therapy services have been documented.<sup>242</sup> Conversely, the advent of managed care has fueled public concern that too little care jeopardizes patient welfare.<sup>243</sup> In order to resolve this dilemma, the author proposes that Congress implement two safeguards to aid in protecting and reassuring the public trust in health care: (1) federal guideline review boards and (2) alternative dispute resolution proceedings.

The allocation of resources is inherent to any health care system, because fixed sums of currency are received by the MCO from its enrollees in consideration for providing health care.<sup>244</sup> These proposals provide safeguards for the allocation of resources to ensure the well-being of the patients.<sup>245</sup> These safeguards do not prohibit MCOs from utilizing cost-efficient formulas to develop guidelines, the determination

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237. Coase, *supra* note 225, at 24 (quoting *Halsbury's Laws of England*, 30 Halsbury, Law of England 690 (3d ed. 1960)).

238. *See id.* at 28.

239. *See Emanuel & Goldman, supra* note 3 at 638; *see also* Council on Ethical and Judicial Affairs, *Ethical Issues in Managed Care*, 273 JAMA 330.

240. *See* Dennis F. Thompson, *Understanding Financial Conflicts of Interest*, 229 NEW ENG. J. MED. 573 (1993).

241. *See Emanuel & Goldman, supra* note 3 at 638.

242. *See id.* at 639.

243. *See id.* at 635.

244. *See id.* at 640.

245. *See id.*

of benefits, and the appropriate use of medical services.<sup>246</sup> These safeguards merely ensure that regardless of what process is utilized to allocate resources, the physician's personal financial gain should not influence decisions about what treatments or services are appropriate for a patient.<sup>247</sup>

Managed care plans typically use guidelines, treatment algorithms, and formulas that specify what tests, procedures, therapies, consultation, and follow-up their practitioners should provide.<sup>248</sup> Optimally, these guidelines improve the quality of medical care by decreasing the potential for opposing financial interests to limit care.<sup>249</sup> However, guidelines are currently also being utilized to restrict access to only medically necessary treatments in order to save money.<sup>250</sup> These determinations invite uncertainty in the eyes of the American public because often there are no definitive research statistics that necessitate what tests, procedures, or treatments are optimal or medically necessary.<sup>251</sup> Above the lack of probative statistics, public trust is further eroded by the looming fact that those developing the guidelines have a pecuniary interest in constraining the costs of health care.<sup>252</sup> Consequently, these guidelines require independent review by a disciplinary board to ensure that patients' interests are protected in the development of parameters fraught with clinical uncertainty and conflict of interest.<sup>253</sup>

The review board would conduct a formal, comprehensive appraisal that evaluates the data endorsing each benefit decision by an MCO as well as the legitimacy for the specified course of action when there is more than one treatment option.<sup>254</sup> To ensure that the review board embodies a multitude of perspectives, it should not be confined to merely physicians. Rather the board should embrace the perspectives of statisticians, lawyers, and members of the general public.<sup>255</sup> Funding for the review board should derive from all health care institutions because guideline review would improve the quality of care for patients which is as relevant and pertinent as legal services, advertisements, and other administrative functions – costs that are presently paid with insti-

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246. *See id.*

247. *See generally* Thompson, *supra* note 240.

248. *See* Emanuel & Goldman, *supra* note 3, at 647.

249. *See id.*

250. *See id.*

251. *See id.*; *see generally* Clement J. McDonald & J. Marc, *Guidelines You Can Follow and Can Trust: An Ideal and an Example*, 271 JAMA (1994).

252. *See* Emanuel & Goldman, *supra* note 3, at 648.

253. *See id.*

254. *See id.* at 649.

255. *See id.*

tutional funds.<sup>256</sup> The anticipated financial costs that arise from the review of guidelines could also be accounted for by making them explicit to the review board.<sup>257</sup> Those affected by the review board's determinations should be granted an opportunity to appeal the decision.<sup>258</sup> This candid consideration of costs would procure public trust that medical services and resources are being allocated efficiently for the MCOs and beneficially to the patients.

Even if the independent review board were in place, some individuals may still believe they have been deprived of necessary health care because of costs.<sup>259</sup> Tort litigation remains to be the ultimate recourse for these individuals. ERISA preemption of state torts suits implicates that state suits are a poor mechanism to remedy situations where patients believe they have been deprived of health benefits because of cost efficiency determinations rather than negligent care.<sup>260</sup> The establishment of either a mediation or arbitration board would enable patients who feel they were denied care due solely to cost considerations to present their case and potentially obtain relief more expeditiously than filing a federal suit under ERISA.<sup>261</sup> Once the patient has presented the case, this board should be authorized to review the patient's case, evaluate the MCO's justification for denying health care, and review the guidelines, algorithms, and procedures utilized in making treatment decisions.<sup>262</sup> Although under this proposal, a mediation panel could only make suggestions, an arbitration panel could either authorize treatment or affirm the MCOs determinations as appropriate.<sup>263</sup>

A beneficiary of an employer-provided benefit plan is authorized pursuant to § 502 of ERISA to recover benefits, enforce rights, or clarify future benefits under the terms of the plan.<sup>264</sup> The remedies actually enunciated under ERISA appear to offer claimants a more pragmatic solution than a drawn-out state lawsuit. In fact, lawsuits offer absolutely no relief to a claimant who needs immediate care. Relying on ERISA's civil enforcement provision, the logical step is to implement an expedited hearing procedure in the form of mediation or arbitration in order for a claimant to appeal a denied benefit.

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256. *See id.*

257. *See id.* at 651.

258. *See id.*

259. *See id.* at 652.

260. *See id.*; *see also* Barbara Williams, *ERISA & State Common Law Causes of Action* 192 N. LAW 29 (1998).

261. *See generally* Council on Ethical and Judicial Affairs, *supra* note 239.

262. *See* Emanuel & Goldman, *supra* note 3, at 653.

263. *See id.*

264. 29 U.S.C. § 1132(a)(1) (1991).

## CONCLUSION

As the costs of health care increase, it remains necessary to discover a means to keep the cost of health care down. While managed care entities are currently the best solution for decreasing costs, the managed care system's methods of controlling costs is often at odds with the desire to provide quality medical care. This apparent conflict has resulted in public distrust and disheartening lawsuits alleging that the MCO negligently denied benefits to its enrollee. Nevertheless, ERISA's preemption clause eviscerates any state law that "relates to" an employee benefit plan, thereby preempting state causes of action. Consequently, ERISA provides MCOs with a safe harbor from lawsuits because the managed care entity's administrative decision relates to an employee benefit plan, thus subjecting the suit to ERISA preemption.

ERISA currently provides that decisions for treatment which result in injury allow a plaintiff to either recover for a benefit which was not given or receive reimbursement for the benefit. If benefits are provided to an employee, those benefits are to be governed by ERISA. If critics advocate that changes be made to ERISA due to public distrust or disapproval of health care, it is necessary for Congress, rather than state legislatures, to effectuate those changes. By virtue of congressional action, the federal law can be amended to reflect the public's disappointment with the insulated managed care entities.

The power of alternative dispute resolution (ADR) to resolve disputes effectively and efficiently should lead parties and Congress to consider applying these approaches to the health care dilemma. The availability of ADR is advantageous because these processes are flexible and capable of addressing the concerns that are prominent in medical disputes. Holding MCOs liable at the state level is, not only unconstitutional, but offers a solution that does not even begin to help those who need immediate care. This article advocates implementing a solution, which ultimately would ensure that managed care entities balance attention between patient welfare and the necessity of limiting the exorbitant costs of health care.

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