

2001

Chipping Away at the ERISA Shield: Managed Care Accountability and the Fifth Circuit's Decision in *Corporate Health Insurance, Inc. v. Texas Department of Insurance*

Bridget S. Kenney

Follow this and additional works at: <https://scholarship.law.marquette.edu/mulr>



Part of the [Law Commons](#)

Repository Citation

Bridget S. Kenney, *Chipping Away at the ERISA Shield: Managed Care Accountability and the Fifth Circuit's Decision in Corporate Health Insurance, Inc. v. Texas Department of Insurance*, 85 Marq. L. Rev. 481 (2001).

Available at: <https://scholarship.law.marquette.edu/mulr/vol85/iss2/5>

This Article is brought to you for free and open access by the Journals at Marquette Law Scholarly Commons. It has been accepted for inclusion in Marquette Law Review by an authorized editor of Marquette Law Scholarly Commons. For more information, please contact elana.olson@marquette.edu.

CHIPPING AWAY AT THE ERISA SHIELD: MANAGED CARE ACCOUNTABILITY AND THE FIFTH CIRCUIT'S DECISION IN *CORPORATE HEALTH INSURANCE, INC. V. TEXAS DEPARTMENT OF INSURANCE*

I. INTRODUCTION

Twenty-seven years ago Congress passed the Employment Retirement Income Security Act of 1974 (ERISA),¹ the most significant statute affecting private or employer health care financing in the United States.² ERISA was enacted in response to the great concern over fraudulent and mismanaged pension and employee benefit plans.³ Yet, Congress did not anticipate the impact that ERISA would have on health care.

Ironically, Congress added the preemption clause, the most controversial component, as a last minute committee compromise.⁴ The preemption clause prevents states from enforcing statutes that "relate to" an ERISA plan.⁵ Thus, employer-provided health plans are legally shielded from patients' negligence claims under state laws because ERISA prevents state law application—arguably including tort actions.⁶ This has caused havoc in state and federal courts and has frustrated individuals pursuing legal actions against their health care plan.

This Comment will discuss the Fifth Circuit's decision in *Corporate Health Insurance, Inc. v. Texas Department of Insurance*,⁷ which held that a Texas law allowing individuals to sue their health insurance carriers was not preempted by ERISA.⁸ Additionally, it will consider recent Supreme Court and other federal circuit case law relating to ERISA. It will also briefly address the state of managed care and some

1. 29 U.S.C. §§ 1001–1461 (1994 & Supp. V 1999).

2. BARRY R. FURROW ET AL., *HEALTH LAW* 418 (2d ed. 2000).

3. *Id.* at 419.

4. *Id.* at 418–19.

5. *See infra* notes 38–39 and accompanying text.

6. Wendy K. Mariner, *What Recourse?—Liability for Managed-Care Decisions and the Employee Retirement Income Security Act*, 343 *NEW ENG. J. MED.* 592, 592 (2000).

7. 215 F.3d 526 (5th Cir. 2000), *reh'g and reh'g en banc denied, petition for cert. filed*, 69 *U.S.L.W.* 3317 (U.S. Oct. 24, 2000) (No. 00-665).

8. *Id.* at 540.

of the characteristics of HMOs and other managed care entities.⁹ Lastly, this Comment will look at the environment surrounding the proposed Patients' Bill of Rights and the subsequent pressure on Congress to amend ERISA in order to provide individuals with more access to sue their managed care provider. While Democrats and Republicans have fought to pass their respective bills, a potential compromise and an amendment to ERISA may be the most effective way to settle the confusion surrounding ERISA preemption.

This Comment concludes that despite the Fifth Circuit decision, managed care entities will remain protected by the ERISA shield. This is primarily because it remains too easy for managed care organizations to categorize their decisions as exclusively eligibility based decisions, which are preempted by ERISA, rather than treatment decisions, which are not preempted by ERISA. Additionally, it remains unclear to what extent courts will permit all mixed eligibility/treatment decisions to not be preempted by ERISA. Further, it seems unlikely that statutes will successfully find a way to circumvent ERISA with respect to independent review provisions. It is ultimately up to Congress to find a way to work in a bipartisan fashion to craft a Patients' Bill of Rights that will amend ERISA, giving individuals more opportunity to seek redress and independent review for harm and other conflicts caused by their managed care organizations.

II. ERISA AND THE PREEMPTION CLAUSE

The goal of ERISA is to provide uniform administration of employee pension and health plans, thus preventing situations that in the past had left thousands of employees without earned retirement benefits.¹⁰ By enacting ERISA, Congress hoped to simplify employee benefit administration by preventing plan administrators from having to work with numerous types of state laws.¹¹ In this respect, employers and

9. HMO is an acronym for "Health Maintenance Organization." It is one type of managed care entity. The term "managed care entity" will be used throughout this Comment as a broad term to encompass the different types of managed care entities available to consumers.

10. See FURROW, *supra* note 2, at 419.

11. See Robert L. Roth, *Recent Developments Concerning the Effect of ERISA Preemption on Tort Claims Against Employers, Insurers, Health Plan Administrators, Managed Care Entities, and Utilization Review Agents*, HEALTH LAW., Early Spring 1996, at 3. ERISA does not cover a number of other health insurance plans. See FURROW, *supra* note 2, at 420. These include state, federal, or local government sponsored plans, as well as those set up by church organizations, and "plans maintained solely to comply with state workers' compensation, unemployment compensation, or disability insurance requirements."

other plan sponsors, acting under ERISA, have greater flexibility to determine plan provisions.¹² "By enacting ERISA, Congress shielded qualifying ERISA plans from inconsistent state regulatory schemes that could increase inefficiency and potentially cause benefit levels to be reduced by diverting available benefit dollars to satisfy additional administrative costs."¹³

Through ERISA, multi-state employers can provide uniform plan coverage without addressing each state's health insurance statutes.¹⁴ Prior to ERISA, many states had mandated benefit laws that specified the types of procedures and conditions that health plans were required to cover in that particular state.¹⁵ If one employer operated in thirty different states, it would have to provide a different health care package for employees in each of those states.¹⁶ With ERISA, however, Congress preempted state laws regarding employee benefit plans, and therefore allowed employers to formulate a nationwide benefit plan.¹⁷

ERISA created not only uniformity of operation, but also uniformity with respect to the remedies available to persons who were denied health insurance or certain benefits associated with their plan.¹⁸ Under section 502(a)(1)(B) of ERISA, an individual can assert a civil claim to recover benefits under the plan, enforce rights under the plan, or clarify rights for future benefits under the plan.¹⁹ Thus, ERISA plan participants can sue their plan in federal court if there is a dispute over benefits and further, the participant may obtain an injunction against the plan and receive attorney's fees.²⁰ These are the only remedies available to an ERISA plan participant.²¹ ERISA displaces state law claims such as a bad-faith denial of benefits, and as a result, there is no

Id. Despite these exemptions, ERISA plans are the largest source of payment for health care services in the United States. *Id.* at 436. More than seventy-five percent of all managed care plans in the United States fall under ERISA's grasp. *Id.*

12. See Roth, *supra* note 11, at 3.

13. *Id.*

14. DEAN M. HARRIS, HEALTHCARE LAW AND ETHICS—ISSUES FOR THE AGE OF MANAGED CARE 285 (1999).

15. *Id.*

16. *Id.*

17. *Id.*

18. *Id.*

19. FURROW, *supra* note 2, at 436 (quoting Larry J. Pittman, *ERISA's Preemption Clause and the Health Care Industry: An Abdication of Judicial Law—Creating Authority*, 46 FLA. L. REV. 355 (1994)).

20. HARRIS, *supra* note 14, at 285.

21. *Id.*

chance to recover punitive damages or damages associated with pain and suffering arising from the denial of benefits.²²

While ERISA regulates pensions, it has a deregulatory effect on health insurance.²³ It imposes minimal conditions on employee benefit plans, and thus, provides few remedies for employees who are ill-served by their health plans.²⁴ Further, "ERISA preempts a wide range of state laws and remedies intended to protect health plan beneficiaries, often leaving beneficiaries wholly stripped of legal protection from health plan abuses."²⁵ Once in federal court, "the most plaintiffs can recover is the cost of the care denied them."²⁶

ERISA's language is principally directed at retirement benefits,²⁷ but its effect on employer-provided welfare benefits, and thus health insurance, has been very significant.²⁸ "ERISA governs participation, funding, and vesting requirements on EBPs [(Employee Benefit Plans)] and sets uniform standards regarding reporting, disclosure, and fiduciary responsibilities, rather than regulating the content of EBPs."²⁹

The "relate to" preemption language in the statute is broader than either the House or Senate contemplated when ERISA was drafted.³⁰ As a result, individuals under an ERISA plan are limited to the remedies, benefits, and enforcement of rights outlined in that specific plan.³¹ Hence, "[n]o punitive or extracontractual damages are allowed [and] suits for wrongful death, personal injury, or other claims for consequential damages caused by improper refusal of care or coverage by an insurer or utilization reviewer are preempted because they pray for relief not enumerated in the statute."³² Therefore, ERISA greatly restricts the amount of damages available to a plaintiff in what would

22. *Id.*; see *infra* notes 82–88 and accompanying text (discussing remedies available to ERISA participants that do not relate to benefit determinations).

23. FURROW, *supra* note 2, at 419.

24. *Id.*

25. *Id.*

26. Linda A. Johnson, *Parents Sue HMO in Baby's Death: N.J. Case Seen as Potential Precedent in Insurer's Accountability*, WASH. POST, Dec. 4, 2000, at A2.

27. 29 U.S.C. § 1001 (1994 & Supp. V 1999).

28. Margaret G. Farrell, *ERISA and Managed Care: The Law Abhors a Vacuum*, 29 J. HEALTH & HOSP. L. 268, 268 (1996).

29. BRYAN A. LIANG, HEALTH LAW & POLICY 76 (2000) (citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983)).

30. FURROW, *supra* note 2, at 424 (citing *Shaw*, 463 U.S. at 98–100).

31. LIANG, *supra* note 29, at 81–82 (citing 29 U.S.C.A. § 1132(a) (West 1999)).

32. *Id.* at 82 (citing 29 U.S.C.A. § 1132(a)(1)(B), (a)(3)).

typically be described as a malpractice case.³³ Due to ERISA preemption, a defendant can remove a malpractice suit to federal court, thus making it an ERISA claim rather than an ordinary malpractice case.³⁴ In doing this, the defendant vastly restricts the scope of potential financial liability.³⁵

National uniformity occurs through a provision of ERISA section 514(a), which states that it "shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan."³⁶ Three statutory clauses expand upon this provision.³⁷

First, under the preemption clause, ERISA preempts a state law if it relates to an employee benefit plan that is regulated by ERISA.³⁸ In other words, a state law claim for a wrongful denial of benefits is preempted, and the individual is limited to the remedy provided by the ERISA statute.³⁹

Second, the "savings clause" exempts insurance, banking, and security state laws from preemption.⁴⁰ Thus, the insurance industry, traditionally regulated by the states, is not preempted by ERISA.⁴¹ A state, however, may indirectly regulate an ERISA plan through regulations that cover the insurance plan that establishes the ERISA plan.⁴²

The final clause, the "deemer clause," however, is an exception to the "savings clause," in that state insurance laws may not regulate self-insured ERISA plans.⁴³ Companies may choose to self-insure themselves rather than seek out other health insurance coverage. These employers are regulated by ERISA and are not "deemed" insurance companies under ERISA, so state law remains inapplicable to these plans.

Some differences arise between insured and self-insured ERISA

33. FURROW, *supra* note 2, at 436.

34. *Id.*

35. *Id.*

36. 29 U.S.C. § 1144(a) (1994 & Supp V 1999).

37. Farrell, *supra* note 28, at 269.

38. *Id.*

39. HARRIS, *supra* note 14, at 288.

40. Roth, *supra* note 11, at 3 (citing 29 U.S.C. § 1144(b)(2)(A)).

41. See HARRIS, *supra* note 14, at 289.

42. *Id.* See *infra* notes 44–50 and accompanying text for a more complete explanation of this fact.

43. FURROW, *supra* note 2, at 430; see also Farrell, *supra* note 28, at 269; Roth, *supra* note 11, at 3 (citing 29 U.S.C. § 1144(b)(2)(B)).

plans.⁴⁴ State laws that mandate certain health benefits will indirectly apply to ERISA plans that purchase insurance in that state.⁴⁵ They do not, however, apply to self-insured ERISA plans.⁴⁶ An example of this type of state law is one that requires health insurance companies to authorize inpatient care coverage for new mothers following normal or Caesarean delivery.⁴⁷ If a particular state has this law and an ERISA plan has purchased insurance there, then it must provide that care.⁴⁸ A self-insured plan, however, does not have to follow this mandatory state law.⁴⁹ This particular and problematic discrepancy was remedied when Congress passed a federal statute not preempted by ERISA that prevented the existence of these so-called "drive-through deliveries" in both types of ERISA plans.⁵⁰

Determining whether a state law is preempted by ERISA typically involves a three-step inquiry.⁵¹ First, does the law "relate to" an ERISA plan?⁵² Second, is it protected from preemption by existing as a law that regulates insurance, banking, or securities?⁵³ Finally, is the particular plan at issue self-insured and thereby excluded from state insurance laws?⁵⁴ The first step, which is the focus of this Comment, has caused the most problems for federal courts in their analysis of ERISA claims.

III. FEDERAL COURT CASE LAW SINCE THE INCEPTION OF ERISA

The Supreme Court has wrestled with ERISA's language, and the lower courts' conflicting interpretations since its adoption.⁵⁵ The Court has even gone so far as to comment that section 514 is "not a model of legislative drafting."⁵⁶ When ERISA's preemption language was first considered, the Court broadly interpreted it.⁵⁷ In *Shaw v. Delta Air*

44. HARRIS, *supra* note 14, at 289.

45. *Id.*

46. *Id.*

47. *Id.*

48. *Id.*

49. *Id.*

50. *Id.*

51. FURROW, *supra* note 2, at 421 (discussing how the three-step inquiry is used in varying degrees by most, but not all, courts).

52. Roth, *supra* note 11, at 3.

53. *Id.*

54. See Farrell, *supra* note 28, at 270.

55. See FURROW, *supra* note 2, at 424 (citing seventeen cases that the Court has decided attempting to resolve ERISA confusion through 1999).

56. Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 739 (1985).

57. See *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96, 98 (1983).

Lines, Inc.,⁵⁸ the Court considered a New York law that made it unlawful to discriminate on the basis of pregnancy in an employee benefit plan. It gave a broad definition to the "relates to" language by holding that a law is preempted if it has a "connection with or reference to" an ERISA plan.⁵⁹ The Court continued to apply this broad analysis to every ERISA implicated situation for over a decade.⁶⁰ As a result of this wide preemption scope, courts interpreted state statutes and tort or contract causes of action to "relate[] to" an employee plan if it expressly referred to ERISA plans, or was essentially a claim for plan benefits, a claim of improper administration of the plan, a claim that depended on the existence of an ERISA plan, or a claim that affected the provision of benefits under [the] plan."⁶¹

The Court finally considered limiting the wide scope of preemption in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*⁶² It determined that the "relate to" language in ERISA section 514(a) was unclear, and therefore, it was necessary to look beyond the text to Congressional intent.⁶³ Congress's objective in this instance was to reduce inter-state conflict and provide uniform distribution of employment benefits law.⁶⁴ The Court realized that, while the "relates to" language was broad, it contained limits and held that ERISA did not preempt a New York law that forced hospitals to differentially charge insured, HMO, or self-insured plans.⁶⁵ Also of importance to the context of this Comment, the Court noted that "nothing in the language of [ERISA] or [in] the context of its passage indicate[d] that Congress chose to displace general health care regulation, which historically has been a matter of local concern."⁶⁶

58. *Id.* at 88.

59. *Id.* at 96-97.

60. FURROW, *supra* note 2, at 425.

61. Farrell, *supra* note 28, at 269 (citing *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825 (1988); *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 130-31 (1992); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992); *Settles v. Golden Rule Ins. Co.*, 927 F.2d 505 (10th Cir. 1991); *Dearmas v. Av-Med, Inc.*, 865 F. Supp. 816 (S.D. Fla. 1994); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990); *Ricci v. Gooberman*, 840 F. Supp. 316, 317 (D.N.J. 1993); *Dukes v. U.S. Health Care Sys. of Pa., Inc.*, 848 F. Supp. 39, 43 (E.D. Pa. 1994), *rev'd on other grounds*, 57 F.3d 350 (3d Cir. 1995)).

62. 514 U.S. 645, 649 (1995).

63. *Id.* at 656.

64. *Id.*

65. *Id.* at 654, 667-68.

66. *Id.* at 661. The Fifth Circuit used similar reasoning in *Corporate Health Insurance, Inc. v. Texas Department of Insurance*, 215 F.3d 526 (5th Cir. 2000). See *infra* notes 133-34, 138-39 and accompanying text.

Since *Travelers*, the Supreme Court has appeared less stringent in its preemption analysis.⁶⁷ For instance, prior to *Travelers*, the Court rarely accepted a state's rationale for a particular law, and after *Travelers*, the Court has denied preemption claims in half of the cases.⁶⁸ The primary thrust of the Court's most recent discussions of ERISA preemption focused upon "the traditional importance of the area of regulation to the state and the purposes of ERISA in determining whether a legal claim or requirement was preempted by ERISA."⁶⁹

This more liberal analysis was apparent in *DeBuono v. NYSA-ILA Medical & Clinical Services Fund*,⁷⁰ in which the Court held that a New York law could legally impose a tax on hospitals operated by ERISA plans. The Court stated that the law was one of "general applicability that impose[s] some burdens on the administration of ERISA plans" but was not preempted by the "relate to" language in ERISA.⁷¹ Such taxes and other laws may increase the cost of providing an ERISA plan or effect the administration of it, but that cannot cause every state law to fall in the face of ERISA preemption.⁷² Further, in a concurring opinion in *California Division of Labor Standards Enforcement v. Dillingham Construction, Inc.*,⁷³ Justice Scalia reproached the Court for not acknowledging in its opinion that the holdings of older cases in this area have been "abandoned."⁷⁴

Despite this, however, in January 2000, the Supreme Court held in *Pegram v. Herdrich*⁷⁵ that the plaintiff's claim against her health care plan, based on the use of the plan's physician incentives, was preempted by ERISA. The plaintiff, Cynthia Herdrich, sued the plan because she claimed that her physicians denied her necessary care in order to save money and take advantage of the HMO's incentive system.⁷⁶ She argued

67. See FURROW, *supra* note 2, at 424, 427. Four cases decided following *Travelers* were *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A.*, 519 U.S. 316 (1997), *DeBuono v. NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806 (1997), *Boggs v. Boggs*, 520 U.S. 833 (1997), and *UNUM Life Insurance, Co. v. Ward*, 526 U.S. 358 (1999). See FURROW, *supra* note 2, at 424 n.5.

68. FURROW, *supra* note 2, at 427.

69. *Id.*

70. *DeBuono*, 520 U.S. at 807, 816.

71. *Id.* at 815.

72. *Id.* at 816.

73. 519 U.S. 316 (1997).

74. *Id.* at 335.

75. 530 U.S. 211, 237 (2000).

76. *Id.* at 216; see *infra* notes 111-15 and accompanying text (discussing the meaning of these incentive plans).

that her HMO violated its ERISA fiduciary duty.⁷⁷ The Supreme Court found for the defendant HMO, concluding that it was not an ERISA plan and thus not subject to ERISA fiduciary provisions.⁷⁸ The origin of ERISA's fiduciary duties arises from the common law of trusts and thus, relates to managing assets and property.⁷⁹ The Court concluded that Congress did not intend for an HMO to be treated as a fiduciary when it makes mixed eligibility decisions through its physicians.⁸⁰

Because the defense of any HMO of a mixed decision would be that its physician acted for good medical reasons, the plausibility of which would require reference to traditional standards of reasonable medical practice . . . the Court was concerned that a decision to view a mixed decision as an act of ERISA fiduciary duty would "federalize malpractice litigation."⁸¹

Perhaps in response to the Supreme Court's willingness to bend the preemption language, various federal circuits have allowed patients to sue their managed care organizations.⁸² In those cases, the courts allowed suits where the individual's doctor was negligent in the administration of care and the doctor acted as an agent for the managed care organization.⁸³ State law covers negligence suits concerning corporate liability for the acts of their corporate employees (i.e., agents) pursuant to agency law.⁸⁴ The courts reasoned that the physicians were making decisions regarding the quality of care and that, by itself, does not "relate to" an ERISA plan.⁸⁵ In turn, this concept permits medical malpractice claims to be brought in state court even when the plaintiff belongs to an ERISA plan.⁸⁶ Most doctors, however, are not employees of managed care organizations, and thus encumber nearly the entire

77. *Pegram*, 530 U.S. at 216.

78. *Id.* at 226-27.

79. *Id.* at 231-32.

80. *Id.* at 232. See *infra* notes 174-84 and accompanying text (discussing *Pegram* and its implications for future cases).

81. *Pappas v. Asbel*, 768 A.2d 1089, 1094 (Pa. 2001) (quoting *Pegram*, 530 U.S. at 235-36).

82. *Mariner*, *supra* note 6, at 592 (citing *Dukes v. U.S. Healthcare, Inc.*, 57 F.2d 350 (3d Cir. 1995); *Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995)).

83. *Id.*

84. *Id.*

85. *Id.*

86. *Id.*

medical malpractice claim load.⁸⁷ Finally, "[t]he Second, Third, and Seventh Circuits have held that medical negligence claims against HMOs for vicarious and direct liability are not... completely preempted because they involve conduct by the HMO in its capacity as a provider and arranger of health services and not as plan administrator."⁸⁸

IV. THE STATE OF MANAGED CARE

The feverishly controversial environment surrounding ERISA is a result of the public outcry regarding the state of managed care. As it stands right now, ERISA acts as a shield to HMOs⁸⁹ that have been accused of being more concerned with saving money than providing quality care. Thus, doctors who may prescribe a certain type of care are barred from doing so because their patient's managed care organization refuses to authorize it. When the patient is adversely affected and covered by an ERISA plan, they have little or no legal redress. Two cases are illustrative of this misfortune. In *Fox v. Health Net*,⁹⁰ the plaintiff, who was not a beneficiary of an ERISA plan, was awarded \$89 million dollars against the HMO after it failed to cover a bone marrow transplant for metastatic breast cancer. In a similar case, *Spain v. Aetna Life Insurance Co.*,⁹¹ a patient, who was covered under an ERISA plan, died after an extensive authorization delay for a bone marrow transplant, and his survivors could not recover any compensatory or punitive damages from the HMO. This discrepancy illustrates the problems associated with ERISA. Frustration with ERISA, however, is partially a result of patients' distrust of and dissatisfaction with their managed care plans.⁹²

87. *Id.*; see also Dionne Koller Fine, *Exploitation of the Elite: A Case for Physician Unionization*, 45 ST. LOUIS U. L.J. 207 (2001) (discussing the negative impact of managed care organizations on physicians and introducing the possibility of collective bargaining between physicians and managed care organizations).

88. *Corporate Health Ins., Inc. v. Tex. Dep't of Ins.*, 215 F.3d 526, 535 n.25 (2000).

89. See *infra* pp. 111-13 for a discussion of the meaning of "HMO" and other managed care organizations.

90. No. 219629, 1993 WL 794305 (Cal. App. Dep't Super. Ct. Dec. 23, 1993); see also HARRIS, *supra* note 14, at 286.

91. 11 F.3d 129 (9th Cir. 1993) (per curiam); see also HARRIS, *supra* note 14, at 286.

92. A recent survey reported that 46% of those surveyed believed that HMOs were doing a bad job, while that number was reported at 25% in a similar survey conducted in 1997. See Bill Brubaker, *Dissatisfaction with HMOs Increasing, Survey Shows*, WASH. POST, Aug. 31, 2001, at E1. Consumer complaints were primarily a result of insurance bills and claims, coverage issues, and disappointment over the amount of access to doctors. *Id.* Despite those numbers, 62% of people still gave their plans a grade of an A or B. *Id.* Also,

Managed care organizations (MCOs)⁹³ arose in an era when health care premiums were increasing at annual rates of seventeen and twenty-one percent in 1988 and 1989 respectively.⁹⁴ Thus, MCOs strove to reduce costs and provide the best value for both the payer and the patient.⁹⁵ The theory of managed care is distinct from "fee-for-service" medicine because it concentrates all the coordinated responsibilities surrounding financing and discharge of care in one place, rather than in multiple arenas like the former, more expensive system.⁹⁶

The giant managed care organization that most people group into the term "HMO" actually began with a rather simplistic structure.⁹⁷ At the outset, the administrators of an HMO contracted with a group of physicians to whom the HMO promised to include on its list of physicians that could be chosen by the HMO's health plan members.⁹⁸ In exchange for this automatic referral service, the physicians charged lower rates for HMO members.⁹⁹ HMO members chose among a list of various types of physicians that they could go to under their plan. Patient dissatisfaction with a restricted number of physicians to choose from resulted in the development of Point of Service (POS) plans, which allow an individual, willing to pay a higher premium, to go beyond the specifications of the original health plan.¹⁰⁰

An HMO may act as both the provider and the insurer.¹⁰¹ There are two main types of HMOs.¹⁰² The first type directly hires physicians to work out of its facilities (the staff model), and the second type contracts with physician groups to provide health care at discounted rates (the group model).¹⁰³ Most consider staff model HMOs to be providers,

80% of those who had contact with their plans commented that it was a positive experience. *Id.* Administrators of managed care entities report that they believe that the "public's view of the industry is shaped largely by HMO-bashing politicians." *Id.*

93. Managed Care Organization (MCO) is a broad category of health plans, ranging from simple pre-authorization plans to HMOs. BARRY R. FURROW ET AL., *HEALTH LAW* 308 (1995).

94. Peggy L. Noble, Comment, *The Mismanagement of Managed Care Legislation: A Comparison Between the Democratic-Proposed Patients' Bill of Rights Act of 1998 and the Republican-Proposed Patient Protection Act of 1998*, 28 CAP. U. L. REV. 685, 689 (2000).

95. FURROW, *supra* note 93, at 308.

96. *Id.* at 308-09.

97. Noble, *supra* note 94, at 689.

98. *Id.* at 689-90.

99. *Id.*

100. *Id.* at 690.

101. *Id.*

102. *Id.*

103. *Id.*

whereas the group model primarily exists only as an insurer.¹⁰⁴ Two types of managed care models include preferred provider organizations (PPOs) and POS plans.¹⁰⁵ A PPO is the most common type of managed care plan that establishes "a network of preferred providers who agree to give medical services at discounted rates."¹⁰⁶ Further, an independent practice association (IPA) is made up of physicians organized as a partnership or corporation.¹⁰⁷ The HMO contracts with IPAs, individual physicians, or both to deliver medical care at physician-provided facilities.¹⁰⁸ In most MCOs, one physician acts as the manager for one patient's health care services.¹⁰⁹ Thus, this can include a referral to other physicians, like specialists, in needed circumstances.¹¹⁰

HMOs or other types of MCOs primarily use two ways to encourage physicians to engage in "cost-conscious decision making."¹¹¹ With "capitation," the physician receives a lump sum of money for each patient, irrespective of the individual's needs and the cost of the individual's treatment.¹¹² The second type, "salary," exists when an HMO hires a group of physicians as employees or contracts with a physician group, and each physician receives a salary for providing health care to a group of individuals in a particular health plan.¹¹³ Both of these payment plans discourage physicians from spending more time with their patients because there is no additional compensation available for doing so.¹¹⁴ Further, "use of ancillary health care services

104. *See id.* This difference is central to the liability issues at stake with respect to managed care entities, because risk can be more easily diverted in the group model. *See id.* The Texas Health Care Liability Act would make both models more vulnerable to civil liability suits. Kristin M. McCabe, Note, *The Texas Health Care Liability Act: Texas is the First State to Listen to the Concerns of Its Health Care Consumers, but How Much has It Heard?*, 16 J. CONTEMP. HEALTH L. & POL'Y 565, 583-84 (2000); TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-.003 (Vernon Supp. 2001).

105. Christine Lockhart, *The Safest Care is to Deny Care: Implications of Corporate Health Insurance, Inc. v. Texas Department of Insurance on HMO Liability in Texas*, 41 S. TEX. L. REV. 621, 626 (2000).

106. *Id.* at 628.

107. *Id.* at 627.

108. *Id.*

109. *See* Patricia Mullen Ochmann, *Managed Care Organizations Manage to Escape Liability: Why Issues of Quantity vs. Quality Lead to ERISA's Inequitable Preemption of Claims*, 34 AKRON L. REV. 571, 576-77 (2001).

110. *See id.*

111. Robert J. Herrington, Note, *Herdrich v. Pegram: ERISA Fiduciary Liability and Physician Incentives to Deny Care*, 71 U. COLO. L. REV. 715, 718 (2000).

112. *Id.*

113. *Id.*

114. *Id.* For example, salaried physicians may spend more time with their patients

like diagnostic tests, referrals, and experimental treatments" are not encouraged since there is often a certain amount of money set aside for these services, and anything left over goes to the physician as a bonus.¹¹⁵ These and other practices aimed at curbing costs, rather than improving patient care, led to legislative action in Texas.

V. THE CHALLENGE TO THE TEXAS HEALTH CARE LIABILITY ACT

A. *The Texas Health Care Liability Act*

The Texas Health Care Liability Act (Act)¹¹⁶ represents the first time that a state passed a law allowing malpractice suits against HMOs.¹¹⁷ The expansion of the managed care industry prompted concern that insurance administrators, rather than physicians, were making the instrumental decisions regarding a patient's health care.¹¹⁸ Employer groups and HMOs opposed the bill, asserting that it would increase health care costs.¹¹⁹ In contrast, the Texas Medical Association fully supported the bill because it requires medical decisions to be made by doctors rather than HMOs.¹²⁰

The Act imposes two duties upon HMOs and provides that patients may sue their HMOs for breaches of either of these duties.¹²¹ First, if an individual's health insurance carrier, HMO, or other managed care entity fails to exercise ordinary care when making a health care treatment decision, then the individual can sue for damages proximately caused by this failure.¹²² Second, these managed care entities may be liable for damages resulting from a health care treatment decision made

because their income is fixed, whereas fee-for-service physicians may be more inclined to rush, because the more patients they visit, the more money they make. *Id.*

115. *Id.* at 718–19. This type of physician incentive system was the issue at stake in *Pegram v. Herdrich*, 530 U.S. 211 (2000).

116. TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001–.003 (Vernon Supp. 2001).

117. McCabe, *supra* note 104, at 581. California, New York, and Ohio all have bills pending in their legislatures that are analogous to the Texas Health Care Liability Act and approximately seventeen more states are considering a similar law. Christine E. Brasel, Comment, *Managed Care Liability: State Legislation May Arm Angry Members with Legal Ammo to Fire at Their MCOs for Cost Containment Tactics . . . But Could It Backfire?*, 27 CAP. U. L. REV. 449, 458 (1999).

118. McCabe, *supra* note 104, at 582.

119. *Id.* at 582–83.

120. *Id.* at 583.

121. *Id.*

122. *Corporate Health Ins., Inc. v. Tex. Dep't of Ins.*, 12 F. Supp. 2d 597, 602 (S.D. Tex. 1998) (citing TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (Vernon Supp. 2001)).

by an employee, agent, or representative.¹²³ Additionally, the Act "establishes an independent review process for adverse benefit determinations and requires an insured or enrollee to submit his or her claim challenging an adverse benefit determination to a review by an independent review organization if such a review is requested by the managed care entity."¹²⁴

B. Corporate Health Insurance, Inc. v. Texas Department of Insurance

Plaintiffs, Corporate Health Insurance, Inc., Aetna Health Plans of Texas, Inc., Aetna Health Plans of North Texas, Inc., and Aetna Life Insurance Co., brought an action against defendants, Texas Department of Insurance, the Commissioner of the Texas Department of Insurance and the Texas Attorney General, seeking declaratory and injunctive relief.¹²⁵ In anticipation of the effect that the Act would have on managed care entities, the plaintiffs filed suit immediately after the Act went into effect on May 22, 1997.¹²⁶ They sought a declaration that the Act was preempted by ERISA and an injunction barring enforcement of the Act as it relates to ERISA plans.¹²⁷

Defendants argued that the Act regulated quality of care provided by managed care entities, while ERISA "governs what types of regulations may be placed on an employee benefit plan."¹²⁸ Further, the purpose of the Act was to make managed care entities accountable "for the medical decisions they 'make,' 'control' or 'influence.'"¹²⁹ The Act "does not seek to regulate how HMO's make benefit or coverage determinations; nor does it proscribe requirements governing the *structure* of a benefit plan. Accordingly, the ERISA . . . preemption clause[] do[es] not apply."¹³⁰

Conversely, plaintiffs argued that the Act interferes with ERISA's objectives, and thus, inserts "state law into an area exclusively reserved for Congress."¹³¹ They further argued that the Act largely related to ERISA "because it purports to impose state law liability on ERISA entities and . . . mandate[s] the structure of plan benefits and . . .

123. *Id.* (citing TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(b)).

124. *Id.* at 602-03 (citing TEX. CIV. PRAC. & REM. CODE ANN. § 88.003(c)).

125. *Id.* at 602.

126. *Corporate Health Ins., Inc. v. Tex. Dep't of Ins.*, 215 F.3d 526, 531 (5th Cir. 2000).

127. *Corporate Health*, 12 F. Supp. 2d at 602.

128. *Id.* at 603.

129. *Id.*

130. *Id.*

131. *Id.*

administration [Further, it] wrongfully binds employers and plan administrators to particular choices and impermissibly creates an alternat[ive] enforcement mechanism."¹³²

The district court and the Fifth Circuit Court of Appeals addressed the preemption issue as it relates to four distinct portions of the Act.¹³³ The District Court found the liability portions of the Act were not preempted by ERISA, while in contrast, the court found the anti-retaliation, anti-indemnification, and independent review provisions were subsumed by ERISA preemption.¹³⁴

On appeal, the Fifth Circuit Court of Appeals partially disagreed and held only the independent review provisions to be preempted by ERISA.¹³⁵ The court first addressed the liability provision by distinguishing managed care entities that function as plan administrators from entities that function as medical care providers.¹³⁶ A state cannot regulate managed care entities when they function as plan administrators, but state regulation may inhere where the entities act as medical care providers.¹³⁷ "ERISA preempts malpractice suits against doctors making coverage decisions in the administration of a plan, but it does not insulate physicians from accountability to their state licensing agency or association charged to enforce professional standards regarding medical decisions."¹³⁸ The court believed that this ensures finer medical standards and that Congress could not have meant to preempt state laws regarding the quality and accountability of medical care.¹³⁹

Additionally, the court concluded that the liability provisions are not

132. *Id.*

133. *Corporate Health Ins., Inc. v. Tex. Dep't of Ins.*, 215 F.3d 526, 540 (5th Cir. 2000).

134. *Id.* at 532.

135. *Id.* at 540.

136. *Id.* at 534. The liability provision states:

A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care.

TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (Vernon Supp. 2001). The Act also defines "health care treatment decision": "[A] determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees." *Id.* § 88.001(5).

137. *Corporate Health*, 215 F.3d at 534 (citing *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987)).

138. *Id.* at 534–35.

139. *Id.* at 535.

preempted by "referring to" ERISA plans.¹⁴⁰ This portion of the preemption analysis determines whether the Act applies impartially to all types of plans, including ERISA plans.¹⁴¹ Since the Act applies independently of the individual's type of plan, it does not "relate to" an ERISA plan.¹⁴² Thus, the liability provisions are simply a part of the state's police powers to ensure the quality of Texas health care.¹⁴³ It makes no difference that the patient's services were paid for by an ERISA plan and arranged by a managed care entity, because medical standards of care fall under a state's regulatory power.¹⁴⁴

Next, the court discussed the anti-retaliation and anti-indemnification provisions of the Act.¹⁴⁵ The anti-retaliation provision prevents a managed care entity from penalizing a doctor or health care provider for "advocating medically necessary treatment."¹⁴⁶ "The anti-indemnification provision prohibits a managed care entity from including an indemnification clause in its contracts with doctors and other health care providers that would hold it harmless for its own acts."¹⁴⁷ The court was not persuaded that these provisions forced the insurer to provide a certain level of coverage, something preempted by ERISA.¹⁴⁸ Instead, "[t]he liability and indemnity provisions force . . . managed care entit[ies]" to assume the same interests as doctors do in providing quality care to patients, because the entities will share the possible "risk of tort liability."¹⁴⁹ Further, the anti-retaliation provision prevents the situation whereby a physician would be forced to choose between the patient and the managed care entity.¹⁵⁰ Finally, the court expressed hope that the liability and indemnity provisions of the Act would promote the autonomy of the physician, despite managed care entities' need to be cost efficient.¹⁵¹

140. *Id.*

141. *Id.* (citing *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 322 (1997)).

142. *See id.*

143. *Id.*

144. *Id.*

145. *Id.*

146. *Id.* at 535-36 (citing TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(f) (Vernon Supp. 2001)).

147. *Id.* at 536 (citing TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(g)).

148. *Id.*

149. *Id.*

150. *Id.*

151. *Id.* The court further states that "[s]uch a scheme is again the kind of quality of care regulation that has been left to the states." *Id.* "In *Pegram v. Herdrich*, the Court held

The final parts of the statute that the court analyzed were those provisions that permitted individuals to appeal determinations made by their managed care entity.¹⁵² There were two types of these provisions. The first allowed independent review of claims for which plan members may later sue under the liability provisions.¹⁵³ The court concluded that these provisions cannot be preempted by ERISA because "[a]ny duty imposed on managed care entities by the independent review provisions extends no further than that imposed by the liability provisions."¹⁵⁴ Further, this review procedure was made voluntary by 1999 amendments to the Act.¹⁵⁵ Thus, the managed care entity had a difficult argument with respect to ERISA preemption where they were not mandated to carry out the review.¹⁵⁶

The court concluded that the second set of provisions, which allow patients to appeal "adverse determinations" regarding coverage, do fall within the breadth of ERISA preemption.¹⁵⁷ An "adverse determination" may derive from a physician's decision or the coverage in the plan.¹⁵⁸ In such a case, a patient is allowed to go to an outside organization for an appeal and review, and "[s]uch an attempt to impose a state administrative regime governing coverage determinations is squarely within the ambit of ERISA's preemptive reach."¹⁵⁹ In the instant case, the court rebutted the argument made by defendants that this independent review provision fell under the ERISA savings clause exception that exempts state laws regulating insurance.¹⁶⁰ The "quasi-

that ERISA confers no cause of action against HMOs for providing incentives to their doctors for limiting the costs of testing and treatment. Part of the Court's reasoning was that states are currently allowed to impose malpractice liability on HMOs for such action." *Id.* at 536 n.34 (citing *Pegram v. Herdrich*, 530 U.S. 211 (2000)).

152. *Id.* at 536 n.35 (citing TEX. CIV. PRAC. & REM. CODE ANN. § 88.003 (Vernon Supp. 2001)).

153. *Id.* A patient can only sue their managed care entity after they have gone through the independent review procedure. *Id.*

154. *Id.* at 536-37.

155. *Id.* at 537.

156. *Id.*

157. *Id.* An "adverse determination" is "a determination by [an HMO] or utilization review agent that the health care services furnished or proposed to be furnished to an enrollee are not medically necessary [or inappropriate]." TEX. INS. CODE § 20A.12A (a) (Vernon Supp. 2001).

158. *Corporate Health*, 215 F.3d at 537.

159. *Id.*

160. *See id.* at 537, 539. The Seventh Circuit disagrees on this point in *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959, 972 (7th Cir. 2000). *See infra* note 162 and accompanying text.

administrative procedure" created by the Act forced the ERISA plan administrators to comply with the decision of the independent review organization respecting the denial of benefits.¹⁶¹ "This scheme creates an alternative mechanism through which plan members may seek benefits due them under the terms of the plan—the identical relief offered under . . . ERISA . . . [and, therefore,] the independent review provisions conflict with ERISA's exclusive remedy and cannot be saved by the saving[s] clause."¹⁶² As a result of the court's finding, this portion of the Act was severed from the remainder because it was the only provision found preempted by ERISA.¹⁶³

C. Implications of the Corporate Health Decision

It is difficult to predict how much of an impact the Fifth Circuit's decision in *Corporate Health* will have in Texas and what sort of influence it may carry to other state legislatures and federal circuit courts. In *Moran v. Rush Prudential HMO, Inc.*,¹⁶⁴ a recent decision from the Seventh Circuit, the court directly disagreed with the Fifth Circuit's analysis in *Corporate Health*. At issue in *Moran* was an Illinois statute that required independent physician review in cases where a patient's primary physician disagreed with the patient's HMO regarding medically necessary treatment; unlike the Fifth Circuit, the Seventh Circuit found that the independent review provision was not preempted by ERISA.¹⁶⁵ The court held that the independent review provisions were covered under the savings clause in ERISA, which exempts state laws that regulate insurance.¹⁶⁶ The court found that the Illinois statute "relates to" ERISA but is nonetheless saved through its regulatory effect on insurance.¹⁶⁷ Additionally, the court noted the intra-circuit conflict, but stated that the Illinois statute does not change or alter the relief contained within ERISA, since the independent review provisions became a part of the plaintiff's insurance contract through the statute's implementation.¹⁶⁸ Further, the Illinois statute did not provide an

161. *Corporate Health*, 215 F.3d at 539.

162. *Id.*

163. *Id.* at 539–40. In response to the Fifth Circuit *Corporate Health* case, the United States Supreme Court has asked the Solicitor General for a brief articulating the stance of the United States. See *Tex. Dep't of Ins. v. Corporate Health Ins., Inc.*, 148 L. Ed. 2d 657 (2001).

164. 230 F.3d 959 (7th Cir. 2000).

165. *Id.* at 971–72.

166. *Id.*

167. See *id.* at 969.

168. *Id.* at 972 & n.7.

alternative remedy to recover benefits, but acted as an additional internal mechanism when coverage disputes arose.¹⁶⁹

The court in *Moran* did not consider the recent Supreme Court decision in *Pegram*, a fact noted by the dissent.¹⁷⁰ The *Moran* court's analysis centered upon the savings clause,¹⁷¹ whereas the *Corporate Health* court's analysis was partially based on the principles discussed in *Pegram*.¹⁷² Unlike *Moran*, the *Corporate Health* decision suggested that an analysis of claims under ERISA was case specific, and that this was due to the particular treatment/eligibility decisions made in each patient's case.¹⁷³

The Supreme Court in *Pegram* distinguished between "treatment" decisions and "eligibility" decisions.¹⁷⁴ Eligibility decisions are based on a patient's health insurance coverage under the patient's specific plan and are preempted by ERISA, whereas treatment decisions are not preempted because they have to do with diagnostic decisions made by a physician based upon an examination of the patient.¹⁷⁵ Further, the Supreme Court in *Pegram* held that "mixed" treatment and eligibility decisions did not establish an ERISA cause of action for a breach of fiduciary duty.¹⁷⁶ The Court did not make clear whether these "mixed" decisions, since they were only partially related to a patient's treatment, would always survive ERISA preemption and thus be subject to state tort law.¹⁷⁷ Perhaps as long as the decision contains some relation to "treatment" and is not entirely based on "eligibility," the decision will not be preempted by ERISA.¹⁷⁸

Thus, before a plaintiff may sue a managed care entity under the Texas Health Care Liability Act, a court must determine whether a decision is based on "treatment" or "eligibility." This distinction is far less clear in the context of real life decision making between a patient, a

169. *Id.* at 971-72.

170. *Id.* at 974.

171. *See supra* note 166.

172. *Corporate Health Ins., Inc. v. Tex. Dep't of Ins.*, 220 F.3d 641, 643-44 (5th Cir. 2000).

173. *See id.* at 643.

174. *Pegram v. Herdrich*, 530 U.S. 211, 228 (2000).

175. *Id.*

176. *See id.* at 229-30.

177. *See Pappas v. Asbel*, 768 A.2d 1089, 1097 (Pa. 2001) (Saylor, J., dissenting). *See also* BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS, AND PROBLEMS* 654 (4th ed. 2001).

178. FURROW ET AL., *supra* note 177, at 654.

physician, and the managed care entity.¹⁷⁹ The Court acknowledged this fact in *Pegram*.¹⁸⁰ For example, in *Pegram*, the physician determined that Herdrich's condition was not severe enough to require immediate treatment.¹⁸¹ Thus, the HMO involved there, Carle, would not cover the care.¹⁸² Carle would, however, have covered the emergency care if Dr. Pegram had decided that her patient, Herdrich, did need the appendectomy.¹⁸³ The interdependency of this decision making anticipates the difficulty in clearly distinguishing between treatment and eligibility decisions.¹⁸⁴

In another case, *Pappas v. Asbel*,¹⁸⁵ the Pennsylvania Supreme Court held that ERISA did not preempt state law medical malpractice claims. Pappas, the plaintiff, was admitted to the hospital at 11:00 a.m. "complaining of paralysis and numbness in his extremities."¹⁸⁶ The emergency room physician consulted with the neurologists on staff, and they collectively determined that Pappas needed emergency neurological treatment and should be transferred to a second hospital.¹⁸⁷ The ambulance arrived at 12:40 p.m. but Pappas's health care provider denied authorization for treatment at the second hospital.¹⁸⁸ After numerous phone calls, the health care provider authorized transfer to the second hospital at 3:30 p.m.¹⁸⁹ The delay allegedly caused Pappas's permanent quadriplegia.¹⁹⁰ Pappas sued his primary care physician and the hospital,¹⁹¹ and the defendants filed a third party claim against Pappas's health care plan.¹⁹²

The court in *Pappas* concluded that there was no ERISA preemption because negligence claims against an HMO did not "relate

179. See Thomas R. McClean & Edward P. Richards, *Managed Care Liability for Breach of Fiduciary Duty after Pegram v. Herdrich: The End of ERISA Preemption for State Law Liability for Medical Care Decision Making*, 53 FLA. L. REV. 1, 27 (2001).

180. *Pegram*, 530 U.S. at 229.

181. *Id.*

182. *Id.*

183. *Id.*

184. See McCabe, *supra* note 104, at 593-95 (noting the distinction between "quality" and "quantity" of benefits discussed in the district court's opinion in *Corporate Health Ins., Inc. v. Tex. Dep't of Ins.*, 12 F. Supp. 2d 597 (S.D. Tex. 1998)).

185. 724 A.2d 889 (Pa. 1998).

186. *Id.* at 890.

187. *Id.*

188. *Id.*

189. *Id.*

190. *Id.*

191. *Id.*

192. *Id.*

to" an ERISA plan.¹⁹³ It noted that the Supreme Court has yet to determine whether state law negligence claims "relate to" an ERISA plan.¹⁹⁴ Based on the Court's narrowing of its "relate to" preemption analysis as well as its reading of the *Travelers* case, the Pennsylvania Supreme Court determined that the state law negligence claims were not preempted by ERISA.¹⁹⁵ In contrast to the majority opinion, Justice Nigro's concurring opinion indicated that the key issue should be whether the state law claims refer to the "quantum" of benefits or the "quality" of benefits.¹⁹⁶ State law may regulate the "quality" of benefits but not the "quantum" of benefits.¹⁹⁷ In other words, negligent medical decisions can surpass summary judgment, but negligent coverage decisions are quickly preempted by ERISA.

The United States Supreme Court vacated this decision without a reason and remanded it to the Pennsylvania Supreme Court to reevaluate it in light of *Pegram*.¹⁹⁸ On remand, the Pennsylvania Supreme Court affirmed its original decision.¹⁹⁹ The court concluded that the decision in this case involved a mixed eligibility and treatment decision.²⁰⁰ Dr. Leibowitz not only decided whether Pappas's condition was covered, which it was, but he also determined when and where the condition should be treated.²⁰¹ Since this was a "mixed decision," "the adverse consequences of which, if any, are properly redressed, as *Pegram* teaches, through state medical malpractice law."²⁰² Both *Pappas* and *Pegram* involve factual situations that seem to draw tenuous lines between those eligibility decisions that are preempted by ERISA and those treatment decisions that are not. The Fifth Circuit in *Corporate Health* upholds the validity of the Texas Health Care Liability Act because it allows suits based on treatment decisions only.²⁰³ The question then arises as to how easily the lower courts will be able to distinguish between treatment, eligibility, and mixed decisions.

193. *Id.* at 893.

194. *Id.* at 891.

195. *Id.* at 893.

196. *Id.* at 894-95 (Nigro, J., concurring) (citing *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 358 (3d Cir. 1995), 516 U.S. 1009 (1995)).

197. *See id.*

198. *Mariner, supra* note 6, at 595.

199. *Pappas v. Asbel*, 768 A.2d 1089, 1091 (Pa. 2001).

200. *Id.* at 1096.

201. *Id.*

202. *Id.*

203. *Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 215 F.3d 526, 534 (5th Cir. 2000) (citing TEX. CIV. PRAC. & REM. CODE ANN. § 88.002 (Vernon Supp. 2001)).

Due to the difficulty in distinguishing between the types of decision-making, HMOs might easily evade state law by characterizing their decisions as strictly eligibility decisions. In these cases, a plaintiff's claim would not survive ERISA preemption.

Despite this difficulty in distinguishing between treatment and eligibility decisions, the distinction between these two types of decisions is valid and fulfills policy goals. For instance, physicians should make treatment decisions, and health care plans should make eligibility decisions. Unfortunately, most disputes arise when there is confusion over what decision is made and who makes it. Thus, the debate over the type of decision will arise frequently and further ERISA preemption confusion. Finally, it remains unclear how courts will treat the status of "mixed" decisions. In *Pappas*, the Pennsylvania Supreme Court treated all "mixed" decisions as subject to tort liability under state law.²⁰⁴ In contrast, the Fifth Circuit in *Corporate Health* seemed unwilling to make that conclusion upon its review of *Pegram*.²⁰⁵ Thus, conflict between the courts as to how to treat mixed decisions will no doubt continue in the future and prolong the debate over the scope of ERISA preemption.²⁰⁶

Further, with no independent review provision, plaintiffs will be discouraged from seeking an internal review of an adverse benefits determination. Internal reviews seem unacceptable because it appears unlikely that review boards could remain unbiased if the boards were employed by the managed care entity. Cost conscious decision making would likely taint the objective analysis that is necessary in evaluating patient needs.

The Fifth Circuit's reasoning with respect to the independent review provisions seemed to follow a clearer path. In *Travelers*, the Supreme Court stated that ERISA "does not go about protecting plan participants and their beneficiaries by requiring employers to provide any given set of minimum benefits."²⁰⁷ By forcing health care entities to comply with an independent review board, the Illinois and Texas

204. See *Pappas*, 768 A.2d at 1095.

205. See *id.* at 1097 (Saylor, J., dissenting). The dissent argues that "other courts have been more circumspect concerning the implications of *Pegram II* in relation to conflict preemption pursuant to ERISA." *Id.* (Saylor, J., dissenting) (citing *Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 220 F.3d 641, 643-44 (5th Cir. 2000) ("stating that 'we do not read *Pegram* to entail that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment, and [our own precedent] held otherwise'" (alteration in original)).

206. See *id.*

207. *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 651 (1995).

statutes can indirectly require them to provide certain benefits. Outside personnel will be in a position to determine how a particular managed care entity should interpret their company contracts and policies. This interpretation clearly "relates to" the administration of an ERISA plan and thus should be preempted.

Given the problems that ERISA causes for the inception of independent review action, as well as the confusion surrounding treatment and eligibility decision making, it seems likely that legislation may be the only clear-cut way to solving this judicial conflict. Health care plans are concerned about increased litigation that may arise if patients are allowed to sue their HMOs under a cause of action based on a denial of treatment.²⁰⁸ Litigation costs in this area will be lessened if consumers are given a chance to first seek independent review. In order to provide independent review, it is up to Congress to amend ERISA.

VI. PRESSURE ON CONGRESS TO AMEND ERISA

Congress attempted unsuccessfully in the last two terms to enact a law that would amend ERISA and give individuals more legal recourse against adverse health plan decision making.²⁰⁹ In January 1998, in his State of the Union address, President Clinton spoke about a proposed Patients' Bill of Rights that would cure some of the abuses associated with managed care.²¹⁰ This proposal was a result of a commission appointed by President Clinton nearly ten months prior, which was formed to examine ways to protect people in the health care market.²¹¹ While the commission was unsure of what type of legislation, if any, was needed, the President and members of Congress were ready to generate legislative drafts.²¹² Interestingly, but not surprisingly, neither the Democrats nor the Republicans produced versions of the Patients' Bill of Rights that resembled the commission's proposals.²¹³

The Democratic version extended the commission's consumer protections, while the Republican version offered much narrower

208. See *infra* note 223.

209. See, e.g., *infra* note 213 and accompanying text.

210. Tiffany F. Theodos, Note, *The Patients' Bill of Rights: Women's Rights Under Managed Care and ERISA Preemption*, 26 AM. J.L. & MED. 89, 89 (2000).

211. David A. Hyman, *Regulating Managed Care: What's Wrong With a Patient Bill of Rights*, 73 S. CAL. L. REV. 221, 231 (2000).

212. *Id.* at 232.

213. *Id.* at 233.

patient protection.²¹⁴ During both the 105th Congress and the 106th Congress, Republican and Democratic versions were proposed but not accepted by majorities in both houses of Congress.²¹⁵ In July 1999, the Senate passed, by a vote of fifty-three to forty-seven, a Republican version that regulated HMOs and insurance companies.²¹⁶ Later that year in October, a broader Democratic bill passed in the House by a vote of 275 to 151 with sixty-eight Republican votes.²¹⁷

Additional versions were proposed in the final quarter of 2000. Two Democrats, Senator Edward Kennedy and Senator Thomas Daschle, introduced the Patients' Bill of Rights Act in the Senate on September 15, 2000.²¹⁸ This legislation would have amended ERISA and allowed state law claims for personal injury or wrongful death, which arise from health care plan decisions that are currently preempted by ERISA.²¹⁹ The legislation further required that health care plans provide an independent appeal mechanism outside the industry for those individuals seeking to appeal a denial of benefits.²²⁰ On November 3, 2000, Republican Representative John Shadegg sponsored the Common Sense Patients' Bill of Rights.²²¹ This legislation provided for an internal appeals mechanism but did not specifically abrogate the ERISA provisions that preempt certain state law claims resulting from the denial of benefits.²²²

There are valid concerns on both sides of the debate regarding to what extent some version of the Patients' Bill of Rights should amend ERISA. Managed care entities argue that health care costs will increase with the corresponding increase in litigation that could arise when the ERISA shield goes down.²²³ During the 106th Congress, Republicans talked about small businesses that would no longer be able to afford health insurance coverage, while Democrats presented daily stories that detailed the horrors of the managed care system.²²⁴ With a new

214. *Id.*

215. Theodos, *supra* note 210, at 89 & n.4.

216. *The 43rd President: What They Did; A Survey of the Voting Record of the 106th Congress*, N.Y. TIMES, Dec. 17, 2000, at 48.

217. *Id.*

218. Patients' Bill of Rights Act, S. 3058, 106th Cong. (2000).

219. *Id.* § 302(a).

220. *Id.* §§ 102, 301.

221. Common Sense Patients' Bill of Rights Act, H.R. 5628, 106th Cong. (2000).

222. *Id.* § 121.

223. Theodos, *supra* note 210, at 105. Despite this concern, only a few such malpractice suits have been filed in Texas since the law was enacted. See Johnson, *supra* note 26.

224. Hyman, *supra* note 211, at 237-38.

President and a new Congress, bipartisan support for a Patients' Bill of Rights may be building.²²⁵

By late June 2001, debates over the Patients' Bill of Rights were numerous and support crossed party lines. Democratic Senators Kennedy and Edwards joined with Republican Senator John McCain to co-sponsor a bill that gave consumers with health insurance better access to care and additional recourse for adverse decisions.²²⁶ More specifically,

[t]he bill would let patients visit emergency rooms, pediatricians and obstetrician-gynecologists without needing permission. It would promise patients access to experimental treatments and let those who are pregnant or seriously ill keep the same doctor temporarily, even if the doctor is dropped from their health plan. It also would cover all Americans, except in states that can prove to federal officials that they offered "substantially equivalent" protections under their own laws.²²⁷

With respect to the most contested point, the consumers' right to sue their health plans, this bill would also allow patients to appeal to outside appeal boards and bring some, but not all, suits in state court.²²⁸ This Senate version also permitted individuals to collect more money damages in state and federal court.²²⁹ Following a compromise that

225. Robert Pear, *Bush to Back States' Laws on Rights for Patients*, N.Y. TIMES, Jan. 14, 2001, at 30. President Bush was quoted as saying, "I do support a national patients' bill of rights As a matter of fact, I brought Republicans and Democrats together to do just that in the state of Texas." *Id.* The Clinton administration issued regulations late in 2000 in order to soften disappointment related to the failed passage of the Patients' Bill of Rights. See *New Rules Order Faster Decisions on Workers' Health Care Claims*, MILWAUKEE J. SENTINEL, Nov. 21, 2000, at 2A. These regulations quicken the claims and appeals process related to health care coverage. *Id.* They are the first such regulations since the passage of ERISA in 1974. *Id.* The regulations go into effect on January 1, 2002, and the managed care industry has said that it will not attempt to have the regulations overturned. *Id.* Unlike the proposed Patients' Bill of Rights, these regulations keep the claims and appeals process a function of the health care provider rather than creating an independent process. *Id.* Upon taking office, President Bush delayed the implementation of these regulations. See Ellen M. Yackin, *HHS Issues 11th Hour Pro-Consumer Federal Medicaid Regulations*, at <http://www.gulphny.org/Legal%20Services%20Journal/LSJ%20March%202001/medicaid2.htm> (last visited Nov. 9, 2001). It is unclear whether these regulations will ever be put into effect. *Id.*

226. Helen Dewar & Amy Goldstein, *Patients' Rights Debate Opens on Angry Note; Senate Republicans Delay Action on Bill*, WASH. POST, June 20, 2001, at A4.

227. *Id.*

228. *Id.*

229. *Id.* The bill "would allow patients to recover up to \$5 million in civil penalties in

protected most employers from lawsuits, the bill passed in the Senate by a vote of fifty-nine to thirty-six.²³⁰

President Bush opposed the Senate bill, explaining that he was against legislation that would lead to expensive and excessive litigation.²³¹ While he wanted consumers to have the right to sue their HMOs, President Bush supported a far more limited right for patient suits.²³² This belief was reflected in the House bill that passed, which Bush supported after the addition of a last minute amendment.²³³ In fact, the House and Senate bills were quite similar and significantly differed only in the liability provisions.²³⁴ Nonetheless, negotiations between the House and the Senate may be strained and difficult to successfully complete by the end of the year.²³⁵

Despite Congress's inability to pass this legislation, managed care entities have made changes due to public pressure. As a result, some observers of the health care industry question whether a Patients' Bill of Rights will make a visible impact.²³⁶ Since the issues covered in both the

federal court, but sets no limits on damages for economic loss or pain and suffering. Patients could recover damages in state courts up to the limits set by state law." Robin Toner, *At Center of Senate Battle, a Lawyer and a Doctor*, N.Y. TIMES, June 28, 2001, at A21.

230. See Robert Pear, *Bush Faces Defeat on Patients' Rights Bill*, N.Y. TIMES, June 29, 2001, at A16; Robert Pear, "House Approves Deal with Bush" on Suing HMOs, N.Y. TIMES, Aug. 3, 2001, at A16 [hereinafter Pear, *House Approves Deal*].

231. Dan Balz & John F. Harris, *For Bush, Losing the Initiative on Patients' Rights*, WASH. POST, July 23, 2001, at A01. The concern over excessive litigation is not supported in states that have already adopted their own versions of the Patients' Bill of Rights. See *The Right Patients' Bill of Rights*, N.Y. TIMES, June 18, 2001, at A22.

232. See Pear, *House Approves Deal*, *supra* note 230, at A16.

233. *Id.* Under the House bill, there are limits in state court on the amount of punitive damages (\$1.5 million) and also on damages for pain and suffering (\$1.5 million). *Id.* According to critics, the amendment worked out between President Bush and Republican Representative Charlie Norwood will destroy many state laws and state court decisions that have provided patient protection. *Id.*

234. *Curing the Patients' Bill of Rights*, N.Y. TIMES, Sept. 4, 2001, at A26. Notwithstanding the similarity in the bills, however, the House bill also implements a number of federal rules that would make it more difficult for patients to pursue successful suits against their health plans. *Id.* Further, insurance companies will also have a lot of input in deciding which individuals will comprise the independent review panels. *Id.* Also, in cases that go to court, deference will be given to the review panel, but only when the decision of the panel favors the HMO. *Id.* Finally, the House bill requires "plaintiffs to prove that an H.M.O.'s negligence was the sole cause of harm." *Id.*

235. Due to the recent and tragic terrorist attacks against the United States, it is unlikely that domestic issues like the Patients' Bill of Rights will pass in the near future. Fighting terrorism both abroad and at home will be Congress's main objective. See generally George F. Will, *On the Health of the State*, NEWSWEEK, Oct. 1, 2001, at 70.

236. See Milt Freudenheim, *Five Questions for Charles B. Inlander; Patients' Rights: What's at Stake?*, N.Y. TIMES, Aug. 19, 2001, § 3, at 11.

Senate and House bills have been stirring for a number of years, health plans have had time to make changes.²³⁷ For example, many plans no longer require pre-approval for emergency room care or for women's visits to a gynecologist or obstetrician.²³⁸ Additionally, many plans have outside review systems in place for coverage conflicts.²³⁹ Thus, the new law will mandate uniformity, but will not impose substantive procedural changes for many large health care plans.²⁴⁰ Notwithstanding this, the pursuance of new claims in court could have a positive effect for consumers,²⁴¹ since the threat of litigation may encourage managed care organizations "to approve more care and to pay [for] more claims."²⁴²

VII. CONCLUSION

In the vast majority of circumstances, managed care entities provide positive treatment results at a reduced cost to the consumer. Tragic circumstances occur, however, in all industries, and the medical industry is no exception. There is no convincing reason for withholding from ERISA health plan participants remedies for harms that are available to all other health care consumers.

The Texas Health Care Liability Act is one state's response to this injustice. The liability portion of the Act restricts claims to circumstances in which the managed care entity engages in treatment decisions. In practice, whether or not such decisions will be distinguishable from eligibility and mixed decisions is questionable. Further, the independent review provisions, crucial in the eyes of consumers who distrust their health insurance plans, were held preempted by ERISA. While the Supreme Court has relaxed its preemption analysis, it seems unlikely that any independent review provisions will withstand the current version of ERISA. Such independent review board decisions are too intricately related to eligibility decisions made by health plan administrators and thus remain

237. *Id.* States have also done their part in filling in where Congress has failed to pass anything in the last few years. See Robert Pear, *States Dismayed by Federal Bills on Patient Rights*, N.Y. TIMES, Aug. 13, 2001, at A1. For example, "[f]orty states . . . guarantee patients an independent medical review if they are denied [medical care]." *Id.* Additionally, ten states have laws that enable patients "to sue [their] health plans for damages caused by the delay or denial of care." *Id.*

238. *Id.*

239. *Id.*

240. *Id.*

241. See Robert Pear, *Matters of Law, and Semantics, In Health Bills*, N.Y. TIMES, Aug. 4, 2001, at A1.

242. *Id.*

preempted by ERISA. There is no question that ERISA fulfills important policy objectives related to pension plans and operational uniformity for national employers. Notwithstanding this, however, it is crucial that Congress re-examine policy objectives and amend ERISA in order to lessen its impact on health care consumers.

The medical industry enjoys a unique place in people's lives. Unlike other industries, everyone is forced to be a direct participant in it. Further, wrong decisions in the medical industry can result in death or serious injury rather than just financial or property loss. Thus, there is more public outcry when its procedures or framework is flawed. Perhaps the impact of some incorrect decisions can be prevented through independent review boards, which place patient care above cost efficiency. Finally, managed care entities must be held accountable for incorrect eligibility decisions. Where there is no liability for errors, ERISA plans have a financial incentive to deny care.²⁴³ The failure to restrain this financial incentive with liability is a consumer concern.²⁴⁴ ERISA prevents this concern from being addressed even though managed care entities should be motivated to be patient care centers first and cost efficient organizations second.

At the time of printing, it was unclear whether or not Congress would be able to successfully negotiate a compromise between the House and Senate bills. With all of the efforts that have gone into constructing a Patients' Bill of Rights, as well as the widespread confusion that exists in state and federal courts, if a compromise could be reached, it would be a satisfying conclusion to many years of debate. A compromise could also represent the first chapter towards additional health care reform. Despite all the positive effects that could result from a Patients' Bill of Rights, it still will ultimately fail in one respect; the Patients' Bill of Rights will only have an impact on people that have health insurance.²⁴⁵

A Patients' Bill of Rights leaves out forty-three million Americans that have no health insurance.²⁴⁶ Additionally, it does not enlarge Medicare or Medicaid nor does it assist the Children's Health Insurance Program or provide tax breaks to individuals who need to purchase

243. Mariner, *supra* note 6, at 595; *see also* HARRIS, *supra* note 14, at 285.

244. Mariner, *supra* note 6, at 595.

245. *See* Freudenheim, *supra* note 236. A Patients' Bill of Rights will affect approximately 180 million people who have private health insurance. Robert Pear, *Shield is Sought for Employers Under Patients' Bill of Rights*, N.Y. TIMES, June 26, 2001, at A17.

246. *Id.*

health insurance.²⁴⁷ It is very important that managed care organizations be held responsible for decisions that negatively impact patients. Nonetheless, the debate cannot end there; discussion must continue over how to improve the quality of health care as well as how to ensure that all Americans have access to quality care that is rightfully theirs.²⁴⁸

BRIDGET S. KENNEY*

247. *Id.*

248. See E.J. Dionne Jr., *Unheard Voices in the Health Care Debate*, WASH. POST, June 29, 2001, at A37.

* The author would like to thank her parents, her sisters, and her fiancé, Chris, for their constant love and support through law school. Additionally, this author thanks Professor Susan Martyn for the idea for this Comment as well as for her insight and teaching in health law.

* * *