THE ERISA PREEMPTION QUESTION: WHY SOME HMO MEMBERS ARE DYING FOR CONGRESS TO AMEND ERISA

I. INTRODUCTION

Linda Visconti's infant daughter, Serena Mary Visconti, was a fully developed baby girl with no signs of congenital abnormalities and weighed five pounds, nine ounces.\(^1\) Despite these statistics, Serena was stillborn.\(^2\) During Mrs. Visconti's third trimester of pregnancy with Serena, she developed symptoms typical of preeclampsia.\(^3\) Mrs. Visconti's obstetrician ignored these symptoms, and his negligence allegedly caused Serena's death.\(^4\) The Viscontis brought suit against their Health Maintenance Organization\(^5\) ("HMO"), U.S. Healthcare, for malpractice.\(^6\) The United States Court of Appeals held that the Viscontis' malpractice claim against their HMO could go forward in state court where the Viscontis could pursue a remedy.\(^7\)

Florence Corcoran was also pregnant and her obstetrician established that it was a high risk pregnancy.\(^8\) He "recommended that she have complete bed rest during [her] final months of pregnancy," and admitted her to the hospital.\(^9\) Her HMO, United Health Care, determined that hospitalization was not necessary and instead authorized home nursing care for ten hours per day.\(^10\) During a time when no nurse

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2. See id.
4. See id.
5. For the purposes of this Comment, "Health Maintenance Organization" is used as a generic term for all managed health care plans. As such, it refers to "any entity which delivers, administers, or assumes risk for health care services with systems or techniques to control or influence the quality, accessibility, utilization, or costs and prices of such services to a defined enrollee population." Tex. Civ. Prac. & Rem. Code Ann. § 88.001(8) (West Supp. 1999). This definition is borrowed from the Texas Statutes, and includes, but is not limited to, Health Maintenance Organizations, Preferred Provider Organizations, and Utilization Review Organizations.
6. See Dukes, 57 F.3d at 353.
7. See id. at 361.
9. Id. at 1322-23.
10. See id. at 1324.
was on duty, Mrs. Corcoran's baby went into distress and died in utero.11 The Corcoran's brought suit against their HMO for wrongful death.12 The United States Court of Appeals held that the Corcoran's wrongful death claim was preempted by the Employee Retirement Income Security Act ("ERISA"),13 and that the Corcorans had no remedy for the alleged wrongful death of their child.14

The disparate outcomes of these two cases illustrate the inequitable force of ERISA. This Comment first analyzes the pertinent provisions of ERISA with respect to bringing an action against an HMO. It then explores the case law which has fleshed-out these ERISA provisions. This Comment then presents legislative, judicial, political, and popular reaction to ERISA's inequitable outcomes. Finally, it proposes how Congress should revise ERISA to preserve its original intent—to protect employees.

II. ERISA

A. The Pertinent ERISA Provisions

In the early 1970s, an increasing number of employees were participating in employee benefit plans.15 Absent minimum standards, some of these plans were depriving plan participants of anticipated benefits.16 In response to this dilemma, President Ford signed the Employee Retirement Income Security Act ("ERISA")17 into law in 1974. ERISA sought to protect employee benefit plan participants by establishing minimum standards, "providing appropriate remedies," and providing "ready access to the federal courts."18 Additionally, ERISA endeavored to standardize the regulation of employee benefit plans by "pre-empt[ing] the field for Federal regulation, thus eliminating the threat of conflicting or inconsistent state and local regulation."19 Put another way, by enacting ERISA, Congress was attempting to protect employees from unfair benefit plan practices while federally protecting the plans

11. See Corcoran, 965 F.2d at 1324.
12. See id.
14. See Corcoran, 965 F.2d at 1338.
15. See 29 U.S.C. § 1001(a) (1994). This is the "Congressional findings and declaration of policy" provision of ERISA.
16. See id. § 1001(a).
17. See id. §§ 1001-1461.
18. Id. § 1001(b).
from inappropriate remedies.

The sections of ERISA pertinent to claims against an HMO include §§ 1002, 1003, 1132, 1133, and 1144. Section 1002 contains the definitions for ERISA. The Act defines an “employee welfare benefit plan” as “any plan... which was... established or maintained by an employer or by an employee organization... for the purpose of providing for its participants... through the purchase of insurance or otherwise... medical, surgical, or hospital care or benefits... in the event of sickness, accident, disability, death or unemployment.” Courts have consistently held that the typical managed health care plan falls within the ERISA definition.21

Section 1003 of ERISA frames the scope of the Act’s coverage.22 The scope of ERISA is broad because it applies to any employee benefit plan that is established or maintained by either an employer or an employee organization which is engaged in activities of commerce.23 ERISA does not apply to several stated exceptions, namely: governmental plans; church plans; plans “maintained solely for the purpose of complying with applicable workmen’s compensation laws;” plans “maintained outside the United States;” and unfunded “excess benefit plans.”24

Section 1132 of ERISA, which was previously section 502 of the Act, is the civil enforcement provision. It delineates who may bring claims, and what claims may be brought, under ERISA.25 This section’s pertinent language is as follows:

§ 1132. Civil enforcement
(a) Persons empowered to bring a civil action
A civil action may be brought—
(1) by a participant or beneficiary—

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of

23. See id. §§ 1003 (a)(1)-(3).
24. Id. §§ 1003 (b)(1)-(5).
25. See id. § 1132.
The Act restricts who can bring a civil action against an employee benefit plan to the Secretary of Labor, the state, and the plan participant (which includes the participant’s beneficiary or fiduciary). 27 For the plan participant, the claims available under ERISA include (1) a claim to “recover benefits due . . . under the terms of his plan,” (2) a claim “to enforce his rights under the terms of the plan,” (3) a claim “to clarify his rights to future benefits under [his] plan,” (4) a claim for the breach of a fiduciary duty under his plan, or (5) a claim for the failure to provide requested information about his plan. 28 The relief available under ERISA includes an injunction of the violative action, equitable relief in the form of redress for the violation, or the enforcement of the provision that the plan failed to discharge. 29

Section 1133 of ERISA outlines the claim procedure that the employee benefit plan must follow when denying a benefit to a plan participant. 30 The Act requires the plan to give the participant a reasonable opportunity for full and fair review of the decision to deny the claim. 31

Section 1144, which was previously section 514 of the Act, is the federal preemption provision of ERISA. The pertinent provision states:

§ 1144. Other laws
(a) Supersedure; effective date
Except as provided . . . the provisions of this subchapter . . . shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this

27. See id. §§ 1132(a)(1)-(9).
28. Id. §§ 1132(a)(1)(A)-(B), (c), 1109, 1025.
29. See id. § 1132(a)(3).
30. See id. § 1133.
31. See id. § 1133(2).
title. This section shall take effect on January 1, 1975.32

The "relate to" phrase of this provision has become the central point of contention in claims brought against HMOs.

B. Why Avoid ERISA Preemption?

ERISA preemption means that an HMO can remove a state claim to the federal court as a federal question. Most plan participants harmed by an ERISA plan will seek to avoid ERISA preemption because of the limited remedies available under the Act.

Section 1132 of ERISA limits the relief available to plan participants to either enjoining the HMO from continuing a violative practice or obtaining an equitable remedy.33 The equitable remedies available under the Act include redress for the ERISA violation or enforcement of the unfulfilled provision.34 In a split of opinion, five circuits of the United States Court of Appeals have adopted the doctrine that "equitable relief" is limited to declaratory and injunctive relief.35 Under this view, § 1132 precludes punitive damages as well as "make whole" damages for injuries resulting from not getting treatment or from receiving improper treatment. For example, if an HMO refuses to pay for a needed test, the damages will likely be limited to the cost of the test.36 Put another way, if a woman dies because a mammogram was refused and her breast cancer was not detected, the damages are limited to $99—or whatever the cost of the mammogram.37 The fact that a plaintiff will have no remedy does not affect whether ERISA will supersede state law.38

The question of whether punitive or extracontractual39 damages are

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32. Id. § 1144(a) (emphasis added).
33. See id. § 1132(a)(3).
34. See id.
37. See id.
38. Corcoran, 965 F.2d at 1333-34 (citing Memorial Hosp. Sys. v. Northbrook Life Ins. Co., 904 F.2d 236, 248, n.16 (5th Cir. 1990)).
39. "Extracontractual" damages refers to "damages that would give an [HMO] beneficiary more than he or she is entitled to receive under the strict terms of the plan." Corcoran, 965 F.2d at 1335.
available under § 1132 of ERISA has not been answered conclusively by the Supreme Court of the United States. In *Massachusetts Mutual Life Insurance Company v. Russell,* the Supreme Court determined that these types of damages were not available under a separate section of ERISA, but did not consider whether such damages were available under § 1132, as the plaintiff did not implicate that section in his complaint. In the concurring opinion of this case, however, Justice Brennan addressed this option. Justice Brennan first observed that Congress integrated trust law principles into the enforcement scheme of ERISA. Under trust law principles, beneficiaries are "entitled to a remedy 'which will put him in the position in which he would have been if the trustee had not committed the breach of trust;’" namely "make-whole" relief. Justice Brennan encouraged courts to first determine to what extent state and federal trust and pension law provides for the recovery of damages beyond any benefits that have been withheld and second, to consider whether extracontractual relief would conflict with ERISA in any way. Further, Justice Brennan encouraged courts to authorize make-whole remedies under § 1132 where they were not available under trust law. But, even after this plea from Justice Brennan, courts are hesitant to award make-whole remedies in an ERISA context.

As suggested by Justice Brennan’s concurrence in *Russell,* contract principles may govern the damage provision of § 1132. Contract principles, if utilized as some courts have suggested, would "enable[ ] an aggrieved party to recover such damages as would place him in the position he would have occupied had the contract been performed . . . in-

40. *See Corcoran,* 965 F.2d at 1335.
42. The Supreme Court determined that punitive and extracontractual damages were not available under section 409(a) of ERISA. *See id.* at 148.
43. *See Corcoran,* 965 F.2d at 1335.
45. *See id.* at 156-57.
46. *Id.* at 157 n.16 (citing RESTATMENT (SECOND) OF TRUSTS § 205, and cmt. a (1959)).
47. *See id.* at 157-58.
48. *See id.*
52. *See id.*
cluding those damages that could reasonably have been foreseen to flow from the breach."\textsuperscript{53} A breach of contract claim is limited, however, and is not available for a contract between a patient and a physician unless they expressly agree to a particular service or a specific cure.\textsuperscript{54} Accordingly, contract principles would be available in a § 1132 analysis in only very limited instances.

Another limitation of ERISA's remedy provisions is that if a plan participant actually dies from the HMO's lack of care, her survivors cannot "enforce [her] rights under the terms of the plan."\textsuperscript{55} At least one court has held that a deceased plan participant's rights under an HMO plan are no longer viable after death.\textsuperscript{56} Accordingly, death precludes the "enforcement" remedy of ERISA.

\textbf{C. How To Avoid ERISA Preemption}

Because the remedies available under ERISA are so uncertain and sometimes non-existent, plaintiffs will generally attempt to avoid ERISA preemption in favor of state law remedies. The following analysis highlights how the preemption provision can be avoided.

1. The Well Pleaded Complaint Rule and Complete Preemption

The first barrier to overcome in successfully avoiding ERISA preemption is meeting the "well pleaded complaint rule" criteria. The "well pleaded complaint rule," as stated by the Supreme Court, provides that a civil action arises under federal law when a federal question appears on the face of the plaintiff's properly pleaded complaint.\textsuperscript{57} Additionally, a defendant cannot convert a plaintiff's state claim into a federal question solely on the basis of an asserted federal defense "even if the defense is anticipated in the plaintiff's complaint, and even if both parties admit that the defense is the only question truly at issue."\textsuperscript{58} Consequently, federal preemption, as a defense, "does not appear on the face of a well-pledged complaint, and, therefore, does not authorize re-

\begin{itemize}
  \item \textsuperscript{53} Id. at 1336-37 (citing \textsc{Restatement (Second) of Contracts} §§ 347, 347 cmt. a, 351 (1981)).
  \item \textsuperscript{54} \textit{See id.} at 1337.
  \item \textsuperscript{56} \textit{See id.} (citing Mertens v. Hewitt Assoc., 508 U.S. 248 (1993)).
  \item \textsuperscript{57} \textit{See Franchise Tax Board v. Construction Laborers Vacation Trust}, 463 U.S. 1, 9-10 (1983) (citing Taylor v. Anderson 234 U.S. 74, 75-76 (1914)).
  \item \textsuperscript{58} Id. at 14.
\end{itemize}
moval to federal court."

An exception exists, however, to the “well pleaded complaint rule” which is “complete preemption.” “Complete preemption” exists when Congress “so completely pre-empt[s] a particular area that any civil complaint raising this select group of claims is necessarily federal in character.” If complete preemption is implicated, a defendant is able to convert a plaintiff’s state claim into a federal question merely by implicating the defense.

2. The Preemption Clause of ERISA and Complete Preemption

The preemption clause of ERISA states that the Act “shall supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.” The Supreme Court has stated that this clause “is conspicuous for its breadth.” Accordingly, it has directed the federal courts to apply ERISA’s preemption clause expansively. Although the phrase “relate to” has been recognized as broad, it is not necessarily unlimited. The Supreme Court has commented that “[i]f ‘relate to’ were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for ‘[r]eally, universally, relations stop nowhere.’” The Court opined that to extend “relate to” to the furthest stretch of indeterminacy “would be to read Congress’s words of limitation as mere sham, and to read the presumption against pre-emption out of the law whenever Congress speaks to [a] matter with generality.”

In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company*, the Court reiterated its previous holding that “[a] law ‘relates to’ an employee benefit plan . . . if it has a connection with or reference to such a plan.” For example, if a claim “rests upon the terms of [a] plan or requires construction of the plan lan-

60. *Id.* at 63.
65. *Id.* (quotation omitted).
66. *Id.*
guage," it will be preempted by ERISA under the "relate to" analysis of § 1144. Additionally, the Court stated that "[p]re-emption does not occur . . . if the state law has only a tenuous, remote, or peripheral connection with [an ERISA] plan . . . ." The Court concluded that "nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." The Court draws the distinction that a state law "relates to" a benefit plan if it "bear[s] indirectly but substantially on all insured benefit plans," but the state law does not "relate to" a benefit plan if it "regulate[s] only the insurer, or the way in which it may sell insurance." Stated another way, if a state law does not jeopardize the nationally uniform administration of employee benefit plans, ERISA will not preempt the local legislation. In this context, state laws include both state statutes as well as common law causes of action. Furthermore, the Supreme Court has held that "lawsuits against ERISA plans for run-of-the-mill state-law claims . . . [including] torts committed by an ERISA plan . . . are not pre-empted by ERISA."

If a § 1144 "relation" is found, the federal court is without removal jurisdiction and the state court must resolve the ERISA preemption dispute. This is termed "ERISA preemption."

70. Id.
71. Id. at 663 (quoting Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 739-41 (1985)).
72. Statutes may also be preempted by ERISA. For example, the Supreme Court found that a statute which was interpreted by state courts as prohibiting an employee benefit plan from discriminating on the basis of pregnancy was preempted. See Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983). The Supreme Court similarly held that ERISA preempted a statute which explicitly barred the garnishment of ERISA plan funds. See Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825 (1988). Likewise, the Court held that ERISA preempted a statute which prohibited an employee benefit plan from offsetting benefits by the amount of worker's compensation payments. See Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504 (1981). Further, the Court held that ERISA preempted a statute which abolished an employee benefit plan's right to subrogation from a tort recovery. See FMC Corp. v. Holliday, 498 U.S. 82 (1990).
This is not the case, however, if the claim embodies a "complete preemption" question. Complete preemption occurs when § 1132 of ERISA is involved. Section 1132 has been interpreted by the Supreme Court as an enumeration of claims which are categorically preempted by ERISA. Consequently, where a plan participant brings a claim against an HMO which seeks to recover benefits due, to enforce his rights, or to clarify his rights, the claim is completely preempted by ERISA and automatically presents a federal question which must be addressed in federal court.

If a party seeks to avoid ERISA preemption, the party must carefully word his complaint to avoid the connotation that the claim is seeking to recover benefits due to the party, or to enforce or clarify the party's rights under an ERISA plan, if these are not the goals sought by the claim.

III. HOW THE FEDERAL COURTS HAVE INTERPRETED THE PREEMPTION CLAUSE OF ERISA

Federal courts have consistently found that the ultimate question of whether a claim is completely preempted by ERISA rests with a "quantity" versus "quality" analysis. A quantity question arises when a claim alleges that the plan "withheld some quantum of plan benefits due." When a claim alleges that a promised benefit was not provided by the plan, the claim is to "recover benefits due" under § 1132 of ERISA and is, thereby, completely preempted.

"Quality," on the other hand, refers to the situation where the plan beneficiary receives the benefit promised by the HMO, but the benefit received is substandard. When a claim alleges that a substandard benefit was received, § 1132 of ERISA is not implicated and complete preemption does not occur. A second analysis is then performed to determine whether the claim "relates to" the ERISA plan at all.

78. See Pilot Life Ins. Co., 481 U.S. at 56.
79. Dukes, 57 F.3d at 357.
80. Id.
81. See id. at 355-57.
82. See id.
83. See id.
A. Within the Scope of Preemption: Claims Based Upon the "Quantity" of Medical Care Received

This section presents various examples of claims brought against HMOs that were determined to be "quantity" challenges. The most straightforward claim involving a "quantity" challenge is the denial of benefits. For example, in Sofo v. Pan American Life Insurance Company the plaintiff sought to be reimbursed by his HMO for medical treatment that he received and paid for out of his own pocket. The court held that Sofo's claim was based upon the quantity of benefits due and was thereby preempted by ERISA. Another case where a claim was preempted on quantity grounds is Lancaster v. Kaiser Foundation Health Plan. Here, the court found that a claim for negligently establishing an incentive plan, whereby physicians received bonuses for avoiding excessive treatments and tests, was a quantity challenge governed by ERISA. Another example is the case of Schmid v. Kaiser Foundation Health Plan where the court held that a claim for breach of contract for (1) failing to perform certain diagnostic tests, (2) providing some kinds of treatment rather than others, (3) failing to authorize visits to a different physician, and (4) failing to heed the opinion of an outside specialist was based upon the quantity of medical care provided.

Fraud and misrepresentation claims based upon the terms of an ERISA agreement have also been held to be quantity challenges which are preempted by ERISA. In Christopher v. Mobil Oil Corporation, the court preempted a claim which alleged that the employment benefit plan contained fraudulent terms. Similarly, a claim against a plan spokesman for misrepresenting available benefits under an employee benefit plan was preempted in Berger v. Edgewater Steel Company.

85. See id. at 241.
87. See id. at 1147-50.
90. 911 F.2d 911, 923 (3rd Cir. 1990); see also Christopher, 950 F.2d at 1218.
B. Beyond the Scope of Preemption: Claims Based Upon the "Quality" of Medical Care Received

The general rule is that a claim brought against an HMO which is based upon the quality of medical care received by the plaintiff is not preempted by ERISA. The main "quality" challenge against HMOs, which has been recognized by the weight of authority, is an HMO's vicarious liability for the medical malpractice of its agents.91

In Schwartz v. FHP International Corporation, the plaintiff, Diane Schwartz, told her doctor "that she had a family history of cancer and that she believed she had found a lump in her left breast."92 Her doctor told her it was nothing.93 A year later, Mrs. Schwartz believed that the lump had increased in size so she scheduled a mammogram.94 The radiologist read the mammogram as normal.95 Finally, two years after Mrs. Schwartz herself found the lump in her breast, an oncologist diagnosed her with breast cancer.96 The Schwartzs brought suit against their HMO under several theories, including vicarious liability for the medical malpractice of the plan's physicians.97 The court identified that there was a split in authority among the federal courts regarding whether vicarious liability claims were preempted by ERISA, and thus remanded the issue to the state court to resolve.98

The court in Elsesser v. Hospital of the Philadelphia College of Osteopathic Medicine recognized the viability of vicarious liability claims against HMOs.99 In Elsesser, Carolyn Verzicco complained to her doc-

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93. See id.
94. See id.
95. See id.
96. See id.
97. See id.
98. See id. at 1360.
99. 802 F. Supp. 1286 (E.D. Pa. 1992). It should be noted that two of the cases which
tor of "chest pain, mild shortness of breath, and numbness in her shoulders." After an abnormal electrocardiogram test result, the doctor ordered a Halter Monitor for Ms. Verzicco. After using the monitor for only one day, Ms. Verzicco's doctor discontinued its use and declined to read its results because her HMO refused to pay for the device. Approximately two weeks later, Ms. Verzicco again experienced chest pain and went to the emergency room. The emergency room doctors gave her medication and told her to return to her regular doctor. The next day, while Ms. Verzicco was driving, she "experienced extreme chest pain and passed out." She was taken to the emergency room and resuscitated, but did not regain consciousness. At the time that the case was heard, Ms. Verzicco remained in a "persistent vegetative state." Ms. Verzicco's guardians brought several claims against her HMO, including a claim for the HMO's vicarious liability for their member doctors.

The court stated that "[a]lthough an HMO is not usually liable for the negligence of the independent contractor physicians and health care providers that service the HMO members, an HMO may nevertheless be held liable if the health care provider is the 'ostensible agent' of the HMO." The court then went on to present the two factors required for a finding of ostensible agency: "(1) whether the patient looks to the institution, rather than the individual physician for care, and (2) whether the HMO 'holds out' the physician as its employee." The court concluded that the plaintiffs met these requirements and that their claim for vicarious liability against the HMO could move forward.


100. Elsesser, 802 F. Supp. at 1288.
101. See id.
102. See id.
103. See id.
104. See id. at 1289.
105. Id.
106. See id.
107. Id.
108. See id. at 1287-88.
109. Id. at 1290 (citation omitted).
110. Id. at 1290 n.3 (quoting Boyd v. Albert Einstein Med. Ctr., 547 A.2d 1229, 1233 (Pa. Super. Ct. 1988)).
111. Id. at 1290.
The court further reasoned that the plaintiff's vicarious liability claim did not rely upon the actual employee benefit plan, but rather on the "principles of professional malpractice." It then relied upon a federal court of appeals holding that "ERISA does not generally pre-empt state professional malpractice actions." Consequently, the effect that a state malpractice law has on an HMO's plan can be found to be too "tenuous, remote, or peripheral" to implicate ERISA. Additionally, referring to a plan to merely establish the relationships between the parties was not sufficient to invoke ERISA preemption.

On the other hand, in the federal courts where vicarious liability is found to be preempted by ERISA, the courts have reasoned that the relationship between the HMO and the member physicians sufficiently "relate[s] to" the terms of the ERISA plan to merit preemption.

In short, a claim which seeks to hold an HMO vicariously liable for the substandard quality of its ostensible agents will not be preempted by ERISA in federal courts that view such a claim as "too tenuous, remote or peripheral" to "relate to" an ERISA plan.

C. What Happens if "Quantity" Affects "Quality:" Utilization Review

"Utilization review" is a cost containment process by which an HMO performs an external evaluation of a medical decision to evaluate its appropriateness. One example of a "utilization review" procedure is illustrated in Corcoran v. United HealthCare, Inc. In Corcoran, United HealthCare performed utilization review, including "pre-certification" whereby participants were required to "get advance approval for overnight hospital admissions and certain medical procedures," as well as "concurrent review" whereby participants were required to "get approval on a continuing basis" after they were admitted to the hospital.
These procedures are marketed to plan participants under the guise that the process ""[p]rovides improved quality of care by eliminating medically unnecessary treatment.""\textsuperscript{120}

Utilization review implicates two competing concepts under the ERISA preemption analysis: (1) the review is used to determine the plan participant's benefits available under the plan which is a "quantity" question, and (2) the review is used to make a medical decision which is a "quality" question.\textsuperscript{121} In balancing these two competing concepts, the \textit{Corcoran} court held that the medical decisions made under the utilization review procedure were "part and parcel" of its benefits determination.\textsuperscript{122} Accordingly, the court concluded that claims based upon negligent utilization review procedures were preempted by ERISA.\textsuperscript{123} Other courts have held likewise.

For example, in \textit{Turner v. Fallon Community Health Plan}, Charlotte Turner was diagnosed with breast cancer and her oncologist determined that she required a bone marrow transplant.\textsuperscript{124} The oncologist recommended that Mrs. Turner enroll in the Dana Farber Cancer Institute's transplant program, but she did not meet their eligibility requirements.\textsuperscript{125} Dana Farber recommended that Mrs. Turner enroll in Duke University's transplant program, but Mrs. Turner's HMO only covered bone marrow transplants for certain diseases, not including the type of solid cancer tumors that Mrs. Turner had.\textsuperscript{126} In response to Mrs. Turner's request to amend their utilization review process to add breast cancer to its covered procedures, the HMO reviewed its protocols and extended its coverage to solid cancer tumors, but only when the patient met Dana Farber requirements.\textsuperscript{127} The HMO's decision effectively precluded Mrs. Turner from receiving the needed treatment.\textsuperscript{128} After Mrs. Turner's unsuccessful final appeal to her HMO for coverage of the Duke program, she began chemotherapy but died ten months later.\textsuperscript{129} The \textit{Turner} court held that the majority rule with respect to claims against utilization re-

\textsuperscript{120} \textit{Id.} at 1324 (quoting United HealthCare's utilization review information booklet).
\textsuperscript{121} See \textit{id.} at 1332.
\textsuperscript{122} \textit{Id.}
\textsuperscript{123} \textit{Id.}
\textsuperscript{125} See \textit{id.} at 420-21.
\textsuperscript{126} See \textit{id.} at 421.
\textsuperscript{127} See \textit{id.}
\textsuperscript{128} See \textit{id.}
\textsuperscript{129} See \textit{id.}
view procedures is that they are preempted by ERISA, and thus concluded that the Turner's claim was preempted.\(^{10}\)

In *Roessert v. Health Net*, the court summed up the rule by stating that claims are preempted by ERISA if the negligent medical advice is "inextricable" from the actions of coordinating benefits under an employee benefit plan.\(^{11}\) Utilization review procedures are viewed as "inextricable" from the coordination of benefits, and thus are preempted by ERISA, in all but one state. California explicitly permits a claim for a negligent medical decision made in the course of the utilization review process.\(^{12}\)

The practical effect of insulating utilization review from claims by injured parties is that it gives HMOs incentives to deny medical procedures in order to save the expense of the procedures, and at the same time it removes any deterrence the HMO may have from potential claims for negligently denying a procedure.\(^{13}\)

### IV. LEGISLATIVE, JUDICIAL, POLITICAL, AND POPULAR REACTION TO THE INEQUITABLE CONSEQUENCES OF ERISA PREEMPTION

The HMO horror stories, and concomitant lack of liability for the resulting wrongdoing, has made ERISA preemption a hot topic in the courts, in the legislatures, and on the campaign trail. As one pundit observed, "'[t]his issue has become a no-brainer politically' . . . 'you have an industry that can't be sued when you can sue your neighbor for running over your lawn.'"\(^{14}\) The issue has prompted action in Texas, Congress, and in the 1998 fall elections.

#### A. The Beginning of the End? One State's Attempt to Push the Preemption Envelope

In September 1997, the Texas legislature enacted Texas Civil Practice and Remedies Chapter 88 ("Chapter 88").\(^{15}\) Chapter 88 allows

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133. *See id.* at 1338.
HMO enrollees to sue their HMO for failing to use "ordinary care when making health care treatment decisions"—allowing HMOs to be sued for malpractice. Under the statute, the HMO may be found liable for damages for harm to enrollees "proximately caused" by the health care treatment decisions of its employees, agents, ostensible agents, or representatives. Additionally, Chapter 88 restrains an HMO from removing a health care provider from its plan, or refusing to renew their contract with the provider, on the grounds that the "health care provider advocated on behalf of [the patient] for appropriate and medically necessary health care." This provision reflects the concern of lawmakers over a common practice of HMOs whereby the plan threatens health care providers with termination from the plan if they are deemed to be giving patients excessive or more expensive medical care than the plan authorizes. A threat of contract termination provides a strong incentive to physicians whose practices commonly depend upon HMO contracts to survive.

Chapter 88 also bans all "indemnification" and "hold harmless" clauses in contracts between HMOs and physicians. This provision protects physicians from another common HMO practice which leaves a physician "holding the bag" for substandard medical care. For example, an HMO may order a physician to abstain from doing a certain procedure through utilization review procedures which ultimately turns out to be medically necessary. Thereupon, the "hold harmless" provision in the HMO contract leaves the doctor solely liable for the consequences of the decision. Additionally, Chapter 88 precludes HMOs from using the defense that they are "not licensed to practice medicine" in order to avoid liability when faced with a medical malpractice action.

Chapter 88 also delineates the procedure to be used by HMO participants when seeking the remedies available under the statute. The statute requires a party to either exhaust the appeals available under the plan or give written notice of his or her claim, together with an agree-
ment to submit the claim to independent review, to the HMO before in-
stituting legal action against an HMO.\footnote{144} If the complained of injury has already occurred, a court may waive the independent review require-
ment of the statute.\footnote{145} Finally, if following the procedures outlined in the statute would place the plan participant’s health in “serious jeopardy,” the statute allows him to bypass the notice and review requirements and pursue other remedies including injunctive relief, declaratory relief, or any other available legal relief.\footnote{146}

One commentator outlines how the typical case would move through Chapter 88 procedures as follows:

1. The HMO refuses to pay for a medical procedure, finding, for example, that the treatment is not medically necessary.
2. The HMO member appeals within the health organization.
3. If the member loses, he or she appeals to an Independent Re-
view Organization [“IRO”], a private company chosen by the state Department of Insurance.
4. If the IRO finds that the treatment is medically necessary, the HMO must pay. If the member loses, he or she may sue in state court.
5. To prevail in court, the member must show that the HMO failed to use ordinary care when deciding to deny treatment.
6. If the HMO’s failure to pay harmed the member, he or she can sue for compensatory and punitive damages. A court can waive IRO review if the injury has already occurred.\footnote{147}

Texas has, in effect, legislatively enacted the federal court decisions that have held that HMOs could be held liable for the acts of their ost-
tensible agents,\footnote{148} and for utilization review decisions.\footnote{149}

The new law was promptly challenged by several health plans doing business in Texas.\footnote{150} In Corporate Health Insurance, Inc. v. Texas De-
partment of Insurance, the health plans sought a declaration that Chap-

145. See id. § 88.003(e)(1).
146. Id. § 88.003(g).
148. See supra Part III.B.
149. See supra Part III.C.
ERISA PREEMPTION

Chapter 88 was preempted by ERISA and an injunction enjoining the enforcement of Chapter 88. Accordingly, the main task of the court was to determine whether Chapter 88 was preempted by ERISA.

The Corporate court first determined that Chapter 88 could not be saved from preemption via the “insurance saving clause” of ERISA. The “insurance saving clause” provides that “nothing in [ERISA] shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . . .” The “insurance saving clause” test was enunciated by the Supreme Court in Metropolitan Life Insurance Company v. Massachusetts. Under the test, the first inquiry is whether the offending regulation fits within the “‘common sense definition of insurance regulation.’” If the answer is “yes,” the court moves on to the second part of the test. The second inquiry under the test is “‘(1) whether the practice [regulated] has the effect of spreading policyholder’s risk; (2) whether the practice [regulated] is an integral part of the policy relationship between the insurer and the insured; and (3) whether the practice [regulated] is limited to entities within the insurance industry.’” If the court answers “yes” to all three factors, the statute is saved from preemption by the “insurance savings clause” of ERISA. Because Chapter 88 was not “limited to entities within the insurance industry,” as it explicitly specified that it also applied to “health maintenance organizations” and “other managed care entities,” the Corporate court found that it could not be saved from ERISA preemption under this particular test.

The Corporate court then turned to the specific preemption provision of ERISA: § 1144(a). The court’s first question under this analysis was whether, in fact, Chapter 88 regulated ERISA plans. The court concluded that Chapter 88 did not regulate ERISA plans because the Texas legislators defined a “managed care entity” as one that “[did] not

152. Id. at 607.
156. See id.
157. Id. (quoting Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 741-47 (1985)).
158. See id.
159. Id.
160. See id.; supra Part II.C.2.
161. See id. at 607-08; see also supra Part II.C.2 (discussing § 1144(a)).
include an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer." Because the principal definitive feature of an ERISA plan is that it is "established or maintained by an employer," the court found that the careful crafting of Chapter 88 enabled it to avoid being found to regulate ERISA plans.

Notably, the plaintiffs in Corporate were not ERISA plans. However, ERISA challenges by HMOs are not necessarily made on the HMO's own behalf. Instead, the non-ERISA HMO hopes that because the regulation may affect an ERISA plan, it can quash the challenge via ERISA preemption and thereby benefit from the resulting diminishment of regulation on the whole in the industry.

Having concluded that Chapter 88 did not directly regulate ERISA plans, the Corporate court next considered whether the statute was "related to" ERISA plans. As the Supreme Court reiterated recently in DeBuono v. NYSA-ILA Medical & Clinical Services Fund, the "relate to" language in ERISA "was not intended to modify the 'starting presumption that Congress does not intend [ERISA] to supplant state law' which falls within areas of traditional state regulation." The Corporate court adjudged that Chapter 88's regulation of "medical decisions [by] health insurance carriers, health maintenance organizations, and other managed care entities" was clearly in an area traditionally regulated by the states. Accordingly, the court again concluded that Chapter 88 was saved from preemption because it did not improperly "relate to" an ERISA plan.

The Corporate court then conducted a lengthy analysis of "quantity" versus "quality" ERISA challenges. Applying the analysis to Chapter 88, the court concluded that a suit may be brought under Chapter 88 that solely challenged the "quality" of health care received without im-

162. Corporate Health Ins., Inc., 12 F. Supp. 2d at 609 (quoting TEX. CIV. PRAC. & REM. CODE ANN. § 88.001(8)) (emphasis omitted).
163. Id. at 609-10 (emphasis added).
164. See id. at 610.
165. See generally id.
166. See Corporate Health Ins., Inc., 12 F. Supp. 2d at 610; see also supra Part II.C.2.
168. Corporate Health Ins., Inc., 12 F. Supp. 2d at 611 (internal quotes omitted).
169. Id. at 611.
170. See id. at 614-19; see also Part III (discussing "quality" versus "quantity" challenges).
plicating "quantity." Accordingly, the court once more concluded that Chapter 88 escaped ERISA preemption.

ERISA preemption may also occur if a regulation impermissively mandates the structure or administration of employee benefits. After analyzing whether Chapter 88 mandated the structure or administration of employee benefits, the Corporate court concluded that some of its provisions in fact did. The court found that Chapter 88's independent review process and its provisions that prohibited certain contract clauses between HMOs and health care providers were preempted by ERISA. However, because these provisions were severable, the court severed them from Chapter 88 rather than invalidating the entire chapter.

In sum, the Corporate court gutted the independent review provision of Chapter 88 and invalidated the mandatory physician/HMO contract clauses. However, significant and important provisions of the chapter remain. In Texas, a party injured by an HMO has statutory authority to sue the plan for malpractice. As previously discussed, several federal courts have allowed suits to be brought against HMOs for the negligence of their employees, agents, and representatives. Several other circuits, however, maintain that such a cause of action is preempted by ERISA. Nonetheless, the final analysis may be forthcoming as the Corporate parties have appealed to the Supreme Court for relief. This feud has not deterred other state legislatures from considering a similar law for themselves. New York, Florida, Arizona, Connecticut, and California are considering similar legislation.

B. Other Popular and Political Reaction

Suing HMOs for malpractice is a popular idea in the United States. One poll revealed that 73 percent of Americans favor a law that would allow patients to sue HMOs for malpractice. One commentator ar-

171. See Corporate Health Ins., Inc., 12 F. Supp. 2d at 619.
172. See id. at 620.
175. See id. at 628.
176. See supra Part IIIB (regarding how some federal courts have allowed suits to be brought against HMOs for the negligence of their employees, agents, or representatives).
179. See id.
gues that "[i]n managed care, all of the economic incentives are for denying care. What an HMO liability law does is make an HMO have to think twice about denying care."

The idea of holding HMOs accountable is also politically popular. The "Patient Protection Act" which passed the House 216 to 210, amends certain provisions of ERISA and would ensure some patient rights that have traditionally been preempted by ERISA including:

1. Requiring HMOs to cover emergency room care.
2. Requiring HMOs to allow participants to choose their own pediatrician, obstetrician, and gynecologist.
3. Prohibiting HMOs from using "gag orders" in their contracts with doctors that prevent doctors from advising their patients about more costly treatments.
4. Imposing $500 per day fines (up to $250,000) on HMOs for improperly denying coverage for health care.

Democrats have also proposed similar legislation, the notable difference being that their plan would allow patients to sue their HMOs for malpractice. Many sources predict that there will be some legislative movement on this issue this year.

Critics of an HMO liability law contend that allowing malpractice suits against HMOs will increase litigation and drive up the cost of health care generally. However, thus far the Texas experience does not support this contention.

V. CONCLUSION AND PROPOSAL FOR CHANGE

Probably the most persuasive argument for disallowing HMO liability laws is the original intent of ERISA: to avoid a "patchwork scheme

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181. Miller, supra note 180, at B7.
183. See Politics & Policy Patients' Rights: Positions Solidify as Issue Heats Up, 6 A.M. POL. NETWORK no. 9, at 5 (Feb. 18, 1999); Chafee Unveils Centrist, Bipartisan Managed Care Reform Legislation, FEDERAL CLEARING HOUSE GOV'T PRESS RELEASE (Feb. 4, 1999); Andy Miller, Doctors Angry at HMOs, Insurers Frustration Over Trimmed Fess, Unpaid Claims Has Spawned Proposed Legislation, ATLANTA J. & CONST., Jan. 31, 1999, at H01; Poll: Public Backs HMO Reform, Even With Higher Cost, CONGRESS DAILY, Jan. 14, 1999.
of regulation" among the states. National HMOs would have a strong argument against such laws, as their costs would increase as they are forced to comply with varying standards between states. This is the exact outcome that Congress attempted to avoid in enacting ERISA.

For this reason, individual state HMO liability laws such as Texas's Chapter 88 are probably not the best solution even though it would rectify most of the inequities in ERISA preemption results.

Instead, this Comment proposes that Congress step in and amend ERISA to preserve the intent of its authors—to protect employees and their benefits. Congress is able, on a national level, to institute provisions to protect HMO participants from injuries sustained from the immune acts of these plans.

As stated by one court, "the landscape of employee benefit plans has shifted dramatically in the . . . 23 years" since Congress enacted ERISA.

For one thing, Congress probably did not foresee that HMOs would run the whole show, including the doctors and the hospitals, which allows them to insulate the whole medical spectrum by invoking ERISA preemption. Congress probably also did not foresee that HMOs would implement cost containment practices such as utilization review, which substitute medical judgment with "nationally accepted medical guidelines" which likewise insulate an HMO from liability. Congress probably did not foresee that it was leaving an enormous gap in which seriously—sometimes fatally—injured parties are left with no remedy for the culpable behavior of HMOs. Finally, Congress probably did not foresee that HMOs would not be deterred from making substandard medical decisions by the fact that injured parties would be unable to pursue a remedy against the erring HMO.

In the best case scenario, Texas's nascent attempt to regulate the inequities of ERISA preemption will prompt Congress to continue its efforts to secure patient rights.

As was mentioned in the Introduction to this Comment, the Visitantis successfully avoided ERISA preemption because they challenged the quality of care they received from their HMO. They were also fortu-
nate enough to have been heard by a court that was willing to allow the state court to entertain a vicarious liability theory against the HMO for the acts of its ostensible agents. The Corcorans, on the other hand, challenged the utilization review process of their HMO, and even though the quality of the health care they received was gravely affected by the quantity of care they were allowed under their HMO plan, they were left without a remedy. Congress should act to eliminate the arbitrary distinctions between these cases which caused such disparate results. An HMO should not be subject to a different set of standards in each state in which it operates, as may be the case if the Texas law is allowed to stand and other states follow suit. However, neither should HMOs be allowed to completely insulate medical care from legal remedies simply by blanketing the different aspects of medical care in their ERISA cloak.

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192. See id.
193. See Corcoran, 965 F.2d at 1338.