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The States, Congress, *or* the Courts: Who Will Be First To Reform ERISA Remedies?

Curtis D. Rooney*

INTRODUCTION

Across the nation, state legislatures, Congress, and the courts have begun to consider the questions surrounding the Employee Retirement Income Security Act's ("ERISA") remedies and preemption provisions.¹ To date, the courts have sent mixed signals to patients who want to sue managed care organizations ("MCOs")² for state law claims when beneficiaries receive their health care through an employee benefit plan governed by ERISA.³ In many jurisdictions MCOs have escaped state tort lia-

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1. *See generally* Patient Access to Responsible Care Act, H.R. 1415, 105th Cong. (1997), S. 644, 105th Cong. (1997) (sponsored by Rep. Charles Norwood (R-Ga.) and Sen. Alphonse D'Amato (R-N.Y.)); *see also* Employee Health Insurance Accountability Act of 1997, S. 1136, 105th Cong. § 1 (1997) (sponsored by Sen. Richard Durbin (D-Ill.)); Managed Care Plan Accountability Act of 1997, H.R. 1749, 105th Cong. (1997) (sponsored by Rep. Pete Stark (D-Cal.)); *Rice v. Panchal*, 65 F. 3d 637 (7th Cir. 1995); *Pacificare of Okla. v. Burrage*, 59 F.3d 151, 153 (10th Cir. 1995); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 351 (3d Cir. 1995); Health Care Liability Act, TEX. CIV. PRAC. & REM. CODE ANN., § 88 (West 1998).

2. Managed care organization ("MCO") refers to an entity that provides a variety of health insurance products, including health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), and point-of-service ("POS") plans.

3. Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1144 (1997). ERISA applies to both employee pension and welfare benefit plans, including health benefit plans. In general, ERISA applies to employee benefit plans that are not offered by governments or churches, and are not established mainly to comply with worker's compensation, unemployment compensation, or disability insurance laws. *See id.* Under ERISA, an employee benefit plan is any entity that meets the following definition:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which is heretofore or is hereafter established or maintained by an employer or by any employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or

bility by successfully asserting that ERISA preempts such actions when they "relate to" an employee benefit plan.⁴ To support these holdings, some courts have cited the corporate practice of medicine bar that exists in many states.⁵

By characterizing the dispute as a "benefits claim" rather than a determination of "medical necessity,"⁶ defendants have successfully used ERISA's preemption provisions as a shield to avoid state law remedies such as extracontractual, compensatory, and punitive or exemplary damages.⁷ In addition, ERISA's preemption provisions have also led to the growth of self-insured plans (and the subsequent decline in the use of insured plans). Employers have found it more affordable to self-insure because under ERISA, states may regulate only the terms of the insurance products purchased by employers; they may not regulate the contents or administration of self-insured plans.⁸ Although the U.S. Supreme Court's recent decision in *Travelers v. Cuomo*⁹ may indicate a new direction in ERISA preemption jurisprudence, jurists continue to labor over providing adequate

hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in [section 302(c) of the Labor Management Relations Act of 1947](other than pensions on retirement or death, and insurance to provide such pensions) . . . (5) The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.

Id. § 1002 (1), (5).

4. See ADVOCACY RESOURCE CENTER, AM. MED. ASS'N, TRENDS IN MANAGED CARE LIABILITY: A CHANGING LEGAL AND LEGISLATIVE LANDSCAPE (1997).

5. See *id.* For a discussion of corporate practice of medicine statutes, see NATIONAL HEALTH LAW ASS'N & AM. ACAD. OF HEALTHCARE ATT'YS, PATIENT CARE AND PROFESSIONAL RESPONSIBILITY: IMPACT OF THE CORPORATE PRACTICE OF MEDICINE DOCTRINE AND RELATED LAWS AND REGULATIONS (1997).

6. See, e.g., *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1333 (5th Cir. 1992) (holding that state malpractice and wrongful death claims against an HMO were preempted under ERISA). In that case, the alleged wrongful death and malpractice resulted from the HMO's denial of precertification of hospital admission despite the recommendation of the treating physician. See *id.* See also Edward B. Hirshfeld & Gail H. Thomason, *Medical Necessity Determinations: The Need for a New Legal Structure*, 3 HEALTH MATRIX 42-43 (1996).

7. See Gabriel J. Minc, *ERISA Preemption of Medical Negligence Claims Against Managed Care Providers: The Search for an Effective Theory and an Appropriate Remedy*, 29 J. HEALTH & HOSP. L. 97, 100-01 (1996).

8. See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 958 (1985).

9. *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 717 (2d Cir. 1994), *rev'd sub nom.* *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 668 (1995).

remedies under the law. Exacerbating the confusion is the rapid merger of health care delivery and finance systems, the widespread use of utilization review, the growth of managed care, and the subsequent public backlash against it.¹⁰

Given this environment, the time has come for both managed care reform and ERISA reform.¹¹ Although ERISA has been amended numerous times since its inception,¹² attempts to change the exclusive damages and preemption provisions have met with considerable controversy.¹³ Not since the death of the Clinton health care plan has the time been so ripe for reform. While recent developments suggest that some type of change may be imminent, the question remains: Who will be the first to reform ERISA's remedies provisions, the states, Congress, or the courts?

The legal and policy issues surrounding ERISA and ERISA preemption have been referred to as a veritable "Sargasso sea of obfuscation."¹⁴ This Article will attempt to break through the morass and provide a clearer definition of ERISA-related problems and concerns. Parts I and II will provide a brief background describing the historical significance of the statute and an explanation of the effect of ERISA on managed care. Part

10. See Amy Goldstein, *Managed Care Is Trusted Less, Survey Shows*, WASH. POST, Nov. 6, 1997, at A17 (reporting on survey sponsored by Henry J. Kaiser Family Foundation and Harvard University).

11. See *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 56 (D. Mass. 1997).

12. For example, the Consolidated Omnibus Budget Reconciliation Act ("COBRA") amended ERISA to provide for the continuation of benefit coverage for specified periods for employees no longer employed. In addition, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") amended ERISA and was itself amended shortly after its enactment to include new federal requirements relating to minimum hospital maternity stays. See Pub. L. No. 104-191, 110 Stat. 1936 (1996). HIPAA also amended provisions relating to the parity of mental health benefits. See Pub. L. No. 104-204, 110 Stat. 2874 (1996).

13. For an example of a failed attempt at Congressional ERISA reform, see S. 794, 102d Cong. §§ 1 (1991), introduced by Senator Howard Metzenbaum (D-Ohio) in April of 1991. The bill was designed, in part, to amend ERISA § 514(b)(2)(A) to save from preemption any statute or common law that provides a remedy against insurance companies regarding such companies' practices in administering employee benefit plans or processing insurance claims. See 137 CONG. REC. 4246 (1991) (statement of Sen. Metzenbaum). Representative Howard Berman (D-Cal) introduced the companion bill in the House of Representatives. See H.R. 1602, 102d Cong. § 2 (1992); see also H.R. 6137, 102d Cong. (1992), which would have given plan participants and beneficiaries a "vested" right to existing benefit levels for the treatment of their existing illness.

14. *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 717 (2d Cir. 1994), *rev'd sub nom.* *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 668 (1995).

III will emphasize ERISA's sweeping preemption provisions, and Part IV will offer a general overview of the major preemption cases. Part V will provide specific examples of ERISA preemption provisions as they relate to medical malpractice claims. Next, Part VI will delineate the various state and federal ERISA reform proposals. Finally, Part VII will conclude by offering a number of alternatives to restore some much needed fairness to patients under ERISA.

I. BACKGROUND

The passage of ERISA in 1974 marked the culmination of approximately a decade of investigations into abuses in the nation's pension system.¹⁵ As a result of the wage and price controls imposed during World War II, employee benefit plans became increasingly popular in the 1940s.¹⁶ Employers utilized employee benefit plans as a supplement to wages and as a means to attract and keep a skilled workforce. In the 1960s, unfavorable media reports of employees unfairly losing their pension benefits earned the attention of John F. Kennedy early in his presidency.¹⁷ At the time, President Kennedy recognized that there was not sufficient regulation of these plans and appointed the Commission on Corporate Pension Funds to study the issues and to make recommendations.¹⁸ The report and recommendations of that commission created an appreciable amount of congressional interest in federal legislation.¹⁹

When Congress enacted ERISA in 1974, it created an almost unprecedented preemption provision. In general, ERISA's preemption provisions supersede all state laws that "relate to" employee benefit plans.²⁰ In addition, Congress created a number of requirements aimed at protecting employee pension benefits from mismanagement, fraud and abuse, and employer bankruptcies under ERISA. The law contains reporting²¹ and disclosure

15. See ERISA, 29 U.S.C. § 1001 (1997) (stating Congress's intent in passing ERISA).

16. See John N. Erleborn, *Foreword* to G. LAWRENCE ATKINS & KRISTIN BASS, ERISA PREEMPTION: THE KEY TO MARKET INNOVATION IN HEALTH CARE (1995).

17. See *id.*

18. See *id.*

19. See *id.*

20. See ERISA, 29 U.S.C. § 1144 (1997).

21. *But see* Taxpayer Relief Act of 1997, Pub. L. No. 105-34, 111 Stat. 788 (1997). This Act modifies ERISA such that sponsors of employee benefit plans are no longer required to file summary plan descriptions and summary material modifications with the Department of Labor. See *id.* The new law does require, however, that such

criteria, fiduciary requirements,²² and a civil enforcement scheme²³ that limits employer liability. Congress also sought to encourage the formation of employer plans through the use of incentives in the Internal Revenue Code.²⁴ During the debate over ERISA, sponsors of employee benefit plans, including health and welfare plans and organized labor, expressed concern that “a patchwork of regulation and remedies would discourage the adoption and maintenance of such plans.”²⁵

As the legislative history of ERISA shows, both the Senate and House bills originally contained preemption clauses. In fact, the conference committee, the committee responsible for resolving the differences between the two bills, included a preemption clause that was even broader than either of the two original measures. Representative John Dent (D-Pa.), one of the original authors of ERISA, stated:

I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority [of] the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation.²⁶

In support of this view, the Supreme Court has stated, “[t]he basic thrust of the preemption clause . . . was to avoid multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.”²⁷ Included in this scheme are ERISA’s comprehensive civil enforcement provisions. The civil enforcement provisions were created to allow a participant or beneficiary enrolled in an employer plan to seek recovery for denied benefits. However, the Supreme Court has

documents be filed upon the request of the Department within 30 days of the origination of the request. *See id.*

22. *See* ERISA, 29 U.S.C. §§ 1021-1031 (1994) (stating ERISA reporting and disclosure rules); 29 U.S.C. §§ 1051-1061 (stating ERISA fiduciary rules).

23. *See* 29 U.S.C. § 1001(b).

24. *See* I.R.C. § 105(h) (1997). The exclusion of employer contributions to self-insured health plans and plan benefits from the taxable income of highly compensated participants is dependent upon the plan meeting the nondiscrimination requirements of IRC § 105(h). *See id.* These provisions require that self-insured plans not discriminate in favor of highly compensated employees in either plan eligibility or provision of benefits. *See id.* To the extent that excess reimbursement is provided to highly compensated employees, the amount of the excess becomes taxable to the employee. *See id.*

25. *See supra* notes 11-13 and accompanying text.

26. 120 CONG. REC. 29,197 (1974).

27. *See* *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 718 (2d Cir. 1994).

held that any state law claims to recover from an ERISA plan are preempted under section 502(a)(1)(B), which provides the exclusive remedies available under ERISA.²⁸ The Supreme Court has sought to shed light on the question of ERISA pre-emption in well over a dozen cases, and Justice Antonin Scalia in his concurring opinion in *Dillingham Construction*²⁹ seems to indicate where the Court has been and where it may be going on this important issue. In that opinion Scalia writes:

I think it would greatly assist our function of clarifying the law if we simply acknowledged that our first take on this statute was wrong; that the "relate to" clause of the pre-emption provision is meant, not to set forth a test for pre-emption, but rather to identify the field in which ordinary field pre-emption applies Our new approach to ERISA pre-emption is set forth in *John Hancock Mut. Life Ins. Co v. Harris Trust and Sav. Bank*, 510 U.S. 86, 99 (1993): I think it accurately describes our current ERISA jurisprudence to say that we apply ordinary field pre-emption, and, of course, ordinary conflict pre-emption.³⁰

It is doubtful, however, that the Supreme Court or the framers of ERISA could have foreseen in 1974 the tremendous growth of managed care and the use of self-insurance by employers in the 1990s. The Department of Labor estimates that about 125 million Americans are provided health insurance benefits through an ERISA plan.³¹ While many of these plans are fully insured, a report by the General Accounting Office ("GAO") estimated that 44 million Americans are in self-insured health plans that cannot be regulated by the states.³² The GAO also reported that 140 million individuals (54% of the U.S. population) obtained coverage through the employment-

28. *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 144 (1985). In addition, the Supreme Court held that even if the participant can prove that the delay or denial constituted a breach of fiduciary responsibility, ERISA only allows for the recovery of "appropriate equitable relief," a term construed not to include any sort of damages or restitution for losses. *See id.*

29. *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 117 S.Ct. 832, 843 (1997).

30. *Id.*

31. *Pension Welfare Benefit Admin.*, U.S. Dep't of Labor, Fact Sheet (August 1997).

32. *See U. S. GEN. ACCT. OFF., EMPLOYER-BASED HEALTH PLANS: ISSUES, TRENDS AND CHALLENGES POSED BY ERISA 9* (1995 [hereinafter GAO REPORT]). Note, however, that this number may be declining. *See Beth C. Fuchs, Managed Health Care: Federal and State Regulation*, CONG. RES. SERVICE, (October 8, 1997).

based system.³³ A more recent study suggests that 85% of those in the employment-based system are enrolled in some form of managed care.³⁴ So much variation in the health care system raises increasing concerns regarding the appropriate level of consumer protection under federal and state laws that govern private-sector employee health coverage.³⁵

II. WHAT IS "MANAGED CARE?"

"Managed care" is a term that generally means "a system of payment or delivery arrangement where the health plan attempts to control or coordinate use of health services by its enrolled member in order to control spending and promote health."³⁶ While there is no single definition of managed care, this description suggests a continuum of care in which patients are afforded a varying degree of choice of physicians and providers. The definition also suggests a system that ranges from more or less financial responsibility required of patients, with another scale of financial risk for providers, plan sponsors, and insurers of health care services.

In the past, the only type of arrangement that offered managed care was a health maintenance organization ("HMO").³⁷ Now, MCOs come in many different shapes and forms. For example, a preferred provider organization ("PPO") may be likened to a health care broker that provides discounted health services directly or through a third-party payor. A provider-sponsored organization ("PSO") is another form of managed

33. See GAO REPORT, *supra* note 32, at 10. The GAO study found that 54% of the population is covered by the employment-based system, and has coverage through an ERISA-governed plan. See *id.* While GAO estimated that 44% of the U.S. population (114 million individuals) was covered by an ERISA plan, another 10% in the employment-based system was exempt from ERISA (e.g., government and certain not-for-profit organization plans). See *id.* ERISA also governs some multiple-employer welfare arrangements ("MEWAs"). See *id.* Other members of the population maintain coverage through Medicare (12%), Medicaid (9%), other government programs such as the Veterans Administration system and CHAMPUS (2%), or individually purchased coverage (8%). See *id.*

34. See *12th Annual Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans*, News Release (Jan. 20, 1997) [hereinafter *Mercer/Foster Higgins Survey*]; see ALSO *Improving Health Care Quality in an Industry in Transition*, Report of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, draft chapter.

35. Patricia Butler & Karl Polzer, *Private-Sector Health Coverage: Variation in Consumer Protections under ERISA and State Law*, in *Nat'l Health Pol'y Forum* 6 (1996).

36. Fuchs, *supra* note 32.

37. See *id.*

care that, like the PPO, offers patients a greater degree of choice.

In addition, many HMO products now offer patients a point-of-service ("POS") option that gives them the ability to seek medical care from providers outside of the network more freely. In exchange for this added choice, patients are charged an additional premium. POS options generally require patients to have a primary care "gatekeeper" physician who monitors referrals and is paid on a capitated basis. While there are a number of organizational types of HMOs, such arrangements traditionally have been associated with entities that provide services through a network. In general, enrollees in managed care plans are given financial incentives to use services within the plan's provider network, but still receive some coverage even if they obtain care from outside providers. However, enrollees who seek services outside the network will be forced to pay higher copayments and deductibles.

On the provider side, MCOs often provide physicians with financial incentives, such as capitation and withhold arrangements, which may effectively reward physicians for limiting referrals to specialists and limiting the number of tests and procedures provided to patients. In general, under the fee-for-service system, physicians and health care providers operated with an incentive to order more tests and offer more procedures than may have been necessary. In contrast, the incentives under managed care are just the opposite. One of the main criticisms of managed care is that patients may be harmed or receive inadequate care in a system that rewards the limitation or underuse of health care services.³⁸

In recent history, employers have fled fee-for-service insurance in favor of managed care products because of the promise of reduced costs associated with managed care. Employers were especially concerned about the rising cost of health care experienced nationally in the late 1980s and early 1990s. Today, managed care has become the dominant form of health care delivery in the country.³⁹ The form of MCOs, of course, varies. Because it is not always clear what form of managed care is being de-

38. See *Lancaster v. Kaiser Found. Health Plan, of Mid-Atlantic States, Inc.*, 958 F. Supp. 1137, 1145 (E.D. Va. 1997); see also *Shea v. Esenstein*, 107 F.3d 625, 628 (8th Cir.), cert. denied, 118 S. Ct. 297 (1997) (stating that HMO had a duty to disclose its financial incentive structure).

39. See *Mercer/Foster Higgins Survey*, *supra* note 34.

scribed, efforts have been made to clarify this situation. For example, one proposed taxonomy⁴⁰ categorizes health insurance products in health plans by whether their sponsor assumes financial risk, whether an intermediary assumes financial risk, whether the associated physicians assume financial risk, whether consumers are restricted in the providers they may select, whether significant utilization controls are placed on providers' practices, and whether plans are obligated to arrange for care provision, versus paying for any care received.⁴¹

While such efforts to accurately characterize managed care may be helpful, in general they have not made deciphering the rights and responsibilities of patients, providers, and plans any more meaningful for courts tasked with deciding remedies issues. This has been especially true when the managed care plan is offered by an employer governed by ERISA that preempts state laws. When an employee benefit plan contracts with an MCO to provide health care services, the MCO acts in the capacity of the plan's administrator and therefore is often a fiduciary under ERISA.⁴² As such, the MCO is allowed to utilize the full force and power of ERISA's preemption provisions.⁴³ MCOs have been squarely criticized for hiding behind ERISA as a shield,⁴⁴ and the Department of Labor has submitted *amicus curiae* briefs in support of plan participants and beneficiaries.⁴⁵

40. See Subcomm. on Roles and Resp. of Pub./Private Purchasers and Quality Oversight Org. of the Comm'n on Consumer Protection and Quality in the Health Care Industry, 105th Cong. (1997) (statement of Marc I. Machiz, Assoc. Solicitor for Plan Benefits Security). "In its *amicus* briefs, the Department has argued, and the courts have largely agreed, that malpractice claims are not preempted under the doctrine of complete preemption discussed in the *Pilot Life* case because such claims arise from the provision of health care, not from denial of a benefit." *Id.*

41. Jonathan P. Weiner & Gregory deLissovoy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. HEALTH POL. POL'Y & L. 75, 82-85 (1993).

42. See ERISA, 29 U.S.C. § 1104 (1998).

43. See 29 U.S.C. § 1104(3)(16)(A)(i). Under section 3(16)(A)(i) of ERISA, a plan administrator constitutes a fiduciary (as defined in section 3(21)(A)). The MCO is considered a fiduciary because it may exercise discretionary authority and control over the ERISA plan's assets, and exercises discretionary authority and responsibility in the administration of the plan. See *id.*

44. See THE CAMPAIGN FOR HEALTH CARE ACCOUNTABILITY ISSUE PAPER/MEDIA BACKGROUNDER, Fall 1997.

45. See *supra* note 40.

III. FEDERAL JURISDICTION, ERISA PREEMPTION AND REMEDIES

The tangle of terminology ensnaring the term “ERISA preemption” has engendered a considerable amount of litigation. A thorough comprehension of the issue of remedies requires not only a familiarity with the specific remedies available under ERISA, but also a general understanding of the dimensions of ERISA’s preemption of state laws. In general, ERISA preemption means that any state law that “relates to” an employee benefit plan is preempted.⁴⁶ A more specific discussion of ERISA’s preemption and its remedies provisions is offered below.

A. Section 514 Preemption

Under section 514(a), ERISA supersedes “any and all state laws insofar as they may now or hereafter relate to any employee benefit plan” as defined under Title 1 of ERISA.⁴⁷ This general rule contains the following exceptions:

- Section 514 (b)(2)(A), known as the “savings clause,” states that “any law of any State which regulates insurance, banking or securities”⁴⁸ is not preempted.
- Section 514(b)(B) known as the “deemer clause” states that “neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance for purposes of any law of any State purporting to regulate insurance companies.”⁴⁹

As the Supreme Court has stated:

If a state law “relate[s] to . . . employee benefit plans,” it is pre-empted. § 514(a). The savings clause excepts from the pre-emption clause laws that “regulat[e] insurance.” § 514(b)(2)(A). The deemer clause makes clear that a state law that “purport[s] to regulate insurance” cannot deem an employee benefit plan to be an insurance company. § 514(b)(2)(B).⁵⁰

46. See 29 U.S.C. § 1144 (a).

47. *Id.* § 1144(b)(2)(B).

48. *Id.* § 1144(b)(2)(A) (1998). State law, defined in section 514(c)(1) of ERISA, “includes all laws, decisions, rules, regulations, or other State action having the effect of law.” *Id.*

49. *Id.* § 1144(b)(2)(B).

50. *Pilot Life Ins. Co. V. Dedeaux*, 481 U.S. 41, 45 (1987).

The question whether a certain state action is preempted by federal law is one of congressional intent. The purpose of Congress is the ultimate touchstone.⁵¹

B. Section 502 (a)(1) (B) Remedies

Regarding remedies, a plaintiff may bring suit under ERISA section 502(a)(1)(B) to recover benefits under the terms of an ERISA plan or to enforce or clarify the plaintiff's rights under an ERISA plan.⁵² This section provides a comprehensive civil enforcement scheme and generally preempts state law.⁵³ Under section 502(a)(1)(B), a plaintiff may bring suit in either state or federal court,⁵⁴ yet this provision is the exclusive remedy for civil claims under ERISA.⁵⁵ As noted above, recovery is limited to either the cost of the benefit denied, or a declaratory judgment or injunction directing the ERISA plan to provide benefits to the plaintiff.⁵⁶ As discussed below, a number of courts have sought to circumvent the preemptive effect of this provision of ERISA, with mixed results.

It is interesting to note that Congress expected that the courts would establish a federal common law to assist in the enforcement of ERISA. Congress stated that “[i]t is also intended that a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under the private welfare and pension plans.”⁵⁷ Unfortunately, the courts have, by and large, hesitated to follow this mandate.

51. See *id.* (citing *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 208 (1985)).

52. See 29 U.S.C. § 1132(a)(1)(B).

53. See *Id.* § 1132(a) Section 502(a) permits suits (i) by participants and beneficiaries of benefits under a plan, (ii) by the Secretary of Labor, a participant, beneficiary, or fiduciary for breach of any fiduciary duty, and (iii) by a participant, beneficiary or fiduciary to obtain other appropriate equitable relief to redress a violation of ERISA or to enforce the terms of the plan. See *id.*

54. See *id.* § 1132(e)(1).

55. See *id.* § 1132(a)(1)(B). (1998). In general, participants and beneficiaries seeking to obtain benefits promised under the plan may go to court after exhausting internal plan procedures. See *id.*

56. See *id.* § 1132(a)(1)(B). Under section 502(a)(1)(B) of ERISA, the only remedies available are the recovery of benefits already accrued under the plan, declaratory judgments, and injunctions against the plan. See *id.* Compensatory, consequential, and punitive damages are not available under ERISA's civil enforcement scheme. See, e.g., *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48 (1987).

57. SUBCOMM. ON LABOR OF THE SENATE COMM. ON LABOR AND PUB. WELFARE, 94TH CONG., LEGISLATIVE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, 4771 (Comm. Print 1976).

C. "Complete Preemption": Removal Jurisdiction v. ERISA Preemption

In general, a defendant may remove a state court action to federal court only if the action originally could have been filed in federal court.⁵⁸ Federal courts have original jurisdiction if there is complete diversity of citizenship between the parties and the amount in controversy is equal to or greater than \$75,000⁵⁹ or if there exists a federal question.⁶⁰ Any civil action brought under ERISA creates a federal question and therefore triggers federal subject matter jurisdiction.⁶¹ This Article will limit its discussion to the issue of removal as it relates to federal question removal in the context of ERISA preemption.

Federal question removal requires that the plaintiff's state court action be "arising under the Constitution, laws or treaties of the United States."⁶² Federal question removal is governed by the "well-pleaded complaint rule." This judicially created rule looks to the complaint in determining subject matter jurisdiction.⁶³ Accordingly, federal jurisdiction exists only when a federal question appears on the face of a well-pleaded complaint.⁶⁴ In general, a federal *defense* does not appear on the face of a complaint, and therefore a defense of ERISA preemption would not be sufficient to remove a case to federal court.⁶⁵

The general rule may be supplanted by the "complete preemption" doctrine, which is a corollary to the well-pleaded complaint rule.⁶⁶ The Supreme Court created this exception to the well-pleaded complaint rule to allow federal jurisdiction in circumstances in which Congress has "so completely preempt[ed] a particular area that any civil complaint raising this select group of claims is necessarily federal in character."⁶⁷

58. See 28 U.S.C. § 1441(a) (1998).

59. See *id.* § 1332(a).

60. See *id.* § 1331.

61. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 55-56 (1997).

62. 28 U.S.C. § 1331.

63. See *Louisville & Nashville R.R. v. Mottley*, 211 U.S. 149, 153 (1908).

64. See *Caterpillar Inc. v. Williams*, 482 U.S. 386, 392 (1987).

65. See *id.* at 398 (holding that the fact that a defendant might ultimately prove that a plaintiff's claims are preempted under a federal statute does not establish that they are removable to federal court).

66. See *id.* at 393.

67. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64 (1987). Congress has completely preempted the field with respect to claims brought under ERISA plans. See ERISA, 29 U.S.C. § 1144(a) (1998); *Taylor*, 481 U.S. at 66; see also *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 55-56 (1987) (holding that Congressional intent is clear "that all suits brought by beneficiaries . . . asserting improper processing of claims

Under the complete preemption doctrine, a federal statute possessing extraordinary preemptive power “converts an ordinary state common-law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule.”⁶⁸

If a federal cause of action completely preempts a state law cause of action, any state law claim that comes within the scope of the federal cause of action is considered federal in nature and the state-based action is consequently preempted.⁶⁹ In the context of the remedies section of ERISA, section 502(a)(1)(B), the Supreme Court has held that the complete preemption doctrine supports the removal to federal court of any state law causes of action that fit within the scope of ERISA’s civil enforcement provision.⁷⁰ The consequences of ERISA’s preemption provisions and removal are significant.

Indeed, if section 514(a) of ERISA is taken literally and afforded its full breadth by the courts, the result is that a plaintiff may not use state common law or statutory causes of action to bring a claim against an ERISA-governed plan.⁷¹ Similarly, if a plaintiff covered by an ERISA plan wishes to recover for the denial of benefits under that plan, the use of state law in this effort against the plan is prohibited because ERISA section 502(a)(1)(B) is the exclusive means by which such a suit may be brought against the plan.⁷² Failure to comprehend ERISA’s preemption provisions may negatively affect a plan participant’s or beneficiary’s ability to seek redress for wrongs carried out under an ERISA plan.

IV. THE SUPREME COURT AND ERISA PREEMPTION

To determine whether a state law claim is preempted under ERISA, courts must first determine whether the plan at issue is

under ERISA-regulated plans be treated as federal questions governed by [ERISA’s civil enforcement mechanisms]”).

68. *Caterpillar*, 482 U.S. at 393 (citing *Taylor*, 481 U.S. at 65).

69. See *Taylor*, 481 U.S. at 65-66.

70. See *id.* at 66.

71. See *Pilot Life*, 481 U.S. at 48 (1987).

72. See, e.g., *Kuhl v. Lincoln Nat’l Health Plan of Kansas City, Inc.*, 999 F.2d 298, 301-02 (8th Cir. 1993) (holding that the decision of the defendant MCO to cancel a heart surgery previously authorized was not medical malpractice, but rather the denial was that of a benefit due under the plan and therefore the state law claims were completely preempted by § 502(a)(1)(B)); *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966, 972-74 (S.D.N.Y. 1994); *Pomeroy v. Johns Hopkins Med. Servs., Inc.*, 868 F. Supp. 110, 113 (D. Md. 1994) (holding that in order for the plaintiff to prove malpractice, the court would be required to examine the underlying benefits of the plan, thereby preempting the state law claim).

an ERISA plan.⁷³ Next, courts must decide if the state law “relates to” an employee benefit plan. Defining this phrase is difficult. As one commentator has stated, “identifying the outermost limits of ERISA preemption under this clause has been problematic.”⁷⁴

For example, in *Shaw v. Delta Air Lines, Inc.*,⁷⁵ the Supreme Court expanded on a previous decision⁷⁶ by stating that a law “relates to” an employee benefit plan, in the normal sense of the phrase, if it has a “connection with or reference to such a plan.”⁷⁷ In *Shaw*, employers petitioned the court for a declaratory judgment that ERISA preempted two New York statutes that prohibited discrimination on the basis of sex and required employers to provide sick leave benefits to their employees for pregnancy or other nonoccupational disabilities. The Court held in favor of the employers and held that the state law was preempted. The Court noted, however, that a state law cause of action is preempted only if the relationship between it and the ERISA plan is not “too tenuous, remote or peripheral.”⁷⁸

The “connection with or reference to such plan” test has been used by the Court frequently as the touchstone in addressing the question of whether a claim is preempted under ERISA section

73. See *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 6-8 (1987), in which the U.S. Supreme Court distinguished between mere employee benefits and an actual employee benefit plan. The Court held that a one-time severance payment made in accordance with a Maine law requiring a “one-time, lump-sum” severance payment in the event of a plant closing was not an employee benefit plan as defined by ERISA and was not therefore preempted. See *id.* at 2, 9-12.

74. Minc, *supra* note 7, at 97.

75. 463 U.S. 85 (1983).

76. See *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981).

77. *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 96-97; see also *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125 (1992) (holding that a state law plan “relates to” a covered benefit plan for section 514(a) purposes even if the law is not specifically designated to do so). Lower courts have set out four categories of laws as a guide to whether a state law has a “connection with or reference to” and therefore “relates to” an employee benefit plan. See, e.g., *id.*; *National Elevator Indus., Inc. v. Calhoon*, 957 F.2d 1555, 1558-1559 (10th Cir.) (1992), reciting the four categories as follows:

First, laws that regulate the type of benefits or terms of the ERISA plans. Second, laws that create reporting, disclosure, funding, or vesting requirements for ERISA plans. Third, laws that provide rules for the calculation of the amount of benefits to be paid under ERISA plans. Fourth, laws and common-law rules that provide remedies for misconduct growing out of the administration of the ERISA plan.

78. *Shaw*, 463 U.S. 85 at 100, n.21 (1983); see also *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 838-40 (1988) (discussing ERISA preemption of state law claims in dicta).

514. While the courts generally start their analysis with a presumption against preemption,⁷⁹ the Supreme Court in *Metropolitan Life Ins. Co. v. Massachusetts*⁸⁰ upheld a Massachusetts law requiring insurance companies to provide specified mental health benefits as part of any health insurance plan offered in the state. The Court held that states may mandate that insured health benefit plans provide certain benefits under the plan. The Court determined that although the state statute came within the scope of ERISA's preemption provision, it was "saved" from preemption under the "savings clause" of section 514(b)(2)(A).⁸¹

The Court's analysis was based on the "connection with or reference to" test used in *Shaw*. In its discussion, the Court noted that although the state law did not directly regulate employee benefit plans, it indirectly required employee benefit plans to purchase state-mandated mental health benefits when purchasing insurance on behalf of their employees.⁸² To many employers, this case stands for the principle that states cannot mandate benefits on self-insured ERISA plans, but are allowed to regulate the standards found in fully insured products. To others, it signifies another example of the poverty of the phrase "connection with or reference to."

The Court further developed its interpretation of the "connection with or reference to" test in *Pilot Life Ins. Co. v. Dedeaux*.⁸³ In *Pilot Life*, the Court held that ERISA preempted state common law causes of action. The law in question was the Mississippi tort of "bad faith," which arose in connection with the plaintiff's claim of an alleged improper processing or denial of a claim for benefits by Pilot Life Insurance Co. under a plan it insured. The Court reasoned that a common-sense understanding of the phrase "regulates insurance"⁸⁴ did

79. See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740-41 (1985) (stating, "The presumption is against pre-emption, and we are not inclined to read limitations into federal statutes in order to enlarge their pre-emptive scope.").

80. 471 U.S. 724 (1985).

81. See *id.* at 739-44.

82. See *id.* at 739 (citing *Alessi v. Raybestos-Manhattan*, 451 U.S. 504, 525 (1981)).

83. 481 U.S. 41, 47-48 (1987).

84. See *id.* The Court, borrowing from the McCarran-Ferguson Act, defined the "business of insurance" by noting the following three criteria: First, the law must have the effect of spreading or transferring a policyholder's risk of loss; second, the law must constitute "an integral part of the policy relationship between the insurer and the insured"; and third, the law must be limited in application to the insurance industry. *Id.* at 48-49 (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)).

not support the argument that the state statute in question fell under the “savings clause.”

The Court stated that ERISA’s preemption was not limited merely to those “state laws specifically designed to affect employee benefit plans.”⁸⁵ The Court said that a common-sense view of the word “regulates” would lead to the conclusion that “in order to regulate insurance, a law must not just have an impact on the insurance industry but must be specifically directed toward that industry.”⁸⁶ Instead, the Court held that the common law claims asserted against the insurer were claims based upon the improper processing of plan benefits and that state common law actions could not be “saved.” In addition, the Court held that the law “undoubtedly [met] the criteria for preemption under Section 514(a).”⁸⁷ After a thorough analysis of each prong of ERISA’s preemption provisions, the Court held that state common law claims for denial of benefits and common law remedies such as punitive and consequential damages were preempted.

In addition, the Court’s opinion pointed out that because the plaintiff’s tort action stemmed from the insurance company’s improper processing of the claim, the cause of action was well within the scope of ERISA’s civil enforcement provision under section 502(a)(1)(B).⁸⁸ The Court decided that the extracontractual damages the plaintiff was seeking under the Mississippi state law were not permitted under section 502(a)(1)(B) and, therefore, the plaintiff was unable to recover consequential or punitive damages.⁸⁹ The Court concluded that ERISA’s civil enforcement provisions were intended to be exclusive. The Court stated that this result was confirmed by the legislative history of those provisions, particularly the history demonstrating that the preemptive force of ERISA’s enforcement provisions was modeled after the powerful preemptive force of section 301 of the Labor Management Relations Act of 1947.⁹⁰

Therefore, preemption attaches with respect to remedies for benefit denials in state law claims by plaintiffs challenging the procedures used in denying and reviewing benefit claims and

85. *Pilot Life*, 481 U.S. at 47-48 (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97-98 (1983)).

86. *Id.* at 50.

87. *Id.* at 48.

88. *See id.* at 52.

89. *See id.*

90. *See id.* at 51-56.

state laws providing that a participant or beneficiary may sue for consequential or punitive damages for abuse in processing of these claims. For example, suppose a plan participant or beneficiary became ill and could not work, and consequently experienced lost wages. If the plan wrongfully refused to precertify a medical procedure that would have reduced the employee's suffering and allowed the employee to return to work earlier, under ERISA, all the employee could recover would be to have the procedure performed.

More recently, the Supreme Court in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*⁹¹ held that ERISA did not preempt a New York statute that imposed a number of surcharges on different classes of payers. By most accounts, this case appears to have marked the end of the era of the ever-expanding doctrine of ERISA preemption. In a unanimous opinion, Justice David Souter wrote that the state surcharge provisions were not preempted by section 514(a) because such provisions did not "relate to" employee benefit plans, in that:

(1) [T]he surcharge provisions neither made reference to ERISA plans in any manner nor bore the requisite connection with ERISA plans to trigger pre-emption; (2) any other conclusion would bar any state regulation of hospital costs; (3) an interpretation that Section 514(a) preempted the surcharge provisions would render nugatory a statute enacted after ERISA by the same Congress; and (4) the history of Medicare regulation confirmed that Congress never envisioned ERISA preemption as blocking state health care cost control.⁹²

The Court held that New York's surcharges had merely an indirect economic effect on ERISA plans. Thus, the Court appears to have reduced the reach of ERISA section 514(a). As such, only those state laws that either directly or indirectly require plan administrators to adopt a minimum level of benefits, that have an effect on the administration of a plan, or that pre-

91. 514 U.S. 645 (1995). The *Travelers* case resolved a conflict between the Second and Third Circuits regarding whether ERISA preempts state health hospital surcharges. In *United Wire, Metal and Machine Health and Welfare Fund v. Morristown Mem'l Hosp.*, 995 F.2d 1179 (3d Cir. 1993), a divided Third Circuit panel held that ERISA did not preempt a New Jersey law imposing surcharges on hospital bills in order to fund an uncompensated care pool. The Second Circuit, however, in *Travelers Insurance Co. v. Cuomo*, 14 F. 3d 708, 719 (2d Cir. 1993), found that a similar New York surcharge law did preempt the state law because of its purposeful interference "with the choices that ERISA plans make for health care coverage."

92. *Travelers*, 514 U.S. at 645.

clude the uniform administration and coverage of interstate employee benefit plans are preempted.⁹³ The limitation of ERISA preemption in *Travelers* is significant because it indicates that the Court has dramatically changed course. *Travelers* strongly suggests that the Court has moved away from reading the statutory text of ERISA for its most literal application and toward a more pragmatic interpretation that may make any further attempts to invoke the preemption of state laws “turn on Congress’ intent.”⁹⁴

The Court has, in fact, stated 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”⁹⁵ The Court, in an effort to provide future guidance, outlined three categories of state laws that Congress intended to preempt: (1) state laws that “mandate employee benefit structures or their administration”; (2) state laws that “provide alternative enforcement mechanisms”; and (3) state laws that “bind plan administrators to a particular choice” and thus function as a regulation of an ERISA plan itself.⁹⁶ Shortly thereafter, the Court reaffirmed this new, less expansive *Travelers* view of ERISA preemption in *De Buono v. NYSA-ILA Medical and Clinical Services Fund*.⁹⁷

V. ERISA AND MEDICAL MALPRACTICE CLAIMS

One commentator has suggested that “an increasing number of medical malpractice claims are likely to be brought against managed care organizations, either instead of or in addition to claims against individual providers.”⁹⁸ The reason for this, it is suggested, is because “managed care organizations combine

93. *See id.* at 659.

94. *Id.* at 655.

95. *Id.*

96. *Id.* at 646.

97. In *De Buono*, 117 S.Ct. 1747 (1997), the Supreme Court held that New York State is not precluded from imposing a gross receipts tax on ERISA self-funded medical centers. *See id.* at 1752. In addition, in *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 117 S. Ct. 832 (1997), the Supreme Court considered whether ERISA preempted California’s prevailing wage law to the extent that the law prohibits payment of an apprentice wage to an apprentice trained in an unapproved program. *See id.* at 835. The Court held that California’s prevailing wage rate law does not “relate to” employee benefit plans, and therefore, is not preempted by ERISA. *See id.* at 842.

98. Wendy K. Mariner, *Liability for Managed Care Decisions: The Employee Retirement Income Security Act (ERISA) and the Uneven Playing Field*, 86 AM. J. PUB. HEALTH 863, 864 (1996).

medical and financial functions in ways that make it difficult to separate vicarious from direct responsibility for patient care.”⁹⁹ The courts have generally agreed that malpractice actions against physicians or other health care professionals who are either employed or retained by an MCO alleging negligent medical treatment are not preempted by ERISA section 514(a).¹⁰⁰ The one area of ERISA litigation that has caused confusion, however, concerns the issue of medical malpractice either as a direct action against an MCO or under a theory of vicarious liability.

A. Direct Malpractice Against an MCO

With some success, MCOs have argued that ERISA preempts liability for malpractice in situations in which a patient’s health care is paid for through an employer-provided health care plan covered by ERISA.¹⁰¹ While more recent trends indicate movement away from this view, the issues in these cases remain. These cases have often turned on whether such claims are preempted under either the language of ERISA that preempts all state laws that “relate to” a plan or the doctrine of “complete preemption.” For example, in *Corcoran v. United HealthCare, Inc.*,¹⁰² the district court held that ERISA preempted state malpractice and wrongful death actions against an HMO, in a situation in which a death was related to the HMO’s refusal to certify the plaintiff’s physician’s hospitalization order during her high-risk pregnancy. In that case, United Healthcare authorized limited home nursing care in lieu of hospitalization. The plaintiff’s fetus went into distress and died during a period of time when the nurse was not on duty.¹⁰³ The district court held that because the plaintiffs were “attempting to recover for a tort alleg-

99. *Id.*

100. See, e.g., *Coyne & Delany Co. v. Selman*, 98 F.3d 1457 (4th Cir. 1996); *Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Lancaster v. Kaiser Found. Health Plan of Mid-Atlantic States, Inc.*, 958 F. Supp. 1137 (E.D. Va. 1997); *Edelen v. Osterman*, 943 F. Supp. 75, 76 (D. D.C. 1996).

101. See, e.g., *Kuhl v. Lincoln Nat’l Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th Cir. 1993); *Altieri v. Cigna Dental Health, Inc.*, 753 F. Supp. 61, 64 (D. Conn. 1990) (“ERISA . . . preempts [state common law actions] . . . since they all ‘have one central feature: the circumstances of [the participant’s] medical treatment under his employer’s [health] services plan for employees.’”) (quoting *Rollo v. Maxicare of La., Inc.*, 695 F. Supp. 245, 248 (E.D. La. 1988)); *Pomeroy v. Johns Hopkins Med. Servs.*, 868 F. Supp. 110, 114 (D. Md. 1994); *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966, 972 (S.D.N.Y. 1994); *Ricci v. Gooberman*, 840 F. Supp. 316, 317 (D. N.J. 1993).

102. 965 F.2d 1321 (5th Cir. 1992).

103. See *id.* at 1322-23.

edly committed in the course of handling a benefit determination," their negligence claims were based upon a benefits determination.¹⁰⁴ Thus, the district court held that the claim "related to" the ERISA plan and consequently was preempted under the federal law.

On appeal, the Fifth Circuit Court of Appeals affirmed the lower court's decision. The Fifth Circuit was, nevertheless, concerned by the implications of its own conclusion:

The result ERISA compels us to reach means that the Corcorans have no remedy This is troubling for several reasons. First, it eliminates an important check on the thousands of medical decisions routinely made in the burgeoning utilization review system. . . . [I]f the cost of compliance with a standard of care (reflected either in the cost of prevention or the cost of paying judgments) need not be factored into utilization review companies' cost of doing business, bad medical judgments will end up being cost-free to the plans that rely on these companies to contain medical costs. ERISA plans, in turn, will have one less incentive to seek out the companies that can deliver both high quality service and reasonable prices. . . . Fundamental changes such as the widespread institution of utilization review would seem to warrant a re-evaluation of ERISA so that it can continue to serve its noble purpose of safeguarding the interests of employees. Our system, of course, allocates this task to Congress, not the courts, and we acknowledge our role today by interpreting ERISA in a manner consistent with the expressed intentions of its creators (footnote omitted).¹⁰⁵

Although the Fifth Circuit clearly was troubled with its own result, in all likelihood the holding in *Corcoran* would not have been any different had it been decided following the *Travelers* case,¹⁰⁶ because of the Supreme Court's unchanging position that ERISA section 502(a)(1)(B) remains the exclusive means of recovery for the denial of a claim for benefits.

B. *Malpractice Actions Against an MCO for Vicarious Liability*

The imposition of liability on one person for the actionable conduct of another, based solely on a relationship between the

104. *Id.* at 1332.

105. *Id.* at 1338-39.

106. *See supra* notes 91-96 and accompanying text.

two persons, is known as “vicarious liability.”¹⁰⁷ As mentioned above, the issue of vicarious liability as it relates to ERISA and MCOs has been the source of considerable confusion in the courts. For example, in *Pomeroy v. Johns Hopkins Medical Services*,¹⁰⁸ the district court held that a malpractice action against an MCO based on vicarious liability was preempted under ERISA section 514(a). The court held that in order to decide a vicarious liability action, a court must refer to the employee benefit plan in order to establish whether the plan creates an agency relationship between the MCO and the physician. A vicarious liability malpractice claim also requires the deciding court to judge the quality of the benefits promised against the quality of the benefits received.¹⁰⁹ The *Pomeroy* court determined that such a “reference to” the employee benefit plan required that the action be preempted, in conformity with the Supreme Court’s holding in *Shaw*.¹¹⁰

In contrast, the Seventh Circuit held in *Rice v. Panchal*¹¹¹ that a malpractice action against an HMO based on vicarious liability was not completely preempted under ERISA section 502(a)(1)(B).¹¹² The court held that although the employee benefit plan administered by the MCO would “serve as evidence of [a physician’s] apparent agency, the alleged agency does not necessarily rise and fall with the Plan. Rather, this is a case in which ‘[b]eyond the simple need to refer to the . . . [Plan], the . . . [Plan] is irrelevant to the dispute’”¹¹³ Similarly, the Tenth Circuit in *Pacificare of Oklahoma, Inc. v. Burrage*¹¹⁴ held

107. See BLACK’S LAW DICTIONARY (6th ed. 1990).

108. 868 F. Supp. 110, 116 (D. Md. 1994).

109. See *id.* at 114 (holding that ERISA preempted the plaintiff’s claims).

110. See *id.* at 113.

111. 65 F.3d 637, 646 (7th Cir. 1995).

112. See *id.*; see also *Kohn v. Delaware Valley HMO, Inc.*, 14 Emp. Benefits Cas. (BNA) 2336 (Dec. 20, 1991), in which the court held that a personal injury claim does “not relate to the benefit plan,” and plaintiffs who alleged personal injury arising under an ERISA plan were allowed to sue without exhausting administrative remedies. The District Court in *Kohn* refused, on a motion for reconsideration, to dismiss the “ostensible agency” count for the negligence of the health care providers but held that the claim for punitive damages was preempted by ERISA. See *id.* at 2340. The court explained that the “malpractice claim did not arise out of the ERISA plan’s contract,” that is, it did not “relate to” the benefit plan. *Id.*; see also *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983 (E.D. Pa. 1990).

113. *Rice*, 65 F.3d at 645 (quoting *Livadas v. Bradshaw*, 512 U.S. 107, 125 (1994)).

114. 591 F.3d 151 (10th Cir. 1995).

that a malpractice claim based on vicarious liability against an MCO was not preempted by ERISA section 514(a).¹¹⁵

While the courts continue to split on whether ERISA preempts medical malpractice claims based on vicarious liability, a number of more recent appellate court opinions may provide new hope to patients and beneficiaries concerned about this important question. For example, in *Dukes v. U.S. Healthcare Inc.*,¹¹⁶ the Third Circuit held that ERISA section 502(a)(1)(B) does not completely preempt an employee health benefit plan participant's state common law malpractice action against an HMO based on the theory of vicarious liability.¹¹⁷ The *Dukes* court held that removal to federal court of the plaintiff's claims of inadequate and negligent care by physicians affiliated with an employer-provided HMO was improper under the "well-pleaded complaint" rule.

The Third Circuit determined that the Supreme Court's holding in *Metropolitan Life*¹¹⁸ effectively narrowed the application of ERISA preemption when it stated that "Congress intended the complete-preemption doctrine to apply to state law causes of action which fit within the scope of ERISA's civil-enforcement provisions."¹¹⁹ Noting that the plaintiffs were not address-

115. *Id.* The Tenth Circuit in *Pacificare* focused its analysis on the meaning of ERISA § 514(a) and its "relates to" language. The court held that the following four types of state laws "relate to" an employee benefit plan and are therefore preempted by ERISA § 514(a): "First, laws that regulate the type of benefits or terms of ERISA plans. Second, laws that create reporting, disclosure, funding, or vesting requirements for ERISA plans. Third, laws that provide rules for the calculation of the amount of benefits to be paid under ERISA plans. Fourth, laws and common-law rules that provide remedies for misconduct growing out of the administration of the ERISA plan." *Id.* at 154 (quoting *National Elevator Indus., Inc. v. Calhoon*, 957 F.2d 1555, 1558-59 (10th Cir. 1992)).

116. 57 F.3d 350 (3d Cir. 1995). In *Dukes*, the widow of an ERISA plan participant and HMO user filed a malpractice suit against a number of defendants including the HMO. *See id.* at 353-56. Mr. Dukes received his medical care through an HMO that provided and supervised the physicians that delivered medical treatment to the plan participants. *See id.* Mrs. Dukes alleged that the HMO was responsible, under Pennsylvania's state ostensible agency law, for the negligence of its health personnel. *See id.* She also alleged direct negligence in the HMO's failure to meet its duty of reasonable care in the selection, retention, screening, monitoring, and evaluation of the medical personnel who actually provided the medical services to her husband. *See id.*

117. *See id.* at 357. *Dukes* consolidated two cases on appeal, *Dukes v. U.S. Health Care Sys., Inc.*, 848 F. Supp. 39 (E.D. Pa. 1994), and *Visconti ex rel. Visconti v. U.S. Health Care*, 857 F. Supp. 1097 (E.D. Pa. 1994).

118. 481 U.S. 58 (1987).

119. *Dukes*, 57 F. 3d at 354 (citing *Metropolitan Life*, 481 U.S. at 66). "State law claims which fall outside of the scope of § 502, even if preempted by § 514(a), are still

ing the denial of benefits but rather the “quality” of the benefits under the employee benefit plan, the court stated that “[a]s a result, the plaintiffs’ claims fall outside of the scope of § 502(a)(1)(B) and these cases must be remanded to the state courts from which they were removed.”¹²⁰ In addition, in an effort to address the issue of section 514(a) preemption, the Third Circuit cited the Supreme Court’s holding in *Travelers* and followed the Court’s characterization of the lawsuit as an action to recover for the inadequate quality of care provided by the HMO. The Third Circuit stated in *Dukes* that “[q]uality control of benefits, such as . . . health care benefits . . . is a field traditionally occupied by state regulation and we interpret the silence of Congress as reflecting an intent that it remain such.”¹²¹

C. Suits Against an MCO Based on Plan Design

In *Lancaster v. Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.*¹²² a federal district court examined a number of the plaintiff’s claims, including direct liability negligence, fraud, and misrepresentation, against an MCO that administered an employee benefit plan. The defendant, Kaiser Foundation Health Plan, had designed an incentive program for purposes of controlling expenditures and provided bonuses to physicians who refrained from ordering unnecessary and costly medical tests and procedures.¹²³ The plaintiffs sued Kaiser on behalf of their minor daughter, arguing that the structure and design of the incentive program encouraged physicians to make treatment decisions for financial rather than medical reasons.¹²⁴

governed by the well-pleaded complaint rule and, therefore, are not removable under the complete-preemption principles established in *Metropolitan Life.*” *Id.* at 355.

120. *Id.* at 356.

121. *Id.* at 357. The *Dukes* court also distinguished the Fifth Circuit’s decision in *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), stating that *Corcoran* focused on the common law liability of a company performing utilization management activities and the denial of a benefit allegedly due under the terms of an ERISA-covered employee benefit plan. In contrast, the issue in *Dukes* concerned the HMO’s vicarious liability for the rendering of poor quality medical services to plan participants. See *Dukes*, 57 F.3d at 360-61. See also *Lazorko v. Pennsylvania Hospital*, EDPA No. 96-9858 (1998).

122. 958 F. Supp. 1137 (E.D. Va. 1997). *Lancaster* is currently on appeal on the issue of whether a state claim for the failure of an HMO, in its capacity as a medical service provider, to disclose physician financial incentives to limit referrals is preempted by ERISA. See also *Shea v. Eesensten*, 107 F.3d 625 (8th Cir. 1997), cert. denied, 118 S. Ct. 297 (1997) (holding that ERISA preempts state law claims against an MCO).

123. See *Lancaster*, 958 F. Supp. at 1140-41.

124. See *id.*

The *Lancaster* plaintiffs sued Kaiser Foundation Health Plans, from whom they sought treatment and who was also the administrator of the Lancasters' employee benefit plan.¹²⁵ The Lancasters sought treatment from Kaiser for their daughter's recurrent and severe vomiting and headaches. For a period of approximately four years, the Kaiser physicians treated the minor with adult-strength narcotics to control her condition.¹²⁶ During that time, the Kaiser physicians did not order an MRI, CAT scan, EEG, or any other diagnostic test to assess the child's headaches.¹²⁷ Finally, tests were ordered and revealed that the girl suffered from a frontal lobe brain tumor and cystic mass that had metastasized to over forty percent of her brain.¹²⁸ Unfortunately, a series of brain surgeries to remove the girl's tumor were not entirely successful.¹²⁹

The court held that the direct liability claims against Kaiser were preempted by ERISA section 502(a)(1)(B).¹³⁰ The court stated that the plaintiffs' negligence claims attacked the MCO's administrative decisions that "had the effect of denying benefits to Lancaster as a plan participant because it inappropriately influenced [the physicians] to take certain non-medical factors, most notably, their incomes, into account when prescribing treatment."¹³¹ The court determined that

the aim and effect of both [the utilization review and the financial incentive programs] are essentially the same: both policies seek to constrain health care costs by denying supposedly unnecessary medical treatment and, thus, both may affect the quantity, as well as the quality, of benefits provided to a patient under a[n] [ERISA] plan.¹³²

The court also held that the characterization of the claims as challenges to Kaiser's administrative structure that caused a denial of benefits did indeed invoke complete preemption under ERISA Section 502(a)(1)(B). As such, the state common law direct liability claims against the MCO were dismissed, as were

125. *See id.*

126. *See id.*

127. *See id.*

128. *See id.*

129. *See id.*

130. *See id.* at 1150. The court ruled that the claims of individual and vicarious liability malpractice were not preempted by ERISA § 502(a)(1)(B) or § 514(a). *See id.* at 1149-50.

131. *Id.* at 1147.

132. *Id.* at 1148.

the claims regarding the establishment of the financial incentive program.

In a similar case, the Eighth Circuit held in *Shea v. Esensten*¹³³ that a plaintiff's state common law claims of fraudulent nondisclosure and misrepresentation against an MCO that flowed from the MCO's financial incentive program were completely preempted. In *Shea*, the plaintiff alleged that her husband had not received proper treatment and diagnosis for a heart condition due to the MCO's financial incentive program that rewarded physicians for refraining from making referrals to specialists.¹³⁴ The court held that the plaintiff's claims were preempted because the result of allowing the common law suit would be to "clearly affect how ERISA-regulated benefit plan[s] [are] administered, and if similar cases are brought in state courts across the country, ERISA plan administrators will inevitably be forced to tailor their plan disclosures to meet each state's unique requirements."¹³⁵ The Eighth Circuit further reasoned that such a holding would contradict the principle established in *Travelers* that the primary intent of Congress in enacting ERISA's preemption provisions was to ensure "the nationally uniform administration of employee benefit plans."¹³⁶

The plaintiff in *Shea* amended her complaint against the MCO following the removal of the case to federal court. The amended complaint alleged that the MCO, in failing to disclose the financial incentive program, had breached its fiduciary duty to disclose all material facts affecting a plan participant's or beneficiary's interest. The court held that the MCO had breached its fiduciary duties in not disclosing its financial incentive program to plan participants.¹³⁷ The court determined that the MCO "was offering financial incentives that could have colored his doctor's medical judgment. . . . Health care decisions involve matters of life and death, and an ERISA fiduciary has a duty to speak out if it 'knows that silence might be harmful.'"¹³⁸ Both *Lancaster* and *Shea* appear to be consistent with the text of ER-

133. 107 F.3d 625 (8th Cir. 1997), *cert. denied*, 118 S. Ct. 297 (1997).

134. *Id.* at 627.

135. *Id.*

136. *Id.* (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657 (1995)).

137. *See id.*; *see also* ERISA, 29 U.S.C. § 1104(a)(1) (1998) (requiring plan fiduciaries to "discharge [their] duties with respect to a plan solely in the interest of the participants and beneficiaries").

138. *Shea*, 107 F.3d. at 629 (quoting *Bixler v. Central Penn. Teamsters Health & Welfare Fund*, 12 F.3d 1292, 1300 (3d Cir. 1993)).

ISA's preemption provision and the holding in the *Travelers* case. Although the courts have sent mixed signals regarding when and if a state law claim may be preempted by ERISA, state legislatures and Congress have begun considering this issue in terms of reform.

VI. THE ROAD TO REFORM

In retrospect, it is ironic that the Congressional intent behind ERISA's preemption provisions was to "round out the protection afforded participants."¹³⁹ While the courts have attempted to sort out the circumstances under which participants and beneficiaries of ERISA plans may sue an MCO for malpractice, this drama has played out against the backdrop of public concern regarding the quality of the health care system in general. "In 1993-1994, President Clinton favored a heavy hand from government to guarantee health coverage to every American. That attempt failed miserably with the public and played a large part in the Republican takeover of Congress in 1994."¹⁴⁰ Prior to this more expansive debate, Congress considered a number of bills that would have amended ERISA's liability provisions. At that time, employers and insurers created a powerful coalition to defeat the legislation that became known as the *Pilot Life* bill, named after the Supreme Court case it sought, in part, to overturn.¹⁴¹ Ultimately, this smaller debate was swept away by the proposals for more comprehensive reform which later, in effect, defaulted to the private market.

Pursuant to the growth of managed care, serious questions concerning the quality of the services received through such plans have been raised.¹⁴² In part, these questions have been driven by the rapid changes in the health care system, which have occurred quickly and without the opportunity for active co-

139. Representative John Dent (D-Pa.), one of the original authors of ERISA, stated: "Finally, I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority [of] the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation." 120 CONG. REC. 29, 197 (1974).

140. Marilyn Werber Serafini, *Micromanaged Care?*, 28 NAT'L J., 2506, 2506 (1997).

141. See *supra* note 13 and accompanying text.

142. See JOHN E. WARE JR. ET AL., DIFFERENCES IN 4-YEAR HEALTH OUTCOMES FOR ELDERLY AND POOR, CHRONICALLY ILL PATIENTS TREATED IN HMO AND FEE-FOR-SERVICE SYSTEMS (1996) (finding that elderly and poor, chronically ill patients have worse physical health outcomes in HMOs than in fee-for-service systems).

operation and partnership with the public. It is true that a number of recent decisions, such as *Dukes*, *Rice*, and *Pacificare*, suggest that the courts are slowly attempting to provide patients with more meaningful ways to find redress for harms caused by MCOs delivering employee benefit health care services. Nevertheless, a public policy void still exists. This void, coupled with the current managed care backlash,¹⁴³ has increased the pressure for an incremental political solution to address the issue of ERISA damages. As a result, patient, consumer, and physician advocacy groups have responded by taking their cases to their elected officials in both the states and the Congress.

A. *The States*

Texas recently became the first state to allow an individual to sue a health insurance carrier, health maintenance organization, or other managed care entity for damages proximately caused by the entities failure to exercise ordinary care when making a health care treatment decision.¹⁴⁴ Under the Texas Health Care Liability Act, these entities may be held liable for substandard health care treatment decision made by their employees agents, or representatives.¹⁴⁵ The Act also 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.¹⁴⁶ Additional responsibilities for HMOs and further requirements concerning review of an adverse benefit determination by an independent review organization are also addressed by the Act.¹⁴⁷

While many believed the law would succumb to ERISA's preemption provisions, Judge Vanessa D. Gilmore of the U.S. District Court for the Southern District of Texas, recently upheld the Texas law that allows individuals the right to sue an MCO

143. A survey conducted by the Kaiser/Harvard Program on the Public and Health/Social Policy found that a majority of Americans (52%) say the government should protect consumers of managed care. See Kaiser/Harvard Nat'l Survey of Americans' Views on Managed Care (1997).

144. Tex. Civ. Prac. & Rem. Code Ann. § 88.002(a) (1998); see also PATRICIA A. BUTLER, *MANAGED CARE PLAN LIABILITY: AN ANALYSIS OF TEXAS AND MISSOURI LEGISLATION PREPARED FOR THE KAISER FAMILY FOUNDATION* (1997).

145. See Tex. Civ. Prac. & Rem. Code Ann. § 88.002(b).

146. Id. at § 88.003(c).

147. See TEX. INS. CODE ANN. arts. 20A.09, 20A.12, 20A.12A, 2158A, and 21.58C (West 1998).

over medical decisions affecting patient quality of care.¹⁴⁸ Aetna Health Plans had sued to block the law, arguing that it was preempted by ERISA because it improperly interfered with the administration of employee benefit plans.¹⁴⁹ Although the Judge did strike down the portion of the Act that created an independent review process to evaluate adverse benefit determinations as preempted, more recently she agreed to stay her September ruling on this issue until a higher court ruled on an appeal.¹⁵⁰

The stay was sought by Texas Attorney General Dan Morales who appealed that part of Gilmore's ruling concerning the review process to the U.S. Court of Appeals for the Fifth Circuit. Judge Gilmore's rulings strongly suggest that there is an increasing willingness on the part of the Courts to recognize the distinction between the quality and the quantity of benefits due under an employee benefit plan. While this distinction may prove to be somewhat tenuous, especially in the area of mental health benefits, the emerging line of cases utilizing this reasoning appears to be growing.

The Texas statute also contains a provision, similar to the recently enacted statute in Missouri, which eliminates the "corporate practice of medicine" defense in certain non-ERISA liability claims.¹⁵¹ Under the "corporate practice of medicine" doctrine, unlicensed individuals and companies are prohibited from engaging in the practice of medicine.¹⁵² Therefore, by asserting the "corporate practice of medicine" defense in cases of alleged liability, MCOs may successfully avoid liability because they are, by definition, not legally capable of practicing medicine as an entity.

The "corporate practice of medicine" doctrine was created by both statute and court opinions, and was developed to ensure that corporate involvement in medical practice would not create undue conflicts that would corrupt the clinical judgment of physicians. The unfortunate consequence of "corporate practice of

148. *CORPORATE HEALTH INSURANCE INC. v. TEXAS DEPARTMENT OF INSURANCE*, S.D. TEX., H-97-2072, SEPTEMBER 18, 1998).

149. *See CORPORATE HEALTH INS., INC. v. TEXAS DEP'T OF INS.*, NO. H-97-2072 (D. Tex. filed June 16, 1997).

150. *HEALTH INSURANCE INC. v. TEXAS DEPARTMENT OF INSURANCE*, S.D. TEXAS, NO. H-97-2-72. (October 8, 1998).

151. *See id.* § 88.002(h).

152. For a complete description of the corporate practice of medicine doctrine, see generally Andre Hampton, *Resurrection of the Prohibition on the Corporate Practice of Medicine: Teaching Old Dogma New Tricks*, 66 U. CIN. L. REV. 489, 490 (1998).

medicine” prohibitions is that plaintiffs, like those in the ERISA context, are left without an appropriate remedy for alleged acts of negligence by non-physicians. In contrast, courts not bound by this doctrine nor limited by the confines of ERISA have found that MCOs may be held accountable under the theory of direct liability for negligence.¹⁵³

Although a majority of states have enacted some sort of managed care reforms, the actual reach of these laws continue to be, in some instances, limited by ERISA’s federal preemption provisions.¹⁵⁴ Proposals to expand or clarify the liability of managed care plans have been considered in several other states, including California and New York. One result of the Texas experience may be to embolden other states to enact similar reforms. At the same time, this develop may also have the effect of providing Congress with the opportunity to postpone consideration of this important issue for several more years to come.

B. The Congress

On the federal level, Congress has enacted miscellaneous insurance and managed care reforms over the years. For example, Congress enacted the Health Insurance Portability and Accountability Act of 1996, (“HIPPA”), which addresses, among other things, the portability of insurance. Like a number of states, Congress has also begun to enact managed care reforms such as a maternity length of stay measure, as well as mental health parity legislation.

During the 105th Congress a number of managed care and ERISA reform proposals were introduced. For example, Representative Charles Norwood (R-Ga.) and Senator Alphonse D’Amato (R-N.Y.) sponsored the Patient Access to Responsi-

153. In *Wickline v. State*, 228 Cal. Rptr. 661 (Cal. Ct. App. 1986), the California Court of Appeals suggested in dicta that “[t]hird-party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms” and all parties responsible for a person’s injuries should be made to answer for those injuries. *Id.* at 670. The *Wickline* court held that public sector third-party payors could be liable for their negligent actions. See *id.* The same court in *Wilson v. Blue Cross of S. Cal.*, 222 Cal. App. 3d 660 (Cal. Ct. App. 1990), extended liability to private third-party payors. More recently, in *Fox v. Health Net*, No. 21962, 1993 WL 794305 (Cal. Super. Ct. Dec. 23, 1993), a jury awarded \$89 million to the estate of a deceased enrollee who had been denied coverage for experimental treatment.

154. See, e.g., *Prudential Ins. Co. v. National Park Med. Ctr., Inc.*, 964 F. Supp. 1285, 1299 (E.D. Ark. 1997) (finding that the Arkansas “Patient Protection Act,” which requires that health plans include any qualified health care service provider who is willing to meet the plan’s participation terms, was preempted by ERISA).

ble Care Act (“PARCA”).¹⁵⁵ This bill was a comprehensive managed care reform bill that would have, among other things, amended ERISA’s preemption provisions and allow plaintiffs to bring state causes of action “to recover damages for personal injury or wrongful death.”¹⁵⁶ The bill was co-sponsored by over 220 members of Congress. Representative Norwood also sponsored the Responsibility in Managed Care Act,¹⁵⁷ which was a stand-alone ERISA reform bill substantially similar to his more comprehensive bill. This more incremental bill sought to ensure that employers cannot be sued unless the plan sponsor uses its discretionary authority to review and make decisions on claims and this error results in personal or financial injury or wrongful death.

In addition, many others in Congress sponsored ERISA reform legislation, including Senator Richard Durbin (D-Ill.), who introduced the Employee Health Insurance Accountability Act.¹⁵⁸ Like the Norwood bill, this measure would remove the force of ERISA’s preemption for “any cause of action under State law to recover damages for medical malpractice, personal injury or wrongful death.” This bill would also attempt to hold employers harmless unless they “exercis[e] discretionary authority” over a claim. Finally, Representative Pete Stark (D-Cal.) introduced the “Managed Care Plan Accountability Act.”¹⁵⁹ While this bill would also amend ERISA, it is interesting because it diverges from the other proposals in that it creates a federal remedy rather than allowing plaintiffs to bring claims under state law.

It is worth noting that during the 1996 Presidential campaign, President Clinton, mindful of the criticisms of his previous reform efforts, established the Advisory Commission on Consumer Protection and Quality in the Health Care Industry. Although the Commission recommended a “Patient Bill of Rights” which included grievance and appeals procedures, it was unable to reach a consensus on the important issue of ERISA damages. The President used the Commission’s work to highlight the need for managed care reforms including the need for more meaningful remedies. He announced that all federal programs would follow the “Patient Bill of Rights” and instructed

155. H.R. 1415 105th Cong. (1997); S. 644, 105th Cong. (1997).

156. H.R. 1415, 105th Cong. § 4 (1997).

157. H.R. 2960, 105th Cong. (1997).

158. S. 1136, 105th Cong. (1997).

159. H.R. 1749, 105th Cong. (1997).

the federal agencies to implement as many of the Commission's recommendations as possible. For example, the Department of Labor recently issued two notices of proposed rulemaking that would provide greater information to beneficiaries of ERISA plans while also amending the current rules regarding the standards for the processing employee benefit claims filed by beneficiaries and participants.¹⁶⁰ The President also threatened to veto any legislation passed by Congress that did not include strong remedies. While many had predicted that the 105th Congress would enact meaningful managed care reforms, albeit without ERISA remedies, the Monica Lewinsky scandal plagued the Clinton White House, thwarting any attempts to support reform efforts in Congress.

In the end, the House of Representatives passed a Republican sponsored version of the "Patient Protection Act," (H.R. 4250) that failed to contain meaningful ERISA liability reforms. In addition, the United States Senate was unable to agree on whether to vote on this or any other managed care reform legislation prior to the adjournment of the 105th Congress leaving any hope for change in the hands of the forthcoming 106th Congress.

C. *The Alternatives*

Currently the most popular stance in the debate over reforming ERISA's preemption and damages provisions appears to be that of maintaining the status quo. Assuming, however, that this will no longer be acceptable in the future given the activities of the courts and state legislatures across the country, there are generally four options for amending ERISA in order to address remedies.¹⁶¹ First, a federal cause of action could be established for plan liability negligence, along with a uniform and expanded remedy under ERISA. This remedy could be capped, as has occurred in states enacting medical malpractice reform laws, or it could allow for the more traditional remedies,

160. Employee Retirement Income Security Act of 1974; Rules and Regulations for Administrative and Enforcement; Claims Procedure, 63 Fed. Reg. 48390 (1998) (to be codified at 29 C.F.R. pt. 2569) (proposed Sept. 9, 1998); Proposed Amendments to Summary Plan Description Regulations, 63 Fed. Reg. 48376 (1998) (to be codified at 29 C.F.R. pt. 2520) (proposed Sept. 9, 1998).

161. See *Remedies, Preliminary Staff Draft prepared for the Subcomm. on Roles and Responsibilities of Public/Private Purchasers and Quality Oversight Organizations, President's Advisory Comm'n on Consumer Protection and Quality in the Health Care Industry* (Jan. 21, 1998).

which include compensatory damages, treble damages, civil penalties, punitive damages, mandatory attorneys' fees, and court costs.¹⁶² The proposal introduced by Representative Stark is faithful to this approach and is consistent with ERISA's intent to preserve uniformity for employee benefit plans. Not surprisingly, the trial bar appears to favor increasing remedies under ERISA while leaving the remedies uncapped.

Second, ERISA's preemption provisions could be amended to allow state tort and contract remedies to apply.¹⁶³ A version of this approach is envisioned in the legislation introduced by Representative Norwood and Senators D'Amato and Durbin. While this approach would be a departure from the original congressional intent of preserving uniformity, it may prove to be the most politically viable option, given the current emphasis on returning power to the states. Although there appears to be a countervailing trend in the area of health care legislation, the fact that Congress is likely to continue to be controlled by Republican majorities assured that the states' rights arguments will be forcefully made if not followed.

Third, legislation could be enacted that would establish a uniform standard to be applied to all insurance arrangements across the board.¹⁶⁴ This approach would create a federal standard that could be used as a floor, thereby allowing states the ability to enact additional remedies, or as a ceiling. This approach was used in the recently enacted HIPPA legislation and could indicate that Congress is interested in balancing the important questions surrounding the extent to which the state or federal governments should regulate the private insurance market.

Finally, Congress could decide that for benefit claims, state remedies would be exclusive and that there would be no ERISA remedies.¹⁶⁵ In other words, claims would be required to be brought in state court rather than allowing such suits to be brought in either state or federal court. Regardless of which approach is taken, the subject of alternative dispute resolution ("ADR") processes will inevitably arise as well. Mediation and arbitration are perhaps the best-known examples of ADR. ADR "refers to a wide range of mechanisms and processes

162. *See id.*

163. *See id.*

164. *See id.* at 6.

165. *See id.*

designed to resolve differences between parties without resorting to litigation.”¹⁶⁶ The more general subject of tort reform will inevitably enter the debate as well.

VII. CONCLUSION

The courts have sent mixed signals regarding whether MCOs can be sued for medical malpractice. Many MCOs have used ERISA to shield themselves against liability. While some federal appellate courts have found a way to make remedies available to patients, the current state of the law is uneven. For example, a federal district court judge recently decried the status quo under ERISA in a strongly worded opinion suggesting that courts have “no choice but to pluck [claims] out of the state court . . . and then . . . slam the courthouse doors in [the plaintiffs’] face . . . without any remedy.”¹⁶⁷ At the same time, many other health care providers continue to be subject to compensatory, consequential, and punitive damages for claims of negligence. While many have blamed the confusion surrounding ERISA preemption provisions and its resulting negative effects on patients on poor drafting, it remains the work of the courts to interpret the law. The front of the U.S. Supreme Court building still bears the motto “equal justice under law.” If this standard of fairness is to be applied more generally, it would certainly appear that the ERISA law should be changed or at least interpreted to provide some fairness for patients that is not wholly dependent on the type of health plan individuals maintain for themselves or their family.

To date, at least one state legislature has attempted to provide patients with an adequate, if not generous, remedy for negligent care provided by an MCO. The backlash against managed care and the lack of appropriate remedies under ERISA are undeniable. It appears that the many changes in the nation’s health care system have made the American public anxious and prepared for reform.¹⁶⁸

166. See NAOMI KARP & ERICA WOOD, RESOLUTION OF CONSUMER DISPUTES IN MANAGED CARE: INSIGHTS FROM AN INTERDISCIPLINARY ROUNDTABLE (American Bar Ass’n Comm’n on Legal Problems of the Elderly, 1997).

167. *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 53 (D. Mass. 1997).

168. See CENTER FOR STUDYING HEALTH SYSTEM CHANGE PUBLIC OPINION POLL (October 7, 1997). Nearly a quarter of patients reported that it has become more difficult to get medical care compared with three years ago, while one in ten are not satisfied with the care that they receive. See *id.*

It is true that individuals continue to maintain the option of paying for the costs of the treatment themselves when benefits are denied. From the patient's perspective, however, a claim denied often means that needed access to treatment is out of reach. ERISA plans arguably have allowed the private sector the ability to provide access to health benefits to millions where there otherwise would be none. These plans should be applauded for their voluntary efforts to provide health benefits to the masses. Any attempts to reform ERISA should account for potential adverse effects that increased costs, stemming from the greater availability of damages, may have on the ability of employers to provide benefits to their employees.

Nevertheless, Congress should undertake an earnest attempt at even-handed reform. This effort should clarify the distinction between ERISA plans and MCOs more clearly. It should also endeavor to make the distinction between "claims determinations" and "medical care decisions" more evident under the law. In addition, Congress should honor the original intent of the law by preserving the goals of uniformity and ease of administration for plan sponsors. To accomplish this goal, Congress should take the federal approach to amending ERISA. Should Congress choose to create a federal floor or ceiling, as it did in the HIPAA legislation, it should be aware that this strategy could be less successful at providing plan sponsors the necessary uniformity they require to continue to provide benefits to their employees. Finally, ERISA reform should include more general tort reforms, such as caps on damages, as a means to preserve employers' interest in sponsoring plans, while allowing MCOs to provide medical care.