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Article

THE "SHARED RISK" OF POTENTIAL TORT LIABILITY OF HEALTH MAINTENANCE ORGANIZATIONS AND THE DEFENSE OF ERISA PREEMPTION

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I. INTRODUCTION

Litigation against Health Maintenance Organizations (HMOs) is steadily increasing,¹ and those who seek recovery for personal injuries negligently inflicted by participating HMO physicians often seek recovery from the HMO as well the physician.² When seeking recovery from the HMO under the doctrine of vicarious liability and utilizing the agency principles of either respondeat superior or ostensible or apparent agency, the decisive factors are control, supervision, and implied representations.³ One critical factor in determining whether the HMO exercised sufficient control in order to impose vicarious liability is the structure of the HMO, whether it is a Staff, Group, Network, or IPA Model HMO.⁴ Moreover, a few recent decisions⁵ suggest

1. See generally Diana Joseph Bearden & Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 BAYLOR L. REV. 285 (1995); Gregory G. Binford, *Malpractice and the Prepaid Health Care Organization*, 3 WHITTIER L. REV. 338 (1981); William A. Chittenden III, *Malpractice Liability and Managed Health Care: History and Prognosis*, 26 TORT & INS. L.J. 451 (1991); Mark G. Cooper, *A "New" Approach to Medical Malpractice: The Liability of HMOs for Member Physician Negligence*, 1994 DET. C. L. REV. 1263; Robert N. Meyer, *Group Prepaid Health Plan Liability When a Physician Provider Malpractices*, 6 N. MEX. L. REV. 79 (1975); Richard C. Reuben, *In Pursuit of Health: With More Patients Suing HMOs for Denial of Treatment Lawyers Are Exploring New Ground in Going up Against the Managed-Care Giant*, A.B.A. J., Oct. 1996, at 54.

2. See, e.g., *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995); *Chaghervand v. Carefirst*, 909 F. Supp. 304 (D. Md. 1995); *Rice v. Panchal*, 875 F. Supp. 471 (N.D. Ill. 1994); *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544 (S.D. Ill. 1994); *Dearmas v. Av-Med, Inc.*, 865 F. Supp. 816 (S.D. Fla. 1994); *Paterno v. Albuerno*, 855 F. Supp. 1263 (S.D. Fla. 1994); *Butler v. Wu*, 853 F. Supp. 125 (D.N.J. 1994); *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966 (S.D.N.Y. 1994); *Ricci v. Gooberman*, 840 F. Supp. 316 (D.N.J. 1993); *Raglin v. HMO Illinois, Inc.*, 595 N.E.2d 153 (Ill. App. Ct. 1992); *Dunn v. Praiss*, 656 A.2d 413 (N.J. 1995); *McClellan v. Health Maintenance Org.*, 660 A.2d 97 (Pa. Super. Ct. 1995); *Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229 (Pa. Super. Ct. 1988).

3. See, e.g., *Raglin v. HMO Illinois, Inc.*, 595 N.E.2d 153 (Ill. App. Ct. 1992); *Chase v. Independent Prac. Ass'n*, 583 N.E.2d 251 (Mass. Ct. App. 1991); *Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229 (Pa. Super. Ct. 1988).

4. See generally Cooper, *supra* note 1; Michael Kanute, *Evolving Theories of Malpractice Liability of HMOs*, 20 LOY. U. CHI. L.J. 841 (1989).

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that litigants may successfully argue corporate negligence in order to establish negligence in utilization review or when cost-containment efforts, especially those that provide financial incentives not to order diagnostic tests, hospitalization, or refer to specialists, are a substantial factor in the physician's negligent treatment.

This Article will discuss the various models of HMOs and potential theories of tort liability that may apply to each. This Article will also discuss the major barrier to HMO litigation for recovery of damages for personal injuries, namely, ERISA preemption.⁶ Congress enacted the Employee Retirement Income Security Act of 1974 (ERISA)⁷ to provide a uniform body of law regarding the administration of employee benefit plans and curtail abuses in the administration of those plans.⁸ Because most HMOs are part of employee benefit plans, they are subject to ERISA.⁹ However, while ERISA preempts conflicting state laws that "relate to" employee benefit plans,¹⁰ courts are divided as to whether state

5. See, e.g., *Wilson v. Blue Cross of Southern Cal.*, 271 Cal. Rptr. 876 (Cal. Ct. App. 1990); *Wickline v. State of California*, 239 Cal. Rptr. 810 (Cal. Ct. App. 1986); *Pulvers v. Kaiser Found. Health Plan, Inc.*, 160 Cal. Rptr. 392 (Cal. Ct. App. 1979); *Bush v. Dake*, File No. 86-25767 NM-2 (Mich. Cir. Ct., Saginaw County 1989); *Dunn v. Praiss*, 656 A.2d 413 (N.J. 1995); *McClellan v. Health Maintenance Org.*, 660 A.2d 97 (Pa. Super. Ct. 1995).

6. See generally Jay Conison, *ERISA and the Language of Preemption*, 72 WASH. U. L. Q. 619 (1994); Robert J. Conrad, Jr. & Patrick D. Seiter, *Health Plan Liability in the Age of Managed Care*, 62 DEF. COUNS. J. 191 (1995); Jim M. Perdue & Stephen R. Baxley, *Cutting Costs—Cutting Care: Can Texas Managed Health Care Systems and HMOs Be Liable for the Medical Malpractice of Physicians?*, 27 ST. MARY'S L.J. 23 (1995).

7. 29 U.S.C. §§ 1001-1461 (1988).

8. Larry J. Pittman, *ERISA's Preemption Clause and the Health Care Industry: An Abdication of Judicial Law-Creating Authority*, 46 FLA. L. REV. 355, 358-60 (1994).

9. BARRY R. FURROW ET AL., *HEALTH LAW* 309 (1995) [hereinafter FURROW ET AL., *HEALTH LAW*].

10. 29 U.S.C. § 1144(a) (1988).

tort causes of action against HMOs "relate to" the benefit plans and are accordingly preempted by ERISA.¹¹ In many jurisdictions, ERISA is the major roadblock to tort causes of actions against HMOs.

II. THE PROS AND CONS OF HMOs

While HMOs emerged in the United States in the 1930s,¹² they did not provide health care coverage to a significant portion of the American population

11. For cases holding that ERISA does not preempt vicarious liability claims against HMOs, see *Prudential Health Care Plan v. Lewis*, 77 F.3d 493 (10th Cir. 1996); *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3rd Cir. 1995); *Prihoda v. Shpritz*, 914 F. Supp. 113 (D. Md. 1996); *Jackson v. Roseman*, 878 F. Supp. 820 (D. Md. 1995); *Kusznir v. Lutheran Gen. Hosp.*, No. 95-C-1325, 1995 WL 404860 (N.D. Ill. May 31, 1995); *Smith v. HMO Great Lakes*, 852 F. Supp. 669 (N.D. Ill. 1994); *Paterno v. Albuerno*, 855 F. Supp. 1263 (S.D. Fla. 1994); *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544 (S.D. Ill. 1994); *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983 (E.D. Pa. 1990); *DeGenova v. Ansel*, 555 A.2d 147 (Pa. Super. Ct. 1988). For cases holding that ERISA preempts causes of action founded on direct corporate liability, but not those founded on vicarious liability, see *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Chaghervand v. Carefirst*, 909 F. Supp. 304 (D. Md. 1995); *Jackson v. Roseman*, 878 F. Supp. 820 (D. Md. 1995); *Dearmas v. Av-Med, Inc.*, 865 F. Supp. 816 (S.D. Fla. 1994); *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182 (E.D. Pa. 1994); *Burke v. Smithkline Bio-Science Lab.*, 858 F. Supp. 1181 (M.D. Fla. 1994); *Elsesser v. Hospital of the Philadelphia College of Osteopathic Med.*, 802 F. Supp. 1286 (E.D. Pa. 1992); *Stroker v. Rubin*, No. Civ.A. 94-5563, 1994 WL 719694 (E.D. Pa. Dec. 22, 1994). For cases holding that ERISA preemption applies to claims based upon the corporate negligence of HMOs without addressing vicarious liability claims, see *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir. 1993); *Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th Cir. 1993); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992). For cases holding that ERISA preempts claims alleging the vicarious liability of HMOs, see *Pomeroy v. Johns Hopkins Med. Servs., Inc.*, 868 F. Supp. 110 (D. Md. 1994); *Visconti v. U.S. Health Care*, 857 F. Supp. 1097 (E.D. Pa. 1994); *Butler v. Wu*, 853 F. Supp. 125 (D.N.J. 1994); *Dukes v. United States Health Care Sys. of Pa., Inc.*, 848 F. Supp. 39 (E.D. Pa. 1994); *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966 (S.D.N.Y. 1994); *Ricci v. Gooberman*, 840 F. Supp. 316 (D.N.J. 1993). For a case holding that ERISA does not preempt a cause of action alleging the liability of an HMO on a theory of direct corporate liability, see *Pappas v. Asbel*, 675 A.2d 711 (Pa. Super. Ct. 1996).

12. Tayebe Shah-Mirany, *Malpractice Liability of Health Maintenance Organizations: Evolving Contract and Tort Theories*, 39 MED. TRIAL TECH. Q. 357 (1993). Prepaid medical plans have existed since the nineteenth century; however, they were usually organized around a small group of people for common ethnic, religious, or employment reasons and were unknown to the general public. A national health committee introduced HMOs in 1932 to provide affordable health care during the Depression. Randolph E. Sarnacki, Comment, *Contractual Theories of Recovery in the HMO Provider-Subscriber Relationship: Prospective Litigation for Breach of Contract*, 36 BUFF. L. REV. 119, 120 n.3 (1987). Moreover, the Kaiser plans began in the West in the 1930s. Paul M. Ellwood, Jr. & George D. Lundberg, *Managed Care—A Work in Progress*, 276 JAMA 1083, 1083 (1996).

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until the 1980s.¹³ The recent popularity and growth¹⁴ of HMOs has occurred because the structure of HMOs creates a unique cost-savings system that, as the proponents contend, allows better health care coverage than traditional fee-for-service plans.

Traditionally, medical services were provided on a fee-for-service basis, meaning that physicians received remuneration only for services provided, thereby creating a potential financial incentive to provide unnecessary tests, procedures, and treatments. Critics of the fee-for-service approach have argued that this approach treats diseases rather than preventing them. President Richard M. Nixon noted the irony that the emphasis on treatment through the traditional fee-for-service approach meant that health care providers would make more money as the number of ill people and the resulting services, treatment, and laboratory tests increased.¹⁵ Concerns over the rising costs of medicine and the provision of medical services to larger segments of the population led President Nixon to endorse HMOs in 1971.¹⁶ In 1973, federal legislation was enacted to spur the growth of HMOs, and today most states have HMO enabling acts.¹⁷

13. FURROW ET AL., HEALTH LAW, *supra* note 9, § 8-1. Today, many perceive HMOs as a partial solution to the problem of providing health care coverage to larger and poorer segments of the American population. See generally Rand E. Rosenblatt, *Equality, Entitlement, and National Health Care Reform: The Challenge of Managed Competition and Managed Care*, 60 BROOK. L. REV. 105 (1994); Louise G. Trubek, *Making Managed Competition a Social Arena: Strategies for Action*, 60 BROOK. L. REV. 275 (1994).

14. In 1980, only 5 to 10% of Americans with health insurance sponsored through employment were enrolled in managed care plans; by 1987, the number had risen to 60%. "By 1992 HMO enrollment had exceeded 40 million members, with 16% of the U.S. population enrolled in an HMO." FURROW ET AL., HEALTH LAW, *supra* note 9, § 8-1. A study of six large HMOs in California found that the number of HMO enrollees whose care was financed through capitation payments increased by 91% from 1990 to 1994. Four of the six HMOs were at one time owned by member physicians. James C. Robinson & Lawrence P. Casalino, *The Growth of Medical Groups Paid Through Capitation in California*, 333 NEW ENG. J. MED. 1684 (1995).

15. Sarnacki, *supra* note 12, at 119.

16. *Id.* at 120. President Nixon did not propose that an independent commission be formed to make HMOs accountable for the impact of managed care on their enrollees' health. Ellwood & Lundberg, *supra* note 12, at 1083. In 1979, managed-care trade associations formed the National Committee for Quality Assurance. However, the National Committee for Quality Assurance did not gain independence from the trade associations until 1990 when it finally became enabled to conduct an independent quality-review system. John K. Iglehart, *Health Policy Report—The National Committee for Quality Assurance*, 335 NEW ENG. J. MED. 995 (1996).

17. FURROW ET AL., HEALTH LAW, *supra* note 9, § 8-1.

Proponents of the HMO approach argue that the traditional fee-for-service approach provides little financial incentive to weigh costs in evaluating the need for additional services in order to reduce potential medical problems.¹⁸ Many medical risks are very unlikely to occur, or they might not cause significant harm to a patient or might not be treatable. Furthermore, treatment itself might create new risks.¹⁹ It is also argued that organizations built on the fee-for-service approach rarely compare the cost versus the benefit of the wide range of health services available.²⁰ Proponents contend that the HMO "is especially well suited to weigh all relevant factors in deciding how, and how much, to reduce the medical risks faced by its enrollee-patients."²¹

HMOs are unique in that they provide comprehensive health care services for a fixed prepaid fee, called a capitation payment.²² Advocates contend that HMOs are "motivated to scrutinize the effectiveness of every risk-reducing measure they take,"²³ "weigh the medical effectiveness and value of their expenditures and . . . curb . . . superfluous . . . tests"²⁴ because HMOs must provide comprehensive care from the limited pool of money provided by the capitation payments. Thus, HMOs concentrate on preventive medicine and treating illnesses before they become acute in order to avoid depleting the fixed budget.²⁵ It is argued that the end result should be better health care at lower costs. Generally, HMOs do cost less, admit fewer patients to hospitals, and use fewer hospital days than fee-for-service plans.²⁶

18. Randall Bovbjerg, *The Medical Malpractice Standard of Care: HMOs and Customary Practice*, 1975 DUKE L.J. 1375, 1377.

19. *Id.* at 1376.

20. *Id.* at 1377.

21. *Id.* at 1376. See also Bruce D. Platt & Lisa D. Stream, *Dispelling the Negative Myths of Managed Care: An Analysis of Anti-Managed Care Legislation and the Quality of Care Provided by Health Maintenance Organizations*, 23 FLA. ST. U. L. REV. 489 (1995).

22. Sarnacki, *supra* note 12, at 122. Capitation payments can either underpay or overpay physicians depending on the patient's health. Jinnat B. Fowles et. al, *Taking Health Status into Account When Setting Capitation Rates*, 276 JAMA 1316 (1996). Between 1987 and 1995, the number of Medicare patients whose health care was paid using capitation tripled. Donald M. Berwick, *Quality of Health Care—Payment by Capitation and the Quality of Care*, 335 NEW ENG. J. MED. 1227 (1996).

23. Bovbjerg, *supra* note 18, at 1376.

24. *Id.* at 1379.

25. *Id.*

26. FURROW ET AL., *HEALTH LAW*, *supra* note 9, § 8-1. HMOs cost 10-40% less, admit patients to the hospital 40% less, and use 40% fewer hospital days. *Id.* A study of California HMOs found that the number of hospital days per 1000 enrollees was substantially less than the national average and the rates of visits per enrollee to physicians were lower. Robinson & Casalino, *supra* note 14, at 1687. "HMO enrollees receive more preventive care than enrollees in traditional health insurance plans. Moreover, . . . studies generally show that HMO patients receive care of the same or better quality than other patients." Maxwell J. Mehlman, *Medical Advocates: A Call for a New Profession*, 1 WIDENER L. SYMP. J. 299, 301 (1996). See also Philip R. Alper, *Learning*

Critics of the HMO approach contend that the capitation system and "shared risk pool" create incentives not to treat patients or not to order expensive medical tests or procedures. Patients enrolled in HMOs must select a primary care doctor, called a "gatekeeper," from a list of participating physicians. Each physician receives the same monthly per capita payment for each patient whether the physician sees the individual patient many times or not at all. Usually the physician does not receive the entire capitation; rather, he or she will receive only a portion, and the remainder will be placed in a shared risk pool. At the end of the year, all participating primary care physicians will share out of the shared risk pool whatever money is not spent on health care. The shared risk pool decreases if tests or consultations are ordered.²⁷ One critic has argued, "The physician, therefore, is given financial incentives not to do his or her best and is no longer the advocate of the patient, but may become

to Accentuate the Positive in Managed Care, 336 NEW ENG. J. MED. 508 (1997). Some categories of enrolled patients might feel they are receiving better care in an HMO as compared with a fee-for-service plan. Paul J. Schilling has noted:

One clear improvement in some of the managed care Medicaid programs is that they do designate a physician and hospital for the patients to have access to care. This is a clear departure from Medicaid non-managed care programs where patients are left to "shop" for a physician who will take Medicaid. By virtue of the fact that they do have an identifiable physician, patients may feel that they are more satisfied with their care, even if they haven't yet received care.

Paul J. Schilling, *Patient Satisfaction with Medicaid Managed Care*, 272 JAMA 1297, 1297 (1996).

27. Ronald Bronow, *HMO Physicians' Shared Risk Pools Are Dangerous to Patients' Health*, HEALTHSPAN, Jan. 1993, at 9. One author suggests three reasons why patients, at times, receive sub-standard care from HMOs and that the dynamic of these three factors create a need for consumer protection. Marc A. Rodwin, *Managed Care and Consumer Protection: What Are the Issues?*, 26 SETON HALL L. REV. 1007, 1011-14 (1996). First, financial incentives, including capitation and shared risk pools, give physicians an "incentive to make frugal use of diagnostic tests, referrals, and hospitalization. Physician risk-sharing can bias physician judgment and lead doctors to deny appropriate services." *Id.* at 1012. The second reason is that HMOs are "complex organizations" and are "vulnerable to organizational pathologies. . . . [L]arge organizations can impede change, become unresponsive, and limit the appropriate use of discretion by professionals. They can diffuse authority and diminish personal responsibility, thereby reducing accountability." *Id.* at 1013. The third factor is that HMOs "restrict choice: an escape valve for consumers if doctors or MCOs [managed care organizations] perform poorly." *Id.* In other words, a fee-for-service patient could seek care elsewhere once poor treatment occurs. Choices for a patient enrolled in an HMO would be limited to those provided within the internal structure of the organization; a patient could only see doctors within the same network, utilization review could block expensive services, and consultations with specialists would be subject to the approval of the primary care specialists who, at the same time, typically has a financial incentive to limit referrals. The combination of these three factors "explain why consumers sometimes receive shoddy treatment from MCOs and demonstrate the need for consumer protection." *Id.* at 1014. Furthermore, no evidence suggests that a plan's clinical performance affects the economic success of managed care plans in today's market, nor will it affect the economic success in the future. "[P]urchasers and consumers have not, so far, rewarded or punished plans based on quality" of care provided. Ellwood & Lundberg, *supra* note 12, at 1085.

the patient's adversary."²⁸ He added that "when financial incentives are provided to physicians to limit costs, the interests of patients and physicians become diametrically opposed. The more the physician attempts to help the patient, the less the physician is compensated."²⁹

Advocates of the traditional fee-for-service plans contend that HMOs had no significant impact on the cost of medicine in the 1980s and are not expected to reduce health care costs in the 1990s.³⁰ Furthermore, they argue that patients enrolled in HMOs may visit their doctors less, may be admitted to the

28. Bronow, *supra* note 27, at 9. See also Mehlman, *supra* note 26 (contending that the presence of HMOs necessitates the existence of a health care advocate to protect the patient's interests). Mehlman argues that developments in managed care

submerge the interests of individual patients and . . . subordinate them to the interests of the group, whether it be a group of managers, insureds, or shareholders. Patients face increasingly large and powerful provider/payer bureaucracies. These organizations are motivated by competitive pressures to earn profits by reducing costs. If necessary, they withhold beneficial services, particularly from patients who are seriously or chronically ill. These individuals are lost in a system of quality measurement approaches that focus on the experiences of large numbers of persons.

Id. at 303. The traditional ally of the patient, who would work to assure proper care and work exclusively to protect the patient's best interest, was the physician. *Id.* at 314. However, managed care forces physicians to develop alliances with third-party payers instead of patients. "The financial incentives and other pressures under managed care place physicians in a conflict of interest between their duties to their patients and their own self-interest." *Id.* at 315. "If individual patients face an increasingly adversarial health care system, yet there is no one willing or able to serve as their allies, then a new profession of patient representatives is needed"—the "Medical Advocate." *Id.* at 320.

29. Bronow, *supra* note 27, at 11. See also David Orentlicher, *Paying Physicians More To Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155 (1996). Interestingly, reported decisions involving coverage disputes between HMOs and enrolled patients are scarce. It has been argued:

Managed care settings such as HMOs are less likely to produce coverage disputes, even though they are more likely to deny treatment, because coverage decisions are frequently made by treating physicians or by a medical director in the physician's practice group. Indemnity insurance requires a third-party medical director with the insurance company to overrule the treating physician's recommendation. HMOs and other forms of managed care, in contrast, use corporate and financial incentives to motivate physicians not to make treatment recommendations in the first place. This absence of patient knowledge that potentially beneficial care is being foregone could easily account for the lack of coverage disputes arising from managed care settings.

Mark A. Hall et al., *Judicial Protection of Managed Care Consumers: An Empirical Study of Insurance Coverage Disputes*, 26 SETON HALL L. REV. 1055, 1060-61 (1996). The lack of judicial decisions could also be partly explained by the presence of arbitration clauses in many policies providing HMO coverage. See generally Eleanor D. Kinney, *Resolving Consumer Grievances in a Managed Care Environment*, 6 HEALTH MATRIX 147 (1996).

30. Bronow, *supra* note 27, at 12 (referring to a Congressional Budget Office report). Others contend that managed care has created a more competitive market and has reduced the rate of increase in health care costs. David F. Drake, *Managed Care: A Product of Market Dynamics*, 277 JAMA 560 (1997).

hospital fewer times, and may spend fewer days in the hospital because HMOs provide their services to a healthier group of patients.³¹

Critics of HMOs perceive that the primary care doctors, as "gatekeepers," restrict patient access to specialists based on an erroneous philosophy that specialists are too expensive and order unnecessary tests. However, the lack of referral to specialists might cause several results: increased medical costs due to improper diagnosis and delayed treatment, additional visits to the primary care provider, potentially inappropriate treatment and improper diagnosis at the hands of the "gatekeeper," dangers to the patient's health and increased costs due to delayed treatment, and additional, more expensive medications and tests when specialized treatment is finally received.³²

The evidence is unclear whether the HMO approach will help curtail the rising cost of medicine while at the same time providing quality health care. However, one certainty is that the structure of the HMO makes it a prime target for civil tort litigation when an enrolled patient is injured through the malpractice of a physician receiving the financial rewards from the HMO capitation and shared risk pool systems. While the precise structure of HMOs vary, the HMO's structure in relationship to the participating physicians will be the key factor in determining the potential theory of recovery in tort law.

31. Robinson & Casalino, *supra* note 14, at 1687 (stating the "possibility that the lower rates of hospital utilization and visits to physicians reflect the provision of services to relatively healthy groups of patients"). Studies comparing the quality of care provided under managed care and under traditional fee-for-service plans are based on "aggregated data from a large number of patients. . . . Individual patients may still suffer from poor quality care." Mehlman, *supra* note 26, at 301 n.7 (citations omitted). Some believe that competitive pressures will force HMOs to withhold treatments with established benefits to patients in order to save money. Maxwell J. Mehlman has argued:

Moreover, it is important to note that the incentive to provide preventive services disappears once prevention has failed and the enrollee becomes ill. Even if managed care providers are willing to make short-term expenditures to reduce long-term costs, they still have an incentive to withhold services from enrollees who become chronically or seriously ill and require extensive, costly care.

Id. at 302. However, very little objective evidence demonstrates an overall decline in the quality of care in managed care systems. See Ellwood & Lundberg, *supra* note 12, at 1085. See generally ABA HEALTH LAW SECTION, ACHIEVING QUALITY IN MANAGED CARE: THE ROLE OF LAW (John D. Blum ed., 1997).

32. Bronow, *supra* note 27, at 11. One study explored the ability of primary care physicians to diagnosis correctly the most encountered skin conditions seen by dermatologists. Primary care physicians correctly diagnosed the patient's problem in only 54% of the cases. Dermatologists correctly diagnosed the patients condition in over 90% of the cases. *Id.*

III. TYPICAL HMO PHYSICIAN CONTRACTUAL ARRANGEMENTS

All HMOs share certain common attributes:

An HMO is defined as an alternative system of health care delivery, whereby health care providers . . . enter into contracts with or are employed by a health care entity to provide comprehensive health care to voluntarily enrolled patients. The most distinguishing characteristic of membership in an HMO is that an enrolled patient pays a prepaid, fixed fee for medical services. . . . [T]he patient pays a one-time charge for subsequent complete health care services. The prepaid fee is paid without regard to the actual amount of services provided to the enrolled patients.³³

The four basic models of HMOs are: (1) the Staff Model HMO; (2) the Group Model HMO; (3) the Network Model HMO; and (4) the IPA Model HMO.³⁴ The nature of the contractual relationship maintained between the administrative corporate structure of the HMO and the participating physicians distinguishes these four different models.³⁵ While these HMO models illustrate the typical arrangements, many HMOs do not fit neatly into one specific category because they may combine features from two or more models.³⁶ Much of the potential

33. Kanute, *supra* note 4, at 841-42. See also Earlene P. Weiner, Note, *Managed Health Care: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine*, 15 J. CORP. L. 535, 541 (1990) (stating that "[t]he essential elements of the HMO concept are (a) provision of comprehensive medical services—including as a minimum, basic physician care, hospital care, and emergency care; (b) to a defined enrolled population; (c) on a prepayment rather than a fee-for-service basis.") (quoting S. REP. NO. 129, 93d Cong. 141, reprinted in 1973 U.S. CODE CONG. & ADMIN. NEWS 3033, 3117).

34. FURROW ET AL., *HEALTH LAW*, *supra* note 9, at 478-79. Regarding the definition of HMO, see *Walsh v. Women's Health Ctr., Inc.*, 376 So. 2d 250 (Fla. Ct. App. 1979); *Huff v. St. Joseph's Mercy Hosp. of Dubuque Corp.*, 261 N.W.2d 695 (Iowa 1978). See also *McClellan v. Health Maint. Org.*, 660 A.2d 97 (Pa. Super. Ct. 1995). In *McClellan*, the Superior Court of Pennsylvania discusses the various forms of HMOs. The type of HMO can determine legal issues other than potential legal liability for negligent care. In *McClellan*, the issue was whether the HMO could claim protection under the Pennsylvania peer review immunity statute. The court concluded that the HMO could not claim the protection or confidentiality of the peer review statute because it was an IPA Model HMO. The court stated that "[i]t is this court's opinion that entities such as Staff or Group Model HMOs may be considered 'health care providers' . . . in an appropriate case. Not so clear, however, is whether IPA Model HMOs, like HMO of Pa., that do not operate their own facilities, but merely act as insurers or quasi-insurers, should be covered." *Id.* at 101-02.

35. Kanute, *supra* note 4, at 842.

36. *Id.* It has been noted that "[m]anaged-care plans, particularly HMOs, have complex systems for selecting, paying, and monitoring their physicians. Hybrid forms are common, and the differences between group or staff HMOs and network or IPA HMOs are less extensive than is commonly assumed." Marsha R. Gold et al., *A National Survey of the Arrangements Managed-Care Plans Make with Physicians*, 333 NEW ENG. J. MED. 1678, 1678 (1995). This survey lumps Staff

liability of the HMO will hinge on the amount of control the HMO exercises over individual physicians in the treatment of patients, and the contractual provisions of the HMO Model will usually dictate the degree of control.

A. Staff Model HMOs

A Staff Model HMO will usually own or lease and operate its own primary care medical facility.³⁷ The Staff HMO will typically employ its own physicians as "staff," and the physicians will receive salaries directly from the HMO.³⁸ Typically, the physicians will treat only HMO enrolled patients and will not treat patients outside the HMO on a fee-for-service basis.³⁹ In many Staff Model HMOs, the individual physicians will receive a given salary plus incentive bonuses paid out of the "shared risk pool" based on the HMO's profitability.⁴⁰

B. Group Model HMOs

Medical Group HMOs, the second most prevalent form,⁴¹ contract with or employ a medical group of physicians, rather than individual physicians, to

and Group Model HMOs together and Network and IPA Model HMOs together in compiling statistics. In 92% of Network or IPA Model HMOs and in 61% of Group or Staff HMOs, patients must select a primary care physician who is responsible for specialist referrals. *Id.* at 1682. Network or IPA Model HMOs use capitation to pay primary care physicians 56% of the time; while Staff or Group HMOs do so 34% of the time. *Id.* at 1681. A fixed salary, with adjusted payments to create incentives, for primary care physicians is common in Staff or Group Model HMOs. *Id.*

In contrast, only 20 percent of the network or IPA HMOs used capitation as a predominant method of payment for individual specialists; 54 percent had some form of risk sharing with specialists, 47 percent used capitated payment for certain specialties, and 33 percent used competitive bidding to obtain some specialty services. The specialties in which physicians were most commonly paid on a capitated basis were cardiology, mental health, radiology, orthopedics, and ophthalmology.

Id. at 1680. Fewer than half of the Staff or Group HMOs paid specialists using capitation. All forms of HMOs commonly employed risk-sharing with physicians, adjusted payments to the "gatekeeper" to create performance-based incentives, and required physicians to care for only plan members or for a predetermined number of patients within the plan. "Fifty percent of the group or staff HMOs and 74 percent of the network or IPA HMOs adjusted payments according to utilization and cost patterns." *Id.* This national survey of HMOs suggested "that many of the differences between specific HMOs cannot be explained by their classification as group or staff HMOs or as network or IPA HMOs." *Id.* at 1682. The Congressional Budget Office's assumption that most of the cost savings result from Group or Staff Model HMOs, rather than Network or IPA Model HMOs, might not be correct. *Id.*

37. Cooper, *supra* note 1, at 1264.

38. O. Mark Zamora, *Medical Malpractice and Health Maintenance Organizations: Evolving Theories and ERISA's Impact*, 19 NOVA L. REV. 1047, 1048 (1995).

39. Weiner, *supra* note 33, at 540.

40. Perdue & Baxley, *supra* note 6, at 27.

41. Kanute, *supra* note 4, at 843.

provide care to their enrollees.⁴² Because the contract is with a single medical group, patients enrolled in this type of HMO will usually have limited choices regarding doctors.⁴³ The treatment is typically provided at an HMO owned or operated facility.⁴⁴ The physicians are compensated through capitation payments;⁴⁵ however, the doctors will usually provide services to fee-for-service patients and are simply adding a pre-paid component to their practices.⁴⁶

C. Network Model HMOs

A Network Model HMO is similar to a Group Model HMO; however, the Network Model HMO contracts with multiple medical groups and/or individual physicians to provide care to enrolled patients rather than a single medical group as in the Group Model HMO.⁴⁷ Individual medical groups may also contract with other HMOs. The care is typically provided in the participating physician's facility; thus, the physician utilizes neither the equipment nor the physical plant owned or operated by the HMO. While the physician is compensated through capitation payments,⁴⁸ the individual physician will usually provide care to unenrolled patients and thus will also be compensated through a fee-for-service trade.⁴⁹

D. IPA Model HMOs

The Independent Practice Association or Indorsement Practice Association (IPA) Model HMO is the most prevalent with approximately fifty percent of all HMOs falling into this category.⁵⁰ The IPA Model differs dramatically from the other models in that no direct contractual relationship is created between the HMO and the individual physicians. Instead, the privity exists between the HMO and the IPA: the HMO contracts with the IPA, and the IPA then contracts with individual physicians to provide care to HMO enrollees at the physician's office.⁵¹ Each physician will utilize his or her own office, equipment, and records, rather than the HMO's.⁵²

42. *Id.*

43. *Id.*

44. Perdue & Baxley, *supra* note 6, at 28.

45. Weiner, *supra* note 33, at 540.

46. Kanute, *supra* note 4, at 843.

47. Weiner, *supra* note 33, at 541.

48. Perdue & Baxley, *supra* note 6, at 28.

49. Weiner, *supra* note 33, at 541.

50. *Id.* See also FURROW ET AL., HEALTH LAW, *supra* note 9, at 479 (noting that "[a] recent study of HMOs found that 48 % were IPAs, 14 % networks, and 38 % staff or group-model HMOs").

51. Perdue & Baxley, *supra* note 6, at 28.

52. Kanute, *supra* note 4, at 844.

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Hence, the IPA model HMO combines, in a single program, features of the staff and group model HMOs. An IPA model HMO provides the comprehensive benefit package of a staff model HMO and care in the office of one of a group of privately practicing physicians who is not directly employed by the HMO's administrative body.⁵³

In the IPA Model HMO, the IPA receives the capitation payment, not the individual physician. The IPA will then compensate the physician on a fee-for-service basis.⁵⁴ Typically, the IPA will withhold a fixed percentage of each payment from the physician, and "[t]he amount withheld may equal twenty to thirty percent of the potential fee, which the physician can recover only by achieving preset cost-containment goals."⁵⁵ Because IPA HMOs employ the shared risk pool in combination with utilization review, they can be subject to potential tort liability along with Staff, Group, and Network Model HMOs.

IV. THE POTENTIAL THEORIES OF TORTIOUS LIABILITY AGAINST HMOs

Arguably, cost-containment procedures which include capitation, shared risk pools, and utilization review create disincentives to providing to HMO enrollees appropriate treatment and referral to specialists. Cost-containment efforts also increase HMO control over individual physicians in treatment decisions, and physicians view them as an "usurpation of their judgment and independence."⁵⁶ Furthermore, "[t]he more HMOs exercise control over their participating physicians, the more their exposure to liability for the torts of the doctors will continue to increase."⁵⁷

Various legal theories may be used to impose liability for medical negligence upon HMOs: vicarious liability based upon respondeat superior or ostensible or apparent agency, and corporate negligence or direct liability.⁵⁸

53. *Id.*

54. *Id.*

55. Perdue & Baxley, *supra* note 6, at 28.

56. Reuben, *supra* note 1, at 56.

57. *Id.*

58. See generally Bearden & Maedgen, *supra* note 1; Gregory G. Binford, *Malpractice and the Prepaid Health Care Organization*, 3 WHITTIER L. REV. 337 (1981); William F. Brossman, Jr. & William M. Mercer, *Legal Liability Issues in Managed Care*, C653 ALI-ABA 471 (1991); William A. Chittenden III, *Malpractice Liability and Managed Health Care: History and Prognosis*, 26 TORT & INS. L.J. 451 (1991); Conrad & Seiter, *supra* note 6; Cooper, *supra* note 1; William J. Curran & George B. Moseley III, *The Malpractice Experience of Health Maintenance Organizations*, 70 NW. U. L. REV. 69 (1975); Michael A. Dowell, *Avoiding HMO Liability for Utilization Review*, 23 U. TOL. L. REV. 117 (1991); Kanute, *supra* note 4; Robert N. Meyer, *Group Prepaid Health Plan Liability When a Physician Provider Malpractices*, 6 N.M. L. REV. 79 (1975); Perdue & Baxley, *supra* note 6; Vernellia R. Randall, *Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 U. PUGET SOUND

These theories have been used in analogous cases to impose liability upon hospitals. Furthermore, the amount of HMO control over the treatment of individual patients injured by the alleged negligence of participating physicians provides the basis for each theory of liability. Of course, physicians remain personally liable for any patient injuries caused by their negligence. The crucial question becomes whether HMOs should be liable, or should share in the liability, when the medical negligence alleged involves the cost-saving structure of HMOs, e.g., where the injuries result from failures to refer, order diagnostic tests, aggressively treat, or hospitalize patients. Thus, the issue is essentially who should bear the burden of paying judgments rendered for negligent medical care, especially when cost-containment efforts are a substantial factor in causing the sub-standard care. Should the individual physician who delivered the negligent care, the HMO who controlled the manner of treatment through planned financial incentives, or both the HMO and the treating physician be liable for the patient's injuries?

Quite clearly, the transition from the fee-for-service system to one based on capitation exposes new defendants to medical negligence litigation, i.e., the HMO. Richard C. Reuben has noted:

In the erstwhile fee-for-service era, lawsuits were relatively straightforward: The doctor performed the services and was the primary target for litigation when something went wrong. But managed care has changed that dynamic dramatically, and is beginning to replace the doctor as the deep pocket of choice in medical-care litigation.⁵⁹

A. Vicarious Liability

1. Respondeat Superior

Under the doctrine of respondeat superior, employers are vicariously liable for torts committed by their employees when the wrongful conduct of the employees occurred during the course of and within the scope of employment.⁶⁰ The determinative factor in imposing such vicarious liability

L. REV. 1 (1994); Shah-Mirany, *supra* note 12; Weiner, *supra* note 33; Zamora, *supra* note 38. On the potential liability of an HMO for breach of contract, see Sarnacki, *supra* note 12.

59. Reuben, *supra* note 1, at 56.

60. See Raglin v. HMO Illinois, Inc., 595 N.E.2d 153 (Ill. App. Ct. 1992). Commentators have noted:

The doctrine of respondeat superior is based on the premise that when an innocent party is injured through tortious conduct committed in the furtherance of a business enterprise, the enterprise should bear the loss as a legitimate business expense. Under this doctrine, courts deliberately place the risk of loss upon the business entity because it can

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is the right of employers to control the activities of their agents. Courts use numerous factors to determine whether a master-servant relationship existed:

[T]he right of the employer to control the details of the work done by the employee, the method of payment, the skill required in the particular occupation, whether the employer supplies the tools, instrumentalities and place of work, as well as the parties' own belief as to whether they are creating a master-servant relationship.⁶¹

Traditionally, the doctrine of respondeat superior did not hold hospitals liable for the negligent conduct of physicians practicing within the hospital. Originally, physicians who were employed by hospitals or who held staff privileges at hospitals were considered independent contractors because they exercised their own professional judgment, skill, and expertise in treating patients, and hospitals lacked sufficient control over the manner and details of their work.⁶² However, by 1957, this rule was rejected as to physician-employees so that hospitals could be vicariously liable like any other employer. One court has pronounced:

Hospitals should, in short, shoulder the responsibility borne by everyone else. There is no reason to continue their exemption from the universal rule of respondeat superior. The test should be, for these institutions, . . . as it is for every other employer, was the person who committed the negligent injury-producing act one of its employees and, if he was, was he acting within the scope of his employment.⁶³

Inasmuch as these principles of liability apply to hospitals, they will generally apply to HMOs as well, and thus HMOs can also be vicariously liable for the negligence of physicians so long as the physicians are considered employees.⁶⁴ As one court has argued, "the test of vicarious liability is still one of control or

better absorb the loss and shift the cost to society as a whole.

Perdue & Baxley, *supra* note 6, at 29.

61. Chase v. Independent Prac. Ass'n, Inc., 583 N.E.2d 251, 253 (Mass. App. Ct. 1991).

62. See Schloendorff v. Society of New York Hosp., 105 N.E. 92 (N.Y. 1914); Kanute, *supra* note 4, at 847.

63. Bing v. Thunig, 143 N.E.2d 3, 8 (N.Y. 1957). The Bing decision only applied to physicians who were actually employed by the hospital. Physicians holding staff privileges are still considered independent contractors, and hospitals cannot be vicariously liable for the torts of staff physicians unless other legal theories support such liability, such as ostensible or apparent agency or the independent negligence of hospitals in failing properly to monitor staff physicians or failing to use reasonable care in selecting or retaining their staff.

64. See Chase v. Independent Prac. Ass'n, Inc., 583 N.E.2d 251 (Mass. App. Ct. 1991).

right of control by the employer (i.e., hospital or HMO) over the actual conduct by the physician (employee) alleged to be negligent."⁶⁵

Most of the cases brought against HMOs seek to impose vicarious liability,⁶⁶ which has been described as the "bedrock" of HMO litigation.⁶⁷ In *Sloan v. Metropolitan Health Council of Indianapolis, Inc.*,⁶⁸ one of the first cases deciding whether HMOs could be vicariously liable for the medical malpractice of their physicians, the court held that "where the usual requisites of agency or an employer-employee relationship exist, a corporation may be held vicariously liable for malpractice for the acts of its employee-physicians."⁶⁹ Litigants will find it easier to establish the requisite master-servant relationship and sufficient control by the HMO over the physician in the Staff Model HMO context, and thus justify vicarious liability, because these HMOs directly employ physicians, the physicians are paid fixed salaries, the physicians deliver care only to HMO enrolled patients, and the physicians utilize HMO facilities and equipment.⁷⁰ In contrast, litigants will find it difficult to establish the requisite

65. *Id.* at 254.

66. See Cooper, *supra* note 1, at 1270. See, e.g., *Schleier v. Kaiser Found. Health Plan of Mid-Atlantic States, Inc.*, 876 F.2d 174 (D.C. Cir. 1989) (imposing vicarious liability because physician could not act independently of the HMO's physician); *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544 (S.D. Ill. 1994) (imposing vicarious liability upon HMO when a physician-employee provided negligent treatment); *Pulvers v. Kaiser Found. Health Plan, Inc.*, 160 Cal. Rptr. 392 (Cal. 1980) (holding that the evidence supported imposing vicarious liability); *Raglin v. HMO Illinois, Inc.*, 595 N.E.2d 153 (Ill. App. Ct. 1992) (refusing to impose vicarious liability on an IPA Model HMO due to lack of control); *Sloan v. Metropolitan Health Council of Indianapolis, Inc.*, 516 N.E.2d 1104 (Ind. Ct. App. 1987) (imposing vicarious liability because the physician was an employee of the HMO); *Gugino v. Harvard Community Health Plan*, 403 N.E.2d 1166 (Mass. 1980) (imposing vicarious liability on a Staff Model HMO); *Chase v. Independent Prac. Ass'n, Inc.*, 583 N.E.2d 251 (Mass. App. Ct. 1991) (holding that an IPA Model HMO was not vicariously liable because it lacked sufficient control over individual physicians); *Dunn v. Praiss*, 606 A.2d 862, 868 (N.J. Super. Ct. App. Div. 1992) (holding HMO vicariously liable when physicians "were not free to accept or reject particular patients" and were paid by capitation); *DeGenova v. Ansel*, 555 A.2d 147 (Pa. Super. Ct. 1988) (holding sufficient allegations of an agency relationship were made to impose vicarious liability upon an HMO); *Williams v. Health America Corp. of Tx.*, 743 S.W.2d 373 (Tex. Ct. App. 1987) (refusing to impose vicarious liability on an HMO because the corporation could not practice medicine under Texas law and denying summary judgment because no control was shown).

67. *Zamora*, *supra* note 38, at 1049.

68. 516 N.E.2d 1104 (Ind. Ct. App. 1987).

69. *Id.* at 1109. In *Sloan*, one of the critical factors that established control was the fact that the physician was supervised by and under the control of a medical director, who was also a physician, and "who policed medical services and established policy. His judgment was final. The circumstances establish an employment relationship where the employee performed acts within the scope of his employment." *Id.*

70. See, e.g., *Gugino v. Harvard Community Health Plan*, 403 N.E.2d 1166, 1168 (Mass. 1980) (holding an HMO could be vicariously liable for its employee-physician's negligence if a "factual basis [existed] for inferring that the Plan had power of control or direction over the conduct in question.") See also Kanute, *supra* note 4, at 864.

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employer-employee relationship between HMOs and participating physicians in the IPA Model HMO context because no contractual relationships are created between the HMOs and physicians (HMOs contract with IPAs who then contract with physicians), physicians are paid on a fee-for-service basis, physicians provide care in their own private offices and with their own equipment, and physicians treat both enrolled and non-enrolled patients.⁷¹

Group and Network Model HMOs are more difficult. The physicians participating in Group and Network Model HMOs are paid by capitation, but the physicians may or may not use HMO owned or operated facilities and equipment, the physicians may or may not treat unenrolled patients on a fee-for-service basis, and the manner and details of the work of physicians may or may not be supervised through utilization review. However, Group and Network Model HMOs could be held vicariously liable under the doctrine of respondeat superior if a court finds that an HMO exercised sufficient control and that a master-servant relationship existed between the HMO and the physician.⁷² To determine whether an HMO exerted sufficient control over the treating physician and whether a master-servant relationship existed so as to justify imposing vicarious liability, courts will consider the following factors: (1) whether the method of payment is fee-for-service or capitation; (2) whether complaints regarding service are made to the physician or the HMO; (3) whether the physician is salaried or has a benefit package; (4) whether the physician treats any unenrolled patients; (5) whether enrollment is made through the HMO or the physician; (6) whether the HMO or the physician bills the patient for services rendered;⁷³ (7) whether the HMO's or the physician's facilities and equipment is used in the treatment of patients; (8) whether the HMO retains power to coordinate or assign the scheduling of physicians;⁷⁴ (9) whether care rendered by a physician is subject to the control or review of a medical director or supervising physician;⁷⁵ and (10) whether the physician has the power to accept or reject a particular patient.⁷⁶

71. See, e.g., *Raglin v. HMO Illinois, Inc.*, 595 N.E.2d 153 (Ill. App. Ct. 1992) (holding that there was not sufficient evidence of control to impose vicarious liability upon an IPA Model HMO for the medical negligence of a participating physician); *Chase v. Independent Prac. Ass'n, Inc.*, 583 N.E.2d 251, 253-54 (Mass. App. Ct. 1991) (holding that the "IPA did not control, or retain the right to control, the professional activities of [the physicians]" and that an IPA Model HMO could not be subject to vicarious liability because it did not directly employ physicians). See generally Kanute, *supra* note 4, at 864.

72. See Cooper, *supra* note 1, at 1270-71; Kanute, *supra* note 4.

73. *Sloan v. Metropolitan Health Council of Indianapolis, Inc.*, 516 N.E.2d 1104, 1109 (Ind. Ct. App. 1987).

74. Kanute, *supra* note 4, at 864-65.

75. Cooper, *supra* note 1, at 1272; Zamora, *supra* note 38, at 1049.

76. *Dunn v. Praiss*, 606 A.2d 862, 868 (N.J. Super. Ct. App. Div. 1992).

Before an HMO will be held vicariously liable, a litigant must establish several things. The employee-physician must have, in fact, acted negligently in the treatment of the patient, and the negligent treatment must have caused the patient's injuries. The litigant must show that the physician's conduct fell below the standard established by the customary practice of his peers and that this departure from customary practice caused the injuries. In determining whether the physician's conduct dropped below the standard of care, the court will measure the physician's conduct against the conduct of other reasonably competent physicians under the same or similar circumstances.⁷⁷

It has been suggested that courts should apply a totally different standard of care to physicians practicing within an HMO structure:

The law could accept HMO custom as determinative of due care, to the same extent that insured fee-for-service custom is now accepted, in effect allowing this subgroup of medical practitioners to set its own malpractice standards. Whether or not a particular HMO practice was negligent would thus be judged by the practice of other HMO providers under comparable circumstances.⁷⁸

77. Two different approaches to the physician's standard of care have developed. The first approach, called the same or similar locality rule, gauges a physician's conduct on what other reasonably competent doctors, in the same or similar circumstances and in the same or similar locality as the defendant-physician, would have done. *See, e.g.,* Reeg v. Shaughnessy, 570 F.2d 309 (10th Cir. 1978). Under the second approach, the national standard of care approach, what other reasonably competent doctors would have done in the same or similar circumstance, determines whether the defendant-physician used reasonable care. The situs of the physician's practice is only one factor in determining whether reasonable care was used. *See, e.g.,* Vergara v. Doan, 593 N.E.2d 185 (Ind. 1992); Brune v. Belinkoff, 235 N.E.2d 793 (Mass. 1968). A variation on this second approach would not consider specific geography considerations. *See, e.g.,* Shilkret v. Annapolis Emergency Hosp. Assoc., 349 A.2d 245 (Md. 1975). Jurisdictions are divided as to which approach to take. W. PAGE KEETON ET AL., PROSSER & KEETON ON THE LAW OF TORTS § 32, at 187-88 (5th ed. 1984) [hereinafter PROSSER & KEETON]. Many states will apply a national standard to specialists and the same or similar locality rule to family practitioners. *See* Wall v. Stout, 311 S.E.2d 571 (N.C. 1984). *See generally* FURROW ET AL., HEALTH LAW, *supra* note 9.

78. Bovbjerg, *supra* note 18, at 1409. Two illustrations will demonstrate the differences between HMO practice and customary practice. First, an HMO might decide to treat a heart patient at home to save money rather than in a hospital coronary care unit. While some medical research from England suggests that at-home care and hospital care produce the same results, customary practice clearly dictates treatment in the hospital. Thus, such a departure from customary practice would cause malpractice liability to attach if a patient's condition were to worsen. *Id.* at 1389-90. Second, a given test might improve "the accuracy of a diagnosis from ninety to ninety-five percent in some moderately serious and generally treatable condition." A fee-for-service doctor would order the test while an HMO might decide to forego the test in order to allocate resources elsewhere. That decision could subject the HMO to liability because the HMO departed from the customary practices of physicians in similar circumstances. *Id.* at 1390. "But most experts for now agree that the primary duty of care is that which a reasonable physician in the community would have provided, regardless of HMO decisions about payments for services." Reuben, *supra* note 1, at 58.

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The following is the main policy argument that is advanced to support an HMO standard of care instead of the customary practice standard:

The main deficiency of the medical custom rule is that it derives the malpractice standard of care from medical practice dominated by insured fee-for-service care, the providers of which can make decisions with little regard for actual social cost. Applying such standards to HMO practice pressures HMOs to conform to this non-optimizing behavior and reduces the likelihood that HMOs will evolve different styles of practice offering valuable insights to other providers and to legal standard-setters alike.⁷⁹

The difficulty with adopting a standard of care determined by the "customary practice of HMOs" would be that it could immunize substandard care from legal liability. Consider the case where an HMO employee advised a woman who had an infection as a result of the Dalkon shield that she should douche with yogurt.⁸⁰ The court described this treatment as a "substandard lay remedy."⁸¹ Under the customary practice rule, this treatment would clearly lead to liability. However, the application of a different standard in the HMO context, i.e., what is customary in an HMO, could immunize such grossly negligent behavior.⁸²

The respectable minority doctrine should sufficiently protect physicians from liability. This doctrine provides that a physician will not be legally liable merely because he decides on a particular course of treatment when several recognized treatments are available so long as reasonably competent members of his profession would have also selected the same treatment. In other words, when reasonable doctors disagree over the appropriate method of treatment, a physician can use his own professional judgment in selecting the method of treatment.⁸³ Arguably, if reasonable doctors would not disagree over the appropriateness of treatment provided by an HMO, then apparently no social benefit would be gained from precluding liability for inappropriate treatment just because other HMOs were providing the same inappropriate treatment.⁸⁴

79. Bovbjerg, *supra* note 18, at 1397.

80. *Gugino v. Harvard Community Health Plan*, 403 N.E.2d 1166, 1167-68 (Mass. 1980) (holding Staff Model HMO vicariously liable).

81. *Id.*

82. The author does not intend to suggest that all HMOs would recommend a yogurt douche under the circumstances presented in the *Gugino* case.

83. FURROW ET AL., *HEALTH LAW*, *supra* note 9, § 6-5, at 382-85; PROSSER & KEETON, *supra* note 77, § 69, at 499-501. See, e.g., *Hood v. Phillips*, 554 S.W.2d 160, 165 (Tex. 1977).

84. Under the doctrine of respondeat superior, a court may impose tort liability provided that the HMO is not immune from liability. ERISA preemption may provide some protection, but this will be discussed later in this article. See *infra* section V. A few states have specifically immunized HMOs from tort liability. See, e.g., N.J. STAT. ANN. § 26:2j-25(c)-(d) (West 1996). In *Harrell*

2. Ostensible or Apparent Agency

When services are rendered at a business location, the consumer may reasonably form the impression that the services were provided by an employee of the business even if the services were provided by an independent contractor. The doctrine of apparent or ostensible agency springs from the reasonable belief of the party receiving the service (determined under the totality of circumstances surrounding the transaction) that an employer-employee relationship existed between the one employing the independent contractor and the person providing the service. If the circumstances reasonably create an implied representation that an employer-employee relationship exists, then vicarious liability will be imposed.⁸⁵ Section 429 of the Restatement (Second) of Torts states the doctrine of ostensible or apparent agency:

One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or by his servants, is subject to liability for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as though the employer were supplying them himself or by his servants.⁸⁶

v. Total Health Care, Inc., the Missouri Supreme Court explained some of the policy reasons for such a statutory grant of immunity:

The purpose of the statutes authorizing this kind of corporation is to sanction one method of combatting the cost of health care. Just as the ancient Chinese are reputed to have paid their doctors while they remained well, a person may elect to pay fixed dues in advance so that medical services may be available without additional cost when they are needed. The legislature well might feel that these arrangements were in the public interest and that those organizations that do not operate for profit should not be burdened by the additional cost of malpractice litigation The legislature well might have considered that one in the position of this plaintiff has an adequate remedy against the persons actually guilty of malpractice, who are licensed physicians, and does not need an additional source of recompense from a not-for-profit corporation.

781 S.W.2d 58, 61 (Mo. 1989). See also *Williams v. Good Health Plus, Inc.*, 743 S.W.2d 373 (Tex. Ct. App. 1987) (determining that the trial court's entry of summary judgment in favor of the HMO was appropriate because the HMO could not practice medicine under Texas law and because the evidence of control was not sufficient to establish vicarious liability).

85. FURROW ET AL., *HEALTH LAW*, *supra* note 9, at 294-97.

86. RESTATEMENT (SECOND) OF TORTS § 429 (1965). Courts will often confuse the concept of apparent or ostensible agency with the concept of agency by estoppel. Occasionally, the terms will be used interchangeably. See, e.g., *Smith v. St. Francis Hosp. Inc.*, 676 P.2d 279 (Okla. Ct. App. 1983). However, agency by estoppel technically requires stricter proof that the plaintiff actually relied upon the representation of the business or principal. See *Jackson v. Power*, 743 P.2d 1376, 1380 (Alaska 1987). The doctrine of agency by estoppel provides:

One who represents that another is his servant or agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.

Under the doctrine of ostensible or apparent agency, a hospital may be vicariously liable for the misconduct of certain physicians, even though they may technically be independent contractors. Emergency room physicians, anesthesiologists, radiologists, and pathologists are among the physicians most commonly found to be ostensible or apparent agents of a hospital.⁸⁷ The doctrine of apparent or ostensible agency has been found to apply when a hospital hires physicians to direct or provide services that the hospital has impliedly represented to the public that it supplies (such as emergency room services) and when patients look to the hospital to provide the necessary care without regard to the identity of a particular physician. In contrast, a hospital will not be vicariously liable when a pre-existing doctor-patient relationship is found (even if the physician holds staff privileges at the hospital) and when the patient is subsequently admitted to the hospital, and the hospital merely provides the situs for the rendition of care.⁸⁸ Thus, "two factors are relevant to a finding of ostensible agency: (1) whether the patient looks to the institution, rather than the individual physician, for care; and (2) whether the hospital 'holds out' the physician as its employee."⁸⁹ The doctrine of ostensible or apparent agency does not require proof of express representations that the physician was a hospital employee, nor does it require proof of specific reliance by the patient.⁹⁰ The following justification is offered in support of such an imposition of vicarious liability upon hospitals:

Certainly, members of the public who avail themselves of a hospital's emergency room services under these circumstances have a right to expect competent medical treatment from the medical personnel cloaked with ostensible authority by the hospital's conduct which reasonably leads the public to believe that medical treatment will be afforded by physicians acting on behalf of the hospital, and not on their respective individual responsibility. Consequently the hospital must be held accountable for the negligence, if any, of its authorized emergency room physician regardless of whether or not he is an independent contractor by secret limitations contained in private contract between the hospital and doctor or by virtue of some other

RESTATEMENT (SECOND) OF AGENCY § 267 (1958). Most cases in the area are decided under the concept of apparent or ostensible agency. A few courts have also held that a hospital is vicariously liable when a physician performs an inherent function of the hospital or a non-delegable duty. See, e.g., *Beeck v. Tucson Gen. Hosp.*, 500 P.2d 1153 (Ariz. Ct. App. 1972).

87. *Hardy v. Brantly*, 471 So. 2d 358, 371 (Miss. 1985).

88. *Id.*; *Smith*, 676 P.2d at 281.

89. *Jackson*, 743 P.2d at 1380 (Alaska 1987), accord *Smith*, 676 P.2d at 282.

90. *Hardy*, 471 So. 2d at 370-71, accord *Smith*, 676 P.2d at 282-83. In contrast, agency by estoppel does require specific proof of reliance. For a discussion of the definitions of and difference between ostensible or apparent agency and agency by estoppel, see *supra* note 86 and accompanying text.

business relationship unknown to the patient and contrary to the hospital's conduct and representations.⁹¹

Courts will generally apply this same doctrine to HMOs because many HMOs, much like hospitals, purport to provide total care coverage for their members.⁹² Therefore, the doctrine of apparent or ostensible agency is one of the primary theories utilized to hold HMOs vicariously liable for the negligence of their participating physicians.⁹³ In the HMO context, litigants must prove the following: (1) that the patient looked to the HMO for care, rather than the individual physician; and (2) that the HMO held out the physician as an employee. Although the doctrine of respondeat superior would result in vicarious liability more commonly in the Staff and Group Model HMO context and more rarely in the IPA Model HMO context, the doctrine of apparent or ostensible agency would likely result in vicarious liability with any HMO model because the facts of each individual case are more determinative with this doctrine. Thus, HMOs may be held vicariously liable for physician misconduct even in the IPA Model⁹⁴ despite the fact that, under this model, physicians do not directly contract with HMOs (HMOs contract with IPAs who in turn contract with individual physicians or physician groups). Furthermore, a litigant could potentially argue the theory of apparent or ostensible agency against any model of HMO, depending on the control exercised and representations made by the HMO, because all HMO models share many similarities.⁹⁵ Under this theory, a court has even imposed liability upon an HMO for a consultant who an HMO physician brought in to review a case.⁹⁶

An inquiry regarding apparent or ostensible agency is fact intensive, and a finding of ostensible agency requires more than the presence of the physician's name on the HMO's approved list of physicians, and more than the requirement

91. *Smith*, 676 P.2d at 282-83.

92. *Chase v. Independent Prac. Ass'n, Inc.*, 583 N.E.2d 251 (Mass. App. Ct. 1991); *Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229, 1231 (Pa. Super. Ct. 1988).

93. *See, e.g., Schleier v. Kaiser Found. Health Plan, Inc.*, 876 F.2d 174 (D.C. Cir. 1989); *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544 (S.D. Ill. 1994); *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182 (E.D. Pa. 1994); *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983 (E.D. Pa. 1990); *Raglin v. HMO Illinois, Inc.*, 595 N.E.2d 153 (Ill. App. Ct. 1992); *Chase*, 583 N.E.2d at 251; *Dunn v. Praiss*, 606 A.2d 862 (N.J. Super. Ct. App. Div. 1992); *McClellan v. Health Maintenance Org.*, 604 A.2d 1053 (Pa. Super Ct. 1992); *DeGenova v. Ansel*, 555 A.2d 147 (Pa. Super. Ct. 1988); *Boyd*, 547 A.2d at 1229.

94. *See, e.g., Raglin*, 595 N.E.2d at 158 (affirming the trial court's holding that the evidence was not sufficient to find an apparent agency with the IPA HMO); *Chase*, 583 N.E.2d at 255 (holding IPA HMO not vicariously liable under the facts using an ostensible agency theory); *Boyd*, 547 A.2d at 1229 (applying ostensible agency theory to an IPA HMO).

95. *See supra* note 36.

96. *See Schleier*, 876 F.2d at 174.

that the patient select a physician from a list provided by the HMO.⁹⁷ Rather, the HMO's conduct must lead the patient reasonably to believe that an employee of the HMO, as an institution, is treating the patient.⁹⁸ Courts have looked to the following factors to ascertain whether ostensible or apparent agency is established: (1) written representations by the HMO, in the form of advertisements, brochures, or contracts, that the HMO provides a comprehensive health care system;⁹⁹ (2) whether "gatekeepers" decide who accesses the health care system, i.e., whether a primary care provider screens hospitalizations and referrals to specialists;¹⁰⁰ (3) whether physicians are paid by capitation and whether a shared risk pool exists;¹⁰¹ (4) whether patients pay the HMO or the physician;¹⁰² (5) whether patients must choose physicians from limited lists of approved HMO physicians;¹⁰³ (6) whether the HMO screens physicians who must comply with HMO regulations;¹⁰⁴ (7) whether patients can see specialists without the recommendation of their primary care physicians;¹⁰⁵ (8) whether patients have choices regarding which specialists to see;¹⁰⁶ (9) whether patients must follow HMO mandates;¹⁰⁷ (10) whether the HMO solicited the patient's participation within the system;¹⁰⁸ (11) whether the HMO's quality assessment program merely tracks physicians to determine whether they are complying with HMO regulations or whether the program reviews the appropriateness of medical diagnoses or care delivered;¹⁰⁹ (12) whether individual physicians are free to accept or reject particular patients;¹¹⁰ (13) whether patients are examined at the HMO's office or the private offices of physicians and whether the HMO or physicians supplied the instruments and supplies;¹¹¹ (14) whether patients complain to the HMO or the physicians; (15) whether the employment contracts between the HMO and physicians provide for salaries, vacation and sick leave, and insurance coverage; (16) whether physicians treat only HMO enrolled patients or non-enrolled patients as

97. *Kearney*, 859 F. Supp. at 187.

98. *Id.* at 185.

99. *Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229, 1232 (Pa. Super. Ct. 1988).

100. *Id.* at 1233.

101. *Dunn v. Praiss*, 606 A. 2d 862, 868 (N.J. Super. Ct. App. Div. 1992); *Boyd*, 547 A.2d at 1234.

102. *Boyd*, 547 A.2d at 1235.

103. *Id.*

104. *Id.*

105. *Dunn*, 606 A.2d at 868; *Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229, 1235 (Pa. Super. Ct. 1988).

106. *Boyd*, 547 A.2d at 1235; *DeGenova v. Ansel*, 555 A.2d 147, 150 (Pa. Super. Ct. 1988).

107. *Boyd*, 547 A.2d at 1235.

108. *Id.*

109. *Raglin v. HMO Illinois, Inc.*, 595 N.E.2d 153, 158, (Ill. App. Ct. 1992).

110. *Dunn v. Praiss*, 606 A. 2d 862, 868 (N.J. Super. Ct. App. Div. 1992).

111. *Id.*; *Smith v. St. Francis Hosp., Inc.*, 676 P.2d 279, 281 (Okla. Ct. App. 1983).

well;¹¹² (17) whether physicians utilize the HMO's forms or stationary; (18) whether the HMO employs medical directors and whether the decisions of the medical directors are final;¹¹³ (19) whether the patient enrolled through the physician or directly with the HMO;¹¹⁴ (20) whether the HMO or the physicians provide the clerical/support staff; (21) whether the HMO or the physicians set the rates;¹¹⁵ and (22) the HMO's overall control over the individual physicians.¹¹⁶

These factors are not meant to be exhaustive, and courts have not indicated how many factors must be present to impose vicarious liability under the doctrine of ostensible or apparent agency. Rather, sufficient evidence must support a conclusion that the patient was looking to the HMO for medical care, not necessarily the treating physician, and that the HMO represented or impliedly represented that the physician was an HMO employee. The imposition of vicarious liability through ostensible agency represents the most common type of liability action against the HMO. Furthermore, the doctrine of apparent agency will likely continue to be a favored litigation tool because a cause of action founded upon vicarious liability is the least likely to be subject to ERISA preemption.¹¹⁷

B. Corporate or Direct Liability

The proposition that a hospital could be liable for corporate negligence, that is, liable for its own acts of negligence as an institution and not just vicariously for the culpable acts of its employees, is of fairly recent origin, emerging from

112. Shah-Mirany, *supra* note 12, at 369 n.47.

113. Cooper, *supra* note 1, at 1272; Zamora, *supra* note 38, at 1049.

114. Sloan v. Metropolitan Health Council of Indianapolis, Inc., 516 N.E. 2d 1104, 1105 (Ind. Ct. App. 1987).

115. *Smith*, 676 P.2d at 281.

116. *Dunn v. Praiss*, 606 A.2d 862, 868 (N.J. Super. Ct. App. Div. 1992).

117. See *infra* section V discussing ERISA preemption. See, e.g., *Prudential Health Care Plan, Inc. v. Lewis*, 77 F.3d 493 (10th Cir. 1996); *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995); *Prihoda v. Shpritz*, 914 F. Supp. 113 (D. Md. 1996); *Chaghervand v. Carefirst*, 909 F. Supp. 304 (D. Md. 1995); *Jackson v. Roseman*, 878 F. Supp. 820 (D. Md. 1995); *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544 (S.D. Ill. 1994); *Dearmas v. Av-Med, Inc.*, 865 F. Supp. 816 (S.D. Fla. 1994); *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182 (E.D. Pa. 1994); *Burke v. Smithline Bio-Science Lab.*, 858 F. Supp. 1181 (M.D. Fla. 1994); *Paterno v. Albuerno*, 855 F. Supp. 1263 (S.D. Fla. 1994); *Smith v. HMO Great Lakes*, 852 F. Supp. 669 (N.D. Ill. 1994); *Elsesser v. Hospital of the Phila. College of Osteopathic Med.*, 802 F. Supp. 1286 (E.D. Pa. 1992); *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983 (E.D. Pa. 1990); *DeGenova v. Ansel*, 555 A.2d 147 (Pa. Super. Ct. 1988).

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the landmark case of *Darling v. Charleston Community Memorial Hospital*.¹¹⁸ Historically, governmental or charitable immunity generally protected hospitals from legal liability. Because only doctors, not hospitals, could practice medicine, hospitals were perceived only to provide a facility for doctors to use as independent contractors, and only doctors, not the hospital, owed a duty to patients to avoid unreasonable risks of harm arising from the rendition of medical treatment.¹¹⁹ The *Darling* court rejected the concept that

the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, [because that concept] no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. . . . Certainly, the person who avails himself of "hospital facilities" expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility.¹²⁰

Darling was the first case to impose corporate negligence upon a hospital, thereby requiring hospitals to monitor the quality of care rendered to individual patients by physicians who hold staff privileges and imposing a duty upon hospitals to supervise staff physicians and to require consultations if necessary for quality patient care.¹²¹ One commentator has argued:

The justifications for the imposition of corporate negligence relate to the emergence of the hospital as a powerful institution. First, the public perceives a hospital as a complex entity responsible for care provided, and relies on the hospital for this care. Second, the hospital is in the best position to "monitor and control physician performance", given its opportunities to observe professional practices on a daily basis, to adopt procedures to detect problems, and to use its medical staff to monitor quality. Third, tort liability creates incentives for hospitals to "insure the competency of their medical staffs."¹²²

118. 211 N.E.2d 253 (Ill. 1965), *cert. denied*, 383 U.S. 946 (1966), *accord* Strubhart v. Perry Mem'l Hosp. Auth., 903 P.2d 263 (Okla. 1995).

119. FURROW ET AL., HEALTH LAW, *supra* note 9, at 289-91.

120. *Darling*, 211 N.E. 2d at 257 (quoting Bing v. Thunig, 143 N.E.2d 3, 8 (N.Y. 1957)).

121. *Darling*, 211 N.E.2d at 253. At least twenty jurisdictions have adopted the corporate negligence doctrine. *See, e.g.*, Strubhart v. Perry Mem'l Hosp. Auth., 903 P.2d 263 (Okla. 1995).

122. FURROW ET AL., HEALTH LAW, *supra* note 9, at 302.

Therefore, the doctrine of corporate liability is a "doctrine under which the hospital is liable if it fails to uphold the proper standard of care owed the patient, which is to ensure the patient's safety and well-being while at the hospital. This theory of liability creates a nondelegable duty which the hospital owes directly to a patient."¹²³

HMOs are analogous to hospitals in that they provide total care coverage, monitor the rendition of professional services, select care givers based on established criteria and the physicians who will participate within the system, and often provide the situs for medical treatment as well as necessary support staff and equipment for care. In so far as applicable theories of liability are concerned, little difference could be found, for example, between a Staff Model HMO and a hospital. Therefore, the same legal theories used to hold hospitals liable can generally be used to hold HMOs liable in appropriate cases.¹²⁴ Several duties might serve as the basis for imposing liability upon HMOs under corporate negligence, including: a duty to oversee all persons who practice medicine and to monitor the quality of patient care,¹²⁵ a duty to use reasonable care in selecting and retaining only competent physicians,¹²⁶ and a duty to use reasonable care in managing utilization control systems.¹²⁷ Because the corporate negligence of HMOs is an evolving theory, case law is scarce.¹²⁸ Because any allegation of corporate negligence is likely to be disallowed because of ERISA preemption, the full boundaries of HMO liability for independent,

123. *McClellan v. Health Maintenance Org.*, 604 A.2d 1053, 1058 (Pa. Super. Ct. 1992).

124. *Chase v. Independent Prac. Ass'n, Inc.*, 583 N.E. 2d 251 (Mass. Ct. App. 1991); *Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229 (Pa. Super. Ct. 1988).

125. *McClellan*, 660 A.2d at 98, *accord* *Dunn v. Praiss*, 656 A.2d 413, 415 (N.J. 1995). HMOs also have a duty to use reasonable care in maintaining their facility and equipment. *McClellan*, 660 A.2d at 98. However, premises liability for HMOs is beyond the scope of this article.

126. *Dunn v. Praiss*, 656 A.2d 413, 415 (N.J. 1995); *McClellan*, 660 A.2d at 98.

127. *Dunn*, 656 A.2d at 415; *McClellan*, 660 A.2d at 98.

128. In many cases, the allegation of corporate negligence has been raised; however, the reported decisions have only addressed whether ERISA preempts the cause of action. Thus, courts do not address the merits of claims of corporate negligence. See, e.g., *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996); *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir. 1993); *Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th Cir. 1993); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992); *Chaghervand v. Carefirst*, 909 F. Supp. 304 (D. Md. 1995); *Jackson v. Roseman*, 878 F. Supp. 820 (D. Md. 1995); *Dearmas v. Av-Med, Inc.*, 865 F. Supp. 816 (S.D. Fla. 1994); *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182 (E.D. Pa. 1994); *Burke v. Smithkline Bio-Science Lab.*, 858 F. Supp. 1181 (M.D. Fla. 1994); *Elsesser v. Hospital of the Philadelphia College of Osteopathic Med.*, 802 F. Supp. 1286 (E.D. Pa. 1992); *Pappas v. Asbel*, 675 A.2d 711 (Pa. Super. Ct. 1996).

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negligent acts are likely to remain a mystery for some time.¹²⁹ However, this Section will address each potential argument regarding the direct liability of HMOs.

1. Duty to Supervise Staff

Hospitals generally have a duty to supervise physicians and monitor the care provided to patients,¹³⁰ and at least two courts have suggested that HMOs should have the duty to monitor patient care. The Supreme Court of New Jersey stated that an HMO could be potentially liable for negligent control of physicians,¹³¹ and a Pennsylvania lower court found it reasonable to require that an HMO "formulate, adopt and enforce adequate rules and policies to ensure quality care for its subscribers."¹³² Although the author is unaware of any cases imposing liability upon an HMO for its failure to properly monitor patient care provided by an individual physician, such an argument could prove to be a new theory of liability-producing conduct. Professor Barry R. Furrow has noted the likelihood of such a liability theory:

Managed care organizations are likely to face similar duties [as hospitals] to supervise. . . . As courts continue to characterize MCOs [Managed Care Organizations] as health care providers, suits are likely to increase. Managed care is likely to be forced to undertake both a duty to select with care and a duty to engage in continuous supervision.¹³³

2. Selection of Staff

HMOs owe a duty to use reasonable care in selecting and retaining participating physicians in order to ensure that only reasonably competent physicians treat enrolled patients.¹³⁴ Stronger logic supports imposing a duty to

129. For a discussion of ERISA preemption, see *infra* section V. See, e.g., *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996); *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir. 1993); *Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th Cir. 1993); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992).

130. *Darling v. Charleston Community Mem. Hosp.*, 211 N.E.2d 253 (Ill. 1965); *Strubhart v. Perry Mem'l Hosp. Trust Auth.*, 903 P.2d 263 (Okla. 1995).

131. *Dunn v. Praiss*, 656 A.2d 413, 415 (1995).

132. *McClellan v. Health Maintenance Org.*, 660 A.2d 97, 99 (Pa. Super. Ct. 1995).

133. *FURROW ET AL.*, *HEALTH LAW*, *supra* note 9, at 319.

134. *Dunn*, 656 A.2d at 415; *McClellan*, 660 A.2d at 99. Hospitals are potentially liable for negligence in the credentialing of physicians. *Strubhart v. Perry Mem'l Hosp. Trust Auth.*, 903 P.2d 263 (Okla. 1995). Accreditation standards for hospitals requires that "[t]he hospital's governing body . . . ultimately is responsible for the quality of care the hospital provides. To carry

properly select physicians on HMOs than on hospitals:

In the hospital setting, the patient usually has selected the physician. He is then admitted to the hospital because his physician has admitting privileges at that hospital. By contrast, in a managed care program the patient has chosen the particular program, but not the physicians who are provided. The patient must use the physicians on the panel. The patient thus explicitly relies on the MCO [Managed Care Organization] for its selection of health care providers. The MCO's obligations for the patient's total care are more comprehensive than in the hospital setting.¹³⁵

In *McClellan v. Health Maintenance Organization of Pennsylvania*,¹³⁶ Marilyn McClellan contracted with an IPA Model HMO to provide health care coverage for herself and her family. From the list provided by the HMO, she selected Dr. Hempsey as her primary care physician. In 1985, Dr. Hempsey

out this responsibility, the governing body . . . must provide for the effective functioning of activities related to . . . medical staff credentialing." 1996 ACCREDITATION MANUAL, JOINT COMMISSION OF HEALTHCARE ORGANIZATIONS (JCAHO) G.O.2. Furthermore, Medicare regulations mandate that the governing board must be responsible for credentialing physicians holding staff privileges. 42 C.F.R. § 482.12 (1996). In the hospital setting, the importance of a duty to use reasonable care in appointing and retaining staff physicians is demonstrated by studies that show five percent of physicians applying for positions in a national ambulatory care program had falsified credentials. FURROW ET AL., HEALTH LAW, *supra* note 9, at 317 n.8 (citing W. A. Schaffer et al., *Falsification of Clinical Credentials by Physicians Applying for Ambulatory-Staff Privileges*, 318 NEW ENG. J. MED. 356 (1988)).

135. FURROW ET AL., HEALTH LAW, *supra* note 9, at 318. See also Karen A. Jordan, *Managed Competition and Limited Choice of Providers: Countering Negative Perceptions Through a Responsibility to Select Quality Network Physicians*, 27 ARIZ. ST. L.J. 875 (1995). Professor Jordan has suggested that one of the biggest consumer concerns regarding managed care springs from the inhibition of patient choice in selecting physicians caused by the structure of managed care organizations. Professor Jordan has written:

Limitation of provider choice concerns consumers largely because of the risk of being forced to use a lower quality physician. After all, it is unlikely that one MCN can attract all of the best physicians. . . . [I]ndividuals . . . feel that without control over choice, they are less able to assure that a physician is qualified and of sufficient integrity to withstand the financial incentives to undertreat that are inherent in managed care.

Id. at 884. Professor Jordan has argued that "state tort law, with its dual purpose of deterring unsafe behavior and compensating persons injured by tortfeasors, may provide a particularly effective means of enforcing the MCN's duty to use reasonable care in selecting network physicians" and assist in promoting the quality of individual patient care and the overall quality of the managed care system in general. *Id.* at 945-946. Furthermore, "[o]ne means of countering negative public perception of the quality of network physicians is for MCNs to engage in a responsible selective-contracting process through which those controlling the network formation use reasonable care to assure that all contracting providers can deliver high-quality health care." *Id.* at 887. See also John D. Blum, *The Evolution of Physician Credentialing into Managed Care Selective Contracting*, 22 AM. J.L. & MED. 173 (1996).

136. 604 A.2d 1053 (Pa. Super. Ct. 1992).

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removed a mole from Marilyn's back, and Dr. Hempsey discarded the mole without performing a biopsy, even though Marilyn told him that the "mole had recently undergone a marked change in size and color." Because a biopsy was not performed on the mole, Marilyn's malignant melanoma was not timely diagnosed, and she died in 1988.¹³⁷ In a negligence action against the HMO, the plaintiffs alleged that the HMO had a duty to properly select physicians who were competent to provide care, that Marilyn relied upon the expertise of the HMO in screening physicians when she selected Dr. Hempsey as her primary care physician, that the HMO breached that duty because Dr. Hempsey was not qualified to render medical care, and that Marilyn would have survived had the HMO used reasonable care in selecting participating physicians.¹³⁸ The court found that allegations in the complaint were sufficient to state a cause of action for "negligence in the selection, retention, and/or evaluation of the primary care physician."¹³⁹ In reaching its decision to impose liability on the HMO, the court relied on established law as contained within the Restatement (Second) of Torts section 323,¹⁴⁰ which provides:

One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if

(a) his failure to exercise such care increases the risk of such harm, or

(b) the harm is suffered because of the other's reliance upon the undertaking.¹⁴¹

Thus, in order to state a cause of action that the HMO breached its duty to use reasonable care in selecting participating physicians, the litigant must sufficiently prove four factual allegations. First, the litigant must allege that the HMO undertook to render the service of physician screening to the patient. Second, the plaintiff must sufficiently allege that the HMO should recognize that the service is necessary for the protection of subscribers. Third, the plaintiff must also show that the "HMO failed to exercise reasonable care in selecting, retaining, and/or evaluating the plaintiff's primary care physician." Fourth, the litigant must allege that the risk of harm to the plaintiff has increased as a result

137. *Id.* at 1054-55.

138. *Id.* at 1057.

139. *Id.* at 1059.

140. *Id.*

141. RESTATEMENT (SECOND) OF TORTS § 323 (1965).

of the HMO's failure to use reasonable care.¹⁴²

Although *McClellan* is apparently the only reported decision to impose liability under this theory, increased litigation will follow based on the theory of an HMO's direct liability for its failure to use reasonable care in the selection and retention of participating physicians. All HMO models could be susceptible to this liability theory because most require patients to choose their primary care provider and specialists from approved lists. One survey concluded that "[n]inety-two percent of the network or IPA HMOs and 61 percent of the group or staff HMOs required their patients to select a primary care physician."¹⁴³ Therefore, most HMOs could become potential defendants under the theory espoused in the Restatement (Second) of Torts section 323 (undertaking to render the service of screening participating physicians upon which a patient relies with resulting injuries) especially when ninety-three percent of all HMOs have a "formal process for recredentialing physicians."¹⁴⁴

3. Utilization Review

A 1995 survey published in the *New England Journal of Medicine* collected empirical data on HMOs nationally and concluded that procedures for utilization review were present in almost all plans.¹⁴⁵ Written quality assurance plans were present in ninety-five percent of the HMOs. According to the survey, "[s]eventy-nine percent of the group or staff HMOs and 70 percent of the network or IPA HMOs required outcome studies for particular clinical conditions," with the most common being the study of asthma and diabetic treatments and the use of mammography.¹⁴⁶ "About three quarters of the HMOs . . . used formal, written practice guidelines. These most commonly applied to childhood immunizations, the management of asthma, mammographic screening, and screening for colorectal cancer [cancer of the colon]."¹⁴⁷ Utilization review is a defining characteristic of HMOs so it is indeed not

142. *McClellan v. Health Maintenance Organization of Pennsylvania*, 604 A.2d 1053, 1059 (Pa. Super. Ct. 1992).

143. Gold, *supra* note 36, at 1678.

144. *Id.* at 1680.

145. *Id.* at 1681. Utilization review is a cost-containment process which examines health care services "to ensure that the services provided are both necessary and cost-efficient." Cheralyn E. Schessler, *Liability Implications of Utilization Review as a Cost Containment Mechanism*, 8 J. CONTEMP. HEALTH L. & POL'Y 379, 380 (1992). "[H]ealth care servic[e] for a specific patient is compared to an established norm for the use of similar services for comparable patients." *Id.* at 382. An HMO employee, who may or may not be a physician, or an independent corporation specializing in utilization review may conduct the utilization review. *See id.* at 390. *See also* Thomas M. Wickizer, *The Effects of Utilization Review on Hospital Use and Expenditures: A Covariance Analysis*, 27 HEALTH SERVICES RES. 103 (1992).

146. Gold, *supra* note 36, at 1681.

147. *Id.*

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surprising that courts have begun to impose a duty upon HMOs to use reasonable care "in the management of utilization control systems"¹⁴⁸ in order to avoid subjecting patients to unreasonable risks of harm caused by negligent utilization review.

In *Wickline v. California*,¹⁴⁹ the California Court of Appeals held:

The patient who requires treatment and who is harmed when care which should have been provided is not provided should recover for the injuries suffered from all those responsible for the deprivation of such care, including, when appropriate, health care payors. Third 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 as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden.¹⁵⁰

In *Wickline*, the plaintiff, Lois Wickline, suffered from arteriosclerosis and occlusion of the aorta into her legs, known as Leriche's Syndrome. The only medical treatment was to remove a part of the artery and insert a synthetic graft. The plaintiff underwent the surgery, but complications led to the performance of a lumbar sympathectomy. Her treating physician requested an additional eight days of hospitalization which he deemed medically necessary because of the danger of infection and/or clotting. The HMO refused the additional eight days, allowing only four. The treating physician did not appeal the HMO's decision, and the plaintiff was released. Further complications developed, and physicians were unable to save the plaintiff's leg when she returned to the hospital. According to her treating physician, the plaintiff would not have lost

148. *Dunn v. Praiss*, 656 A.2d 413, 415 (N.J. 1995). See also *Williams v. HealthAmerica*, 535 N.E.2d 717 (Ohio Ct. App. 1987) (holding that an HMO could be liable for bad faith conduct in administering its established complaint system). In *Williams*, the primary care physician had seen the plaintiff for over a year for abdominal pain, severe cramping, and rectal pain. *Id.* at 718. The primary care physician repeatedly refused to refer her to a gynecologist despite her frequent requests for referral. *Id.* at 719. When the plaintiff complained to HealthAmerica, a representative told her that referral to a specialist was "strictly up to" the primary care physician. *Id.* Plaintiff finally went to the emergency room and was referred to a specialist outside the plan who diagnosed her condition as endometriosis. *Id.* The court held that material questions of fact existed on the issue of whether the HMO had handled the claim in good faith. *Id.* at 721. When the coverage is purchased through an employer-sponsored plan, however, ERISA is likely to preempt any allegation of bad faith in the denial of a claim. See generally *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

149. 239 Cal. Rptr. 810 (Cal. Ct. App. 1986).

150. *Id.* at 819.

her leg had she remained in the hospital for the additional eight days, as he requested.¹⁵¹

The *Wickline* court first noted the danger posed by prospective utilization review, which is common in HMOs:

A mistaken conclusion about medical necessity following retrospective review will result in the wrongful withholding of payment. An erroneous decision in a prospective review process, on the other hand, in practical consequences, results in the withholding of necessary care, potentially leading to a patient's permanent disability or death.¹⁵²

The court did acknowledge that a cause of action could be stated against an HMO when "a cost containment program is applied in a manner which is alleged to have affected the implementation of the treating physician's medical judgment."¹⁵³ However, the facts in *Wickline* did not support such a theory of recovery because the treating physician ultimately decided to discharge the plaintiff without making some attempt to keep her in the hospital, such as by appealing the medical director's decision to disallow the additional time in the hospital. As the court stated,

[T]he physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour.¹⁵⁴

In *Wilson v. Blue Cross of Southern California*,¹⁵⁵ however, the same court that decided *Wickline* held that the *Wickline* language suggesting that "civil liability for a discharge decision rests solely within the responsibility of a treating physician in all contexts is dicta."¹⁵⁶ The California court reaffirmed its commitment to impose a duty on HMOs to use reasonable care when implementing their utilization review to avoid injuring subscribers by unreasonably withholding necessary medical care.¹⁵⁷ In *Wilson*, the decedent

151. *Id.* at 812-17.

152. *Id.* at 812.

153. *Id.* at 811.

154. *Id.* at 819.

155. 271 Cal. Rptr. 876 (Cal. Ct. App. 1990).

156. *Id.* at 880.

157. *Id.* at 878.

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was admitted to the hospital on March 1, 1983, for major depression, anorexia, and drug dependency. On March 11, the insurance company announced it would not pay for further care although the treating physician determined that the patient needed three to four weeks of in-patient care at the hospital. The decedent was discharged because no one could afford the hospitalization without insurance coverage. Shortly thereafter, decedent committed suicide.¹⁵⁸ An expert testified that "there was a reasonable medical probability that the decedent would have been alive if his hospital stay had not been prematurely terminated."¹⁵⁹ The appellate court held that the trial court erred in granting the defendant's motion for summary judgment because material issues of fact existed in the record as to whether the insurance company was a substantial factor in causing the decedent's death.¹⁶⁰

The *Wilson* court distinguished *Wickline*, arguing that three factors were present in *Wickline* that were absent in *Wilson*. In *Wickline*, a statutorily created HMO system was involved which was designed to provide medical care to indigents; testimony was presented that the final decision to discharge, despite the initial request for additional days in the hospital, complied with the standards of the medical community; and the cost-containment program in *Wickline* was not shown to have corrupted medical judgment.¹⁶¹ The *Wilson* court concluded that the holding in *Wickline* was not applicable because none of these three factors were present in *Wilson*; therefore, granting summary judgment was inappropriate.¹⁶²

Certainly, the holding in *Wilson*, that the treating physician's failure to challenge a third-party payor's decision to deny coverage will not automatically preclude liability against the HMO or insurance carrier, conforms more to traditional tort law.¹⁶³ If HMOs have a duty to use reasonable care in

158. *Id.* at 877-78.

159. *Id.* at 882.

160. *Id.* at 878.

161. *Id.* at 879.

162. *Id.*

163. The physician's negligence in failing to challenge the HMO's decision not to cover recommended care would appear to be a foreseeable intervening cause with regard to the HMO's negligence in utilization review. In this context, an intervening cause is a cause that "actively operates" in producing a patient's harm after the HMO's prior negligent act in utilization review. See RESTATEMENT (SECOND) OF TORTS § 441(1) (1965). Generally, a foreseeable intervening cause will not exonerate or supersede the liability of the original tortfeasor. See PROSSER & KEETON, *supra* note 77, § 44, at 303-06. For the definition of superseding cause, see RESTATEMENT (SECOND) OF TORTS § 440 (1965). A negligent intervening cause will generally not break the causal chain. *Id.* § 447. The Restatement provides three alternatives when negligent intervention is foreseeable. Applying these alternatives to an HMO's failure to use reasonable care in utilization review and assuming that the physician's failure to fight the outcome of utilization review is a negligent act, the physician's conduct would clearly be foreseeable because it complies with all three

implementing their utilization review procedures in order to avoid exposing patients to unreasonable risks of harm from inappropriate decisions not to treat, not to refer to a specialist, not to hospitalize, or not to order diagnostic tests, decisions that do not comply with customary medical practice, then the physician's failure to appeal or challenge in some way the decision to deny services would appear to be a foreseeable intervening cause which would generally not supersede the initial tortfeasor's liability.¹⁶⁴ Application of traditional tort principles leads to the conclusion that the physician's conduct is foreseeable, and the physician's intervening conduct is not independent of the situation the HMO created.¹⁶⁵ In fact, the physician's conduct is very dependent upon the HMO's failure to authorize or provide care, and the physician's conduct causes the very harm to the patient that one would expect to result from improper utilization review.¹⁶⁶ Where the negligent utilization review creates a risk of harm, "the fact that the harm is brought about through the intervention of another force does not relieve" the HMO of liability.¹⁶⁷ Furthermore, the Restatement (Second) of Torts section 443 provides: "The intervention of a force which is a normal consequence of a situation created by the actor's negligent conduct is not a superseding cause of harm which such conduct has been a substantial factor in bringing about."¹⁶⁸ The physician's compliance with the dictates of the utilization review, and failure to challenge those dictates, appears to be a normal consequence of a situation created by the HMO.¹⁶⁹

For example, the HMO in *Wickline* was negligent in not authorizing eight additional days of hospitalization, and the plaintiff would not have lost her leg had the request for additional time for hospital care been granted.¹⁷⁰ The physician's misconduct, in failing to challenge the decision to deny care, is a normal consequence of the negligent prospective utilization review.¹⁷¹ The physician's conduct exposed the patient to the same risk of losing her limb as the HMO's initially rendered negligent decision not to allow further

alternatives for foreseeability, not just one. First, the HMO should have realized the physician might so act. Second, a reasonable person would not regard it as extraordinary that the physician might not challenge the HMO utilization review. Third, the action of the physician is a normal consequence of the situation the HMO created. See *Id.* § 447. Furthermore, a court will usually consider the physician's negligence to be foreseeable when a third party injures an individual and the physician's negligence increases the plaintiff's damages. See PROSSER & KEETON, *supra* note 77, § 44, at 309.

164. RESTATEMENT (SECOND) OF TORTS § 447 (1965).

165. *Id.* § 442(c).

166. *Id.* § 442(a). See, e.g., *Marshall v. Nugent*, 222 F.2d 604 (1st Cir. 1955).

167. RESTATEMENT (SECOND) OF TORTS § 442B (1965).

168. *Id.* § 443.

169. See *id.*

170. *Wickline v. California*, 239 Cal. Rptr. 810, 812-817 (Cal. Ct. App. 1986).

171. RESTATEMENT (SECOND) OF TORTS §§ 443, 447(c) (1965).

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hospitalization.¹⁷² The physician's misconduct does not "operat[e] independently of any situation created by"¹⁷³ the HMO's negligence in declining needed care. The physician's acquiescence with the HMO's decision to decline services is seemingly foreseeable because a physician would reasonably believe that the HMO has the power to dictate when a patient must be discharged from the hospital.¹⁷⁴

Or, as the *Wilson* court stated, the treating physician's failure to request that the third-party payor reconsider did not justify the granting of summary judgment, especially when no evidence suggested that such reconsideration would have been granted.¹⁷⁵ At most, the HMO's negligent conduct (utilization review declining treatment provided in accordance with customary practice) and the physician's conduct (failing to fight or appeal the decision resulting from utilization review) would appear to be concurrent causes.¹⁷⁶ Thus, both the HMO and the physician should be held liable for the entire cost of the patient's injury,¹⁷⁷ not just the physician.

Furthermore, the treating physician's failure to appeal the medical director's decision or to request reconsideration would appear to be very foreseeable in the HMO context because the physician is acting under circumstances where a conflict of interest arguably exists. The more the physician fights for the patient to receive appropriate treatment, the less the physician might be paid, and the more the physician might be threatened with the removal of his or her name from the list of approved physicians. If cost-containment goals are not achieved, the physician might not be allowed to continue to treat enrolled patients.¹⁷⁸

172. *Id.* §§ 442(a), 442B.

173. *Id.* § 442(c).

174. *Wickline*, 239 Cal. Rptr. at 815.

175. *Wilson v. Blue Cross of Southern Cal.*, 271 Cal. Rptr. 876, 884-85 (Cal. Ct. App. 1990).

176. See PROSSER & KEETON, *supra* note 77, § 41, at 268, and § 47, at 328-29. Each defendant's misconduct can be a legal cause of the plaintiff's harm so long as each defendant's misconduct is "a substantial factor in bringing about the harm." RESTATEMENT (SECOND) OF TORTS § 431 (1965). Furthermore, a defendant's misconduct does not need to be the sole cause of the harm to impose liability. The fact that multiple defendants produced harm to the plaintiff will not exonerate the defendants from liability; each defendant's misconduct can still be considered a substantial factor in causing the loss. *Id.* § 439.

177. If two defendants cause indivisible harm to a plaintiff, harm that is incapable of a reasonable basis of apportionment between the defendants, then both defendants are liable for the plaintiff's damages. RESTATEMENT (SECOND) OF TORTS § 433A (1965).

178. See Mehlman, *supra* note 26, at 300. For a description of the conflict of interest, see *supra* note 28. "Quite frequently MCOs shift financial risk for medical decisions to doctors, creating conflicts of interests and possibly biasing their judgment." Marc A. Rodwin, *Consumer Protection and Managed Care: Issues, Reform Proposals, and Trade-Offs*, 32 HOUS. L. REV. 1319, 1379 (1996). See also David C. McGraw, *Financial Incentives to Limit Services: Should Physicians Be Required to Disclose These to Patients?*, 83 GEO. L.J. 1821 (1995); Frances H. Miller, *Doctors' Conflicts of Interest (& Altruism) in the United States and Great Britain*, 27 IND. L. REV. 687

Thus, the physician could experience severe economic ramifications from fighting the system. Therefore, a physician's failure to appeal or challenge seems very foreseeable (more so than in a fee-for-service plan) and should not negate the HMO's liability for failing to use reasonable care in implementing utilization review.

Given the *Wickline* and *Williams* decisions, litigation against HMOs on a theory of their failure to use reasonable care in the utilization review process will likely increase.¹⁷⁹ When utilization review results in inappropriate or no treatment, failures to refer to specialists, failures to hospitalize patients, and failures to render proper care that result in injuries to patients, HMOs will likely be forced to bear some of the burden that treating physicians already bear through exposure to malpractice liability. Arguably, fairness dictates that physicians should not be the sole targets for malpractice litigation when cost-containment efforts and utilization review procedures impede the professional judgment of physicians and preclude them from exercising the standard of care the medical profession customarily follows in similar circumstances. "Such payor accountability for withholding necessary care due to defective utilization review is consistent with both insurer bad faith cases and hospital liability principles, and reinforces the value of a well-designed system of review."¹⁸⁰

(1994); Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J.L. & MED. 241 (1995).

179. See generally Conrad & Seiter, *supra* note 6; Michael A Dowell, *Avoiding HMO Liability for Utilization Review*, 23 U. TOL. L. REV. 117 (1991). Litigants frequently allege corporate negligence against HMOs as a basis for relief. See authorities collected *supra* note 128. Legislation is likely to increase as well as litigation. Legislation will likely target certain instances where plans are not providing sufficient coverage to enrollees. In California alone, one hundred health care bills have been introduced. Ellwood & Lundberg, *supra* note 12, at 1085. In 1996, state legislatures throughout the country introduced 1000 bills regulating HMOs, and 35 states ultimately enacted 56 laws. Thomas Bodenheimer, *The HMO Backlash—Righteous or Reactionary?*, 335 NEW ENG. J. MED. 1601 (1996). The most notable of such legislative attempts to curb abuses of utilization review was the Mothers' Health Protection Act of 1995 which requires a minimum hospital stay of 48 hours for the mother and child after delivery of the child. Mother's Health Protection Act of 1995, S. 969, 104th Cong. (June 1995).

180. FURROW ET AL., *HEALTH LAW*, *supra* note 9, at 326. At least one case has dealt with the bad faith denial of coverage. See *Williams v. HealthAmerica*, 535 N.E.2d 717 (Ohio Ct. App. 1987) See discussion *supra* note 148. One author suggests that a "Medical Injury Compensation Fund" could be set up to compensate patients for injuries resulting from cost-containment efforts and utilization review. The fund would be created out of insurance premium payments and would appear to work in much the same way as worker's compensation. Vernellia R. Randall, *Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1 (1993).

4. Cost-Containment Incentives

All types of HMOs, regardless of the model, usually employ performance-based incentives and cost-containment mechanisms, such as risk-sharing, capitation payments, and adjusted payments.¹⁸¹ The purpose of these cost-containment incentives is to save costs. A secondary effect of these financial incentives and mechanisms is that they may create disincentives for physicians to refer patients to specialists, to order hospitalization, or to order diagnostic tests. The question whether the financial incentives contained within the HMO structure cause negligent medical care or inappropriate denial of services is ripe for judicial determination.

In *Pulvers v. Kaiser Foundation Health Plan*,¹⁸² the plaintiff argued that the defendant had an incentive payment plan which lead participating physicians to make conservative decisions regarding diagnostic tests and treatments. Under the incentive plan, physicians would receive extra compensation for ordering less expensive care.¹⁸³ In *Pulvers*, the patient died after the physicians delayed a diagnostic biopsy that would have revealed Bowen's disease.¹⁸⁴ However, testimony was presented that the delay was medically justified because the patient was also being treated for leukemia.¹⁸⁵ Although the *Pulvers* court seemed to recognize that in appropriate cases litigants may utilize this theory of relief, no evidence suggested that the "individual doctors act[ed] negligently or that they refrain[ed] from recommending whatever diagnostic procedures or treatments the accepted standards of their profession require[d]."¹⁸⁶

In *Bush v. Dake*,¹⁸⁷ an unreported decision, the plaintiff, Sharon Bush, sued her HMO contending that its system of financial incentives delayed the diagnosis of her cervical cancer. The financial incentive program included a shared risk pool and capitation payments. Sharon selected Dr. Dake as her primary care physician and consulted him in August, 1985, regarding vaginal bleeding and mucus discharge. In January, 1986, Sharon requested a referral to a specialist in gynecology, which Dr. Dake granted. The specialist performed

181. Gold, *supra* note 36, at 1680. See statistical breakdown *supra* note 36. On the pros and cons of cost-containment incentives, see David Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155 (1996); Henry T. Greely, *Direct Financial Incentives in Managed Care: Unanswered Questions*, 6 HEALTH MATRIX 53 (1996).

182. 160 Cal. Rptr. 392 (Cal. Ct. App. 1979).

183. *Id.* at 393-94.

184. *Id.* at 393.

185. *Id.* at 395.

186. *Id.* at 394.

187. File No. 86-25767 NM-2 (Mich. Cir. Ct., Saginaw County 1989), reprinted in BARRY R. FURROW ET AL., *HEALTH LAW, CASES, MATERIALS & PROBLEMS* 719-22 (2d ed. 1991) [hereinafter FURROW ET AL., *CASES & MATERIALS*].

a vaginal smear test but did not perform a pap smear. Although Sharon's condition persisted, Dr. Dake denied her request for a second referral. In May, 1986, Sharon went to an emergency room where a pap smear was taken, and the diagnosis of cervical cancer was made. Had a pap smear been performed earlier, the cancer would have been diagnosed at an earlier date. However, under the HMO system, only the primary care physician could perform pap smears, and the primary care physician was not compensated above the normal capitation payment for performing the pap smear. In her suit, the plaintiff alleged that the financial incentives not to perform the pap smear delayed the diagnosis of her cervical cancer.¹⁸⁸

The court rejected the plaintiff's first contention that the HMO's financial disincentives to proper treatment, referral, and hospitalization were against public policy, reasoning that the legislature had sanctioned such systems, including financial incentives, through an HMO enabling act.¹⁸⁹ However, the court held that a genuine issue of material fact existed as to whether the HMO's system of cost-containment incentives "in and of itself proximately contributed to the malpractice in this case. . . ." The court continued, "Documentary evidence has been presented which supports the plaintiff's theory that the manner in which the system operated in this case contributed to the improper treatment and delay in diagnosis of Mrs. Bush's cancerous condition. . . . The question should be submitted to the jury for determination at trial."¹⁹⁰

The physicians in *Bush v. Dake* were glaringly negligent, clearly failing to follow the customary medical practice of their peers—other doctors in the same or similar circumstances would have performed the pap smear. However, the financial incentives not to perform the test could make the physician's negligent conduct foreseeable, and the physician's negligence should not exonerate the HMO that created the financial disincentives that caused the physician not to follow customary medical practice.¹⁹¹ Section 442A of the Restatement provides: "Where the negligent conduct of the actor creates or increases the foreseeable risk of harm through the intervention of another force, and is a substantial factor in causing the harm, such intervention is not a superseding cause."¹⁹² If a physician's negligence (in failing to order diagnostic tests, hospitalization, or referrals to specialists) is caused by the HMO's financial incentives, it is the HMO's negligence that actually created or increased the risk of harm when it created the financial incentive program, and the HMO's

188. See FURROW ET AL., CASES & MATERIALS, *supra* note 187, at 720-21.

189. *Id.* at 721.

190. *Id.* *Bush v. Dake* was settled on appeal. See FURROW ET AL., HEALTH LAW, *supra* note 9, at 315.

191. For a discussion of intervening causes, see *supra* notes 163-78 and accompanying text.

192. RESTATEMENT (SECOND) OF TORTS § 442A (1965).

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misconduct should still be considered a substantial factor in causing the patient's harm because the physician's intervention is in response to the HMO's initial negligence and, as such, is not a superseding cause.¹⁹³

Once again, participating physicians, operating within the HMO context, encounter a clear conflict of interest¹⁹⁴—the more treatment he provides, the more he orders diagnostic tests, the more he refers to specialists, the less he will be compensated. When cost-containment incentives are a substantial factor in causing negligent medical care, the HMO, not just the physician, will likely be the target of future litigation.

5. Duty to Disclose Financial Incentives

In the landmark case of *Moore v. Regents of the University of California*,¹⁹⁵ the Supreme Court of California held that a physician had a fiduciary duty to disclose to the patient potential conflicts of interest, "personal interests unrelated to the patient's health, whether research or economic, that may affect the physician's medical judgment."¹⁹⁶ The court stated:

The possibility that an interest extraneous to the patient's health has affected the physician's judgment is something that a reasonable patient would want to know in deciding whether to consent to a proposed course of treatment. It is material to the patient's decision and, thus, a prerequisite to informed consent.¹⁹⁷

193. *Id.*

194. See Mehlman, *supra* note 26; *supra* note 28 and accompanying text; *supra* note 178 and accompanying text; sources cited *infra* note 198.

195. 793 P.2d 479 (Cal. 1990), *accord* Arato v. Avedon, 11 Cal. Rptr. 2d 169 (Cal. Ct. App. 1992), *pet. review granted*, 839 P.2d 983 (Cal. 1992).

196. *Moore*, 793 P.2d at 483.

197. *Id.* The doctrine of informed consent is premised on the notion that every person has the right to determine what shall be done to his own body. *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92 (N.Y. 1914). In some jurisdictions, physicians are required to disclose what other physicians would disclose under similar circumstances, i.e., medical custom sets the informational obligation. *Fuller v. Starnes*, 597 S.W.2d 88 (Ark. 1980); *Wooley v. Henderson*, 418 A.2d 1123 (Me. 1980); *Troy v. Long Island Jewish-Hillside Med. Ctr.*, 86 A.D.2d 631 (N.Y. App. Div. 1982). Other jurisdictions base the physician's disclosure obligation upon the informational needs of the patient, not medical custom. See, e.g., *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972); *Scott v. Bradford*, 606 P.2d 554 (Okla. 1979). The physician must disclose all material risks to the patient, that is, all risks that would materially influence a patient's decision to forego the recommended treatment. Material risks include inherent risks of the proposed treatment, alternative treatments and their risks, and the risks involved with no treatment. See *Canterbury*, 464 F.2d at 786-87; *Harnish v. Children's Hosp. Med. Ctr.*, 439 N.E.2d 240 (Mass. 1982); *Scott*, 606 P.2d at 566.

The academic literature suggests that physicians should at least disclose financial disincentives for treatment, tests, referrals, or hospitalization.¹⁹⁸ However, courts have yet to recognize a duty to disclose to patients the financial incentives of HMOs. Although litigants have argued that a duty to disclose financial disincentives for referrals to specialists or hospitalization should exist, they have not yet met with successful results.¹⁹⁹

Moreover, "gag clauses," which are contained in contracts between physicians and HMOs, are the major impediment to such a duty of disclosure. A "gag clause" is a contractual provision that precludes a physician from discussing certain information with patients: the financial incentives that the HMO provides, alternative treatments that the HMO does not cover, and possibly even anything that presents the HMO in a negative fashion.²⁰⁰ These "gag clauses" prevent physicians from performing their ethical obligation to provide proper disclosure of treatment alternatives,²⁰¹ and it would seem that they would clearly subject HMOs to the possibility of being defendants in tort actions under the doctrine of informed consent. Furthermore, HMOs could arguably have an independent informational obligation to disclose financial disincentives to treatment, referrals to specialists, or hospitalization when patients enroll with them.²⁰²

198. See MARC A. RODWIN, *MEDICINE, MONEY & MORALS: PHYSICIANS' CONFLICTS OF INTEREST* 214-17 (1993); Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients from Their Physicians*, 55 U. PITT. L. REV. 291 (1994); Alan L. Hillman et al., *How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations?*, 321 NEW ENG. J. MED. 86 (1989); Alan L. Hillman, *Financial Incentives for Physicians in HMOs: Is There a Conflict of Interest?*, 317 NEW ENG. J. MED. 1743 (1987); Donald F. Levinson, *Toward Full Disclosure of Referral Restrictions and Financial Incentives by Prepaid Health Plans*, 317 NEW ENG. J. MED. 1729 (1987); McGraw, *supra* note 178, at 1837.

199. *Anderson v. Humana, Inc.*, 24 F.3d 889 (7th Cir. 1994); *Teti v. U.S. Healthcare*, 1989 WL 143274 (E.D. Pa.), *aff'd*, 904 F.2d 696 (3d Cir. 1990) (dismissing case for lack of federal jurisdiction).

200. *HMOs Shouldn't Gag Doctors*, *NEWSDAY*, Feb. 9, 1996, at 42, available in 1996 WL 2512044.

201. *AMA Condemns "Gag Clauses."* *THE INDIANAPOLIS STAR*, Feb. 9, 1996, at A11, available in 1996 WL 3121775. In 1996, Congress introduced legislation to curb the use of gag clauses. See Patient Right to Know Act of 1996, H.R. 2976, 104th Cong. (1996). Under the Act, contractual provisions between a health plan and participating physician could not restrict or interfere with medical communications between a physician and his or her patient. Thus, "gag clauses" would be prohibited. *Id.* § 2(a)(1). Medical communications between the physician and patient would include treatment options, variation of services of other providers, the utilization review process, and any financial incentives or disincentives to limit services. *Id.* § 2(b)(2). The penalty imposed under the Act was up to \$25,000 for each violation or up to \$100,000 per violation if there was a pattern of such violations. *Id.* § 2(c).

202. McGraw, *supra* note 178, at 1836-39.

Any cause of action for failure to disclose encounters a serious difficulty—in order to establish a causal link between the failure to achieve informed consent and the patient's resulting injuries, the plaintiff must show not only that the physician had a obligation to inform the patient and failed to do so, but also that the patient would have chosen a different course of treatment had the disclosure been made.²⁰³ Assume that a physician believes a patient should be hospitalized for a certain treatment or procedure, but the HMO will not cover the cost of hospitalization, and the physician recommends out-patient care. The physician discloses neither the alternative of hospitalized care nor the fact that the doctor will receive more money out of the shared risk pool if fewer hospitalizations are ordered. Because both facts would appear to be material to the patient's decision regarding the out-patient treatment, the physician appears to have violated his duty of disclosure. The patient then suffers injuries from complications that would have been treated earlier had the patient been in the hospital. However, the patient probably would not have acted differently had proper disclosure been made. It is difficult to see how a patient would make a decision for treatment within a hospital when the HMO will not pay for the hospitalization costs. If the treatment were necessary for the patient's health, the reasonable patient would probably "choose" the covered out-patient care. If the procedure were truly elective, then the patient could have foregone the treatment altogether, and thus avoided the resulting injuries. However, this latter scenario would appear remote because the HMO's plan would probably not cover truly elective procedures. Patients under the fee-for-service system would appear to have more choice.²⁰⁴

Thus, the plaintiff who brings a lawsuit alleging a failure to receive informed consent might confront an insurmountable causal burden because a disclosure of the HMO's financial incentive program would not likely result in different treatment or care and thus would not avoid the resulting injuries. For this reason, litigation arguing a duty to disclose might not be the best avenue to

203. Compare *Canterbury v. Spence*, 464 F.2d 772 (D. C. Cir. 1972) (establishing causation when a reasonable patient in the same situation as the plaintiff would have foregone the treatment, i.e., an objection standard for causation), with *Scott v. Bradford*, 606 P.2d 554 (Okla. 1979) (establishing causation when the individual patient, regardless of what a reasonable patient would have done, would have decided against the treatment, i.e., a subjective standard for causation).

204. Marc A. Rodwin has argued:

The consumer is sovereign only at the point of choosing between managed care plans. Once enrolled, choices that consumers traditionally would make are mediated by the organization and subject to its approval. For instance, consumers usually must get a referral from a primary care physician to see a specialist, and primary care physicians have financial incentives to limit such referrals. Furthermore, consumers frequently must obtain approval from the organization to receive many specialty services and nonemergency procedures.

Rodwin, *supra* note 178, at 1330-31. See also Jordan, *supra* note 135, at 883-84.

recover against HMOs.²⁰⁵ Furthermore, "conflicts of interest can cloud physician's judgment and affect their assessment of whether a medical service is needed,"²⁰⁶ even if a physician were to comply with any duty to disclose the HMO's financial incentives. Arguably, "[p]atients need an opinion from a physician who is not compromised,"²⁰⁷ not just the information that the physician is, in fact, compromised.

6. The Physician as Plaintiff

In HMO litigation, a new theory of liability could arise whereby the plaintiff is the financially injured physician, not a physically injured patient. *Harper v. Healthsource New Hampshire, Inc.*²⁰⁸ involved a physician, Dr. Harper, who had been a participating surgeon with Healthsource HMO for over ten years. In 1994, Dr. Harper realized that Healthsource was "manipulating and skewing the records of treatment he had provided to several of his patients and that such inaccuracies adversely affected other subsequent reports."²⁰⁹ Shortly after Dr. Harper complained to Healthsource regarding his patients' records, Healthsource notified him that his contract was terminated because he had not satisfied Healthsource's recredentialing criteria. However, the credentialing committee had, in fact, reviewed his record and found no quality of care problem.²¹⁰ The New Hampshire Supreme Court allowed Dr. Harper to challenge the decision not to reappoint him because the termination could violate public policy and the implied covenant of good faith and fair dealing. The court stated, "We conclude that the public interest and fundamental fairness demand that an HMO's decision to terminate its relationship with a particular physician provider must comport with the covenant of good faith and fair dealing and may not be made for a reason that is contrary to public policy."²¹¹

The *Harper* decision provides recourse, on public policy grounds, for physicians who are not reappointed as participating physicians within an HMO. The plaintiff-physician who must pay monetary damages because of a medical

205. McGraw, *supra* note 178, at 1843-47 (arguing that, in the HMO context, the cause of action for informed consent is cumbersome and not a likely avenue of relief).

206. RODWIN, *supra* note 198, at 215. See also McGraw, *supra* note 178, at 1839 (suggesting that physicians might not consciously refrain from recommending treatment due to costs but instead might "internalize the need to consider cost in treatment decisions; in other words, they will still make treatment decisions based on medical necessity, but couched within the definition of medical necessity is a consideration of how much the treatment may personally cost the physician").

207. RODWIN, *supra* note 198, at 215.

208. 674 A.2d 962 (N.H. 1996).

209. *Id.* at 963.

210. *Id.*

211. *Id.* at 966. See Aynah V. Askanas, *Physician Terminations in Managed Care: Why Are They Occurring? How Do We Ensure They Are Just?*, 6 HEALTH MATRIX 167 (1996).

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malpractice verdict in a case involving injury that resulted from an HMO's improper utilization review or cost-containment procedures may also have a cause of action for contribution.²¹² In *Dunn v. Praiss*,²¹³ Dr. Marmar settled a claim brought by an injured patient for \$2,904,160.54.²¹⁴ Dr. Marmar then brought a contribution suit against the HMO, claiming that the HMO had a duty to coordinate the care of the patient among its physicians, that the coordination of care had not occurred in the critical stages of the patient's treatment, and that the HMO's failure to coordinate care was a contributing factor to the negligent care that the plaintiff received.²¹⁵ The New Jersey Supreme Court recognized that such a right of contribution could exist but concluded in *Dunn* that the physician did not do the "finger pointing" at the proper stage of the litigation and therefore could not raise the issue.²¹⁶ Rather, Dr. Marmar should have "stake[d] out his position as to the causative fault" of the HMO at the first trial of the case.²¹⁷

A defense that "the HMO made me do it" may be on the legal horizons for physician-defendants in malpractice actions.²¹⁸ A physician might use this defense in a contribution suit in which the physician contends that the HMO's improper utilization review or financial incentive structure was a significant factor in causing the malpractice and patient's resulting injuries. However, "there are many strategic reasons for initially declining to prosecute a claim for contribution. Physicians, for example, may choose to defend charges of malpractice by denying that there was any negligence at all because finger-pointing among the defendants would accrue only to the benefit of the plaintiff."²¹⁹

212. While contribution rules vary greatly from jurisdiction to jurisdiction, contribution among multiple defendants is allowed in most jurisdictions. If the negligence of two defendants causes the plaintiff's damage and the plaintiff collects his damages from only one defendant, the defendant who has paid the plaintiff's damages may seek contribution from the other negligent defendant. See PROSSER & KEETON, *supra* note 77, at 336-41. Some require a joint judgment against both defendants before contribution is allowed; others have trial procedures to join defendants in the plaintiff's action to permit contribution. *Id.* at 338.

213. 656 A.2d 413 (N.J. 1995).

214. *Id.* at 418.

215. *Id.* at 421-22.

216. *Id.*

217. *Id.* at 421.

218. Reuben, *supra* note 1, at 60.

219. *Dunn v. Praiss*, 656 A.2d 413, 421 (N.J. 1995).

V. THE ISSUE OF ERISA PREEMPTION

A. Overview of ERISA Preemption

Congress enacted the Employee Retirement Income Security Act of 1974²²⁰ (ERISA) to "protect employees from administrative and funding abuses" in employee pension plans and to establish "fair vesting requirements for pensions."²²¹ The goal of ERISA was to protect employees, not employers.²²² In an effort to create national uniformity of laws governing pension plans, ERISA was designed to preempt conflicting state laws. However, "the use of ERISA's preemption clause to protect employers and ERISA benefit plans from conflicting state laws is only an ancillary purpose to the primary purpose of protecting employees' benefits from the employers' administrative and funding abuses."²²³

In displacing state law, ERISA's preemption clause provides that ERISA "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."²²⁴ This preemption clause is "the most expansive preemption provision contained in federal law,"²²⁵ and the question whether a state law "relates to" an employee benefit plan and is thus preempted is "one of the most heavily litigated topics in the law of plans."²²⁶ The United States Supreme Court has held that the term "relates to" should be given a broad, common-sense meaning.²²⁷ With the sheer amount of litigation and varying interpretations, it is questionable whether the term "relates to" has any "common-sense" meaning.²²⁸ Perhaps, as a result of the multitude of varying judicial interpretations, the law regarding ERISA preemption "remains unsettled and confused."²²⁹

220. 29 U.S.C. §§ 1001-1461 (1988).

221. Pittman, *supra* note 8, at 358.

222. *Id.* at 359.

223. *Id.* at 360.

224. 29 U.S.C. § 1144(a) (1988).

225. JAY CONISON, EMPLOYEE BENEFIT PLANS IN A NUTSHELL 314 (1993). *See also* Spain v. Aetna Life Ins. Co., 11 F.3d 129, 131 (9th Cir. 1993).

226. CONISON, *supra* note 225, at 315.

227. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987), *accord* Dearmas v. Av-Med, Inc., 865 F. Supp. 816, 817 (S.D. Fla. 1994).

228. Conison, *supra* note 6, at 624.

229. CONISON, *supra* note 225, at 315.

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Enrollees purchase approximately seventy-five percent of all coverage provided by HMOs through employment benefit plans.²³⁰ ERISA governs such plans, and matters that "relate to" the plans are subject to ERISA preemption. Thus, when an enrollee is injured through the negligent provision of medical care and sues the HMO alleging that the HMO is either vicariously liable for the conduct of the treating physician (under the doctrine of respondeat superior or ostensible or apparent agency) or directly liable as an institution (under the doctrine of corporate negligence), one question becomes important—should ERISA preempt such a negligence cause of action, which is grounded in state law, because the suit "relates to" the benefit plan?

If a cause of action is subject to ERISA preemption, then the doctrine of "complete preemption" applies, and federal jurisdiction exists as an exception to the "well-pleaded complaint rule."²³¹ Normally, a court only examines the plaintiff's "well-pleaded complaint" to ascertain the presence of federal question jurisdiction.²³² The "well-pleaded complaint rule" provides that the "issues raised in the plaintiff's complaint, not those added in the defendant's response, control the litigation"²³³ and "the defendant cannot cause a transfer to federal court simply by asserting a federal question in his responsive pleading."²³⁴ An exception to the "well-pleaded complaint rule" arises when Congress intends so completely to preempt state law²³⁵ that subject matter jurisdiction resides in federal court, "even if the complaint does not mention a federal basis of jurisdiction."²³⁶ Thus, the "complete preemption" doctrine addresses federal

230. FURROW ET AL., *CASES & MATERIALS*, *supra* note 187, at 52 n.1 (Supp. 1996-97). Approximately, 150 million people are covered by employer-sponsored health plans governed by ERISA. Wendy K. Mariner, *State Regulation of Managed Care and the Employee Retirement Income Security Act*, 335 NEW ENG. J. MED. 1986 (1996).

231. *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1486-87 (7th Cir. 1996).

232. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987).

233. *Jass*, 88 F.3d at 1486.

234. *Id.* (quoting *Rice v. Panchal*, 65 F.3d 637, 639 (7th Cir. 1995) (quoting *Metropolitan Life*, 481 U.S. at 63)). A preemption defense raised in the defendant's answer is not the basis of original federal jurisdiction nor for the removal to federal court of a claim filed in state court. *Jass*, 88 F.3d at 1486.

235. See *Avco Corp. v. Aero Lodge No. 735*, 390 U.S. 557 (1968) (applying the doctrine of complete preemption to a claim pursued under state law because it came within the scope of the Labor Management Relations Act). Congress intended to preempt completely this area of the law; therefore, the case was removable to federal court, and jurisdiction rested with the federal court even if the federal question did not appear on the face of the plaintiff's well-pleaded complaint. The Supreme Court has emphasized that the scope of ERISA preemption is to be interpreted with reference to preemption under the Labor Management Relations Act. *Metropolitan Life*, 481 U.S. at 64-66; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52-57 (1987); *Rice*, 65 F.3d at 637.

236. *Jass*, 88 F.3d at 1487.

subject matter jurisdiction.²³⁷ In *Metropolitan Life Insurance Co. v. Taylor*, the Supreme Court applied the "complete preemption" exception to the "well-pleaded complaint rule" in ERISA cases.²³⁸ The Supreme Court stated that the doctrine of "complete preemption" applied due to the congressional intent "to make all suits that are cognizable under ERISA's civil enforcement provisions federal question suits."²³⁹

Furthermore, once "complete preemption" is recognized under ERISA, the plaintiff's complaint is recharacterized as a complaint arising under federal law, and the injured plaintiff is restricted to the remedies provided within ERISA.²⁴⁰ The remedies available under ERISA are essentially the recovery of any benefits due under the plan, or injunctive or declaratory relief to obtain or clarify benefits.²⁴¹ Obviously, if a plaintiff were limited to the remedies available in ERISA, a severely injured plaintiff would not receive adequate compensation or would be left without a remedy. However, the Supreme Court has ruled that Congress intended the remedies provided within ERISA to be exclusive,²⁴² even if an individual is left without a remedy.²⁴³ The Supreme Court has stated, "The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free

237. The term "complete preemption" is misleading because complete preemption does not really deal with preemption; rather, it is a doctrine of federal jurisdiction. *Lister v. Stark*, 890 F.2d 941, 943 n.1 (7th Cir. 1989). As one commentator has noted:

"Complete" preemption . . . is a removal jurisdiction doctrine which divests a state court of *jurisdiction* by recharacterizing otherwise valid state-law claims (in areas subject to the doctrine) as "necessarily federal in character." In such cases, preemption—normally a federal *defense*—loses that character and causes the federal question to inhere in the complaint.

Dennis W. Arrow, *Federal Question Doctrines and American Indian Law*, 14 OKLA. CITY U. L. REV. 263, 319-20 (1989) (quoting *Metropolitan Life*, 481 U.S. at 63-64) (emphasis original).

238. 481 U.S. 58 (1987).

239. *Id.* at 63-64.

240. *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1487 (7th Cir. 1996).

241. 29 U.S.C. § 1132 (a)(1)(B). ERISA provides that a participant in a plan or beneficiary may bring a civil action "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 the plan." *Id.* For cases in which the plaintiff sought injunctive relief or recovery of benefits due under a benefit plan, see, e.g., *Whitney v. Empire Blue Cross/Blue Shield*, 920 F. Supp. 477 (S.D.N.Y. 1996); *Pirozzi v. Blue Cross-Blue Shield of Virginia*, 741 F. Supp. 586 (E.D. Virginia 1990); *Cole v. Blue Cross/Blue Shield of Mass., Inc.*, 738 F. Supp. 42 (D. Mass. 1990); *Rollo v. Blue Cross/Blue Shield of New Jersey*, Civ.A. No. 90-597, 1990 WL 312647 (D.N.J. Mar. 22, 1990); *Dozsa v. Crum & Forster Ins. Co.*, 716 F. Supp. 131 (D.N.J. 1989). See also Julia Field Costich, *Denial of Coverage for "Experimental" Medical Procedures: The Problem of De Novo Review Under ERISA*, 79 KY. L.J. 801 (1991).

242. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

243. *Tolton v. American Biodyne, Inc.*, 48 F.3d 937, 943 (6th Cir. 1995); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 132 (9th Cir. 1993).

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to obtain remedies under state law that Congress rejected in ERISA."²⁴⁴

It is an unclear question whether Congress ever intended ERISA to preempt causes of actions based on state tort law. One commentator has noted that "[t]here is no indication in the language of ERISA's preemption clause, or in ERISA's legislative history, that employers and benefit plans were to obtain some self-promoting protection from state law obligations."²⁴⁵ However, the federal courts are divided on whether ERISA preempts medical negligence causes of actions against employer-sponsored HMOs.²⁴⁶ The Supreme Court has declined to resolve the controversy²⁴⁷ in what has been described as a "most shocking abdication of judicial law-creating authority by the Supreme Court," resulting in a "zone of no liability for negligent acts."²⁴⁸

B. The Ambiguity of ERISA's "Relates to" Clause

A cause of action founded in state law "relates to" a benefit plan if the "operation of the law impinges on the functioning of an ERISA plan" or if the "state law in its application directly relates to the administration and disbursement of ERISA plan benefits."²⁴⁹ In the context of an injured plaintiff suing an HMO for medical negligence either under a theory of vicarious liability or corporate or direct liability (for example, its failure to use reasonable care in a prospective utilization review process), some federal courts have held that the state cause of action "relates to" the benefit plan and thus is preempted.²⁵⁰

244. *Pilot Life*, 481 U.S. at 54.

245. Pittman, *supra* note 8, at 360.

246. *Jackson v. Roseman*, 878 F. Supp. 820, 825 (D. Md. 1995). See authorities collected *supra* note 11.

247. See, e.g., *Kuhl v. Lincoln Nat'l Health Plan*, 999 F.2d 298 (8th Cir. 1993), *cert. denied*, 510 U.S. 1045 (1994); *Corcoran v. United Healthcare Inc.*, 965 F.2d 1321 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992).

248. Pittman, *supra* note 8, at 356-57.

249. *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 131 (9th Cir. 1993). A law relates to an employee benefit plan if the law has a "connection with or reference to such a plan." *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151, 154 (10th Cir. 1995). The Tenth Circuit has held that four categories of laws "relate to" benefit plans:

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.

250. *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995) (alleging corporate negligence in utilization review); *Spain*, 11 F.3d at 129 (alleging corporate negligence in refusing to authorize bone marrow transplant); *Kuhl*, 999 F.2d at 298 (applying preemption to corporate negligence); *Corcoran*, 965 F.2d at 1321 (alleging corporate negligence in the denial of hospitalization for pregnant woman); *Pomeroy v. Johns Hopkins Med. Servs.*, 868 F. Supp. 110 (D.

Under this line of authority, the same rationale applies whether “the claim is for the HMO’s own negligence or is being asserted against the HMO on the theory of vicarious liability.”²⁵¹ Four primary reasons are given in support of preemption. First, any ostensible agency claim and any claim regarding the quality of treatment actually received must be measured against what the benefit plan provided; therefore, such claims relate to the benefit plan.²⁵² Second, any claim based on ostensible or apparent agency will involve inquiry into representations that the plan made to determine if the HMO held out the physician as an ostensible agent. As one court reasoned, “[a] claim based on such references, descriptions, or explanations is ‘related to’ the benefit plan. Matters relating to a benefit plan are pre-empted by ERISA.”²⁵³ Third, HMO enrollees are assured of a certain quantity and quality of medical services. A malpractice claim alleging vicarious or direct liability against an HMO “asserts the services provided did not measure up to the benefit plan’s promised quality. The question is one of relating plan performance to plan-promise, and is therefore pre-empted by ERISA.”²⁵⁴ Fourth, higher costs in benefit plans will result if liability were imposed, and some courts are reluctant to adopt such “potentially widesweeping policy.” Some courts believe that Congress, not the courts, should properly re-examine the scope of ERISA preemption to determine if malpractice liability should be allowed.²⁵⁵

The courts that have held that ERISA preempts malpractice claims alleging vicarious liability and direct corporate liability are giving an indiscriminate, all-inclusive, and sweeping interpretation to ERISA’s “relates to” language. Such a broad or expansive interpretation acts as a judicial grant of immunity from tort liability to HMOs.²⁵⁶ However, only federal district courts, not federal courts of appeal, have interpreted ERISA so broadly or all-inclusively to preempt both

Md. 1994) (applying ERISA preemption to vicarious liability claims); *Visconti v. U.S. Health Care*, 857 F. Supp. 1097 (E.D. Pa. 1994) (holding ERISA preemption applies to vicarious liability claims); *Butler v. Wu*, 853 F. Supp. 125 (D.N.J. 1994) (applying ERISA preemption to vicarious liability claims); *Dukes v. United States Health Care Sys., Inc.*, 848 F. Supp. 39 (E.D. Pa. 1994) (drawing no distinction between corporate negligence and vicarious liability for ERISA preemption); *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966 (S.D.N.Y. 1994) (applying ERISA preemption to vicarious liability claim); *Ricci v. Gooberman*, 840 F. Supp. 316 (D.N.J. 1993) (holding vicarious liability claim preempted by ERISA).

251. *Dukes*, 848 F. Supp. at 42, *rev’d*, 57 F.3d 350 (3rd Cir. 1995), *cert. denied*, 16 S. Ct. 564 (1995).

252. *See Dukes*, 848 F. Supp. at 42.

253. *Id.*

254. *Id.*

255. *Id.* at 43.

256. *See* authorities collected *supra* note 240.

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vicarious liability and corporate liability causes of action.²⁵⁷ These lower court decisions have relied predominately on two legal precedents. The first precedent involves two federal district court cases—*Dukes v. United States Health Care Systems of Pennsylvania, Inc.*²⁵⁸ and *Visconti v. U.S. Health Care*.²⁵⁹ However, the Third Circuit reversed both *Dukes* and *Visconti* on appeal.²⁶⁰ The Third Circuit specifically held that ERISA preemption did not apply to claims challenging the "quality" of care provided; rather, ERISA only preempted cases attacking the "quantity" of benefits provided.²⁶¹ Arguably, the Third Circuit's reversal of *Dukes* and *Visconti* undermines the credibility of the line of decision that have preempted both vicarious and corporate liability causes of action against HMOs.

The second precedent is found in the Fifth Circuit case *Corcoran v. United Healthcare, Inc.*²⁶² In this case, the court held that ERISA preempted a state tort action against an employer-sponsored HMO because the action "related to" the benefit plan.²⁶³ However, in the *Corcoran* case, the plaintiff's allegations were premised upon corporate liability principles, claiming that the HMO was negligent in its prospective utilization review when it required in-home care and denied the physician's request to hospitalize the woman who was experiencing complications in her pregnancy which resulted in her baby's death.²⁶⁴ *Corcoran* lends little support for a broad or expansive interpretation of ERISA's "relates to" language because the court's holding should have application only to cases involving corporate liability because *Corcoran* did not address the possibility of vicarious liability under ERISA. Factually, the case involved only corporate negligence, not vicarious liability.²⁶⁵ This line of authority from federal district courts, holding that ERISA preempts all tort cases against employer-sponsored HMOs, including those based on a theory of vicarious

257. *Pomeroy v. Johns Hopkins Med. Servs.*, 868 F. Supp. 110 (D. Md. 1994) (applying ERISA preemption to vicarious liability claims); *Visconti v. U.S. Health Care*, 857 F. Supp. 1097 (E.D. Pa. 1994) (holding ERISA preemption applies to vicarious liability claims); *Butler v. Wu*, 853 F. Supp. 125 (D.N.J. 1994) (applying ERISA preemption to vicarious liability claims); *Dukes v. United States Health Care Sys. Inc.*, 848 F. Supp. 39 (E.D. Pa. 1994) (drawing no distinction between corporate negligence and vicarious liability for ERISA preemption); *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966 (S.D.N.Y. 1994) (applying ERISA preemption to vicarious liability claim); *Ricci v. Gooberman*, 840 F. Supp. 316 (D.N.J. 1993) (holding vicarious liability claim preempted by ERISA).

258. 848 F. Supp. 39 (E.D. Pa. 1994).

259. 857 F. Supp. 1097 (E.D. Pa. 1994).

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

261. *Id.* at 356-58.

262. 965 F.2d 1321 (5th Cir. 1992).

263. *Id.* at 1331.

264. *Id.* at 1322-24.

265. *Id.*

liability, is currently a minority view.²⁶⁶ The decided trend in the law is to give a narrow, discerning interpretation to ERISA's "relates to" language and to confine ERISA preemption to cases founded upon allegations of corporate liability, but not allegations of vicarious liability.²⁶⁷

Unfortunately, courts often fail to note this distinction when ruling on the preemption issue. Thus, the federal appellate courts that have held that ERISA preemption applies to medical negligence actions were reviewing cases involving the application of corporate liability principles. In all of the cases, the federal courts of appeals considered cases alleging the denial of medical treatment or hospitalization, i.e., negligence in the utilization review process, a form of corporate negligence.²⁶⁸ These decisions did not specifically address whether ERISA would preempt vicarious liability causes of action against HMOs.²⁶⁹ A court could easily determine that a claim of corporate negligence, alleging improper denial of benefits, "relates to" the administration of employee benefits

266. See *supra* note 257.

267. For cases that have specifically held that ERISA preempts corporate negligence claims, but not claims based upon vicarious liability, see *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995), *rev'g*, 875 F. Supp. 471 (N.D. Ill. 1994); *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Chaghervand v. Carefirst*, 909 F. Supp. 304 (D. Md. 1995); *Jackson v. Roseman*, 878 F. Supp. 820 (D. Md. 1995); *Dearmas v. Av-Med, Inc.*, 865 F. Supp. 816 (S.D. Fla. 1994); *Kearney v. U.S. HealthCare, Inc.*, 859 F. Supp. 182 (E.D. Pa. 1994); *Burke v. Smithkline Bio-Science Laboratories*, 858 F. Supp. 1181 (M.D. Fla. 1994); *Stroker v. Rubin*, Civ. A. No. 94-5563, 1994 WL 719694 (E.D. Pa. Dec. 22, 1994); *Elsesser v. Hospital of the Philadelphia College of Osteopathic Med.*, 802 F. Supp. 1286 (E.D. Pa. 1992). For cases holding that ERISA did not preempt a state tort claim, even though they factually dealt with vicarious liability, see *Prudential Health Care Plan, Inc. v. Lewis*, 177 F.3d 493 (10th Cir. 1996); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995); *Prihoda v. Shpritz*, 914 F. Supp. 113 (D. Md. 1996); *Jackson v. Roseman*, 878 F. Supp. 820 (D. Md. 1995); *Kusznir v. Lutheran Gen. Hosp.*, No. 95-C-1325, 1995 WL 404860 (N.D. Ill. May 31, 1995); *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544 (S.D. Ill. 1994); *Paterno v. Albuerne*, 855 F. Supp. 1263 (S.D. Fla. 1994); *Smith v. HMO Great Lakes*, 852 F. Supp. 669 (N.D. Ill. 1994); *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983 (E.D. Pa. 1990); *DeGenova v. Ansel*, 555 A.2d 147 (Pa. Super. Ct. 1988). See also *Conrad & Seiter*, *supra* note 6, at 199; *Perdue & Baxley*, *supra* note 6, at 61-64.

268. *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1485 (7th Cir. 1996) (denying plan coverage of physical therapy to patient after knee surgery which resulted in premature discharge from the hospital); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937, 939 (6th Cir. 1995) (declining in-patient psychiatric treatment under the plan); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 130 (9th Cir. 1993) (holding plan refused bone marrow transplant); *Kuhl v. Lincoln Nat'l Health Plan Inc.*, 999 F.2d 298, 300 (8th Cir. 1993) (holding plan failed to precertify heart surgery); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1324 (5th Cir. 1992) (holding that the plan allowed home care for complications during pregnancy, not hospitalization).

269. *Jass*, 88 F.3d at 1485 (denying plan coverage of physical therapy to patient after knee surgery which resulted in premature discharge from the hospital); *Tolton*, 48 F.3d at 939 (declining in-patient psychiatric treatment under the plan); *Spain*, 11 F.3d at 130 (holding plan refused bone marrow transplant); *Kuhl*, 999 F.2d at 300 (holding plan failed to precertify heart surgery); *Corcoran*, 965 F.2d at 1324 (holding that the plan allowed home care for complications during pregnancy, not hospitalization).

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or the amount of benefits provided by a benefit plan and, therefore, is preempted under ERISA. A court could easily perceive a claim of corporate negligence (failure to use reasonable care in the supervision of participating physicians, in the selection or retention of physicians, in the implementation of utilization review or cost-containment incentives) as a direct challenge to the administration of the employee benefit plan and would be justified in concluding that ERISA would preempt such a claim.

Some courts have specifically distinguished between claims of corporate liability and vicarious liability. This line of decisions provides a discerning interpretation of ERISA's "relates to" language as applied to medical negligence causes of action against employer-sponsored HMOs. Under this narrow interpretation, the "relates to" language is applied to preempt allegations of corporate negligence but not allegations of vicarious liability.²⁷⁰ The federal courts that have held that ERISA does not preempt medical negligence causes of action have all dealt with claims based on vicarious liability, even though these courts have not clearly articulated the distinction between direct liability and vicarious liability.²⁷¹

Only federal district courts, not federal appellate courts, are in disagreement. The district courts are divided as to whether ERISA preempts vicarious liability causes of action against employer-sponsored HMOs, but the clear trend is not to allow preemption.²⁷² Furthermore, the federal appellate

270. For cases holding that ERISA preempted corporate negligence claims, but not claims based upon vicarious liability, see *supra* note 267.

271. *Prudential Health Care Plan, Inc. v. Lewis*, 77 F.3d 493 (10th Cir. 1996); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3rd Cir. 1995); *Prihoda v. Shpritz*, 914 F. Supp. 113 (D. Md. 1996); *Jackson v. Roseman*, 878 F. Supp. 820 (D. Md. 1995); *Kusznir v. Lutheran Gen. Hosp.*, No. 95-C-1325, 1995 WL 404860 (N.D. Ill. May 31, 1995); *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544 (S.D. Ill. 1994); *Paterno v. Albuerno*, 855 F. Supp. 1263 (S.D. Fla. 1994); *Smith v. HMO Great Lakes*, 852 F. Supp. 669 (N.D. Ill. 1994); *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983 (E.D. Pa. 1990); *DeGenova v. Ansel*, 555 A.2d 147 (Pa. Super. Ct. 1988). The author is aware of only one decision that has held that ERISA did not preempt a claim of corporate negligence. This case was rendered by a Pennsylvania court, not a federal court. *Pappas v. Asbel*, 675 A.2d 711 (Pa. Super. Ct. 1996). However, this case also contained allegations that the treating physician was negligent so it is possible the court did not understand the distinction. *Id.*

272. For cases that have held that ERISA preemption applies to claims based on vicarious liability, see *Pomeroy v. Johns Hopkins Med. Servs.*, 868 F. Supp. 110 (D. Md. 1994); *Visconti v. U.S. Health Care*, 857 F. Supp. 1097 (E.D. Penn. 1994), *rev'd* 57 F.3d 350 (3d Cir. 1995); *Butler v. Wu*, 853 F. Supp. 125 (D.N.J. 1994); *Dukes v. United States Health Care Sys., Inc.*, 848 F. Supp. 39 (E.D. Pa. 1994), *rev'd*, 57 F.3d 350 (3d Cir. 1995); *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966 (S.D.N.Y. 1994); *Ricci v. Gooberman*, 840 F. Supp. 316 (D. N.J. 1993). For cases specifically holding that ERISA preempts corporate negligence claims, but not claims based upon vicarious liability, see *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995), *rev'g*, 875 F. Supp. 471 (N.D. Ill. 1994); *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Chaghervand v. Carefirst*, 909 F. Supp. 304 (D. Md. 1995); *Jackson v. Roseman*, 878 F. Supp. 820

courts that have specifically ruled on whether ERISA preempts state tort claims based on vicarious liability have agreed that ERISA does not preempt this form of state claim.²⁷³ The federal appellate courts are in agreement that ERISA preempts claims of corporate negligence against HMOs because the failure to use reasonable care in the utilization review process "relates to" the benefit plan.²⁷⁴

The disagreement results partly from confusion as to the appropriate level of generality that courts should use when interpreting ERISA's "relates to" language and whether to take a broad, all-inclusive approach or a narrow discerning approach in interpreting the language. The disagreement also stems from the failure of federal appellate courts to clearly distinguish between corporate or direct liability and vicarious liability in rendering decisions in cases involving corporate liability. In these cases, the federal appellate courts held that ERISA preemption applied to the causes of action, but these cases factually involved arguments regarding corporate negligence and did not address whether a different result would be reached in the case of vicarious liability.²⁷⁵ Thus,

(D. Md. 1995); *Dearmas v. Av-Med, Inc.*, 865 F. Supp. 816 (S.D. Fla. 1994); *Kearney v. U.S. HealthCare, Inc.*, 859 F. Supp. 182 (E.D. Pa. 1994); *Burke v. Smithkline Bio-Science Laboratories*, 858 F. Supp. 1181 (M.D. Fla. 1994); *Stroker v. Rubin*, Civ.A. No. 94-5563, 1994 WL 719694 (E.D. Pa. Dec. 22, 1994); *Elsesser v. Hospital of the Philadelphia College of Osteopathic Med.*, 802 F. Supp. 1286 (E.D. Pa. 1992). For cases holding that ERISA did not preempt state tort claim, but factually dealing with allegations of vicarious liability, see *Prudential Health Care Plan, Inc. v. Lewis*, 77 F.3d 493 (10th Cir. 1996); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995); *Prihoda v. Shpritz*, 914 F. Supp. 113 (D. Md. 1996); *Jackson v. Roseman*, 878 F. Supp. 820 (D. Md. 1995); *Kusznir v. Lutheran Gen. Hosp.*, No. 95-C-1325, 1995 WL 404860 (N.D. Ill. May 31, 1995); *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544 (S.D. Ill. 1994); *Paterno v. Albuene*, 855 F. Supp. 1263 (S.D. Fla. 1994); *Smith v. HMO Great Lakes*, 852 F. Supp. 669 (N.D. Ill. 1994); *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983 (E.D. Pa. 1990); *DeGenova v. Ansel*, 555 A.2d 147 (Pa. Super. Ct. 1988). See also *Conrad & Seiter*, *supra* note 6, at 199; *Perdue & Baxley*, *supra* note 6, at 61-64.

273. See *Burrage*, 59 F.3d at 151; *Dukes*, 57 F.3d at 350.

274. *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996) (applying ERISA preemption to case where recovery was sought for the plan's denial of physical therapy following knee surgery and for premature release from the hospital); *Burrage*, 59 F.3d at 151 (applying ERISA preemption to corporate negligence, but not vicarious liability); *Dukes*, 57 F.3d at 356 (holding ERISA preempts claims challenging the "quantity of benefits" provided, not "quality" of provided benefits); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995) (declining in-patient psychiatric treatment under the plan); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir. 1993) (holding plan refused bone marrow transplant); *Kuhl v. Lincoln Nat'l Health Plan Inc.*, 999 F.2d 298 (8th Cir. 1993) (holding plan failed to precertify heart surgery); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992) (plan allowed home care for complications during pregnancy, not hospitalization).

275. *Jass*, 88 F.3d at 1482 (applying ERISA preemption to a case where recovery was sought for the plan's denial of physical therapy following knee surgery and the resulting premature release from the hospital); *Tolton*, 48 F.3d at 937 (declining in-patient psychiatric treatment under the plan); *Spain*, 11 F.3d at 129 (stating plan refused bone marrow transplant); *Kuhl*, 999 F.2d at 298 (holding

the emerging standard regarding ERISA preemption involves corporate liability cases, but not vicarious liability.²⁷⁶ It has been argued that "[i]f ERISA was interpreted to preempt all claims that affect an HMO . . . , such as vicarious liability claims under appropriate circumstances, then HMOs would have a unique status in the law. HMOs would enjoy a charmed existence that was never contemplated by Congress."²⁷⁷

C. Vicarious Liability Claims Avoid ERISA Preemption

Although "[i]t is undisputed that ERISA preempts claims which arise from the manner in which an HMO administered plan benefits or which derive from the type or extent of benefits the . . . HMO promised or provided,"²⁷⁸ federal courts have advanced various policy arguments in support of their conclusion that preemption does not apply to claims founded upon vicarious liability. ERISA does not preempt state laws of general application and laws involving areas of traditional state regulation.²⁷⁹ Accordingly, a malpractice claim would not be preempted because it is based on a law of general application, one that neither targets ERISA plans nor "affect[s] the structure, administration, or benefits provided by the plan."²⁸⁰ A malpractice claim is "too tenuous, remote, or peripheral . . . to warrant a finding that the law 'relates to' the plan."²⁸¹ The mere fact that the tort litigation would have "some economic impact" on the plan, such as having to pay a judgment, does not require that the law be preempted.²⁸² A tort cause of action under state law can be characterized as a "run-of-the-mill" state law claim and, according to the Supreme Court, should not fall victim to the ERISA preemption clause.²⁸³

Furthermore, a cause of action against an HMO that seeks to impose vicarious liability on the HMO for the negligence of an employee-physician or an ostensible or apparent agent is an action to recover for personal injuries, not

plan failed to precertify needed heart surgery); *Corcoran*, 965 F.2d at 1321 (holding plan allowed home care for complications during pregnancy, not hospitalization).

276. Conrad & Seiter, *supra* note 6, at 199; Perdue & Baxley, *supra* note 6, at 60-64.

277. Perdue & Baxley, *supra* note 6, at 63-64.

278. *Jackson v. Roseman*, 878 F. Supp. 820 (D. Md. 1995).

279. *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151, 154 (10th Cir. 1995) (quoting *National Elevator Indus. v. Calhoon*, 957 F.2d 1555, 1558-59 (10th Cir. 1992)).

280. *See Burrage*, 59 F.3d at 154.

281. *Id.* (quoting *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 100 n.21 (1983)). *See also Smith v. HMO Great Lakes*, 852 F. Supp. 669, 672 (N.D. Ill. 1994).

282. *Burrage*, 59 F.3d at 154.

283. *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983, 989 (E.D. Pa. 1990) (citing *Mackey v. Lanier Collections Agency & Serv.*, 486 U.S. 825 (1988)).

to challenge the denial of any rights under the plan.²⁸⁴ The court would not have to refer to the benefit plan in order to determine whether the physician was negligent and to impose vicarious liability upon the HMO. Rather, the court would examine the evidence to determine what happened and whether the physician acted negligently in providing treatment admittedly covered under the plan.²⁸⁵ While ERISA would preempt a claim that a patient did not receive a promised benefit under the plan,²⁸⁶ ERISA would not preempt a claim that a patient "received promised service from a provider who performed that service negligently. . . ." ²⁸⁷ One court stated the argument as follows:

The plaintiffs are not attempting to define new "rights under the terms of the plan"; instead, they are attempting to assert their already-existing rights under the generally-applicable state law of agency and tort. . . . [P]atients enjoy the right to be free from medical malpractice regardless of whether or not their medical care is provided through an ERISA plan.²⁸⁸

Just as ERISA does not preempt a malpractice claim against a physician in his individual capacity, ERISA should not preempt causes of action under a theory of vicarious liability when the HMO employed the physician or when the HMO "holds out" the physician as its agent.²⁸⁹ A simple reference to a benefit plan in a state tort action in order to resolve an agency issue should not "sufficiently relate to the plan so as to warrant preemption."²⁹⁰

Moreover, Congress intended, in preempting state law, to secure uniform laws regulating employee benefit plans. The "preemption of state common law claims which are not premised on a violation of duties imposed by ERISA" would not promote that intended goal.²⁹¹ A state medical malpractice action would not interfere with or alter Congress' carefully-crafted statutory scheme.²⁹² ERISA's legislative history does not evidence any congressional intent to provide under ERISA a remedy for medical malpractice, and

284. *Smith v. HMO Great Lakes*, 852 F. Supp. 669, 672 (N.D. Ill. 1994) (citing *Elsesser v. Hospital of the Philadelphia College of Osteopathic Med.*, 802 F. Supp. 1286, 1290 (E.D. Pa. 1992)); *Independence HMO*, 733 F. Supp. at 988.

285. *Jackson v. Roseman*, 878 F. Supp. 820, 826 (D. Md. 1995).

286. *Id.*

287. *Id.*

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

289. *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151, 155 (10th Cir. 1995).

290. *Id.* at 154-55.

291. *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983, 988 (E.D. Pa. 1990) (quoting *Albert Einstein Med. Ctr. v. Action Mfg. Co.*, 697 F. Supp. 883, 885 (E.D. Pa. 1988)).

292. *Independence HMO*, 733 F. Supp. at 988; *Smith v. HMO Great Lakes*, 852 F. Supp. 669, 672 (N.D. Ill. 1994).

congressional silence may suggest that Congress intended not to preempt malpractice actions against HMOs founded on state tort law.²⁹³ Preemption would lead to the "anomalous result" of an "unwise federalization of an entire class of state tort claims which, absent diversity, would be decided in state court."²⁹⁴ Furthermore, courts are reluctant to preempt an area of traditional state law without clear evidence of congressional intent to do so.²⁹⁵

The better-reasoned decisions support the proposition that ERISA preemption does not apply to claims under state law based on a theory of vicarious liability. However, a unique decision by the Third Circuit Court of Appeals adds to the confusion as to permissible state tort actions. Instead of drawing the line between permissible state claims and those preempted by ERISA with the vicarious liability/corporate liability distinction, the Third Circuit in *Dukes v. U.S. Healthcare, Inc.*²⁹⁶ distinguished between claims that challenge the "quality" of benefits provided by the plan and claims that challenge the "quantity" of benefits provided.²⁹⁷ In *Dukes*, the plaintiff claimed that an HMO was vicariously liable for the negligence of a physician who was allegedly an ostensible agent of the HMO. The plaintiff also argued a theory of corporate negligence, alleging that the HMO was negligent in selecting, retaining, and monitoring the physician.²⁹⁸ The Third Circuit held

293. *Dukes*, 57 F.3d at 357.

294. *Jackson v. Roseman*, 878 F. Supp. 820, 826 (D. Md. 1995) (quoting *Page v. Heeman*, No. 93-372, at 2 (D. Md. 1993)).

295. *Smith*, 852 F. Supp. at 672.

296. 57 F.3d 350 (3d. Cir. 1995), *rev'g*, 848 F. Supp. 39 (E.D. Pa. 1994), and *rev'g*, *Visconti v. U.S. Health Care*, 857 F. Supp. 1097 (E.D. Pa. 1994).

297. *Dukes*, 57 F.3d at 357, *accord* *Prihoda v. Shpritz*, 914 F. Supp. 113 (D. Md. 1996) In *Prihoda*, the court found that the physician misdiagnosed a kidney tumor which permitted the tumor to metastasize to the lung of the patient. The court held that the alleged negligence dealt only with the quality of the benefits provided, not the denial or withholding of benefits under the plan, and as such ERISA did not preempt the cause of action against the plan for the vicarious liability of the physician, and the suit was allowed to proceed. *Prihoda*, 914 F. Supp. at 133. Many times the same result would be obtained by drawing the line between permissible and impermissible claims using a "quality/quantity" distinction or a corporate liability/vicarious liability distinction in determining whether ERISA preempted the claims. Claims challenging the plan's "quality" of care would typically involve claims based upon physician neglect in selecting or performing treatment and would usually allege the plan's vicarious liability for the treating physician's negligence. Causes of action alleging corporate negligence many times challenge the "quantity" of benefits provided (i.e., the plan's failure to provide coverage for certain modes of treatment), especially allegations of negligence in prospective utilization review. Therefore, the preemption issue would likely be resolved the same whether approached from a "quality/quantity" or corporate liability/vicarious liability standpoint. However, as *Dukes* pointed out, the "distinction between the quantity of benefits due under a welfare plan and the quality of those benefits will not always be clear . . ." *Dukes*, 57 F.3d at 358. A clearer, easier line distinguishes between allegations of vicarious liability and corporate liability, and thus ERISA would not preempt claims of vicarious liability but would preempt claims of corporate negligence.

298. *Dukes*, 57 F.3d at 352.

that ERISA preempted causes of action claiming injury from the HMO's withholding of "some quantum of plan benefits due."²⁹⁹ Congress did not intend ERISA to regulate the "quality of benefits received by plan participants."³⁰⁰ The Third Circuit was "confident that a claim about the quality of a benefit received is not a claim under [ERISA] to recover benefits due . . . under the terms of [the] plan."³⁰¹ The Third Circuit acknowledged that distinguishing between quantity and quality might not be easy in all cases:

We recognize that the distinction between the quantity of benefits due under a welfare plan and the quality of those benefits will not always be clear in situations like this where the benefit contracted for is health care services rather than money to pay for such services. There well may be cases in which the quality of a patient's medical care or the skills of the personnel provided to administer that care will be so low that the treatment received simply will not qualify as health care at all. In such a case, it well may be appropriate to conclude that the plan participant or beneficiary has been denied benefits due under the plan. This is not such a case, however.³⁰²

Accordingly, the Third Circuit remanded the case to state court for resolution under both vicarious liability and corporate liability theories.³⁰³

The Third Circuit made clear that a case alleging corporate negligence in utilization review would challenge the "quantity" of benefits, would "relate to" the benefit plan, and, as such, would be subject to ERISA preemption.³⁰⁴ In *Dukes*, the plaintiff alleged corporate negligence for the HMO's failure to use reasonable care in the selection, retention, and monitoring of participating physicians,³⁰⁵ not a failure to use reasonable care in utilization review.³⁰⁶ Two possible explanations exist as to why the Third Circuit did not conclude that ERISA preempted this type of corporate negligence cause of action and why the court also remanded this portion of the case. First, the Third Circuit believed that an HMO's failure to use reasonable care in selecting and

299. *Id.* at 357.

300. *Id.*

301. *Id.*

302. *Dukes*, 57 F.3d at 358. This approach would lead to the rather peculiar result— as the quality of care drastically declined, an injured patient would be less likely to have a state tort cause of action in medical malpractice against the HMO because ERISA would more likely preempt the claim as a determination regarding the quantity of benefits due under a plan.

303. *Id.* at 361.

304. *Dukes*, 57 F.3d at 360-61 (citing *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992)).

305. *Dukes*, 57 F.3d at 352.

306. *Id.* at 361.

supervising physicians involved a "quality," not a "quantity," issue. However, such an allegation of corporate negligence clearly would affect the structure or administration of the benefit plan,³⁰⁷ could arguably directly "relate to" the benefit plan, and thus would be subject to ERISA preemption. Furthermore, an HMO's failure to properly screen or monitor physicians could, in certain fact situations, result in a physician's negligent failure to provide certain treatments, not merely the negligent administration of provided care, which would then clearly fall within the purview of the "quantity" of benefits provided. It is unclear whether courts will follow the Third Circuit and allow certain forms of corporate negligence claims to proceed, but recognize ERISA preemption of other corporate negligence claims, most noticeably negligence in utilization review.

A second explanation as to why the Third Circuit remanded the corporate negligence claim is simply that it was too intertwined with the vicarious liability claim. The court may have considered it impossible to separate the two allegations because the court lacked complete understanding of the plan's benefits and the participants' rights because the case was on appeal from orders granting motions to dismiss.³⁰⁸ Furthermore, the Third Circuit left "open for resolution by the state courts the issue of whether the plaintiffs' claims are preempted under [section] 514(a)."³⁰⁹ Nevertheless, the Third Circuit clearly held that preemption does not apply to vicarious liability claims under its "quality/quantity" distinction.³¹⁰ However, it is not so clear that the *Dukes* opinion sets a precedent for the proposition that ERISA might not preempt certain claims of corporate liability.

D. Vicarious Liability Versus Corporate Liability

Various arguments can be made that ERISA should not preempt either type of state tort claim:

First, state medical malpractice claims are based upon laws of general applicability which generally will affect the benefit plan in a too tenuous, remote, and peripheral manner. Second, even if the same negligent act may give rise to a cause of action for both a state malpractice claim and for a breach of fiduciary duty under ERISA, the state malpractice claim should not be preempted when it is based on liability theories outside of those covered under ERISA. There is no indication from the language, or from the legislative history, of ERISA

307. *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151 (1995).

308. *Dukes*, 57 F.3d at 356.

309. *Id.* at 361.

310. *Id.* at 357.

that Congress' intent in enacting ERISA is to "eviscerate all state laws that touch on employee benefits." Third, the public policy reason that has been cited by the Supreme Court to support preemption of state laws is based upon an outdated rationale that should not be followed in the future.³¹¹

This outmoded rationale was that the individual variations of laws among the states "would produce considerable inefficiencies, which the employer might choose to offset by lowering benefit levels."³¹²

311. Pittman, *supra* note 8, at 426-27 (citations omitted).

312. Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1332 (5th Cir. 1992) (quoting Fort Halifax Packing Company, Inc. v. Coyne, 482 U.S. 1, 10 (1987)). A practical argument could be made that ERISA should not preempt either claims of corporate liability or vicarious liability. A case alleging corporate liability (e.g., a failure to use reasonable care in selecting or retaining staff, in monitoring physician performance, in utilization review, or in implementing or designing cost-containment incentives) ultimately suggests that an individual within the corporation made a negligent decision. Therefore, a litigant could attempt to avoid ERISA preemption, in a case involving allegations of corporate negligence, by phrasing the complaint in terms of the negligence of the individual and couching the terms of relief in terms of vicarious liability. For example, a plaintiff injured by prospective utilization review could attempt to sue the medical director who denied the requested treatment, allege that the HMO was vicariously liable for the medical director's negligence, and attempt to avoid ERISA preemption of the corporate negligence claim for failure to use reasonable care in utilization review. However, artful pleading does not avoid complete preemption. Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482 (7th Cir. 1996). The Seventh Circuit held:

[A] federal court may, in some situations, look beyond the face of the complaint to determine whether a plaintiff has artfully pleaded his suit so as to couch a federal claim in terms of state law. . . . Such a situation exists where . . . federal law displaces an area of state law and the plaintiff frames her complaint in such a way as to avoid the appearance of complete preemption.

Id. at 1488-89. In *Jass*, the plaintiff underwent knee replacement surgery, and she claimed that "her condition required a course of physical therapy to rehabilitate her knee." *Id.* at 1485. A nurse administering the utilization review of the plan decided it was not necessary, and "as a result Jass was prematurely discharged from the hospital without the necessary rehabilitation" causing injury to her knee. *Id.* Jass argued that the plan was vicariously liable for the nurse's actions in denying the rehabilitation and for her physician's failure to treat. *Id.* The court held that the plaintiff had artfully pled her complaint to avoid ERISA preemption. *Id.* at 1489. Clearly, the court was looking beyond the complaint itself because the vicarious liability claim rested upon a determination of the benefits due under the plan and thus was clearly subject to ERISA preemption. *Id.* This claim, actually a claim of corporate negligence (negligence in utilization review), was clearly subject to ERISA, and deceptive allegations should not have avoided this. *Id.* "Jass' negligence claim against Margulis [the nurse], a utilization review administrator for the plan, is properly recharacterized as a claim arising under federal law." *Id.* at 1490. The vicarious liability claim, premised upon the treating physician's negligence, was based upon the claim that the physician did not provide the needed rehabilitation, not that the services were preformed negligently. *Id.* at 1493. Thus, the doctor's "failure to treat stemmed from Margulis' denial of benefits based on her conclusion, as PruCare's utilization review administrator, that treatment was unnecessary." *Id.* at 1492. The plaintiff, through artful pleading, attempted to reclassify the corporate negligence cause of action as a vicarious liability cause of action in order to avoid ERISA preemption. *Id.* at 1489. Accordingly,

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Larry J. Pittman has suggested that the Supreme Court should interpret ERISA to allow corporate negligence claims or at least should create a cause of action for beneficiaries under ERISA plans who are injured through corporate negligence so that they may recover compensatory damages.³¹³ He has argued that "[a] claim for compensatory damages will serve as a deterrence mechanism and a counter balance to negligent decision-making by a benefit plan or an independent utilization reviewer as they attempt to cut health care costs. Creation of this remedy accords with ERISA's legislative history."³¹⁴ This argument that ERISA should not preempt corporate negligence causes of action has merit; however, the Supreme Court might not necessarily agree.

Arguably, no split in the federal appellate courts exists regarding ERISA preemption of malpractice claims. The circuit courts that have specifically addressed this issue have agreed that ERISA does not preempt vicarious liability claims,³¹⁵ but does preempt corporate liability claims.³¹⁶ The disagreement occurs at the district court level over ERISA preemption of causes of action founded upon vicarious liability.³¹⁷ The disagreement at the federal district

the court applied the doctrine of complete preemption. *Id.* at 1491. The court distinguished *Jass* from other cases in which ERISA was held not to preempt causes of action alleging the vicarious liability of HMOs for the negligence of treating physician's. *Id.* at 1443. The physician's alleged negligence was "intertwined with the benefits determination because the alleged negligence concerned a failure to treat where the Plan denied payment for the treatment." *Id.* at 1494. Attempting to avoid complete preemption through artful pleading can have severe ramifications. As the court stated, "[A]rtful pleading of an ERISA case to avoid federal jurisdiction may result in dismissal, without an opportunity to amend." *Id.* at 1491.

313. Pittman, *supra* note 8, at 441.

314. *Id.*

315. *Prudential Health Care Plan Inc. v. Lewis*, 77 F.3d 493 (10th Cir. 1996); *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995).

316. *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996); *Rice v. Panchel*, 65 F.3d 637 (7th Cir. 1995), *rev'd*, 875 F. Supp. 471 (N.D. Ill. 1994); *Pacificare*, 59 F.3d at 151 (applying ERISA preemption to corporate negligence claims, but not vicarious liability claims); *Dukes*, 57 F.3d at 350 (holding ERISA preempts claims challenging the "quantity of benefits" provided, not "quality" of provided benefits); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995) (declining in-patient psychiatric treatment under the plan); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir. 1993) (holding plan refused bone marrow transplant); *Kuhl v. Lincoln Nat'l Health Plan Inc.*, 999 F.2d 298 (8th Cir. 1993) (stating plan failed to precertify needed heart surgery); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992) (holding plan allowed home care for complications during pregnancy, not hospitalization).

317. For cases holding that ERISA preemption applies to claims based on vicarious liability, see *Pomeroy v. Johns Hopkins Med. Servs.*, 868 F. Supp. 110 (D. Md. 1994); *Visconti v. United States Health Care*, 857 F. Supp. 1097 (E.D. Penn. 1994), *rev'd*, 57 F.3d 350 (3d Cir. 1995); *Butler v. Wu*, 853 F. Supp. 125 (D. N.J. 1994); *Dukes v. United States Health Care Sys. Inc.*, 848 F. Supp. 39 (E.D. Pa. 1994), *rev'd*, 57 F.3d 350 (3d Cir. 1995); *Nealy v. U.S. Healthcare HMO*, U.S. 844 F. Supp. 966 (S.D.N.Y. 1994); *Ricci v. Gooberman*, 840 F. Supp. 316 (D.N.J. 1993). For cases specifically holding that ERISA preempts corporate negligence claims, but not claims

court level, but not at the appellate level, may explain why the Supreme Court has exercised judicial restraint in this area of the law.

Furthermore, as far as ERISA preemption is concerned, decisions already rendered by the Supreme Court seem consistent with a distinction between state tort claims based on corporate liability and those based on vicarious liability. In 1987, the Supreme Court held in *Pilot Life Insurance Co. v. Dedeaux*³¹⁸ that ERISA preempts a state tort cause of action for the bad faith processing of a claim for ERISA benefits.³¹⁹ Litigants brought bad faith claims under a fee-for-service approach when a benefit plan refused to pay a medical bill after services were rendered, retrospective review. Prospective utilization review performs much the same function, but it denies coverage before treatment is rendered.³²⁰ With regard to ERISA preemption, little difference is evident between bad faith and corporate negligence claims based on failure to use reasonable care in utilization review. The Supreme Court is likely to follow the precedent established in *Pilot Life* and conclude that ERISA preempts causes of action alleging corporate negligence.

However, "other Supreme Court decisions warn against extending *Pilot Life* to preempt state claims for medical malpractice,"³²¹ especially those that base liability upon vicarious liability principles. In 1988, the Supreme Court stated in *Mackey v. Lanier Collection Agency & Service, Inc.*:³²²

ERISA plans may be sued in a . . . civil action These cases—lawsuits against ERISA plans for *run-of-the-mill state-law claims* such as unpaid rent, failure to pay creditors, *or even torts*

based upon vicarious liability, see *Pacificare*, 59 F.3d at 151; *Chaghervand v. Carefirst*, 909 F. Supp. 304 (D. Md. 1995); *Jackson v. Roseman*, 878 F. Supp. 820 (D. Md. 1995); *Dearmas v. Av-Med, Inc.*, 865 F. Supp. 816 (S.D. Fla. 1994); *Kearney v. U.S. HealthCare, Inc.*, 859 F. Supp. 182 (E.D. Pa. 1994); *Burke v. Smithkline Bio-Science Laboratories*, 858 F. Supp. 1181 (M.D. Fla. 1994); *Stroker v. Rubin*, Civ. A. No. 94-5563, 1994 WL 719694 (E.D. Pa. Dec. 22, 1994); *Elsesser v. Hospital of the Philadelphia College of Osteopathic Med.*, 802 F. Supp. 1286 (E.D. Pa. 1992). For cases holding that ERISA does not preempt some state tort claims, but factually involving allegations of vicarious liability, see *Dukes*, 57 F.3d at 350; *Prihoda v. Shpritz*, 914 F. Supp. 113 (D. Md. 1996); *Jackson*, 878 F. Supp. at 820; *Kusznir v. Lutheran Gen. Hosp.*, No. 95-C-1325, 1995 WL 404860 (N.D. Ill. May 31, 1995); *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544 (S.D. Ill. 1994); *Paterno v. Albuerno*, 855 F. Supp. 1263 (S.D. Fla. 1994); *Smith v. HMO Great Lakes*, 852 F. Supp. 669 (N.D. Ill. 1994); *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983 (E.D. Pa. 1990); *DeGenova v. Ansel*, 555 A.2d 147 (Pa. Super. Ct. 1988). See also *Conrad & Seiter*, *supra* note 6, at 199; *Perdue & Baxley*, *supra* note 6, at 61-64.

318. 481 U.S. 41 (1987).

319. *Id.*

320. *Wickline v. California*, 239 Cal. Rptr. 810, 812 (Cal. Ct. App. 1986).

321. *Pittman*, *supra* note 8, at 388.

322. 486 U.S. 825 (1988).

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committed by an ERISA plan—are relatively commonplace. Petitioners and the United States (appearing here as *amicus curiae*) concede that these suits, although obviously affecting and involving ERISA plans and their trustees, are not pre-empted by ERISA³²³

Claims that seek to impose vicarious liability on HMOs would appear to be such "run-of-the-mill state-law claims" and would thus fall within the *Mackey* description of permissible actions under state law. On the other hand, allegations of corporate negligence would still be perceived as challenges to the administration of benefit plans, would "relate to" benefit plans, and accordingly would be preempted by ERISA.

Furthermore, the scope of the terms "relates to" a benefit plan was restricted by the 1995 Supreme Court decision of *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*³²⁴ The Court observed that were the phrase "relates to" given a literal interpretation, ERISA preemption would never stop because "relations stop nowhere."³²⁵ "Infinite relations cannot be the measure of preemption";³²⁶ rather, the extent of ERISA preemption should be measured by what state law "Congress understood would survive."³²⁷ The Supreme Court clearly held that ERISA should not preempt a state law simply because the state law has an indirect economic influence on the price of a benefit plan:³²⁸

In sum, cost-uniformity was almost certainly not an object of pre-emption, just as laws with only an indirect economic effect on the relative costs of various health insurance packages in a given State are a far cry from those "conflicting directives" from which Congress meant to insulate ERISA plans.³²⁹

The Supreme Court stated that "Congress could not possibly have intended to eliminate" the myriad of state laws that indirectly impact the cost of benefits in areas "traditionally subject to local regulation."³³⁰

323. *Id.* at 833 (emphasis added).

324. 115 S. Ct. 1671 (1995).

325. *Id.* at 1677.

326. *Id.*

327. *Id.*

328. *Id.* at 1679. The Court noted that "[t]he basic thrust of the pre-emption clause, then, was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Id.* at 1677-78.

329. *Id.* at 1680.

330. 115 S. Ct. at 1683.

Thus, the Supreme Court has given strong indication that ERISA should not preempt causes of action against employer-sponsored HMOs alleging vicarious liability and grounded in state law, although the law is less clear regarding claims alleging corporate negligence. Arguably, the Supreme Court should grant *certiorari* in an appropriate case in order to resolve the issue of ERISA preemption in corporate negligence claims, and this author contends the Court should allow this type of claim under state law. However, a congressional solution would appear more appropriate.

A distinction between vicarious liability and corporate liability seems appropriate for ERISA preemption purposes. Corporate liability claims relate to the administration of benefit plans and should arguably be subject to ERISA preemption. Furthermore, this distinction complies with a common-sense understanding of the term "relates to" a benefit plan.³³¹ In *Corcoran v. United Healthcare, Inc.*,³³² the Fifth Circuit held that ERISA preempts a state cause of action for failure to use reasonable care in utilization review. The court concluded that ERISA's preemption clause, as drafted by Congress, would preclude the corporate negligence claim.³³³ However, the Fifth Circuit identified three reasons why Congress should amend ERISA to allow state tort actions for failure to use reasonable care in utilization review.

First, ERISA preemption "eliminates an important check on the thousands of medical decisions routinely made in the burgeoning utilization review system."³³⁴ Without state tort liability, "substandard medical decision-making" goes undeterred.³³⁵ As a result, the cost of using reasonable care will not be factored into the cost of doing business, and HMOs will have less incentive to "deliver both high quality services and reasonable prices."³³⁶

Second, ERISA should be amended to allow corporate negligence cases because making compensatory damages available to the victim of negligent utilization review "might ease the tension between the conflicting interests of the beneficiary and the plan."³³⁷ The court noted that "some tension between the interest of the beneficiary in obtaining quality medical care and the interest of the plan in preserving the pool of funds available" for all beneficiaries has always existed.³³⁸ Prospective utilization review exacerbates the tension

331. *Pilot Life Ins. Co., v. Dedeaux*, 481 U.S. 41, 47 (1987).

332. 965 F.2d 1321 (5th Cir. 1992).

333. *Id.* at 1332-34.

334. *Id.* at 1338.

335. *Id.*

336. *Id.*

337. *Id.*

338. *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1338 (5th Cir. 1992).

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because a patient is less likely to pursue an uncovered course of treatment.³³⁹ The possibility of recovering damages for negligence might rectify to some degree some of the harmful results of cost-saving approaches.

Third, Congress should re-examine ERISA because the "world of employee benefit plans has hardly remained static since 1974" when Congress enacted ERISA.³⁴⁰ In 1974, prospective utilization review and cost-containment incentives that HMOs utilize were not present to any degree. Thus, "[f]undamental changes such as the widespread institution of utilization review would seem to warrant a reevaluation of ERISA so that it can continue to serve its noble purpose of safe-guarding the interests of employees. Our system, of course, allocates this task to Congress, not the courts."³⁴¹

VI. CONCLUSION

HMOs will continue to experience increased tort litigation.³⁴² The doctrine of vicarious liability is well established as a potential theory of recovery, either vicarious liability claims against HMOs for the negligence of employee-physicians³⁴³ or claims regarding physicians who are the ostensible or apparent agents of the HMO.³⁴⁴ Under the doctrine of respondeat superior, imposing vicarious liability on an HMO will depend upon a finding that the HMO exercised the requisite control over the details of the physician's work and that an employer-employee relationship existed between the HMO and the physician;³⁴⁵ whereas, under the ostensible agency theory, vicarious liability will require proof of sufficient implied representations from the surrounding circumstances to establish that the HMO "held out" the physician as an employee and that the patient was looking to the HMO to provide medical care,

339. *Id.*

340. *Id.*

341. *Id.* at 1338-39.

342. Reuben, *supra* note 1, at 55.

343. *See, e.g.,* Schleier v. Kaiser Found. Health Plan of Mid-Atlantic States, Inc., 876 F.2d 174 (D.C. Cir. 1989); Haas v. Group Health Plan, Inc., 875 F. Supp. 544 (S.D. Ill. 1994); Pulvers v. Kaiser Found. Health Plan, 160 Cal. Rptr. 392 (Cal. Ct. App. 1979); Sloan v. Metropolitan Health Council of Indianapolis, Inc., 516 N.E.2d 1104 (Ind. Ct. App. 1987); Gugino v. Harvard Community Health Plan, 403 N.E.2d 1166 (Mass. 1980); Dunn v. Praiss, 606 A.2d 862 (Pa. Super. Ct. 1992); DeGenova v. Ansel, 555 A.2d 147 (Pa. Super. Ct. 1988).

344. *See, e.g.,* Schleier, 876 F.2d at 174; Haas, 875 F. Supp. at 544; Kearney v. U.S. Healthcare, Inc., 859 F. Supp. 182 (E.D. Pa. 1994); Independent HMO, Inc. v. Smith, 733 F. Supp. 983 (E.D. Pa. 1990); Raglin v. HMO Illinois, Inc., 595 N.E. 2d 153 (Ill. App. Ct. 1992); Chase v. Independent Prac. Ass'n, Inc., 583 N.E.2d 251 (Mass. Ct. App. 1991); Dunn, 606 A.2d at 862; McClellan v. Health Maintenance Org. of Pa., 604 A.2d 1053 (Pa. Super. Ct. 1992); Boyd v. Albert Einstein Med. Ctr., 547 A.2d 1229 (Pa. Super. Ct. 1988); DeGenova, 555 A.2d at 147.

345. *See, e.g.,* Raglin, 595 N.E.2d at 153; Sloan, 516 N.E.2d at 1104; Chase, 583 N.E.2d at 251.

not just to the individual physician to provide treatment.³⁴⁶ Whether the HMO is a Staff, Group, Network, or IPA Model can affect a determination regarding vicarious liability because, in these various models, the HMO exercises varying degrees of control over physicians.³⁴⁷

Most litigation against HMOs seeks to make HMOs liable through vicarious liability.³⁴⁸ This may be the case because an allegation of vicarious liability, unlike an allegation of corporate negligence, is less likely to be subject to ERISA³⁴⁹ preemption³⁵⁰ when the HMO's coverage is part of an employee benefit plan.³⁵¹ Although some federal district courts have held that ERISA preempts vicarious liability claims,³⁵² the better-reasoned decisions, the decisions of federal appellate courts, and the current trend in the law all appear to suggest that ERISA does not preempt causes of action alleging vicarious liability and that the claims should be allowed to proceed against employer-sponsored HMOs.³⁵³

346. See *Kearney*, 859 F. Supp. at 185; *Boyd*, 547 A.2d at 1234. See also RESTATEMENT (SECOND) OF TORTS § 429 (1965).

347. See, e.g., *Raglin*, 595 N.E.2d at 153 (holding that evidence was not sufficient under the facts to find an apparent agency with an IPA HMO); *Chase*, 583 N.E.2d at 251 (holding IPA HMO not vicariously liable as an ostensible agent under the facts); *Gugino*, 403 N.E.2d at 1168-69 (imposing vicarious liability for an employee-physician in a Staff Model HMO); *Boyd*, 547 A.2d at 1229 (applying ostensible agency to an IPA Model HMO). See generally *Cooper*, *supra* note 1; *Kanute*, *supra* note 4.

348. *Cooper*, *supra* note 1, at 1270.

349. 29 U.S.C. §§ 1001-1461 (1988).

350. *Id.* § 1144(a).

351. See, e.g., *Prudential Health Care Plan, Inc. v. Lewis*, 77 F.3d 493, 1996 WL 77018 (10th Cir. 1996); *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995); *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Dukes v. United States Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995); *Prihoda v. Shpritz*, 914 F. Supp. 113 (D. Md. 1996); *Chaghervand v. Carefirst*, 909 F. Supp. 304 (D. Md. 1995); *Jackson v. Roseman*, 878 F. Supp. 820 (D. Md. 1995); *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544 (S.D. Ill. 1994); *Dearmas v. Av-Med, Inc.*, 865 F. Supp. 816 (S.D. Fla. 1994); *Kearney v. United States Healthcare, Inc.*, 859 F. Supp. 182 (E.D. Pa. 1994); *Burke v. Smithkline Bio-Science Lab.*, 858 F. Supp. 1181 (M.D. Fla. 1994); *Paterno v. Albuerne*, 855 F. Supp. 1263 (S.D. Fla. 1994); *Smith v. HMO Great Lakes*, 852 F. Supp. 669 (N.D. Ill. 1994); *Elsesser v. Hospital of the Philadelphia College of Osteopathic Med.*, 802 F. Supp. 1286 (E.D. Pa. 1992); *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983 (E.D. Pa. 1990); *DeGenova v. Ansel*, 555 A.2d 147 (Pa. Super. Ct. 1988).

352. See, e.g., *Pomeroy v. Johns Hopkins Med. Servs. Inc.*, 868 F. Supp. 110 (D. Md. 1994); *Visconti v. U.S. Health Care*, 857 F. Supp. 1097 (E.D. Pa. 1994); *Butler v. Wu*, 853 F. Supp. 125 (D.N.J. 1994); *Dukes v. United States Health Care Sys., Inc.*, 848 F. Supp. 39 (E.D. Pa. 1994); *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966 (S.D.N.Y. 1994); *Ricci v. Gooberman*, 840 F. Supp. 316 (D.N.J. 1993). Both *Dukes* and *Visconti* were overruled. See *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995).

353. See, e.g., *Lewis*, 77 F.3d at 493; *Dukes*, 57 F.3d at 350; *Burrage*, 59 F.3d at 151; *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995), *rev'g*, 875 F. Supp. 471 (N.D. Ill. 1994); *Prihoda*, 914 F. Supp. at 113; *Chaghervand*, 909 F. Supp. at 304; *Jackson*, 878 F. Supp. at 820; *Haas*, 875 F. Supp. at 544; *Burke*, 858 F. Supp. at 1181; *Dearmas*, 865 F. Supp. at 816; *Kearney*, 859 F. Supp.

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The boundaries of the tort liability of HMOs under the theory of corporate or direct liability are beginning to emerge. Like hospitals,³⁵⁴ HMOs may become subject to the duty to use reasonable care in monitoring physicians during the treatment of patients³⁵⁵ and the duty to use reasonable care in selecting and retaining participating physicians.³⁵⁶ Because enrollees have limited choice regarding their treating physicians and rely on the HMO's credentialing process and its representations regarding the quality of their physicians, the law should impose liability on HMOs in order to protect enrollees. Such liability would ensure that HMOs properly monitor the care enrollees receive and the treatment physicians provide.³⁵⁷

A patient who is negligently injured will likely sue the treating physician and the HMO. A patient is likely to sue both when the improper care results from a failure to order diagnostic tests, a failure to refer to a specialist, a failure to hospitalize, or a failure to authorize expensive treatments and when cost-containment incentives³⁵⁸ or a failure to use reasonable care in utilization review³⁵⁹ are a substantial factor or contributing cause³⁶⁰ in the physician's failure to use the care that other reasonably competent physicians would have used in the same or similar circumstances.³⁶¹ The cost-containment incentives employed by the HMO create a conflict of interest between physicians and patients because physicians earn less when more tests, procedures, referrals, or hospitalizations are ordered for patient care.³⁶² A physician's foreseeable negligence should not be an intervening or superseding cause that cuts off the liability of the HMO, especially when the HMO's cost-containment incentives contributed to the physician's negligent conduct.³⁶³ Likewise, a physician's

at 182; *Paterno*, 855 F. Supp. at 1263; *HMO Great Lakes*, 852 F. Supp. at 669; *Elsesser*, 802 F. Supp. at 1286; *Independence HMO*, 733 F. Supp. at 983; *DeGenova*, 555 A.2d at 147.

354. See, e.g., *Darling v. Charleston Community Mem'l Hosp.*, 211 N.E.2d 253 (Ill. 1965); *Strubhart v. Perry Mem'l Hosp. Trust Auth.*, 903 P.2d 263 (Okla. 1995).

355. *Dunn v. Praiss*, 656 A.2d 413, 415 (N.J. 1995); *McClellan v. Health Maintenance Org.*, 660 A.2d 97, 99 (Pa. Super. Ct. 1995).

356. *Dunn*, 656 A.2d at 415; *McClellan*, 660 A.2d at 99.

357. RESTATEMENT (SECOND) OF TORTS § 323 (1966).

358. *Pulvers v. Kaiser Found. Health Plan*, 160 Cal. Rptr. 392 (Cal. App. Ct. 1979); *Bush v. Dake*, File No. 86-25767 NM-2 (Mich. Cir. Ct., Saginaw County 1989), reprinted in FURROW ET AL., CASES & MATERIALS, *supra* note 187, at 719-22.

359. See, e.g., *Wilson v. Blue Cross of S. Cal.*, 271 Cal. Rptr. 876 (Cal. App. Ct. 1990); *Wickline v. State*, 239 Cal. Rptr. 810 (Cal. App. Ct. 1986); *Dunn*, 656 A.2d at 415; *Williams v. HealthAmerica*, 535 N.E.2d 717 (Ohio Ct. App. 1987).

360. RESTATEMENT (SECOND) OF TORTS §§ 431 & 439 (1965).

361. See *supra* notes 77-84 and accompanying text.

362. See Bronow, *supra* note 27, at 11; Mehlman, *supra* note 26, at 299-306; authority cited *supra* notes 178 and 198.

363. RESTATEMENT (SECOND) OF TORTS §§ 442(a), 442(c), 442A, 442B, 443, 447, 447(c) (1965).

failure to use reasonable care in treatment decisions is also foreseeable when the HMO, after utilization review, negligently denies the prescribed treatment.³⁶⁴

Imposing corporate liability upon HMOs will not increase litigation. Physicians will continue to be exposed to liability, regardless of whether courts impose corporate negligence upon HMOs. However, what imposing corporate negligence on HMOs will do is to shift the burden, or a portion of the burden, of tort liability onto the shoulders of the HMO rather than leaving the burden solely to physicians. The issue really comes down to the question of who should bear the loss because the cost is already reflected in the price of individual treatment.

Shifting liability, or at least a portion of it, would seem appropriate for at least three reasons. First, HMOs, in their unique structure and arrangements, save money. But, when this structure results in substandard care, HMOs as institutions should appropriately bear the burden of liability for the resulting injuries, not just the treating physicians who are restricted in their medical judgment by the cost-containment incentives and the prospective utilization review process created by HMOs. Second, making individual physicians bear the bulk of liability exposure exacts many societal costs. Physicians react with bitterness and anger to the prospect of being defendants,³⁶⁵ and the fear of personal liability arguably leads to the practice of defensive medicine.³⁶⁶

364. *Id.*

365. FURROW ET AL., *HEALTH LAW*, *supra* note 9, at 334 (citing F. Patrick Hubbard, *The Physician's Point of View Concerning Medical Malpractice: A Sociological Perspective on the Symbolic Importance of "Tort Reform,"* 23 GA. L. REV. 295 (1989)); FURROW ET AL., *CASES & MATERIALS*, *supra* note 187, at 162-63.

366. FURROW ET AL., *HEALTH LAW*, *supra* note 9, at 537 (citing PATRICIA DANZON, *MEDICAL MALPRACTICE: THEORY, PRACTICE, AND PUBLIC POLICY* 225-27 (1985)); A.G. Lawthers, *Physicians' Perceptions of the Risk of Being Sued*, 17 J. HEALTH POL. POL'Y & L. 463 (1992); Paul C. Weiler et al., *Proposal for Medical Liability Reform*, 267 JAMA 2355, 2356 (1992). Defensive medicine has been defined as "those medical practices that are *not medically justified* and are performed primarily to prevent or defend against the threat of liability." David Klingman et al., *Measuring Defensive Medicine Using Clinical Scenario Surveys*, 21 J. HEALTH POLS., POL'Y & L. 185, 187 (1996) (emphasis added). From the standpoint of patient health concerns, "good" and "bad" types of defensive medicine exist. "Good" defensive medicine "avoids adverse outcomes," contributes to the goal of avoiding risks of injuries to patients, and "might increase or decrease health care costs." *Id.* "Bad" defensive medicine encourages "physicians to order tests or procedures that both raise health care costs and pose a risk of injury to patients." *Id.* The American Medical Association estimated that defensive medicine added approximately \$12 billion to health care cost in America in 1985. FURROW ET AL., *HEALTH LAW*, *supra* note 9, at 352 (citing Martin Hatlie, *Professional Liability: The Case for Federal Reform*, 263 JAMA 584 (1990)). If true, the figure could be over \$20 billion today. *Id.* However, this figure did not distinguish between "good" and "bad" defensive medicine. Moreover, one recent study suggests that the practice of defensive medicine does not exist to the extent previously suggested and that "[i]n most cases, medical indication, not malpractice concerns, motivated clinical choices." Klingman, *supra*, at 185.

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While nearly all major tort litigation targets institutions, and not individuals, medical malpractice litigation uniquely targets individual physicians as the defendants, resulting in non-monetary societal costs. By shifting the focus onto the HMOs as institutional defendants, medical negligence litigation would fall in line with other major tort litigation and perhaps avoid the non-tangible impact of litigation on individual health care providers. Third, imposing corporate liability on HMOs would only require that they use reasonable care in managing their businesses. Nothing more. Nothing less. Other businesses, such as hospitals, airlines, railroads, construction companies, taverns, florists, and bakeries, must use reasonable care in operating their respective enterprises. Justice would seem to dictate that HMOs also be held to the same standard of reasonable care in the management of their business.

However, the major roadblock to the corporate liability of HMOs is ERISA preemption which courts have generally held to preclude corporate liability of employer-sponsored HMOs.³⁶⁷ Courts are more likely to conclude that claims

The misperception, which has no rational basis, that the poor are more likely to bring malpractice suits has purportedly resulted in the unwillingness of physicians to treat lower income and Medicaid patients. FURROW ET AL., *HEALTH LAW*, *supra* note 9, at 353 (citing Helen R. Burstin et al., *Do the Poor Sue More? A Case-Control Study of Malpractice Claims and Socioeconomic Status*, 270 JAMA 1697 (1993)); Karen H. Rothenberg, *Myth and Reality: The Threat of Medical Malpractice Claims by Low Income Women*, 20 LAW, MED. & HEALTH CARE 403 (1992). Surprisingly, personal malpractice experience does not clearly cause the practice of defensive medicine. One study concluded that "[p]ersonal malpractice experience is not a predominant factor . . . that prompts physicians to engage in defensive practices, to the extent that such practices exist." Peter A. Glassman et al., *Physicians' Personal Malpractice Experiences Are Not Related to Defensive Clinical Practices*, 21 J. HEALTH CARE POL'Y & L. 219, 220 (1996). Furthermore, it has been suggested that defensive medicine might well be needed to provide quality care under managed care health care systems:

For all its problems, the medical malpractice system is designed to hold the medical profession to an acceptable level of quality by deterring negligence. Whether the current malpractice system is effective in achieving this objective is a matter of debate. . . . Nevertheless, given new incentives to do less rather than more in a "reformed" health care system, major reforms of the medical malpractice system that reduce or remove incentives for physicians to practice defensively could reduce or remove a deterrent to providing too little care when such mechanisms are most needed.

Klingman, *supra*, at 204.

367. See, e.g., *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996); *Pacificare of Oklahoma, Inc., v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir. 1993); *Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th Cir. 1993); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992); *Jackson v. Roseman*, 878 F. Supp. 820 (D. Md. 1995); *Chaghervand v. Carefirst*, 909 F. Supp. 304 (D. Md. 1995); *Dearmas v. Av-Med, Inc.*, 865 F. Supp. 816 (S.D. Fla. 1994); *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182 (E.D. Pa. 1994); *Burke v. Smithkline Bio-Science Lab.*, 858 F. Supp. 1181 (M.D. Fla. 1994); *Stroker v. Rubin*, Civ. A. No. 94-5563, 1994 WL 719694 (E.D. Pa. Dec. 22, 1994); *Elsesser v. Hospital of the Philadelphia College of Osteopathic Med.*, 802 F. Supp. 1286 (E.D. Pa. 1992).

alleging corporate liability “relate to” the administration of benefit plans and accordingly are subject to ERISA preemption.³⁶⁸ The Supreme Court³⁶⁹ or Congress³⁷⁰ needs to resolve the issue whether ERISA preempts causes of action alleging corporate liability against HMOs and to clarify whether HMOs may permissibly be held liable under the time-honored principles of vicarious liability.

368. See, e.g., *Burrage*, 59 F.3d at 154; *Tolton*, 48 F.3d at 941-42; *Spain*, 11 F.3d at 131; *Kuhl*, 999 F.2d at 298; *Corcoran*, 965 F.2d at 1321.

369. See generally *Pittman*, *supra* note 8.

370. See *Corcoran*, 965 F.2d at 1338-39.