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Legal Accountability for Utilization Review in ERISA Health Plans

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LEGAL ACCOUNTABILITY FOR UTILIZATION REVIEW IN ERISA HEALTH PLANS

JEFFREY E. SHUREN*

Rising costs in the U.S. health care system have led to the creation of various cost-saving measures, including utilization review, that have impacted the roles of both health plan providers and administrators. Traditionally, health care professionals made medical decisions whereas health plan administrators made coverage decisions. Under prospective utilization review, one form of utilization review, however, medical care and benefit determinations overlap. Currently, plan participants injured as a result of a negligent utilization review decision may not receive adequate redress if the plan to which they belong is subject to the provisions of the Employee Retirement Income Security Act ("ERISA"). Enacted in 1974, the statute includes a preemption provision barring most state law-based causes of action. Combined with the limited remedies available to participants for harms imposed by their plans, the act has shielded entities performing utilization review ("UROs") from liability. This Article addresses those incongruities in ERISA and recommends that any reform efforts should be directed to the realization of the goal of U.S health care policy to provide quality, economically efficient health care. This Article proposes that ERISA be amended to hold UROs to the medical standard of care but with the ability to defend their actions if they demonstrate by reasonable scientific evidence that their decisions and guidelines furnish plan participants with a level of care of comparable efficacy and safety to the medical standard of care. As a result, participants would receive quality health care while holding UROs to a standard that permits them to implement more cost-effective health care without necessarily incurring liability for unsuccessful treatment outcomes.

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The views expressed in this article are those of the author and do not necessarily reflect the opinion of the U.S. Food and Drug Administration.

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I. INTRODUCTION

The Employee Retirement Income Security Act ("ERISA") of 1974¹ created a set of requirements with which employers must comply if offering certain benefits to their employees.² ERISA's statutory scheme distinguishes "employee welfare benefit plans" from "employee pension benefit plans"³ and imposes different sets of

1. 29 U.S.C.A. §§ 1001-1461 (West 1985 & Supp. 1998).

2. *See id.*

3. 29 U.S.C. §§ 1002(1)-(3)(1994). An employee welfare benefit plan is defined by ERISA as any plan, fund, or program established or maintained by an employer or an employee organization for the purpose of providing "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services" to its participants or their beneficiaries. *Id.* § 1002(1). An employee pension benefit plan is similar to a welfare plan except that the pension plan, fund, or program "provides retirement income to employees, or results in a deferral of income by employees for periods extending to the termination of covered employment or beyond." *Id.* § 1002(2)(A) (1994). ERISA defines an "employee benefit plan" as "an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan." *Id.* § 1002(3) (1994).

requirements on each type of plan. In an effort to encourage the growth of employer-sponsored benefit plans through the establishment of uniform standards, Congress preempted the field of ERISA plan regulation.⁴ As a result, the actions taken by an employee benefit plan or those who administer the plan may be protected under ERISA preemption from state law-imposed liability. Moreover, ERISA limits available remedies and precludes the award of compensatory and punitive damages.⁵

The U.S. system of health care delivery and financing has evolved since the enactment of ERISA. In an effort to stem the continuous rise of health care expenditures, third-party payers have sought to impose restrictions on medical decision-making through a variety of techniques, including utilization review.⁶ The effect of one type of utilization review, prospective utilization review,⁷ is to determine what treatment a patient should receive. Because most patients are unable to pay for treatment in the absence of reimbursement from their insurer, a utilization review decision that treatment is not appropriate and, therefore, will not be reimbursed, is, in effect, a decision not to treat.⁸ The result is undertreatment. Although several circuits no longer raise ERISA preemption as a bar to medical malpractice claims against physicians offering services to plan participants, decisions by plan administrators still receive wide protection against state law causes of action.⁹ Moreover, as third-party payers continue to merge financing and delivery of care while requiring providers to consider costs when making medical decisions, the differing treatment of claims against plan providers, such as physicians, and those against plan administrators, which may include UROs¹⁰ appears artificial and contrary to the stated goals of ERISA.¹¹ Plan participants injured as a result of a negligent utilization review decision, therefore, do not obtain adequate redress because courts have interpreted ERISA preemption to apply to

4. See *id.* § 1144(a) (1994); *infra* Part IV.A.

5. See 29 U.S.C.A. § 1132 (West 1985 & Supp. 1998); *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 260-61 (1993).

6. See *infra* notes 54-58 and accompanying text.

7. The other types of utilization review are retrospective and concurrent review. See *infra* text accompanying note 58 (defining the three types of utilization review).

8. See *infra* notes 100-03 and accompanying text.

9. See *infra* note 244 (listing federal cases addressing the issue of preemption of state law claims by ERISA).

10. See *infra* notes 56-58, 233-46 and accompanying text. A plan administrator is "the person specifically so designated by the terms of the instrument under which the plan is operated." 29 U.S.C. § 1002(16)(A) (1994).

11. 29 U.S.C. § 1001 (1994); see *infra* notes 116 and 119 and accompanying text.

utilization review decisions.

This Article describes the limitations of ERISA preemption as exemplified by the judiciary's treatment of claims against UROs. Although several articles have addressed this issue in detail, these works focused on either the legal theories under which claims against UROs could avoid ERISA preemption¹² or the policy reasons behind why preemption of utilization review claims runs counter to the goals of ERISA.¹³ The critical issue, however, is not how Congress or the judiciary can modify ERISA to bring claims in line with the Act's goals and with the goals of our tort system. Rather, the important questions are, how should Congress and the judiciary conceptualize the roles of UROs, physicians, and other health care players in light of current health care policy objectives and what liabilities should we impose to alter the behavior of these players to develop the kind of health care system we desire? Only then can we address the narrower issue of how ERISA should be modified to advance its goals while fostering our vision of the health care system.

Part II of this Article summarizes the evolution of U.S. health care insurance and the implementation of cost-containment measures. Part III analyzes the changing roles of UROs and physicians, and explores how liability should be assigned to effectuate the goals of the health care system. Part IV reviews ERISA's preemption provisions, fiduciary duty requirements, and the legal liability of UROs under both state law and ERISA. Finally, Part V addresses the need for congressional modification of ERISA to accord with ERISA's goals and the goals of health care policy.

12. See, e.g., Brian P. Battaglia, *The Shift Toward Managed Care and Emerging Liability Claims Arising from Utilization Management and Financial Incentive Arrangements Between Health Care Providers and Payers*, 19 U. ARK. LITTLE ROCK L.J. 155, 216-17 (1997); O. Mark Zamora, *Medical Malpractice and Health Maintenance Organizations: Evolving Theories and ERISA's Impact*, 19 NOVA L. REV. 1047, 1061-62 (1995) (concluding that a broad preemption of state laws that relate to ERISA plans is consistent with Congress's intent); Mary R. Kohler, Note, *When the Whole Exceeds the Sum of Its Parts: Why Existing Utilization Management Practices Don't Measure Up*, 53 U. PITT. L. REV. 1061, 1097-98 (1992); Peter H. Mihaly, Note, *Health Care Utilization Review: Potential Exposures to Negligence Liability*, 52 OHIO ST. L.J. 1289, 1305-06 (1991).

13. See, e.g., David D. Griner, Note, *Paying the Piper: Third-Party Payor Liability for Medical Treatment Decisions*, 25 GA. L. REV. 861, 919-20 (1991); H.R. Scheel, Recent Development, *Corcoran v. United HealthCare, Inc.: ERISA Preemption of a Louisiana Tort Action*, 67 TUL. L. REV. 821, 837, 840 (1993); Diana Slivinska, Note, *Health Care Cost-Containment and Small Business: The Self-Insurance Option*, 12 J.L. & COM. 333, 352-53 (1993).

II. HEALTH INSURANCE AND THE IMPLEMENTATION OF COST-CONTAINMENT MEASURES

Until the 1920s, patients paid their physicians directly for services rendered.¹⁴ Physicians absorbed the costs of health care administered to the poor, or local communities reimbursed physicians for such services.¹⁵ The rising costs of health care, however, forced providers to seek alternative methods of payment.¹⁶ Yet, the introduction of insurance, which had been successful in the early twentieth century in the area of "industrial" life insurance,¹⁷ proved to be problematic when applied to health care. General principles of insurance require that the insured event (1) can be clearly described; (2) is not something over which the insured has control; and (3) has a low, but predictable, occurrence.¹⁸ In the case of health care, however, the use of physician services remained in the control of the patient, who elected to seek aid, and the physician, who selected which tests to perform and which treatment to prescribe. Thus, prior to the Great Depression, health insurance was not commonplace because it was understood that offering such insurance would result in adverse selection while encouraging greater use of health services.¹⁹ When the stock market crashed in 1929, however, the resultant drop in hospital occupancy, combined with the increasing costs of health care, encouraged the American Hospital Association and its members to establish service-benefit plans for hospital care.²⁰ Under a service-benefit plan, the subscriber receives care from the hospital which then collects reimbursement from a third-party payer.²¹ This action resulted in the creation of the non-profit Blue Cross plans.²² Subsequently, private insurance companies

14. See Jack K. Kilcullen, *Groping for the Reins: ERISA, HMO Malpractice, and Enterprise Liability*, 22 AM. J.L. & MED. 7, 15 (1996).

15. See *id.* at 16.

16. See *id.*

17. The success of companies like Metropolitan Life and Prudential in selling life insurance policies to working-class families was driven by the fear of a pauper burial. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 242-43 (1982).

18. See Kilcullen, *supra* note 14, at 16.

19. Adverse selection is the purchase of insurance by those most likely to become ill. See STARR, *supra* note 17, at 294. The insurance companies, at the time, were treating group health insurance as "experimental" because they were concerned about "malingering"—that is feigning sickness (for whatever reason) because the health care would be paid for by the insurance company and not the patient. See *id.*

20. See *id.* at 295-96. In 1931, only 62% of hospital beds were filled. See *id.* Moreover, in the year following the crash, average hospital receipts dropped from about \$236 to \$59 per patient. See *id.* at 295.

21. See *id.* at 292.

22. See *id.* at 294.

entered the market.²³

At first, health insurance only covered hospitalization. The American Medical Association ("AMA") adamantly opposed employing insurance coverage for medical services.²⁴ Under pressure from local medical societies, however, the AMA loosened its stance.²⁵ Soon thereafter, the medical societies of California and Michigan established prepayment plans, the predecessors of Blue Shield, to allow guaranteed payments of medical services.²⁶ Blue Shield arose as provider-controlled plans that combined service and indemnity benefits.²⁷ Commercial insurers, on the other hand, offered indemnity plans, under which a subscriber is directly reimbursed for the portion of medical costs covered by the policy. Because the third-party payer in an indemnity plan conducts all financial transactions with the subscriber, indemnity benefits create the least involvement between payers and providers.²⁸

Health insurance enrollment grew during World War II, due largely to the labor movement. In 1942, the War Labor Board ruled that fringe benefits, such as health insurance, equal to or below five percent of wages were not considered inflationary.²⁹ In response, employers offered health benefits to compensate for the New Deal's shortcomings and to attract workers.³⁰ Health insurance plans had

23. See Kilcullen, *supra* note 14, at 16.

24. See STARR, *supra* note 17, at 299. The AMA feared that physicians would lose control over medical decisionmaking and patients would lose their freedom of choice if medical services were furnished on a prepaid basis. See *id.* at 299-306.

25. See *id.* at 306.

26. See *id.* at 306-07. Soon after, similar plans arose in New York, Pennsylvania, and other states. See *id.* Blue Shield grew slowly. By 1945, Blue Shield had two million subscribers nationally as compared to 19 million people enrolled in Blue Cross. See *id.* at 308.

27. See *id.* at 294. Blue Cross was created to cover hospital costs. Initially it resembled a prepayment plan. See STARR, *supra* note 17, at 308. Blue Cross has evolved over the years moving more towards indemnity plans and today may offer such options as preferred provider organizations. Blue Shield was established to cover physician services. It initially combined elements of both service-benefit and indemnity plans whereas most commercial insurers used just indemnity plans.

28. See Griner, *supra* note 13, at 871. A third type of health insurance plan is the direct-service plan. Under this scheme, the third-party payer provides a specified range of services on a prepaid basis. The direct-service plan imposes the most limitations on providers as compared to service-benefit and indemnity plans. See *id.* at 873.

29. See STARR, *supra* note 17, at 311. Therefore, employers could offer health benefits up to five percent of wages in value without producing an adverse inflationary effect on the cost of employment, thereby making the provision of health benefits an attractive means for employers to obtain workers.

30. See *id.* The New Deal did not adequately address the workforce shortages created by the war. Therefore, employers used benefits as one means to obtain workers.

already received a boost when labor unions acquired the right to bargain collectively for health benefits through the passage of the National Labor Relations Act³¹ (known as the Wagner Act) in 1935. Although all types of plans witnessed increased enrollment, commercial insurers received the largest gains. In 1949, commercial insurers covered 28 million people, whereas Blue Cross covered 31 million enrollees.³² By 1953, commercial insurers furnished health insurance to 29 percent of the population and Blue Cross to 27 percent.³³ As a result of the advantages offered by commercial insurers' indemnity plans, low-risk workers enrolled with commercial insurers.³⁴ In response, Blue Cross and Blue Shield adopted plans similar to indemnity insurance.³⁵ With the rise in indemnity plan enrollment, the gap between the insured and the uninsured widened as low-income families and the chronically ill found it increasingly difficult to obtain health insurance.³⁶

Congress responded to the limited health insurance coverage for the elderly and poor with the creation of Medicare³⁷ and Medicaid³⁸

31. See Wagner Act of 1935, ch. 372, 49 Stat. 449 (1935) (codified as amended at 29 U.S.C. §§ 151-169 (1994)).

32. See STARR, *supra* note 17, at 327.

33. See *id.* at 328.

34. See *id.* at 330. In the late 1940s, the provision of employee benefits increased as labor unions wielded their new collective bargaining powers. The Blues (Blue Cross and Blue Shield) were at a significant disadvantage as compared to commercial insurers. The commercial insurers offered the convenience of receiving a variety of insurances, such as life insurance, through a single entity. See *id.* at 329. The Blues' enabling laws, on the other hand, restricted the Blues to providing only health coverage. See *id.* Local control of different Blues plans also precluded their ability to supply national coverage. See *id.* Furthermore, indemnity plans offered greater flexibility in health benefits, gave employers the opportunity to play a direct administrative role, and, most significantly, offered coverage of healthy, low-risk workers at a lower price through the use of "experience ratings." *Id.* Under an experience rating, the commercial insurers charged each employee group based on the costs that group "experienced." *Id.* In contrast, Blue Cross used a community rating system wherein each group paid the same rate regardless of their level of risk demands. See *id.* By redistributing costs from high- to low-risk groups, the Blues disenfranchised low-risk groups. See *id.*

35. The Blues abandoned community rating and adopted an experience rating system. See *id.* at 332. According to Professor Starr, Blue Shield became more like indemnity insurance because physicians disfavored service benefits. See STARR, *supra* note 17, at 308.

36. See *id.* at 333-34. Under an indemnity plan, the plan reimburses only for covered services; the amount covered depends on the amount of the premiums paid. As the more well-to-do purchased indemnity insurance, premiums went up making health insurance less affordable. This is one of the reasons why Congress enacted the Medicare and Medicaid statutes.

37. See Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended at 42 U.S.C. §§ 1395-1395ggg (1994)). Congress enacted Medicare to furnish medical care coverage for the elderly.

in 1965. Medicare and Medicaid initially furnished repayment to physicians on a charge basis, under which physicians received reimbursement based on the reasonable costs of treatment.³⁹ Commercial insurers reimbursed health services on a fee-for-service basis. Neither system gave physicians or patients an incentive to economize the care rendered. Instead, the economic incentives of both systems encouraged the overuse of services. Health care costs skyrocketed, due in large part to the reimbursement system of the fee-for-service regime, the practice of defensive medicine by physicians to avoid lawsuits, and the use of emerging technologies by the medical community.⁴⁰ By the late 1960s, Medicare hospital expenditures had increased by 18.1% annually.⁴¹ In the 1980s, the annual cost of health care more than doubled.⁴² According to the Bureau of the Census, Americans spent \$249.1 billion on health care in 1980, rising to \$604.1 billion, or 11.6% of the Gross National Product ("GNP"), in 1989.⁴³ By 1993, the U.S. spent 14% of its GNP on health care, totaling \$942.5 billion.⁴⁴ In response to the cost of health care's increasing financial burden on the U.S. economy and on individuals and groups seeking health insurance, the public and private sectors initiated several cost control measures.

Medicare's Diagnosis-Related Group ("DRG") reimbursement

38. See Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended at 42 U.S.C. §§ 1396-1396v (1994)). Medicaid, a cooperative state-federal program, furnishes health insurance to income-eligible individuals and families.

39. See Kenneth R. Pedroza, *Cutting Fat or Cutting Corners, Health Care Delivery and Its Respondent Effect on Liability*, 38 ARIZ. L. REV. 399, 404 (1996).

40. See *id.* at 401-02. Defensive medicine may cost the United States \$15 billion each year. See Jonathan J. Frankel, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 YALE L.J. 1297, 1298 (1994). Widespread use of unnecessary tests may increase health costs as well. See Marcia Angell, *Cost Containment and the Physician*, 254 JAMA 1203, 1205 (1985). For an argument that physicians' personal malpractice experience does not prompt them to engage in defensive medicine, see Peter A. Glassman et al., *Physicians' Personal Malpractice Experiences Are Not Related to Defensive Clinical Practices*, 21 J. HEALTH POL. POL'Y & L. 219, 233-34 (1996). This article also contends that defensive medical practices may not be as common as previously thought. *Id.*

41. See Kilcullen, *supra* note 14, at 18.

42. See Paul O'Neil, *Protecting ERISA Health Care Claimants: Practical Assessment of a Neglected Issue in Health Care Reform*, 55 OHIO ST. L.J. 723, 724 (1994).

43. See *id.* at 724 n.11.

44. See Pedroza, *supra* note 39, at 400. The United States spends nearly twice as much of its GNP on health care as does the United Kingdom, although morbidity and mortality remain roughly the same for the two countries. See Frances H. Miller, *Denial of Health Care and Informed Consent in English and American Law*, 18 AM. J.L. & MED. 37, 42 (1992). For an alternative view that rising health care costs derive principally from inflation, see Griner, *supra* note 13, at 909-10.

system represents one of the early efforts to contain medical costs.⁴⁵ Introduced in 1983, the DRG system pays a predetermined amount to the physician or hospital independent of the care provided.⁴⁶ Hospitals and physicians can generate profits only by supplying care below the DRG amount. The inherent risk is to underconsume resources and undertreat patients, in contrast to the fee-for-service incentive to overconsume and overtreat. Although the federal government made early attempts at cost-containment, the principal efforts to control health care costs came on the part of employers.⁴⁷

The trend in health insurance coverage since 1980 has been to decrease the number of individuals covered by an insurance policy (known as "covered lives"), limit benefits, and constrict the scope of coverage.⁴⁸ In an attempt to control their exposure to rising health care costs and maintain or increase health benefits for their employees, employers pressured the insurance industry to design more cost-effective health plans. Several large corporations invited insurers and health plans to compete for the opportunity to provide coverage to their employees.⁴⁹ By establishing a demand for affordable, comprehensive health coverage, these corporate giants encouraged the growth of managed care and managed competition.⁵⁰ Managed care is a system that integrates the financing and delivery of health care within a single entity.⁵¹ Managed competition, on the other hand, is the use of market forces to shape the delivery and financing of health care into a cost- and resource-efficient system.⁵² Managed competition encourages the alignment of employers, health plans, and individuals into purchasing groups that can negotiate prices with payers.⁵³

Managed care plans seek to "manage" costs by shifting the risk of excess cost and utilization to those providers directly responsible

45. See Pedroza, *supra* note 39, at 406.

46. See *id.*

47. See Eleanor D. Kinney, *On Physician Decision-Making and Managed Care: Resolving Consumer Grievances in a Managed Care Environment*, 6 HEALTH MATRIX 147, 150 (1996).

48. See *id.* at 147.

49. See, e.g., GEORGE ANDERS, HEALTH AGAINST WEALTH: HMOs AND THE BREAKDOWN OF MEDICAL TRUST 16-18 (1996) (describing Allied Signal Corporation's efforts to control the cost of employee health benefits).

50. See *id.* at 18.

51. See John D. Wilkerson et al., *The Emerging Competitive Managed Care Marketplace*, in COMPETITIVE MANAGED CARE: THE EMERGING HEALTH CARE SYSTEM 3, 3 (John D. Wilkerson et al. eds., 1997).

52. See Battaglia, *supra* note 12, at 156.

53. See *id.*

for supplying care to plan members, thereby furnishing providers with an incentive to limit unwarranted medical services.⁵⁴ The control of utilization is the key concept behind managed care. These entities employ various cost control measures, many falling under the rubric of utilization management.⁵⁵ One approach used by utilization management is utilization review, the process whereby patients' needs are evaluated in light of objective criteria to determine whether to pay for an individual's medical care. Payment is denied by a utilization reviewer if the care provided or to be provided is not necessary.⁵⁶ Thus, physician compliance is induced through financial "risk shifting."⁵⁷ Utilization review is further differentiated into three

54. See Kinney, *supra* note 47, at 148. As much as one-third of total health care spending is unnecessary. See Larry J. Pittman, *ERISA's Preemption Clause and the Health Care Industry: An Abdication of Judicial Law-Creating Authority*, 46 FLA. L. REV. 355, 362 n.28 (1994).

55. Utilization management entails three principal elements: benefit design, quality control, and health services delivery. See Susan J. Stayn, *Securing Access to Care in Health Maintenance Organizations: Toward a Uniform Model of Grievance and Appeal Procedures*, 94 COLUM. L. REV. 1674, 1679 (1994). By designing a benefits package that covers only medically necessary care, monitoring the plan's resources and providers, and assessing physicians' performance through a quality assurance program, Utilization management controls costs prospectively. See *id.* Utilization management may employ one or more approaches. Three approaches—second-opinion programs, discharge planning, and case management—utilize specialized personnel. See BRADFORD H. GRAY, *THE PROFIT MOTIVE AND PATIENT CARE: THE CHANGING ACCOUNTABILITY OF DOCTORS AND HOSPITALS* 275 (1991). Second-opinion programs require patients to obtain an opinion from a second physician before undergoing procedures considered to be subject to unnecessary use. See *id.* at 276. Discharge planning refers to the arrangement for post-hospitalization services for a patient prior to their discharge from the hospital, typically performed to decrease the length of hospital of stays. See *id.* at 278-79. Case management entails the use of an external case manager who reviews individual cases and develops alternative patient care plans. See John D. Blum, *An Analysis of Legal Liability in Health Care Utilization Review and Case Management*, 26 HOUS. L. REV. 191, 193 (1989). Typically, case management is used in the ambulatory setting. See *id.*

56. See Cheralyn E. Schessler, Comment, *Liability Implications of Utilization Review as a Cost Containment Mechanism*, 8 J. CONTEMP. HEALTH L. & POL'Y 379, 380 (1992).

57. Third-party payers induce financial risk shifting through an assortment of arrangements, such as ownership interest, joint venture, bonus arrangements, rewards, penalties, or a combination thereof. See 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, 30 (1993). Common methods used by payers to shift risk to providers include capitation (predetermined fee per enrollee), withholding (payer keeps a portion of the reimbursement to use for reward or punishment), discounted fee-for-service (provider gives discount to payer), per diem payments (set fee per day per patient), and profit sharing. See *id.* at 30-31. Not all risk shifting methods produce the same effect. Capitation forces the provider to shoulder personal loss. As a result, capitation produces the greatest risk of undertreatment because the provider receives no reimbursement for providing additional services but is responsible for covering costs in excess of the capitation fee. See *id.* at 31-32.

The underlying rationale of these cost-containment efforts is to furnish providers

types of review: (1) retrospective review, under which the determination for payment is made after services are rendered; (2) concurrent review, in which a decision regarding payment is made while treatment is ongoing, and length of stay and resource consumption are monitored if the reviewer deems inpatient care necessary; and (3) prospective (or pre-admission) review, under which a payment determination is made prior to the institution of care.⁵⁸

Utilization review arose out of the movement to standardize medical practice and improve quality.⁵⁹ In the early 1960s, Blue Cross formed utilization review committees to review the necessity of an individual patient's hospital admission and length of stay.⁶⁰ Under Medicare, hospitals receiving Medicare payments were required to form review panels to oversee the appropriateness and quality of care.⁶¹ Under the 1972 amendments to the Medicare Act, the Secretary of Health, Education, and Welfare (now the Department of Health and Human Services) established separate professional standards review organizations ("PSROs") to monitor appropriateness of care.⁶² In addition, the amendments empowered Medicare and Medicaid to deny payment for services unnecessary for efficient care.⁶³ These early PSROs proved inefficient and unmanageable; therefore, in 1982 Congress replaced the PSROs with Medicare Utilization and Quality Control Peer Review Organizations ("PROs").⁶⁴ The PROs differed from PSROs in that private entities performed utilization review for government-sponsored health programs.⁶⁵ Moreover, the PROs possessed the authority to deny claims and impose sanctions for care deemed unnecessary, inappropriate, or of inadequate quality.⁶⁶

with economic incentives to act as gatekeepers for the third-party payer. *See id.* at 18. Consequently, providers will offer services to patients in accordance with payer guidelines, or else risk incurring financial losses. *See id.*

58. *See Battaglia, supra* note 12, at 171-72.

59. *See Kilcullen, supra* note 14, at 18.

60. *See id.*

61. *See* Social Security Amendments of 1965, Pub. L. No. 89-97, § 1861(k), 79 Stat. 286, 318-19 (1965) (codified as amended at 42 U.S.C. § 1395x(k) (1994); Battaglia, *supra* note 12, at 168.

62. *See* Social Security Amendments of 1967, Pub. L. No. 92-603, § 249F(b), 86 Stat. 1329, 1429-1445 (1972) (repealed 1982); Kilcullen, *supra* note 14, at 18-19.

63. *See* Social Security Amendments of 1967, Pub. L. No. 92-603, § 223, 86 Stat. 1329, 1393 (1972) (codified as amended at 42 U.S.C. § 1395x(v)(1)(A) (1994)); *see id.*

64. *See* Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 143, 96 Stat. 324, 382 (codified as amended at 42 U.S.C. §§ 1320c-1 (1994)).

65. *See Battaglia, supra* note 12, at 169-70.

66. *See Kilcullen, supra* note 14, at 19.

The potential benefits of PROs also affected the private sector. Between 1982 and 1985, twenty-seven percent of U.S. companies introduced utilization review into their health plans.⁶⁷ By the end of the 1980s, fifty percent of large employers used utilization review programs.⁶⁸ During that same period, the American Hospital Association determined that hospitals may have had to interact with approximately 50 to 250 different utilization review entities.⁶⁹ In 1996, approximately ninety percent of employers used some type of utilization review in their health plans.⁷⁰ Today, utilization review is conducted by managed care organizations, insurance companies, third-party administrators, private companies, and federal and state governments.⁷¹

Although each of the three types of utilization review is still used in the current market, prospective review offers the greatest opportunity to control costs.⁷² Because of its singular importance, for the remainder of this Article, "utilization review" is used interchangeably with prospective utilization review. Although prospective review more effectively restrains costs, it, as a result of this cost control, increases the potential for malpractice liability when

67. See Battaglia, *supra* note 12, at 170.

68. See Kohler, *supra* note 12, at 1063 n.8.

69. See Kilcullen, *supra* note 14, at 23.

70. See Battaglia, *supra* note 12, at 170.

71. See *id.* at 170-71.

72. See *id.* at 171-72. The Fifth Circuit Court of Appeals stated in *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992):

By its very nature, a system of prospective decisionmaking influences the beneficiary's choice among treatment options to a far greater degree than does the theoretical risk of disallowance of a claim facing a beneficiary in a retrospective system. Indeed, the perception among insurers that prospective determinations result in lower health care costs is premised on the likelihood that a beneficiary, faced with the knowledge of what the plan will and will not pay for, will choose the treatment option recommended by the plan in order to avoid risking total or partial disallowance of benefits.

Id. at 1332. Thus, the court concluded that "[a] beneficiary in [a prospective review] system would likely be far less inclined to undertake the course of treatment that the insurer has at least preliminarily rejected." *Id.*

Proponents of prospective utilization review argue that use of the method results in significant savings—as much as an eight-to-one savings-to-cost ratio, according to one study. See Griner, *supra* note 13, at 910; see also Paul J. Feldstein et al., *Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures*, 318 NEW ENG. J. MED. 1310, 1313-14 (1988) (concluding that utilization review produces a one-time reduction in hospital use and medical expenditures). But see Stephen N. Rosenberg et al., *Effect of Utilization Review in a Fee-For-Service Health Insurance Plan*, 333 NEW ENG. J. MED. 1326, 1328-29 (1995) (finding no difference in rates of hospital admission, average lengths of hospital stay, and percentage of patients who received preadmission testing between actual utilization reviews and sham reviews).

attempts to reduce utilization and constrain costs conflict with the ability to provide adequate health care consistent with established medical standards. As a method of health care rationing, prospective utilization review risks sacrificing quality of care for lower costs. When utilization control efforts result in the provision of inadequate care, the central issue in apportioning liability is determining who owes what duty to whom. The next Part explores this topic.

III. PHYSICIAN AND URO ROLES UNDER THE CURRENT HEALTH CARE SYSTEM

The roles of physicians and utilization review organizations (“UROs”) continue to evolve as the health care landscape changes. The following sections describe the functions of physicians and UROs and discuss liability concerns raised by the changing health care market.

A. *Descriptive Roles*

Under the traditional fee-for-service system, physicians, unhindered by outside influence, possessed the authority to determine what constituted good care. With full reimbursement for services rendered, physicians could decide their patients’ needs without considering the costs of these services.⁷³ Moreover, physician and patient interests converged when abundant funding of health care was available.⁷⁴ From an ethical perspective, the medical profession has placed the responsibility for patient care squarely on the shoulders of physicians since the time of Hippocrates.⁷⁵ In accordance, malpractice law traditionally governed physicians and physicians alone. From a legal perspective, physicians were and still are held to a customary standard of care that requires the physician to have and to use “the same degree of skill, knowledge, and care that is ordinarily possessed . . . by members of the medical profession under similar circumstances.”⁷⁶ Physicians who fail to comport with the standard of care risk incurring tort damages. In addition, the

73. See E. Haavi Morreim, *Redefining Quality by Reassigning Responsibility*, 20 AM. J.L. & MED. 79, 81 (1994).

74. See *id.* at 82-83; see also *supra* notes 37-44 and accompanying text (describing the increased reimbursements for medical care during the late 1960s to the early 1990s).

75. See Morreim, *supra* note 73, at 81; see also 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) (discussing the misapplication of a fiduciary role to physicians).

76. MILES J. ZAREMSKI & LOUIS S. GOLDSTEIN, 1 MEDICAL AND HOSPITAL NEGLIGENCE § 6:11, at 23 (1988).

prevalence of new technologies covered by insurance plans and the fear of liability for adverse outcomes resulting from the failure to use these innovations encouraged physicians to inject emerging technologies into the standard of care, driving up the cost of providing adequate patient care.⁷⁷ Quality came to mean administering every intervention of potential benefit.⁷⁸ Therefore, the ethics, law, and economics of medicine imbued physicians with the authority to define quality of care and required them to provide costly treatments to their patients.⁷⁹

With the advent of managed care and the institution of financial risk shifting and prospective utilization review, conflicts of interest arose between physicians and patients. Under a standard indemnity plan, the payer contracts with the patient and the patient contracts with the physician, whereas under managed care, the payer has an independent contractual relationship with the physician that may specify utilization controls and financial incentives. A physician under a contract with a managed care organization ("MCO") must, therefore, weigh several factors. Physicians still retain their ethical obligation to provide quality medical care; failure to provide such care may incur malpractice liability. On the other hand, physicians risk losing a bonus, receiving a monetary penalty, or being dropped from the plan if spending exceeds predetermined targets.⁸⁰

Under utilization review, third-party payers require that the physician or the enrollee obtain its permission before instituting an expensive treatment or arranging for hospitalization.⁸¹ Utilization reviewers examine medical decisions that were once the sole domain of physicians and patients.⁸² Consequently, through utilization review and financial incentives, third-party payers threaten the core of our

77. See Morreim, *supra* note 73, at 83.

78. American culture favors the rescue of "the doomed." See Kent G. Rutter, *Democratizing HMO Regulation to Enforce the "Rule of Rescue,"* 30 U. MICH. J.L. REF. 147, 160 (1996). In medicine, this "rule of rescue" is evidenced by elaborate critical care units and transplant teams. As a result of the rule of rescue, Americans expect expensive interventions for the critically ill—those least likely to benefit from treatment. See *id.* at 160-61. This expectation raises the bar defining the standard of quality care. By comparison, British patients, who have been subject to a capped budget for medical care since the creation of the National Health System in 1948, generally cooperate in medical rationing by requiring less from their physicians. See Miller, *supra* note 44, at 52.

79. See Morreim, *supra* note 73, at 84.

80. Sixty-eight percent of MCOs that employ their own physicians and 84% of other MCOs use some form of physician financial incentive to decrease costs. See Rutter, *supra* note 78, at 176.

81. See *id.* at 153.

82. See Scheel, *supra* note 13, at 824.

health care system, the physician-patient relationship. This relationship stems from trust. Patients expect their physicians to act in the patients' best interests. Cost-containment efforts, however, undermine this trust⁸³ and alter a physician's ability to honor the medical, ethical, and legal values of the medical profession and American culture.⁸⁴ Patient expectations remain unchanged, but without the economic base required to support them.⁸⁵

Furthermore, the advent of prospective utilization review and other cost control measures create the possibility that patients may be harmed in new ways, such as negligent decisions by UROs.⁸⁶ These measures challenge us to ponder the social value of cost-containment and to redefine who owes what duties to whom. It is beyond the scope of this Article, however, to assess critically the normative roles of each player in the health care system. Instead, this Article makes some general observations on physician and employer conduct while focusing primarily on the role of UROs.⁸⁷ To ascertain what duties should be imposed on UROs first requires an analysis of the functions UROs perform within the health care system.

All prospective utilization review ("UR") programs share certain common features.⁸⁸ Virtually all use telephone rather than face-to-face contact between a reviewer and a health care provider.⁸⁹ Patients typically retain the responsibility of initiating review, although physicians often make the first call to avoid a denied claim. Prospective UR programs then implement a two-stage assessment

83. See Randall, *supra* note 57, at 36-37.

84. See Morreim, *supra* note 73, at 85.

85. See *id.* at 85-86.

86. Of 2000 physicians surveyed, 83.6% of those physicians who are MCO members and 92% of those who are not MCO members indicated that financial incentives diminish the quality of care. See Laura H. Harshbarger, Note, *ERISA Preemption Meets the Age of Managed Care: Toward a Comprehensive Social Policy*, 47 SYRACUSE L. REV. 191, 221 (1996).

87. For an in-depth analysis of physician, payer, and patient duties, see Morreim, *supra* note 73. Morreim suggests that patients, as the ultimate payers, should make the actual cost-value tradeoff decisions after receiving adequate information about treatments and their effectiveness and costs. See *id.* at 79. Consequently, Morreim contends that the need for utilization review will decrease as patients decide which interventions are cost-justified. See *id.* at 102. In addition, better informed patients will be more amenable to working with physicians as partners in such economic matters. See *id.*

88. See COMMITTEE ON UTILIZATION MANAGEMENT BY THIRD PARTIES, INSTITUTE OF MEDICINE, CONTROLLING COSTS AND CHANGING PATIENT CARE? THE ROLE OF UTILIZATION MANAGEMENT 66 (1989) [hereinafter CONTROLLING COSTS].

89. See *id.* One exception is the use of on-site review nurses by UROs to review continued stays. See *id.*

process. In the first stage, a reviewer—usually a nurse⁹⁰—obtains information about the patient and the proposed services and applies objective criteria, called utilization review guidelines⁹¹ in order to determine whether the proposed services are “medically necessary” or “medically appropriate.”⁹² The reviewer further determines whether the site for performing the services, the timing of the services, and the length of any requested hospital stay are appropriate as well.⁹³

In the second stage, a reviewer makes a final determination whether to approve or deny payment. If the reviewer ascertains that the planned services falls within the guideline’s criteria, some UROs allow the nurse to make decisions to approve payment. Other UROs require that a physician reviewer make the final determination.⁹⁴ In general, UROs require that a physician reviewer make the final determination to deny payment.⁹⁵ If services are denied, the nurse or the physician may or may not directly contact the patient’s treating physician. If the second stage reviewer denies approval, URO policies differ as whether to direct the first stage reviewer to negotiate with the treating physician to achieve conformity in the

90. In some cases, the URO uses experienced medical secretaries rather than nurses. See *id.* at 72.

91. Utilization review protocols may vary between UROs, but in general, each seeks to combine quality control and cost containment to create guidelines for appropriate care while eliminating overutilization. See Schessler, *supra* note 56, at 391. These guidelines differ from clinical practice guidelines, which are developed by physicians to provide a standard of care tailored to a specific disease or procedure. See *id.*

92. “Medically necessary” and “medically appropriate” refer to what is “necessary” and “appropriate” under the particular UR guideline, not to what the medical community considers necessary or appropriate care for that patient. Retrospective utilization review typically makes “medical necessity” determinations as to whether a proposed treatment is necessary for a medical reason but not whether the particular treatment is the most appropriate. Prospective utilization review, on the other hand, usually determines whether the proposed therapy is both necessary and appropriate.

93. See CONTROLLING COSTS, *supra* note 88, at 66. Some nurse reviewers handle 40 to 50 calls and between 10 to 20 certifications each day. See *id.* at 72.

94. See *id.* at 66. UROs employ physician reviewers on a full-time or a part-time basis. See *id.* at 74. However, some UROs do not use licensed physicians as reviewers. Kohler, *supra* note 12, at 1078.

95. See CONTROLLING COSTS, *supra* note 88, at 66. According to a 1989 study on UROs by the Institute of Medicine, all organizations visited said their physician reviewers were not bound to follow the organization’s criteria. See *id.* at 74. It is questionable, however, how much expertise these physician reviewers actually possess to make these decisions. In addition, physician reviewers may be more lenient than the criteria they are expected to implement. See Lawrence C. Kleinman et al., *Adherence to Prescribed Explicit Criteria During Utilization Review: An Analysis of Communications Between Attending and Receiving Physicians*, 278 JAMA 497, 500 (1997). This raises questions about the efficacy of UR guidelines in containing costs.

review standards.⁹⁶ UROs also differ as to whether to instruct their nurse reviewers to coach treating physicians on how to obtain approval.⁹⁷ In addition, the amount of training received by both nurse and physician reviewers varies as does the extent of reviewer monitoring.⁹⁸ UROs may themselves seek to comply with accreditation standards developed by the Utilization Review Accreditation Commission, along with the American Medical Peer Review Association, Health Insurance Association of America, and Blue Cross and Blue Shield Association.⁹⁹ In sum, under utilization review, a URO reviews the treating physician's recommendations and determines whether the proposed treatment is medically necessary or medically appropriate for a particular patient.

Although third-party payers claim that their decisions are benefits determinations and not medical decisions, the effect of their decisions is to determine what treatment a patient should receive. Because most patients cannot afford treatment without reimbursement from the plan and most physicians cannot afford to provide care without reimbursement,¹⁰⁰ a determination that treatment is not appropriate and, therefore, will not be paid for by the plan, is in effect a decision not to provide care or to provide alternative care. A UR decision is, therefore, akin to and frequently has the effect of a medical decision by a treating physician.¹⁰¹ This similarity is highlighted by the fact that UROs use health care providers, such as physicians and nurses, to make UR determinations and to design UR guidelines.¹⁰² This scenario is clearly distinct from a decision dealing solely with benefits determinations, such as when a

96. See CONTROLLING COSTS, *supra* note 88, at 72.

97. See *id.*

98. Nurse reviewers receive anywhere from two to six weeks of formal training whereas UROs provide physician reviewers with one day to several days of training. See *id.* at 73, 77. Nurse supervisors oversee nurse reviewers, and medical directors oversee physician reviewers. Each nurse supervisor may oversee from six to seventy-six nurses and monitor by informal oversight, such as walking around and overhearing conversations, or by more systematic monitoring, such as using a computer or listening in on calls. Monitoring of physicians varies from employing an outside panel to review a sample of the URO physicians' determinations to relying on the nurse reviewers to whom the decisions are communicated. See *id.*

99. See Battaglia, *supra* note 12, at 173 (overviewing the standards employed).

100. See Scheel, *supra* note 13, at 824.

101. According to the Institute of Medicine, one of the UROs visited during the 1989 study said that under its state's law, decisions about whether services should be certified as medically appropriate "could be construed to be the practice of medicine and thus must be carried out by a physician who is licensed to practice in the state." CONTROLLING COSTS, *supra* note 88, at 73.

102. See *supra* notes 90-98 and accompanying text.

plan administrator determines whether a particular treatment is covered by the plan at all or whether a participant is eligible for a particular benefit.

Not only are UROs interposing themselves into medical decisionmaking by determining what is medically necessary, they are also changing the physician standard of care by affecting physician decisionmaking and, therefore, physician practice. UROs evaluate a treating physician's plan of care using their own medical experts.¹⁰³ Moreover, they "recommend" alternative courses of treatment with the knowledge that most patients will follow their directions. The arrangements between third-party payers, UROs, and physicians, therefore, distribute medical authority among several actors.

B. Liability Issues Under the Current System

The reality of utilization review in today's health care system provides the strongest argument for imposing liability on those who make negligent UR decisions. First, it is immaterial whether or not a utilization review determination is characterized as a medical decision if, as a result, the patient decides to forgo treatment. Many patients must choose not to receive treatment if payment is denied because they cannot afford to pay for the treatment themselves. Second, it would be unfair to allow UROs and third-party payers to influence or interfere with medical decisionmaking, and yet avoid liability for their actions.

Under the currently evolving health care system, physicians are caught between the demands of plan sponsors and administrators to become cost conscious and their patients' needs for quality care. Arguably, physicians can no longer avoid factoring economic concerns into their treatment decisions.¹⁰⁴ Cost-containment measures will prove ineffective if physicians can insulate themselves from economic considerations. Moreover, the reduction of Medicare reimbursement for many services and the use of utilization review techniques in the Medicare and Medicaid programs suggest that

103. See *supra* notes 90-98 and accompanying text.

104. See David M. Eddy, *Broadening the Responsibilities of Practitioners: The Team Approach*, 269 JAMA 1849, 1852-53 (1993). Furthermore, the current system puts physicians in conflict with URO reviewers. Physicians may try to "front load" their claims to assure payment. See Kohler, *supra* note 12, at 1078-79. For example, if a patient's insurance allows her a particular number of office visits, the physician may design a treatment plan that includes a number of office visits just below the maximum to ensure that some reimbursement is received early on in the course of treatment. See *id.* at 1079.

Congress intends to encourage cost conscious medical practice. However, physicians must continue to act in the best interests of their patients to protect the physician-patient relationship and to ensure the provision of quality care. Modifying the standard of care to include cost considerations runs counter to physicians' self-imposed ethical obligation to do everything possible for the patient and could disproportionately affect the poor and elderly.¹⁰⁵ The infusion of cost considerations into the equation of health care determinations raises concerns regarding where liability for negligent decisions should fall.

Even in an environment of cost-containment, physicians still retain control over their knowledge, skill, and judgment. The limited resources available to physicians and the restrictions imposed on medical decisionmaking by UROs and third-party payers do not justify immunizing physicians from their decisions when they deviate from standard medical practice. It would be unfair, however, to hold physicians negligent when customary medical practice warrants health care rationing by third parties.¹⁰⁶ Placing additional responsibilities on physicians, such as requiring physicians to disclose whether a potentially beneficial treatment is being denied for financial reasons, could serve as a necessary prerequisite to limit physician liability.¹⁰⁷ Furthermore, mandating physician disclosure could improve physician-patient relations by casting physicians in the role of ally rather than enemy.¹⁰⁸ The next issue, therefore, is whether Congress or the courts should formulate the duties of health care players.

Leaving the judiciary with the task of determining what duties apply to UROs and third-party payers places an inappropriate burden on the courts to resolve the tension between the goal of containing costs and the goal of the tort system to compensate harmed individuals. Some commentators have argued that employing tort liability to address the inequities of utilization review would frustrate the purpose behind constraining health care expenditures.¹⁰⁹ The critical issue behind liability in this context,

105. Some commentators argue, however, that professional ethics, prestige, and the competition for patients will prevent physicians from depressing the standard of care too much in response to cost-containment pressures. See, e.g., Mark A. Hall, *The Malpractice Standard Under Health Care Cost Containment*, 17 LAW MED. & HEALTH CARE 347, 352 (1989).

106. See Miller, *supra* note 44, at 70.

107. See *id.* at 70-71.

108. See *id.* at 71.

109. See, e.g., Rex O'Neal, Note, *Safe Harbor for Health Care Cost Containment*, 43 STAN. L. REV. 399, 421 (1991). Other commentators prefer using contracts and contract

however, is who should be responsible for making what decisions. American jurisprudence provides that those who make a decision should remain liable for the consequences of that decision. Joint decisions require joint liability.

The potential categories of liability for UROs, physicians, and payers under tort common law are: (1) coverage determination by payer; (2) medical necessity or appropriateness decision by URO (negligent UR decisionmaking or negligent design or implementation of utilization review criteria, including delay in approving payment); (3) negligent selection or supervision of physicians by payer, including physician financial incentive programs; (4) negligent selection or supervision of reviewers by URO; (5) negligent design or implementation of the plan by the payer; (6) malpractice by physician; and (7) vicarious liability by payer for physician malpractice.¹¹⁰ Categories 1, 3, and 4 involve nonmedical, cost-based

damages to ration health care. See, e.g., Clark C. Havighurst, *Prospective Self-Denial: Can Consumers Contract Today to Accept Health Care Rationing Tomorrow?*, 140 U. PA. L. REV. 1755 (1992). However, the imposition of a contract regime on patient care will probably provide less compensation and, therefore, less deterrent effect, than a tort regime.

110. The following hypothetical illustrates the various forms of potential liability: Dr. Smith, a general practitioner, determines that his patient, Mr. Johnson, experiences chest pains as the result of coronary artery atherosclerosis ("CAA"), for which he decides to order a cardiac stress test but not to refer Mr. Johnson to a cardiologist. Mr. Johnson receives health benefits from his employee benefit plan, which is offered by a health maintenance organization ("HMO") that uses a URO. The HMO had established a series of financial incentives to encourage physicians, like Dr. Smith, not to refer patients to specialists. The HMO denies payment for the stress test because the procedure is not covered by the plan and the URO denies payment for angioplasty (the use of a balloon on the end of a tube inserted into the coronary arteries to remove any obstructions to blood flow) because the procedure is not medically appropriate. Dr. Smith does not question the URO's decision or inform his patient of the need to perform a cardiac stress test. Instead, Dr. Smith prescribes medication to Mr. Johnson, reimbursement for which is approved by the URO. After twelve months, Mr. Johnson switches his care to Dr. Bennet, a cardiologist, because he has not noted any improvement on the medication. Dr. Bennet finds on an EKG (a test measuring the heart rhythm) that Mr. Johnson suffered a minor heart attack several months before. Dr. Bennet recommends that Mr. Johnson undergo an angioplasty, but the URO denies payment because, in its judgment, the procedure is not medically appropriate. Instead, the URO will approve a change in medication. Dr. Bennet appeals the judgment. The HMO sends Mr. Johnson to another physician for a second opinion. This physician agrees with Dr. Bennet. After three months, the URO approves the angioplasty. Mr. Johnson's CAA has advanced rapidly, however, precluding him as a candidate for angioplasty. As a result, Dr. Bennet, with the URO's approval, arranges for Mr. Johnson to undergo coronary artery bypass surgery to reopen his clogged arteries, a procedure that carries a greater risk of stroke (obstruction of blood vessel to the brain leading to brain injury) than an angioplasty. The HMO will, however, approve the surgery only if performed by Dr. Jenkins. During the surgery, Dr. Jenkins nicks a large artery and Mr. Johnson's blood pressure falls precipitously in response to the loss of blood; the drop in blood pressure places Mr. Johnson at risk for

determinations. Categories 6 and 7 entail purely medical decisions. However, category 5 and, in particular, category 2 involve both medical and cost-based determinations. Category 2—UR decisionmaking and design and implementation of utilization review criteria—pertains to the current goal of health policy: efficient utilization of our health care resources to provide quality health care. Because there are many potential areas of liability and because some of these areas involve both medical and cost-containment issues, the duties of UROs, physicians, and payers in the UR decisionmaking process and the design and implementation of utilization review criteria should be established at the outset.¹¹¹ Only after outlining these duties can an analysis of what reform measures should be undertaken proceed. The remainder of this Article will examine the potential duties of UROs, physicians, and payers in utilization review determinations and UR guideline design and implementation, focusing primarily on how well ERISA addresses these concerns and what changes to ERISA would best enhance the performance of these duties.¹¹²

brain injury from inadequate blood flow to the brain. When Mr. Johnson awakens from the anesthesia, he cannot move the right side of his body. Dr. Bennet concludes that Mr. Johnson suffered a stroke during the surgery.

The potential liability in this case can be broken down into the following categories: (1) negligent determination of medical appropriateness (or necessity) by URO secondary to negligent design or implementation of its guidelines (i.e., determinations that both angioplasty and a cardiac stress test are not appropriate, as well as the delay in the approval of angioplasty); (2) physician malpractice secondary to the HMO's independent negligence in provider supervision due to its incentive program (i.e., Dr. Smith received monetary rewards for limiting specialist referrals); (3) physician malpractice independent of the HMO's actions (i.e., Dr. Jenkins nicked Mr. Johnson's artery); (4) the HMO could be liable for negligent physician selection (by approving bypass only if performed by Dr. Jenkins, the HMO, in effect, determined which physician would operate on Mr. Johnson); and (5) vicarious liability of the HMO for Dr. Jenkins's actions.

111. The duty analysis may be parsed into two components: (1) Does a duty exist?; and (2) What is the standard of care? *See* Mihaly, *supra* note 12, at 1290. Courts will impose a duty on those responsible for utilization review decisions where it is clearly foreseeable that UR decisions may cause injury to patients. If a court concludes that a duty exists, it will have two options in selecting a duty of care. The court may find either a procedural standard, such as a standard of care in the design and implementation of the utilization review program, or a medical standard, such as the standard of care for determining medical necessity, or both. *See id.* at 1291-92. Although some courts have held that UROs owe a duty towards patients, *see infra* Part IV.C, at least one court found that an HMO acted in bad faith in denying coverage by looking to the HMO's coverage booklet; the coverage booklet had indicated that the HMO would pay for the procedure. *See, e.g., Fox v. HealthNet*, No. 219692 (Sup. Ct., Riverside County, California, 1993), *noted in* 1993 WL 794305. Under this approach, UROs may avoid liability by altering their guidelines. The question remains, however, whether to impose a nondelegable duty of care on UROs.

112. *See Battaglia, supra* note 12 (discussing the current state of common law tort

IV. ERISA

The primary roadblock to enforcing a utilization review organization's duty of care to patients is ERISA.¹¹³ Courts have invoked ERISA's preemption and civil enforcement provisions to bar monetary recovery for tort claims against payers of self-insured plans and UROs. The following discussion focuses on the judiciary's interpretations of the preemption and civil enforcement provisions for breach of fiduciary duty and how they apply to utilization review liability.

ERISA applies to pension plans and welfare plans, the latter of which include health plans sponsored by an employer (self-insured health plans) or by an insurer (insured health plans).¹¹⁴ Whereas ERISA provides a comprehensive regulatory scheme for pension plans, only the disclosure, reporting, and fiduciary duty requirements apply to health plans.¹¹⁵ Therefore, ERISA does not require that an employer offer a health plan or that the plan provide for certain benefits.

ERISA's primary purpose is to "protect . . . the interests of participants in employee benefit plans and their beneficiaries"¹¹⁶ by

claims against UROs and payers, primarily managed care organizations in further detail); Diana Joseph Bearden & Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 BAYLOR L. REV. 285 (1995) (same); Susan O. Scheutow, *A Framework for Analysis of ERISA Preemption in Suits Against Health Plans and a Call for Reform*, 11 J.L. & HEALTH 195 (1996-97) (same).

113. Because rising health care costs take a greater toll on small businesses than on large employers, see Slivinska, *supra* note 13, at 333-34, the opportunity for small businesses to establish cooperatives for the purpose of creating employee benefit plans may expand the number of employees covered under an ERISA plan.

114. See 29 U.S.C. § 1002(1)-(3) (1994). The key difference between a self-insured and an insured health plan is who assumes the financial risks of the plan. Under a self-insured plan, the employer assumes the risks whereas an insurer assumes the risks under an insured plan. ERISA applies to roughly 65% of employer plans. See Harshbarger, *supra* note 86, at 193.

115. See 29 U.S.C.A. §§ 1021-1029, 1101-1109 (West 1985 & Supp. 1998). Under ERISA, every plan must furnish written notice to any participant of the reasons underlying a denial of benefits and afford a "reasonable opportunity" to the participant "for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. § 1133 (1994). The plan administrator must provide each participant with a summary plan description, see 29 U.S.C.A. § 1021(a)(1) (West Supp. 1998), and file with the Secretary of Labor the summary plan description, a plan description, and an annual report, see *id.* § 1021(b) (West Supp. 1998).

116. 29 U.S.C. § 1001(b) (1994); see also H.R. REP. NO. 93-533, at 1 (1974), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4640 (discussing the purpose of ERISA). The Act defines a "participant" as any employee, former employee, member or former member of an employee organization who may become eligible to receive a benefit from an employee benefit plan that covers such employees or members, or whose beneficiaries may be eligible to receive such a benefit. See 29 U.S.C. § 1002(7) (1994). A "beneficiary" means

creating disclosure and reporting requirements, "by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts."¹¹⁷ Although employers are not required to provide benefit plans to their employees or maintain a certain level of benefits once a plan is offered, employers who do establish a plan must comply with various funding, reporting, and disclosure requirements.¹¹⁸ In an effort to encourage the creation of employee benefit plans by reducing inefficiencies, Congress established uniform statutory requirements¹¹⁹ by enacting sweeping preemption provisions.¹²⁰

a person chosen by a participant or by the terms of an employee benefit plan to receive or be entitled to receive benefits under the plan. *See id.* § 1002(8) (1994).

117. *Id.* § 1001(b) (1994).

118. *See* 29 U.S.C.A. §§ 1021-1031, 1051-1086 (West 1985 & Supp. 1998).

119. Congress feared that compliance with different federal and state laws would encourage employers to shift the cost of the administrative burdens to employees by lowering the benefits levels. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10-11 (1987). Some courts have stressed the goal of uniformity over the goal to protect participants. *See, e.g., Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1332-33 (5th Cir. 1992).

120. Occasionally, courts have confused "conflict preemption" with "complete preemption." Section 514 of ERISA refers to the federal defense of preemption, known as "conflict preemption." 29 U.S.C.A. § 1144 (West 1985 & Supp. 1998). Under this doctrine, a claim preempted by ERISA is dismissed. In contrast, "complete preemption" is a jurisdictional doctrine. A defendant in state court may remove a claim to federal court if the complaint raises a question pertaining to a federal statute, such as ERISA (the "well-pleaded complaint" rule). If, however, the state court can recharacterize the suit as an ERISA § 502(a) claim for benefits—§ 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) (1994), provides that a participant 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"—it may remove to federal court even if a federal question is not raised on the face of the plaintiff's complaint. *Id.* This is the "complete preemption" exception to the well-pleaded complaint rule. *See Rice v. Panchal*, 65 F.3d 637, 646 (7th Cir. 1995); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 352 (3rd Cir. 1995). A complaint that can be recharacterized as a claim for benefits may be subject to complete preemption but not § 514 conflict preemption because it is, in fact, an ERISA claim. Instead, the plaintiff, if successful, could only receive remedies available under ERISA—typically the award of benefits originally denied. The sole limitation is that the claim for benefits must be brought against the plan, a plan fiduciary, or a plan administrator. *See* 29 U.S.C. § 1132(d) (1994).

Congress debated and enacted ERISA in the days preceding and following Watergate. Some commentators have proposed that Watergate interrupted congressional activities to such an extent that Congress did not adequately consider the consequences of a broad preemption provision. *See* Donald J. McNeil, Note, *ERISA Preemption of State Vacation Pay Laws: California Hospital Association v. Henning*, 16 LOY. U. CHI. L.J. 387, 419 (1985). As a result, these authors contend that the legislators' intent is unreliable. *See id.* at 418-19.

The initial bills that passed the House and Senate, however, included more

A. Preemption

The preemption provisions are comprised of three components: (1) § 514(a) preempts all state laws that "relate to" any employee benefit plan;¹²¹ (2) § 514(b)(2)(A), the "savings clause," removes state laws regulating insurance, banking, or securities from ERISA's preemptive field;¹²² and (3) § 514(b)(2)(B), the "deemer clause," prohibits a state law from deeming an employee benefit plan to be an insurance company by purporting to regulate the business of insurance.¹²³ The Supreme Court, however, has read the deemer clause to mean that state insurance laws may regulate insured plans but may not regulate self-insured plans,¹²⁴ thereby affording self-insured plans greater protection from the reach of state laws under ERISA.

For many years, the Supreme Court broadly interpreted and applied ERISA's preemption provisions. In *Alessi v. Raybestos-Manhattan, Inc.*,¹²⁵ the Court noted that state laws that affect

conservative preemption provisions. Under the Senate bill, preemption would only have applied to state laws that related to the administration of an ERISA plan, whereas under the House version, state laws regarding topics covered by the Act would have been preempted. See Harshbarger, *supra* note 86, at 215-16. Arguably, because both Houses expanded ERISA preemption from their original versions, Congress intended to employ broad preemption. See *id.* Furthermore, the bill's primary sponsors stated that broad preemption was an important part of the legislation. See *id.* at 216-17; Seema R. Shah, Comment, *Loosening ERISA's Preemptive Grip on HMO Medical Malpractice Claims: A Response to PacifiCare of Oklahoma v. Burrage*, 80 MINN. L. REV. 1545, 1552-53 & nn.45, 48 (1996). Judicial interpretation of the scope of the preemption provisions will depend, therefore, on the courts' view on congressional intent. In the past, the Supreme Court adopted the view that Congress intended to create broad preemption. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983); *Alessi v. Raybestos Manhattan, Inc.*, 451 U.S. 504 (1981); *infra* notes 125-31 and accompanying text.

121. 29 U.S.C. § 1144(a) (1994).

122. See *id.* § 1144(b)(2)(A) (1994). According to the Supreme Court, a state law regulates insurance if: (1) the practice at issue transfers or spreads a policyholder's risk; (2) "the practice is an integral part of the policy relationship between the insurer and the insured;" and (3) the practice is restricted to members of the insurance industry. *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982) (describing the three-part test outlined in *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 211-17, 20-24 (1979) (interpreting the meaning of "business of insurance" in § 2(b) of the McCarran-Ferguson Act)). For a discussion of whether utilization review constitutes the business of insurance, see Blum, *supra* note 55, at 205-06.

123. See 29 U.S.C. § 1144(b)(2)(B) (1994).

124. See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985) (holding that ERISA did not preempt a Massachusetts statute requiring all group health insurance plans and employee health care plans to provide certain minimum mental health care benefits except as the statute pertained to self-insured health plans).

125. 451 U.S. 504 (1981).

employee benefit plans in only an indirect manner still fall within the scope of § 514(a).¹²⁶ This expansive approach continued in *Shaw v. Delta Air Lines, Inc.*,¹²⁷ where the Court established that “a law ‘relate[s] to’ an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan.”¹²⁸ Applying this framework to state common law tort and contract claims, a unanimous Court in *Pilot Life Insurance Co. v. Dedeaux*¹²⁹ held that common law causes of action based on allegations of improper benefits claim processing relate to an employee benefit plan and, thus, are preempted by ERISA.¹³⁰ Justice O’Connor indicated that § 514 was not limited to “state laws specifically designed to affect employee benefit plans.”¹³¹ After several years of consistently employing a broad reading of § 514(a), the Court vacillated for the next several years¹³² until its ruling in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*¹³³ In *Travelers*, the Supreme Court expanded its preemption analysis to include an examination of both the statutory language of the provision in question and ERISA’s underlying purposes. A unanimous Court held that ERISA did not preempt a New York law requiring the addition of surcharges to hospital bills of

126. *See id.* at 525.

127. 463 U.S. 85 (1983).

128. *Id.* at 96-97. Although stressing the broad preemptive effect of ERISA, the Court qualified this premise by stating that some laws might “affect employee benefit plans in too tenuous, remote or peripheral a manner to warrant a finding that the law ‘relates to’ the plan.” *Id.* at 100 n.21.

129. 481 U.S. 41 (1987).

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

131. *Id.*

132. In *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), a divided Court held that ERISA did not preempt a Maine severance pay statute because the statute only mandated a one-time, lump-sum payment. Because the statute did not require an administrative scheme, the law concerned “benefits” and not “benefit plans.” *Id.* at 11-12. Justice Brennan, writing for a 5-4 majority, focused his analysis on whether preemption would further the purpose of § 514. *See id.* at 8-15. Brennan concluded that the Maine statute would not subject employee benefit plans to a non-uniform set of regulations. *See id.* at 14-15. The Court’s more narrow approach continued in *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988), where the Court held that ERISA did not preempt Georgia’s general garnishment law. *See id.* at 831-32.

In *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), the Court returned to its expansive analysis under *Shaw* when it held that ERISA preempted a Pennsylvania statute precluding subrogation of an individual’s tort claim. *See id.* at 65. The Court continued this broad interpretation of § 514 in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 145 (1990), reaching its zenith in *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 126-27 (1992). After this case, the Supreme Court gradually read the preemptive scope of § 514 more narrowly.

133. 514 U.S. 645 (1995).

patients covered by commercial insurance plans but not to bills covered by Blue Cross or Blue Shield plans.¹³⁴ The New York statute had only an “indirect economic influence” that “[did] not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself.”¹³⁵ Justice Souter wrote that the focus of preemption analysis is congressional intent and not ERISA’s language.¹³⁶ He noted that the term “relate[s] to” in § 514(a) was difficult to define; if this “unhelpful text” “were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course.”¹³⁷ Citing *Ingersoll-Rand* and Representative Dent and Senator Williams, sponsors of the Act, Justice Souter indicated that the primary underlying rationale for preemption “was to . . . permit the nationally uniform administration of employee benefit plans” by eliminating conflicting state regulation.¹³⁸ The Supreme Court’s emphasis on congressional intent and statutory purpose in *Travelers* marked a shift from the earlier textualist interpretation of the preemption provisions. The Court sought to clarify this inquiry in *California Division of Labor Standards Enforcement v. Dillingham Construction, Inc.*¹³⁹

In *Dillingham*, the Court examined whether ERISA’s preemption provision supplanted California’s prevailing wage law. Under this law, a contractor on a public works project must pay its workers the current wage in the project’s area. The contractor could, however, pay a lower wage to those workers who took part in an approved apprenticeship program.¹⁴⁰

134. *See id.* at 649.

135. *Id.* at 559.

136. *See id.* at 655-56.

137. *Id.*

138. *Id.* at 656-57.

139. 117 S. Ct. 832 (1997).

140. *See id.* at 835. *Dillingham Construction* was awarded a public works contract for the construction of the Sonoma County Main Adult Detention Facility. *See id.* at 836. *Dillingham* subcontracted electronic installation work to Sound Systems Media, who paid its apprentices an apprentice wage provided in its collective bargaining agreement and in affiliation with a joint apprenticeship committee. *See id.* Sound Systems Media did not, however, seek nor receive approval for its apprenticeship program from the State’s apprenticeship agency, the California Apprenticeship Council, as required by California regulations, until a later date. *See id.* The State issued a notice of noncompliance to Sound Systems Media and *Dillingham*, charging Sound Systems Media with violating California’s prevailing wage law for paying apprentices from a non-approved program lower wages than required by law. *See id.* *Dillingham* and Sound Systems Media filed suit alleging that the committee was an employee welfare benefit plan and that California’s prevailing statute “related to” the plan and, therefore, was preempted by

The *Dillingham* Court outlined a two-part inquiry to determine whether the ERISA preemption provision applies to a particular state law: A “law “relate[s]” to a covered employee benefit plan for purposes of § 514(a) “if it [1] has a connection with or [2] reference to such a plan.” ’ ”¹⁴¹ A state law “refers” to an ERISA plan if it acts “immediately and exclusively” on the plan or the plan is “essential to the law’s operation.”¹⁴² Even if the state law does not refer to an ERISA plan, it will be preempted if it has a “connection with” such a plan.¹⁴³

Under the “connection with” part of the inquiry, a court must use a two-step analysis, examining first ERISA’s objective as a guide to state laws Congress intended should survive ERISA preemption and, second, “the nature of the effect” the state law would have on an ERISA plan.¹⁴⁴ Under this approach, a court must first appraise whether ERISA’s provisions or its legislative history indicate a congressional intent to preempt the type of state law at issue.¹⁴⁵

ERISA. See *id.* The district court granted summary judgment for the agency. See *Dillingham Constr., Inc. v. County of Sonoma*, 778 F. Supp. 1522, 1530 (N.D. Cal. 1991). The Ninth Circuit reversed, holding that ERISA preempted the statute. See *Dillingham Constr., Inc. v. County of Sonoma*, 57 F.3d 712, 721 (9th Cir. 1995). The Supreme Court reversed the Ninth Circuit, holding that ERISA did not preempt California’s prevailing wage statute because the statute neither referred to nor had a connection with an ERISA plan. See *Dillingham*, 117 S. Ct. at 835.

141. *Dillingham*, 117 S. Ct. at 837 (quoting *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 129 (1992) (alterations in original) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983))).

142. *Id.* at 838. Under this part of the test, the Court has held as preempted the District of Columbia Workers’ Compensation Equity Amendment Act of 1990, § 2(c)(2), D.C. CODE ANN. § 36-307(a-1)(1) (Supp. 1992), which required employers who furnished health insurance for their employees to provide equivalent coverage for injured employees eligible for workers’ compensation benefits, see *Greater Washington Bd. of Trade*, 506 U.S. at 126-27; a Georgia statute, GA. CODE ANN. § 18-4-22.1 (1982), that singled out employee benefit plans for protective treatment under state garnishment procedures because of the statute’s express reference to ERISA plans, see *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 841 (1988); and a state wrongful discharge claim, see *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 145 (1990).

143. *Dillingham*, 117 S. Ct. at 838.

144. *Id.* Under this analysis, the Court held preempted New York’s Human Rights Law, N.Y. EXEC. LAW §§ 290-301 (McKinney 1982 and Supp. 1982-1983), which prohibited employers from organizing their employee benefit plans in a manner that discriminates on the basis of pregnancy, see *Shaw*, 463 U.S. at 108; Pennsylvania’s Motor Vehicle Financial Responsibility Law, 75 PA. CONS. STAT. § 1720 (1987), which precluded subrogation against a person’s tort recovery arising out of an automobile accident, see *FMC Corp. v. Holliday*, 498 U.S. 52, 65 (1990); and New Jersey’s Workers’ Compensation Act, N.J. STAT. ANN. § 34:15-29 (West Supp. 1980-1981), which prohibited plans from offsetting benefits by the amount of worker compensation payments, see *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 506 (1981).

145. See *Dillingham*, 117 S. Ct. at 840-41.

Although the Supreme Court recognized an underlying presumption not to preempt a state law pertaining to an area of traditional state regulation, such a finding would not in itself insulate that law against preemption.¹⁴⁶ Under the second step, if Congress did not intend to preempt the type of state law at issue, that law would still be preempted if it dictates the choices facing the plan or the plan administrator and thereby regulates the plan itself.¹⁴⁷

The *Dillingham* decision probably signals an attempt by the Court to bring ERISA preemption analysis more in line with traditional preemption analysis.¹⁴⁸ The Court recently affirmed its two-part inquiry in *De Buono v. NYSA-ILA Medical and Clinical Services Fund*.¹⁴⁹

B. Fiduciary Duty

Although ERISA's preemption provisions do not shield from liability plan administrators who breach their fiduciary duty, the limited application of the duty and insufficient remedies may furnish administrators indirect protection in some instances. A person is a fiduciary to the extent he or she uses any "discretionary authority or discretionary control" regarding the plan's management, management or disposition of plan assets, or administration of such plan.¹⁵⁰ Under § 1104(a)(1), plan fiduciaries have a duty to act "solely in the interests of the [plan] participants and beneficiaries."¹⁵¹

146. *See id.*

147. *See id.*

148. *See id.* at 843 (Scalia, J., concurring); *see also* *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 518 (1992) (discussing the traditional preemption analysis); *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947) (same).

149. 117 S. Ct. 1747, 1751 (1997).

150. 29 U.S.C. § 1002(21)(A) (1994). Section 1002(21)(A) states in part:

[A] person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

Id.

151. 29 U.S.C. § 1104(a)(1) (1994). Section 1104(a)(1) states in part:

[A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—(A) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan; (B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims

Sections 1132(a)(2) and 1132(a)(3) provide the means to enforce ERISA's fiduciary standards.¹⁵²

In *Massachusetts Mutual Life Insurance Co. v. Russell*,¹⁵³ the Supreme Court held that under a § 1132(a)(2) claim, relief for breach of duty is available only to the plan as a whole and not to the individual participants.¹⁵⁴ The Court concluded that Congress did not grant a cause of action under § 1109(a)—and, therefore under § 1132(a)(2)—for “extracontractual damages” resulting from the improper or untimely processing of benefit claims.¹⁵⁵ In *Varity Corp. v. Howe*,¹⁵⁶ however, the Supreme Court determined that § 1132(a)(3) permits individual remedies.¹⁵⁷ Justice Breyer concluded

Id.

152. Section 1132(a)(2) states that a civil action may be brought “by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title.” 29 U.S.C. § 1132(a)(2) (1994). Section 1132(a)(3) provides that a civil action may be brought by a participant, beneficiary, or fiduciary: “(A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.” *Id.* § 1132(a)(3).

153. 473 U.S. 134 (1985). In this case, Doris Russell received plan benefits for disability arising from a back ailment. *See id.* at 136. Based on a report by an orthopedic surgeon, Massachusetts Mutual terminated Mrs. Russell's benefits. *See id.* Subsequently, Mrs. Russell's psychiatrist sent a report to Massachusetts Mutual stating that Mrs. Russell suffered from a psychosomatic disability with physical manifestations rather than a true orthopedic disorder. *See id.* After a second psychiatrist confirmed these findings, the plan administrator reinstated Mrs. Russell's benefits, including retroactive payment. *See id.* Although Mrs. Russell received the full benefits to which she was contractually entitled, she filed a claim alleging injury arising from the improper refusal to pay benefits. *See id.*

154. *Id.* at 140. Because Mrs. Russell expressly disclaimed reliance on § 1132(a)(3), the Court did not address whether that section provided for individual remedies. *See id.* at 139.

155. *Id.* at 148. Section 1109(a) states:

Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary, which have been made through use of assets of the plan by the fiduciary and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.

29 U.S.C. § 1109(a) (1994).

156. 116 S. Ct. 1065 (1996).

157. *See id.* at 1076. In *Varity*, Varity Corporation (“Varity”) transferred its money-losing divisions to one of its subsidiaries, Massey-Combines. *See id.* at 1068. Varity then convinced employees to change their employee benefit plans to Massey-Combines by offering assurances that the benefits would remain secure. Massey-Combines was, however, insolvent from the outset. *See id.* at 1068-69. When the company entered receivership in its second year, the employees who had transferred their plans lost their employee welfare benefits. *See id.* at 1069. These employees filed a claim against Varity for breach of fiduciary duty and requested “appropriate equitable relief” under

that § 1132(a)(3) acts as a “safety net, offering appropriate equitable relief for injuries caused by violations that [§ 1132] does not elsewhere adequately remedy.”¹⁵⁸ Although Justice Breyer found it unimaginable that Congress would intend to shield breaches of fiduciary responsibility that injure individuals by denying such individuals a remedy,¹⁵⁹ the Court did not specify what remedies are available to injured beneficiaries under § 1132(a)(3).¹⁶⁰ Moreover, *Varity* did not outline what constitutes fiduciary obligations or address whether individuals may bring claims regarding future benefits. Several post-*Varity* cases have tried to fill in these gaps.¹⁶¹ Yet the absence of a clear blueprint for fiduciary responsibilities as well as potential limitations on available remedies for breach of duty do not constitute the sole deficiencies in ERISA’s fiduciary provisions. The central precept of ERISA’s fiduciary law, the exclusive benefit rule, is at odds with the reality of modern employee benefit trust.¹⁶²

ERISA’s exclusive benefit rule requires plan fiduciaries to discharge their duties solely in the interest of the plan’s participants and beneficiaries.¹⁶³ The drafters of ERISA sought to “‘apply rules and remedies similar to those under traditional trust law to govern the conduct of fiduciaries.’”¹⁶⁴ As a result, ERISA’s exclusive

§ 1132(a)(3). *See id.*

158. *Id.* at 1078.

159. *See id.*

160. In an earlier decision, the Supreme Court cautioned against expanding equitable remedies and suggested that “appropriate equitable relief” under § 1132(a)(3) means traditional remedies, such as injunction, back pay, and mandamus. *See Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993). Trust law, however, permits make-whole relief in certain instances. *See Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1336 (5th Cir. 1992). For a brief description of trust law duties, see *infra* text accompanying notes 165-68.

161. *See, e.g., Lockheed Corp. v. Spink*, 116 S. Ct. 1783, 1790 (1996) (holding that plan sponsor does not act as a fiduciary when amending an ERISA plan); *Shea v. Esensten*, 107 F.3d 625, 629 (8th Cir. 1997) (holding that breach of fiduciary duty includes the failure to disclose the plan’s financial incentives when those incentives serve to discourage the treating physician from providing essential health care referrals for disorders covered under the plan); *McLeod v. Oregon Lithoprint, Inc.*, 102 F.3d 376, 378-79 (9th Cir. 1996) (holding that relief available under § 1132(a)(3) is limited to equitable and not compensatory damages); *Coyne v. Delaney Co. v. Selman*, 98 F.3d 1457, 1465 (4th Cir. 1996) (finding that a sponsor does not become a fiduciary by undertaking settlor-type activities such as crafting benefits); *Doe v. Travelers Ins. Co.*, 971 F. Supp. 623, 640 (D. Mass. 1997) (holding that plan fiduciaries must disclose medical necessity guidelines used by its utilization review process when requested by a participant and that such failure to disclose is subject to § 1132(c) civil remedies).

162. For a detailed analysis, see Daniel Fischel & John H. Langbein, *ERISA’s Fundamental Contradiction: The Exclusive Benefit Rule*, 55 U. CHI. L. REV. 1105 (1988).

163. *See* 29 U.S.C. § 1104(a)(1)(A) (1994); *supra* note 151 (quoting relevant language).

164. Fischel & Langbein, *supra* note 162, at 1108 (quoting H.R. REP. NO. 93-1280, pt.

benefit rule adopts trust law's duty of loyalty.¹⁶⁵ An employee benefit plan differs, however, from an ordinary trust. Under an ordinary private trust, the property owner, or settlor, transfers property for the benefit of one or more beneficiaries to a third party, the trustee. The rationale behind imposing fiduciary obligations on the trustee stems from the typical trust creation scenario wherein the settlor may die or the beneficiaries are incapable of managing the funds. Under such circumstances, the parties involved lack the ability to monitor the trustee. To substitute for such monitoring deficiencies and to prevent the trustee from engaging in self-interested behavior at the expense of the beneficiaries, trust law imposes an irrebuttable presumption of wrongdoing whenever there exists a conflict of interest on the part of the trustee.¹⁶⁶ Under an employee benefit plan, however, the employer's and employee's interests do not fully align.¹⁶⁷ The employer is the settlor, a beneficiary,¹⁶⁸ and, sometimes, a fiduciary. Whereas in a private trust, the settlor's welfare is maximized if the beneficiaries receive all the benefits from the trust, in an employee benefit plan, the employer's welfare is maximized if it can either limit or divert some of the benefits to its own pockets that would otherwise flow to the beneficiaries (or participants). The private trust also typically involves a small number of beneficiaries with similar interests. Under an employee benefit plan, different classes of employees share dissimilar interests. For example, young workers may prefer to receive a greater bulk of compensation in the form of family leave time whereas older employees may prefer greater emphasis on health care benefits. In addition, when an employee becomes ill, the interests of that participant and the plan may diverge. The sick employee may want the plan to spend more money on his health care whereas the plan, in an effort to conserve resources for the other participants, may conclude that the other participants would receive a greater benefit if the sick employee received less medical care.

A larger conflict of interest arises when independent UROs act

5, at 295 (1974), reprinted in 1974 U.S.C.C.A.N. 5038, 5076).

165. *See id.*

166. *See id.* at 1114-15.

167. Employers and employees share certain mutual interests. For example, employee benefits may reduce employee turnover, thereby decreasing employers' training costs and increasing employee satisfaction. Moreover, the compensation employees receive through health benefits is a tax advantage for their employer. *See id.* at 1117-18.

168. The employer can be viewed as a beneficiary because an employee benefit plan comprises a portion of the total package that an employer agrees to pay an employee as compensation. *See id.* at 1117.

as fiduciaries,¹⁶⁹ although physician and nurse reviewers who make decisions based on established plan guidelines arguably are not acting as fiduciaries.¹⁷⁰ Though self-dealing behavior by a URO may result in employee dissatisfaction, the URO lies further removed from employee objections than the employer. Moreover, the URO does not experience the training and supervision costs of employee turnover. Therefore, the current schema of ERISA fiduciary duties

169. As the *Corcoran* court noted:

[I]n any plan benefit determination, there is always 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 to compensate all beneficiaries. In a prospective review context, with its greatly increased ability to deter the beneficiary (correctly or not) from embarking on a course of treatment recommended by the beneficiary's physician, the tension between interest of the beneficiary and that of the plan is exacerbated. A system which would, at least in some circumstances, compensate the beneficiary who changes course based upon a wrong call for the costs of that call might ease the tension between the conflicting interests of the beneficiary and the plan.

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

170. The Department of Labor published the following question and answer regarding ERISA's fiduciary obligations:

Q: Are persons who have no power to make any decision as to plan policy, interpretations, practices or procedures, but who perform the following administrative functions for an employee benefit plan, within a framework of policies, interpretations, rules, practices and procedures made by other persons, fiduciaries with respect to the plan:

- (1) Application of rules determining eligibility for participation or benefits;
- (2) Calculation of services and compensation credits for benefits;
- (3) Preparation of employee communications material;
- (4) Maintenance of participants' service and employment records;
- (5) Preparation of reports required by government agencies;
- (6) Calculation of benefits;
- (7) Orientation of new participants and advising participants of their rights and options under the plan;
- (8) Collection of contributions and application of contributions as provided in the plan;
- (9) Preparation of reports concerning participants' benefits;
- (10) Processing of claims; and
- (11) Making recommendations to others for decisions with respect to plan administration?

A: No. Only persons who perform one or more of the functions described in section 3(21)(A) of the Act with respect to an employee benefit plan are fiduciaries. Therefore, a person who performs purely ministerial functions such as the types described above for an employee benefit plan within a framework of policies, interpretations, rules, practices and procedures made by other persons is not a fiduciary because such person does not have discretionary authority or discretionary control respecting management of the plan, does not exercise any authority or control respecting management or disposition of the assets of the plan, and does not render investment advice with respect to any money or other property of the plan and has no authority or responsibility to do so.

29 C.F.R. § 2509.75-8 (1998).

misreads the conflicts of interest inherent in employee health benefit plans as well as the cost-control mentality of today's health care system. Any reform directed at ERISA's fiduciary duties must address both who should be a fiduciary and what should comprise the duties of a fiduciary.

C. *Liability for Utilization Review Decisions Under State Law*

*Wickline v. State of California*¹⁷¹ was the first instance where a court determined that third-party payers could be held liable for medically inappropriate decisions resulting from defects in the design or implementation of cost-containment mechanisms. In this case, Lois Wickline was admitted to a local hospital with back and leg problems by her family practitioner, Dr. Daniels, and diagnosed with Leriche's syndrome¹⁷² by Dr. Polonsky, a vascular surgeon.¹⁷³ After approval by Medi-Cal, California's state medical assistance program, Dr. Polonsky performed a surgical procedure on Mrs. Wickline wherein a portion of her artery was removed and replaced with a synthetic graft.¹⁷⁴ Dr. Polonsky reoperated on Mrs. Wickline later that same day to remove a clot that had formed postoperatively and, several days later, performed a lumbar sympathectomy, the severing of a chain of nerves near the spinal cord, to treat persistent leg pain and arterial spasms.¹⁷⁵ Near the time of discharge, Dr. Polonsky concluded, and Dr. Daniels and a third physician agreed, that Mrs. Wickline should remain in the hospital for an additional eight days for observation.¹⁷⁶ After performing a prospective utilization review, Medi-Cal rejected the request for an eight day extension but authorized an additional four days of hospitalization.¹⁷⁷ None of Mrs. Wickline's physicians tried to obtain a further extension of her hospital stay.¹⁷⁸ After returning home, Mrs. Wickline developed recurrent pain in her right leg and the leg progressively turned gray and then blue.¹⁷⁹ Nine days after her discharge, Mrs. Wickline was

171. 239 Cal. Rptr. 810 (Ct. App. 1986).

172. Leriche's syndrome is hip, thigh, and buttock pain when walking as the result of occlusion of the distal aorta from arteriosclerosis. The aorta is the principal and largest artery bringing oxygenated blood from the heart to the rest of the body. Arteriosclerosis is hardening and narrowing of the arterial wall. See HARRISON'S PRINCIPLES OF INTERNAL MEDICINE 1492-93 (Kurt J. Isselbacher ed., 10th ed. 1983).

173. See *Wickline*, 239 Cal. Rptr. at 812.

174. See *id.*

175. See *id.* at 812-13.

176. See *id.* at 813.

177. See *id.* at 814.

178. See *id.* at 815.

179. See *id.* at 816.

readmitted to the hospital where she eventually had her right leg amputated above the knee because of clotting in the leg and an infection at the graft site.¹⁸⁰ Mrs. Wickline brought a claim against Medi-Cal for negligently discontinuing her Medi-Cal eligibility, thereby resulting in her discharge from the hospital.¹⁸¹ As a result, Mrs. Wickline argued that she suffered clot formation in her right leg necessitating amputation of that leg.¹⁸² The trial court found for the plaintiff.¹⁸³ A California Court of Appeal reversed.¹⁸⁴

The court of appeal determined that under California law, all persons must use ordinary care to prevent harm to others as a result of their conduct.¹⁸⁵ Persons are exempt from this duty if there is a statutory exception or an exception should be made based on public policy.¹⁸⁶ Although the court agreed that third-party payers may be held liable when medically inappropriate decisions arise from defects in the design or implementation of cost-containment measures,¹⁸⁷ the court ruled that the statutory law governing the Medi-Cal program created an exception to tort law liability by permitting Medi-Cal to deny benefits when its decision accorded with the standards of medical practice in the community.¹⁸⁸ The court went on to note that the "stakes . . . are much higher" for prospective review than for the retrospective review process.¹⁸⁹ An error in determining medical necessity following retrospective review can lead to the wrongful withholding of payment, but an incorrect decision from prospective review may lead to the wrongful withholding of necessary care and to subsequent injury to the patient.¹⁹⁰ The court concluded, "[w]hile we

180. *See id.*

181. *See id.* 811.

182. *See id.*

183. *See id.*

184. *See id.* at 820.

185. *See id.* at 818.

186. *See id.*

187. *See id.* at 819. The court noted:

[t]he 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.

Id.

188. *See id.* at 820; *see also* *Wilson v. Blue Cross of S. Cal.*, 271 Cal. Rptr. 876, 879 (Dist. Ct. App. 1990) (discussing the legal and factual components of the *Wickline* case).

189. *Wickline*, 239 Cal. Rptr. at 811.

190. *See id.* at 812.

recognize, realistically, that cost consciousness has become a permanent feature of the health care system, it is essential that cost limitation programs not be permitted to corrupt medical judgment."¹⁹¹

The California Court of Appeal revisited the issue of utilization reviewer liability in *Wilson v. Blue Cross of Southern California*.¹⁹² Howard Wilson was hospitalized for the treatment of major depression, and his attending physician determined that Mr. Wilson required three to four weeks of inpatient care.¹⁹³ Mr. Wilson's insurance company disagreed, however, and denied payment for hospitalization beyond ten days.¹⁹⁴ Because Mr. Wilson could not afford to pay for additional inpatient care, he was discharged from the hospital.¹⁹⁵ Three weeks later, he committed suicide.¹⁹⁶ Mr. Wilson's family brought suit for breach of contract, inducement of breach of contract, and wrongful death against the insurance company, the utilization review organization, and the physician who determined the denial of payment by the utilization review organization.¹⁹⁷ The trial court granted defendants' motions for summary judgment based upon the holding in *Wickline*.¹⁹⁸ The court of appeals reversed by limiting the holding of *Wickline* to its facts. The *Wilson* court distinguished three key components that distinguished it from *Wickline*. First, *Wickline* held as a matter of law that the discharge decision in that case met the standard of care for physicians, while *Wilson* found no evidence to support that the discharge decision was within the medical standard of care.¹⁹⁹ Second, although a statutory exception applied in *Wickline*, no such exception was available in *Wilson*.²⁰⁰ Instead, the contract between Mr. Wilson and the insurance company imposed a duty on the insurer

191. *Id.* at 820. The court stated, however, that a physician who complies with a third-party payer decision that is contrary to his or her medical judgment, as was the case with Dr. Polonsky, retains the ultimate responsibility for the patient's care. *See id.* at 819. The court's dicta implies that treating physicians possess an obligation to appeal limitations imposed by third-party payers that run counter to the physician's medical judgment.

192. 271 Cal. Rptr. 876 (Ct. App. 1990).

193. *See id.* at 877.

194. *See id.*

195. *See id.* at 877-78.

196. *See id.* 878.

197. *See id.* 880-81.

198. *See id.* 878.

199. *See id.* at 882; *Wickline*, 239 Cal. Rptr. at 819.

200. *See Wilson*, 271 Cal. Rptr. at 879; *Wickline v. State of Cal.*, 239 Cal. Rptr. 810, 820 (Ct. App. 1986).

to provide funds.²⁰¹ Finally, in *Wickline*, the Medi-Cal review process did not "corrupt medical judgment."²⁰² The sole basis for Mr. Wilson's discharge stemmed, however, from the absence of funds to pay for continued inpatient care.²⁰³ The *Wilson* court shifted the focus on the issue of third-party payer liability from the characterization of the decision-making conduct to whether the decision to deny benefits was a substantial factor in causing plaintiff's injury.²⁰⁴ Therefore, the court rejected the *Wickline* dicta which stated that the responsibility for discharge lies exclusively with the treating physician.²⁰⁵ Because a triable issue remained as to whether the refusal to extend Mr. Wilson's inpatient treatment was a "substantial factor" in causing Mr. Wilson's death, the court remanded the case.²⁰⁶

Several courts have subsequently held UROs liable for their decisions.²⁰⁷ In *Murphy v. Board of Medical Examiners of the State of*

201. See *Wilson*, 271 Cal. Rptr. at 879.

202. *Wickline*, 239 Cal. Rptr. at 820; see *Wilson*, 271 Cal. Rptr. at 879.

203. See *Wilson*, 271 Cal. Rptr. at 883.

204. The court adopted the test for joint tort liability from the Second Restatement of Torts:

"The actor's negligent conduct is a legal cause of harm to another if (a) his [or her] conduct is a substantial factor in bringing about the harm, and, (b) there is no rule of law relieving the actor from liability because of the manner in which his negligence has resulted in the harm."

Wilson, 271 Cal. Rptr. at 883 (quoting RESTATEMENT (SECOND) OF TORTS § 431) (1965) (alteration in original)).

205. See *id.* The court also left unresolved whether a treating physician incurs liability if she fails to appeal a utilization review decision that runs counter to her medical judgment. See *id.* at 884-85. Implicit in *Wilson* and *Wickline*, however, is the court's acceptance of concurrent utilization review as an appropriate method of health care cost containment.

206. *Id.* at 885. After the appellate court's decision to remand, the URO settled with the Wilsons. See Frankel, *supra* note 40, at 1309. In 1992, a jury found the insurer liable for tortious breach of contract. See David Azevedo, *Courts Let UR Firms Off the Hook—And Leave Doctors On*, MED. ECON., Jan. 25, 1993, at 30, 42. The parties subsequently settled. See Frankel, *supra* note 40, at 1309.

207. See, e.g., Fox v. HealthNet, No. 219692 (Sup. Ct., Riverside County, California, 1993), noted in 1993 WL 794305, where a California jury awarded over \$89 million in damages against an HMO. The HMO had denied coverage for a breast cancer patient's bone marrow transplant on the basis that the treatment was experimental. The HMO's coverage booklet indicated, however, that the procedure was covered. The jury awarded \$12 million in compensatory damages for bad faith, breach of contract, and reckless infliction of emotional distress, and \$77 million in punitive damages. See Michael Meyer & Andrew Murr, *Not My Health Care*, NEWSWEEK, Jan. 10, 1994, at 36, 36; Christine Woolsey, *Jury Hits HMO for Coverage Denial*, BUS. INS., Jan. 3, 1994, at 1, 23; see also *Bush v. Dake*, No. 86-25767NM-2, slip op. (Mich. Cir. Ct. Apr. 27, 1989), reprinted in BARRY F. FURROW ET AL., THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE 384-86 (2d ed. 1991) (holding that HMO may be sued for negligently establishing utilization review procedures).

Arizona,²⁰⁸ an Arizona court of appeals held that a decision to deny precertification for gallbladder surgery was a medical decision.²⁰⁹ Dr. Murphy, the medical director of Blue Cross Blue Shield of Arizona, declined to precertify patient S.B. for gallbladder surgery, determining that the procedure was not "medically necessary," contrary to the advice of S.B.'s surgeon, Dr. Johnson, and her referring physician.²¹⁰ Dr. Johnson performed the operation and Blue Cross eventually paid the claim.²¹¹ In response to a letter sent by Dr. Johnson complaining that Dr. Murphy displayed unprofessional conduct and medical incompetence regarding S.B.'s precertification request, the Arizona Board of Medical Examiners ("BOMEX") issued a letter of concern to Dr. Murphy.²¹² Dr. Murphy filed a lawsuit in superior court alleging that BOMEX had violated his due process rights.²¹³ After losing on a summary judgment motion, BOMEX appealed.²¹⁴ The Arizona court of appeals determined that Dr. Murphy was an employee who makes medical decisions as to whether or not procedures are medically necessary.²¹⁵ The court held that Dr. Murphy's conclusion was a medical decision because he had substituted his medical judgment for that of S.B.'s doctors and determined that the gallbladder surgery was not medically necessary.²¹⁶ The court was not persuaded by the fact that Dr. Murphy was following Blue Cross's contract.²¹⁷

The Wyoming Supreme Court reached a similar conclusion in *Long v. Great West Life & Annuity Insurance Co.*²¹⁸ Dr. Hollifield, Larry Long's neurologist, recommended that Mr. Long undergo back surgery for a herniated disc which caused Mr. Long to experience chronic pain.²¹⁹ Great-West, Mr. Long's insurer, required pre-authorization for surgery, which was administered by a utilization

208. 949 P.2d 530 (Ariz. Ct. App. 1997).

209. *See id.* at 536.

210. *See id.* at 532-33.

211. *See id.* at 533.

212. *See id.* at 533-34.

213. *See id.* at 534.

214. *See id.* at 535. The principal issue on appeal was whether or not BOMEX had jurisdiction over Dr. Murphy. *See id.*

215. *See id.* at 536.

216. *See id.*

217. *See id.* at 532, 536; *see also* *Morris v. District of Columbia Bd. of Med.*, 701 A.2d 364, 368 (D.C. 1997) (holding that under certain circumstances, a medical administrator of an insurer who monitors and routinely questions physicians' treatment decisions could be found to have practiced medicine).

218. 957 P.2d 823 (Wyo. 1998).

219. *See id.* at 824.

review program, Health Care Review Service ("HCRS").²²⁰ Surgery performed without pre-authorization would be paid at a sixty percent penalty rate.²²¹ HCRS denied authorization and instead determined that Mr. Long should receive treatment with steroid injections.²²² Dr. Steffen, an anesthesiologist, informed Mr. Long that he could not administer the injections because he believed that the injections posed a risk but offered no benefit.²²³ After several attempts by Mr. Long to obtain approval for surgery, HCRS recommended treatment with physical therapy.²²⁴ Dr. Metz, a neurosurgeon, examined Long and determined that physical therapy would not be beneficial and that surgery was the appropriate course of treatment.²²⁵ Mr. Long's condition progressively deteriorated resulting in weakness of his left foot and increased pain.²²⁶ He, therefore, underwent surgery which Great-West paid at the sixty percent penalty rate.²²⁷ Mr. Long brought suit against Great-West under various theories, including breach of contract.²²⁸ Great-West filed a motion for summary judgment, claiming that Long had failed to exhaust his administrative remedies under the contract.²²⁹ Long appealed after losing on the summary judgment motion at the trial court level.²³⁰ The Wyoming Supreme Court reversed and remanded, holding that the grievance procedure in Great-West's contract applied to claims for payment and not to treatment decisions during the utilization review process.²³¹ The court ruled that the utilization review process entails involvement in medical decisions by the insurer's administrator and is beyond the traditional realm of insurance claims and coverage.²³² These cases suggest, therefore, that some courts now view utilization review decisions, or at least precertification determinations, as medical decisions.

D. *Liability for Utilization Review Decisions Under ERISA*

ERISA preemption has provided a shield for UROs against state

220. *See id.*

221. *See id.* at 825.

222. *See id.*

223. *See id.*

224. *See id.*

225. *See id.*

226. *See id.* at 826.

227. *See id.*

228. *See id.*

229. *See id.*

230. *See id.*

231. *See id.* at 832-33. Long, therefore, could pursue a judicial remedy. *See id.* at 833.

232. *See id.* at 832.

common law-based tort claims. Under preemption analysis, either the suit is dismissed for failure to state a claim or the remedies offered under ERISA prove insufficient to warrant further litigation.²³³

In *Corcoran v. United HealthCare, Inc.*,²³⁴ the Fifth Circuit Court of Appeals addressed whether ERISA preempted a Louisiana tort action for wrongful death. In *Corcoran*, a utilization review organization denied coverage for hospitalization of a pregnant mother.²³⁵ While the mother was at home, the fetus went into distress and died.²³⁶ The Corcorans argued that the URO's refusal to permit hospitalization was an erroneous medical decision.²³⁷ The URO, however, characterized itself as a plan fiduciary that performs administrative duties akin to claims handling.²³⁸ The court of appeals did not fully agree with either party. Instead, the court determined that although the URO makes medical decisions, it does so in the context of determining whether benefits are available under the plan; accordingly, the court held that ERISA preempted the Corcorans' claims.²³⁹ The court of appeals also looked to the purpose of ERISA to buttress its decision. Acknowledging that Congress's goal to create a uniform federal scheme to regulate employee benefit plans required a broad reading of the preemption provision,²⁴⁰ the court concluded that imposing liability on the URO would threaten this scheme by placing employee benefit plans at risk from different state liability laws and would, therefore, increase costs for health benefit plans using cost-containment mechanisms.²⁴¹ The absence of a remedy under ERISA for medical malpractice committed in connection with a plan benefit determination,²⁴² the possibility that

233. Arguably, UROs may escape liability if they are deemed ERISA fiduciaries. For example, under the rationale of *McManus v. Travelers Health Network*, 742 F. Supp. 377 (W.D. Tex. 1990), "a person is a fiduciary if that person has discretion in deciding whether claims are to be paid or establishes the policies and procedures to be followed in evaluating claims." *Id.* at 382; see also *supra* Part IV.B (discussing this fiduciary duty).

234. 965 F.2d 1321 (5th Cir. 1992).

235. See *id.* at 1324.

236. See *id.*

237. See *id.* at 1326.

238. See *id.* at 1329-30.

239. See *id.* at 1331. The court of appeals concluded that the Corcorans sought to recover for a tort allegedly committed in the process of handling a benefits determination. The *Corcoran* court relied on the Supreme Court's decision in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 57 (1987), where the Court had held that ERISA preempted state law claims alleging improper handling of benefit claims. See *Corcoran*, 965 F.2d at 1331.

240. See *Corcoran*, 965 F.2d at 1331.

241. See *id.* at 1332-33.

242. See *id.* at 1338. The court stated:

imposing liability on UROs would deter poor quality medical decisions, and the greater impact of prospective review on beneficiaries, as compared to retrospective review,²⁴³ did not dissuade the court from its holding that ERISA preempted the Corcorans' claims.²⁴⁴ The *Corcoran* decision, however, preceded the Supreme

The result ERISA compels us to reach means that the Corcorans have no remedy, state or federal, for what may have been a serious mistake. This is troubling for several reasons. First, it eliminates an important check on the thousands of medical decisions routinely made in the burgeoning utilization review system. With liability rules generally inapplicable, there is theoretically less deterrence of substandard medical decisionmaking. Moreover, if the cost of compliance with a standard of care (reflected either in the cost of prevention or the cost of paying judgments) need not be factored into utilization review companies' cost of doing business, bad medical judgments will end up being cost-free to the plans that rely on these companies to contain medical costs. ERISA plans, in turn, will have one less incentive to seek out the companies that can deliver both high quality services and reasonable prices.

Id. Other courts have also refused to limit the scope of ERISA preemption even though recharacterization of the claim as a denial of benefits under an employee benefit plan left plaintiffs without a meaningful remedy. *See, e.g., Turner v. Fallon Community Health Plan, Inc.*, 953 F. Supp. 419, 424 (D. Mass. 1997).

243. *See Corcoran*, 965 F.2d at 1331-33.

244. Other courts have reached the same conclusion. *See, e.g., Cannon v. Group Health*, 77 F.3d 1270, 1273-74 (10th Cir.) (holding that ERISA preempted claim for damages for death of patient caused by delayed preauthorization of an autologous bone marrow transplant), *cert. denied*, 117 S. Ct. 66 (1996); *Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc.*, 999 F.2d 298, 304 (8th Cir. 1993) (holding that ERISA preempted a medical malpractice claim against an HMO for delaying payment approval for decedent's heart transplant because the suit was based on an allegedly improper processing of a medical benefits claim). In *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996), the Seventh Circuit ruled that a negligence claim against an employee of an URO for determining that inpatient physical therapy was not medically necessary should be recharacterized as an ERISA § 502(a)(1)(B) claim to recover benefits due under an employee benefit plan. *See id.* at 1489. ERISA, therefore, did not preempt the claim. However, the court dismissed the suit against the employee because ERISA allows claims to recover benefits only against the plan as an entity. *See id.* at 1490; *see also Tolton v. American Biodyne, Inc.*, 48 F.3d 937, 942 (6th Cir. 1995) (holding that ERISA preempts claim against UROs for refusal to authorize psychiatric benefits because it "relates to" the benefits plan); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 132 (9th Cir. 1993) (holding that ERISA preempts state common law wrongful death actions); *Clark v. Humana Kansas City, Inc.*, 975 F. Supp. 1283, 1289 (D. Kan. 1997) (holding that claim against URO for negligent provision of psychiatric screening was preempted by ERISA, although plaintiff was allowed to amend complaint to add a claim against URO for breach of fiduciary duty); *Turner*, 953 F. Supp. at 425 (holding wrongful death claim against URO preempted); *Kohn v. Delaware Valley HMO, CIV.A.91-2745*, 1992 WL 22241, at *1 (E.D. Pa. Feb. 5, 1992) (reasoning that utilization review decisions are benefits determinations); *Elsesser v. Hospital of the Phila. College of Osteopathic Med.*, 802 F. Supp. 1286, 1292 (E.D. Pa. 1992) (holding claim against HMO for refusal to pay for certain procedures preempted because claim has a "connection with or reference to a benefit plan"). *But see Pappas v. Asbel*, 675 A.2d 711, 715-16, 718 (Pa. Super. Ct.) (holding that ERISA does not preempt a negligence claim against an MCO for delay in approval of patient transfer to another facility that resulted from a cost-containment

Court's ruling in *Travelers*. In dicta, the *Travelers* Court suggested that ERISA might not preempt medical malpractice claims against UROs based on either direct or vicarious liability.²⁴⁵ The Supreme Court found that "nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern," such as quality standards.²⁴⁶ Consequently, the courts still

protocol), *appeal granted*, 686 A.2d 1312 (Pa. 1996).

245. See *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 659-62 (1995); Sylvia L. Wenger, Comment, *New York State Conference of Blue Cross & Blue Shield Plans, et al. v. Travelers Insurance Company, et al.: Medical Malpractice and Enabling Regulation in States Again*, 51 U. MIAMI L. REV. 131, 146 (1996). In the context of HMO liability, HMOs have successfully employed ERISA preemption as a defense against medical malpractice claims based on direct negligence. See Shah, *supra* note 120, at 1560-61; see also *Jass*, 88 F.3d at 1493-94 (holding that vicarious liability claim against HMO administrator of employee benefit plan for the medical malpractice of the treating physician preempted because the alleged negligence by the physician for failure to treat stemmed from the HMO's denial of benefits, and, therefore, "relates to" the plan); *Ricci v. Gooberman*, 840 F. Supp. 316, 318 (D.N.J. 1993) (holding that ERISA preempts state tort claims arising under the theory of vicarious liability).

HMOs, however, have achieved limited success with indirect claims, such as ostensible agency. See, e.g., *PacificCare of Okla. v. Burrage*, 59 F.3d 151, 155 (10th Cir. 1995) (holding that ERISA does not preempt a medical malpractice claim based on vicarious liability against an HMO); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 357 (3rd Cir. 1995) (holding that ERISA does not result in complete preemption of an ostensible agency malpractice suit because such a claim attacks the quality of the benefits provided rather than alleging an improper denial of benefits and that quality control of benefits "is a field traditionally occupied by state regulation and we interpret the silence of Congress as reflecting an intent that it remain such"); *Hoyt v. Edge*, CIV.A.97-3631, 1997 WL 356324, at *3-4 (E.D. Pa. June 20, 1997) (relying on *Dukes* and holding that ERISA does not preempt claims against HMO's physicians for medical malpractice and against HMO for failure to refer plaintiff to a competent physician for a second opinion because these allegations attack the quality of the benefits provided); *Lancaster v. Kaiser Found. Health Plan of Mid-Atlantic States, Inc.*, 958 F. Supp. 1137, 1149 (E.D. Va. 1997) (holding that ERISA does not preempt state law medical malpractice claims or vicarious liability claims); *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182, 187 (E.D. Pa. 1994) (holding that preemption does not extend to claims of vicarious liability for medical malpractice); *Pickett v. Cigna Healthplan*, 742 F. Supp. 946, 947 (S.D. Tex. 1990) (holding that common law medical malpractice case does not raise questions regarding claims administration); *Independence HMO v. Smith*, 733 F. Supp. 983, 988 (E.D. Pa. 1990) (holding that state tort claim based on theory of ostensible agency does not "relate to" an ERISA plan).

246. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995). In *Corporate Health Insurance Inc. v. Texas Department of Insurance*, 12 F.Supp. 2d 597 (S.D. Tex. Sept. 18, 1998), the court held that ERISA does not preempt the provisions of the Health Care Liability Act, TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-88.003 (West 1998), that require a managed care entity to exercise ordinary care when making health care treatment decisions and permit individuals injured as a result of a failure to conform to this duty of care, to bring suit. See *id.* at 602, 620. The court reasoned that ERISA does not preempt claims of improper care, because such claims challenge the quality of care received, but ERISA does preempt claims of failure

grapple with whether or not ERISA protects UR decisionmakers from liability for negligent determinations in the context of employee benefit plans. The next Part analyzes potential alternatives to rectify this controversy.

V. PROPOSED MODIFICATIONS OF ERISA

The time has come to amend ERISA.²⁴⁷ ERISA's preemption provisions combined with the limited remedies available under ERISA for breach of fiduciary duty have shielded UROs, as well as third-party payers, from the consequences of UR decisions. Several options exist to resolve this inadequacy:²⁴⁸ (1) place those who make UR decisions under ERISA's fiduciary obligations; (2) remove ERISA's preemption provisions as they relate to UR decisions; or (3) impose new obligations on UR decisionmakers under ERISA.

A. *Fiduciary Duty*

The imposition of a fiduciary duty is appropriate when there is no or only minimal conflict of interest between the fiduciary and the party to whom the duty is owed.²⁴⁹ As discussed in Part IV, a significant conflict of interest exists between UROs and plan participants.²⁵⁰ UROs seek to lower costs through the denial of care, whereas participants try to obtain care. Furthermore, the use of ERISA's fiduciary duty requirement in the absence of effective remedies creates an unrealistic mandate without teeth.²⁵¹ Therefore, the legislature should not extend ERISA's fiduciary duty to include UROs.²⁵²

to cover a particular treatment, these claims are benefit determinations. *See id.* at 619-20.

247. This view is shared by the National Governors' Association which, in 1994, at its annual conference in Washington, D.C., made ERISA reform a priority. *See* Jesselyn Alicia Brown, Note, *ERISA and State Health Care Reform: Roadblock or Scapegoat?*, 13 YALE L. & POL'Y REV. 339, 342 (1995).

248. These options apply only to an ex post scenario wherein a participant who is harmed as the result of a negligent UR decision seeks compensation for the injury. In contrast, in an ex ante situation, the URO has denied payment for a participant's medical care but the participant has not been injured and cannot, therefore, recover in tort. The participant seeks to appeal the UR decision in an effort to obtain approval for payment of medical care yet to be provided.

249. *Cf.* Fischel & Langbein, *supra* note 162, at 1114 ("The duty of loyalty is prophylactic; its purpose [is] to deter the trustee from engaging in self-interested conduct at the expense of the beneficiaries.").

250. *See supra* notes 162-70 and accompanying text.

251. *See supra* notes 150-61 and accompanying text.

252. Instead, the application of the fiduciary duty standard under ERISA should be limited to employers and should be imposed only under the following circumstances: (1) the decision to offer a particular health benefit plan designed by an independent entity,

B. Preemption

Congress enacted ERISA “to promote the interests of employees and their beneficiaries in employee benefit plans”²⁵³ and “to protect contractually defined benefits.”²⁵⁴ An interpretation of ERISA’s preemption provisions that situates plan participants in a position worse than that under pre-ERISA state law runs counter to congressional intent.²⁵⁵ However, even if amending ERISA preemption provisions to permit state common law actions against UROs and third-party payers would respect ERISA’s policy of preserving state regulation of insurance,²⁵⁶ allowing such actions

such as an MCO, or by the employer; (2) the decision to change the plan(s) offered; (3) the decision to terminate a plan; (4) the determination that the plan does not cover a particular treatment, diagnostic test, etc. for a specific disease or disorder but not a determination that the plan does not cover a particular treatment, etc. for a specific participant; (5) disclosure and adequate representation of all information that would be material to the average participant when making a decision whether to subscribe to or continue to subscribe to the plan; and (6) denial of benefits claims. Fiduciary duty should be limited to these actions because each regards either the plan as a whole or the employees as a whole—situations where the employer’s interests are in the least conflict with the employees’ interests. Such a formulation is consistent with ERISA’s conception of fiduciary duty. See 29 U.S.C. § 1104 (1994); *supra* note 151 (quoting the statute). By imposing these obligations on employers as fiduciary duties, Congress would force employers, the parties in the best position to know of and to dispense the resources of the business and who retain authority to determine the scope and availability of plan benefits, to consider the best interests of their employees when making plan decisions and when negotiating with their employees regarding plan benefits. However, narrowing the field of fiduciary duty will prove insufficient if remedies for breach of fiduciary duty are not expanded to correspond to the injuries suffered.

Arguably, decisions by employers to terminate a plan or change plan terms should be left to the market. The threat of employee discontent may provide employers with an incentive not to terminate a plan without suitable justification. Not all employers, however, will take their employees’ interests into consideration, and not all employees possess sufficient power to bargain with their employer over health benefits. Imposing a fiduciary duty on employers only in the scenarios listed above will protect employees from employers who will alter health benefits without any consideration of the interests of the employees as a whole. Because the fiduciary duty extends to the plan as a whole or to employees as a whole, however, an employer’s decision to change the terms of a plan or to terminate a plan because it is no longer feasible for the business to incur those costs would be consistent with the employer’s fiduciary duty.

253. *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983).

254. *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985).

255. The Supreme Court in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), rejected the use of a standard of review that “would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted.” *Id.* at 114.

256. Arguably, utilization review is not the business of insurance, as defined under section 2(b) of the McCarran-Ferguson Act, ch. 24, § 2(b), 59 Stat. 34, 34 (1945), as amended ch. 326, 61 Stat. 448, 448 (1947) (codified at 15 U.S.C.A. § 1012(b) (1994)). The United States Department of Labor has filed amicus briefs in support of narrowing ERISA’s preemption to allow participants to sue ERISA plans for physician malpractice. See Scheutzow, *supra* note 112, at 196.

threatens to impose unnecessary costs and runs counter to ERISA's purpose of protecting employee benefit plans from a patchwork of state regulation. Furthermore, because of the wide disparity in permissible tort actions between states, the redress available to injured participants will vary depending upon the state in which the participant is injured.²⁵⁷ Although the protection of employee interests arguably supersedes the protection of employer interests, a solution that satisfies both goals would best serve the congressional intent behind ERISA as well as the interests of the parties for whom ERISA was enacted. Moreover, an increase in employer costs risks a shift in costs to employees. Therefore, measures that hinder employer interests in uniformity also threaten to interfere with employee interests.

The imposition of common law tort liability on UROs may carry certain disadvantages. Permitting UROs to define their standard of care, as physicians currently do, risks setting a low floor for URO negligence.²⁵⁸ Furthermore, if the patient wins in court, she may not receive compensation for several years.²⁵⁹ A tort regime may offer its greatest advantage, however, by creating an effective deterrent rather than providing adequate compensation. In particular, the risk of tort

257. It remains possible that a participant injured in one state as the result of a negligent UR decision would receive compensation, yet a participant injured by the same decision but living in a neighboring state would receive no compensation. The result unnecessarily threatens ERISA plan UROs with complying with as many as 50 different standards of care while leaving the extent of participant recovery to the variability of state tort systems.

258. As Judge Learned Hand stated in *The T.J. Hooper*, 60 F.2d 737 (2d Cir. 1932): "Indeed in most cases reasonable prudence is in fact common prudence; but strictly it is never its measure; a whole calling may have unduly lagged in the adoption of new and available devices. It never may set its own tests, however persuasive be its usages." *Id.* at 740. The standard of care applied under a negligence regime is the reasonable person standard: what the reasonable person would do under like circumstances. See W. PAGE KEETON ET AL., PROSSER & KEETON ON TORTS § 32, at 173-75 (5th ed. 1984). In contrast, the medical malpractice standard is a custom-based standard: what a doctor with the skill, knowledge, and care commonly possessed by members of the profession in good standing would do. See *id.* § 32, at 185-87.

259. If UROs are allowed to determine their standard of care, the outcome of negligence cases may depend on who obtains the better expert. Injured patients may decide not to file negligence claims because of the difficulty of proving negligence. It has been argued that such an effect is seen with medical malpractice claims. See Randall, *supra* note 57, at 18. In addition, as in the case of medical malpractice, compensation may be inequitable with a few plaintiffs receiving excessive awards while the majority of injured parties receive none. Yet, short of a no-fault system, any tort regime imposed for negligent UR decisions will require expert testimony and risk insufficient compensation. A no-fault system for compensation risks abuse by inappropriate parties and does not provide a deterrent effect, which, arguably, is more important than the compensatory function. See *infra* text accompanying notes 276-79.

liability may prove sufficient to improve quality of care while limiting the number and severity of patient injuries, thereby also diminishing the need for compensation. Moreover, placing liability for particular actions on the shoulders of those parties responsible for the actions would discourage third-party payers and UROs from demanding too great a role in treatment decisions while also acting as a deterrent against underutilization of care.²⁶⁰ Therefore, the optimal solution

260. Alternatively, liability for all decisions and actions, including medical malpractice, could be imposed solely on the payers since they, at least some of the larger ones, maintain deep pockets. See Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381 (1994) (advocating imposing enterprise liability on hospitals); William M. Sage et al., *Enterprise Liability for Medical Malpractice and Health Care Quality Improvement*, 20 AM. J.L. & MED. 1 (1994); William M. Sage & James M. Jorling, *A World that Won't Stand Still: Enterprise Liability by Private Contract*, 43 DEPAUL L. REV. 1007 (1994). But see Sharon M. Glenn, *Tort Liability of Integrated Health Care Delivery Systems: Beyond Enterprise Liability*, 29 WAKE FOREST L. REV. 305 (1994) (arguing that, in the absence of enterprise liability, health care organizations will nonetheless be subject to common law tort principles of medical liability). However, "enterprise liability" holds disadvantages, particularly when applied to ERISA. By holding only payers responsible, enterprise liability shields those involved in the provision of care, physicians and other providers, from liability. Although payers could monitor physician behavior, the resources involved to both monitor and cover the costs of increased liability may exceed the capacity of many employers who offer employee benefit plans, forcing current sponsors to abandon their plans and deterring potential sponsors from establishing plans. As a result, enterprise liability could work to undermine ERISA's objectives.

While shifting liability onto UROs and third-party payers is one key reform, additional reforms are necessary to sufficiently protect employee interests. Liability only furnishes retrospective damages. To receive adequate benefits, plan participants require sufficient information pertaining to the financial incentives that affect physician decisionmaking so that they can make informed choices. ERISA may require plan fiduciaries to disclose those financial arrangements that may adversely affect a physician's medical judgments. See *Herdrich v. Pegram*, 154 F.3d 362, 372-73 (7th Cir. 1998) (holding that failure by an HMO, as an ERISA fiduciary, to disclose its incentive scheme to plan participants is a breach of fiduciary duty if, as a result of these incentives, physicians withhold or delay providing necessary medical care); *Shea v. Esenstein*, 107 F.3d 625, 628-29 (8th Cir. 1997) (holding that an HMO, under ERISA's fiduciary obligations, has a duty to notify plan participants of financial incentives it offers that discourage physicians from providing necessary referrals to specialists for illnesses covered by the plan). But see *Weiss v. CIGNA Healthcare, Inc.*, 972 F. Supp. 748, 754-55 (S.D.N.Y. 1997) (holding that ERISA does not impose on plan fiduciaries a duty to disclose physician compensation agreements).

Participants also need adequate grievance and appeal procedures to contest adverse benefits determinations and to receive quick redress when appropriate. See Scheutzow, *supra* note 112, at 216. ERISA's mandate that each participant receive a reasonable opportunity for review of a benefits denial and the judiciary's interpretation that exhaustion of remedies is applicable together prove insufficient to meet this challenge because they delay resolution of a patient's grievance and unduly limit access to the judicial system. See *id.* at 218; see also Kinney, *supra* note 47 (discussing ways to improve grievance procedures and arguing for the need to implement strategies to avoid grievances); Stayn, *supra* note 55, at 1676, 1701-06 (describing the absence of a uniform

would be to impose liability on UROs and third-party payers under federal law for negligent utilization review decisions without narrowing ERISA's preemption to such an extent as to expose UROs and third-party payers to liability under state law.²⁶¹

C. Recommendations

Congress should amend ERISA to add incentives that advance health policy objectives while promoting the goals of ERISA by: (1) imposing a duty of care on those who make UR decisions;²⁶² (2) creating a federal cause of action for a negligent UR decision and negligent design of UR guidelines; (3) establishing incentives to deter UR decisionmaking that would adversely impact participants' health; and (4) furnishing appropriate remedies to injured participants by providing adequate redress. Fashioning such a duty would offer uniformity of requirements and predictability of legal obligations. Consistent with ERISA's goal of uniform regulation, claims for a negligent UR decision or negligent UR design should be adjudicated under federal law. ERISA's legislative history indicates that "a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans."²⁶³ The Supreme Court has recognized Congress's intent that federal courts establish federal substantive law under ERISA.²⁶⁴ Therefore, two avenues exist by which to bring claims, one through the federal district courts and one through the state courts as long as the right to appeal lies only to the federal court of

recourse system across HMOs to protect patients from undertreatment). Current HMO procedural protections, such as the voluntary National Committee for Quality Assurance standards and state and Medicare HMO regulations, are also of limited utility for employee protection. See Eleanor D. Kinney, *Procedural Protections for Patients in Capitated Health Plans*, 22 AM. J.L. & MED. 301, 307-10, 314-18 (1996).

261. In light of the Supreme Court's dicta in *Travelers*, and its willingness in *Dillingham* to try to return to a more traditional preemption doctrine, there is the possibility that the judiciary independently will continue to chip away at ERISA's preemption provisions until UROs are exposed to state common law tort claims. Imposing uniform liability on UR decisionmakers through an amendment to ERISA would prevent the courts from exposing ERISA plans to a patchwork of state tort regimes and eroding preemption protections beyond those proposed in this Article.

262. Third-party payers who do not make UR decisions do not incur direct liability for such determinations, though a URO and a payer could agree that the payer would indemnify the URO if the URO is sued. Such arrangements are left, however, to the market.

263. 120 CONG. REC. 29,942 (1974) (statement of Senator Javits, one of the bill's sponsors).

264. See *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 24 & n.26 (1983).

appeals system.

Creating original jurisdiction in state courts for negligent decision claims offers several advantages over federal district courts, including judicial economy, judicial efficiency, and expertise. Federal dockets remain backlogged and overcrowded²⁶⁵ in comparison to state courts. In addition, claims for a negligent UR decision are generally tied to allegations of medical malpractice, a cause of action that state courts typically address and for which they have developed broad expertise. Such medical malpractice claims may require presentation of the same evidence as that used for the claim of a negligent UR decision or negligent design of UR guidelines. Allowing certain claims to proceed in state court and other claims to proceed in federal court would increase judicial inefficiency and raise the litigation costs of both employees and UROs; therefore, negligence claims under ERISA should be brought under a single judicial system. For these reasons and because state courts collectively control more extensive judicial resources than federal district courts, claims under ERISA against UROs and third-party payers regarding utilization review decisions and the design of utilization review guidelines should be permitted only in state court. To create a body of federal common law consistent with congressional intent, however, and to provide greater uniformity of court-imposed obligations on UROs and third-party payers, plaintiffs should be granted a right of appeal only to the federal courts of appeal.²⁶⁶

1. Legislative Proposal

Congress should create a duty of care under ERISA for those entities that make utilization review decisions affecting plan participants or beneficiaries by including the following provision:

All utilization review decisions and utilization review guidelines shall meet the medical standard of care, as defined by the practice of the ordinary, competent physician under like circumstances, unless the entity making the utilization review decision or designing the utilization

265. See *Hearing on Federal Jurisdiction over Class Action Suits Before the House Subcomm. on Courts and Intellectual Property*, 105th Cong. (1998), available in 1998 WL 375020 (testimony of Richard H. Middleton, Jr., Vice President of the Association of Trial Lawyers of America) (discussing federal court backlog and noting that Chief Justice Rehnquist recently stated in his speech to the American Law Institute that federal courts are overburdened).

266. Such a system would also prohibit forum shopping, thereby reducing the drain on the resources of both the judiciary and the litigating parties.

review guidelines demonstrates by reasonable scientific evidence that its decision or guidelines provide a participant or beneficiary with a level of care of reasonably similar efficacy and safety as the medical standard of care. The imposed duty of care is nondelegable²⁶⁷ and applies to any entity that makes a utilization review decision or designs a utilization review guideline.²⁶⁸ Participants or beneficiaries may bring a cause of action for a negligent utilization review decision²⁶⁹ or negligent design of a utilization review guideline in state court against any entity that makes a utilization review decision or designs a utilization review guideline.²⁷⁰ To succeed on the merits, the participant or beneficiary must prove by a preponderance of the evidence that the entity's decision or guideline did not conform to the medical standard of care as established by expert testimony and that the decision or guideline was a proximate cause of the injury. If the participant or beneficiary meets his or her burden of proof, the burden shifts²⁷¹ to the entity to prove by a preponderance of the evidence, based on reasonable scientific evidence, as established by expert testimony and the records of the entity, that the decision approves or the design provides medical care of reasonably similar efficacy and safety as the medical standard of care and, in the case of a negligent decision claim, that the entity complied with its guidelines. A participant or beneficiary who succeeds on the merits may receive attorneys' fees, compensatory and

267. The duty should be nondelegable to prevent UROs or third-party payers from contracting out of their obligations.

268. In a definitions section of the proposed legislation, "entity" should be defined so as to preclude the liability of an individual for injury caused by a utilization review decision made as an agent of an entity, if the decision is consistent with the entity's UR guidelines.

269. A negligent utilization review decision includes a delay in decisionmaking that causes injury to the participant or beneficiary as the result of the delay. Alternatively, Congress could establish set time periods in which different categories of utilization review decisions must be made thereby providing greater predictability for a URO of its legal obligations.

270. This provision addresses the situation in which a utilization review decision caused harm to a participant or beneficiary under an ERISA plan (ex post scenario). A separate scenario exists when a participant or beneficiary disagrees with a utilization review decision and seeks approval for care denied because the URO determined that such care was not medically appropriate or medically necessary (ex ante scenario). In this circumstance, an alternative appeals process through the URO, an independent state review board, or another entity should be implemented rather than using the court system as the first line of appeal.

271. See *infra* notes 277-82 and accompanying text for a discussion of the rationale for permitting an entity an opportunity to escape liability even though a plaintiff has demonstrated that the UR decision did not meet the medical standard of care.

punitive damages.²⁷² State court decisions may be appealed to the federal court of appeals for the district in which the state court resides. A treating physician who disagrees with a utilization review decision remains liable for medical malpractice for his or her own decisions but will not incur additional responsibility for the utilization review decision if he or she appeals the utilization review decision to the entity on a one-time basis and explains to the participant or beneficiary the course of care that he or she recommends and why he or she disagrees with the utilization review decision.²⁷³

2. Rationale

In adopting the proposed standard of care, Congress would promote the policy objective of providing quality, cost-efficient health care. Because utilization review decisions are akin to and often have the effect of medical decisions, UR decisionmakers should be expected to maintain a standard of care similar to the medical standard of care—that is, the standard of practice of the ordinary, competent physician in like circumstances.²⁷⁴ By using this medical standard, plan participants could expect a minimum level of quality in UR guidelines and in UR decisions.²⁷⁵ The UR industry should, however, be permitted to design a different standard if it maintains similar levels of quality and supports its alternative standard of care with scientific evidence. Therefore, Congress should require that all UR decisions and UR guidelines meet the medical standard of care unless the entity making the UR decision or designing the UR guidelines demonstrates by reasonable scientific evidence that its

272. Because imposing liability may place some self-insured plans at risk for insolvency, a cap on punitive damages is recommended, possibly as a multiple of the compensatory damages awarded.

273. Some commentators would allow physicians a cost-based defense. Under a cost-based defense, a physician could present evidence that, although she breached the standard of care, the breach was not the result of negligence but was an appropriate response to incentives to contain cost. See, e.g., John J. Howard, *Medical Malpractice Liability and Cost Containment: Law and Economics in Conflict*, 43 FOOD DRUG COSM. L.J. 309, 329 (1988). However, offering such a defense for physician conduct reintroduces the economic conflict of interest between physicians and patients that this proposal seeks to remove.

274. See, e.g., *Smith v. Menet*, 530 N.E.2d 277, 279-80 (Ill. App. Ct. 1988). The most common standard of medical practice is a national standard. See, e.g., *Brune v. Belinkoff*, 235 N.E.2d 793, 798 (Mass. 1968).

275. Although the medical standard of care describes the level of quality we expect of the medical community, it remains a low hurdle to clear as the result of its emphasis on the practice of the average rather than the best physician. See *Menet*, 530 N.E.2d at 279.

decision or guidelines provide a participant with a level of care of reasonably similar efficacy and safety as the medical standard of care. This standard provides a measure of protection for participants, consistent with ERISA's mandate, while also providing a shield against liability for entities that make UR decisions. Although imposing the risk of liability may indirectly raise the costs of an ERISA plan, the proposed standard affords an opportunity to avoid such liability.

The proposal offers several additional benefits. The threat of tort liability would provide UROs with an incentive to invest in effective *ex ante* procedures, appropriate UR guidelines, and competent UR reviewers. Greater accountability and increased transparency of negligent UR processing through documentation in court records—and the subsequent risk of negative publicity—will encourage UROs to make more responsible decisions up front to avoid risking injury to participants. If appropriate decisions are made *ex ante*, the issue of compensation becomes less relevant. At the same time, UROs and third-party payers would receive an inducement to align with the medical community rather than create further conflict.²⁷⁶

A standard of care that permits the UR industry to avoid liability by justifying its actions through scientific evidence offers an economic incentive to the industry and third-party payers to invest in medical research on the diagnosis, treatment, and management of diseases to ascertain alternative, lower-cost means of care.²⁷⁷ This, in turn, would create new sources of funding for medical research and provide UROs and third-party payers with an opportunity to both lower the costs of ERISA plans and adequately protect themselves from inappropriate and indiscriminate liability. The medical profession would also retain its authority to determine the medical standard of care without the outside threat currently posed by UROs. At the same time the medical community would have greater incentives to pursue outcomes research²⁷⁸ in an effort to justify

276. This proposal removes the need to use financial incentives to encourage physicians to alter their clinical practice since UROs or third-party payers may determine the appropriateness of medical care with relative assurance that their decision will survive scrutiny if adequately supported by scientific data.

277. Both the public and the medical community have assumed that the medical standard of care offers optimal patient care. However, the practices of different physicians for the same illness may vary widely and there may not be adequate scientific evidence supporting the use of certain diagnostic tests, treatments, and forms of management, either alone, or in conjunction with each other. See *infra* notes 279, 282.

278. Outcomes research is the investigation of outcomes of health care from delivery

current practices.²⁷⁹

The presence of medical uncertainty²⁸⁰ and the absence of scientific justification for many current medical practices²⁸¹ remain important sources of rising costs in the health care system, and, consequently, in ERISA plans as well.²⁸² The imposition of a duty of care and the proposed standard of care create an opportunity for the private sector's business and medical communities to align to correct this information failure. As a result, the medical standard of care itself may improve through the proposal's incentive to study fully the justifications and rationales underlying current practice, thereby furthering the goal of providing quality health care more effectively and at lower costs.

VI. CONCLUSION

The evolution of UROs in response to the escalating costs of domestic health care has affected the provision of health care in the United States. As a consequence of ERISA's preemption provisions, however, UROs have avoided liability for injuries incurred by ERISA plan participants due to negligent utilization review decision-making. This article has recommended that any reform of ERISA should be undertaken with the intent to promote the

systems and practices in an effort to identify which practices best promote positive patient outcomes. See David N. Sundwall, *Foreward* to CLINICAL PATHS: TOOLS FOR OUTCOMES MANAGEMENT at xix (Patricia L. Spath ed., 1994).

279. Practice guidelines promulgated by the medical community may lead to increased uniformity of practice but will not lower costs unless physicians receive an incentive to connect value to costs when researching and designing their own guidelines. See Louis P. Garrison, Jr., *Assessment of the Effectiveness of Supply-Side and Cost-Containment Measures*, HEALTH CARE FINANCING REV., 1991 Annual Supp., at 13, 16-17. This Article's proposal seeks to furnish that incentive.

280. See Eric E. Fortess & Marshall B. Kapp, *Medical Uncertainty, Diagnostic Testing, and Legal Liability*, 13 LAW MED. & HEALTH CARE 213, 213 (1985). Medical uncertainty refers to "those clinical situations, in which, based on available data, absolute scientific proof regarding some aspects of a patient's health status cannot be obtained." See *id.*

281. See, e.g., Henry E. Simmons, *The Nation's Least Understood Healthcare Problem—The Quality of Medical Care (Where is Healthcare Headed?)*, 20 GENERATIONS 57, 58 (1996).

282. Medical uncertainty may lead to overly conservative treatment decisions as well as overtreatment. See, e.g., Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CAL. L. REV. 1951 (1986). Between 20% to 30% of physician actions, although well-intentioned, may be inappropriate and unnecessary. Such actions stem from medical uncertainties. See Leonard Abramson, *Better Quality Through Accountability*, BUS. & HEALTH, Nov. 11, 1990, at 64, 64. Therefore, this Article's proposal serves to correct a market failure that has resulted from inadequate information to providers, patients, and payers.

domestic policy goal of quality, economically efficient health care. By looking at the preemption issue in the larger context of health care policy, modifications of ERISA's framework could be enacted for the universal benefit through improved and cost-efficient health care rather than limited to the redress of injured plan participants.