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ERISA Preemption of Medical Malpractice Claims in Managed Care: Asserting a New Statutory Interpretation

Karla S. Bartholomew

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**ERISA Preemption of Medical Malpractice
Claims in Managed Care: Asserting a
New Statutory Interpretation**

I.	INTRODUCTION	1132
II.	THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974	1136
	A. <i>The History and Purpose Behind ERISA</i>	1136
	B. <i>The Language and Structure of ERISA</i>	1138
	1. Defining “Employee Welfare Benefit Plan”	1138
	2. Section 514: ERISA Preemption	1141
	3. Section 502: Remedies Under ERISA	1145
III.	ERISA PREEMPTION OF MEDICAL MALPRACTICE CLAIMS	1147
	A. <i>Liability in the World of Managed Care</i>	1147
	1. Managed Care Organizations: Structure and Cost-Containment	1147
	2. Theories of Managed Care Liability	1151
	B. <i>Courts Interpret ERISA Preemption</i>	1152
	1. ERISA Preempts Direct Liability Claims.....	1153
	2. Courts Split over Whether ERISA Preempts Vicarious Liability Claims.....	1154
	3. <i>Dukes v. U.S. Healthcare’s “Denial of Benefits Versus Quality of Care”</i>	1157
IV.	ASSERTING A NEW STATUTORY INTERPRETATION	1159
	A. <i>Redefining an ERISA Plan</i>	1159
	1. Statutory Language and Structure	1160
	2. Congressional Intent.....	1161
	3. Legislative History	1162
	4. ERISA Plan Jurisprudence.....	1162
	B. <i>The Implications of a New Statutory Interpretation</i>	1164
V.	CONCLUSION	1164

I. INTRODUCTION

If Congress wants the American citizens to have access to adequate health care, then Congress must accept its responsibility to define the scope of ERISA preemption and to enact legislation that will ensure every patient has access to that care.¹

Congress enacted the Employee Retirement Income Security Act of 1974 ("ERISA")² to protect employee interests³ and ensure a uniform body of law for pension and benefit plans.⁴ The statute's expansive preemption clause⁵ and preclusion of extra-contractual damages⁶ have since been used to immunize Managed Care Organizations ("MCOs")⁷ from liability for patient⁸ injuries resulting from medical malpractice. Because plaintiffs with preempted claims may receive only the remedies provided for under ERISA—the right or benefit due under the plan⁹—many injured patients have been left with no meaningful remedy.¹⁰

1. *Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 12 F. Supp. 2d 597, 616 n.7 (S.D. Tex. 1998).

2. ERISA, 29 U.S.C. §§ 1001-1461 (1994).

3. See *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983).

4. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45-46 (1987).

5. See ERISA § 514(a), 29 U.S.C. § 1144(a) (1994) ("[ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . .").

6. See ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) (1994) (authorizing a participant or beneficiary to bring an action "to recover benefits, . . . enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan").

7. The term Managed Care Organization ("MCO") will be used throughout this Note to refer generally to Health Maintenance Organizations ("HMOs"), Preferred Provider Organizations ("PPOs"), Point of Service plans ("POS"), Physician-Hospital Organizations ("PHOs"), and Independent Practice Associations ("IPAs"). For a discussion of MCO structures and cost-containment methods, see *infra* Part III.A.1. See also Diana Joseph Bearden & Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 BAYLOR L. REV. 285, 287-95 (1995) (detailing the characteristics, structure, and types of HMOs); Domenick C. DiCicco, Jr., *HMO Liability for the Medical Negligence of Member Physicians*, 43 VILL. L. REV. 499, 500-04 (1998) (describing the history of HMOs and the various HMO models); Vicki Lawrence MacDougall, *The "Shared Risk" of Potential Tort Liability of Health Maintenance Organizations and the Defense of ERISA Preemption*, 32 VAL. U. L. REV. 855, 856-67 (1998) (describing the HMO physician contractual arrangements in the various types of HMO models); O. Mark Zamora, *Medical Malpractice and Health Maintenance Organizations: Evolving Theories and ERISA's Impact*, 19 NOVA L. REV. 1047, 1048 (1995) (giving an overview of the structure of HMOs).

8. In this context, "patient" refers to either an ERISA plan participant—"any employee or former employee of an employer, or any member or former member of an employee organization"—or beneficiary—"a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit." ERISA § 3(7)-(8), 29 U.S.C. § 1002(7)-(8) (1994).

9. ERISA preemption provides for the displacement of state law for claims that "relate to" an employee benefit plan. See ERISA § 514(a), 29 U.S.C. § 1144(a). Under ERISA, plaintiffs are entitled to certain remedies allowed under the act. See ERISA § 502(a), 29 U.S.C. § 1132(a)

“[N]ot a model of legislative drafting,”¹¹ the statute’s broad preemption clause provides that state law claims that “relate to” an ERISA plan are preempted.¹² The ambiguous phrase “relate to” has been the primary focus of the Supreme Court’s attempts to determine the reach of the preemption clause.¹³ Relying primarily on a textual interpretation of the statute, the Court has held that, while ERISA does not preempt “run-of-the-mill state-law claims,”¹⁴ those plans that have a “connection with or reference to”¹⁵ an ERISA plan, without being a “tenuous, remote, or peripheral connection,”¹⁶ are preempted. The Supreme Court’s tortured attempts to give effect to the statutory language have led to doctrinal confusion and “chaos” in the lower courts.¹⁷ Little judicial guidance, therefore, currently exists for interpreting ERISA’s poorly constructed preemption clause.

ERISA is implicated in medical malpractice claims through its regulation of employee welfare plans.¹⁸ An “employee welfare benefit plan” under ERISA is a “plan, fund, or program” that an employer establishes or maintains to provide medical, surgical, or hospital care or benefits to participants through the purchase of insurance.¹⁹

(1994) (“A civil action may be brought, (1) by a participant or beneficiary . . . 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”); *see also infra* Part II.B.3.

10. A woman whose breast cancer went undetected for lack of a mammogram, for example, could only recover approximately \$100, the cost of the mammogram, but would be barred from actual damages. *See infra* Part II.B.3.

11. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985).

12. *See* ERISA § 514(a), 29 U.S.C. § 1144(a); *see also infra* Part II.B.2.

13. *See infra* Part II.B.2.

14. *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 833 (1988) (describing such claims as “unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan” as “run-of-the-mill state-law claims”).

15. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983).

16. *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 130 n.1 (1992) (citation omitted).

17. Catherine L. Fisk, *The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 HARV. J. ON LEGIS. 35, 60-82 (1996) (describing the failure of the Supreme Court to establish a coherent doctrine, and the “chaos” in the lower federal courts that has ensued).

18. *See* ERISA, 29 U.S.C. §§ 1001-1461 (1994). ERISA regulates two categories of employer-provided benefits plans: pension plans and employee welfare plans. *See infra* Parts II.B.1 & IV.A.1.

19. ERISA §3(1), 29 U.S.C. § 1002(1) (1994). An “employee welfare benefit plan” is:

[A]ny plan, fund, or program . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . . or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

Id.; *see also infra* Parts II.B.1 & IV.

Employer-provided health insurance, therefore, has been interpreted as an employee benefit within the scope of ERISA. If a state cause of action involving health care provided through an ERISA plan, such as a medical malpractice claim, is deemed to "relate to" the employee benefit plan, the cause of action is preempted by ERISA under section 514(a).²⁰

Although most courts agree that direct liability actions against MCOs²¹ are limited to remedies provided by ERISA, vicarious liability claims against MCOs²² have divided federal courts,²³ leading to calls for legislative action.²⁴ While the Supreme Court has not yet spoken directly to the case of a medical malpractice claim against an MCO, lower courts are increasingly adopting the reasoning put forth by the Third Circuit in *Dukes v. U.S. Healthcare, Inc.*²⁵ The *Dukes* court held that ERISA preempts claims interpreted as a denial of benefits, but not those claims challenging the quality of care of benefits received.²⁶ Appealingly simple, this distinction may ultimately prove untenable; often a reasonable argument can be made for an action based on either a denial of benefit or substandard medical care.

The current jurisprudence of ERISA preemption contravenes both of the congressional goals set forth for ERISA. First, the interests of employees are not being protected. ERISA's broad preemption clause has left many injured patients without meaningful remedy. Second, the body of law for benefit plans is not uniform. There are differences in the treatment of direct and vicarious liability claims, employer-provided health care and non-employer-provided health care, self-insured plans and commercial insurance, and hospi-

20. ERISA § 514(a), 29 U.S.C. § 1144(a) (1994).

21. Direct liability claims are typically those claims involving MCO cost-containment systems or negligent hiring or supervision of physicians. For a discussion of theories of tort liability against HMOs, see Bearden & Maedgen, *supra* note 7, at 298-337; DiCicco, *supra* note 7, at 504-16; MacDougall, *supra* note 7, at 867-91; Zamora, *supra* note 7, at 1048-56. See also *infra* Parts III.A.2 & III.B.1.

22. Vicarious claims are typically asserted against an MCO for the negligence of an affiliated physician. See sources cited *supra* note 21; see also *infra* Parts III.A.2 & III.B.2.

23. See *infra* Part III.B.2.

24. See, e.g., *Turner v. Fallon Community Health Plan, Inc.*, 127 F.3d 196, 200 (1st Cir. 1997), *cert denied*, 118 S. Ct. 1512 (1998) ("Whether or not Congress ever thought about the impact on health care . . . when it wrote ERISA[,] Congress is well equipped to revisit the issue and alter the statutory language . . ."); *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 60 (D. Mass. 1997) ("The task of reforming ERISA . . . falls squarely upon the shoulders of Congress."); *Ricci v. Gooberman*, 840 F. Supp. 316, 318 (D.N.J. 1993) ("If it sees fit, Congress can clarify the scope of ERISA preemption so that litigation of the gray areas . . . may be avoided in the future.").

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

26. *Id.* at 356-58.

tals and MCOs.²⁷ Despite calls for legislative action, Congress has been unsuccessful in passing legislation amending ERISA to better protect health care plan members.²⁸

Courts have the power to interpret the statute to comply with ERISA's goals of employee protection and uniformity. Thus far courts have failed to accomplish these goals because they have interpreted the preemption clause based on the assumption that the health plan is the employee welfare benefit plan, and the health care received is the ERISA benefit. The statutory language and structure, as well as the congressional intent and available legislative history, suggest another valid interpretation: ERISA regulates employer administrative plans that provide for employee health coverage, rather than the health plan itself. The benefit that ERISA guarantees, therefore, is the health plan membership, not the health care. By adopting such a

27. See *infra* Parts II.B.2, III.B.1, & III.B.2.

28. Congress introduced over 30 health care-related federal bills that addressed ERISA preemption, managed care, health insurance, or provider-patient communications in 1997. See, e.g., H.R. 135, S. 143, 105th Cong. (1997) (providing for a minimum hospital stay following mastectomy or lymph node dissection); H.R. 328, S. 89, 105th Cong. (1997) (prohibiting discrimination on the basis of genetic information); H.R. 444, 105th Cong. (1997) (assuring health coverage for workers over 55 years of age who leave employment); H.R. 616, S. 249, 105th Cong. (1997) (defining requirements for coverage surrounding mastectomies); H.R. 617, S. 727, 105th Cong. (1997) (requiring annual screening mammography for women aged 40 and over); H.R. 760, 105th Cong. (1997) (mandating coverage for screening mammograms and Pap smears); H.R. 815, S. 356, 105th Cong. (1997) (assuring access to emergency medical services); H.R. 1222, 105th Cong. (1997) (requiring MCOs to meet certain consumer protection requirements); H.R. 1515, 105th Cong. (1997) (establishing requirements for portability, participation in insurance and access to coverage); H.R. 1525, 105th Cong. (1997) (establishing requirements for prescription drug coverage); H.R. 1737, 105th Cong. (1997) (mandating a specific level of access to OB/GYN services); H.R. 1749, 105th Cong. (1997) (clarifying accountability for violations with respect to managed care plans); H.R. 1854, 105th Cong. (1997) (requiring offer of children-only coverage to dependents); H.R. 2152, 105th Cong. (1997) (requiring coverage for annual screening mammograms); H.R. 2409, S. 1147, 105th Cong. (1997) (requiring provision of nondiscriminatory coverage for substance abuse treatment); H.R. 2525, S. 1208, 105th Cong. (1997) (prohibiting restrictions on contraceptive drugs, services, and devices); H.R. 2532, 105th Cong. (1997) (requiring expanding access to health insurance coverage with pre-existing conditions exclusions); H.R. 2693, S. 1536, 105th Cong. (1997) (requiring coverage for bone mass measurements as appropriate); H.R. 2854, 105th Cong. (1997) (requiring 48 hours health care after delivery following vaginal delivery and 96 hours following cesarean section); H.R. 2967, 105th Cong. (1997) (establishing requirements for managed care); S. 24, 105th Cong. (1997) (providing for access and choice in health care); S. 1307, 105th Cong. (1997) (providing for coverage of benefits for retirees).

Some states have enacted legislation that specifically addresses the ERISA preemption dilemma. See, e.g., MO. REV. STAT. §§ 354.400-551 (1997), amended by H.R. 335, 89th Gen. Assembly, 1st Reg. Sess. (Mo. 1997) (amending state law governing MCOs so as to preclude financial inducements, regulate utilization review procedures and review of adverse benefit determinations, and to arguably open MCOs to liability by eliminating statutory section stating MCOs "not . . . deemed to be practicing medicine"); TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-88.003 (West 1999) (allowing plan members to appeal benefit determinations and imposing liability on MCOs).

statutory construction, ERISA would regulate membership in an employer-provided health plan, assure the "benefit or right" of health plan membership, and preempt only claims for improper administration of the health plan or withdrawal or denial of membership. All medical malpractice claims would be outside of ERISA's scope, providing uniform treatment of direct and vicarious claims, employer-provided and non-employer-provided health care, self-insured and commercial insurance plans, and hospitals and MCOs.

Part II of this Note provides an overview of ERISA, including statutory text and structure, congressional intent, and legislative history. It explores the Supreme Court's attempts to define "employee welfare benefit plan," its jurisprudence of ERISA preemption, from its earlier broad interpretation to its arguably more narrow interpretation today, and its limit on remedies under ERISA. Part III provides an overview of MCO structures and cost-containment measures, as well as theories of MCO liability. It then explores the current division among lower courts in deciding ERISA preemption of medical malpractice claims. Part IV develops an alternative interpretation of ERISA's "employee welfare benefit plan" that views an ERISA plan as the employer's administrative plan providing for employee health coverage.

II. THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

A. *The History and Purpose Behind ERISA*

Congress enacted ERISA after employer mismanagement left thousands of workers and retirees without their pensions.²⁹ Prior to ERISA, these benefit plans had been subject to widespread abuse,³⁰ leaving employees responsible for policing their individual plans³¹ or at risk of losing their benefits.³² Prompted by this mismanagement and the considerable growth in the "size, scope, and numbers of em-

29. See BARBARA J. COLEMAN, PRIMER ON EMPLOYEE RETIREMENT INCOME SECURITY ACT 1, 3 (4th ed. 1993). Although Senator Jacob Javits introduced the bill in 1967, ERISA was not enacted until September 2, 1972, after years of debate. See *id.* Previous measures were apparently insufficient to regulate employee benefit plans. See *id.*; see also U.S. Office of Management and Budget, *Administration of the Employee Retirement Income Security Act: ERISA: A Report to Congress in Fulfillment of Provisions of Section 107 of Reorganization Plan No. 4 of 1978*, at 6-7 (1980).

30. See COLEMAN, *supra* note 29, at 1.

31. See H.R. REP. NO. 93-533, at 4 (1974), reprinted in 1974 U.S.C.C.A.N. 4639, 4642.

32. See COLEMAN, *supra* note 29, at 1, 3.

ployee benefit plans,³³ Congress sought to protect employees by requiring plan disclosure, establishing standards of conduct, and providing employees access to the federal court system.³⁴

ERISA attempted to provide a uniform body of employee benefit law for vesting, funding, insurance, and portability standards.³⁵ It proposed to eliminate conflicting or inconsistent state and local regulation of employee benefit plans,³⁶ and to establish exclusive federal authority for such regulation.³⁷ ERISA also sought to provide appropriate remedies for employees and access to federal courts for all parties.³⁸

In sum, Congress intended both to protect employees from administrative and funding abuses³⁹ and to ensure uniformity of benefit law.⁴⁰ These goals, however, are often in conflict. Congress addressed its first goal by establishing standards for the administration of employee benefit plans and for the operations, termination, and substance of pension plans.⁴¹ Congress dealt with its second goal by recognizing the potential for state interference with the proposed law⁴² and inserting a broad provision that preempts state laws that “relate to any employee benefit plan,” the so-called preemption clause.⁴³

33. ERISA § 2(a), 29 U.S.C. § 1001(a) (1994).

34. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 44 (1987) (citing 29 U.S.C. § 1001(b)).

35. See H.R. REP. NO. 93-533, at 17 (1974), reprinted in 1974 U.S.C.C.A.N. 4639, 4655.

36. See *Pilot Life Ins. Co.*, 481 U.S. at 46.

37. See 120 CONG. REC. 29,197 (1974) (“[T]he crowning achievement of this legislation [is] the reservation to Federal authority the sole power to regulate the field of employee benefit plans.”).

38. ERISA § 2(b), 29 U.S.C. § 1001(b).

39. 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, 358 (1994) (stating that ERISA was intended to “protect employees from administrative and funding abuses while establishing fair vesting requirements for pensions”).

40. See sources cited *supra* notes 36-38.

41. See ERISA §§ 101-1017, 29 U.S.C. §§ 1021-1461 (1994).

42. For a discussion of federalism issues surrounding preemption, see generally Michael K. Carrier, *Federal Preemption of Common Law Tort Awards by the Federal Food, Drug, and Cosmetic Act*, 51 FOOD DRUG L.J. 509 (1996) (discussing the history of federal preemption and its development surrounding “the protection of citizens’ health, safety, and welfare”); Pittman, *supra* note 39, at 380-84 (discussing the evolution of federal preemption jurisprudence related to ERISA preemption).

43. ERISA § 514(a), 29 U.S.C. § 1144(a) (1994). Congress excepted from preemption state laws that regulate insurance (“savings clause”), ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (stating that “nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance”), but specifically prohibited states from deeming an employee benefit plan an insurer for purposes of the savings clause (“deemer clause”), ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (stating that “an employee benefit plan . . . shall [not] be deemed to be an insurance company”).

B. *The Language and Structure of ERISA*

The analysis of ERISA preemption of medical malpractice claims typically involves the remedies clause under section 502 and ERISA's preemption clause in section 514. Although not generally evaluated in these claims, the definition of "employee welfare benefit plan"⁴⁴ in section 3(1) is also crucial to the analysis. Only those claims that "relate to an employee benefit plan" are preempted. Thus, an employee benefit plan must exist for the preemption clause to be implicated.

1. Defining "Employee Welfare Benefit Plan"

ERISA defines an "employee welfare benefit plan"⁴⁵ as "any plan, fund, or program" that an employer establishes or maintains to provide "medical, surgical, or hospital care or benefits" to participants through the purchase of insurance.⁴⁶ The Eleventh Circuit converted this definition into five requisite elements in *Donovan v. Dillingham*:⁴⁷ "(1) a 'plan, fund, or program' (2) established or maintained (3) by an employer . . . (4) for the purpose of providing medical, surgical, [or] hospital care [or] . . . benefits . . . (5) to participants or their beneficiaries."⁴⁸ In developing these criteria, the court stated that a "'plan, fund, or program' . . . implies the existence of intended benefits, intended beneficiaries, a source of financing, and a procedure to apply for and collect benefits," and that "established and maintained" does not require "a formal, written plan."⁴⁹ In its definition, therefore, the Eleventh Circuit included an administrative component—"procedure to apply for and collect benefits"—in the definition of employee welfare benefit plan.

44. ERISA § 3(1), 29 U.S.C. § 1002(1) (1994).

45. While most ERISA preemption cases have focused on whether a state law claim "relate[s] to" an employee benefit plan, some cases have centered on whether the benefit program in question was an employee benefit plan. See, e.g., *Meredith v. Time Ins. Co.*, 980 F.2d 352, 355 (5th Cir. 1993) ("We have devised a comprehensive test for determining whether a particular plan qualifies as an 'employee welfare benefit plan'; we ask whether a plan: (1) exists; (2) falls within the safe-harbor provision established by the Department of Labor; and (3) satisfies the primary elements of an ERISA 'employee benefits plan'—establishment or maintenance by an employer intending to benefit employees."); *Peckham v. Gem State Mut.*, 964 F.2d 1043, 1045 (10th Cir. 1992) (stating that the threshold question was "whether the benefit program at issue [was] an 'employee welfare benefit plan' under" ERISA).

46. ERISA § 3(1), 29 U.S.C. § 1002(1); see also *supra* text accompanying note 19.

47. *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982) (en banc).

48. *Id.* at 1371.

49. *Id.* at 1372.

The Supreme Court addressed the contours of the “plan” definition in *Fort Halifax Packing Co. v. Coyne*.⁵⁰ At issue was a Maine statute requiring a one-time severance payment to employees in the event of a plant closing.⁵¹ The Court held that the statute did not establish or require the employer to maintain an employee welfare benefit plan and was not preempted.⁵² In finding the statute not preempted, the Court undertook a thorough analysis of ERISA’s “employee benefit plan.”⁵³ It reasoned that ERISA focuses “on the administrative integrity of benefit plans, which presumes that some type of administrative activity is taking place.”⁵⁴ Further emphasizing the administrative aspect of ERISA plans, the Court stated that “[o]nly a plan embodies a set of administrative practices vulnerable to the burden that would be imposed by a patchwork scheme of regulation.”⁵⁵ Clearly, the Court contemplated an employee benefit plan encompassing administrative components. This administrative component was the object of Congress’s concern over uniformity; that is, Congress intended the *administration* of employee benefit plans to be uniform.

The Court later explicitly ruled on the issue of whether an employer fund was a “plan” within the meaning of ERISA in *Massachusetts v. Morash*.⁵⁶ Massachusetts had enacted a law requiring employers to pay employees for unused vacation time.⁵⁷ Acknowledging that an employer fund to provide vacation benefits “undoubtedly falls within the scope of [ERISA],” the Court held that the “policy here to pay employees for unused vacation time [did not] constitute[] an employee welfare benefit plan.”⁵⁸ The Court reasoned that the benefits regulated by ERISA “accumulate over a period of time and are payable only upon the occurrence of a contingency outside of the control of the employee.”⁵⁹ The Court also realized that including this procedure in the definition of “plan” would force employers to comply with extensive reporting and disclosure requirements—at the risk of employers discontinuing the practice—and “would vastly expand the jurisdiction of the federal

50. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987).

51. *See id.* at 3-4.

52. *See id.* at 6.

53. *Id.* at 11-12.

54. *Id.* at 15.

55. *Id.* at 11-12.

56. *Massachusetts v. Morash*, 490 U.S. 107 (1989).

57. *See id.* at 114.

58. *Id.*

59. *Id.* at 115-16.

courts.⁶⁰ The Court pointed to the states' traditional regulation of payment of wages (including vacation pay) as further support for its holding.⁶¹

The *Morash* Court's description of covered benefits as those that accumulate over a period of time is supported by ERISA's reference to the Labor Management Relations Act ("LMRA").⁶² ERISA defines an employee welfare benefit plan as a plan established by employers through the purchase of insurance to provide medical, surgical, or hospital care or benefits and any benefit described in section 302(c) of the LMRA.⁶³ The LMRA in relevant part refers to situations in which payments are held in trust to pay "for the benefit of employees . . . for medical or hospital care."⁶⁴ This statute, therefore, refers to situations where the employer holds funds to subsequently provide for the employees' benefit. Thus, the LMRA supports *Morash's* definition of an ERISA benefit as one accumulating for distribution, and the definition of an ERISA plan as employer administration for the benefit of employees.

In sum, *Morash*, *Fort Halifax*, and ERISA's reference to the LMRA all suggest that the employee benefit plans regulated by ERISA include administrative practices, and that the benefits protected "accumulate over a period of time." In other words, ERISA regulates employer administration of accumulated benefits. Given this parameter, a health plan could not be considered an ERISA plan because a health plan does not incorporate employer administration, nor does health coverage accumulate for subsequent distribution. Specifically, in the context of health plans, employers provide the administrative and financial support for employee health plans; MCOs, on the other hand, either provide the health care directly or indirectly by administering the employee health plan.⁶⁵ The employer's role, therefore, is to provide administrative support for the

60. *Id.* at 118-19.

61. *See id.* at 119.

62. The Labor Management Relations Act, 1947, 29 U.S.C. §§ 141-188 (1994), is commonly referred to as the Taft-Hartley Act.

63. ERISA § 3(1), 29 U.S.C. § 1002(1) (1994). *See supra* note 19 for full statutory text.

64. 29 U.S.C. § 186(c)(5)(A) (1994).

65. In order to escape the regulatory burdens of state law and state taxes applicable to health insurers, most large employers have self-insured their employees' health benefits utilizing third-party administrators ("TPAs") or insurance companies providing administrative services only ("ASO"). *See* CLARK C. HAVIGHURST ET AL., HEALTH CARE LAW AND POLICY: READINGS, NOTES, AND QUESTIONS 67 (2d ed. 1998). Self-insured plans, representing "approximately 70% of the roughly 160 million Americans covered by employer-sponsored health plans," *id.*, typically "employ[] an insurer or HMO to administer the plan under an [ASO] contract," *id.* at 219.

employee health plan, not to administer the health plan itself. The ERISA plan, and its requisite administrative component, must be the employer's administrative infrastructure providing for the employee health plan, rather than the health plan itself.

2. Section 514: ERISA Preemption

Provided for in section 514(a), ERISA preemption⁶⁶ is a federal defense to state law claims, originally intended to promote uniformity in the federal regulation of benefit law.⁶⁷ This preemption provision provides for the replacement of state law by ERISA when a state law claim "relate[s] to any employee benefit plan."⁶⁸

The analysis of whether ERISA preempts medical malpractice claims against MCOs is limited to ERISA section 514(a),⁶⁹ and does not reach⁷⁰ the savings clause in section 514(b)(2)(A)⁷¹ or the deemer clause in section 514(b)(2)(B).⁷² The dispositive analysis is whether a cause of action "relate[s] to any employee benefit plan."⁷³

66. This term is also known as substantive, conflict, or federal preemption. ERISA preemption is distinguishable from complete preemption, a jurisdictional doctrine providing for removal jurisdiction for otherwise non-federal claims when the federal defense of preemption is asserted. The complete preemption doctrine was first recognized in *Avco Corp. v. Aero Lodge No. 735, Int'l Ass'n of Machinists*, 390 U.S. 557, 561 (1968), and applies when the force of the federal statutory preemption is sufficiently powerful so as to displace a state cause of action addressed by the federal statute. See *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64 (1987) (stating that "Congress may so completely preempt a particular area that any civil complaint raising this select group of claims is necessarily federal in character"). Complete preemption in ERISA can be understood as an exception to the well-pleaded complaint rule, allowing removal to federal courts when the federal defense of ERISA preemption is raised in actions detailed in ERISA section 502(a)(1)(B)—to recover benefits, or enforce or clarify rights. See generally Karen A. Jordan, *The Complete Preemption Dilemma: A Legal Process Perspective*, 31 WAKE FOREST L. REV. 927 (1996) (discussing complete preemption); see also Robert A. Cohen, Noto, *Understanding Preemption Removal Under ERISA § 502*, 72 N.Y.U. L. REV. 578 (discussing the process of "preemption removal"). Because removal jurisdiction is based on ERISA preemption as a federal defense, the analyses of complete preemption and ERISA preemption often become intertwined. Several cases have attempted to clarify the complete preemption/ERISA preemption distinction. See, e.g., *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1487-88 (7th Cir. 1996); *Rice v. Panchal*, 65 F.3d 637, 639-42 (7th Cir. 1995); *Warner v. Ford Motor Co.*, 46 F.3d 531, 533 (6th Cir. 1995).

67. See *supra* Part II.A.

68. ERISA § 514(a), 29 U.S.C. § 1144(a) (1994).

69. *Id.*

70. See, e.g., *O'Reilly v. Ceuleers*, 912 F.2d 1383, 1389 (11th Cir. 1990) (holding that MCOs are not engaged in the business of insurance for the purposes of applying ERISA's preemption provision, making the savings (§ 514(b)(2)(A)) and deemer clauses (§ 514(b)(2)(B)) irrelevant to the ERISA preemption analysis of state law claims against MCOs).

71. See *supra* note 43 and accompanying text.

72. See *supra* note 43.

73. ERISA § 514(a), 29 U.S.C. § 1144(a). There has been limited litigation over the definition of "plan" as applied to ERISA's preemption clause. Instead, the vast majority of

The development of the current preemption clause in section 514 is difficult to describe.⁷⁴ The original ERISA bill contained a limited preemption clause, applicable only to state laws relating to specific subjects covered by ERISA.⁷⁵ The House bill would have preempted only those state laws that "relate to" funding and benefits vesting provisions of pension plans and those that "relate to the reporting and disclosure responsibilities and fiduciary responsibilities."⁷⁶ The Senate bill would instead have preempted state laws that "relate to the subject matters regulated by this Act."⁷⁷ Congress, however, hoped to eliminate controversy over interpretation by making the language broad and simple.⁷⁸ The Conference Committee abandoned these attempts in favor of the statute's current broad "relate to" language with little explanation.⁷⁹

Despite Congress's hope that the broad language would eliminate controversy, lower courts struggle to decide whether ERISA preempts direct and vicarious liability claims. The Supreme Court, although silent on the issue of ERISA preemption of medical malpractice claims, has made attempts to clarify the broad language of ERISA's preemption clause.

Early Supreme Court decisions asserted an expansive interpretation of ERISA's ambiguous "relate to" language, leaving a wide variety of state claims within ERISA's reach. The Court initially defined "relate to" as a "connection with or reference to" an ERISA plan,⁸⁰ offering little guidance for applying this standard. The Court has, however, applied this standard to hold preempted state statutes such as anti-discrimination laws,⁸¹ an anti-garnishment act,⁸² an anti-

medical malpractice claims against MCOs have hinged on an evaluation of whether the cause of action "relate[s] to" an ERISA plan under section 514(a). *See, e.g.*, cases cited *infra* notes 147, 151, 163-71.

74. *See, e.g.*, Jay Conison, *ERISA and the Language of Preemption*, 72 WASH. U. L.Q. 619, 646-48 (1994) (discussing the inability to understand the development of ERISA's preemption clause based on legislative history).

75. *See id.* at 646-47.

76. 120 CONG. REC. 4742 (1974).

77. *Id.* at 5002.

78. *See id.* at 29,942.

79. *See* H.R. CONF. REP. NO. 93-1280, at 125 (1974), *reprinted in* 1974 U.S.C.C.A.N. 5038, 5162; *see also* Conison, *supra* note 74, at 646-47; Fisk, *supra* note 17, at 53 (noting that the change appears to have been related to a desire to prohibit prepaid legal services plans).

80. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983) (holding two New York laws forbidding employee benefit discrimination on the basis of pregnancy preempted by ERISA insofar as they pertained to ERISA plans).

81. *See id.* at 88. The Human Rights Law prohibited discrimination in employment, including employee benefits, on the basis of pregnancy. The State's Disability Benefits Law required employers to pay sick-leave benefits to employees unable to work due to pregnancy. *See id.* at 88-90.

subrogation statute,⁸³ and a statute requiring equity in workers' compensation benefits,⁸⁴ as well as actions such as a wrongful discharge claim⁸⁵ and improper processing of claims for benefits.⁸⁶ These cases resulted in the preemption of claims that had only an indirect effect on ERISA plans and those "not specifically designed to affect [ERISA] plans."⁸⁷ The breadth of the Court's interpretation raised the question of the extent of ERISA's preemptive reach.

The Court attempted to limit the "connection with or reference to" standard by holding that claims with a "tenuous, remote, or peripheral" connection with the plan were not preempted.⁸⁸ As with the "connection with or reference to" standard, however, the Court has provided little guidance for determining the claims that fall under this exception.⁸⁹ Despite this attempt to limit the reach of "relate to" language, it was not until *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance* that the Court arguably restricted its interpretation of the "relate to" language.⁹⁰

The New York statute at issue in *Travelers Insurance* in effect charged different hospital rates for commercial insurance plan and MCO participants than it did for Blue Cross & Blue Shield participants.⁹¹ Recognizing the limited usefulness of the statutory text, the Court looked to the statutory intent to determine the scope of pre-

82. See *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 829 (1988) (holding a Georgia statute proscribing garnishment of employee benefits preempted because the statute applied exclusively to ERISA plans).

83. See *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) (holding that a Pennsylvania statute prohibiting employee benefit plans from subrogating a claimant's tort recovery following injury "related to" ERISA plans and was, therefore, preempted).

84. See *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 126-27 (1992) (holding a District of Columbia statute requiring employers who provide employee health insurance to also provide comparable worker's compensation benefits preempted because it referred to ERISA plans as a baseline).

85. See *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990) (holding respondent's claim preempted because it was predicated on his subscription to an employee benefit plan).

86. See *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 60, 62-63 (1987) (refining *Pilot Life's* holding by stating that not only are such claims preempted by ERISA, but they are "also displaced by ERISA's civil enforcement provision"); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57 (1987) (holding state law causes of action for improper processing of benefit claims preempted).

87. *Ingersoll-Rand Co.*, 498 U.S. at 139.

88. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 n.21 (1983).

89. See, e.g., *Greater Wash. Bd. of Trade*, 506 U.S. at 130 n.1 (cautioning that many laws of general applicability have such a relationship but giving no further indication of how to best determine "tenuousness").

90. *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Ins.*, 514 U.S. 645, 649 (1995) (holding a New York hospital rate-setting statute that subjected commercial insurance and MCO participants—but not Blue Cross & Blue Shield plan participants—to a surcharge was not preempted).

91. *Id.*

emption.⁹² Ultimately, however, a unanimous Court decided the case based on ERISA's "unhelpful text," once again applying the "connection with or reference to" standard.⁹³ Specifically addressing the economic effect of the New York statute, the Court stated that the differential rates would only indirectly affect what an ERISA plan could afford, and that the mere indirect economic effect did not satisfy the "relate to" threshold.⁹⁴ In so holding, the Court arguably raised the threshold for ERISA preemption.⁹⁵

Although based on ERISA's statutory text, *Travelers Insurance* included a discussion of preemption in general. The Court stated that there is a presumption against federal preemption of a "state action in fields of traditional state regulation."⁹⁶ Discussing the field of regulation at issue, the Court stated that "nothing in the language of [ERISA] or in the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern."⁹⁷ Further exploring the issue of preemption and field of regulation, the Court found that, because "quality control" efforts were deemed to only indirectly affect ERISA plans,⁹⁸ they were not subject to ERISA preemption.⁹⁹

Although the Supreme Court's jurisprudence does not lead to clearly articulable principles, several relevant themes do exist. State laws that directly regulate the employer-employee relationship¹⁰⁰ and those that relate to the administration of employer-provided benefit

92. See *id.* at 656 ("We simply must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.").

93. *Id.*

94. See *id.* at 661 (citing the "tenuousness" exception from preemption in *Greater Washington Board of Trade*, 506 U.S. at 130 n.1). The Court did not, however, state that an indirect economic effect can *never* trigger preemption.

95. Subsequent cases have confirmed *Travelers Insurance's* narrower interpretation of "relate to." See *DeBuono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 809 (1997) (holding that ERISA's preemption clause did not reach a New York gross receipts tax on ERISA-funded medical centers); *California Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 319 (1997) (holding that a California wage law did not "relate to" ERISA plans and was not preempted).

96. *Travelers Ins.*, 514 U.S. at 655 (citations omitted).

97. *Id.* at 661.

98. *Id.*

99. This finding raises questions as to whether medical malpractice claims could be characterized as "quality control" efforts, thereby avoiding ERISA preemption.

100. See, e.g., *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) (holding anti-subrogation state law preempted); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 (1983) (holding state laws prohibiting employer discrimination preempted).

plans¹⁰¹ are preempted. In contrast, state laws that regulate the substance of employee welfare benefit plans are not preempted.¹⁰² Considering these themes, the Court's interpretation of ERISA preemption arguably contemplates federal regulation of the administrative aspects of employer-provided benefit plans, but not the substance of these plans. This, then, supports the proposition that ERISA regulates employer administration, which precludes an interpretation of a health plan as the ERISA plan.

3. Section 502: Remedies Under ERISA

Congress set forth the remedies allowed under ERISA in section 502.¹⁰³ Section 502(a)(1) allows plan participants to bring civil actions to recover benefits due, enforce rights under the plan, or clarify rights to future benefits.¹⁰⁴ Participants may also seek "other appropriate equitable relief" under section 502(a)(3)(B).¹⁰⁵

The Supreme Court has held that the civil enforcement remedies enumerated in section 502 are the exclusive remedies available under ERISA.¹⁰⁶ Interpreting the statutory enforcement scheme as "strong evidence that Congress did not intend to authorize other remedies,"¹⁰⁷ the Court has denied the award of extra-contractual damages¹⁰⁸ under section 502(a)(3).¹⁰⁹ The Court reasoned that allow-

101. *See, e.g.*, *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 60, 62-63 (1987) (state causes of action for improper processing of claims preempted); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57 (1987) (same).

102. *See, e.g.*, *Massachusetts v. Morash*, 490 U.S. 107, 114 (1989) (state law requiring payment for unused vacation time not preempted); *Fort Halifax Packing Co., v. Coyne*, 482 U.S. 1, 11-12 (1987) (state law requiring a one-time severance payment not preempted).

103. ERISA § 502, 29 U.S.C. § 1132 (1994).

104. ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B); *see also supra* notes 6, 9-10 and accompanying text.

105. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3). "A civil action may be brought . . . (3) by a participant . . . (B) to obtain other appropriate equitable relief . . ." *Id.* at § 1132(a)(1), (3).

106. *See Pilot Life Ins. Co.*, 481 U.S. at 52 n.3, 54. The Court reached this decision despite prior cases in which it had allowed recovery of damages because it was "difficult to believe that Congress would, without comment, remove all means of judicial recourse for those injured by illegal conduct." *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 251 (1984) (allowing punitive damages for claims resulting from a plutonium escape from a federally licensed nuclear facility).

107. *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146-47 (1985) (holding that a cause of action for extra-contractual damages under ERISA § 409(a), 29 U.S.C. § 1109(a) (1994) (breach of fiduciary duty), could not be asserted by a plan beneficiary under ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2), because damages are not available).

108. Extra-contractual damages include damages outside of a benefit plan, such as compensatory, consequential, and punitive damages. *See Drinkwater v. Metropolitan Life Ins. Co.*, 846 F.2d 821, 824 (1st Cir. 1988).

109. *See, e.g.*, *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 257-58 (1993) (holding that "equitable relief" under section 502(a)(3)(B) precludes awarding damages).

ing various state law remedies to supplement ERISA's civil enforcement remedies would undermine ERISA's goal of uniform regulation of benefit plans.¹¹⁰ The rights and benefits delineated in a benefit plan are thus the only remedies available for civil actions under section 502.

Federal courts have also consistently held that punitive damages are not recoverable as "other appropriate equitable relief" under section 502(a)(3).¹¹¹ Because plan participants and beneficiaries are limited to the rights and benefits due under a benefit plan,¹¹² medical malpractice claims preempted by ERISA offer no extra-contractual damages.

Several courts have noted that, while ERISA was intended to protect the interests of employees, it has often denied these workers an adequate remedy.¹¹³ Plaintiffs with medical malpractice claims have often been limited to plan benefits even when damages were justified.¹¹⁴ While courts have lamented the injustice and called for congressional action,¹¹⁵ they have often followed precedent and denied

110. See *Pilot Life Ins. Co.*, 481 U.S. at 54.

111. See, e.g., *Pane v. RCA Corp.*, 868 F.2d 631, 635 (3rd Cir. 1989); *Drinkwater*, 846 F.2d at 824; *Sage v. Automation, Inc. Pension Plan & Trust*, 845 F.2d 885, 888 n.2 (10th Cir. 1988); *Bishop v. Osborn Transp., Inc.*, 838 F.2d 1173, 1173-74 (11th Cir. 1988); *Varhola v. Doe*, 820 F.2d 809, 817 (6th Cir. 1987); *Kleinhaus v. Lisle Sav. Profit Sharing Trust*, 810 F.2d 618, 627 (7th Cir. 1987); *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enters., Inc.* 793 F.2d 1456, 1462-65 (5th Cir. 1986); *Hancock v. Montgomery Ward Long Term Disability Trust*, 787 F.2d 1302, 1306-07 (9th Cir. 1986); *Powell v. Chesapeake and Potomac Tel. Co.*, 780 F.2d 419, 424 (4th Cir. 1985); *Dependahl v. Falstaff Brewing Corp.*, 653 F.2d 1208, 1216-17 (8th Cir. 1981). *But see* *Weems v. Jefferson-Pilot Life Ins. Co.*, 663 So. 2d 905, 914 (Ala. 1995) (affirming a lower court holding that state law claims were preempted by ERISA but reversing its holding that ERISA denies punitive or extra-contractual damages).

112. See ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) (1994).

113. See, e.g., *Tolton v. American Biodyne, Inc.*, 48 F.3d 937, 943 (6th Cir. 1995) ("One consequence of ERISA preemption . . . is that plan beneficiaries . . . bringing certain types of state actions . . . may be left without a meaningful remedy."); *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp., 49, 59 (D. Mass. 1997) ("[I]n the managed care context, the wrongful denial of benefits by an insurer . . . can lead to damages far beyond the out-of-pocket cost of the treatment at issue [I]f a beneficiary never receives treatment because of the insurer's failure to pre-approve, ERISA leaves him without any meaningful remedy."). *But see* *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1333 (5th Cir. 1992) ("[T]he lack of an ERISA remedy does not affect a pre-emption [*sic*] analysis."); *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272, 1276 (6th Cir. 1991) ("Nor is it relevant to an analysis of the scope of federal preemption that appellants may be left without remedy.")

114. See, e.g., *Corcoran*, 965 F.2d at 1338 ("The result ERISA compels us to reach means that the [plaintiffs] have no remedy, state or federal, for what may have been a serious mistake."). Other courts have taken the lack of remedy into account in determining ERISA preemption. See, e.g., *Pappas v. Asbel*, 675 A.2d 711, 718 (Pa. Super. Ct. 1996) ("We, too, do not believe that Congress can have intended, prior even to invention of the cost containment system [of MCOs], to foreclose recovery to plan beneficiaries injured by negligent medical decisions.")

115. See, e.g., cases cited *supra* notes 113-14.

damages to deserving plaintiffs, leaving some injured employees without a remedy.¹¹⁶

III. ERISA PREEMPTION OF MEDICAL MALPRACTICE CLAIMS

A. *Liability in the World of Managed Care*

1. Managed Care Organizations: Structure and Cost-Containment

The traditional health care delivery system has utilized a “fee-for-service” payment system. Under fee-for-service, the health care provider offers services to the patient and receives payment for these services from a third-party payor, the patient’s insurer. Because the patient is effectively insulated from the cost of the services and the provider receives payment only for providing services, there is arguably an incentive for greater provision of health care services—more services and more costly services.¹¹⁷

As health care costs have risen, traditional fee-for-service has given way to a system of managed care.¹¹⁸ In contrast to the tradi-

116. See, e.g., *Cromwell*, 944 F.2d at 1276 (disregarding the fact that “appellants [were] left without remedy”); see also *Andrews-Clarke*, 984 F. Supp. at 60 (“This Court can neither simply disregard its sworn oath to comply with the opinions of the Supreme Court, nor can it legislate by judicial decree nor apply a statute, such as ERISA, other than as drafted by Congress.” (quoting *Turner v. Fallon Community Health Plan, Inc.*, 953 F. Supp. 419, 424 (D. Mass. 1997))).

117. For a discussion of this phenomenon, see Clark C. Havighurst & James F. Blumstein, *Coping with Quality/Cost Trade-Offs in Medical Care: The Role of PSROs*, 70 NW. U. L. REV. 6, 15-20 (1975).

118. From 1993 to 1997, the enrollment of American workers in MCO plans rose from 52% to 85%. See Ron Winslow, *Health-Care Inflation Kept in Check Last Year*, WALL ST. J., Jan. 20, 1998, at B1.

Enacted in the days of traditional fee-for-service insurance, ERISA has never been amended by Congress to keep pace with the transition to managed care. Recent federal legislation has attempted to address this apparent lag. See, e.g., Health Insurance Portability and Accountability Act of 1996, 29 U.S.C. § 1181 (1994 & Supp. 1996) (attempting to limit exclusion from insurance plans based on pre-existing conditions); Newborns’ and Mothers’ Health Protection Act of 1996, 29 U.S.C. § 1185 (1996) (establishing standard benefits for mothers and newborns); Mental Health Parity Act of 1996, 29 U.S.C. § 1185(a) (1994 & Supp. 1996) (ensuring parity in the application of limits to mental health benefits).

States have also attempted to address concerns over managed care. In the first six months of 1997, nearly 1,000 bills addressing various managed care issues were introduced across the states. See Milt Freudenheim, *Pioneering State for Managed Care Considers Change*, N.Y. TIMES, July 14, 1997, at A1. For a discussion of earlier state attempts, see Milt Freudenheim, *H.M.O.’s Cope with a Backlash on Cost Cutting*, N.Y. TIMES, May 19, 1996, at A1 (stating that 34 states had enacted laws that limit managed care in the preceding 18 months), and Leigh Page,

tional fee-for-service payment system that separates health care providers and third-party payors, managed care integrates health care financing and delivery through contracts with physicians and hospitals to provide "comprehensive health care services to enrolled members for a predetermined . . . premium."¹¹⁹ MCOs, functioning as payors, are financially at risk for the health care costs of their enrollees. To decrease this financial risk, MCOs typically use capitation payment methods—a fixed monthly per-capita payment—and employ a variety of cost-containment measures, such as utilization review, pre-authorization requirements, the use of primary care provider "gatekeepers," limitations in choice of providers, and provider financial incentives.¹²⁰ With the pre-set capitated payment system to cover all provided services, there are arguably incentives to provide fewer and/or less costly services in managed care.¹²¹

To fully recognize the impact and functioning of cost-containment measures—as well as potential exposure to liability—it is important to understand the structure of MCOs. The most familiar of the MCOs is the Health Maintenance Organization ("HMO"), "an organized system of health care which provides or arranges for a comprehensive array of basic and supplemental health care services."¹²² The HMO contracts both with health care providers to provide health care services to its enrollee patients, and with enrollees to pre-pay per-capita premiums. Through these contractual relationships, the HMO "both insures for the cost and provides for the

State Legislators Spent Busy Year Trying to Manage Managed Care, AM. MED. NEWS, Sept. 9, 1996, at 3 (stating that 35 states had enacted laws involving managed care).

For a general discussion of the emergence of and issues related to managed care, see Daniel N. Burton & Micheal S. Popok, *Managed Care 101*, FLA. B.J. Apr. 1998, at 26. See also James F. Henry, Comment, *Liability of Managed Care Organizations After Dukes v. U.S. Healthcare: An Elemental Analysis*, 27 CUMB. L. REV. 681, 685-88 (1996-97) (describing the current structure of the managed care industry); Edward P. Richards & Thomas R. McLean, *Physicians in Managed Care*, 18 J. LEGAL MED. 443, 444-50 (1997) (describing the changing role of physicians with the advent of managed care).

119. John K. Iglehart, *Health Policy Report: Physicians and the Growth of Managed Care*, 331 NEW ENG. J. MED. 1167, 1167-70 (1994). The American Medical Association defines managed care as: "[T]he control of access to and limitation on physician and patient utilization of services by public or private payers or their agents through the use of prior and concurrent review for approval of or referral to service or site of service, and financial incentives or penalties." J.K. Iglehart, *Health Policy Report: The American Health Care System*, 326 NEW ENG. J. MED. 962, 965 (1992).

120. For a discussion of methods by which MCOs manage costs, see Ila S. Rothschild et al., *Recent Developments in Managed Care*, 32 TORT & INS. L.J. 463, 463-68 (1997).

121. For a discussion of the cost-containment aspects of managed care, see MacDougall, *supra* note 7, at 891-96. See also Pittman, *supra* note 39, at 361-62 (1994) (describing cost-containment in managed care); Rothschild et al., *supra* note 120, at 463-68 (1997) (discussing methods for cost-containment in managed care).

122. *Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229, 1230 n.1 (Pa. Super. Ct. 1988).

delivery of health care services” to its enrollees;¹²³ the health care provider provides services to the patient and the HMO pays the health care provider a negotiated capitated payment.

There are several types of HMOs in operation: the Staff Model HMO, the Group Model HMO, the Network Model HMO, and the Individual Practice Associations (“IPAs”). The structure of the HMO dictates the relationship of the HMO to the physician, and is, therefore, often determinative in the imposition of liability. The Staff Model HMO employs its own physicians and owns the medical facility.¹²⁴ Because the physicians are HMO staff, an employer-employee relationship exists and the HMO is susceptible to a respondeat superior claim for physician malpractice. A Group Model HMO contracts with a group of physicians—rather than individual physicians—to provide care to its enrollees.¹²⁵ There is no employer-employee relationship with the group model, and the medical group often provides services to private fee-for-service patients in addition to their HMO enrollees. Network Model HMOs are similar to group models, but instead contract with several medical groups to provide services rather than with one group.¹²⁶ Like the group model, network model physicians are compensated with capitated payments for their HMO enrollees, but retain the ability to provide services to private fee-for-service patients. In an IPA Model HMO, the HMO contracts with an IPA, a legal entity consisting of a partnership or corporation of physicians.¹²⁷ The IPA, in turn, contracts with its independent physicians to provide services to plan enrollees.¹²⁸ While the IPA is paid a capitated rate by the HMO, the individual physicians are paid on a fee-for-service basis.¹²⁹

Other types of MCOs include the Preferred Provider Organization (“PPO”) and Point of Service (“POS”) plans. A PPO is a “health care delivery model in which physicians, hospitals, and/or other providers of health care contract to administer their services on

123. Bearden & Maedgen, *supra* note 7, at 289.

124. For a full description of the Staff Model HMO, see Bearden & Maedgen, *supra* note 7, at 292; L. Frank Coan, Jr. Note, *You Can't Get There From Here—Questioning the Erosion of ERISA Preemption in Medical Malpractice Actions Against HMOs*, 30 GA. L. REV. 1023, 1028 (1996); DiCicco, *supra* note 7, at 503-04; MacDougall, *supra* note 7, at 865.

125. For a full description of the Group Model HMO, see Bearden & Maedgen, *supra* note 7, at 292-93; Coan, *supra* note 124, at 1028-29; DiCicco, *supra* note 7, at 504-05; MacDougall, *supra* note 7, at 865-66.

126. For a full description of the Network Model HMO, see DiCicco, *supra* note 7, at 505; MacDougall, *supra* note 7, at 866.

127. See Coan, *supra* note 124, at 1029.

128. See *id.*

129. See Bearden & Maedgen, *supra* note 7, at 293.

a predetermined fee-for-service basis to a defined group of patients."¹³⁰ Like traditional fee-for-service plans, enrollees pay a premium to the PPO, which then reimburses the health care providers for services provided,¹³¹ typically at a reduced rate.¹³² PPO physicians are independent contractors who may maintain their own private practice and may also participate in more than one PPO.¹³³ Similar to the PPO, the POS plan has greater emphasis on controlling costs, offering greater coverage for enrollees who stay within the plan for services than for those who seek care outside of the plan.¹³⁴

Although the various types of MCOs differ in structure, they all have a similar focus on controlling costs. In addition to limiting costs through capitated payment systems, MCOs utilize various cost-containment methods to reduce health care costs. A common practice in controlling costs is utilization review ("UR")—a determination of whether a service is medically necessary and appropriate.¹³⁵ By refusing payment for services not deemed medically necessary, the HMO acts as "rationer" of medical services, effectively reducing health care costs.¹³⁶ While UR is generally "based on 'established clinical criteria' . . . to evaluate the quality and appropriateness of medical care,"¹³⁷ there is concern about the intrusion of a third-party payor into a provider's medical decision making—a concern only somewhat alleviated by potential MCO liability for negligent refusal of medically necessary services. Pre-authorization (or pre-certification) functions in a similar manner to UR. MCOs often require prospective authorization be obtained prior to the provision of services, particularly for costly services.¹³⁸ Such authorization processes are common requirements for hospital admissions and emergency room care. By refusing

130. John Lewis Smith III & Lawrence L. Lamade, *Preferred Provider Plans Break New Legal Ground*, LEGAL TIMES, Nov. 21, 1983, at 27.

131. See Catherine Butler, *Preferred Provider Organization Liability for Physician Malpractice*, 11 AM. J.L. & MED. 345, 346 (1985).

132. See Bearden & Maedgen, *supra* note 7, at 297; Rothschild et al., *supra* note 120, at 464.

133. See Bearden & Maedgen, *supra* note 7, at 298.

134. See Rothschild et al., *supra* note 120, at 465.

135. See Pittman, *supra* note 39, at 362. For a discussion of the types of UR, see Burton & Popok, *supra* note 118, at 30.

136. See Pittman, *supra* note 39, at 363.

137. David D. Griner, Note, *Paying the Piper: Third-Party Payor Liability for Medical Treatment Decisions*, 25 GA. L. REV. 861, 883-85 (1991).

138. See Burton & Popok, *supra* note 118, at 30 (describing prospective certification); Rothschild et al., *supra* note 120, at 464 (describing health plan requirement for approval prior to rendering services). For cases involving pre-authorization, see *Spain v. Aetna Life Insurance Co.*, 11 F.3d 129, 131 (9th Cir. 1993) (involving withdrawal of authorization of surgery) and *Kuhl v. Lincoln National Health Plan*, 999 F.2d 298, 300 (8th Cir. 1993) (involving delay in pre-certification for surgery).

payment for services not deemed medically necessary, the MCO can maintain greater control over health care costs. Again, attempting to reduce services not deemed medically necessary, MCOs often employ primary care provider “gatekeepers.” These health care providers serve to minimize the inappropriate use of specialists by evaluating the appropriateness of a patient’s referral.¹³⁹ Provider financial incentives are often coupled with the use of “gatekeepers.” MCOs often offer providers financial incentives to restrict services to those deemed absolutely necessary.¹⁴⁰

These MCO cost-containment measures arguably compromise provider autonomy and medical decision making—as well as quality of care.¹⁴¹ There is, therefore, an argument that MCOs should be held liable for the results of these cost-containment measures and the actions of affiliated physicians working under the cost-conscious guidelines imposed by MCOs.¹⁴²

2. Theories of Managed Care Liability

Injured patients often seek tort recovery from MCOs for their actions and for the actions of affiliated physicians. Claims based on direct actions of MCOs are direct liability claims, and those based on the actions of an affiliated physician are vicarious liability claims.

Hospital liability for corporate negligence—imposing a duty on hospitals to supervise staff physicians and monitor quality of patient

139. See Rothschild et al., *supra* note 120, at 464-65. For cases involving UR, see *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995) (involving UR organization’s failure to authorize hospitalization) and *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992) (involving UR organization’s denial of hospitalization).

140. For a case involving a physician’s failure to disclose a financial incentive program, see *Shea v. Esensten*, 107 F.3d 625, 627 (8th Cir. 1997), *cert. denied*, 522 U.S. 914 (1997) (involving physician’s financial incentive to minimize referrals).

141. See, e.g., Stephen R. Latham, *Regulation of Managed Care Incentive Payments to Physicians*, 22 AM. J.L. & MED. 399, 407-11 (1996) (raising concern that physician incentive payments may result in a lower standard of care); John E. Ware, Jr. et al., *Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems: Results From the Medical Outcomes Study*, 276 JAMA 1039, 1042 (1996) (describing health outcomes for specific patient groups as worse among HMOs than among fee-for-service plans). *But see* Paul M. Ellwood, Jr. & George D. Lundberg, *Managed Care: A Work in Progress*, 276 JAMA 1083, 1085 (1996) (stating that there is “no objective evidence of any overall decline in the quality of care in the new system”).

142. Many scholars suggest the imposition of liability on specific parties serves to improve quality. See, e.g., GUIDO CALABRESI, *THE COSTS OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS* 135-73 (1970) (suggesting targeting those parties in the best position to control quality and assigning them liability).

care—is a relatively recent occurrence.¹⁴³ The justifications for imposing corporate liability on hospitals include the public perception of hospitals as responsible for the care provided, their unique position in monitoring physicians, and the creation of incentives for hospitals to insure staff competency.¹⁴⁴ MCOs, like hospitals, provide health care coverage, select health care providers, and are capable of monitoring the quality of care. MCOs are, therefore, potentially susceptible to direct liability claims.¹⁴⁵ These claims include negligent supervision or selection of health care providers, utilization review practices, and cost-containment measures.¹⁴⁶ But, despite the similarities between the functioning of MCOs and hospitals, ERISA preemption serves to immunize the MCOs from direct liability claims.

Vicarious claims against MCOs for the negligence of physicians are based on either a respondeat superior or ostensible (apparent) agency theory.¹⁴⁷ Under the theory of respondeat superior, the MCO employer is liable for the negligence of the employee physician.¹⁴⁸ Respondeat superior, therefore, is only applicable in the case of Staff Model HMOs. The theory of ostensible, or apparent, agency involves situations in which a principal MCO represents or creates the appearance that the independent contractor physician is an agent, a third-party patient reasonably relies on the representation or appearance, and the physician's negligence results in harm.¹⁴⁹ Claims under ostensible agency, therefore, can occur in any type of MCO utilizing independent contractor physicians. Courts are currently divided on the issue of whether ERISA preempts vicarious liability claims.

B. Courts Interpret ERISA Preemption

Because the Supreme Court has never specifically spoken to the issue of medical malpractice and ERISA preemption, federal

143. See, e.g., *Darling v. Charleston Community Mem'l Hosp.*, 211 N.E.2d 253, 257 (Ill. 1965) (rejecting the traditional view that hospitals do not undertake to treat patients and imposing a duty on hospitals to supervise physicians and monitor quality of care).

144. See BARRY R. FURROW ET AL., *HEALTH LAW* 467-70 (1995). Some scholars advance the role of enterprise liability and nondelegable duty in medical malpractice liability of MCOs. See, e.g., Clark C. Havighurst, *Making Health Plans Accountable for the Quality of Care*, 31 GA. L. REV. 587, 615-18 (1997).

145. See MacDougall, *supra* note 7, at 880.

146. See *id.* at 881-96.

147. See, e.g., *Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229, 1231-35 (Pa. Super. Ct. 1988) (extending ostensible agency theory to the MCO context and delineating criteria with which to determine the relationship).

148. See RESTATEMENT (SECOND) OF AGENCY § 219 (1958).

149. See *id.* § 267.

courts have struggled to interpret and appropriately apply seemingly inconsistent Supreme Court precedent in the context of medical malpractice. The Supreme Court's lack of clarity in ERISA preemption cases and its historically broad interpretation of the preemption provision has provided little guidance for the lower courts. Apart from the medical malpractice realm, federal courts have attempted to establish guidelines to assist in interpreting and applying the ERISA preemption provision.¹⁵⁰ Within the context of medical malpractice, however, there have been few guidelines regarding ERISA preemption.

1. ERISA Preempts Direct Liability Claims

Most courts have agreed that ERISA preempts causes of action against MCOs that relate directly to the administration of claims or benefits under an ERISA plan.¹⁵¹ The courts have preempted such claims based on a statutory interpretation assuming that the ERISA plan is the health insurance plan, with the "benefit" under the plan being the health care itself. In holding such claims preempted, courts have focused on the role of MCOs and UR providers as "arrangers" of delivery of care—rather than as health care providers themselves—as well as the real need for MCOs to make certain decisions regarding health plan administration.

In *Corcoran v. United Healthcare, Inc.*, the Fifth Circuit held that a wrongful death action against a UR organization was preempted by ERISA.¹⁵² In analyzing the malpractice claim for the death of plaintiffs' unborn child following denial of authorization for hospitalization, the court wrestled with the question of whether the UR organization made medical decisions or benefit determinations.¹⁵³ The court ultimately found that UR organizations make medical decisions "in the context of making a determination about the

150. See, e.g., *Arkansas BC & BS v. St. Mary's Hosp., Inc.*, 947 F.2d 1341, 1244-45 (8th Cir. 1991); *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550, 555-58 (6th Cir. 1987); *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enters., Inc.*, 793 F.2d 1456, 1467 (5th Cir. 1986).

151. See, e.g., *Tolton v. American Bidyne, Inc.*, 48 F.3d 937, 941-43 (6th Cir. 1995) (preempting claim against UR organization for failure to authorize hospitalization); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 131-32 (9th Cir. 1993) (preempting claim for withdrawal of authorization of surgery); *Kuhl v. Lincoln Nat'l Health Plan, Inc.*, 999 F.2d 298, 301-04 (8th Cir. 1993) (preempting claim for delay in pre-certification for surgery); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1329-34 (5th Cir. 1992) (preempting claim against UR organization for denial of hospitalization).

152. *Corcoran*, 965 F.2d at 1338.

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

availability of benefits."¹⁵⁴ The court, therefore, viewed the health care as the ERISA benefit and the UR organization as simply determining available benefits under ERISA section 502. Since the claim involved the administration of plan benefits, it was preempted by ERISA.

The Sixth Circuit followed the *Corcoran* decision in *Tolton v. American Biodyne, Inc.*¹⁵⁵ The *Tolton* court held that the failure to hospitalize a psychiatric patient who later committed suicide involved utilization review, which "is a means of processing claims."¹⁵⁶ ERISA, therefore, preempted the claim. Because the activities of UR organizations clearly "[fell] within the scope of § 502(a)"—which determines availability of benefits—such claims were preempted.¹⁵⁷ As in *Corcoran*, the *Tolton* court considered claims against UR organizations to be claims based on the administration of benefit plans, and, therefore, preempted by ERISA.

The Eighth Circuit in *Kuhl v. Lincoln National Health Plan, Inc.* had "no difficulty in concluding that the . . . state law claims . . . [were] preempted by ERISA."¹⁵⁸ The court held that ERISA preempted a plaintiff's medical malpractice claim for a delay in pre-certification for heart surgery that ultimately led to the patient's death.¹⁵⁹ In arriving at its holding, the court relied on its interpretation that ERISA preempts those claims dealing with the administration of benefits.¹⁶⁰

The Ninth Circuit followed the other circuits in *Spain v. Aetna Life Insurance Co.* when it held that a wrongful death claim against a UR organization for withdrawal of authorization for surgery involved a "benefit determination[]."¹⁶¹ ERISA, therefore, preempted the claim.¹⁶²

2. Courts Split over Whether ERISA Preempts Vicarious Liability Claims

While there has been some consensus about ERISA preemption of direct liability claims, federal district courts disagree on whether

154. *Id.* at 1331.

155. *Tolton*, 48 F.3d at 937.

156. *Id.* at 942.

157. *Id.*

158. *Kuhl v. Lincoln Nat'l Health Plan, Inc.*, 999 F.2d 298, 302 (8th Cir. 1993).

159. *See id.* at 303.

160. *See id.*

161. *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 132 (9th Cir. 1993).

162. *See id.*

ERISA preempts vicarious liability claims against MCOs.¹⁶³ Those courts holding that ERISA preempts vicarious liability claims emphasize the Supreme Court's expansive interpretation of the preemption provision.¹⁶⁴ These courts reason that a malpractice claim based on the quality of care is actually a claim for denial of benefits.¹⁶⁵ Some courts have also suggested that these claims are preempted because the ERISA plan is the source of the parties' relationship.¹⁶⁶ Other courts look to the level of inquiry required in deciding these claims—for instance, reviewing the terms of the benefit plan—to determine whether a claim "relate[s] to" the plan.¹⁶⁷

Courts holding against preemption look to the congressional intent of uniformity in regulating ERISA plans.¹⁶⁸ These courts recognize the Supreme Court's expansive preemption interpretation, but hold that vicarious liability cases are not equivalent to actions to collect benefits.¹⁶⁹ The courts state that the level of judicial inquiry into the benefit plans to decide the claim does not sufficiently "relate to" ERISA plans so as to trigger preemption.¹⁷⁰ Instead, these courts look to the physician-patient interaction and evaluate it based on pro-

163. So much confusion exists that some districts have case law on both sides of the preemption issue. Compare *Jackson v. Roseman*, 878 F. Supp. 820, 826 (D. Md. 1995) (holding that a vicarious liability claim was not preempted by ERISA), with *Pomeroy v. Johns Hopkins Med. Servs., Inc.*, 868 F. Supp. 110, 116 (D. Md. 1994) (preempting a vicarious liability claim).

164. See, e.g., *Butler v. Wu*, 853 F. Supp. 125, 128 (D.N.J. 1994) (looking to the Supreme Court's expansive reading of ERISA's preemption clause in preempting a vicarious claim).

165. See, e.g., *Altieri v. Cigna Dental Health, Inc.*, 753 F. Supp. 61, 63-64 (D. Conn. 1990) (holding a vicarious liability claim preempted because it arose from the delivery of health benefits).

166. See, e.g., *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966, 973 (S.D.N.Y. 1994) (holding a vicarious liability claim preempted because the relationship between the provider and patient was based on the terms of the benefit plan).

167. See, e.g., *Pomeroy*, 868 F. Supp. at 116 (holding that a vicarious liability claim was preempted because it involved an examination of the MCO's representations); *Ricci v. Gooberman*, 840 F. Supp. 316, 317-18 (D.N.J. 1993) (preempting a claim because the contract defined the relationship between the provider and the patient and ultimately affected the circumstances of the medical treatment).

168. See, e.g., *Roseman*, 878 F. Supp. at 826 (holding that a reference to an ERISA plan in order to prove ostensible agency does not implicate the policy concerns of ERISA).

169. See, e.g., *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544, 547-49 (S.D. Ill. 1994) (holding that the alleged substandard care was unrelated to plan administration and was not preempted); *Smith v. HMO Great Lakes*, 852 F. Supp. 669, 671-72 (N.D. Ill. 1994) (stating that the vicarious liability claim was not a claim for denial of benefits, but rather rested on the MCO's contractual relationship with affiliated physicians and was not preempted).

170. See, e.g., *Pacificare, Inc. v. Burrage*, 59 F.3d 151, 159 (10th Cir. 1995) (holding that a reference to the ERISA plan for purposes of establishing the agency relationship did not compel preemption); *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182, 186 (E.D. Pa. 1994) (holding that ERISA was not implicated by reference to the plan as evidence that the MCO held a provider out as an agent).

professional standards of conduct, an area of law traditionally reserved for states.¹⁷¹

Among federal courts, there is also a question about the Supreme Court's arguably evolving interpretation of ERISA's preemption provision: the expansive reading of *Pilot Life* and *Shaw*, or the more narrowly defined interpretation of *Travelers Insurance*. Some courts have apparently taken no judicial notice of *Travelers Insurance*,¹⁷² while others have embraced this higher threshold for preemption.¹⁷³

Several cases decided after *Travelers Insurance* relied entirely upon Supreme Court decisions prior to *Travelers Insurance*. In *Jass v. Prudential Health Care Plan, Inc.*, the Seventh Circuit held that vicarious liability claims directly "related to" a benefit plan because the agency relationship existed as a result of the ERISA plan.¹⁷⁴ The Court relied on Supreme Court decisions pre-dating *Travelers Insurance*.¹⁷⁵ A Texas district court also looked to earlier Supreme Court cases to define its ERISA preemption standard in *Blum v. Harris Methodist Health Plan*.¹⁷⁶ The court held that the plaintiffs' claims did "not directly affect the relationship between the principle entities" and were therefore preempted by ERISA.¹⁷⁷ A Kansas district court also apparently disregarded *Travelers Insurance* and "followed the Supreme Court in reading the preemption clause broadly" in *Clark v. Humana Kansas City, Inc.*¹⁷⁸

Other courts have followed *Travelers Insurance*, finding its more narrow interpretation of ERISA's preemption provision

171. See, e.g., *Elsesser v. Hospital of Philadelphia College of Osteopathic Med.*, 802 F. Supp. 1286, 1290-92 (E.D. Pa. 1992) (holding that professional malpractice actions are traditionally reserved for state law and are not preempted in the absence of congressional intent). There is also a line of cases holding that professional malpractice is traditionally a state law claim. See *Coyne & Delany Co. v. Selman*, 98 F.3d 1457, 1467 (4th Cir. 1996) (insurance); *Custer v. Sweeney*, 89 F.3d 1156, 1165-67 (4th Cir. 1996) (legal); *Vickers v. Nash Gen. Hosp., Inc.*, 78 F.3d 139, 142 (4th Cir. 1996) (medical negligence claims); *Painters Dist. Council No. 21 Welfare Fund v. Price Waterhouse*, 879 F.2d 1146, 1152-53 (3rd Cir. 1989) (state professional malpractice actions).

172. See, e.g., *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1486-95 (7th Cir. 1996); *Blum v. Harris Methodist Health Plan, Inc.*, No. 3:97-CV-0374-P, 1997 U.S. Dist. LEXIS 19732, at *4-*13 (N.D. Tex. July 31, 1997); *Clark v. Humana Kansas City, Inc.*, 975 F. Supp. 1283, 1286-89 (D. Kan. 1997).

173. See, e.g., *Lancaster v. Kaiser Found. Health Plan, Inc.*, 958 F. Supp. 1137, 1148-50 (E.D. Va. 1997); *Chaghervand v. CareFirst*, 909 F. Supp. 304, 310-12 (D. Md. 1995).

174. *Jass*, 88 F.3d at 1482.

175. See *id.* at 1486-88.

176. *Blum*, 1997 U.S. Dist. LEXIS 19732, at *4-*12.

177. See *id.* at *10.

178. *Clark v. Humana Kansas City, Inc.*, 975 F. Supp. 1283, 1286 (D. Kan. 1997).

“particularly instructive.”¹⁷⁹ A Maryland district court reviewed the Supreme Court precedent in *Chaghervand v. CareFirst* and stated that *Travelers Insurance* had recently clarified the scope of ERISA preemption.¹⁸⁰ Looking to the decision’s language regarding the presumption against federal preemption in areas of traditionally local concern and its attempt to comply with the underlying statutory objective, the district court held that the vicarious liability claim against the MCO was not preempted by ERISA.¹⁸¹ Similarly referring to *Travelers Insurance*, a Virginia district court relied on the decision’s narrowing interpretation of the scope of ERISA preemption in *Lancaster v. Kaiser Foundation Health Plan*.¹⁸² The court held that the plaintiffs’ vicarious liability claims were not preempted because the federal defense of ERISA preemption did not preempt professional malpractice actions—an area of traditional state regulation.¹⁸³

3. *Dukes v. U.S. Healthcare’s “Denial of Benefits Versus Quality of Care”*

*Dukes v. U.S. Healthcare, Inc.*¹⁸⁴ consolidated two federal district court cases alleging medical malpractice.¹⁸⁵ The Third Circuit reversed the district court’s holding that removal jurisdiction existed because the state law claims fell within section 502(a)(1)(B).¹⁸⁶ In the lower court *Dukes* case, the plaintiff filed suit against the MCO claiming that the death of her husband was due to the hospital’s refusal to perform a blood test.¹⁸⁷ In *Visconti v. U.S. Health Care*, the companion case to *Dukes* at the appellate level, the plaintiffs brought a negligence claim against the MCO following the birth of their stillborn daughter, claiming the obstetrician had failed to recognize signs of preeclampsia.¹⁸⁸

The lower courts found the medical malpractice claims preempted. In so holding, the lower courts in both cases mixed the

179. *Lancaster v. Kaiser Found. Health Plan, Inc.*, 958 F. Supp. 1137, 1148 n.38 (E.D. Va. 1997).

180. *Chaghervand v. CareFirst*, 909 F. Supp. 304, 310 (D. Md. 1995).

181. *See id.* at 312.

182. *Lancaster*, 958 F. Supp. at 1148 n.38.

183. *See id.* at 1149.

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

185. *Id.* at 351; *see also Visconti v. U.S. Health Care*, 857 F. Supp. 1097 (E.D. Pa. 1994), *rev’d, Dukes*, 57 F.3d at 350; *Dukes v. U.S. Health Care, Sys., Inc.*, 848 F. Supp. 39 (E.D. Pa. 1994), *rev’d, Dukes*, 57 F.3d at 350.

186. *See Dukes*, 57 F.3d at 361.

187. *Dukes*, 848 F. Supp. at 40.

188. *Visconti*, 857 F. Supp. at 1099.

analysis of complete preemption—a jurisdictional doctrine providing the basis for removal jurisdiction¹⁸⁹—with that of ERISA preemption. A corollary to the well-pleaded complaint rule, complete preemption in this context provides for federal jurisdiction of state-law medical malpractice claims where the federal defense of ERISA preemption is asserted.¹⁹⁰ The lower courts ultimately held that federal jurisdiction existed and that removal had been proper.¹⁹¹ Because claims that are completely preempted¹⁹² are, by definition, preempted by ERISA, the cases were dismissed.

The Third Circuit reversed the consolidated cases, holding that the state claims were improperly removed because the claims were not completely preempted.¹⁹³ The cases were remanded to state court for ERISA preemption determination.¹⁹⁴ In its attempt to clarify the complete preemption analysis, the court ultimately defined the reasoning for ERISA preemption claims for both direct and vicarious liability claims.

The court relied strongly on congressional intent in its analysis. The court reasoned that Congress intended to assure plan benefits in section 502, but did not attempt to control the quality of benefits received—an area traditionally reserved for state regulation.¹⁹⁵ The seminal distinction for complete preemption, therefore, was whether the claim was “about the quality of benefits received” or an attempt to enforce rights under a plan.¹⁹⁶

Recognizing that “the distinction between the quantity of benefits due under a welfare plan and the quality of those benefits will not always be clear,” the court admitted that there may be situations where the quality of care is so low as to “not qualify as health care at all.”¹⁹⁷ The court did not, however, offer any guidance in deciding whether a claim is a denial of a benefit or a claim about quality of care.

Because the analyses of complete preemption and ERISA preemption are so intertwined, subsequent courts have relied on the di-

189. See sources cited *supra* note 66.

190. See *supra* note 66.

191. See *Visconti*, 857 F. Supp. at 1105.

192. Complete preemption in this context means the claim falls under ERISA § 502(a)(1)(B). See *supra* note 66 for further explanation.

193. See *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 356 (3d Cir. 1995).

194. See *id.* Note, however, that this—and similar decisions—leaves the determination of the federal issue of ERISA preemption to state courts.

195. See *id.* (finding that removal was improper when based solely on an attack of the quality of the benefits received).

196. *Id.* at 356-57.

197. *Id.* at 358.

chotomy set forth in *Dukes* to evaluate ERISA preemption.¹⁹⁸ These courts have attempted to effectively differentiate claims as either a denial of a benefit or a claim for quality of care.¹⁹⁹ Many medical malpractice claims when re-phrased can be considered a claim concerning the quality of care or a denial of benefit. For example, the case of a failure to provide a mammogram can be either negligence or a denial of benefit. For this reason, the *Dukes* distinction between a denial of benefit or a claim for quality of care fails to provide a workable solution.

IV. ASSERTING A NEW STATUTORY INTERPRETATION

A. Redefining an ERISA Plan

The current interpretation of ERISA as regulating health plans and providing for the benefit of health care contravenes the statutory goals of protecting employee interests and establishing uniformity in benefits law. Patients are often left without meaningful remedy for medical malpractice claims against MCOs, and courts remain split on ERISA preemption—direct liability claims are treated differently than vicarious liability claims, and employer-provided health care is treated differently than non-employer-provided health care.²⁰⁰ An interpretation of ERISA as regulating employer administration of health plans and guaranteeing the “benefit” of health plan membership—rather than health care—would serve to effectuate ERISA’s goals of employee protection and uniformity of benefit law. Such an interpretation is supported by statutory language and construction, congressional intent, legislative history, and ERISA preemption jurisprudence.

198. See, e.g., *Schmid v. Kaiser Found. Health Plan*, 963 F. Supp. 942, 944 (D. Or. 1997); *Dykema v. King*, 959 F. Supp. 736, 740-41 (D.S.C. 1997); *Lancaster v. Kaiser Found. Health Plan, Inc.*, 958 F. Supp. 1137, 1144-45 (E.D. Va. 1997); *Hoyt v. Edge*, No. 97-3631, 1997 U.S. Dist. LEXIS 8846, at *4-*7 (E.D. Pa. June 19, 1997); *Roessert v. Health Net*, 929 F. Supp. 343, 349-50 (N.D. Cal. 1996); *Muller v. Maron*, No. Civ.A. 94-5052, 1995 WL 605483, at *3 (E.D. Pa. Oct. 13, 1995); *Frappier v. Wishnov*, 678 So. 2d 884, 887 (Fla. Dist. Ct. App. 1996).

199. See, e.g., *Lancaster*, 958 F. Supp. at 1146 (asserting that physician’s decision not to obtain an MRI was a medical determination rather than a decision to deny benefits); *Roessert*, 929 F. Supp. at 350-51 (finding action for medical malpractice related to the quality of benefits received, and, therefore, was a medical rather than an administrative decision).

200. Also, self-insured plans are treated differently than commercial insurance and MCOs are treated differently than hospitals.

1. Statutory Language and Structure

ERISA's statutory language and structure suggest that the "plan" regulated by ERISA cannot be the health care plan itself. ERISA defines an "employee welfare benefit plan" as "any plan, fund, or program . . . established or maintained by an employer . . . for the purpose of providing for its participants . . . through the purchase of insurance . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness."²⁰¹ Restated, an ERISA plan is a plan that an employer establishes by purchasing insurance to provide medical care or benefits to participants. An ERISA plan, therefore, is one that an *employer*—not an MCO—establishes or maintains to *provide for* employee health care. As such, the statutory language clearly contemplates the regulation of an employer's role of providing for health care through insurance, rather than the regulation of the provision of health care. Specifically, the statute implies, and the caselaw interpreting a "plan" indicates,²⁰² that ERISA regulates employer administrative operations—er "plans"—that provide for health care rather than regulating the health care itself. ERISA, therefore, preempts only those claims that "relate to" employer administrative plans that provide for employee health care: claims for improper administration of a health plan and claims of withdrawal or denial of health plan membership.

The statutory construction of ERISA also supports this interpretation. ERISA regulates both pension plans and employee welfare plans in various sections of the statute. Specifically, ERISA regulates the administration of both pension and employee welfare benefit plans: (1) reporting and disclosure rules; (2) fiduciary obligations; and (3) preemption.²⁰³ However, ERISA only regulates the "content" of pension plans—it does not cover the content of employee welfare benefit plans.²⁰⁴ This statutory construction clearly implies that Congress intended to regulate only the administration of employee welfare benefit plans, not the content of those plans. Any

201. ERISA § 3(1), 29 U.S.C. § 1002(1) (1994).

202. See *supra* Part II.B.1.

203. See Peter J. Wiedenbeck, *Implementing ERISA: Of Policies and "Plans,"* 72 WASH. U. L.Q. 559, 567-71, 586-96 (1994).

204. See *id.* at 577-86. There are few exceptions to this assertion. Congress amended ERISA in substantive part in the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82 (codified at 29 U.S.C. §§ 1161-1168 (1994)) (including continuation of coverage requirements for employer-provided health plans); and Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (codified at 29 U.S.C. § 1181 (1996)) (restricting limitations for pre-existing conditions).

interpretation of ERISA that provides for the regulation of anything but the administration of an ERISA plan would, therefore, be antithetical to the intent of the statute. Therefore, ERISA cannot preempt medical malpractice claims, since such claims deal with the content (the health care provided) rather than the conduct (the administration) of the plan. It is, instead, more consistent with ERISA's construction to view ERISA as regulating plan membership, leaving traditional tort law to regulate the health care provided.

2. Congressional Intent

Congress intended to promote uniformity when it enacted ERISA.²⁰⁵ As ERISA is currently interpreted, this goal is not realized.²⁰⁶ Courts are split on ERISA preemption: direct liability is treated differently than vicarious liability; employer-provided health care is treated differently than non-employer-provided health care; self-insured plans are treated differently than commercial insurance; and MCO providers are treated differently than hospitals. Interpreting an ERISA plan as the employer's administrative infrastructure providing for health care would promote uniformity. Such an interpretation would provide for uniformity in the administration of plans—that is, uniformity in the offering of health care plan membership. All claims of withdrawal of plan membership would be preempted, coming under federal rather than state law.

A second goal in enacting ERISA was to protect employee interests.²⁰⁷ Because the current interpretation allows preemption of medical malpractice claims, injured patients are denied adequate remedy. Employee interests, therefore, are best served by allowing these claims to be brought in state court where extra-contractual damages could be granted. In other words, employee interests in the context of medical malpractice claims are best served when these claims are not preempted. By interpreting ERISA as regulating the employer's administrative infrastructure providing for health care, rather than the health care plan itself, courts could avoid preemption of medical malpractice claims.

Congress enacted ERISA in response to pervasive employer administrative and funding abuses.²⁰⁸ The purpose was, therefore, to

205. See *supra* text accompanying notes 4, 35.

206. See *supra* text accompanying note 27; see also *supra* note 200 and accompanying text.

207. See *supra* notes 3, 34, 39 and accompanying text.

208. See *supra* note 29 and accompanying text; see also Pittman, *supra* note 39, at 357-59.

regulate employer actions to protect employees. Because the ERISA plan is currently interpreted to be the health care plan, ERISA regulates the health care provider—the provider of the “benefit” of health care—rather than the employer as intended. If, instead, an ERISA plan were interpreted to be the employer’s administrative plan that provides for health coverage, ERISA would appropriately regulate the employer in protection of employees. Clearly, this interpretation is more consistent with the purpose of the statute.

3. Legislative History

The employer abuses that led to ERISA’s enactment resulted in thousands of workers and retirees losing their pensions.²⁰⁹ These events were unrelated to health care, and there is no indication that Congress intended to regulate health care plans or medical malpractice claims, deny patients legal recourse for negligent medical care, or to effectively deny an appropriate forum for medical malpractice claims traditionally regulated at the state level.²¹⁰ The current interpretation implicates ERISA in the regulation of health care in ways clearly not anticipated at its inception.

ERISA is now used to immunize MCOs from medical malpractice claims. At the time of ERISA’s enactment (1974), managed care essentially did not exist. There is no—and could be no—indication that Congress sought to regulate managed care, much less immunize MCOs. Such a reading has no support in the historical context in which ERISA was enacted.

4. ERISA Plan Jurisprudence

The interpretation of ERISA argued for in this Note would be consistent with Supreme Court and lower court jurisprudence. In considering the benefit protected by ERISA, the Supreme Court has stated that a benefit “accumulate[s] over a period of time and [is] payable only upon the occurrence of a contingency outside of the control of the employee.”²¹¹ There is obvious difficulty in reconciling such a description with a benefit of health care: health care is

209. See *supra* note 29 and accompanying text.

210. See *supra* notes 29-34 and accompanying text.

211. *Massachusetts v. Morash*, 490 U.S. 107, 116 (1989).

provided to employees as warranted upon request, and does not accumulate. Furthermore, the Supreme Court has stated that an ERISA plan includes an “ongoing administrative program” and a “set of administrative practices.”²¹² The employer’s role is to administratively and financially provide for employee health plans, not to administer the health plan. The MCO—which either directly or indirectly provides the health care—administers the health plan. Because an ERISA plan is provided by the employer and includes “administrative practices,” the ERISA plan cannot be the health plan—a plan in which the employer has no administrative role. The ERISA plan must, instead, be the employer’s administrative scheme providing for the health plan membership.²¹³

212. *Fort Halifax v. Coyne*, 482 U.S. 1, 11-12 (1987). Lower courts have also contemplated the inclusion of an “ongoing administrative program” in ERISA plans. See, e.g., *Peckham v. Gen State Mut.*, 964 F.2d 1043, 1048 (10th Cir. 1992) (“[W]e agree that such an ongoing administrative program is required under *Fort Halifax*”); *Donovan v. Dillingham*, 688 F.2d 1367, 1372 (11th Cir. 1982) (stating that the definition of an ERISA plan “implies the existence of intended benefits, intended beneficiaries, a source of financing, and a procedure to apply for and collect benefits”); *Corporate Health Ins. Inc. v. Texas Dep’t of Ins.*, 12 F. Supp. 2d 597, 614 (S.D. Tex. 1998) (finding that a “health care plan” cannot constitute an ERISA plan because a “managed care entity . . . does not include an employer purchasing coverage.” (quoting TEX. CIV. PRAC. & REM. CODE ANN. § 88.001(8) (West 1999))).

In analyzing whether an employee benefit plan is a “plan” for purposes of ERISA, courts have looked at the employer’s involvement with the administration of the plan, see *Gahn v. Allstate Life Ins. Co.*, 926 F.2d 1449, 1452 (5th Cir. 1991) (stating that to make a determination of whether a plan is an employee welfare benefit plan, the lower “court should have focused on the employer . . . and his involvement with the administration of the plan”); whether the employer administered the policy or its benefits, see *Taggart Corp. v. Life and Health Benefits Admin., Inc.*, 617 F.2d 1208, 1211 (5th Cir. 1980) (stating that ERISA does not regulate the purchase of health insurance if “the purchasing employer neither directly nor indirectly owns, controls, administers or assumes responsibility for the policy or its benefits”); and whether there was an intention by the employer to provide benefits, see *Wickman v. Northwestern Nat’l Ins. Co.*, 908 F.2d 1077, 1083 (1st Cir. 1990) (stating that the “crucial factor in determining if a ‘plan’ has been established is whether the purchase of the insurance policy constituted an expressed intention by the employer to provide benefits on a regular and long term basis”).

213. The leading case for deciding ERISA preemption cases is instructive on this point. See *supra* Part III.B.3. The *Dukes* court’s distinction between a claim for denial of benefit versus quality of care—a distinction which under the current statutory interpretation is unworkable—could provide the basis for analysis under the statutory interpretation suggested by this Note. If the benefit guaranteed by ERISA is health plan membership—not the health plan—then a claim based on the denial of membership is covered by the ERISA preemption clause. A claim regarding the quality of the health care received or provided—that is, a medical malpractice claim—would not be preempted.

B. The Implications of a New Statutory Interpretation

Clearly, it is Congress's role to clarify and revise ERISA.²¹⁴ But this is not to say that the judiciary cannot participate in clarifying ERISA preemption and vindicating employee rights. If courts were to interpret the ERISA "plan" as the employer administrative infrastructure providing for employee health coverage, medical malpractice claims would not be preempted. Specifically, neither direct liability claims nor vicarious liability claims against MCOs for medical malpractice would be preempted. Injured patients would have access to state law and adequate remedies. If MCOs were liable for direct and vicarious liability claims, the jurisprudence surrounding hospital liability for physician negligence would be instructive.²¹⁵

If the judiciary were to embark on this path, ERISA would instead preempt only those claims of denial of health plan membership. Both of ERISA's goals would be realized: employees would be protected and the "benefits law" surrounding plan administration would be uniform.

V. CONCLUSION

ERISA as currently interpreted contravenes both statutory goals of uniformity and employee protection. Injured patients' medical malpractice claims against MCOs are left without meaningful redress and courts have failed to provide consistency in regulating liability claims. The current judicial interpretation of ERISA preemption must change to effectuate these goals. If ERISA is interpreted as regulating the employer administration of benefit plans,

214. See *supra* note 24. Congress has introduced several bills amending ERISA: (a) bills that make section 514 inapplicable to state causes of action (Managed Care Bill of Rights for Consumers Act of 1997 H.R. 2606, 105th Cong. § 4 (1997); Patient Access to Responsible Care Act of 1997 (PARCA), S. 644, H.R. 1415, 105th Cong. § 2 (1997)); Responsibility in Managed Care Act of 1997, H.R. 2960, 105th Cong. § 2 (1997); Employee Health Insurance Accountability Act of 1997, S. 1136, 105th Cong. (1997)); (b) bills that amend section 502 to allow for federal remedy under ERISA for "failure to provide benefits" (Managed Care Plan Accountability Act of 1997, H.R. 1749, 105th Cong. § 2(a) (1997)); (c) bills that establish a review process for denial of benefits (Health Insurance Bill of Rights Act of 1997, S. 373, H.R. 820, 105th Cong. (1997)); (d) bills that impose liability on MCOs for withholding medically necessary care (Comprehensive Managed Health Care Reform Act of 1997 (H.R. 2905, 105th Cong. § 3(f) (1997); and (e) bills that set forth managed care requirements and standards for utilization review (Managed Care Bill of Rights for Consumers Act of 1997, H.R. 2606, 105th Cong. (1997), and Health Insurance Bill of Rights of 1997, S. 373, H.R. 820, 105th Cong. (1997)).

215. See *supra* Part III.A.2.

ERISA would protect the benefit of membership in a health plan, rather than the health care itself. Such an interpretation is supported by the statutory text and structure, as well as the statute's purpose and history. This interpretation promotes uniformity in employer administration of benefit plans by allowing both direct and vicarious liability claims against MCOs, and protects employee interests by allowing damages following injury.

*Karla S. Bartholomew**

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