The ERISA Amendment: A Prescription to Sue MCOs for Wrongful Treatment Decisions

Julia K. Locke
Note

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Julie K. Locke*

Rarely does one turn on the television or open a newspaper without encountering horror stories of patients suffering or dying because their health maintenance organizations (HMOs) denied them necessary medical procedures or restricted their ability to receive treatment. Increasingly, the managed care industry is under attack because of these reports, which have increased as patients who have been denied

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1. HMOs are associations that provide health care services for their members by contracting with health care providers and covering the medical costs of the treatment. See Gordon K. MacLeod, An Overview of Managed Health Care, in THE MANAGED HEALTH CARE HANDBOOK 3, 4-5 (Peter R. Kongstvedt ed., 2d ed. 1993). Typically, patients who subscribe or enroll in an HMO plan pay a fixed annual premium. See Allison Faber Walsh, The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability for Physicians and Managed Care Organizations, 31 J. MARSHALL L. REV. 207, 207 n.2 (1997). The HMO then covers a predetermined list of health services, including required medical services, hospitalization, and emergency care, and limits patients to seeking treatment from a list of approved providers. See id.

2. Horror stories of patients denied medical treatment are abundant. See, e.g., Erik Eckholm, $89 Million Awarded Family Who Sued H.M.O., N.Y. TIMES, Dec. 30, 1993, at A1 (describing the story of a California woman who died of breast cancer after her HMO refused to cover a bone marrow transplant); Larry Keller & Fred Schulte, Grievance System Criticized, SUN-SENT. (Ft. Lauderdale), Nov. 10, 1993, at 1A (recounting the experience of a Florida man who died of a heart attack in his daughter's car outside an HMO clinic after the HMO refused to hospitalize him); Treatment Trouble, SUN-SENT. (Ft. Lauderdale), Nov. 7, 1993, at 25A (depicting one patient's agony after his HMO refused to provide a drug needed to manage his prostrate cancer, insisting that he undergo surgery to remove his testicles because this was a more cost effective procedure).

3. See Marsha Austin, HMO Pioneer a Survivor, DENV. BUS. J., Sept. 4,
proper care sue their managed care organizations (MCOs) and the physicians affiliated with them. Most of these lawsuits fail, however, because the plaintiffs obtain their health insurance from employee benefit plans covered by the Employee Retirement Income Security Act (ERISA). When a patient brings a state law claim against the MCO, the case is often removed to federal court and subsequently dismissed because federal courts hold that ERISA preempts direct claims against an

1998, at 1A (describing the current decade as "an age when for-profit HMOs are under attack for sacrificing patients to the almighty dollar"); see also Horror Stories Propel Debate over HMO Bills, FLA. TODAY, Aug. 21, 1998, at 7A (discussing one patient who told her story in thousands of newspapers, on "Good Morning America," and in letters to 1,000 federal and state legislators and reporters after her HMO would not pay for rehabilitation to help her walk and speak again); Maggie Mahar, Time for a Checkup, BARRON'S, Mar. 4, 1996, at 29, 30 ("[N]ewspapers and magazines have turned from cheerful if boring tales of HMOs' ability to contain costs to horror stories about patients who requested a particular procedure, were turned down by HMO administrators, and subsequently died.").

4. "Managed care organization" is a comprehensive label that describes a variety of health insurance systems that provide health care at a reduced cost by using methods like reduced-price purchasing agreements with health care providers and pre-authorization requirements for facility admissions or surgical procedures. See Jeffrey O'Connell & James F. Neale, HMO's, Cost Containment, and Early Offers: New Malpractice Threats and a Proposed Reform, 14 J. CONTEMP. HEALTH L. & POL'Y 287, 288 n.8 (1998). MCOs encompass a number of entities, including HMOs and preferred provider organizations (PPOs). See Barry R. Furrow, Managed Care Organizations and Patient Injury: Rethinking Liability, 31 GA. L. REV. 419, 431 (1997). For a description of HMOs, see supra note 1. PPOs are panels of physicians that contract with insurers to provide medical services for insureds at reduced rates. See Jack K. Kileullen, Groping for the Reins: ERISA, HMO Malpractice, and Enterprise Liability, 22 AM. J.L. & MED. 7, 25-26 (1996).

5. See Edward Felsenthal, When HMOs Say No to Health Coverage, More Patients Are Taking Them to Court, WALL ST. J., May 17, 1996, at B1 (stating that people are increasingly willing to sue their HMOs when they receive what they consider inadequate care and that "some patients are going straight to a lawyer as soon as coverage for routine care is denied").


7. State law causes of action brought against MCOs generally include direct liability claims for medical malpractice, wrongful death, and breach of contract. See, e.g., Tolton v. American Biodyne, 48 F.3d 937, 939 (6th Cir. 1995) (involving claims of wrongful death, improper refusal to authorize benefits, medical malpractice, and insurance bad faith against employee benefit plan); Kuhl v. Lincoln Nat'l Health Plan, 999 F.2d 298, 300 (8th Cir. 1993) (suing health plan for medical malpractice, emotional distress, tortious interference with right to contract for medical care, and breach of contract as a third party beneficiary); Corcoran v. United HealthCare, 965 F.2d 1321, 1324 (5th Cir. 1992) (asserting medical malpractice and wrongful death claims against health plan).
MCO that relate to employment benefits. Although Congress enacted ERISA in 1974 to protect employees from employer mismanagement of benefit plans, the practical effect of this legislation has been to disadvantage employees by protecting MCOs from direct liability.

As a result, the federal judiciary, state governments, and Congress have recognized the need for health care reform to provide patients with an effective form of redress against MCOs when they have been wrongly denied treatment. Federal courts have altered ERISA's effect on patient claims by finding that ERISA imposes fiduciary obligations on MCOs, including HMOs and PPOs, and that patients may sue their MCOs for breach of these obligations. Although these decisions demonstrate that MCOs may be liable under ERISA, ERISA protects MCOs from the harsh damages, including compensatory and punitive damages, available under state causes of action. State legislatures have addressed ERISA preemption by passing laws attempting to regulate managed

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8. See 29 U.S.C. § 1144(a) (providing that the Act "shall supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan"). For further discussion of ERISA preemption, see infra notes 49-51 and accompanying text.

9. See infra notes 56-60 and accompanying text for a discussion of patients' direct liability claims against MCOs for negligent provision of care.

10. See Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49, 61 (D. Mass. 1997) (noting that ERISA preemption has led Congress, the states, and the health care industry to recognize the need for reform); Kent G. Rutter, Democratizing HMO Regulation to Enforce the Rule of Rescue, 30 U. MICH. J.L. REFORM 147, 149 (1996) (describing extensive efforts to regulate HMOs at state and federal levels of government as public confidence in HMO care has been badly shaken).

11. For a discussion of managed care entities, including HMOs and PPOs, see supra note 4.

12. See Herdrich v. Pegram, 154 F.3d 362, 373 (7th Cir. 1998) (holding that HMOs' financial incentive schemes may constitute a breach of fiduciary duty where plan doctors and administrators delay or withhold necessary treatment or proper care for the sole purpose of increasing their bonuses); Shea v. Esensten, 107 F.3d 625, 629 (8th Cir. 1997), cert. denied, 118 S. Ct. 297 (1997) (ruling that the fiduciary obligations imposed by ERISA require HMOs to disclose the financial incentives imposed on physicians that affect their medical decisionmaking); Ries v. Humana Health Plan, No. 94-C-6180, 1995 WL 669583, at *7 (N.D. Ill. Nov. 8, 1995) (holding that a health plan insurer breaches its fiduciary obligations under ERISA when it collects more from insureds than it pays out on their claims under an undisclosed discounting agreement with health care providers).

Although MCOs contend that ERISA’s preemption clause invalidates these laws, a recent decision from a Texas federal court demonstrates that state laws regulating managed care may withstand the ERISA challenge.15

Like many state governments, Congress has debated legislation that would permit patients to sue MCOs for unreasonable treatment decisions.16 Congress recently considered the Patients’ Bill of Rights, which placed restraints on MCOs, provided patients with a “bill of rights,” and extended to MCO participants the power to sue their health plans for damages on an individual basis.17 The legislation was fiercely debated among Democrat and Republican members of Congress whose distinct versions of the bill indicate substantial differences of opinion on many significant health care reform issues.18 On October 7, 1998, President Clinton and Democratic leaders made it official that the Patients’ Bill of Rights legislation was dead for the year.19 However, the lack of action in 1998 does not mean the death of the managed care reform issue; political candidates are already using health care reform in their campaign ads, and members of Congress expect health care reform proposals to be back this year.20

This Note proposes that Congress amend ERISA to provide patients with the right to sue an MCO in federal court for damages when the patient believes the MCO unreasonably re-

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14. Approximately 1,000 bills regulating managed care have been introduced by state legislatures, 182 of which have already been enacted into law. See Milt Freudenheim, Pioneering State for Managed Care Considers Change, N.Y. TIMES, July 14, 1997, at A1; see also infra Part I.B (discussing state legislative proposals to hold HMOs accountable for negligent patient care).

15. See Corporate Health Ins. v. Texas Dep’t of Ins., 12 F. Supp. 2d 597, 630 (S.D. Tex. 1998). For a discussion of the decision, see infra notes 87-90 and accompanying text.

16. An unreasonable treatment decision may include refusing to pay for desired medical services, restricting treatment options, or both.


20. See id.
fused to cover desired medical treatment. Part I examines the inadequate care received by patients enrolled in MCOs and explores how ERISA preemption has made it impossible for patients to sue MCOs when they have been victims of such abuse. Part II discusses attempts by courts, state governments, and Congress to circumvent ERISA preemption, including the recently rejected Patients' Bill of Rights. Part III argues that amending ERISA to permit patients to sue MCOs for making negligent health care coverage decisions is a much more effective means of protecting patients. Part IV asserts that Congress must limit this right to sue, however, by incorporating an appeals process into the ERISA amendment to ensure that patients bringing suit were unreasonably denied health care coverage and that their MCOs were responsible for the resulting consequences. This process offers the most effective means to protect patients, returns physicians to the practice of medicine, and maintains the cost-cutting purpose of managed care.

I. THE MANAGED CARE INDUSTRY UNDER ATTACK

A. THE RISE OF MANAGED CARE AND THE INCREASED RISK OF PATIENT ABUSE

As health insurance premiums reached astronomical levels in the 1980s, numerous employers eliminated the old fee-for-service form of health care coverage and began offering em-
ployees insurance through managed care plans. MCOs reduce insurance premiums through various cost containment mechanisms such as capitation and risk-sharing arrangements, which encourage physicians to minimize their use of medical services. MCOs also attempt to keep costs down by subjecting physicians to "gag clauses," which prohibit physicians from discussing treatment options with patients until after they receive authorization from the plan. Despite the possible financial rewards of cost-cutting mechanisms and clauses, they risk inhibiting physician-patient communication and may diminish the quality of care that patients receive.

23. See Anders, supra note 21, at 17.

24. Capitation means that managed care organizations pay physicians or their practice groups a set dollar payment per patient per unit of time (usually per month) to cover a specified set of services and administrative costs for that patient. See 42 C.F.R. § 417.479(c) (1997). This payment remains constant regardless of the expense and number of services provided. See id.

25. A risk-sharing program allows MCOs to withhold a percentage of the physician's monthly capitation payment, pool it with that of other providers, and use it to pay for specialist referrals, lengthy hospital stays, expensive medical tests or procedures, and other services exceeding budget expectations. See Bethany J. Spielman, After the Gag Episode: Physician Communication in Managed Care Organizations, 22 SETON HALL LEGIS. J. 437, 444 (1998). If the physician keeps expenditures low enough, she will receive a portion of the money pooled. See id. at 444-45. However, if the funds have been depleted due to an excessive number of services, the physicians in the program share the loss. See Walsh, supra note 1, at 219.


27. See generally id. (discussing current communication conflicts between physicians, patients, and MCOs). Physicians signing contracts that limit their ability to disclose treatment options to patients are under a great deal of pressure to comply with conflicting duties. On the one hand, they are legally and ethically bound to disclose treatment alternatives to satisfy their duty to obtain patients' informed consent. See id. at 441-42. On the other hand, they are contractually prohibited from disclosing the same treatment alternatives to MCO patients. See id. An increasing number of physicians have left the medical profession due to these conflicting duties and their disgust with administrators who have limited medical knowledge forcing them to limit patient care in order to increase the salaries of insurance company executives and HMO organizations. See Herdrich v. Pegram, 154 F.3d 362, 376 (7th Cir. 1998).

28. See, e.g., Julia A. Martin & Lisa K. Bjerknes, The Legal and Ethical Implications of Gag Clauses in Physician Contracts, 22 AM. J.L. & MED. 433, 439 (1996) (arguing that patient care has suffered because HMO policies create a conflict of interest between a physician's economic incentives and her interest in caring for her patients); Susan R. Martyn & Henry J. Bourguignon, Physician-Assisted Suicide: The Lethal Flaws of the Ninth and Second Circuit Decisions, 85 CAL. L. REV. 371, 424 (1997) (discussing studies showing substantially reduced patient satisfaction with care in HMOs as compared to fee-
As enrollment in MCOs continues to grow at an explosive rate, the greatest fear is that health plans will deny their patients diagnostic procedures, multiple treatment options, and expensive referrals in order to ensure their own economic gain. This fear is a reality for those patients who have been denied lifesaving treatment. In some cases, the MCO determined the desired treatment to be experimental, investigational, or not medically necessary, and thus refused to pay.

Whether MCOs provide lower quality care than the fee-for-service system is a topic of much debate. Some critics assert that patients enrolled in HMOs and other managed care entities receive care of the same or better quality than patients enrolled in fee-for-service plans. See Maxwell J. Mehlman, Medical Advocates: A Call for a New Profession, 1 WIDENER L. SYMP. J. 299, 301 (1996). In reaching this conclusion, these commentators have focused on HMO enrollees who have received more preventive care than enrollees in traditional health insurance plans. See id.; see also Philip R. Alper, Learning to Accentuate the Positive in Managed Care, 336 NEW ENG. J. MED. 508, 508-09 (1997). For populations requiring more than preventive care, the benefits of managed care do not clearly outweigh the risks. See Barry R. Furrow, Regulating the Managed Care Revolution: Private Accreditation and a New System Ethos, 43 VILL. L. REV. 361, 377-85 (1998). Furrow examines studies conducted to determine whether elderly, child, and cancer patients enrolled in HMOs had worse quality of care outcomes than their fee-for-service counterparts, and finds that the evidence is inconclusive. See id.

29. According to a 1997 KPMG survey, 33% of employees working for employers with more than 200 workers were enrolled in HMOs, up from 22% in 1992, and 31% of such employees were enrolled in PPOs, up from 26% in 1992. By contrast, 18% of such employees were enrolled in fee-for-service plans. By the end of 1996, the total number of HMO members grew to 67.5 million Americans, an 85% increase since 1990. See American Association of Health Plans, Managed Care Facts (visited Jan. 4, 1999) <http://www.aahp.org/menu/index.cfm>. The total number of PPO members grew to 97.8 million people, an enrollment increase of 154% since 1990. See id.


31. See supra note 2 (describing patients who suffered serious illnesses, extreme pain, or death after their MCOs denied coverage for their medical treatment).

32. See Richard C. Reuben, In Pursuit of Health: With More Patients Suing HMOs for Denial of Treatment Lawyers Are Exploring New Ground in Going up Against the Managed-Care Giants, A.B.A. J., Oct. 1996, at 55, 58. Critics of managed care argue that using words like "experimental," "investigational," and "medically necessary" to label possible treatment procedures allows HMOs to ration care without saying so. See id. HMOs use these broad terms to provide a label for anything they do not want to pay for because they do not want to list specific treatment methods that are excluded by
In other cases, the MCO denied treatment after failing to evaluate adequately the severity of the patient's condition. As a result, the tension between patients, doctors, and managed care entities has increased, reducing public trust in the health care industry and sparking increased litigation. If a patient is injured because her MCO refused to cover medical treatment, the patient may attempt to recover her losses by suing the MCO under state common law theories of liability. Although physicians have been the traditional targets of medical malpractice claims brought by patients denied sufficient care, MCOs are increasingly named in patient lawsuits. Claims asserting MCO liability for medical malpractice, wrongful death, and breach of contract fall into two main categories: vicarious liability and direct liability. Managed care entities may be vicariously liable for the negligence of their plan physicians and administrators under theories such as respondeat superior and ostensible agency. As MCOs as-

their plans. See id. 33. See id. at 58.
34. See supra notes 3-5 and accompanying text (describing the public's negative perception of managed care and people's increasing willingness to sue MCOs that have denied coverage).
35. See supra note 7 (noting that the state law causes of action generally brought against negligent MCOs are direct liability claims for medical malpractice, wrongful death, and breach of contract).
36. See John R. Penhallegon, Emerging Physician and Organization Liabilities Under Managed Health Care, 64 DEF. COUNS. J. 347, 352 (1997). MCOs are attractive defendants because they have deeper pockets than the average physician and because juries are not particularly sympathetic to the managed care industry. See id. at 352-53.
37. See Angela M. Easley, Comment, A Call to Congress to Amend ERISA Preemption of HMO Medical Malpractice Claims: The Dissatisfactory Distinction Between Quality and Quantity of Care, 20 CAMPBELL L. REV. 293, 304 (1998).
38. To prevail under a respondeat superior theory, a plaintiff must prove that her physician acted negligently in treating her, that an employer-employee relationship existed between the HMO and the physician, and that the physician's tortious behavior fell within the scope of his employment. See William A. Chittenden III, Malpractice Liability and Managed Health Care: History & Prognosis, 26 TORT & INS. L.J. 451, 453-54 (1991) (referring to W. PAGE KEETON ET AL., PROSSER & KEETON ON THE LAW OF TORTS § 69 (5th ed. 1984) and RESTATEMENT (SECOND) OF AGENCY § 219 (1958)). Plaintiffs typically do not prevail under this theory, however, because in a majority of MCOs physicians are not employees of the MCO but are independent contractors. See Penhallegon, supra note 36, at 353.
39. The doctrine of ostensible agency provides that "where an organization represents that a physician is its agent or employee, and causes a patient to rely on that representation in submitting to care, the organization will be
sert greater control over the manner in which physicians deliver care, courts may hold them directly liable for negligent credentialing of plan physicians or for negligent decisions made through utilization review and peer review processes.

vicariously liable for the torts of the purported agent, irrespective of the fact that the relationship was actually that of an independent contractor." Penhallegon, supra note 36, at 353 (referring to RESTATEMENT (SECOND) OF AGENCY § 267 (1958)). When determining whether the patient looks to the organization for care, courts consider factors including the degree of control the plan exerts over physician selection, and whether the physician's malpractice arose out of the "performance of an inherent function" of the plan. See Chittenden, supra note 38, at 459. In determining whether the organization represented the physician as its employee, courts look to the representations made by the organization to the patient. See id.

40. The doctrine of negligent credentialing is a theory of institutional liability that places a duty on MCOs to select and retain only competent physicians. See Penhallegon, supra note 36, at 355. The elements for a cause of action for negligent selection, retention, or evaluation of a physician are: (1) the MCO rendered services to the plaintiff subscriber; (2) the MCO should have recognized the services as necessary for the protection of its subscriber; (3) the MCO failed to exercise reasonable care in selecting, retaining, and/or evaluating the plaintiff's primary care physician; and (4) as a result of the MCO's failure to use such reasonable care, the risk of harm to the subscriber was increased. See id.

41. MCOs often operate utilization review processes that evaluate medical services before permitting physicians to administer them. See Easley, supra note 37, at 305. This allows MCOs to ascertain whether less costly treatments and tests are available. See id. A review agent, who is usually not a physician, applies a predetermined set of criteria established by the managed care plan to a patient's medical situation as presented by the attending physician. See J. Scott Andresen, Is Utilization Review the Practice of Medicine?, 19 J. LEGAL MED. 431, 433 (1998). If the treatment given or proposed by the physician meets the criteria, the review agent will approve insurance coverage. See id. If the criteria are not met, the matter is referred to an administrator, who consults with the attending physician about the particular facts of the case. See id. The administrator determines whether the desired treatment meets plan specifications, and ultimately approves or denies coverage. See id. In some plans, the administrators making the final coverage determination are non-physicians; however, in a majority of cases, they are physicians. See id. at 433-34. Liability arising from cost containment systems is imposed where a utilization review administrator deliberately overrides a physician's request for certain tests or treatments in order to lower costs. See id. at 435-38.

42. Peer review is the process by which a special committee of medical peers reviews an individual physician's credentials, including medical education, residency training, board certification, and the number of procedures the physician has performed, and determines whether the physician should be granted staff privileges. See Judith E. Orié, Economic Credentialing: Bottom-Line Medical Care, 36 DUQ. L. REV. 437, 446 (1998). The more training, expertise, and proven ability a physician has, the more privileges he may be granted. See id. Peer review decisions have commonly been designed to ensure quality medical care for hospital patients. See id. at 447. In today's
dures. Although these causes of action appear to be attractive means for targeting negligent MCOs, patients asserting direct and vicarious liability claims against MCOs have had little success because of the preemptive effect of ERISA. 43

B. ERISA HAMPERS PATIENT CLAIMS AGAINST HMOs

In 1974, Congress enacted ERISA 44 to eliminate abuses occurring in employee pension plans. 45 Congress's primary purpose in enacting ERISA was to protect participants in employee benefit plans and their beneficiaries by requiring disclosure of financial and other pertinent information. 46 In particular, Congress intended ERISA to address inadequate funding of employee benefit plans and the resulting hardship to employees who had relied on anticipated benefits. 47

In addition, Congress enacted ERISA to protect employers from conflicting state regulation of employee benefit plans. 48 Congress accomplished this goal through ERISA's preemption clause, 49 which has insulated MCOs, the entities responsible for administering employee benefit plans, from being held accountable under state malpractice, wrongful death, and breach of contract claims as well as claims brought under state laws regulating health care. 50 The clause has also made it virtually

managed care world, however, hospitals and HMOs are expanding the peer review process beyond traditional quality of care criteria to include financial and economic factors. See id. at 452. Therefore, the process has become more of a cost containment mechanism through which a hospital or HMO may exclude a physician "for treating too many poor people, having too many acutely ill patients, or simply for providing thorough and effective medical care." Id.

43. See infra notes 56-59 and accompanying text (discussing cases in which courts have held that ERISA preempted state law claims brought by patients against allegedly negligent HMOs).


47. See id. § 1001(a).


49. See 29 U.S.C. § 1144(a); see also supra note 8 (quoting the language of ERISA's preemption clause).

50. See infra notes 56-59 and accompanying text (discussing cases in
impossible for a patient to prevail against her MCO on any claim brought under state law.\textsuperscript{51}

In spite of ERISA preemption, patients have had some success bringing vicarious liability claims against MCOs. The more control a managed care entity exerts over the provision of care, the greater the probability the entity will be vicariously liable for the torts of its independent contractor physicians.\textsuperscript{52} A number of federal and state courts have held that patients who have been injured by negligent treatment decisions made by a health care provider acting as an agent of an MCO may pursue vicarious liability claims against the MCO.\textsuperscript{53} In reaching this which ERISA preemption shielded HMOs from liability under state law). Congress expressly exempted state laws governing insurance from the scope of ERISA's preemption clause. See 29 U.S.C. § 1144(b)(2)(B). However, this does not aid patients enrolled in employee benefit plans because the statute also provides that no state insurance law shall deem a self-insured pension or benefits plan an "insurance company or other insurer." Id. ERISA defines self-funded health care plans as those established or maintained by an employer through the purchase of insurance to provide medical, surgical, or hospital benefits for employees and their beneficiaries. See id. § 1002(1)(A). As a result of these provisions, when an injured patient sues an MCO engaged by an employer to administer the employer's self-funded health care plan, the MCO asserts ERISA preemption as a defense to avoid liability for the patient's injuries.

\textsuperscript{51} See infra notes 55-60 and accompanying text.

\textsuperscript{52} See supra note 39 (discussing the doctrine of ostensible agency, which subjects HMOs to vicarious liability for the negligent acts of independent contractor physicians).

\textsuperscript{53} See, e.g., Pacificare of Okla. v. Burrage, 59 F.3d 151, 155 (10th Cir. 1995) (holding that ERISA did not preempt a claim of vicarious liability for malpractice against a managed care organization); Dukes v. U.S. HealthCare, 57 F.3d 350, 356 (3d Cir. 1995) (finding that ERISA did not preempt plaintiff's vicarious liability malpractice claim against U.S. HealthCare). In Pacificare, the court held that the plaintiff's vicarious liability claim was not preempted by ERISA because it did not sufficiently relate to an ERISA plan; therefore, the court remanded the claim to state court for resolution. 59 F.3d at 155. The court reasoned that vicarious liability claims against HMOs for the malpractice of their physicians are attacks on the quality of care, not the administration of benefits. See id. at 154. Therefore, the court reasoned, it is not necessary to reference a benefit plan to determine the issue of a physician's negligence in treating a patient. See id. Moreover, the court reasoned, an agency arrangement between an HMO and the physician is too tenuous a relationship to the plan to warrant preemption. See id. In Dukes, the court found that the plaintiff was not asserting a claim that the HMO withheld benefits due under the plan, but was complaining about the low quality of the benefit actually received. 57 F.3d at 356-57. Although the ERISA statute provides a remedy for benefits not received, the court noted that it does not refer to the quality of benefit received. See id. at 357. Therefore, the court held that ERISA did not preempt the plaintiff's state law claim against U.S. HealthCare. See id. at 356.
conclusion, courts emphasize that ERISA was not intended to bar injured patients from seeking state law remedies against managed care organizations that have negligently controlled or arranged for their medical treatment. 54 Although these decisions demonstrate that state health care regulation in the vicarious liability context may be preserved despite ERISA preemption, "[t]he rulings are not without loopholes." 55 Furthermore, several federal courts have ruled that all vicarious liability claims are preempted, 56 demonstrating the many roadblocks ERISA preemption presents for patient lawsuits. 57

Patients have had even less success holding their MCOs directly liable. 58 MCOs have consistently escaped liability by persuading courts that ERISA preempts medical malpractice and other state tort actions brought directly against the MCO because the claims result from the denial or improper processing of benefits, and not from the quality of medical advice. 59

54. See Easley, supra note 37, at 309.
55. Id. at 312. For example, HMOs have argued that one of the contractual benefits of being enrolled in an HMO is an implied promise that HMO physicians and services will be of acceptable quality. Therefore, a claim that the physician's care or the services provided were not of acceptable quality could essentially be a claim that benefits were denied, thus subjecting the claim to ERISA preemption. See id.
57. See Easley, supra note 37, at 314.
58. See e.g., Jass v. Prudential Health Care Plan, 88 F.3d 1482 (7th Cir. 1996); Tolton v. American Biodyne, 48 F.3d 937 (6th Cir. 1995); Spain v. Aetna Life Ins. Co., 11 F.3d 129 (9th Cir. 1993); Kuhl v. Lincoln Nat'l Health Plan, 999 F.2d 298 (8th Cir. 1993); Corcoran v. United HealthCare, 965 F.2d 1321 (5th Cir. 1992).
59. See, e.g., Tolton, 48 F.3d at 942 (finding that Mr. Tolton's family's wrongful death, improper refusal to authorize benefits, medical malpractice, and insurance bad faith claims were preempted by ERISA because they resulted from benefit determinations made by his health plan); Kuhl, 999 F.2d at 302-03 (ruling that Mr. Kuhl's family's claim that his health plan negligently delayed his heart surgery was essentially a claim that the plan denied him benefits or improperly processed his benefits under the plan, which is exactly the type of claim that ERISA preempts); Corcoran, 965 F.2d at 1331 (finding that health plan's decision not to hospitalize a woman in a high-risk pregnancy involved a benefit determination and thus was preempted by ERISA).
These claims thus "relate to" the administration of benefits under the patient's health care plan and fall within the scope of ERISA preemption. 60

Granted, federal preemption does not end the patient's case; it simply substitutes a federal forum and remedy for the preempted state action. 61 However, a plaintiff who successfully demonstrates that her MCO denied her medically necessary treatment may only recover the amount of benefits that were denied under the plan. 62 For example, if a patient was denied a diagnostic procedure such as an ultrasound, she will only be able to recover the cost of the ultrasound. As a result, the plaintiff cannot recover for the extensive pain and suffering, injury, or loss of life which likely motivated her to sue the MCO in the first place. 63

II. EARLY RESPONSES TO ERISA PREEMPTION EMPHASIZE THE NEED FOR REFORM

The injustice surrounding ERISA preemption has led federal courts, state legislatures, and Congress to propose health care reform that provides plaintiffs with a means of redress when they have been injured by their MCOs. Federal courts worked with the current ERISA statute to accomplish reform, and state legislatures and Congress introduced new legislation. They have made some headway toward providing greater pro-

60. See supra note 59 and accompanying text.
62. See 29 U.S.C. § 1132(a)(1)(B) (1994) (permitting an employee-beneficiary to bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan"). ERISA also allows the prevailing plaintiff to collect attorneys' fees. See id. § 1132(g)(1).
63. See supra note 13 and accompanying text (noting that compensatory and punitive damages are not available under ERISA). Because ERISA preemption only applies to claims against MCOs, patients may still collect compensatory and punitive damages by bringing state medical malpractice claims against their treating physicians. See Barbara A. Noah, The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?, 48 MERCER L. REV. 1219, 1243 (1997). Therefore, many patients name their individual physicians as defendants in the lawsuit against their MCOs. Suing one's physician is less appealing than suing one's HMO, however, since most physician malpractice insurance policies have million dollar caps. This amount is usually not even close to the sum of money that a plaintiff could potentially be awarded by a jury in the typical wrongful death or catastrophic injury case. See Penhallegon, supra note 36, at 352-53.
tection for patients, but they have yet to find a uniform means of eliminating ERISA preemption.

A. FEDERAL COURTS DISRUPT ERISA PREEMPTION

Federal courts were among the first government actors to attempt to overcome ERISA preemption. As discussed above, some courts circumvented ERISA preemption in the context of vicarious liability claims against MCOs.64 The United States Supreme Court addressed ERISA preemption in New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company.65 Although the Court did not address ERISA preemption in the context of patient claims against allegedly negligent MCOs, the Court’s opinion offers some insight into the inconsistencies between the language and purpose of the statute. Noting that the language of ERISA’s preemption clause was “unhelpful,”66 the Court looked to the purpose of the statute to determine whether Congress intended a state law to survive preemption.67 Because the goal of ERISA’s preemption clause is to “minimize the administrative and financial burden[s]” on interstate employee benefit plans,68 a state law will only be preempted if it imposes unacceptable burdens on a plan, such as mandating benefit structures or their administration, or providing alternate enforcement mechanisms.69 The disparity between ERISA’s text and pur-

64. See supra note 53 and accompanying text.
65. 514 U.S. 645 (1995). In Travelers, the Supreme Court reviewed a New York statute that imposed a surcharge on hospital rates. See id. at 649-50. Although the Court recognized that the surcharges would affect the cost of providing hospital benefits in New York, the Court concluded that this was an indirect economic effect that did not bind plan administrators to any particular benefits choice. See id. at 659. Therefore, the Court held that the statute was not preempted by ERISA. See id. at 662.
66. Id. at 656.
67. See id. In adopting this approach, the Court rejected a broad literal interpretation of the “related to” language of the ERISA preemption clause. See id. at 655-56. The Court also concluded that Congress did not intend for ERISA to federalize health care costs. See id. at 662 (“[C]ost uniformity [among States] was almost certainly not an object of pre-emption, just as laws with only an indirect economic effect on the relative costs of various health insurance packages in a given State are a far cry from those ‘conflicting directives’ from which Congress meant to insulate ERISA plans.”).
68. Id. at 656.
69. See id. at 657-59, 661 (“While Congress’s extension of pre-emption to all ‘state laws relating to benefit plans’ was meant to sweep more broadly than ‘state laws dealing with the subject matters covered by ERISA’... nothing in the language of the Act or the context of its passage indicates that Congress
pose uncovered by the Court in *Travelers* demonstrates the need for ERISA reform.

Although MCOs continue to persuade federal courts that ERISA preempts state tort actions challenging the quality of care delivered by HMOs, a few courts have interpreted ERISA to provide a more meaningful cause of action for plaintiffs whose claims have been removed to federal court. The Eighth Circuit initiated this effort in *Shea v. Esensten* by holding that ERISA imposes a duty on plan physicians and administrators to disclose the existence and nature of financial incentives.

The Department of Labor has adopted a similar approach, which is demonstrated in its amicus briefs on the ERISA preemption issue. These briefs are posted on the Department of Labor's internet site. See Health Administration Responsibility Project, *The Secretary of Labor's Amicus Briefs on ERISA Preemption of Medical Malpractice Claims Against HMOs* (visited Feb. 20, 1998) <http://www.harp.org/dol.htm>. The Department argues that an ERISA "benefit" is simply membership in the HMO and an ERISA "plan" is the terms, conditions, and procedures for instigating that membership. See Ayling, supra note 61, at 419 (discussing the Department of Labor's argument in its amicus brief for the appellant in *Shea v. Esensten*, 107 F.3d 625 (8th Cir. 1997)). The operation and quality of care delivered by the HMO may be a health "plan" in the everyday sense, but not in the ERISA sense. See id. Therefore, quality of care issues are part of state health insurance and tort law, and are not preempted by ERISA. See id.

70. See supra note 12 (discussing three federal cases in which courts upheld claims brought by patients against HMOs for breach of fiduciary obligations).

71. 107 F.3d 625 (8th Cir. 1997), cert. denied, 118 S. Ct. 297 (1997). Mr. Shea, a man with a family history of heart disease and symptoms of heart problems, died of heart failure after his family doctor led him to believe that he did not need a referral to a cardiologist. See id. Mr. Shea, his HMO (Medica) had a contract with his family doctor which included financial incentives to minimize these referrals. See id. at 627.
used to affect physicians' medical decisionmaking.\(^{72}\) The court stated that financial incentive schemes between an HMO and a physician are material facts requiring disclosure because silence about such facts has the potential to harm patients.\(^{73}\) Noting that a patient needing specialized care relies on her doctor's advice about treatment options, the court stated that the "patient must know whether the advice is influenced by self-serving financial considerations created by the health insurance provider."\(^{74}\)

The Seventh Circuit took the Eighth Circuit's decision in *Shea* one step further in *Herdrich v. Pegram*.\(^{75}\) In *Herdrich*, the court held that financial incentive schemes may constitute a breach of fiduciary duty when plan physicians and administrators delay or withhold necessary treatment or proper care to beneficiaries for the sole purpose of increasing their bonuses.\(^{76}\) The court noted that the mere existence of a bonus incentive scheme in a managed care setting does not automatically give

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72. See id. at 629. In reaching this decision, the court first rejected the HMO's claim that a decedent whose estate claims breach of fiduciary duty is not a current plan participant and therefore lacks standing to sue. See id. at 628. The court recognized an exception to ERISA's provision authorizing only "current" plan participants to assert a claim for breach of fiduciary duty, reasoning that any other result would unfairly reward the HMO. See id.

73. See id. at 628-29. In particular, silence about financial incentives is harmful if it keeps a patient from making an informed decision about whether to trust her doctor's recommendation that a referral is unnecessary, as was the case in *Shea*. See id. at 629.

74. Id. at 628.

75. 154 F.3d 362 (7th Cir. 1998). Ms. Herdrich brought suit after her HMO delayed diagnosing a mass in her abdomen as appendicitis, causing her appendix to rupture, deteriorate, and inflict her with peritonitis, a life-threatening illness. See id. at 374. Ms. Herdrich's doctor insisted that she wait eight days to obtain an ultrasound because her employer-sponsored HMO required plan participants to receive medical care from plan-staffed facilities. See id. After Ms. Herdrich's appendix ruptured, her HMO continued to defray costs, insisting that she have the surgery to drain and cleanse her ruptured appendix at a plan facility. See id.

76. See id. at 373. *Herdrich* has significant implications for physician-owned health care plans, since the defendant Carle and its subsidiaries were owned and operated by physicians. See id. at 370. Physicians managed the health plan, including the doctor referral process, the nature and duration of patient treatment, and the extent to which participants were required to use Carle-owned facilities. See id. The court also noted that physicians were in control of year-end bonuses administered to plan administrators. See id. As a result of this authority, the court held that Carle's physician-owners fit the statutory definition of fiduciaries and thus were subject to ERISA's mandate. See id. at 369-71.
rise to a breach of fiduciary duty. However, when a plaintiff alleges that a managed care entity used an incentive system to benefit plan physicians and administrators to the detriment of patients, the plaintiff has presented sufficient information for a trial on the merits.

As these cases demonstrate, it is possible to interpret ERISA so that HMOs are not completely shielded from liability. However, Shea and Herdrich do not offer sufficient guidance for lower courts deciding cases with similar issues. In particular, the scope of fiduciary duties owed by a plan physician or administrator and what factual circumstances must be present before the MCO will be held liable for breaching those duties are unclear. Moreover, even if a plaintiff is successful on a breach of fiduciary duty claim, she is still left with the limited remedies provided by ERISA.

B. STATE LAWS SUBJECT MANAGED CARE ENTITIES TO LIABILITY

State legislatures have also attempted to hold MCOs accountable by proposing and enacting laws that subject them to liability for wrongful treatment decisions. In early 1997, Texas became the first state to enact a law subjecting MCOs to liability for unreasonably granting or denying medical treatment to patients. Many state legislatures are following Texas's

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77. See id. at 373.
78. See id. at 380. Throughout its lengthy decision, the court subtly attacked managed care, stating at one point that "medical care should not be subject to the whim of the new layer of insurance bureaucracy now dictating the most basic, as well as the important, medical policies and procedures from the boardroom." Id. at 377.
79. See Johnson, supra note 22, at 1634 (arguing that the Shea court's opinion fails to provide courts or commentators with significant guidance); Barbara Yuill, Seventh Circuit Allows Patient to Sue Alleging ERISA Breach of Fiduciary Duty, Health L. Rep. (BNA), at 1349 (Aug. 27, 1998), available in WESTLAW, BNA-HLR File (presenting the views of various health law practitioners as to the ambiguities surrounding the Herdrich decision).
80. In both Shea and Herdrich, the courts held that the district courts erred in dismissing the injured plaintiff's claim that the defendant-HMO breached its ERISA fiduciary duties. However, neither court set forth a rule or test that defined what events must be present for a breach of fiduciary duty to be found. Therefore, it appears that the scope of an HMO's fiduciary duties and what constitutes a breach of those duties will be determined on a case-by-case basis.
81. See TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-88.003 (West Supp. 1998). The law requires health insurance carriers, health maintenance organizations, or other managed care entities to exercise ordinary care when
lead. For example, late in 1997, Missouri legislators passed a managed care law\textsuperscript{82} that adds HMOs to the definition of health care provider and subjects them to liability for making negligent medical decisions.\textsuperscript{83} Lawmakers in Arizona, California, Georgia, New York, and New Jersey have proposed similar legislation.\textsuperscript{84} New York's managed care law also gives customers the right to ask for an independent review if they believe their claims for service were wrongly denied.\textsuperscript{85} This permits patients to challenge treatment decisions made by MCOs without litigation and the threat of ERISA preemption.

Although these laws protect patients in theory, whether patients will be able to take advantage of the legislation remains uncertain, because the health care industry is arguing that ERISA preempts the statutes. For example, before the Texas law took effect, Aetna Health Plans of Texas and related companies sued to overturn the law as it applies to employee benefit plans on the grounds that it violates ERISA.\textsuperscript{86} The Texas law withstood the challenge at the district court level in \textit{Corporate Health Insurance, Inc. v. Texas Department of Insurance}.\textsuperscript{87} The \textit{Corporate Health} court upheld sections of the new Texas law after a lengthy analysis of cases and commentary on ERISA preemption.\textsuperscript{88} If the ruling survives appeal, Texas making health care treatment decisions, and holds these entities liable for any harm resulting from their failure to exercise ordinary care. \textit{See id.} § 88.002. The law also requires patients' negligence claims to undergo independent review prior to suit, thus paralleling notice procedures for medical malpractice suits against physicians under Texas law. \textit{See William M. Sage, Enterprise Liability and the Emerging Managed Health Care System}, \textit{60 LAW & CONTEMP. PROBS.} 159, 178 (1997).

\textsuperscript{82} \textit{See MO. ANN. STAT. §§ 538.205-538.30 (West 1997).}

\textsuperscript{83} \textit{See id.} § 538.205(4). The Missouri law has been described as one of the nation's toughest and most comprehensive managed care laws. \textit{See John G. Carlton, Federal Law Protecting Managed Care Comes Under Fire: HMOs Receive "Shield of Immunity" from Lawsuits}, ST. LOUIS POST DISPATCH, Aug. 30, 1998, at A1.

\textsuperscript{84} \textit{See Wayne J. Guglielmo, Sharp Shootin': Texas Doctors Put HMOs in the Malpractice Target Zone, MED. ECON., Dec. 22, 1997, at 88, 97.}


\textsuperscript{86} \textit{See Guglielmo, supra} note 84, at 98.

\textsuperscript{87} 12 F. Supp. 2d 597 (S.D. Tex. 1998).

\textsuperscript{88} \textit{See id.} at 629. In reaching this conclusion, the court first determined
health plan members will have a right to sue for damages when their health plan, a plan employee, or a plan agent fails to exercise ordinary care.\textsuperscript{89}

Although the Texas statute withstood the ERISA challenge at the district court level,\textsuperscript{90} it is very possible that other states will not be as successful, resulting in state-to-state inconsistencies and ambiguities over the rights of patients and the obligations of MCOs. Patients and HMOs might even consider moving to states where the health care law is most favorable to them, creating economic and employment issues that many states will not be able to handle.

The efforts of federal courts and state legislatures to hold HMOs accountable are commendable but ineffective means of overcoming the barriers of ERISA preemption. Rather than searching for ways to make the current law work for patients denied proper treatment, the government must pass a new law that gives patients the right to sue MCOs for wrongful treatment decisions. Congress can best guarantee patients this protection by amending ERISA.

C. RECENT CONGRESSIONAL PROPOSALS FOR HEALTH CARE REFORM

In 1997 Congress debated two bills, the Managed Care Plan Accountability Act (MCPAA)\textsuperscript{91} and the Patient Access to

\textsuperscript{89} See Allison Bell, \textit{Texas Members Can Sue HMOs, Court Rules}, NAT'L UNDERWRITER LIFE \& HEALTH, Sept. 28, 1998, \textit{available in 1998 WL 20199224}.

\textsuperscript{90} See supra notes 87-88 and accompanying text.

\textsuperscript{91} H.R. 1749, 105th Cong. (1997).
Responsible Care Act (PARCA). MCPAA was proposed to amend ERISA's civil enforcement provision. It would have allowed an ERISA plan participant to sue her MCO in federal court for damages if she proved that she was wrongfully denied benefits as a result of a cost containment technique. Furthermore, the MCPAA would have required managed care plans to indemnify physicians for liability resulting from the failure to provide a benefit as a direct result of plan restrictions on doctor-patient communications. PARCA, in contrast, would have made ERISA's preemption provision inapplicable to any state cause of action brought against a health plan or insurer to recover damages for personal injury or wrongful death. Neither PARCA nor the MCPAA survived the 1997 legislative session.

Prompted by PARCA's sweeping proposal to permit patients to sue for damages against HMOs that deny treatment, Democratic Congressman John Dingell and Senator Edward Kennedy introduced their own bill, the Patients' Bill of Rights.

93. See H.R. 1749 § 2(a).
94. See id. Democratic Congressmen Pete Stark and George Miller introduced the Managed Care Plan Accountability Act (MCPAA) with the belief that it would close the “loophole” in ERISA that HMOs use to avoid liability in court. See Bill Would Allow Patients to Sue Plans, AM. POL. NETWORK, May 23, 1997, at 3. Stark and Miller hoped that the Act would help make sense of the legal confusion over ERISA by giving patients the right to sue HMOs in federal court for compensatory as well as punitive damages. See id.

Because the MCPAA permitted patients to sue for damages in federal court, it attracted its share of critics and supporters. Expressing opposition to the proposed legislation, representatives from the American Association of Health Plans argued that “[t]he Stark bill, and the free-for-all legal expenses that would accompany its passage, would work an extraordinary hardship on the ability of employer-sponsored health plans to continue providing low-cost, high-quality health care.” Id. In contrast, the Consumers Union applauded the bill's introduction, stating:

When managed care companies put profits ahead of patient care, when they use their power to overturn medical professionals' decisions and deny care, they use ERISA as a shield.... This is anti-consumer, unfair and unconscionable.... It is time that Congress answers the question whether managed care plans be allowed to evade responsibility for their actions with a resounding no.

Id.

95. See Suzanne M. Grosso, Rethinking Malpractice Liability and ERISA Preemption in the Age of Managed Care, 9 STAN. L. & POL. REV. 433, 449 (1998). MCPAA also would have imposed adverse tax consequences on plans committing statutory violations. See id.
96. See S. 644 § 4; H.R. 1415 § 4.
in March of 1998. This legislation was characterized as the “most sweeping of the HMO bills on the agenda,” and it attracted its share of proponents and opponents. Republican Congressmen introduced similar legislation in July, but both the House and Senate proposals lacked many of the protections offered by the Kennedy-Dingell plan.

Congressional Republicans and Democrats differ on how to accomplish managed care reform, as was demonstrated by their proposals for the Patients’ Bill of Rights legislation. The Kennedy-Dingell plan proposed that ERISA be amended to enable patients to hold health plans accountable for harmful treatment decisions. The proposal provided internal and ex-

99. One firm supporter of the Democrats’ proposal was President Clinton. He promised to veto any managed care bill that was not “a real Patients’ Bill of Rights,” urging that the United States needs “a bill of rights, not a bill of goods.” Clinton Threatens to Veto Republican Bills, Sets Tests for “Real Patients’ Bill of Rights”, Health Care Daily Rep. (BNA), at d5 (Aug. 11, 1998), available in WESTLAW, BNA-HCD File. By “real,” President Clinton meant a bill that provides the essential protections offered by the Democrats’ proposal for the “Patients’ Bill of Rights.” See infra notes 101-06 and accompanying text (discussing the protections offered by the Democrats’ proposal).
101. The provision governing internal appeals of adverse treatment decisions permitted a patient enrolled in an HMO to appeal treatment decisions to “a physician or other health care professional (or professionals) who has been selected by the plan or issuer and who has not been involved in the appealable decision at issue in the appeal.” H.R. 3605 § 132(b)(2)(A); S. 1890 § 132(b)(2)(A). Appealable treatment decisions include any of the following:
   (A) Denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit, including a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.
   (B) Failure to provide coverage of emergency services or reimbursement of maintenance care or post-stabilization care.
   (C) Failure to provide a choice of provider.
   (D) Failure to provide qualified health care providers.
   (E) Failure to provide access to specialty and other care.
   (F) Failure to provide continuation of care.
   (G) Failure to provide coverage of routine patient costs in connection with an approval clinical trial.
   (H) Failure to provide access to needed drugs.
   (I) Discrimination in delivery of services.
   (J) An adverse determination under a utilization review pro-
ternal processes for patients to appeal adverse determinations by their MCOs. The internal review process permitted a patient enrolled in an MCO to appeal various enumerated treatment decisions to a physician or other health care professional selected by the health plan. The external review procedure provided patients with the ability to appeal a treatment decision before a board of medical and legal professionals outside of the MCO's administration. In addition to these review mechanisms, the Kennedy-Dingell proposal granted patients the right to sue MCOs for denying them medically necessary treatment. Moreover, the proposal allowed physicians, rather than MCOs, to determine whether a treatment is "medically necessary." Neither Republican proposal permitted patients to sue their MCOs. However, if an MCO denies treatment to a patient in a life-threatening situation, the

gram.

(K) The imposition of a limitation [on the provision of services].

102. The provision governing external appeals permitted a patient enrolled in an HMO to appeal an "externally appealable decision" to a review board meeting the following requirements:

(A) There is no real or apparent conflict of interest that would impede the entity conducting external appeal activities independent of the plan or issuer.

(B) The entity conducts external appeal activities through clinical peers.

(C) The entity has sufficient medical, legal, and other expertise and sufficient staffing to conduct external appeal activities for the plan or issue on a timely basis.

(D) The entity meets such other requirements as the appropriate Secretary may impose.
H.R. 3605 § 133(c)(1)(A)-(D); S. 1890 § 133(c)(1)(A)-(D). An "externally appealable decision" means an appealable decision as defined in section 132(a)(2) if:

(A) the amount involved exceeds a significant threshold; or

(B) the patient's life or health is jeopardized as a consequence of the decision.

103. See supra note 101.

104. See supra note 102.

105. See H.R. 3605 § 133(d); S. 1890 § 133(d).

106. See H.R. 3605 § 151(c); S. 1890 § 151(c); see also David Nather, Medical Necessity Proposal Poses Threat to Managed Care, Health Executives Warn, Health Care Daily Rep. (BNA), at d4 (Sept. 2, 1998), available in WESTLAW, BNA-HCD File (introducing the medical necessity provision of the Kennedy-Dingell proposal for the Patients' Bill of Rights and discussing arguments in support of and in opposition to the provision).

House GOP plan permitted the patient to have another doctor within the plan consider the case within three days. If that internal reviewer did not agree with the patient, the proposal provided that a doctor outside the plan could make an independent recommendation.

By the end of September, it became clear that the debate over the Patients' Bill of Rights legislation had developed into a political battle as Democrats tried to attach their proposal to a series of other bills and Republicans resisted. These political conflicts inhibited the passing of the Patients' Bill of Rights legislation, but did not kill the health care reform issue. Both Republicans and Democrats expect the reform proposals to be an issue in next year's legislative session.

In spite of the death of the Patients' Bill of Rights, the need for legislation that removes the threat of ERISA preemption remains significant. Congressional Democrats demand that prospective health care legislation contain powerful protections for patients. Congressional Republicans assert that such legislation must not disrupt the cost containment purpose of managed care. Future health care reform must address both of these positions, balancing the needs of patients with the objectives of today's health care industry.

109. See id. The Kennedy-Dingell plan had an appeals mechanism nearly identical to the Republican proposal. See supra notes 101-02. However, unlike the GOP plan, which permitted an insurance company to charge a patient up to $100 per review, the Kennedy-Dingell plan provided for free appeals to an outside doctor. See Cohn, supra note 107, at 15. Furthermore, the Kennedy-Dingell bill made external appeals binding by imposing an automatic fine on MCOs that failed to follow the decision of the review board. See id. The GOP bill, in contrast, required the patient to go to court to impose the fine. See id. at 15-16.
110. See Chafee Puts off Managed Care Proposal Until Next Year As Deadlock Drags on, Health Care Daily Rep. (BNA), at d6 (Sept. 25, 1998), available in WESTLAW, BNA-HCD File.
111. See supra note 19 and accompanying text (discussing plans to include the health care reform issue in next year's political agenda).
MINNESOTA LAW REVIEW

III. HEALTH CARE REFORM LEGISLATION:
AMENDING ERISA TO PROVIDE PATIENTS WITH
A FEDERAL REMEDY AGAINST MCOs THAT DENY OR
RESTRICT TREATMENT

Congress should amend ERISA to provide patients with the right to sue MCOs in federal court for damages caused by wrongful treatment decisions. Prior to litigation, a board of impartial physicians should review a patient's complaint to determine whether the patient should have been provided with the medical treatment denied by the MCO. In amending ERISA, Congress must consider the social and economic implications of providing patients with this powerful right, and in particular, the effects the right will have on the cost-cutting purpose of managed care.

A. THE BENEFITS OF GRANTING PATIENTS THE RIGHT TO SUE

The ERISA amendment will have numerous positive effects if it permits patients to sue MCOs for wrongful treatment decisions. First, the amendment will benefit patients by eliminating the shield of immunity that ERISA has provided for MCOs. This will ensure that ERISA's purpose of promoting the interest of individuals enrolled in employee benefit plans and their beneficiaries will apply to the health care industry.

In particular, amending ERISA to provide patients with the opportunity to hold MCOs liable in federal court would adapt ERISA to the changing realities of modern health care. When ERISA was passed in 1974, managed care was in its infancy, and doctors provided abundant service and treatment to patients at a high cost to employers. As more employers re-

112. A federal cause of action ensures that ERISA's purpose of protecting employers from conflicting state regulation of employee benefit plans is maintained. For further discussion of the benefits of amending ERISA to create a uniform federal cause of action for patients, see infra notes 119-23 and accompanying text.

113. See Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49, 53 (D. Mass. 1997) (arguing that there is a "glaring need for Congress to amend ERISA" to stop the evolution of ERISA as a "shield of immunity that protects health insurers, utilization review providers, and other managed care entities from potential liability").

114. See supra notes 45-47 and accompanying text (noting that Congress's primary objective in enacting ERISA was to protect employee-participants and their beneficiaries from the abuses occurring in employee benefit plans).

115. See Aylng, supra note 61, at 405; see also supra note 22 (discussing the fee-for-service form of health insurance prevalent at the time of ERISA's
eralized the cost benefits of managed care, membership in MCOs exploded, but physicians and MCOs began to abuse the cost containment features of managed care health plans to the detriment of employee beneficiaries.\textsuperscript{116} Although ERISA's text and legislative history indicate that Congress enacted ERISA to preempt state law causes of action that relate to employee benefit plans, Congress's main purpose in enacting ERISA was to safeguard the interests of employees.\textsuperscript{117} Because ERISA has been used to regulate health care benefits in a way that jeopardizes the interest of employees in obtaining quality health care, ERISA is harming employees rather than protecting them.\textsuperscript{118} Therefore, for Congress to stay true to its intentions, it must amend ERISA to keep the statute's purpose in line with modern health care.

In addition to protecting patients, ERISA reform legislation will benefit the states and the federal judiciary by providing a uniform statute under which all patients could hold MCOs accountable for denying them treatment. As more and more states pass laws permitting patients to sue MCOs, ERISA's purpose of ensuring that employees are subject to a uniform body of benefits law\textsuperscript{119} arguably will be defeated, because an MCO may cover employees in various states and thus be confronted with conflicting statutes. Permitting patients to sue under state common law claims also defeats this purpose, since the elements of malpractice, wrongful death, and breach of contract claims may differ among the states.\textsuperscript{120} In order to

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\item 116. \textit{See supra} notes 21-34 and accompanying text (referring to the rise of managed care and the negative effects the system has had on patients).
\item 117. \textit{See supra} notes 44-49 and accompanying text (discussing the purposes behind Congress's decision to enact ERISA in 1974).
\item 118. \textit{See supra} note 2 and accompanying text (describing the abuses suffered by some patients enrolled in managed care health plans).
\item 119. \textit{See} New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656 (1995) (stating that one of the purposes of ERISA's preemption clause is "to ensure that [employee benefit] plans and plan sponsors would be subject to a uniform body of benefits law").
\item 120. The major problem with ERISA preemption of patient claims against MCOs is that patients do not have sufficient means of targeting wrongful treatment denials or restrictions by MCOs. The proposed amendment eliminates this difficulty by granting patients a uniform federal cause of action against MCOs to challenge such decisions. If patients are injured purely as a result of their physicians' negligence, the proposed amendment does not hamper their ability to bring state claims against their physicians. However, the amendment continues to preempt such claims if they are brought against MCOs under the doctrine of vicarious liability. This ensures that MCOs will
eliminate this problem, Congress must amend ERISA to state explicitly that the Act preempts patient claims brought under state common law causes of action and statutes like the Texas and Missouri managed care laws. As a result, states will no longer have the burden of enacting legislation that permits patients to sue because the amendment would provide a uniform cause of action for all patients in all states. Moreover, federal courts will no longer need to engage in the difficult task of interpreting ERISA's ambiguous preemptive language and determining the scope of the fiduciary obligations imposed by ERISA on MCOs.

Congress will also benefit the health care industry by enacting ERISA reform legislation. Currently, due to ERISA preemption, patients denied treatment may only be able to sue and collect damages by bringing state causes of action against their treating physicians and hospitals. This places an enormous amount of pressure on physicians affiliated with managed care entities, because many MCOs encourage physicians to place financial considerations ahead of their duty to provide quality health care to patients, increasing the probability of negligent treatment outcomes. An ERISA amend-

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121. See supra notes 81-83 and accompanying text.
122. See 29 U.S.C. § 1144(a) (1994). By specifically preempting state claims, the ERISA amendment would save courts from the arduous task of determining whether a patient's claims are preempted by ERISA because they "relate to [an] employee benefit plan." Id.
123. Although federal courts have recognized that ERISA imposes fiduciary obligations on HMOs, thus permitting patients to bring suit in federal court against HMOs for breach of these obligations, the courts have not yet determined the scope of these duties and the proof that a patient must present to show that the HMO has breached its duties. See supra notes 12, 70-78 and accompanying text (discussing federal cases exploring HMOs' fiduciary obligations under ERISA).
124. Although some patients have managed to collect damages from HMOs by bringing vicarious liability claims against them, these claims are not always successful. See supra note 55 and accompanying text. Since ERISA preemption does not prevent patients from bringing medical malpractice, wrongful death and other state law claims against their treating physicians, patients are most certain to collect damages by bringing suits against them. See supra note 63.
125. See supra notes 24-28 (discussing the financial pressures faced by physicians contracting with HMOs).
ment that permits patients to sue MCOs would help eliminate some of this strain by encouraging patients to target the actions and decisions of their MCOs when they have been denied adequate care.

B. THE COST-BENEFIT ANALYSIS

Although permitting patients to sue MCOs in federal court for damages carries numerous benefits, critics including House and Senate Republicans argue that this right is the ticket to increased health insurance premiums.\(^\text{126}\) The critics assert that the purpose of MCOs is to reduce the costs of health care, and any legislation that encourages patients to bring lawsuits against MCOs would motivate them to raise insurance premiums at a substantial rate.\(^\text{127}\) The obvious negative effect of a substantial increase in health care costs is that many Americans will be forced to go without health insurance because they and their employers cannot afford the premiums. In response to these concerns, lobbyists, consumer protection groups, and Congressional offices have commissioned studies to determine whether and to what extent ERISA reform would actually lead to increased insurance premiums.\(^\text{128}\) Because these studies have produced inconsistent, inconclusive results,\(^\text{129}\) the likelihood of an increase in premiums remains uncertain.

\(^{126}\) One critic fears that regulating managed care by giving patients the right to sue will result in either of two consequences: (1) insurance will become too expensive for many people; or (2) the insurance companies will cut their costs by insuring only healthier people. See Cohn, supra note 98, at 22.

\(^{127}\) See id.

\(^{128}\) Acting on its belief that ERISA reform will hamper MCOs’ ability to control costs, the insurance industry and its lobby commissioned studies that showed such reform would produce an increase in health care premiums ranging from 3 to 23%. See id. at 21. This range of increase would make health insurance too expensive for millions of Americans, especially those employed by small businesses. See id. Insurance lobbyists and Republicans have latched onto these figures, casting themselves not as opponents of reform but as protectors of the needy. See id.

The nonpartisan Congressional Budget Office (CBO) conducted its own study, finding that even the sweeping proposals of the Democrats’ Patients’ Bill of Rights would only cause a modest premium hike of approximately 4%. In particular, the CBO found that each ERISA reform provision would individually produce a premium hike of 1.4%. See id.

\(^{129}\) See Litvan, supra note 17, at A1 (acknowledging that various political groups have come up with widely different cost estimates for health care reform proposals). These inconsistent results and the political struggles between those commissioning the studies make it difficult to know which studies are reliable.
Insurance lobbyists and Republicans assume that granting patients the right to sue MCOs will automatically increase litigation and thus force MCOs to increase premiums. It is very possible, however, that granting patients the right to sue will decrease litigation by deterring MCOs from wrongfully denying or restricting a patient's medical treatment. This result has actually occurred in states with statutes granting patients the right to sue MCOs. In Texas, for example, no lawsuits have been filed against HMOs since the law allowing patients to sue their HMOs was passed in 1997, leading some to conclude that the law has actually diverted lawsuits and saved patients' legal costs. Moreover, Congress can decrease the financial threat of increased litigation by restricting the damages injured patients can collect in the ERISA amendment.

Because ERISA reform will likely benefit patients, federal courts, the health care industry, and the states, Congress should amend ERISA despite the uncertain, politically charged speculation that premiums might increase. The Democrats'

130. See supra note 128 and accompanying text.
131. This has been one of the arguments made in response to concerns that exposing MCOs to vicarious liability for the malpractice of plan physicians will lead to increased premiums. See Natalie Zellner, Note & Comment, Duking it out: Beating the Complete Preemption of ERISA Under Dukes v. U.S. Healthcare, Inc., 14 GA. ST. U. L. REV. 925, 948-49 (1998). Those in support of exposing MCOs to malpractice liability argue that it will deter MCOs from hiring incompetent physicians and will encourage them to heighten the standard of care used in making medical decisions. See id.; see also Helene L. Parise, Comment, The Proper Extension of Tort Liability Principles in the Managed Care Industry, 64 TEMP. L. REV. 977, 1004-05 (1991). As a result, the quality of healthcare delivered by MCOs and physicians will increase, and the threat of costly malpractice claims will decrease. See Zellner, supra, at 949; see also Seema R. Shah, Comment, Loosening ERISA's Preemptive Grip on HMO Medical Malpractice Claims: A Response to Pacificare of Oklahoma v. Burrage, 80 MINN. L. REV. 1545, 1575 (1996).
133. See id.
134. Congress could limit the financial implications of granting patients the right to sue MCOs in a variety of ways. The ERISA amendment might provide that a patient can only collect punitive damages when the patient demonstrates that the MCO willfully or recklessly denied or restricted medical treatment. In addition, the amendment could place caps on the amount of punitive damages based on the size of the MCO. The amendment might also state that MCOs are entitled to collect attorney's fees and costs if they show that the patient's claim is frivolous or unreasonable.
135. See supra Part III.A (discussing the positive implications of an ERISA amendment that grants patients the right to sue MCOs in federal court for damages).
proposal for the Patients' Bill of Rights appears to recognize this by granting patients the right to sue in spite of the financial risks. On this point, the Democrats’ legislation offers patients greater protection than that proposed by Congressional Republicans.

IV. THE NECESSITY OF PRE-TRIAL REVIEW AS A PREREQUISITE TO SUIT IN FEDERAL COURT

In amending ERISA to permit patients to sue MCOs in federal court for damages, Congress should provide safeguards to ensure that patients do not abuse this newfound right. In addition to the threat of increased insurance premiums, permitting patients to sue MCOs creates the possibility that patients will bring lawsuits without considering whether the MCO was truly unreasonable or negligent in denying treatment. Due to the time and money that must be spent to litigate cases, the ERISA amendment should provide that patients may sue only after they have exhausted other means of obtaining the treatment they desire.

A. A MANDATORY APPEALS PROCESS AS A PREREQUISITE TO BRINGING SUIT

Congress can best ensure that patients bringing suit were unreasonably denied care and that their MCOs were responsible for the resulting consequences by incorporating a mandatory administrative review procedure into the ERISA amendment. An external appeals process is one mechanism that effectively achieves this purpose. The process would occur as follows: after an MCO denies a patient coverage for treatment that the patient and her physician agreed was in her best medical interest, the patient would appeal the decision to an external review board paid for by the MCO. The board would be comprised of medical, legal, and other professionals who have the expertise and staffing necessary to administer a review hearing. Potential members include physicians in the specialty relevant to the treatment decision, health administrators not affiliated with the patient’s MCO, and persons familiar with the financial and legal aspects of health care administration.

136. See supra note 105 and accompanying text.
In determining whether the patient-claimant was unreasonably denied treatment by the MCO, the board would first evaluate the patient's condition and the reasons her treating physician believed the treatment was in her best interest. The board would then consider the cost of the proposed treatment and the availability of similarly effective, more cost-efficient alternatives, but only after the members have a complete understanding of the medical aspects of the patient's situation. Once this analysis is complete, the board members would vote on whether to uphold or reverse the MCO's decision, and the treating physician and MCO would be subject to the board's judgment. The time allotted for the committee to conduct this process would be correlated with the severity of the patient's condition. The board must be prepared to conduct a hastened review where the patient's condition is so severe that the time taken for normal review would jeopardize the life or health of the patient. If the board is unable to perform a hastened review of the emergency situation, the MCO must permit the patient's physician to make the final treatment decision.

B. BRINGING THE CLAIM TO FEDERAL COURT

If the board upholds the MCO's treatment decision, the patient has two options: she can rest her case and accept the treatment the MCO is willing to provide, or she can challenge the decision by filing suit in federal district court. The ERISA amendment should allow patients choosing litigation to elect a jury trial. At trial, the findings of the review board would be probative but not binding. This enables the factfinder to examine the substance of the patient's claim without presuming that the MCO and review board acted reasonably. Because review board members are not elected but are chosen by MCO representatives and patient advocates, it is possible that their decisions will not be as impartial as they are supposed to be. A trial on the merits will enable the district court to check for evidence of corruption and to overturn decisions reflecting such bias.

C. ADVANTAGES OF A LIMITED RIGHT TO SUE

Incorporating a mandatory pre-trial review process into the ERISA amendment presents numerous advantages. First, the process eliminates frivolous treatment denials and restrictions by having impartial medical and health care professionals make final treatment decisions. By reducing the role of
MCO administrators, the process gives MCOs much less incentive and opportunity to put financial considerations before patients’ well-being. It also motivates MCOs to exercise greater caution when initially granting or denying treatment so that the patient will not challenge the treatment decision, thus saving the MCO the cost of paying for both the desired treatment and an appeal to the review board.

Second, the mandatory review process benefits MCOs by providing them with valuable evidence in their favor if dissatisfied patients challenge adverse treatment decisions in court. If review board members agree with an MCO’s treatment decision, the MCO can rely upon their testimony to support its case. Although the district court is not bound by the findings of the review board, these findings will likely educate the court about the circumstances of the patient’s case. The court may even defer to the judgment of these medical and health care experts in cases where there is no evidence of bias or corruption. Third, assuming the board is competent and independent, it may be difficult for the patient-plaintiff to find an array of witnesses that will sufficiently undermine the review board’s expertise. For these reasons, MCOs will be motivated to make sound, medically-supported treatment decisions that will survive appeal.

Critics argue that taking from MCOs the final authority to determine whether treatment should be administered will eliminate their ability to control health care costs. This assertion should not be a concern with the body of impartial professionals suggested above. By establishing a committee of unbiased medical and health care experts to review treatment denials, the ERISA amendment would assure MCOs that people who are involved with managed care are part of the decisionmaking process. Moreover, whether affiliated with an

137. See Nather, supra note 106.

138. Health insurance and business lobbyists, as well as House and Senate Republicans, are the major actors who oppose permitting physicians, rather than plan administrators, to determine whether treatment is a medical necessity. See id. They believe that the medical necessity provision “could force health plans to cover virtually any service a physician wants to provide, regardless of whether there is any scientific evidence that it is the right treatment for the patient’s condition.” Id. They also argue that the medical necessity provision would harm managed care’s ability to increase the use of preventive services “because physicians would see no reason to discuss treatments with the health plan and ‘would talk about a cure to the exclusion of prevention.’” Id.
MCO or not, today's medical professionals know that authorizing physicians to administer unnecessary medical treatment leads to financial crises that ultimately hurt patients. Therefore, review board members will likely use great care in exercising their power to determine whether to uphold a treatment decision in order to ensure that employers will be financially able to provide health care benefits for their employees into the future.

Commentators have also questioned the efficacy of external appeals processes because they are paid for by MCOs, which gives them an element of control that will ultimately leave patients where they would have been without the appeals process. For example, in the Medicare context, studies show that more than half of MCOs do not fully comply with the federal rules for grievance procedures. In particular, MCOs often mishandle appeals from the denial of treatment or reimbursement as grievances about quality or other matters, denying enrollees access to external review. Even if MCOs comply with these rules, some critics question whether MCOs will inform beneficiaries about their right to make a complaint to an external review board about treatment denials. They also argue that most beneficiaries will not understand the kinds of denials that trigger their appeal rights or have sufficient knowledge to exercise their rights effectively.

These criticisms fail to recognize the positive influence that the mandatory review process will have on MCOs. Requiring MCOs to fund review board appeals will encourage MCOs to make better treatment decisions to avoid the cost of the appeal and future litigation costs. MCOs will realize that sound medical decisions are much more cost-effective than mishandling a patient's appeal. In addition, although MCOs will fund review board appeals, the amount of control that the

139. See supra notes 24-28 and accompanying text (discussing the cost containment aspects of managed care and their effects on today's physicians).
140. See OFFICE OF INSPECTOR GENERAL, U.S. DEPT OF HEALTH AND HUMAN SERVICES, MEDICARE HMO APPEAL AND GRIEVANCE PROCESSES (1996). In particular, the report found that 66% of HMOs distributed information about appeal and grievance rights that was either incorrect or incomplete.
141. See id.
142. See Tracy E. Miller, Center Stage on the Patient Protection Agenda: Grievance and Appeal Rights, 26 J.L. MED. & ETHICS 89, 90 (1998).
143. See id.
144. See supra notes 131-33 and accompanying text.
ERISA amendment will permit the MCO to have over the appeal is minimal. First, medical and health care professionals will not be chosen for the review board if they have a conflict of interest with the patient or her MCO. Second, an unfavorable decision at the review level can always be challenged in court, and the court, after hearing evidence presented by the patient and the MCO, can determine whether the MCO exerted undue control over the review process. Third, the ERISA amendment could provide patients with a statutory remedy (e.g., attorney's fees and costs, liquidated damages, or punitive damages) if they show that the MCOs acted inappropriately in providing their appeal.

As far as informing patients of their right to appeal and helping them understand when they can bring the appeal, responsibility should lie with treating physicians. Treating physicians have just as much interest in making sure that MCOs do not unreasonably deny treatment to patients as the patients themselves. Therefore, they must demand that MCOs make clear the situations in which an appeal is acceptable. They also must educate patients about the efficacy of bringing an appeal based on their medical conditions, and about the steps they must take to accomplish effective appeals. Furthermore, Congress could aid physicians by dictating in the ERISA amendment the form of disclosure that should be made to patients. By building these safeguards into the ERISA amendment, Congress can ensure that patients are protected while maintaining a balance of authority between patients, physicians, review boards, courts, and MCOs.

CONCLUSION

As patients continue to suffer from the injustice of ERISA preemption, the need for ERISA reform is apparent. The scope of reform that federal courts and state legislatures can bring about is limited. Therefore, Congress must amend ERISA to permit patients to sue MCOs in federal court for damages. In order to diminish the risk that this right will lead to increased premiums and to ensure that the MCO truly acted unreasonably in denying treatment, a patient should not be able to exercise her right to sue until after an external review board comprised of impartial health care professionals has reviewed her claim. This arrangement enables medically-trained professionals to protect patients without the pressure of financial in-
centives while ensuring that the cost-cutting purpose of managed care is not destroyed by unnecessary litigation.