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Comment

Loosening ERISA's Preemptive Grip on HMO Medical Malpractice Claims: A Response to PacifiCare of Oklahoma v. Burrage

Seema R. Shah*

Barbara Jean Davidson arrived at St. John Medical Center in Tulsa, Oklahoma with severe abdominal pain.1 Upon admittance, a physician determined that Davidson had an acute abdomen and heavy internal bleeding.2 Despite her condition, the hospital released Davidson, who bled to death later that night.3 The personal representative of Davidson's estate, Clare Davidson Schachter,4 brought suit against the physician who directly provided Davidson's medical care, as well as PacifiCare of Oklahoma, Davidson's employer-provided health maintenance organization (HMO). In addition to fraud and loss of consortium,5 Schachter alleged that PacifiCare was vicariously

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* J.D. Candidate 1997, University of Minnesota Law School; B.A. 1992, Duke University.
2. Id. Dr. Rayburne W. Goen determined that Ms. Davidson's symptoms resulted from a massive hematoma caused by internal bleeding and pernicious anemia. Id. A hematoma is a localized mass of blood that is fairly confined within a space. STEADMAN'S MEDICAL DICTIONARY 772 (Marjory Spraycar ed., 26th ed. 1995) [hereinafter STEADMAN'S]. Patients with anemia have low levels of red blood cells (oxygen carrying components). Ms. Davidson's low level of red blood cells was further complicated by an increased prothrombin time. Schachter, 1995 U.S. Dist. LEXIS 14278, at *2. Prothrombin is a blood clotting agent. STEADMAN'S, supra, at 1446. Ms. Davidson thus had low levels of red blood cells and compromised blood clotting mechanisms.
4. Ms. Schachter not only filed the original lawsuit as personal representative of the Davidson estate, but also on behalf of herself and Ms. Davidson's other surviving children, Jack Davidson and Jill Davidson Rooney. Id. at *1.
5. Schachter alleged PacifiCare fraudulently induced Davidson to rely upon PacifiCare for her health care. Schachter, 1995 U.S. Dist. LEXIS 14278, at *3. Schachter brought a loss of consortium claim based on her mother's alleged wrongful death. Id.
liable under an ostensible agency theory\(^6\) for the medical malpractice\(^7\) of its alleged agent physician.\(^8\)

Arguing that the Employee Retirement Income Security Act (ERISA)\(^9\) preempted Schachter's state tort claims,\(^10\) PacifiCare removed the case to federal court\(^11\) and moved for summary judgment.\(^12\) The federal district court granted summary judgment on the fraud claim,\(^13\) but remanded the remaining pendent state law claims of medical malpractice and loss of consortium to state court.\(^14\) In an attempt to keep the claims

\[6. \text{See infra note 81 and accompanying text (defining ostensible agency).}\]

\[7. \text{Malpractice usually is defined as a failure to exercise the required degree of care, skill, and diligence under the circumstances. BARRY R. FURROW ET AL., HEALTH LAW § 6-2, at 237 (1995); Michael Day, Attacking Defensive Medicine Through Utilization Practice Parameters, 16 J. LEGAL MED. 101, 114 (1994). A physician's duty of care entails a "duty to render a quality of care consonant with the level of medical and practical knowledge the physician may reasonably be expected to possess and the medical judgment he may be expected to exercise." Hall v. Hilbun, 466 So.2d 856, 872 (Miss. 1985). Medical malpractice historically drives the "law of medical quality." Barry R. Furrow, The Changing Role of the Law in Promoting Quality in Health Care: From Sanctioning Outlaws to Managing Outcomes, 26 Hous. L. REV. 147, 152 (1989). Although in a state of reform, medical malpractice liability nevertheless has a significant impact on quality in our health care system. The current widespread use of medical practice guidelines, for example, grew out of malpractice liability concerns. Eleanor D. Kinney, Malpractice Reforms in the 1990s: Past Disappointments, Future Success?, 20 J. HEALTH POL., POLY & L. 99, 103 (1995).}\]

\[8. \text{Schachter, 1995 U.S. Dist. LEXIS 14278, at *3.}\]


\[10. \text{Schachter, 1995 U.S. Dist. LEXIS 14278, at *3.}\]

\[11. \text{Id. Judge Burrage heard the case in the United States District Court for the Northern District of Oklahoma. Id. at *1. The federal district court exercised removal jurisdiction over the fraud claim on the basis of the "complete preemption" doctrine. Id. at *11; see infra notes 54-65 and accompanying text (discussing complete preemption and removal jurisdiction in the context of ERISA preemption).}\]

\[12. \text{Schachter, 1995 U.S. Dist. LEXIS 14278, at *3.}\]

\[13. \text{The district court held ERISA preempted the fraud claim and therefore PacifiCare was entitled to summary judgment. Id. at *10-*11. The court found the fraud claim "related to" the employee benefit plan. Id. at *10. See generally infra note 48 and accompanying text (noting ERISA explicitly preempts state common law claims that "relate to" employee benefit plans).}\]

out of state court, PacifiCare applied for a writ of mandamus, maintaining that ERISA preempted the medical malpractice and loss of consortium claims. In *PacifiCare of Oklahoma v. Burrage*, the United States Court of Appeals for the Tenth Circuit denied PacifiCare's request for a writ of mandamus and held ERISA did not preempt the medical malpractice claim.

Medical malpractice claims against HMOs based on vicarious liability theories are the latest state common law malpractice claims encountering ERISA's formidable preemption structure. Courts already hold that ERISA preempts direct liability claims against HMOs for corporate negligence in the selection and retention of physicians and negligence involving utilization review. By preserving vicarious liability claims, *PacifiCare* restrains ERISA preemption. Because *PacifiCare* is a case of first impression among the federal circuit courts, future courts undoubtedly will rely on it for guidance on how to loosen state common law medical malpractice claims from ERISA's preemptive grip.

This Comment contends that courts should not follow *PacifiCare*’s approach in future HMO medical malpractice cases.

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15. Typically, a remand order does not represent a final judgment reviewable by appeal. A writ of mandamus to compel action, however, can be used to seek review of a remand order. *PacifiCare of Okla. v. Burrage*, 59 F.3d 151, 153 (10th Cir. 1995) (citing Thermtron Prods. v. Hermansdorfer, 423 U.S. 336, 352-53 (1976)). PacifiCare sought a writ of mandamus because a writ was the only method for the circuit court to review the ERISA preemption issues raised in the case. *Id.* at 152. PacifiCare sought a revocation of the remand order and a holding that ERISA preempted Schachter's two remaining claims. *Id.*

16. 59 F.3d 151 (10th Cir. 1995).

17. *Id.* at 155. The court also held ERISA did not preempt the loss of consortium claim to the extent the claim was based on PacifiCare's vicarious liability. *Id.*


Part I briefly reviews ERISA and its preemption jurisprudence with respect to HMO malpractice claims based on vicarious liability. Part II discusses the Tenth Circuit's holding and analysis in PacifiCare. Part III critiques the court's reasoning in PacifiCare and concludes that notwithstanding its proper result, the court's approach has shortcomings that could jeopardize future ERISA preemption cases. PacifiCare's approach rests on a deficient characterization of the vicarious liability medical malpractice claim, increases inconsistency within the field of ERISA preemption, and ignores the purpose of ERISA. This Comment proposes that courts adopt an approach to ERISA preemption of HMO vicarious liability claims that better reflects ERISA's purpose, current preemption jurisprudence, and public policy concerns regarding equity and quality in the health care system.

I. THE HMO'S ROLE IN HEALTH CARE AND THE ERISA PREEMPTION SCHEME

A. THE CONTINUING RISE OF THE HMO

The national health care cost crisis has prompted significant changes in the health care industry. While the public and private sectors continue to debate the best remedy for the nation's health care ills, many reform plans prominently feature measures designed to control health care costs. Given the increasing call for cost-containment mechanisms, the concept of managed care has experienced rapid growth.

20. BENDA & ROZOVSKY, supra note 18, §§ 1.1-1.2.
22. See G.A. Pane & E.H. Taliaferro, Health Care Cost Containment: An Overview of Policy Options, 23 ANNALS EMERGENCY MED. 103 (1987) ("While health care has become one of the leading policy concerns of the American public, cost containment has emerged as the most prominent underlying factor."); Jonathan J. Frankel, Note, Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures, 103 YALE L.J. 1297, 1297 (1994) (describing how medical expenditures are consuming an increasing proportion of the nation's resources).
23. Defined broadly, managed care organizations combine health care financing and delivery functions within a single entity focusing on utilization control. FURROW ET AL., supra note 7, at 308-09; Michael Day, Attacking Defensive Medicine Through Utilization Practice Parameters, 16 J. LEGAL MED. 101, 114 (1994).
24. Elizabeth W. Hoy et al., Change and Growth in Managed Care, HEALTH AFFAIRS, Winter 1991, at 19.
Of the various types of managed care organizations, HMOs are the most common. HMOs function as both health care insurers and providers in the health care industry. As insurers, HMOs typically employ utilization review, a cost control strategy which evaluates the necessity and appropriateness of the medical care provided to individual patients. The rapid growth of HMOs and the consequent expanded use of cost-containment techniques have increased the influence that HMOs have on medical decision making and health care delivery.

25. FURROW ET AL., supra note 7, at 309. HMOs exist in various forms, distinguishable by their relationship between the HMO and physicians. See BENDA & ROZOVSKY, supra note 18, § 1.1 (discussing different types of HMOs). The staff model HMO directly employs salaried physicians; the Independent Practice Association (IPA) model contracts with an association, which in turn contracts with independent physicians; and the group model HMO contracts with physician groups or partnerships. Chittenden, supra note 18, at 452-53. Approximately 48% of HMOs are IPAs and 38% are staff or group model HMOs. FURROW ET AL., supra note 7, at 309. An HMO's form may determine its potential malpractice liability. For example, staff model HMOs are susceptible to respondeat superior liability, while the IPA and Group models are vulnerable to vicarious liability via ostensible agency. Chittenden, supra note 18, at 455, 464.

Other types of managed care organizations include preferred provider organizations (PPOs) and physician-hospital organizations (PHOs). Unlike HMOs, which act as both insurer and health care deliverer, PPOs are organizations made up of health care providers that contract with independent insurers and employers to deliver care for patients covered by a particular health plan. BENDA & ROZOVSKY, supra note 18, § 2.4.2. Like PPOs, PHOs obtain health care delivery contracts from insurers or employers. PHOs, however, are jointly set up and owned by a hospital and a group of physicians. Id. § 2.4.4.

26. BENDA & ROZOVSKY, supra note 18, § 1.2; FURROW ET AL., supra note 7, at 309. In the high-cost fee-for-service system, insurers and providers are separate entities. BENDA & ROZOVSKY, supra note 18, § 1.2. HMOs are further distinguished from high-cost fee-for-service medicine in that they prospectively charge a fixed per capita fee. Id.

27. See FURROW ET AL., supra note 7, at 321-22 (noting that HMOs design utilization review or management into their structure); Frankel, supra note 22, at 1302 (defining utilization review and discussing management techniques). Utilization review often mandates precertification or concurrent review, which differs from the traditional health insurance practice of determining whether the health plan will pay for the care after treatment is provided. BENDA & ROZOVSKY, supra note 18, § 3.3.2.

28. See Frankel, supra note 22, at 1320 (describing the process by which HMOs make medical decisions that traditionally are reserved solely for physicians). This diffusion of medical authority from individual physicians to cost-containment actors, such as HMOs, leaves physicians in an uncomfortable position. See id. (discussing HMOs' review of physicians' treatment plans and imposition of alternative courses of treatment). HMOs take away costly resources physicians need to maintain the current standard of care, but the
Now, instead of merely reviewing and paying for participants’ health care, many HMOs enter into contracts with health care provider groups or directly hire their own health care professionals to provide medical services.\

B. THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

1. Enactment and Purpose

In the early 1970s, improper management of welfare and retirement plan funds and the lack of certain minimum standards compromised the stability of the growing number of employee benefit plans. In response, Congress enacted the Employee Retirement Income Security Act of 1974 for the “continued well-being and security of millions of employees and their dependents” who relied on the plans. Dubbed the current system of liability nonetheless holds physicians directly and primarily liable for not meeting that standard of care. Id. at 1322; see also Arnold S. Relman, The Future of Medical Practice, 22 PHYSICIAN EXECUTIVE 23, 24 (1996) (lamenting the end of physician autonomy in the face of managed care’s intrusion into clinical decision making and control of medical care spending).

29. The number of employees covered by group health plans enrolled in HMOs and Preferred Provider Organizations increased from 4% in 1981 to 27% in 1987. FURROW ET AL., supra note 7, at 309. In 1988, HMOs served more than 31 million subscribers. Chittenden, supra note 18, at 451 n.1. Between 1980 and 1992, the number of HMOs more than doubled while HMO enrollment quadrupled to 41.4 million (16% of the U.S. population). BENDA & ROZOVSKY, supra note 18, § 2.4. By the end of 1994, an estimated 50.5 million participants enrolled in HMOs for their health care needs. Id. § 2.4.

30. See supra note 25 (discussing HMO-physician relationships).


33. Id. § 2, 88 Stat. at 832.
“pension ‘bill of rights,’” ERISA reflects Congress’s primary purpose of protecting individual pension rights. Although the primary objective was the protection of employees, Congress also recognized the need to minimize the burdens on those employers who voluntarily set up employee benefit plans.

2. ERISA’s Coverage

To protect employee participants and beneficiaries, ERISA imposes federal regulatory control over the establishment, operation, and administration of employee benefit plans, including employee health care plans often administered by HMOs or other managed care organizations. ERISA provides safeguards that require reporting and disclosure, and establishes standards for minimum vesting, fiscal responsibility, and

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ERISA’s legislative history further documents the motivation behind its enactment. In the hearings over earlier employee benefit plan reform bill, the Senate Labor Committee heard the tragic stories of employees deprived of expected pension benefits after years of loyalty and hard work. 120 CONG. REC. 29,934-35 (statement of Senator Javits). William Wheeler of Ohio testified that after 42 years of service to a Cleveland plant, he was given $46.02 a month in pension benefits after the plant was downsized. Id. at 29,934. Similarly, Robert Pratt of New York received no pension benefits despite 47 years of service because the failing company laid off workers and terminated the employee benefit plans. Id. at 29,934-35; see also 1974 CONGRESSIONAL INFORMATION SERVICE/ANNUAL 157-58 (summarizing the hearings); 1973 CONGRESSIONAL INFORMATION SERVICE/ANNUAL 144-45 (same).


38. 29 U.S.C. § 1001(a) (requiring that “safeguards be provided with respect to the establishment, operation, and administration of [employee benefit] plans”).

39. 29 U.S.C. § 1002(1) (1994) (defining an employee benefit plan as any fund “established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries . . . medical, surgical, or hospital care or benefits”). Some HMOs are within ERISA’s purview because ERISA covers health plans offering participants membership in an HMO. 46 Fed. Reg. 5883 (1981).

By 1994, the percentage of employees covered under managed health care plans had grown to approximately 63% of all employees. BENDA & ROZOVSKY, supra note 18, § 1.1. Experts predict that by 1996, nine out of ten employers will have managed care components in their health benefit plans. Id.

In addition to its regulatory sections, ERISA contains several enforcement provisions. ERISA's civil enforcement scheme, § 502(a), provides employee participants with access to judicial remedies. Under § 502(a)(1)(B), an employee benefit plan participant or beneficiary can bring a civil action in federal or state court to "recover benefits due," enforce rights, or clarify rights to future benefits under the terms of the plan.

ERISA also includes a broad preemption provision, § 514(a), among its enforcement provisions. Congress enacted ERISA's preemption clause to achieve protective regulatory uniformity without the encumbrances of potentially conflicting state laws. The preemption clause explicitly states that ERISA's


42. ERISA's civil enforcement scheme limits the available remedies to accrued benefits, declaratory judgments, and injunctions. Id. § 1132(a)(1)(B). In reality however, these remedies are not readily available, especially the recovery of benefits. See Jay Conison, Suits for Benefits Under ERISA, 54 U. PITT. L. REV. 1, 3 (1992) (arguing courts have created legal obstacles to the recovery of benefits which often result in the denial of benefits, despite ERISA's purpose). Plaintiffs who bring a federal cause of action under ERISA's civil enforcement provision cannot recover punitive and extra-contractual (monetary compensatory) damage awards. Richard Rouco, Available Remedies Under ERISA Section 502(a), 45 ALA. L. REV. 631, 637-40 (1994).


45. In enacting ERISA, Congress aimed to "clear the field" for exclusive federal control. Shaw v. Delta Air Lines, 463 U.S. 85, 98-99 (1983). Senator Javits, one of the sponsors of the original Senate bill, explained the Conference Committee's adoption of the present preemption clause:

Both House and Senate bills provided for preemption of State law, but—with one major exception appearing in the House bill—defined the perimeters of preemption in relation to the areas regulated by the bill. Such a formulation raised the possibility of endless litigation over the validity of State action that might impinge on federal regulation, as well as opening the door to multiple and potentially conflicting State laws . . . . [T]he emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans
provisions, with a few exceptions, 46 "shall supersede any and all State laws" 47 insofar as they may now or hereafter relate to any employee benefit plan. 48 Preemption of state common law is required—but for certain exceptions—the displacement of State action in the field of private employee benefit programs.


The rationale behind uniformity was to avoid the administrative burdens that compliance with different federal and state laws would impose upon employers. Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 10 (1987). Members of Congress were concerned employers would shift the cost of the administrative burdens to employees and their beneficiaries by lowering benefit levels. Id. To avoid this problem, "Congress intended pre-emption to afford employers [and employee benefit plans] the advantages of a uniform set of administrative procedures governed by a single set of regulations." Id. at 11.

46. The most notable exception to ERISA's seemingly absolute preemption provision is the "savings clause," which states that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A) (1994). ERISA's "deemer clause," however, restrains this exception. This clause prohibits states from deeming an employee benefit plan to be an insurance company or other insurer, bank, trust, or investment company in order to use the savings clause. 29 U.S.C. § 1144(b)(2)(B) (1994).


48. 29 U.S.C. § 1144(a) (emphasis added). A state law "relates to" an employee benefit plan if it has a connection with or reference to such a plan. Shaw, 463 U.S. at 97 n.16. Drawing upon Shaw's interpretation of the phrase, lower federal courts recognize four categories of laws that "relate to" employee benefit plans:

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


Congress, at the last moment, changed the language of the preemption provision to its present form. The language in the original House version of the bill limited preemption to those areas specifically regulated by ERISA. Shaw, 463 U.S. at 98. The Act's conference committee rejected that language in favor of the current version of the preemption provision. 120 CONG. REC. 29,942 (1974) (statement of Senator Javits). Senator Javits' comments confirm that the Conference Committee did not accept the change in language lightly. Congress was aware that the preemption policy might have "the effect of precluding essential legislation at either the State or Federal level." Id. Hence, Congress intended that federal courts would step in when preemption was questionable and develop federal common law to resolve the ambiguity. Id.; Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 46 (1987). Absent legislative amendments, the
significant because state law claims generally permit damage awards, while ERISA causes of action do not. Sections 502(a)(1)(B) and 514(a) are integral to ERISA's preemption structure and thus greatly influence federal courts' role in ERISA preemption cases.

4. The Role of Federal Courts

Before deciding whether ERISA preempts a state common law claim, federal courts must resolve the threshold removal jurisdiction issue. If a federal court determines that removal is proper, it can readily dispose of the preemption issue. If, however, the court determines that removal is improper, it must remand the case to state court for resolution of the preemption issue.

only check on ERISA preemption currently available is the federal court system and the development of federal common law.

The creation of federal law turns on the question of "whether common law is needed to fulfill Congress's purposes in adopting a particular statute. . . . Congress cannot foresee every possibility. Inevitably, statutes have gaps and the application of statutes to specific situations requires the development of rules not created within the laws." ERWIN CHEMERINSKY, FEDERAL JURISDICTION § 6.3 (2d ed. 1994).

49. See supra notes 42-43 and accompanying text (discussing ERISA's remedies).

50. See CHEMERINSKY, supra note 48, § 5.1 (observing that jurisdiction is the legal authority to hear, deliberate, and decide the merits of a case). To determine whether removal is appropriate, the court must assess whether the state law claim can fall within ERISA's civil enforcement provision as a federal cause of action.

51. If a federal cause of action under ERISA exists, the plaintiff's state common law actions are preempted. See Pilot Life, 481 U.S. at 52-54 (finding claims falling under ERISA's civil enforcement provisions are meant to be exclusive and state claims are thus preempted).

52. Removal is improper if the state common law claim does not satisfy the principles of complete preemption, namely that the state common law claim is not a claim for benefits, a claim to enforce rights, or a claim to clarify rights. See infra notes 54-58 and accompanying text (discussing the complete preemption doctrine).

C. ERISA'S PREEMPTION STRUCTURE

1. Complete Preemption and Federal Preemption Within ERISA

ERISA's primary civil enforcement provision, § 502(a)(1)(B),\(^{54}\) directly implicates the complete preemption doctrine, thereby establishing federal question jurisdiction.\(^{55}\) Because federal question jurisdiction exists, a defendant can remove an ERISA claim from state court to federal court.\(^{56}\) Specifically, suits brought by employee benefit plan participants or beneficiaries under § 502(a)(1)(B) to recover benefits due, enforce employee benefit plan rights, or clarify plan rights are removable to federal court.\(^{57}\) Moreover, if federal courts can properly recharacterize a state common law claim as a federal cause of action arising under § 502(a)(1)(B), they can exercise removal jurisdiction.\(^{58}\)


\(^{55}\) Under the “well-pleaded complaint rule” original federal jurisdiction only exists when a federal question is presented on the face of a plaintiff's properly pleaded complaint. Caterpillar Inc. v. Williams, 482 U.S. 386, 392 (1987). The complete preemption doctrine is an independent corollary to the well-pleaded complaint rule. Id. at 393. Under the complete preemption doctrine, a federal statute endowed with such extraordinary preemptive power “converts an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule.” Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 65 (1987). The complete preemption doctrine provides that if a federal cause of action completely preempts a state cause of action, any claim that comes within the federal cause of action is necessarily federal in character. See id. at 66; Franchise Tax Bd. v. Construction Laborers Vacation Trust, 463 U.S. 1, 24 (1983); see also Goepel v. National Postal Mail Handlers Union, 36 F.3d 306, 308-12 (3d Cir. 1994) (reviewing the Supreme Court's complete preemption doctrine), cert. denied, 115 S. Ct. 1691 (1995).

\(^{56}\) Removal jurisdiction is based on original federal jurisdiction. See 28 U.S.C. § 1441(a) (“Any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States.”). ERISA's primary enforcement provision creates a federal cause of action under the complete preemption doctrine. See Rice v. Panchal, 65 F.3d 637, 639 (7th Cir. 1995) (identifying § 502(a) as the basis of complete preemption in ERISA); Warner v. Ford Motor Co., 46 F.3d 531, 534 (6th Cir. 1995) (same); Dukes, 57 F.3d at 355 (same).

\(^{57}\) Metropolitan Life, 481 U.S. at 66 (finding the legislative history clearly indicates Congress intended to make causes of action in § 502(a) removable to federal court); see supra note 43 and accompanying text (identifying the three types of ERISA claims that plaintiffs may bring).

\(^{58}\) See Rice, 65 F.3d at 642 (determining whether a vicarious liability medical malpractice claim can be properly recharacterized as a suit within the
Whereas ERISA's civil enforcement provision implicates the complete preemption doctrine, ERISA's preemption clause triggers traditional federal preemption. Under traditional preemption doctrine, ERISA overrides and displaces state law by virtue of its express preemption provision. Although complete preemption and federal preemption inquiries are separate, their results are linked. If a claim is completely preempted under ERISA, it is necessarily preempted because claims subject to complete preemption constitute a subset of the claims subject to preemption. Hence, even if a federal court determines that a state common law claim escapes complete preemption, removal to federal court, the claim may still fall prey to ERISA preemption.

The preemption doctrine does not advocate the wholesale displacement of state law. Instead, in traditional preemption

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59. Complete preemption and federal preemption are two distinct concepts. Federal preemption is typically a defense to a state common law claim. As such, it does not appear on the face of the plaintiff's complaint. Metropolitan Life, 481 U.S. at 63. Hence, unlike complete preemption in § 502(a), preemption under § 514(a) does not by itself confer removal jurisdiction over an arguably preempted state common law claim. Id. at 64; see also Caterpillar, 482 U.S. at 393 ("It is now settled law that a case may not be removed to federal court on the basis of a federal defense, including the defense of preemption."). For clarity, this Comment uses the phrases complete preemption and ERISA preemption to distinguish between complete preemption under ERISA § 502(a) and federal preemption under § 514.


62. Dukes v. U.S. Healthcare, Inc., 57 F.3d 350, 355 (3d Cir.), cert. denied, 116 S. Ct. 564 (1995). Claims subject to complete preemption are those that seek to recover benefits, enforce rights, or clarify the benefits under the employee benefit plan. 29 U.S.C. § 1132(a)(1)(B). These three federal claims all directly "relate to" the employee benefit plan and are thus preempted by the ERISA preemption clause. Plaintiffs with completely preempted state law claims can still bring their claims as an ERISA cause of action, but their remedies will be severely limited. See supra note 42 and accompanying text (discussing ERISA's judicial remedies).

63. Dukes, 57 F.3d at 355. Because ERISA preemption applies to a larger group of state common law claims than complete preemption, more claims than just the three designated for complete preemption can "relate to" an employee benefit plan.
cases, courts begin with a presumption against preemption and, therefore, construe express preemption provisions narrowly. In ERISA cases, however, courts have rarely invoked this canon to limit the reach of ERISA's preemption clause.  

64. See, e.g., Cipollone v. Liggett Group, Inc., 505 U.S. 504, 518 (1992) (examining the Federal Cigarette Labeling and Advertising Act's preemption provision through a "presumption against preemption" lens); Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 741 (1985) ("The presumption is against pre-emption, and we are not inclined to read limitations into federal statutes in order to enlarge their pre-emptive scope."); Maryland v. Louisiana, 451 U.S. 725, 746 (1981) (noting a presumption that "Congress did not intend to displace state law").

The canon has its roots in federalism, which counsels against federal abrogation of the states' police powers, particularly in matters of health and safety. Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230 (1947); see also Hillsborough County v. Automated Medical Lab., 471 U.S. 707, 719 (1985) (affirming that "the regulation of health and safety matters is primarily, and historically, a matter of local concern"). The presumption against preemption of state law applies equally to legislatively enacted (state statute) or judicially mandated law (common law). Sperry v. Florida, 373 U.S. 379, 403 (1963).

65. Cipollone, 505 U.S. 518. Supporting Cipollone's articulation of the "presumption against displacement of state law" canon, Justice Blackmun, in partial concurrence, stated, "[t]he principles of federalism and respect for state sovereignty that underlie the Court's reluctance to find pre-emption where Congress has not spoken directly to the issue apply with equal force where Congress has spoken, though ambiguously." Id. at 533. Courts embarking on such an analysis must determine "not whether Congress intended to pre-empt state regulation, but to what extent." Id. (Blackmun, J., Kennedy J., Souter, J., concurring in part and dissenting in part). Courts attempting to infer the scope of preemption will most likely rely heavily on explicit statements or indications of a statute's purpose. For example Cipollone, considered the 1965 Federal Cigarette Labeling and Advertising Act's statement of purpose first in its analysis. The Court then narrowly interpreted the Act's preemption provision and confirmed the Act does not preempt state law damages claims. Id. at 518-19.

2. ERISA Preemption's Scope and Application

The parameters of ERISA preemption are broad, but not unlimited. ERISA does not preempt state common law claims that "affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." ERISA also does not preempt "run-of-the-mill" state common law claims. In addition, ERISA preemption jurisprudence has continued to evolve. The Supreme Court, vexed by the inadequacy of ERISA's text, determined that courts should "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


67. A state law "relates to" an employee benefit plan if it has a connection with or reference to such a plan. Shaw, 463 U.S. at 96-97 & n.16. Shaw asserted the encompassing language of ERISA's preemption provision demanded an equally broad preemptive reach. Id. at 96 (noting "[t]he breadth of § 514(a)'s pre-emptive reach is apparent from that section's language."); see also Metropolitan Life, 471 U.S. at 739-40, 745-46 & n.23 (1985) (citing Shaw and describing § 514 as a "sweeping general pre-emption clause"). Shaw's establishment of the broad nature of ERISA preemption is an enduring fixture in ERISA preemption jurisprudence; numerous Supreme Court and lower federal court opinions have cited to it.


69. Mackey, 486 U.S. at 833.

70. See generally Karen A. Jordan, Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption, 13 YALE J. ON REG. 255 (1996) (examining past ERISA preemption cases and discussing a recent Supreme Court case that signals a change in ERISA preemption analysis).

state law that Congress understood would survive."\textsuperscript{72}

Amid enormous growth in ERISA preemption litigation,\textsuperscript{73} the scope of ERISA's preemption provision also has prompted debate among legal commentators.\textsuperscript{74} ERISA supporters applaud the uniformity and reduced administrative burdens that ERISA's preemption provision secured.\textsuperscript{75} Some critics, however, cite ERISA preemption's negative impact on injured plaintiffs and state-initiated health care reform.\textsuperscript{76} Others

\textsuperscript{72} New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins., 115 S. Ct. 1671, 1677 (1995). The Court's conclusion appears to echo Justice Stevens' dissent in an earlier ERISA preemption case. See District of Columbia v. Greater Wash. Bd. of Trade, 506 U.S. 125, 133-38 (1992) (Stevens, J., dissenting). In the face of "burgeoning" ERISA preemption litigation, Justice Stevens favored a retreat from the Court's fixation on the text of ERISA's preemption clause:

Several years ago a District Judge who had read "nearly 100 cases about the reach of the ERISA preemption clause" concluded that "common sense should not be left at the courthouse door." A recent LEXIS search indicates that there are now over 2,800 judicial opinions addressing ERISA preemption. This growth may be a consequence of the growing emphasis on the meaning of the words "relate to," thus pre-empting reliance on what the District Judge referred to as "common sense."


\textsuperscript{74} See \textit{id.} at A1, A26 (surveying the positions of supporters and critics of ERISA preemption).

\textsuperscript{75} \textit{Id.} at A26.

\textsuperscript{76} See generally Devon P. Groves, \textit{ERISA Waivers and State Health Care Reform}, 28 \textit{COLUM. J.L. & SOC. PROBS.} 609 (1995) (criticizing the disastrous effects of ERISA preemption on state health care reform plans); James E. Holloway, \textit{ERISA, Preemption, and Comprehensive Federal Health Care: A Call for "Cooperative Federalism" to Preserve the States' Role in Formulating Health Policy}, 16 \textit{CAMPBELL L. REV.} 405 (1994) (maintaining ERISA has a negative impact on state health care law but that amending ERISA may not be the answer); Samborn, \textit{supra} note 73, at A26 (noting the effects of preemption on ERISA plaintiffs). Injured ERISA-covered plaintiffs are caught in a tragic situation. They are unable to bring an ERISA cause of action for monetary awards, yet they also are deprived of monetary remedies normally available under state common law because ERISA bars all state common law suits that "relate to" employee benefit plans. 29 U.S.C. \textsection 1144(a) (1994). As one ERISA
criticize the federal courts for their "abdication of judicial law-making authority" in the face of ERISA's primary purpose.77

D. FEDERAL COURT APPROACHES TO ERISA PREEMPTION OF HMO MALPRACTICE CLAIMS

While HMOs have successfully raised ERISA preemption as a defense in medical malpractice76 cases based on direct negligence,78 district courts disagree on whether ERISA preempts

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expert remarked, "the broad pre-emption and the lack of remedies . . . [make] plan participants worse off now than they were 20 years ago, before ERISA was passed." Samborn, supra note 73, at A26. As a result, plaintiffs' attorneys note the cost of filing an ERISA suit is often far greater than the potential recovery. Id. The Department of Labor has also joined the struggle for participant benefits as amicus curiae in several suits. Id. See generally Michael Daly, Attacking Defensive Medicine Through the Utilization of Practice Parameters, 16 J. LEGAL MED. 101, 120-23 (1995) (arguing that either Congress should amend ERISA to allow state law actions directly against HMOs or courts should carve out a preemption exception for HMOs); Jayne Elizabeth Zanglein, Employee Benefits for General Practitioners: Ten Rules that Every Attorney Should Know About ERISA, 26 TEx. TECH L. REv. 579, 580 (1995) (referring to ERISA as "Every Ridiculous Idea Since Adam").


78. Large-scale health care providers, such as hospitals, are subject to malpractice liability under a number of theories. See FURROW ET AL., supra note 7, §§ 7-2 to 7-4. Increasingly, courts appear more willing to extend these negligence theories to HMOs. See generally Chittenden, supra note 18, at 453-85 (comparing various theories of liability and their application to hospitals and HMOs). HMOs, however, have several defenses available to them to minimize their potential liability exposure. See id. at 465-68, 485-92 (discussing the preventive measures and statutory defenses that HMOs can bring).

79. Courts appear more willing to preempt direct negligence claims because such claims involve the administration of plan benefits or assert a denial of benefits, both clearly within ERISA's mandate. Two of the most well-known and harshly criticized direct negligence cases were brought against HMOs on the basis of their utilization review role. Corcoran v. United HealthCare was originally filed as a wrongful death action in a Louisiana state court. 965 F.2d 1321, 1324 (5th Cir.) (involving the death of an unborn child during the last stage of a high-risk pregnancy in which the HMO denied pre-certification for a hospital stay against the physician's recommendation), cert. denied, 506 U.S. 1033 (1992). The defendant HMO removed the malpractice claim to federal court and raised preemption. Id. at 1324-25; see supra notes 55-58 and accompanying text (discussing the removal of claims arguably preempted by ERISA). On review, the Fifth Circuit Court of Appeals held ERISA preempted the state tort action. Corcoran, 965 F.2d at 1339. Though troubled that its holding denied the Corcorans any form of state or federal remedy, the court nevertheless maintained that ERISA compelled such a result and the task of
indirect negligence claims, such as ostensible agency malpractice claims. An ostensible agency malpractice claim asserts that a physician was negligent, and that an ostensible agency relationship exists between the negligent physician and the HMO. Such a relationship generally exists if the HMO "holds out" the physician as its agent and the patient looks to the HMO, rather than to the individual physician, for medical care.

Several district courts hold ERISA does not preempt ostensible agency malpractice claims because such claims do not "relate to" the employee benefit plan. Those courts found that reevaluating ERISA lies with Congress. Id. at 1328-39. Corcoran held ERISA's remedial scheme did not include the extracontractual damages sought by the Corcorans despite agreement that the Corcorans did not have any available remedy under ERISA. Id. at 1334-39.

Analogously, the Eighth Circuit Court of Appeals held ERISA preempted a wrongful death action against an HMO allegedly responsible for making a utilization review decision regarding a heart transplant that led to a patient's death. Kuhl v. Lincoln Nat'l Health Plan, 999 F.2d 298, 303 (8th Cir. 1993), cert. denied, 114 S. Ct. 694 (1994). Like Corcoran, Kuhl agreed with the district court that ERISA did not permit the Kuhls to recover monetary damages. Id.

Significantly, the plaintiffs in Corcoran and Kuhl unsuccessfully sought to challenge administrative decisions made by HMOs whose role was limited to utilization review and were not health care providers. In contrast, the HMO in Kohn v. Delaware Valley HMO, No. CIV.A.91-2745, 1992 WL 22241, at *1 (E.D. Pa. Feb. 5, 1992), faced state tort claims both for its failure to precertify treatment (utilization review) and for vicariously providing negligent medical services through its physician-agents. Kohn held ERISA preempted the negligence claim for failure to precertify treatment, but did not preempt the ostensible agency claim. Id. at *4 (reasoning ostensible agency claims are not based on benefit plan obligations, while utilization review decisions are basically determinations for benefits).

81. Ostensible agency liability is based on vicarious liability-agency principles. FURROW ET AL., supra note 7, at 292; see also infra note 99 (discussing vicarious liability principles).
82. Chittenden, supra note 18, at 458; see also Weldon v. Seminole Mun. Hosp., 709 P.2d 1058, 1059-61 (Okla. 1985) (discussing Oklahoma courts' articulation of the ostensible agency relationship); RESTATEMENT (SECOND) OF TORTS § 429 (1965) (stating that "[o]ne who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or by his servants, is subject to liability for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as though the employer were supplying them himself or by his servants").
83. See Jackson v. Roseman, 878 F. Supp. 820, 825 (D. Md. 1995) (disagreeing with courts that hold medical malpractice claims based on direct or vicarious liability theories relate to the benefit plan); Haas v. Group Health
minor reference to the plan to establish the ostensible agency relationship does not justify preemption. More importantly, the courts rejected the argument that the ostensible agency malpractice suits involve claims for denied benefits and are therefore preempted under ERISA's primary civil enforcement provision. Instead, the courts determined that, under these claims, the patient received medical benefits that were negligently provided. Other courts also hesitated to eliminate state tort claims without the express authorization of Congress.

District courts holding ERISA preempts HMO vicarious liability malpractice claims generally have maintained that agency claims are based on "circumstances of medical treatment." Because these ostensible agency claims were made

Plan, 875 F. Supp. 544, 548 (S.D. Ill. 1994) (holding that a vicarious liability malpractice claim does not "refer to and apply solely to an ERISA plan, but rather . . . is tort law of general application with an incidental effect on ERISA plans"); Kearney v. U.S. Healthcare, Inc., 859 F. Supp. 183, 185-86 (E.D. Pa. 1994) (noting "the term 'related to' is not to be taken literally but rather must be applied consistent with the policies underlying ERISA"); Independence HMO v. Smith, 733 F. Supp. 983, 988-89 (E.D. Pa. 1990) (rejecting the HMO argument that the malpractice claim against the HMO was a state tort claim that relates to the ERISA plan).

84. Jackson, 878 F. Supp. at 826 (finding that reference to the plan only to prove agency does not implicate the policy concerns of ERISA); Haas, 875 F. Supp. at 549 (holding the mere fact that a claim requires examination of the plan to resolve a contractual issue of whether the HMO held out a physician as its agent does not justify preemption); Kearney, 859 F. Supp. at 186 (arguing ERISA concerns are not implicated by a reference to the plan as evidence that the HMO held someone out as its agent).

85. See, e.g., Kearney, 859 F. Supp. at 186.

86. E.g., Kearney, 859 F. Supp. at 186.

87. See Haas, 875 F. Supp. at 549 ("This Court is reluctant to preempt state tort law claims based on substandard treatment, a claim unrelated to administration of a plan, where there is no reliable evidence of Congressional intent to do so."); Elsesser v. Hospital of Phila. College of Osteopathic Medicine, 802 F. Supp. 1286, 1290 (E.D. Pa. 1992) (refusing to find that ERISA preempts traditionally state law professional malpractice actions in the absence of congressional intent).

pursuant to the employee health care plan, the courts deemed them "related to" to the plan. Furthermore, the malpractice claims involved the quality of benefits promised by the plan. According to these courts, ERISA preempts these claims attacking the denial of promised quality benefits because they involve referencing the plan to determine what was promised.

In contrast, in *Dukes v. U.S. Healthcare, Inc.*, the Third Circuit held that claims attacking quality are not claims to recover denied medical benefits and, therefore, are not completely preempted. The court found that the legislative history, structure, purpose, and civil enforcement provision of ERISA say nothing about controlling the quality of benefits received by plan participants. Accordingly, the court reversed the lower court ruling and adopted the characterization of the ostensible agency malpractice claim as one involving the quality of the benefits.

89. *See, e.g.*, Pomeroy, 868 F. Supp. at 113 (maintaining ostensible agency malpractice claims necessarily involve an examination of the HMO’s representations regarding its physician and that such an inquiry focuses on explanations of the benefit plan); Visconti v. U.S. Health Care, 857 F. Supp. 1097, 1104-05 (E.D. Pa. 1994) (noting that determination of an ostensible agency relationship would require examination of the plan and thus "relates to" it), rev’d and remanded sub nom., Dukes v. U.S. Healthcare, Inc., 67 F.3d 350 (3d Cir.), cert. denied, 116 S. Ct. 564 (1995); Nealy, 844 F. Supp. at 973 (noting the relationship between the HMO, doctor, and patient is based on the terms of the plan); Ricci, 840 F. Supp. at 317 (noting the contract defines the relationship between provider and physician and affects the circumstances of medical treatment).


91. “The question is one of relating plan-performance to plan-promise, and is therefore pre-empted by ERISA.” *Id.* at 42; cf. Visconti, 857 F. Supp. at 1102-03 (contending the terms of the employee health benefits plan determine the requisite quantity and quality of benefits provided by doctors and the HMO).

92. *Dukes*, 57 F.3d at 356-58. The court held the vicarious liability claim cannot be characterized as any of the three causes of action available under ERISA. *Id.* at 351-52 (holding “the plaintiffs’ claims are not claims ‘to recover [plan] benefits due . . . under the terms of [the] plan, to enforce . . . rights under the terms of the plan, or to clarify . . . rights to future benefits under the terms of the plan’ as those phrases are used in § 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B)).

93. *Id.* at 356-57.

94. *Id.* at 356, 361. The court noted, however, that its holding could prompt HMOs to state explicitly in the employee benefit plan that the participant would receive medical care from high quality physicians. *Id.* at 358 (“We recognize the
II. PACIFICARE OF OKLAHOMA V. BURRAGE

In PacifiCare of Oklahoma v. Burrage, the United States Court of Appeals for the Tenth Circuit became the first circuit court to decide whether ERISA preempts a medical malpractice claim based on a vicarious liability theory against an ERISA-regulated managed care entity. Relying heavily on principles developed in prior ERISA cases, the court analyzed the vicarious liability malpractice claim in light of the "relates to" language in ERISA's preemption clause.

PacifiCare carefully explored the nature of the vicarious liability malpractice claim. The court used the more inclusive possibility that an ERISA plan may describe a benefit in terms that can accurately be described as related to the quality of the service.

Courts would thus be tempted to construe a malpractice claim as one "to recover benefits." The court reserved judgment on whether an employer and an HMO could agree that a quality of health care standard articulated in the employee benefit plan would replace applicable state tort standards and instead opt for the more advantageous federal law of ERISA. This Comment urges courts to reject such transparent attempts by HMOs to manipulate ERISA to their advantage.

PacifiCare frequently cited two of its prior ERISA cases, National Elevator Indus., Inc. v. Calhoon, 957 F.2d 1555 (10th Cir.), cert. denied, 506 U.S. 953 (1992), and Airparts Co. v. Custom Benefit Serv., 28 F.3d 1062 (10th Cir. 1994), which in turn relied on reasoning from the Second, Fifth, Sixth, and Ninth circuit courts. Based upon this reasoning, PacifiCare observed:

ERISA does not preempt "laws of general application—not specifically targeting ERISA plans—that involve traditional areas of state regulation and do not affect relations among the principal ERISA entities.... As long as a state law does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the [law] has some economic impact on the plan does not require that the [law] be invalidated."

PacifiCare noted the "tenuous, remote, or peripheral" limitation on the Shaw "relates to" test. PacifiCare made these observations, it did not use them in its analysis. Instead, the court suggested the lack of any effect on the relations among the principal ERISA entities—the employer, the ERISA plan, the beneficiaries, and any fiduciaries—ultimately settles the preemption question.

See PacifiCare, 59 F.3d at 154 (holding the law "relates to" an employee benefit plan if it has connection with or reference to the plan). PacifiCare noted the "tenuous, remote, or peripheral" limitation on the Shaw "relates to" test. PacifiCare then examined whether the benefit plan "related to" any of the recognized four categories of laws thereby subjecting the plan to ERISA.
phrase, vicarious liability, to refer to the ostensible agency claim at issue in the original suit and categorically rejected characterization of the vicarious liability malpractice claim as a claim for quality. The court also discarded the argument that the claim involved the level of benefits promised by the plan. Instead, it accepted a characterization of the claim as directed toward its two elements: the doctor's negligence and the agency relationship between the doctor and the HMO. The court agreed with the district court finding that "reference to the plan to resolve the agency issue does not implicate the concerns of ERISA preemption." The court further held that the issue of negligence involves an examination of the relationship between the patient and physician, and an evaluation of whether the physician failed to meet the proper standard of care.

Following other district courts' interpretation of pertinent ERISA language, PacifiCare concluded that "reference to" the plan for purposes of establishing the agency relationship between PacifiCare and its physicians does not compel preemption of the claim. The court further reasoned that since ERISA does not preempt the malpractice claim against the plan's doctor, it should not preempt the vicarious liability

99. See Schachter v. PacifiCare of Okla., No. 94-C-203-BU, 1995 U.S. Dist. LEXIS 14278, at *1, *3 (N.D. Okla. Mar. 16, 1995) (referring to Davidson's physician as PacifiCare's "ostensible agent"). "Vicarious liability" denotes both respondeat superior/actual agency and ostensible/apparent agency doctrines. Chittenden, supra note 18, at 453. An HMO is liable under the respondeat superior theory if it employed the negligent physician. Id. at 454. The employer-employee relationship implies that the HMO exercises actual control over the physician. Id. at 454-56. "Where no employment relationship exists, however, vicarious liability may still attach to the [HMO]... under the doctrine of 'ostensible agency.'" Id. at 458.

100. 59 F.3d at 155. PacifiCare reacted to the district court's reasoning in Dukes v. United States Health Care Systems that ERISA preempts vicarious liability malpractice claims because of the claim questions whether the actual benefits received measured up to those outlined in the employee benefit plan. Id. PacifiCare presumably rejected the "quality" construction in an attempt to avoid the district court's per se preemption.

101. See id. (restating the observation of the district court that the claim did not involve the level of benefits promised by the health plan).

102. See id. ("The claim alleges negligent care by the doctor and an agency relationship between the doctor and the HMO.").

103. Id.

104. Id.

105. See supra notes 83-87 and accompanying text (discussing the reasoning of courts holding that ERISA's "relates to" language does not require preemption of ostensible agency malpractice claims brought against HMOs).

106. PacifiCare, 59 F.3d at 155.
malpractice claim against the HMO. According to the court, however, the vicarious liability claim will only survive if the HMO "held out" the doctor as its agent. Consistent with these findings, PacifiCare held ERISA does not preempt the medical malpractice claim brought against the HMO and denied the HMO's petition for a writ of mandamus.

III. SOLID RESULT, SHAKY REASONING: LEGAL AND PRACTICAL SHORTCOMINGS OF THE PACIFICARE CHARACTERIZATION OF VICARIOUS LIABILITY CLAIMS

PacifiCare of Oklahoma v. Burrage correctly decided ERISA does not preempt HMO medical malpractice claims based on a vicarious liability theory. The decision, however, rests on a deficient characterization of the vicarious liability malpractice claim that emphasizes the two separate elements of the claim rather than the quality of benefits received. Although the PacifiCare construction of the claim is legitimate, the court's express rejection of the "quality" standard is inconsistent with the characterization of the vicarious liability malpractice claim advanced by the only other circuit court to consider ERISA preemption in this context. In addition, PacifiCare's approach mires the question of ERISA preemption of vicarious liability malpractice claims in a morass of textual ambiguity. Future courts will need a stronger approach to ensure that PacifiCare's desirable result withstands scrutiny.

107. Id.
108. Id.
109. Id. PacifiCare affirmed the district court's decision and ruled the court acted within its discretion when remanding the loss of consortium claim to state court. Id. Loss of consortium claims maybe based on vicarious liability and fraudulent administration of a plan. Id. ERISA preempts loss of consortium claims based upon fraud. Id. The district court, therefore, correctly concluded the plaintiff's loss of consortium claim was not preempted by ERISA to the extent that the claim was based on vicarious liability. Id.
110. 59 F.3d at 155.
111. The elements of an ostensible agency malpractice claim are the doctor's negligence and the parallel agency relationship between the doctor and the HMO. See supra text accompanying note 103 (discussing PacifiCare's articulation of the ostensible agency claim).
112. See supra notes 92-94 (discussing the Third Circuit's characterization of the vicarious liability claim as one attacking the quality of received benefits in Dukes v. U.S. Healthcare, Inc.).
113. PacifiCare's reliance on the text of ERISA is a departure from the current trend in ERISA preemption jurisprudence. See supra note 68 (discussing the Supreme Court's recent approach to ERISA preemption).
A. PacifiCare's Solid Result: Loosening ERISA's Preemptive Grip

PacifiCare properly ruled that ERISA does not preempt ostensible agency malpractice claims brought against HMOs, thereby checking ERISA's largely unrestrained preemption power. Past courts relied heavily on the text of ERISA's preemption clause and ignored the policy behind ERISA, thereby denying injured plaintiffs judicial remedy.114 Given that ERISA's goal is to protect employee-benefit-plan beneficiaries from injury, Congress certainly could not have intended such an absurd result. In addition, the Supreme Court115 and various district courts116 have experienced difficulty in assigning boundaries to ERISA preemption. PacifiCare's narrow holding quells some of this judicial confusion and may resolve the district court split. By restraining ERISA preemption of indirect medical malpractice claims, PacifiCare avoids the absurd result reached by earlier courts and offers injured patients an avenue to bring these claims against their HMOs.

B. PacifiCare's Shaky Reasoning: Shortcomings of the PacifiCare Approach

1. Legal Paradox and the Loss of Quality

In resolving the inconsistency among district court holdings, PacifiCare ironically adopts an inconsistent approach of its own that creates a troubling legal paradox. In its "complete preemption" inquiry, the Third Circuit in Dukes v. U.S. Healthcare, Inc., characterized the ostensible agency malpractice claim against the HMO as a claim touching upon the quality of medical services received.117 PacifiCare, however, discards this "quality" construction in its ERISA preemption analysis.118 In doing so,

114. See supra notes 68, 72 (noting the Supreme Court's early loyalty to ERISA's text); supra note 80 and accompanying text (discussing the injurious results in "direct negligence" cases, in which federal courts held that ERISA preempted medical malpractice actions because they "relate to" the employee benefit plan).
115. See supra note 66 (discussing the Supreme Court's inconsistent approach to ERISA preemption cases).
116. See supra notes 83-91 and accompanying text (describing the district court split over the issue of ERISA preemption of HMO vicarious liability malpractice claims).
117. See supra notes 92-94.
118. PacifiCare of Okla. v. Burrage, 59 F.3d 151, 155 (10th Cir. 1995).
PacifiCare creates a legal paradox: an ostensible agency malpractice claim is a claim attacking quality for purposes of ERISA "complete preemption" but not for purposes of ERISA preemption.

This paradox could jeopardize the fate of future ERISA preemption challenges to ostensible agency malpractice claims. In ERISA litigation, a challenged state common law claim generally must survive both complete preemption under ERISA § 502(a) and federal preemption under ERISA § 514 (ERISA preemption). Under Dukes, vicarious liability malpractice claims escape complete preemption because such claims merely attack the quality of benefits received and federal district courts must thus remand the claims to state courts.

Charged with deciding the federal preemption issue, state courts face the difficult task of reconciling the federal court's "quality" characterization of the malpractice claim and the PacifiCare legal paradox.

State courts, looking to federal courts for guidance on whether ERISA preempts claims attacking the quality of benefits, must turn to PacifiCare. By rejecting the "quality" construction of the vicarious liability malpractice claim, PacifiCare arguably concluded that ERISA preempts claims concerning quality of benefits. Consequently, state courts are left with an inadvertent presumption for ERISA preemption of HMO ostensible agency malpractice claims, a result contrary to

119. See supra notes 50-53 and accompanying text (explaining that federal courts must first determine whether they have removal jurisdiction to hear the claim before reaching the merits of the preemption issue). The federal district court in PacifiCare had supplemental jurisdiction over the ostensible agency claim and, therefore, it did not need to engage in the "complete preemption" inquiry for removal jurisdiction. See supra note 11 and accompanying text (explaining how the court retained jurisdiction over the ostensible agency claim in PacifiCare).


121. See supra notes 54-58 (discussing how the applicability of complete preemption determines whether federal courts can exercise removal jurisdiction).

PacifiCare's holding.\textsuperscript{123}

Admittedly, state courts may interpret PacifiCare's rejection of the "quality" construction as a strategy to save the malpractice claim from ERISA preemption.\textsuperscript{124} By refusing to include quality in its characterization of the claim, however, PacifiCare indirectly reinforces the reasoning of district courts that hold ERISA preempts vicarious liability medical malpractice claims.\textsuperscript{125} In fact, PacifiCare supported this misguided notion despite a reversal of the district court ruling that gave rise to this line of reasoning.\textsuperscript{126}

Furthermore, the PacifiCare court's strategy is unnecessary. The characterization of a medical malpractice claim as a state common law form of quality control can withstand a preemption challenge. States have traditionally had exclusive authority over the field of quality control.\textsuperscript{127} Absent an explicit congressional mandate to the contrary, courts have held that states will continue to have exclusive power to regulate quality.\textsuperscript{128} In addition, ERISA does not preempt laws that may have an indirect economic effect on the plan.\textsuperscript{129} Common law aimed at quality control of health care, like other state quality control regulation, indirectly affects the relative cost of providing medical services to HMO enrollees.\textsuperscript{130} Hence, ERISA does not

\textsuperscript{123} It is uncertain how state courts will rule on this issue.

\textsuperscript{124} See supra note 100 and accompanying text (discussing PacifiCare's reliance on a district court's reasoning that ERISA preempts claims for quality, leading to the court's rejection of the quality standard).

\textsuperscript{125} See supra notes 90-91 and accompanying text (noting that district courts mandated preemption because ostensible agency malpractice claims merely assert the denial of the benefit plans' promised quality, which arguably constitute claims for denied benefits).


\textsuperscript{127} Dukes, 57 F.3d at 357 (citing New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 115 S. Ct. 1671, 1678-79 (1995)).

\textsuperscript{128} "Quality control of benefits, such as the health care benefits provided here, is a field traditionally occupied by state regulation and we interpret the silence of Congress as reflecting an intent that it remain such." Id.

\textsuperscript{129} Travelers Ins., 115 S. Ct. at 1679; see supra note 68 (noting federal district court use of this limitation on ERISA preemption).

\textsuperscript{130} Travelers Ins., 115 S. Ct. at 1679 (noting that even though quality control regulation has some indirect economic effect, if ERISA preemption were interpreted to displace all state laws that affect costs, it would effectively eliminate any limitation on ERISA preemption, thus violating basic principles of statutory interpretation).
preempt quality control common law.

2. Back to "Relate To": The Ambiguity of ERISA's Preemption Clause

PacifiCare expresses a willingness to be bound by the Supreme Court's early textual approach used in ERISA preemption cases. The Supreme Court's broad reading of ERISA's preemption clause created uncertainty over the extent to which a state law has to make "reference to" or have a "connection with" an ERISA plan in order to trigger preemption. PacifiCare's approach produces a similar ambiguity.

In PacifiCare, the central issue was whether "reference to" the plan to establish an agency relationship between the doctor and the HMO was sufficient to warrant preemption. While determining that the reference was insufficient, PacifiCare unfortunately failed to provide the threshold level of "reference to an ERISA plan" that is required to trigger ERISA preemption. The court simply states "any reference to the plan to resolve that issue [of the agency relationship] does not implicate the concerns of ERISA preemption." Much like the Supreme Court, PacifiCare found it difficult to overcome the "relate to" hurdle.

Moreover, PacifiCare's strict reliance on ERISA's ambiguous text weakens its reasoning. Injured plaintiffs could argue that reference to the plan to establish the agency relationship is insignificant or, at most, "indirect." Some courts, however, have already ruled that such reference is sufficient for pre-

131. See supra notes 67, 71 (noting the Supreme Court's early loyalty to ERISA's text).
132. Travelers Ins., 115 S. Ct. at 1677 (recognizing that attempts to construe the "relate to" language have not helped the Supreme Court to delineate the boundaries of ERISA preemption).
133. See supra note 102 and accompanying text (discussing PacifiCare's analysis).
134. See supra notes 67-68 and accompanying text (referring to the Supreme Court's test for preemption under Shaw).
136. See supra note 72 and accompanying text (discussing the Supreme Court's inability to offer further guidance on the "relate to" text).
137. See supra notes 68, 130 and accompanying text (discussing the federal court limitation on the broad reading of ERISA's preemption clause).
eminent. Hence, the debate deteriorates into a textualist stalemate.

With the enormous growth in ERISA litigation, federal courts should be attempting to diffuse such stalemates by moving beyond the unhelpful text. Unfortunately, *PacifiCare* rests on the problematic text of the statute despite the Supreme Court's recent movement away from textual interpretation of ERISA's preemption clause toward examination of Congress's overall objective in enacting ERISA. Accordingly, *PacifiCare* should have bolstered its reasoning by noting ERISA's purpose and the presumption against preemption.

By failing to fill in the gaps in ERISA's broad statutory preemption mandate, *PacifiCare* did not fully assume its judicial role. Congress clearly intended federal common law to act as a check on ERISA preemption. In this respect, *PacifiCare* properly ruled that ERISA did not preempt ostensible agency malpractice claims brought against HMOs, thereby checking ERISA's largely unrestrained preemption power. *PacifiCare*, however, widened the gaps in ERISA preemption jurisprudence by creating an untenable legal paradox over quality and stubbornly relying solely on the text of ERISA's preemption clause. These serious deficiencies in *PacifiCare*'s characterization of the ostensible agency claim and overall approach weaken its holding against future attacks by HMOs.

C. BROADENING THE BASE: AN ALTERNATIVE APPROACH TO ERISA PREEMPTION OF VICARIOUS LIABILITY MALPRACTICE CLAIMS

To avoid the problems that plagued *PacifiCare*, courts...
should adopt an approach effectuating ERISA's primary objectives, giving greater weight to the presumption against preemption canon, and recognizing important public policy concerns such as equity and quality. When in doubt whether a particular state common law malpractice claim triggers ERISA preemption, courts should follow a three-prong approach to resolve the issue. Courts should first determine which result, preemption or nonpreemption, would frustrate the policy behind ERISA's enactment. Courts should then examine the claim within a presumption against preemption framework. Finally, courts should consider principles of equity and quality in their analysis.

1. Effectuating Congress's Primary Objectives

Recent debates over ERISA's effectiveness in eliminating conflicting regulations have masked ERISA's primary purpose. Although Congress intended ERISA to create uniformity in the field of employee benefit plans, Congress's primary purpose in enacting ERISA was to protect employees. Accordingly, the alternative approach should preserve for employees the traditional opportunity to redress their injuries: the state common law claim of medical malpractice. Congress could not have intended to deny state tort remedies to employee-participants of HMO health care plans. Such a result would frustrate the overall objective to protect employees and beneficiaries.

Moreover, nonpreemption of vicarious liability malpractice claims conforms with Congress's ancillary purpose of creating administrative uniformity. Laws that do not affect HMOs' administrative practices or procedures do not compromise HMO administrative integrity. Vicarious liability malpractice claims do not infringe upon HMOs' administrative procedures such as utilization review/cost-containment, benefit eligibility decision making and processing, or calculation of benefit

144. See supra notes 33-37 and accompanying text (discussing the policy behind ERISA's enactment).
145. See supra note 45 and accompanying text (noting the purpose behind ERISA's preemption clause).
146. See supra note 45 and accompanying text (discussing the rationale behind ERISA's preemption clause's goal of uniformity).
147. Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 10 (1987).
Accordingly, these malpractice claims do not interfere with ERISA's goal of administrative uniformity for health plans.

Contrary to the view taken by some, ERISA's goal of uniformity was not designed to protect employers, employee benefit plans, or plan fiduciaries. In fact, ERISA bestowed the advantages of federal uniformity to ensure that employers and employee benefit plans would not offset their administrative costs onto vulnerable employee beneficiaries and their dependents. Regulatory uniformity was the means to achieve the desired end of protecting employees. Given ERISA's purpose, HMOs should not receive ERISA's solicitude; any special benefits arising from ERISA's regulatory control should be conferred to the employee-participants of health care plans, not the ERISA-regulated HMO plan. Preemption of malpractice claims would give HMOs a protective benefit that disrupts ERISA's intended balanced protection.

2. Adopting a Presumption Against Preemption

In light of the federalism interest underlying the presumption against preemption, the presumption's operation in the preemption analysis of a state HMO vicarious liability malpractice claim is particularly appropriate. According to the presumption against preemption canon, federal law should not intrude upon areas historically left to the states. Indeed, ERISA preemption "must be guided by respect for the separate spheres
of government authority preserved in our federalist system."\textsuperscript{154} States have long prescribed health and medical professional liability standards.\textsuperscript{155} Moreover, medical malpractice claims protect the public's health and safety, a task belonging to the states under their police power.\textsuperscript{156} By allowing ERISA to preempt malpractice claims, courts leave states bereft of their traditional power to regulate in this area. Future courts must give the presumption of preemption canon its proper weight and curb ERISA's preemptive encroachment on the historically state-regulated domain of medical malpractice. Indeed, refusal to extend ERISA preemption to HMO vicarious liability malpractice claims deftly forestalls the elimination of an entire field of state law claims.\textsuperscript{157}

3. Advancing Equity and Quality in a Changing Health Care System

Willing hostages of ERISA preemption, federal courts have already disallowed direct negligence medical malpractice claims against ERISA-regulated HMOs.\textsuperscript{158} Further extension of ERISA preemption to indirect negligence claims, such as ostensible agency claims, would functionally immunize HMOs from any such tort liability.\textsuperscript{159} In fact, HMOs would be free of both tort claims and ERISA causes of action.\textsuperscript{160} Considering


\textsuperscript{155} "[S]tate law has traditionally prescribed the standards of professional liability . . . ." Painters of Phila. Dist. Council No.21 Welfare Fund v. Price Waterhouse, 879 F.2d 1146, 1152 (3d Cir. 1989). "Thus, we conclude that ERISA does not generally preempt state professional malpractice actions." Id. at 1152 n.7.

\textsuperscript{156} See supra note 64 (noting state police power over matters of health and safety).

\textsuperscript{157} Congress was silent with regard to ERISA preemption of the medical malpractice field despite its prominence in state common law when ERISA was enacted. See generally H.R. REP. No. 533, 93d Cong., 1st Sess. (1973), reprinted in 1974 U.S.C.C.A.N. 4639 (not mentioning malpractice claims of any kind with regard to ERISA preemption).

\textsuperscript{158} See supra note 79 and accompanying text (discussing the Corcoran, Kuhl, and Kohn cases).

\textsuperscript{159} ERISA preemption already functionally immunizes HMOs because of HMOs' role in administering health benefit plans. See supra note 45 (discussing Congress's desire to provide a uniform set of administrative procedures for health care systems).

\textsuperscript{160} To bring an ERISA cause of action, the claim must fall within ERISA's civil enforcement scheme. See supra note 43 and accompanying text (discussing the causes of action available under ERISA). Under Dukes v. U.S. Healthcare,
the public interest in equity and the changing role of HMOs in health care, the alternative approach appropriately withholds this functional immunity from HMOs.

Holding other health care providers accountable to state laws161 but relieving ERISA-regulated HMOs of the same obligation is inherently inequitable. If HMOs choose to enter the field of health care provision, then they should remain susceptible to the same tort liability under ostensible agency theory as other large health care providers. Moreover, eliminating HMOs' current protected status would not render them completely defenseless.162 Indeed, potential exposure to tort liability is an incentive to institute preventive measures as an alternative to blanket immunity.

HMO immunity from ostensible agency claims appears even more misplaced when considering the HMOs' changing role in the health care system. The health care system has witnessed a "diffusion of power" from physicians to HMOs and hospitals.163 Changes in medical decision making authority have accompanied this shift in power.164 Physicians traditionally enjoyed undisturbed autonomy in supervising patient medical care, but in the race to control costs, HMOs have taken over a large amount of medical treatment decision making from doctors.165 If HMOs want to control certain aspects of medical care, they should be exposed to liability for malpractice; HMOs must share in the liability implications that accompany decision-making authority. In other words, HMOs should not be allowed to leave physicians carrying the brunt of the liability.

Moreover, if HMOs will play a truly major role in health care reform, the quality guarantees inherent in tort liability must remain alongside cost-cutting strategies. Medical malpractice claims are a method of quality control.166 The alternative

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161. See Chittenden, supra note 18, at 453-65 (noting that hospitals have long been subject to ostensible agency liability).

162. See Chittenden, supra note 18, at 465-68 (discussing various preventive measures HMOs can use to protect themselves from vicarious liability).

163. See Frankel, supra note 22, at 1320.

164. Id.

165. See supra notes 22-29 (discussing HMOs' role in cost containment).

166. See supra note 78 (discussing the role of medical malpractice in promoting quality within the health care system).

an ostensible agency malpractice claim does not fall within ERISA's civil enforcement provisions. See supra note 92 and accompanying text (discussing the Third Circuit's holding in *Dukes*).
approach preserves an essential form of medical quality control at a time when cost, access, and quality issues remain at the cornerstone of health care reform.

D. PacifiCare Under the Broad-Based Approach

Application of the alternative approach to PacifiCare yields the same result as the court's approach: nonpreemption of the vicarious liability medical malpractice claim. Barbara Jean Davidson's surviving children would have had the opportunity to litigate their malpractice case in state court. The court would have best effectuated ERISA's primary purpose of protecting employees by allowing them an opportunity to redress their injury in state court for monetary damages. By reading the preemption clause narrowly and noting the states' traditional regulation in the field under the presumption against preemption canon, the court would have found against preemption of the vicarious liability malpractice claim. The court's holding would be justified considering the importance of equity between HMOs and other health care providers and quality control through tort liability.

As precedent, the broad-based approach would provide future courts with a stronger foundation upon which to rest their holdings. The approach remedies the deficiencies in the PacifiCare court's reasoning. It accommodates both the "quality" standard and the PacifiCare characterizations of the ostensible agency claim, thereby eliminating any inconsistency and highlighting the strengths of the courts' approaches. Following the current trend in ERISA preemption jurisprudence, the broad-based approach diffuses the ability of HMOs to carve out exceptions for themselves within the preemption clause's problematic text. Most importantly, this approach limits ERISA preemption and gives injured plaintiffs recourse against HMOs for the negligence of their agent physicians, a result compatible with ERISA's purpose.

Unfortunately, even the broad-based approach may not prevent ERISA preemption of utilization review malpractice claims. Utilization review is an integral part of HMO administrative structure. ERISA mandates noninterference

167. See supra note 79 and accompanying text (discussing utilization review cases).
168. See supra note 27 (discussing utilization review management).
with administrative standards set up by the employee benefit plan. 169 Sadly, the personal tragedies associated with negligent HMO utilization review decisions echo those of the testimony that initially led to ERISA's enactment. 170 ERISA's drafters never contemplated these ironies. Hence, if courts are unable to prevent such an absurd result, the only remedy may lie in legislative, rather than judicial, action.

CONCLUSION

Federal courts interpreting ERISA's preemption structure have deprived injured employee-beneficiaries of their state common law malpractice claims against HMO-sponsored health plans. In PacifiCare of Oklahoma v. Burrage, the Tenth Circuit reexamined ERISA preemption with regard to a medical malpractice claim based on ostensible agency. Although the court correctly held that ERISA did not preempt HMO malpractice claims based on a vicarious liability theory, it offered a weak approach that compounds the inconsistency and frustration already plaguing courts faced with increasing ERISA preemption litigation.

In response to PacifiCare, courts should adopt a broad-based approach that is more consistent with ERISA's purpose and gives proper regard to the presumption against preemption and traditional state powers. The reduction of HMOs' present blanket immunity and the promotion of quality in our changing health care justify the broad-based approach to ERISA preemption. This alternative approach ensures the survival of medical malpractice claims based on ostensible agency and should serve as a model for limiting ERISA preemption of other HMO medical malpractice claims.

169. See supra note 45 and accompanying text (discussing Congress's intention to provide regulatory uniformity to increase efficiency thus easing the overall administrative burden).

170. See supra note 36 (recounting stories presented to congressional committees); supra note 79 (recounting the facts which gave rise to the utilization review suits).