THE ERISA SHIELD AROUND HMOs CANNOT BE JUSTIFIED

I. INTRODUCTION

Richard Clarke had a drinking problem, and he also attempted suicide.[1] His doctor recommended a 30-day detoxification and medical evaluation program and admitted him to a program at an area hospital.[2] But, Mr. Clarke's Health Maintenance Organization ("HMO") refused to pay for more than 5 days, even though his health plan explicitly permitted 30 days per twelve-month period.[3] The HMO refused two more attempts to hospitalize Mr. Clarke, even defying a court order to that effect.[4] As a consequence of the HMO's failure to cover Mr. Clarke, "which he so desperately" needed, he "suffered horribly." Mr. Clarke finally committed suicide at the age of 41.[5] "Under traditional notions of justice, the harms alleged—if true—should" allow Mr. Clarke's widow to collect monetary damages for herself and for her children against the HMO and the UR firm.[6] But, because federal law preempts state law claims in this area, the Court "had no choice but to pluck [her] case out of state court . . . and . . . to slam the courthouse doors in her face and leave her without any remedy."[7]

The federal law that preempted Mrs. Clarke's claim is the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA was to be an employee's "version of an emancipation proclamation";[8] "designed to promote the interest of employees and their beneficiaries in employee benefits plans."[9] How then, has ERISA become the guardian of the HMO; the immunity shield that "thwarts the legitimate claims of the very people it was designed to protect?"[10]

The purpose of this note is to discuss options for holding HMOs liable for actions that harm their beneficiaries. To do so, it briefly outlines the nature and history of HMOs in the part II, the history of ERISA in the part III, and the courts' application of ERISA to HMO liability in the part IV. Part V analyzes the collective results of past

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1 *See* Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49, 51 (D. Mass. 1997).

2 *See id.* at 50.

3 *See id.*

4 *See id.*

5 *See id.* at 52.

6 *Id.*

7 *Id.* at 53.

8 120 CONG. REC. 29,193 (1974) (statement of Sen. Biaggi).

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

10 *Andrews-Clarke*, 984 F. Supp. at 56.

federal and state legislation and court decisions and the view on the horizon relative to holding HMOs liable for their actions that cause harm to their beneficiaries.

II. HEALTH MAINTENANCE ORGANIZATIONS (HMOS)

Health care expenditures in 1981 amounted to 9.1% of the gross domestic product.[11] By 1992, that figure had risen to 14%,[12] and by the year 2005, health care spending will probably exceed the defense budget, comprising nearly 18% of the gross domestic product by that time.[13] "To combat these skyrocketing costs, private and government insurers have moved away from traditional indemnity or fee-for-service health plans and have introduced aggressive cost-containment programs in the form of Managed Care Organizations," which include Health Maintenance Organizations (HMOs).[14] These organizations rely on the mechanism of utilization review to provide quality health care at reduced costs.[15] Utilization review requires the patient to notify the HMO and receive approval before the HMO approves reimbursement for medical treatment, such as certain medical procedures or admission to medical facilities.[16] The purpose of utilization review is to assure that only procedures deemed medically necessary and appropriate to the patient's needs are reimbursed.[17] If the required criteria are not met, then coverage is denied. In many instances, a denial of coverage results in the patient foregoing the procedure altogether.[18]

III. EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

As the name suggests, Congress enacted ERISA primarily to protect retirement benefits of working Americans. Congress' statement of Findings and Declaration of Policy for ERISA stated that "many employees with long years of employment are losing anticipated retirement benefits" because of a lack of minimum financial and administrative standards and a lack of financial stability in retirement plans.[19] Congress also provided for regulation of employee welfare

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[11] *See* Susan B. Garland, *Managed Care: Dr. Clinton Has Grim News*, BUS. WK., Jan. 18, 1993, at 35.

[12] *See id.*

[13] *See* Alan Baseden, *Health Care Prognosis*, BUS. WK., April 7, 1997, at 8; *see also* J. Scott Andresen, *Is Utilization Review the Practice of Medicine?*, 19 J. LEGAL MED. 431, 431 (1998).

[14] Andresen, *supra* note 13, at 431.

[15] *See id.*

[16] *See id.*

[17] *See id.*

[18] *See id.*

[19] 29 U.S.C. § 1001(a) (1999).

benefit programs within ERISA because it was also concerned about the provision of other employee benefits through employer programs.[20] These welfare benefit programs included those that provide medical, surgical, or hospital care or benefits through the purchase of insurance, or by other means.[21] While ERISA enacted broad and sweeping requirements for pension plans, it had very little to say about welfare benefit plans.[22] ERISA "simply imposes fiduciary and reporting obligations on private employee benefit plans."[23]

Congress also intended to provide for a remedy if promised benefits from any ERISA-covered plan were not forthcoming from the plan.[24] However, the remedy structure of ERISA for health care delivery has proved grossly inadequate. When ERISA was passed in 1974, traditional fee-for-service health insurance plans were the overwhelming norm.[25] Under this traditional system of health care delivery, the covered employee or dependant went to the doctor, had treatment, and filed for payment with the health insurance plan. If payment was denied, ERISA provided for recovery of the denied payment.[26] ERISA's civil enforcement provision also provided for the beneficiary of the plan to seek an injunction ordering the insurer to authorize the disputed treatment.[27] As health care delivery evolved from the traditional system to a system dominated by utilization review and cost containment, the ERISA civil provision proved less than adequate. Seeking an injunction often proved to be impractical, "either because of time constraints or . . . the incapacity of the beneficiary brought on by his medical condition."[28] So, despite ERISA, many beneficiaries never received treatment or any other meaningful remedy.[29]

The primary reason that the beneficiary in the above scenario has no meaningful remedy is the controversial "preemption" clause of ERISA.[30] Prior to ERISA, numerous state laws and regulations created confusion and inefficiency for plans and plan administrators.[31] Congress

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20 29 U.S.C. § 1002(1)(A) (1999).

21 *Id.*

22 *See* Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49, 56 n.29 (D. Mass. 1997).

23 *Id.*

24 *See* Dukes v. United States Healthcare, 57 F.3d 350, 357 (3rd Cir. 1995).

25 *See* Kent G. Rutter, *Democratizing HMO Regulation to Enforce the "Rule of Rescue"*, 30 U. MICH. J.L. REFORM 147, 171 (1996).

26 29 U.S.C. § 1132(a)(1)(B) (1999).

27 29 U.S.C. § 1132(a)(3) (1999).

28 *Andrews-Clarke*, 984 F. Supp. at 59.

29 *See id.*

30 29 U.S.C. § 1144(a) (1999).

31 *See* Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990).

was concerned that an overly restrictive and complex pension law, coupled with state laws and regulations, would discourage employers from instituting benefit programs for their employees.[32] Congress' answer was to reserve "to Federal authority the sole power to regulate the field of employee benefit plans" to eliminate "the threat of conflicting and inconsistent State and local regulation."[33] ERISA became law superceding "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."[34] Disadvantaged, denied, disgruntled employees and benefit providers quickly turned to the courts to litigate the meaning of the phrase "relate to" in reference to health care plans.[35]

IV. APPLICATION OF ERISA TO HMO LIABILITY

The preemption question of ERISA has produced an avalanche of litigation; a Westlaw search in June of 1997 noted 4,963 federal and state cases addressing this issue.[36] The underlying cause of this avalanche is the breadth of the U.S. Supreme Court's interpretation of the meaning of "relate to." A state law "'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan."[37] The only exception noted by the Court to this interpretation is a case where "state actions . . . affect [the] employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan."[38]

Lower courts have struggled to consistently apply the "relates to" and "too tenuous" guidelines. In applying the "relates to" criterion of ERISA, courts have reviewed the preemption question based upon claims of direct liability and vicarious liability and have found no consistent answer to the question of whether the claims are preempted.[39]

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[32] *See id.*

[33] 120 CONG. REC. 29,197 (1974) (statement of Rep. Dent).

[34] 29 U.S.C. § 1144(a) (1999).

[35] *See Ingersol-Rand Co.*, 498 U.S. at 142.

[36] *See* Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49, at 57 n.31 (D. Mass. 1997).

[37] Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97 (1983); *see also* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 44, 47 (1987) ("relates to" should be construed expansively).

[38] *Shaw*, 463 U.S. at 100 n.21.

[39] *See* Jass v. Prudential Health Care Plan, 88 F.3d 1482 (7th Cir. 1996) (vicarious negligence preempted); Dukes v. U.S. Healthcare, 57 F.3d 350 (3d Cir. 1995) (medical malpractice not preempted—concerned the "quality" of benefits received and therefore, not preempted); Dykema v. King, 959 F. Supp. 736 (D.S.C. 1997) (direct and vicarious liability not preempted); Lancaster v. Kaiser Foundation Health Plan of Mid-Atlantic States, Inc., 958 F. Supp. 1137 (E.D. Va. 1997) (vicarious liability not preempted, direct negligence is preempted); Fritts v. Khoury, 933 F. Supp. 668 (E.D. Mich. 1996) (vicarious liability for negligent selection of physician in wrongful death claim not preempted); Prihoda v. Shpritz, 914 F. Supp. 113 (D. Md. 1996) (vicarious liabilty concerned the quality of benefits

The U.S. Supreme Court addressed the interpretation of "relates to" in its decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*[40] The Court first recognized that its "prior attempt to construe the phrase 'relate to' [did] not give us much help" in determining when a law relates to ERISA.[41] It noted that "[i]f 'relates to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for 'really, universally, relations stop nowhere.'"[42] The Court then reiterated its observation in *Shaw v. Delta Air Lines, Inc.*[43] that "a law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a *connection with* or *reference to* such a plan."[44] The Court further noted that just as there can be no "infinite relation" concerning ERISA for preemption determination, neither can there be any "infinite connection."[45] As helpful as this "clarification" might be, the Court noted that "we . . . must go beyond the unhelpful text and the frustrating difficulty of defining [ERISA's] key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive" preemption.[46] The Court recalled that Congress intended to minimize administrative and financial burdens on plans and plan sponsors that might be caused by conflicting federal and state laws regulating plans.[47] "The basic thrust of the pre-emption clause . . . was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans."[48]

Some courts relied on the Court's discussion of "no infinite relation"[49] and "no infinite connection"[50] to determine that ERISA's

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and not preempted); Pomeroy v. John Hopkins Med. Servs., 868 F. Supp. 110 (D. Md. 1994) (medical malpractice, direct and vicarious negligence all preempted); Kearney v. U.S. Healthcare, Inc., 859 F. Supp. 182 (E.D. Pa. 1994) (misrepresentation, negligence, and breach of contract preempted; vicarious liability not preempted); Smith v. HMO Great Lakes, 852 F. Supp. 669 (N.D. Ill. 1994) (HMO negligent with doctor and hospital in delivery of baby; professional malpractice has nothing to do with denial of plaintiff's rights under plan and, therefore, not preempted); Nealy v. United States Healthcare HMO, 844 F. Supp. 966 (S.D.N.Y. 1994) (medical malpractice, negligence, breach of contract, misrepresentation, wrongful death, and related tort claims preempted); Ricci v. Gooberman, 840 F. Supp. 316 (D.N.J. 1993) (vicarious liability preempted).

40 514 U.S. 645 (1995).

41 *Id.* at 655.

42 *Id.*

43 463 U.S. 85 (1983).

44 *Travelers*, 514 U.S. at 656 (emphasis added).

45 *Id.*

46 *Id.*

47 *Id.* at 656-57.

48 *Id.* at 657.

49 *Id.*

preemption clauses have been read too broadly. "Cases since *Travelers* have been much less prone to find preemption under ERISA."[51] Other courts have responded to the Court's instruction by looking to the intent of ERISA.[52] In *Dukes v. U.S. Healthcare*[53] the court found "nothing in the legislative history suggesting that § 502 [of ERISA] was intended as part of a federal scheme to control the quality of the benefits received by plan participants."[54]

An appellate court in *Geweke Ford v. St. Joseph's Omni Preferred Care, Inc.*[55] stated that, "where state law claims fall outside the three areas of concern identified in *Travelers*,[56] arise from state laws of general application, do not depend on ERISA, and do not affect the relationships between the principal ERISA participants; the state law claims are not preempted."[57]

A federal district court in *Moreno*[58] applied the holding in *Gweke* and found that

> [a]pplying the *Travelers* three-part test, the ability to sue on a medical malpractice claim does not mandate employee benefit structures or their administration, nor does it bind employers or plan administrators to particular choices or preclude uniform administrative practice, thereby functioning as a regulation of an ERISA plan itself, nor does it provide an alternative enforcement

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[50] *Id.*

[51] Moreno v. Health Partners Health Plan, 4 F. Supp. 2d 888, 892 (D. Ariz. 1998) (citing Pacificare of Oklahoma v. Burrage, 59 F.3d 151 (10th Cir. 1995) (a vicarious liability medical practice claim based on substandard treatment by an HMO is not preempted)); *see also* Coyne & Delany v. Selman, 98 F3d 1457 (4th Cir. 1996) (malpractice claim is not preempted because it does not "relate to" an employee benefit plan within the meaning of ERISA's preemption provision); Jass v. Prudential Health Care Plan, 88 F.3d 1482 (7th Cir. 1996) (negligence action based on a vicarious liability theory relied on the existence of an ERISA plan and found to be preempted); Rice v. Panchal, 65 F.3d 637 (7th Cir. 1995) (medical malpractice against two doctors and against health plan does not rest upon the terms of an ERISA plan and is therefore not preempted).

[52] *See infra* text accompanying notes 54-65.

[53] 57 F.3d 350 (3d Cir. 1995).

[54] *Id.* at 357 (medical malpractice of HMO-affiliated hospital and personnel; court made distinction between quantity of benefits (would be ERISA preempted) and quality of benefits (would not be ERISA preempted)).

[55] 130 F.3d 1355 (9th Cir. 1997).

[56] The court noted that the *Travelers* Court's areas of concern were that the state statute did not: (a) "mandate employee benefit structures or their administration," (b) "bind employers or plan administrators to particular choices or preclude uniform administrative practice," or (c) "provide alternate enforcement mechanisms for employees to obtain ERISA plan benefits." *Id.* at 1360; *see also Moreno*, 4 F. Supp. 2d at 891-92 (district court summarized areas of concern in same way).

[57] *Gweke Ford*, 130 F.3d at 1360 (quoting Arizona State Carpenters Pension Trust Fund v. Citibank, 125 F.3d 715 (9th Cir. 1997)).

[58] 4 F. Supp. 2d 888.

mechanism for employee[s] to obtain ERISA plan benefits. *Malpractice actions are post facto, obviating the last test.*[59]

The *Moreno* court found that the allegations were nothing more than a traditional common law negligence claim.[60] Each of the defendants was accused of being a health care provider who was negligent in the creation and implementation of a substandard care plan.[61] The court ruled that medical malpractice claims are grounded in generally applicable common law without regard to whether they are covered by an employee benefit plan, and the possibility of a medical malpractice action would not affect the relationship between the principal ERISA participants.[62] The malpractice claim had no relationship to the recovery of benefits nor the demand of future benefits and was, therefore, not preempted by ERISA.[63] The court also found support for its determination in the U.S. Supreme Court's reference to "general health care regulations"[64] as examples of historic state powers that are not superceded by ERISA.[65]

The general views of *Dukes, Gweke* and *Moreno* were shared by the court in *Bauman v. U.S. Healthcare, Inc.*[66] In *Bauman*, a newborn baby was discharged the day after birth in accordance with the HMO's policy.[67] The HMO's policy required the discharge of newborns within twenty-four hours of birth.[68] The baby died the day after release from the hospital because of a tumor.[69] The plaintiff/parents of the deceased infant alleged that the HMO was negligent in adopting a policy "that encouraged, pressured, and/or directly or indirectly required that its participating physicians discharge newborns infants and their mothers within 24 hours of the infant's birth."[70] The plaintiff also alleged that the HMO was reckless because its policy relating to newborn discharge showed indifference to the health of the newborn and that its policies discouraged the readmission of newborns after release, even when health problems were identified.[71] The *Bauman* court found that these claims sought to hold the HMO accountable for adopting policies that

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59 *Id.* at 892-93 (emphasis added).

60 *Id.* at 889.

61 *See id.*

62 *Id.* at 893.

63 *See id.*

64 New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 661 (1995).

65 *Moreno*, 4 F. Supp. 2d at 892.

66 1 F. Supp. 2d 420 (D.N.J. 1998).

67 *Id.* at 421.

68 *Id.*

69 *See id.*

70 *Id.*

71 *See id.*

caused inadequate health care to be provided to its members.[72] The focus, according to the court, was on "the quality of care provided by the physician and the impact of [the HMO's] policies on that quality of care."[73] The court found that these claims were not preempted by ERISA.[74]

The common thread among *Dukes, Gweke* and *Bauman* is that that a malpractice action against an HMO can withstand an ERISA preemption challenge.[75] This is based upon the theory that HMOs cease to be ERISA plan administrators, becoming instead health care providers. HMOs performing in this function will find that negligent decisions regarding providing health care for their members will not be subject to ERISA preemption. Under this theory, the HMO becomes an "intervening cause": the physician recommends treatment to the patient; the HMO reviews the recommendation based upon medical criteria and changes/rejects the recommendation; the patient puts his faith in the HMO and follows the HMO rather than the physician; the patient is injured because the HMO's decision was wrong; therefore, the HMO has "intervened" and can be held accountable under the same malpractice theories as the physician. The HMO is not shielded by ERISA preemption because it shed its ERISA-governed duties and assumed the duties of a health care provider.

While this theory is gaining acceptability,[76] some courts still struggle with the preemption question. The court in *Andrews-Clarke*[77] examined the issue and found that even in light of *Travelers*,[78] the court must determine the plaintiff's claim to be preempted.[79] The plaintiff in *Andrews-Clarke* was the widow of a man who was denied medical treatment, even though his employer-provided health plan explicitly listed the treatment as a covered item.[80] The deceased was admitted to an alcohol detoxification program.[81] Even though his health plan covered a thirty-day program, the plan's utilization review ("UR") firm only approved a five-day hospitalization for detoxification.[82] Within twenty-five days of his release, the deceased began drinking again and admitted

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72 *Id.* at 423.

73 *Id.*

74 *See id.* at 426.

75 *See supra* cases cited in notes 39, 51, 55-59, 72-74.

76 *See supra* text accompanying notes 53-71.

77 Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49 (D. Mass. 1997).

78 New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995); *see also* text accompanying notes 36-44.

79 *Andrews-Clarke*, 984 F. Supp. at 58. *See also* text accompanying notes 1-7.

80 *See id.* at 51.

81 *See id.*

82 *See id.*

himself to another detox program.[83] Again, UR denied coverage for him in spite of his medical history of alcoholism.[84] He was released after eight days and, within twenty-four hours of his release, attempted suicide by drinking a substantial amount of alcohol mixed with cocaine and prescription drugs and enclosed himself in his car with carbon monoxide.[85] He was rescued and resuscitated by paramedics.[86] A commitment hearing found that the deceased was a danger to himself and ordered him to a thirty-day detoxification and rehabilitation program.[87] In the court's words, the UR "incredibly refused" the court-ordered program and the court was forced to commit the deceased to a correctional facility for treatment.[88] While at the correctional facility, the plaintiff's husband was forcibly raped and assaulted.[89] After his release from the correctional facility, the deceased went on a three-week drinking binge and finally succeeded in committing suicide.[90] Even under this tragic set of facts, the court found that all of the plaintiff's claims arose out of an alleged improper denial of benefits and were, therefore, preempted by ERISA.[91] The court then noted that the practical effect of ERISA in this case was to "immunize Travelers and [the UR] from potential liability for the consequences of their denial of benefits."[92]

The court in *Andrews-Clarke* stated that ERISA preemption forces the federal court to "pluck [the] case out of state court in which [plaintiff] sought redress (and where relief to other litigants is available) and then, at the behest of [the defendants], to slam the courthouse doors in her face and *leave her without remedy*."[93] ERISA permits plaintiffs to pursue a civil remedy against a plan to recover benefits due, to enforce rights under the terms of the plan, or to clarify future benefits under the plan.[94] However, ERISA's civil enforcement provision

> does not authorize recovery for wrongful death, personal injury, or other consequential damages caused by an improper refusal of an insurer or utilization review provider to authorize treatment. ERISA permits a beneficiary to seek an injunction ordering an insurer to authorize the disputed treatment, but such action is often impractical, either because of time constraints or . . . the incapacity of the

83 *See id.*
84 *See id.*
85 *See id.*
86 *See id.*
87 *See id.*
88 *Id.*
89 *See id.*
90 *See id.* at 52.
91 *See id.* at 54-55.
92 *Id.* at 55-56.
93 *Id.* at 53 (emphasis added).
94 29 U.S.C. § 1132 (a).

> beneficiary brought on by his medical condition. Thus, if a beneficiary never receives treatment because of the insurer's failure to pre-approve, ERISA leaves him without any meaningful remedy.[95]

Perhaps the lack of meaningful remedy is the reason courts are searching for a basis of avoiding ERISA preemption.

While courts struggle to find remedies not preempted by ERISA, some proffer that the courts already have that right. For example, the House of Representatives' Committee on the Budget explained that amending ERISA to allow additional remedies was unnecessary because "the legislative history of ERISA . . . support[s] the view that Congress intended for the courts to develop a Federal common law with respect to employee benefit plans, including the development of appropriate remedies, even if they are not specifically enumerated in section 502."[96] If this be so, why has the U.S. Supreme Court been unwilling to infer remedies from its reading of ERISA?[97] The Court in *Massachusetts Mutual Life Insurance Co. v. Russell*[98] noted that, while an original version of ERISA contained a provision for allowing a full range of legal and equitable remedies under federal and state laws, this provision did not make the final version.[99] The Court further noted that "[t]he six . . . integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted, however, provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly."[100]

So it appears that the injured participant/beneficiary of an employee benefit plan is left without remedy in this paradox of the law. Congress believes courts should be creating "federal common law" regarding ERISA, but the Supreme Court is reluctant to create remedies because ERISA specifically spells out the available remedies.[101]

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[95] *Andrews-Clarke*, 984 F. Supp. at 59; *see also*, Tolton v. American Biodyne, Inc., 48 F.3d 937, 943 (6th Cir. 1995) (ERISA preemption plan participants/beneficiaries may be left without remedy); Corcoran v. United HealthCare Inc., 965 F.2d 1321, 1338 (5th Cir. 1992) (result of ERISA is that plaintiff has no remedy); Turner v. Fallon Community Health Plan, 953 F. Supp. 419, 424 (D. Mass. 1997) (ERISA preemption's consequence is that no meaningful remedy is available), *aff'd*, 127 F.3d 196 (1st Cir. 1997).

[96] H.R. Rep. 101-247, at 56 (1989), *reprinted in* 1989 U.S.C.C.A.N 1906, 1948.

[97] *See* Mertens v. Hewitt Assocs., 508 U.S. 248, 254 (1993) (quoting Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134, 146 (1985)).

[98] 473 U.S. 134 (1985).

[99] *Id.* at 146.

[100] *Id.*

[101] *See supra* text accompanying notes 91-95.

V. THE FUTURE

None of the cases cited in this note[102] have been appealed to, or reviewed by, the United States Supreme Court. These cases involve decisions by the United States Courts of Appeal for the Third, Fourth, Seventh, and Tenth Circuits.[103] Interestingly, *all* these courts found, in some form, that HMO medical malpractice, and/or vicarious liability, were *not* preempted.[104] The case of *Dukes v. U.S. Healthcare, Inc.*[105] was appealed to the U.S. Supreme Court, and certiorari was denied.[106] While there may be diverse reasons why the Court chose not to grant certiorari, it is, nonetheless, interesting that it did not grant certiorari in light of the confusion over ERISA preemption. Perhaps the Court believes that its ruling in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*[107] eliminated the confusion. Perhaps the Court noted that the courts of appeals were properly interpreting the "relates to" question and that the courts were correct in allowing malpractice claims against HMOs. Considering the devastating effect of ERISA preemption on the right to redress by injured parties, the Court should grant review to stop the injustice or, at a minimum, send a clear message to Congress that Congress must change the law.

Given the continued confusion surrounding ERISA preemption law and HMO liability, what options are available? First, courts can continue to deny nearly all claims alleging direct liability of an HMO for its decision-making because they are preempted under ERISA, which already provides adequate remedies. But this "head-in-the-sand" approach will continue to leave many parties without meaningful compensation for their damages. Secondly, courts can assume the aggressive posture of *Dukes, Gweke, Moreno* and *Bauman* by finding that malpractice claims against HMOs are not preempted. By doing so, courts will leave room for state-law claims that provide recovery for the alleged injury. [108] Third, the courts can continue to wait for Congress to amend ERISA.

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[102] *See* cases listed *supra* notes 51, 53.

[103] *See* cases listed *supra* notes 51, 53.

[104] The Seventh Circuit has, however, gone both ways. *See* Jass v. Prudential Health Care Plan Inc., 88 F.3d 1482 (7th Cir. 1996) (state law preempted in case involving alleged negligent vicarious liability).

[105] 57 F.3d 350 (3d Cir. 1995).

[106] U.S. Healthcare, Inc. v. Dukes, 516 U.S. 1009 (1995).

[107] *See supra* text accompanying notes 36-46.

[108] At least one state (Texas) has enacted a statute that specifically provides that HMOs and managed care entities owe a "duty of care to exercise ordinary care when making health care treatment decisions and is liable . . . for harm to an insured . . . proximately caused by its failure." TEX. CIV. PRAC. & REM. CODE ANN. § 88.002 (West 1997). The applicability and use of this statute to hold an HMO liable for medical

The option of waiting on Congress does not look encouraging. The House of Representatives and the Senate entertained bills during the 105th Congress to amend ERISA.[109] Both bills provided for increased civil penalties,[110] but neither bill provided for civil actions against HMOs, UR firms or any other intermediary whose actions harmed covered employees or beneficiaries. In fact, the Senate version stated that "[n]othing in Title I shall be construed to affect or modify the provisions of section 514 [the preemption section] of the Employee Retirement Income Security Act of 1974 with respect to group health plans."[111] While both bills contained similar provisions dealing with the availability of UR decisions and appeals of those decisions, neither granted any recourse if those decisions proved to be harmful to the employee or beneficiary.[112] To add to the irony (or perhaps the insult), the House bill included a section on health care lawsuit reform but stated that the new section would not apply to an action under ERISA.[113] The House bill was passed by the House and sent to the Senate where it was not acted upon before the end of the Senate legislative session.

On September 29, 1998, a bill entitled the Patients' Bill of Rights Act of 1998,[114] was introduced in the Senate. This bill also contained many of the same provisions as H.R. 4250 and S. 2416, improving health care access and appeal rights of adverse UR decisions.[115] However, it also contained a provision for allowing a claim of action by a plan participant or beneficiary to recover damages for personal injury.[116] The new provision would have amended ERISA so as not to preclude a claim for personal injury

> against an employer or other plan sponsor maintaining the group health plan (or against an employee of such an employer or sponsor

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malpractice was upheld by a Texas federal judge. Corporate Health Ins., Inc. v. Texas Dept. of Ins., 12 F. Supp. 2d 597 (S.D. Tex. 1998).

[109] *See* H.R. 4250, 105th Cong. (1998); S. 2416, 105th Cong. (1998).

[110] *See* H.R. 4250, 105th Cong. Title I, Subtitle C, § 1201(b) (1998) provides civil penalties of up to $500 per day with a maximum of $250,000; S. 2416, 105th Cong. Title I, Subtitle D, § 141 (c) (1998) provides similar penalties.

[111] S. 2416, 105th Cong. § 3(a)(2) (1998).

[112] *See* H.R. 4250, 105th Cong. (1998); S. 2416, 105th Cong. (1998).

[113] *See* H.R. 4250, 105th Cong. Title IV, Subtitle A, § 4001 (a)(2) (1998). "This title shall apply with respect to any health care liability action brought in any State or Federal court, except that this title shall not apply to . . . an action under the Employee Retirement Income Security Act of 1974." *Id.*

[114] S. 2529, 105th Cong. (1998).

[115] The bill contained provisions for access to emergency care, access to specialty care such as gynecological care and pediatric care, selection of a primary care physician, and other specialty care. It also contained provisions concerning standards for UR activities, appeals of UR decisions, and the timeliness of responses to appeals. For more detail and specific provisions, see *id.*

[116] S. 2529, 105th Cong. Subtitle C, Section 302 (a)(1) (1998).

> acting within the scope of employment) if (i) such action is based on the employer's or other plan sponsor's (or employee's) exercise of discretionary authority to make a decision on a claim for benefits covered under the plan or health insurance coverage in the case at issue; and (ii) the exercise by such employer or other plan sponsor (or employee) of such authority resulted in personal injury or wrongful death.[117]

This bill, however, was not acted upon before the end of the Senate session and was not carried over to the new session.[118]

VI. CONCLUSION

Dukes, Gweke, Moreno, Bauman and *Andrews-Clarke* are but a few examples of the heart-wrenching fact patterns that courts are forced to review in ERISA preemption cases. In many cases, the damage done is catastrophic and irreversible, and courts feel that they are being forced to overlook those damages and preempt the state-law claims because of ERISA preemption.[119]

But the trend is changing.[120] Courts are holding that malpractice claims against HMOs can fall outside the ERISA preemption shield and be held accountable for their negligence in making health care determinations.[121] It is doubtful that Congress intended that two people, with identical claims, should have different results when injured just because one was covered by an employer-provided plan and the other covered by a plan not provided by an employer. For example, contrast the results of *Wilson v. Blue Cross of Southern California*[122] with those of *Andrews-Clarke*. In *Wilson*, Mr. Wilson had a drug problem.[123] He was covered by a health plan that allowed for thirty days of inpatient hospital care.[124] Mr. Wilson's doctor admitted him to a hospital prescribing three to four weeks of inpatient care.[125] After eleven days, the UR firm determined that Mr. Wilson's hospital stay was not

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[117] S. 2529, 105TH Cong., Subtitle C, Section 302 (a)(2) (1998).

[118] A Westlaw search through March 16, 1999 indicated, however, that 15 bills have been introduced in the 1st session of the 106th Congress dealing with HMOs, Managed Care, and patients' rights.

[119] *See* Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49, 53 (D. Mass. 1997). Judge Young stated, "[T]his Court has no choice but to pluck Diane Andrews-Clarke's case out of the state court in which she sought redress . . . and then, at the behest of Travelers and [the UR], to slam the courthouse doors in her face and leave her without any remedy." *Id.*

[120] *See supra* text accompanying notes 51-70.

[121] *See supra* text accompanying notes 51-70.

[122] 271 Cal. Rptr. 876 (Cal. App. 2 Dist. 1990).

[123] *Id.* at 877.

[124] *See id* at 882.

[125] *See id.*

"justified or approved."[126] Mr. Wilson had to leave the hospital because neither he nor his family could afford in-patient hospitalization.[127] Twenty days later, Mr. Wilson committed suicide.[128] The court ruled that the UR firm could be liable under the theory of joint liability for tortious conduct.[129] The court noted that the test for joint tort liability was (1) whether the actor's negligent conduct was a substantial factor in bringing about the harm; and (2) whether there existed sufficient evidence to raise a triable issue of material fact as to whether the [UR firm's] conduct was a substantial factor in causing the decedent's death.[130] Mr. Wilson's family was allowed its day in court to redress the son's death. Under very similar circumstances, the surviving spouse in *Andrews-Clarke v. Travelers Insurance Co.*[131] was denied her day in court because the Court believed her claim was preempted under ERISA.[132] The court felt compelled to "pluck Diane Andrews-Clarke's case out of the state court in which she sought redress . . . and then, at the behest of Travelers and [the UR firm], to slam the courthouse doors in her face and leave her without any remedy."[133] Both these surviving families were the victims of negligent UR decisions. One was allowed to seek damages for a wrongful death allegedly caused by the negligence of the UR firm and the other was not. The only difference was that one had health coverage through an ERISA plan and the other did not. This was not Congress' intention in ERISA, and "the shield of near absolute immunity now provided by ERISA simply cannot be justified."[134] The courts have precedent to allow malpractice liability against HMOs and their UR firms, and they should use it to provide for meaningful remedies to injured parties. Additionally, Congress is responsible for curing the problem of ERISA by passing an amendment allowing participants and their beneficiaries to hold their HMOs responsible for their negligent decisions.

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[126] *Id.*

[127] *See id.* at 877-78.

[128] *See id.* at 878.

[129] *See id.* at 883.

[130] *See id.* at 885. This case was before the Court on appeal of summary judgment in favor of the defendants, which included the UR firm.

[131] 984 F. Supp. 49 (D. Mass. 1997).

[132] *See supra* text accompanying notes 71-86.

[133] *Andrews-Clarke*, 984 F. Supp. at 53.

[134] *Id.* at 63.