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ERISA RIGHT TO SUE: AN RX FOR HEALTH CARE THAT PLACES FORUM OVER SUBSTANTIVE CONSUMER RIGHTS

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I. INTRODUCTION

One of the major debates currently facing Congress is whether to allow patients of Managed Care Organizations (MCOs) to sue in state court to enforce legal rights. Such legislation would eliminate the current shield of immunity created by the preemption provisions of the Employee Retirement Income Security Act (ERISA), which protect MCOs from lawsuits by preempting state court proceedings and limiting federal court remedies under ERISA. This has resulted in an outcry for relief championed as the right to sue in state court in order to receive traditional state court remedies such as compensatory and punitive damages.

This Article will review the current limits on lawsuits against health plans in state court, federal and state legislative proposals, state law preemption, as well as consumer protections in non-judicial forums. This Article concludes that real reform lies in protecting substantive consumer rights through a variety of forums and providing for adequate redress for harm in whichever forum relief is sought.

II. BACKGROUND

Before managed care, health care cost issues were raised retrospectively when patients sought reimbursement for care that had already been rendered. With managed care, a prospective denial of payment becomes an issue of access to quality health care, since denial of payment often precludes the person from receiving the desired care.[1] Managed care has changed the incentives within the health care system through capitation, financial penalties, withholding, and other financial incentives to encourage cost containment. The same incentives that control costs may induce physicians to limit tests or withhold needed care in order to increase compensation and can negatively impact the quality of care.[2] Some claim that "the insurance industry's drive to cut costs has reduced dramatically the overall quality of health care, limiting not only their access to the best doctors and hospitals but also putting such time and financial strain on physicians that they can't possibly provide first-rate treatment."[3] For consumers, the key concern is access to medically necessary health care that is delivered in a high quality manner for a reasonable cost.

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1. Cynthia Ransberg-Brown *The Ultimate Jigsaw Puzzle: ERISA Preemption and Liability in the Utilization Review Process*, 28 CUMB. L. REV. 403, 407-08 (1997/1998).

2. Scott Thornton, *The Texas Health Care Liability Act: Managed Care Organizations Can Say Goodbye to Their Extensive Immunity from Lawsuits—or at Least That Was How It Was Supposed to Work*, 30 TEX. TECH. L. REV. 1227, 1235 (1999).

3. Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49, 50 (D. Mass. 1997) (quoting Mary Leonard, *'Boutique Medicine' Is Not for Everybody*, BOSTON GLOBE, July 6, 1997, at C1).

A. *ERISA Statute and Standards*

In 1974 the Employee Retirement Income Security Act (ERISA)[4] was enacted to regulate employee welfare and benefit plans.[5] When employers establish an employee welfare plan to provide health insurance coverage to their employees, they are subject to ERISA regulation. An ERISA welfare plan is defined under the statute as

> any plan, fund, or program...established or maintained by an employer or by an employee organization, or by both...for the purpose of providing for its participants or their beneficiaries through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident disability....[6]

In 1999 there were about 122 million Americans covered by ERISA-sponsored health plans.[7] Of the total 161 million Americans with private health insurance, it is estimated that forty-eight million Americans are insured through companies that self-insure.[8]

ERISA was enacted to establish fiduciary standards and prevent fraudulent fiduciary conduct.[9] Because of this focus on fiduciary standards, the statute itself does not focus on specific requirements of substantive coverage by an ERISA welfare plan but leaves the decision to the employer regarding whether or not the company should provide a plan and, if provided, the extent of benefits that will be covered.[10] Thus, there is no affirmative obligation on the employer to provide any plan or benefits at all.[11]

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4. *History of the Pension & Welfare Benefits Administration & the Employee Retirement Income Security Act of 1974*, (March 8, 2000). [hereinafter *ERISA History*].

5. 29 U.S.C. § 1001-1461 (2001).

6. 29 U.S.C. §1002(1) (2001).

7. Pension and Welfare Benefits Administration Strategic Enforcement Plan 4/26/00, 65 Fed. Reg. 18207-12.

8. *Legislative Purpose Bill Status Outlook*, Health Care Daily Rep. (BNA) (Aug. 12, 1999).

9. The fiduciary may establish a written plan that establishes a funding policy, provide allocations for operation and administration, and establish methods to amend the plan. The fiduciary will oversee any trust amounts individually or through a named employee or investment manager. These amounts must be managed without inurement to the employer. 29 U.S.C. § 1102 & 1103 (2001). The fiduciary is held to a prudent man standard of care. The fiduciary

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

29 U.S.C. § 1104 (a) (1) (2001).

10. The fiduciary is also required to furnish plan beneficiaries a Summary Plan Description (SPD) and file an annual report with the Secretary of Labor. 29 U.S.C. § 1021 (2001). The annual report must include a detailed financial statement of the assets and liabilities of the plan, fund balances, and any changes in position since the last statement. 29 U.S.C. § 1023(a) & (b) (2001).

Upon termination of a welfare plan, plan assets are distributed as indicated in the plan. 29 U.S.C. § 1103 (d)(2) (2001). When a claim has been denied, ERISA requires that the plan (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim. 29 U.S.C. § 1133 (2001).

11. *ERISA History*, *supra* note 4.

Recently several amendments to ERISA, however, have created affirmative obligations affecting substantive health care coverage for ERISA plan participants. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) amendments extended employee insurance coverage on termination of employment.[12] Employers are now required to inform employees of COBRA rights upon termination of employment and give them the opportunity to continue coverage for employer-provided group health insurance.[13] The Health Insurance Portability and Accountability Act of 1996 (HIPPA) established requirements to limit use of pre-existing conditions when an individual changes employment.[14] HIPPA limits pre-existing condition (PEC) review to six months preceding enrollment date and limits the pre-existing condition exclusion period to twelve months following enrollment.[15] Coverage credits for prior periods of continuous coverage are given. Therefore, if an employee continues coverage from one employer to the next or continues coverage through COBRA, HIPPA provides for continuous insurance coverage without a PEC.[16] The Newborn and Mother Health Protection Act (NMHPA) mandated hospital stays following delivery to at least forty-eight hours after normal vaginal delivery and ninety-six hours after a caesarean-section.[17] Minimum mental health benefits were mandated through the Mental Health Parity Act.[18] The Women's Health and Cancer Rights Act (WHCRA), enacted in 1998, requires health plans to cover reconstructive surgery and other benefits such as prosthesis as needed after mastectomy.[19] These mandated substantive standards set a minimum level of benefits with which ERISA welfare plans must comply.

Despite these amendments, consumers still complain that MCOs limit their access to health care. One way this happens is through coverage denials, where the requested medical services do not fall within a "category of services" offered by the plan or when they are excluded from the plan policy.[20] Because there is no requirement that ERISA plans provide coverage for any more than the narrow mandated benefits, ERISA offers little protection for the consumer complaining about coverage denials.[21] MCOs also limit consumer access to health care when determining whether or not requested services are medically necessary. Management procedures such as pre-authorization, concurrent review of the length of stay, or retrospective review are performed by a physician or health care provider to

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12. 29 U.S.C. § 1161-1169 (2001).
13. 29 U.S.C. §1162, 1166 (2001).
14. 29 U.S.C. § 1181 (2001).
15. 29 U.S.C. § 1181(a)(1) & (2) (2001).
16. 29 U.S.C. § 1181 (2001).
17. 29 U.S.C. § 1185 (a)(1)(A) (2001).
18. 29 U.S.C. § 1185a (2001). The Department of Labor has established a hotline to help inform people about their benefits. *See* Press Release, PWBA, White House Announces Labor Department Outreach to Inform Consumers about Mental Health Benefits (June 7, 1999), *available at* http://www.dol.gov/dol/opa/public/media/press/pwba/pwb99160.htm.
19. 29 U.S.C. § 1185b (2001).
20. Karl Polzer & Patricia A. Butler, *Employee Health Plan Protections Under ERISA: How Well Are Consumers Protected Under Managed Care and "Self-insured" Employer Insurance Plans?* HEALTH AFFAIRS (Sept. 1997–Oct. 1997).
21. 29 U.S.C. § 1161-1169, 1181, 1185a, 1185b (2001).

determine if the medical care is appropriate according to the established guidelines of the organization.[22] MCOs will deny services after a utilization review either because (1) the services were not accessed according to plan guidelines or (2) the services were considered to be non-medically necessary or experimental.[23] Medical necessity denials are more subjective than coverage denials, and there is wider variation in determination of medical necessity.

Many consumers, feeling that their MCOs have wrongly denied access to care, have sought legal redress in court. ERISA, however, protects employers from conflicting state regulations by preempting state law,[24] including state tort and contract law, unless they deal with the business of insurance.[25] As discussed below, some state lawsuits can proceed on a medical malpractice theory, and plaintiffs then are entitled to both compensatory and punitive damages.[26] Most plaintiffs, however, must seek redress in federal court and are only entitled to those remedies allowed under the ERISA statute, and those remedies do not include either compensatory or punitive damages.[27] While ERISA provides a remedy to enforce services determined to be medically necessary, it does not provide a remedy for those who were denied services since the statute doesn't include compensatory damages. For these people, the ERISA remedy is too little too late.[28]

B. Federal Right to Sue Legislation

In response to the inability of consumers to find adequate redress in the federal courts, both federal and state legislatures have discussed proposals that include the right to sue in state court. It has been suggested that Congress should amend ERISA to prevent preemption of state lawsuits against MCOs that deny services to ERISA beneficiaries.[29] Federal legislation allowing the right to sue under ERISA has been proposed based on the rationale that a federal amendment to ERISA would "benefit patients by eliminating the shield of immunity that ERISA has provided for MCOs."[30] The proposed federal legislation also provides for uniform legislation that continues to protect the ERISA interest in avoiding conflicting state law provisions for ERISA welfare plans.[31] Unless patients are allowed to sue MCOs, proponents argue, "health plans will deny their patients diagnostic procedures, multiple treatment options, and expensive referrals in order to ensure their own economic gain."[32]

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22. Ransberg-Brown, *supra* note 1, at 407.

23. Karen Jordan, *Coverage Denials in ERISA Plans: Assessing the Federal Legislative Solution*, 65 MO. L. REV. 405, 415 (2000).

24. 29 U.S.C. § 1144(a) (2001).

25. 29 U.S.C. § 1144(b)(2) (2001). *See also infra* part III(A).

26. *See infra* part II(B).

27. *See infra* part II.

28. Kathy L. Cerminara, *Protecting Participants in and Beneficiaries of ERISA-Governed Managed Health Care Plans*, 29 U. MEM. L. REV. 317, 327 (1999).

29. Jana K. Strain & Eleanor D. Kinney, *The Road Paved with Good Intentions: Problems and Potential for Employer-Sponsored Health Insurance Under ERISA*, 31 LOY. U. CHI. L. J. 29, 64-65 (1999).

30. Julie K. Locke, *The ERISA Amendment: A Prescription to Sue MCOs for Wrongful Treatment Decisions*, 83 MINN. L. REV. 1027, 1049 (1999).

31. *Id.* at 1050-53.

32. *Id.* at 1033.

Critics of federal legislation claim that permitting claims for damages against MCOs will increase health care costs as litigation and court recovery amounts increase.[33] Employers have opposed the removal of liability protection under ERISA.[34] They claim that if employees have the right to sue the employer, the employer will have to "reduce benefits, increase premiums and out-of-pocket costs, or eliminate coverage altogether."[35] A poll of small businesses indicated that fifty-seven percent would drop healthcare coverage for their employees if they had increased liability.[36] Others fear that health plans will control costs by raising the price of premiums or selecting only healthy people to insure.[37]

A number of legislative proposals have been made to enact federal right to sue legislation. In 1999, the Senate debated right to sue legislation in the Patient's Bill of Rights Act of 1999.[38] As introduced, the bill contained a provision allowing a right under state law to recover damages resulting from personal injury or for wrongful death against any person.[39] The version of the bill approved in July 1999 did not contain any right to sue language.[40] In the meantime, the Norwood-Dingell bill, which included the right to sue, passed the House.[41]

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33. *Id.* at 1053.

34. A national Kaiser Foundation survey of 1900 employers found that sixty-one percent of small businesses supported the right to sue health plans, while only twenty-six percent of larger firms with more than 200 employees supported the right to sue. Employers were not asked about whether they supported the right to sue if it were to impact cost or coverage. These questions typically cause a drop in support of the right to sue. *See Many Businesses Support Right to Sue Plans Despite Lobbyists' Opposition, Survey Finds*, 7 Health Care Policy Rep. (BNA) 43, 1731 (Nov. 1, 1999) and Press Release, Kaiser Family Foundation, New Annual Survey of Employer Health Benefits Shows Health Insurance Premiums Rising; Coverage & Choice Remain the Same (Oct. 28, 1999). [hereinafter Kaiser Press Release]. The differences in large and small firm responses were attributed to the weaker bargaining power of small business in negotiating with health insurers. *See* Kaiser Press Release. Employers were more concerned with the cost of care than the quality of care as seventy-two percent of employers were somewhat or very worried about health care costs and sixty-five percent were worried they would have to switch health plans because of concerns about cost, while only twenty-six percent were worried about switching health plans because of concerns about the quality of care. *See id.*

35. Douglas A. Hastings, *Patient Rights Meet Managed Care: Understanding the Underlying Conflicts*, 31 J. HEALTH L. 241, 255 (1998).

36. *Id.*

37. Locke, *supra* note 30, at 1053. A Health Benefits Coalition national survey of eight hundred registered voters found that sixty-seven percent believe giving HMO patients the right to sue would benefit America's trial lawyers, while only twenty-five percent felt that the right to sue would benefit patients. The survey also found that sixty-eight percent of those surveyed opposed allowing health care lawsuits against employers and eighty percent believed their employers would drop health insurance coverage if they could be sued. Based on this, the coalition was urging Congress not to pass broad right-to-sue provisions too hastily. See *Coalition Urges Careful Consideration of Patients' Rights Measure, Right-to-Sue Issue*, 8 Health Care Policy Rep. (BNA) 279 (Feb. 14, 2000).

38. *Patients' Bill of Rights Act of 1999*, S. 1344, 106th Cong. (1999).

39. *Id.* at § 302.

40. S. 1344 (Engrossed in Senate). Specific patient protection standards adopted in the Senate bill include provisions relating to access to emergency care, point-of-service coverage, choice of providers, access to specialty care, coverage for approved clinical trials, access to prescription drugs, provider network adequacy, quality assurance, participation of health care professionals, benefits for breast cancer treatment, nondiscrimination in delivery of services, prohibition of interference with medical communications, incentive arrangements, prohibit retaliation, and promotion of good medical practice. *See* S. 1344, 106th Cong. § 301 (1999).

41. Bipartisan Consensus Managed Care Improvement Act of 1999, H.R. 2723, 106th Cong. § 101 (1999). Specific rights incorporated into the ERISA statute include choice of providers, emergency care, access to specialty care, access to obstetrical and gynecological care, access to pediatric care, continuity of care, access to prescription drugs, coverage for individuals participating in clinical trials, grievance and internal appeals, external appeals, prohibitions of interference with medical communications, prohibition of discrimination against providers based

The Senate and House bills were moved to the Managed Care Reform Conference Committee in February 2000 for further discussion, with the right to sue as a primary difference between the proposals.[42] On January 22, 2001, Senate Bill 6, entitled "Patients Bill of Rights Act," was introduced and referred to the Committee. It set forth grievance and appeal procedures that included external review, required access to care and information, and protected the doctor-patient relationship by prohibiting improper incentives, but did not include the right to sue in state court. Nonetheless, it preserved the right to sue under existing ERISA provisions.[43]

A few weeks later, the "Bipartisan Patient Protection Act of 2001" was introduced.[44] This bill focused on improving managed care and set parameters for claims review and appeal procedures through internal and external review provisions.[45] It also included access to care provisions,[46] coverage requirements,[47] access to information,[48] and prohibited certain financial incentives.[49] The bill also included the right to sue in state court for personal injury and wrongful death, but limited punitive damages when the plan has complied with the provisions of the statute. It also precluded class action lawsuits against the plan and lawsuits against employers.[50] In March, President Bush indicated that he was for patient rights, but he would veto this version of the bill.[51]

In July 2001, another Bipartisan Patient Act was introduced into the House with provisions for utilization review programs as well as claims and appeal procedures.[52]

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on license, prohibition against improper incentive arrangements, and protection for patient advocacy. *See* H.R. 2723, 106th Cong. § 301 (1999).

42. David Nather, *Managed Care Reform Faces Next Hurdle: Conferees Likely to Oppose House-Passed Bill*, Health Care Daily Rep. (BNA) (October 12, 1999) and *Nickles to Chair Managed Care Panel; Lott Hints Again of Limited Right to Sue*, Health Care Daily Rep. (BNA) (Feb. 2, 2000).

43. SB 6, 107th Cong. (2001).

44. SB 872/HR 526, 107th Cong. §§ 111-118 (2001). These provisions require coverage of clinical trials and second opinions.

45. It has been suggested that external review processes prior to the right to sue in federal court under ERISA for damages serve a useful pre-trial claim review prior to filing a lawsuit. *See* Locke, *supra* note 30, at 1055. Like medical malpractice pre-litigation panels, a pre-trial review by an external review board would give early feedback on the merits of the case encouraging withdrawal of non-meritorious claims or early settlement based on early feedback regarding the merits of the claims. *See* Amy E. Elliott *Arbitration & Managed Care: Will Consumers Suffer If the Two Are Combined?* 10 OHIO ST. J. ON DISP. RESOL. 417, 420-21 (1995). The proposed process would be:

> [A]fter an MCO denies a patient coverage for treatment that the patient and her physician agreed was in her best medical interest, the patient would appeal the decision to an external review board paid for by the MCO. The board would be comprised of medical, legal and other professionals who have the expertise...to administer a review hearing.

Locke, *supra* note 30, at 1055. This would include provisions for expedited review when care was urgently needed. The process would preclude medical and health care professionals from serving on the review board if they have a conflict of interest. It would provide further statutory remedies in federal court including attorney's fees and costs, liquidated damages, or punitive damages. *Id.*

46. SB 283/HR 526, 107th Cong. §§ 111-118 (2001). These provisions include the right to emergency room treatment, access to an obstetrician and pediatrician, and access to prescription drugs.

47. SB 283/HR 526, 107th Cong. §§ 119-20 (2001). These provisions require coverage of clinical trials and second opinions.

48. SB 283/HR 526, 107th Cong. § 121 (2001).

49. *Id.* at § 133.

50. *Id.* at §§ 152, 302.

51. *Bush Threatens to Veto Health Bill, Rejects Bipartisan Measure Allowing HMO Lawsuits*, Anne F. Kornblut, BOSTON GLOBE, March 22, 2001, at A2.

52. H.R. 2563, 107th Cong. (2001).

This amended bill passed the House in August 2001, with compromise amendments that precluded liability for things that do not include a medical review decision (hence no liability for coverage denials). It also provided for independent medical review requiring exhaustion of administrative processes prior to filing a lawsuit.[53] Civil penalties are capped when administrative remedies are utilized. The bill also precludes lawsuits against employers and limits class actions. Some feel that the compromises excised substantive consumer protections, leaving only a pretext of relief.

III. ERISA PREEMPTION AND THE RIGHT TO SUE IN STATE COURT

Many patients are currently prevented from suing MCOs in state court and thereby seeking compensatory and punitive damages, because ERISA preempts such claims. Federal preemption proscribes a federal forum and limits remedies to those specified in the ERISA statutes.[54] ERISA preemption takes place through two statutory provisions. The first is the "complete preemption" provision under section 502, which states that a "participant or beneficiary" may sue "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."[55] The second provision is the "conflict preemption" provision under section 514, which states that "[e]xcept as provided in subsection (b) of this section, the provisions of this subchapter...shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan...."[56]

Complete ERISA preemption under section 502 allows a state court defendant to raise ERISA preemption as a defense and remove the case to federal court, even though the plaintiff has only raised state common law claims in his complaint.[57] Thus, ERISA cases are an exception to the well-pleaded complaint rule.[58] The Supreme Court has found that Congress intended ERISA complete preemption of an entire field of law with exclusively federal remedies.[59] Thus, a defendant can remove a plaintiff's state law claim to federal court by claiming that the case "really" involves a federal claim relating to an ERISA plan.[60] Once the case has been removed, the federal court determines whether ERISA does or does not preempt the state law claim, either in response to a motion to remand from the plaintiff, who will argue that removal under section 502 was improper, or a motion to dismiss from the defendant, who will assert that the state law claim conflicts with the ERISA statute and is therefore preempted under section 514.

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53. Cong. Rec. H. 5213, 5226-27 (Aug. 2, 2001).

54. Locke, *supra* note 30, at 1038.

55. 29 U.S.C. §1132(a)(1)(B) (2001).

56. 29 U.S.C. §1144(a) (2001). An employee benefit plan is defined as an employee welfare benefit plan or an employee pension benefit plan or a combination of both. See 29 U.S.C. 1002(3) (2001).

57. *See generally* Robert Cohen, *Understanding Preemption Removal Under ERISA 502*, 72 N.Y.U. L. REV. 578 (1997).

58. Franchise Tax Bd. of Cal. v. Constr. Laborers Vacation Trust for S. Cal., 463 U.S. 1, 22-27 (1983). The well-pleaded complaint rule generally prevents a state court defendant from removing a case to federal court unless a substantial federal issue is set forth in the plaintiff's complaint. *Id.* at 9-10.

59. Pilots Life Ins. Co. v. Dedeaux, 481 U.S. 41, 52 (1987).

60. *Id.* at 56.

If removal was proper under section 502, then those state law claims are necessarily preempted under section 514,[61] and only the remedies provided in section 502 are available to the plaintiff. [62] ERISA remedies are limited to "recover benefits due ... to enforce his rights ... or to clarify his rights to future benefits."[63] Unlike state court remedies, federal remedies do not include compensatory damages, consequential damages, punitive damages, or injunctive relief. The effect of the federal preemption is to leave the plaintiff without a real remedy in the federal forum.

A. Supreme Court Standards for ERISA Preemption

Under section 514, states cannot regulate ERISA benefit plans.[64] As a result, ERISA preempts any state laws that have a "connection with" or "reference to" an employee benefit plan to determine whether ERISA preempted the state statutes.[65] In *Pilots Life Insurance Company v. Dedeaux*,[66] the Supreme Court held that ERISA preempts some state common law causes of action.[67] *Pilots Life* involved a plaintiff who suffered a work-related injury, leading to a permanent disability requiring benefits administered under an employee benefit plan.[68] The plaintiff sued to receive benefits, claiming breach of contract, breach of fiduciary duty, and fraud in the inducement.[69] The Court found that section 514 clearly applied since the state law includes causes of action "related to" an employee benefit plan.[70]

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61. The converse, however, is not true. Section 502 is narrower than section 514. Therefore, it is possible that a state law claim can be preempted under section 514 but removal is not proper under section 502. When that occurs, the district court does not have jurisdiction to determine the preemption question, and instead the issue should be resolved by a state court. *See Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 355 (3rd. Cir. 1995).

62. When health plans give the administrator discretionary authority regarding plan benefits, then plan administrative decisions will be upheld unless the decision was arbitrary and capricious. See Moran v. Rush Prudential HMO, 230 F.3d 959, 972 (7th Cir. 2000), *cert. granted*, 121 S.Ct. 2589 (June 29, 2001). On the other hand, when the plan administrator does not have discretion, the court will conduct a de novo review. *See Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 112 (1989).

63. 29 U.S.C. §1132(a)(1) (2001).

64. *See* Shaw v. Delta Airlines, Inc., 463 U.S. 85, 106-08 (1983).

65. *Id.* at 96.

66. 481 U.S. 41 (1987).

67. *Id.* at 47-48.

68. *Id.* at 44.

69. *Id.*

70. *Id.* at 47-48. The plaintiff in *Pilots Life* also argued that the state common law regulated the business of insurance, and therefore his state law claims fit into the insurance savings clause. *Id.* at 48; see *infra* part III(A) for a discussion of the insurance savings clause. The Court first looked at the common sense view of insurance and found that bad faith was linked to insurance but also to other tort and contract actions. The bad faith claim could be broader than the business of insurance. *Id.* Second, the court looked at the three McCarran-Ferguson factors regarding the "regulation of insurance" to determine if the law regulated insurance. *Id.* at 48-49. The court found that bad faith did not spread risk, did not determine the terms of the contract, and was not limited to entities in the insurance industry. *Id.* at 50-51. Therefore, the claim was found not to relate to the business of insurance. Third, the court looked at the statute as a whole based on the statutory language and congressional intent. *Id.* at 51. In doing so, the court found the section 502 civil enforcement to be an exclusive remedy under ERISA based on the language of the statute and congressional intent. The court characterized the lawsuit as focusing on the processing of claims that related to ERISA under section 514. In finding ERISA preemption of the state law causes of action, the court found that the state law claims could not be saved from preemption under the insurance savings clause because Congress intended ERISA to be the exclusive remedy for actions involving employee benefit plans. Thus, the impact of *Pilots Life* was to preempt state common law claims of breach of contract, breach of fiduciary duty, and fraud when an employee benefit plan was involved.

In *Metropolitan Life Insurance Co. v. Taylor*,[71] the Court held that ERISA preempted a state common law action regarding payment of disability benefits by an ERISA insurer. The Court considered three factors in determining whether Congress intended the statute to preempt state-law claims:

> (1) the statute contained a federal cause of action that the plaintiff could bring in place of his state-based causes of action; (2) if the federal statute contained a provision that federal courts have jurisdiction over actions under the statute notwithstanding the amount in controversy or citizenship of the parties; and (3) if the statute's legislative history states that a court should regard all actions arising out of the statute as a federal question....[72]

Applying these factors, the Court held that ERISA preempted the state common law causes of action that related to the employee benefit plan.

The Supreme Court then addressed conflict preemption under section 514 in a trilogy of cases. First, in *New York Blue Cross Plans v. Travelers Insurance Co.*,[73] the Court held that ERISA preempts state laws that either mandate specific employee benefits or that provide plan beneficiaries with alternative mechanisms to enforce benefits provided through an ERISA plan.[74] Nonetheless, the Court found that section 514 did not preempt New York state surcharge laws.[75] The Court indicated that the intent of preemption was "to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans."[76] The Court also reiterated the standard that a claim "relates to" administration of benefits "if it has a connection with or reference to such a plan."[77] In applying that standard, the Court found that the surcharge act did not make reference to the ERISA plans and did not have any connection with the ERISA plans that would cause it to "relate to" an ERISA plan under section 514 to be subject to preemption,[78] nor was ERISA intended to prevent states from regulating hospital cost, nor did the Medicare history indicate an intent to preempt state health care cost controls.

The second and third cases in the trilogy followed the *Travelers* rationale. The second case, *De Buono v. NYSA-ILA Medical and Clinical Services Fund*,[79] found that a state tax statute was not preempted by section 514. Similarly, the third case, *California Division of Labor Standards Enforcement v. Dillingham Construction N.A., Inc.*,[80] reviewed a California statute that required a contract awarded for public

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71. 481 U.S. 58 (1997).

72. J. Matthew Cross, *The Fifth Circuit Provides a Reproducible Framework for the Application of the Complete Preemption Doctrine*, 50 BAYLOR L. REV. 205, 216 (1998).

73. 514 U.S. 645 (1995).

74. *Id.*

75. *Id.* at 649.

76. *Id.* at 657.

77. *Id.* at 656.

78. The Court used ERISA objectives as a guide to determine the scope of state law that would survive preemption. ERISA does not require a minimum amount of benefits, but does regulate the administration of the benefits. The Court noted that an indirect economic influence does not bind the plan administrator and is not a regulation of an ERISA plan. *Id.* at 656, 659.

79. DeBuono v. NYSA-ILA Med & Clinical Servs. Fund, 520 U.S. 806; 117 S.Ct. 1747; 138 L.Ed. 2d 21 (1997).

80. 519 U.S. 316 (1997).

works to not pay less than the prevailing wage for local workers. In following the *Travelers* standard of review, which used ERISA objectives as a guide to determine whether a state statute was preempted, the Court found that the California wage did not "relate to" an employee benefit plan and was not preempted by ERISA.[81]

B. Medical Malpractice Cases: Quality versus Quantity

Generally, ERISA will not preempt claims of medical malpractice, even when brought against an employee welfare plan, rather than just the individual medical practitioners who provided care. Thus, a plaintiff claiming that his physician was negligent in the provision of medical services will be able to pursue a claim in state court with state-court remedies against both the physician and the health plan. The key distinction in determining whether a suit should be characterized as claim for medical malpractice and therefore allowed to remain in state court or a claim involving an ERISA plan and therefore subject to preemption is whether the claim involves the quality or quantity of services provided, respectively.

In *Rice v. Panchal*, for example, the Seventh Circuit determined that a claim against a health plan was not preempted by section 502 because the case could be resolved without interpreting an ERISA plan.[82] In that case, the plaintiff brought a malpractice action in state court for injuries from allegedly negligent treatment. He sued two doctors as well as the Prudential Insurance Company, the administrator of his employer's welfare benefit plan, claiming the company was liable under the theory of respondeat superior.[83] After the health plan removed the case to federal court, where the case was dismissed, the plaintiff appealed and sought a remand to state court.[84] In reviewing whether the medical malpractice claim was completely preempted by section 502, the court applied three factors: (1) whether the plaintiff was eligible to bring a claim under section 502; (2) whether a claim is within the subject matter of section 502; and (3) whether the plaintiff's state law claim can be resolved without interpretation of the contract.[85] The court found that the medical malpractice claim would not require review of the plan terms or interpretation of the plan and therefore was not completely preempted by section 502. Thus, the case was remanded to state court for lack of subject matter jurisdiction.[86]

Similarly, the Third Circuit also determined that medical malpractice claims were not subject to section 502 preemption in *Dukes v. U.S. Healthcare, Inc.*[87] In that case, a health plan beneficiary died after a test was initially denied by the MCO, U.S. Healthcare. The beneficiary's wife brought suit in state court, alleging medical malpractice and negligence. The court, in holding that the claims were not

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81. *Id.* at 325-28.
82. Rice v. Panchal, 65 F.3d 637 (7th Cir. 1995).
83. *Id.* at 638.
84. *Id.*
85. *Id.* at 641-43.
86. *Id.* at 645.
87. 57 F.3d 350 (3d. Cir. 1995). The court reviewed two consolidated cases. *Id.* at 351. The first was in regard to the Dukes, who were refused a blood test by the hospital initially. *Id.* at 352. The next day the test was performed, but Mr. Dukes died shortly after. His blood sugar was high at the time of death. *Id.*

The *Visconti* case involved the birth of a stillborn child. The mother developed symptoms of pre-eclampsia and subsequently died. Both parties claimed direct and vicarious negligence. *Id.* at 353.

preempted, distinguished between claims for the quality of medical care received, typically regulated by state law, and recovery of a quantity of benefits due under the terms of the ERISA plan.[88] The court found that there was "no plan-created right implicated by the plaintiffs' state law medical malpractice claims."[89] Rather, the plaintiffs were asserting rights that already existed under state agency and tort law.[90]

The Third Circuit also found that ERISA plan participants could sue an HMO in state court for malpractice in *In re U.S. Healthcare*.[91] The parents sued, claiming negligence in the discharge policy, diagnosis and treatment, and utilization management policies, and also claiming that appropriate medical care required a home visit after their newborn died.[92] The circuit court affirmed the district court decision that the negligent claims were not preempted by section 502 since they related to the quality of care and did not fall under ERISA civil enforcement processes for benefits due.[93] The circuit court reversed the district court decision in regard to the claim for home care, finding that the federal court did not have subject matter jurisdiction over the section 514 preemption defense.[94]

Various district courts have reviewed allegations of negligence and found they were not preempted by ERISA, resulting in their remand to state court. These negligence claims were found to concern the quality of benefits provided and were therefore not preempted under section 502 complete preemption. They relate to the quality of medical care as opposed to the quantity of benefits provided under the ERISA plan.[95] These allegations include negligent treatment and inappropriate treatment.[96] In *Moscovitch v. Danbury Hospital*, for example, the claimant alleged negligence in failing to provide inpatient care. When the failure to cover inpatient care claim was dropped, the medical malpractice claims for negligence were

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88. *Id.* at 356-57.

89. *Id.* The threshold question raised by the DOL in some of the briefs is whether the claim involves an ERISA plan. In the amicus curiae brief for *Dukes*, the DOL claimed that the health system involved in the lawsuit was not an ERISA plan providing benefits nor was it a plan administrator. It claimed that the employer who decided to provide the benefits was the welfare plan and that the health system had not been designated as a plan administrator. Further, the employer could not be liable for medical malpractice, but only the health system could be liable directly or vicariously for the providers in its health system. *See* DOL Amicus Curiae Reply Brief in Dukes v. U.S. Healthcare, 57 F.3d. 350 (3rd. Cir. 1995), *available at* http://www.dol.gov/dol/sol/public/info_about_sol/pbsbriefs/dukes.txt.

90. *Dukes*, 57 F.3d at 358.

91. 193 F.3d 151 (3d Cir. 1999), *cert. denied*, U.S. Healthcare Inc. v. Bauman, 530 U.S. 1242 (2000).

92. *Id.* at 156. The infant was discharged from a hospital within twenty-four hours after delivery. When the baby became ill, the parents contacted their physician, who did not tell the parents to bring the baby back to the hospital. The HMO was also contacted, but did not authorize a home visit. A strep infection resulted in meningitis and death of the infant. The federal district court found that the claims for negligence were not completely preempted under section 502 and remanded those claims to state court. *Id.* at 157. It found, however, that the claim for a home visit related to an ERISA plan was preempted under section 514. *Id.*

93. *Id.* at 162.

94. *Id.* at 165. Therefore, that count was also remanded to the state court where it would be decided if there was preemption under section 514. *Id.* at 164. In doing so, the court distinguished between section 502 complete preemption, which allows the federal court to exercise removal jurisdiction over claims that are completely preempted, and section 514 conflict preemption, which serves as a defense in state court claims but which creates no removal jurisdiction to federal court. *Id.*

95. AETNA U.S. Healthcare Inc. v. Maltz, 1999 U.S. Dist. LEXIS 6708 (S.D. N.Y. 1999).

96. *See* Berger v. Livengrin Found., 2000 U.S. Dist LEXIS 3832 (E.D. Pa. 2000), which involved allegations of abuse by a counselor in the facility where the claimant received treatment for alcohol addiction.

remanded to state court.[97] Similarly, in *Miller v. Riddle* the claimant was denied admission to a skilled nursing facility after hospitalization and was discharged home. The court characterized the claim as an attack on the quality of care and remanded the case to state court.[98] In *Morton v. Mylan Pharmaceuticals*, the plaintiff claimed that an inappropriate medication resulted in hair loss. The court also remanded this case to state court.[99] In each of these cases, the courts characterization of the claims as quality of care issues resulted in the ability to sue in the state court forum.

Similarly, when the facts involve a misdiagnosis, most courts have found that the claim is not preempted by ERISA. In *Blum v. Harris Methodist Health Plan*[100] the court granted a plaintiff's motion to remand to state court on claims of negligent misdiagnosis.[101] In reviewing the claim the court applied a two-part test established by the Fifth Circuit to determine whether the state laws "relate to" an ERISA plan. The test is whether "(1) it falls within an area of exclusive federal concern; and (2) it directly affects the relationship between the principle entities: the employer, the health plan, the fiduciaries, and the participants and beneficiaries."[102] *Phommyvong v. Muniz* also involved misdiagnosis, which the court characterized as a quality of care issue, and the plaintiff was allowed to sue in state court with state court remedies.[103] Likewise, claims for failure to diagnose have also been found to be outside ERISA preemption and state court forum and remedies have been upheld.[104]

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97. Moscovitch v. Danbury Hosp., 25 F. Supp. 2d. 74 (D. Conn. 1998).

98. Miller v. Riddle Mem'l Hosp., 1998 U.S. Dist. LEXIS 7752 (D. Pa. 1998).

99. Morton v. Mylan Pharm., 2000 U.S. Dist. LEXIS 4047 (E.D. Pa. 2000).

100. Blum v. Harris Methodist Health Plan, 1997 U.S. Dist. LEXIS 19732 (N.D. Tex. 1997).

101. In this case, the plan beneficiary received medical care for right leg pain. An X-ray diagnosed calcium deposits; later, the patient was diagnosed with cancer. There were no claims of denial of access to treatment or denial of benefits under the plan. *Id.*

102. *Id.* The court relied on the Fifth Circuit decisions in *Sommers Drug Stores v. Corrigan Enter., Inc.*, 793 F.2d. 1456, 1467 (5th Cir. 1986) and *Mem'l Hosp. System v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990).

103. Phommyvong v. Muniz, 1999 Dist. LEXIS 3101 (N.D. Tex. 1999). In this case the patient's lupus was misdiagnosed. This court followed *Dukes* and found that the misdiagnosis was a quality of care issue, not a benefit denial of claims that would be preempted by ERISA. In *Rice v. Kaiser Foundation Health Plan of Texas, Inc.*, 2000 U.S. Dist. LEXIS 14062 (N.D. Tex. 2000), the court reviewed claims of negligence and medical malpractice when a man went to the emergency room where he was diagnosed with acute gastroenteritis, but was later accurately diagnosed as having perforated diverticulitis requiring surgery. This court noted the *Lancaster* and *Silva* opinions where negligent financial incentives were found to be preempted but found that no claims of negligent incentives had been raised. The plaintiff's motion to remand to state court for trial of the medical malpractice claims was granted.

104. In *Tiemann v. U.S. Healthcare*, 93 F. Supp.2d 585 (E.D. Pa. 2000), the court found that failure to diagnose the problem until a lung transplant was needed was not preempted by ERISA allowing for state court remedies. The court distinguished between quality of medical treatment based on state law principles of negligence and the quantum of benefits due that related to plan benefit administration. *Id.* at 592. In *Eaccirino v. Canlas*, 1998 U.S. Dist. LEXIS 4904 (E.D.Pa. 1998), the court found that misdiagnosis of a lump as due to a cough when it was due to Hodgkins disease was also not preempted by ERISA and the lawsuit in state court was allowed. *See also* Prihoda v. Shpritz, 914 F. Supp 113 (D. Md. 1996), which involved failure to diagnosis a tumor of the left kidney, leading to lung metastasis. The case was remanded to state court after a finding that section 502 complete preemption was not applicable to the quality of care. *Id.* at 118.

Wrongful death claims based on inadequate treatment[105] and poor quality of service in not extending the hospital stay,[106] as well as negligence of an advisory nurse,[107] have similarly been remanded to state court. In *Crum v. Health Alliance-Midwest, Inc.*, the district court characterized negligent nurse triage activities that prevented a man from obtaining emergency room care prior to his death as negligent medical decision making, not utilization management. In making a decision, the court applied the three factors used in *Rice* to reach its conclusion. The first factor, that the plaintiff is eligible to bring a claim, was met because this was an ERISA plan. The second factor, that the cause of action fell under this section, was not met because the claim was not for a denial of benefits under ERISA but for wrongful death due to the misdiagnosis of the patient's condition during nurse triage.[108] The court relied on the *Phommyvong* case, which found that the misdiagnosis of disease was a quality of care issue.[109] The court also relied on the *Dukes* quality of care analysis that claims regarding quality of care are not subject to ERISA. Third, the court found that there was no need to construe the ERISA plan to determine if faulty medical advice had been given.[110] Thus, the characterization by the court of triage activities as medical decision making rather than utilization management allowed the wrongful death claims to survive preemption and be remanded to state court.

Nascimento v. Harvard Community Health Plan involved claims of medical malpractice and breach of contract based on negligent treatment and diagnosis. This case involved a woman with breast cancer that had spread to her lymph nodes. Her doctor told her she would be an excellent candidate for bone marrow transplantation therapy.[111] Her doctor took the case to a tumor conference, where the oncologists discussed treatment. After the conference, the doctor decided that she was not a

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105. *Dykema v. King*, 959 F. Supp. 736 (D. S.Car. 1997), involved a man who was checked and evaluated by a clinic and emergency room medical student and resident respectively, then died of a pulmonary embolism after being sent home. The court relied on *Rice* and *Dukes* decisions that medical malpractice actions were not preempted by section 502 in making the decision. *Id.* at 740-42. The court found that ERISA preemption does not include all state law causes of action. If the cause of action is too tenuous, remote, or peripheral, it will not relate to the plan. *Id.* at 739. These direct and vicarious liability claims were considered state law causes of action not subject to ERISA preemption. *Id.* at 742.

106. Rivers v. Health Options Connect, Inc., 96 F. Supp. 2d. 1370 (S.D. Fla. 2000).

107. Crum v. Health Alliance-Midwest, Inc., 47 F. Supp. 2d 1013 (C.D. Ill 1999).

108. *Id.* at 1019-20.

109. Phommyvong v. Muniz, 1999 Dist. LEXIS 3101 (N.D. Tex. 1999). In this case the patient's lupus was misdiagnosed. This court followed *Dukes* and found that the misdiagnosis was a quality of care issue, not a benefit denial of claims that would be preempted by ERISA.

110. *Crum*, 47 F. Supp. 2d at 1020.

111. Nascimento v. Harvard Comm. Health Plan, 1997 Mass. Super. LEXIS 166 (1997). In *Nascimento*, the DOL argued that physician denial of bone marrow transplant treatment was part of the provision of medical services. This was distinguished from plan administration of utilization management services in which a patient would request coverage of services from the plan that would approve or deny care. The DOL also argued that breach of a duty to refer a patient to a specialist in a timely manner was not preempted by ERISA because the failure to refer was a breach of contract subject to state court review and did not conflict with ERISA provisions that applied to plan administration.

Applying the DOL reasoning, utilization management could be delegated to physicians using criteria to determine if services were appropriate without the patient requesting coverage and the process would be considered part of medical care and not preempted by ERISA, while the same activity performed by the health plan administrator would be a review of a benefit decision subject to ERISA preemption. This blurs the distinction between administrative utilization management services and medical care activities. *See* DOL Amicus Curiae Brief in Nascimento v. Harvard Comm. Health Plan, No. 942534 (Mass. Super. Ct.), *available at* http://www.dol.gov/dol/sol/public/info_about_sol/pbsbriefs/nascimento.txt.

good candidate for bone marrow transplantation therapy and should be given chemotherapy instead. The court reviewed cross motions for summary judgment to determine whether the claims were preempted by ERISA. In applying section 502, the court found that the breach of contract claim was pre-empted because the claim that a higher level of care was agreed to than was rendered could not be determined without construing the terms of the contract. The court then applied section 514 to the other claims for emotional distress and medical malpractice and found that they did not "relate to" the employee benefit plan and were not preempted by ERISA.[112]

C. Benefit Denial Cases

In contrast to cases involving medical malpractice, claims involving the denial of benefits are usually preempted by ERISA. In *Corcoran v. United HealthCare*, for example, the Fifth Circuit found that ERISA preempts state law claims involving medical decisions made in the context of determining available benefits.[113] In *Corcoran*, parents claimed that their fetus died as a result of negligence of the health plan in not approving hospitalization during a high-risk pregnancy.[114] They brought claims for wrongful death and emotional distress. The plaintiffs claimed the utilization management decision was a medical decision subject to state law enforcement, while defendants claimed that the utilization management decision was a benefit determination subject to ERISA preemption. The court found that the decision had characteristics of both a medical decision and a benefit determination to hold that ERISA preempted the mixed decision. The court's characterization of the Corcoran claim as a mixed decision subject to ERISA preemption resulted in no remedy for the Corcorans in federal court.

Similarly, the Eighth Circuit found that the survivors of a man who died while waiting for heart surgery could not sue his health plan in *Kuhl v. Lincoln National Health Plan*.[115] In *Kuhl*, the patient's physician recommended surgery at an out-of-network hospital. The health plan initially refused to pay for the surgery but approved the treatment two weeks later, after a physician designated by the health plan checked the patient and recommended care at the facility. The surgery team at the facility was not available until several months later, and by then his condition had deteriorated so that surgery was not an option. He was then listed on the heart transplant list, but died while waiting for an available heart.[116] The survivors brought a suit alleging tortious interference, breach of contract, and medical malpractice.[117] The district court viewed the cancellation of the surgery as similar to a denial of pre-authorization that was preempted under ERISA.[118] The appeals court then affirmed the order of the district court that ERISA preempted the state law claims and did not

112. *Id.*

113. Corcoran v. United HealthCare, 965 F.2d 1321, 1331-32 (5th Cir. 1992).

114. The health plan failed to approve disability when her doctor recommended she stay on bedrest during her high-risk pregnancy. The doctor then requested inpatient hospitalization as she neared her due date, but the plan instead approved ten days of home nursing. She entered the hospital, but because the state was not certified, she returned home. During a period when the home nurse was not there, the baby died. *See id.* at 1322-23.

115. 999 F.2d 298 (8th Cir. 1993).

116. *Id.* at 300.

117. *Id.*

118. *Id.* at 301.

authorize financial damages for the claim.[119] This claim was left without remedy in the ERISA vacuum.

Several circuit court decisions in the 1990s found that utilization management decisions were a means of claims processing and therefore a component of administration of benefits under an ERISA plan. In *Tolton v. American Biodyne, Inc.*,[120] the court reviewed a claim for denial of psychiatric care for a man addicted to drugs who claimed suicidal intent.[121] He later committed suicide. A wrongful death lawsuit was filed alleging medical malpractice, negligent refusal to authorize treatment, bad faith, breach of contract, medical malpractice, and statutory violations.[122] The court conducted a de novo review, found that the claims were preempted by ERISA, and affirmed summary judgment in favor of the defendants.[123] The heirs of the patient were left with no forum to redress harm and no remedy for the harm that occurred.

In *Jass v. Prudential Health Care Plan, Inc.*,[124] the Seventh Circuit reviewed a claim for negligence and vicarious liability. The plaintiff had knee replacement surgery but was denied physical therapy as not medically necessary.[125] The court applied the three factors set forth in *Rice* to conclude that section 502 preempted the claim.[126] First, this was a claim by a plan beneficiary that the court recharacterized from a liability claim to a denial of benefit claim since what the plaintiff wanted was the physical therapy services.[127] Second, the court found that the issue could not be resolved without interpreting the contract; therefore, the negligence claims failed to assert a claim for which section 502 had a remedy and the vicarious liability claims were found to "relate to" an employee benefit plan.[128] The court then dismissed the claims as preempted but gave the plaintiff leave to amend the complaint to state a cause of action under section 502.[129] Here, the re-characterization of the negligence claim as a claim for plan benefits led to preemption and dismissal of the case in the federal forum with no remedy for the plaintiff.

Hull v. Fallon[130] reviewed a claim for negligence and vicarious liability in medical malpractice when plaintiff with heart disease did not receive authorization

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119. *Id.* at 302. In making the decision, the court looked at the legislative intent regarding whether the state law related to ERISA. *Id.* at 301-02.

120. 48 F.3d 937 (6th Cir. 1995).

121. *Id.* at 940. The psychologist who performed utilization review for the plan challenged the claimant to remain drug free for five days. He used drugs and was challenged again. He was scheduled for an outpatient appointment that he did not keep. He also went to the emergency room, where he was referred to a local crisis shelter. Later, he signed a pledge not to commit suicide. Nonetheless, he did in fact commit suicide. *Id.*

122. *Id.* at 939.

123. The court found that no causation could be shown between EMTALA and the suicide. The bad faith claim and other state law claims were found to be preempted. *Id.*

124. 88 F.3d 1482 (7th Cir. 1996).

125. *Id.* at 1484.

126. *Id.* at 1487; *see supra* notes 82-86 and accompanying text.

127. *Jass*, 88 F.3d at 1489. Because the physician was listed as a health plan provider within the health plan network and the allegations against the doctor were for negligent failure to treat, the allegation was seen as directly relating to the health plan benefit. The failure to treat was a direct result of the utilization review decision that treatment was unnecessary, which relates to health plan benefits. *Id.*

128. *Id.*

129. *Id.* at 1490-92.

130. 188 F.3d. 939 (8th Cir. 1999), *cert. denied*, 528 U.S. 1189 (2000).

for a thallium stress test but was given a treadmill test instead.[131] In reviewing the case, the court found that the gravamen of the claim was the denial of the thallium stress test. This was determined to be a denial of benefits under an ERISA plan and preempted by section 502.[132] The court found that artful pleading could not change the claims for denial of plan benefits under ERISA into a claim for medical malpractice.[133] The circuit court affirmed defendants' motion to dismiss, and plaintiffs did not amend the complaint to state a complaint under ERISA.[134] Therefore, the plaintiff was left without a forum or remedy for the claim. Similarly, in *Holdsworth v. Allegheny*, a district court re-characterized a medical malpractice claim based on a request for experimental treatment for cancer at Sloan-Kettering or John Hopkins as a claim for the denial of benefits that was therefore preempted by ERISA.[135]

District courts have also found that utilization management decisions are preempted by ERISA. In *Schusteric v. United Healthcare Insurance Co.*,[136] a district court reviewed whether the defendant negligently practiced medicine by deciding physical therapy was not medically necessary.[137] The court found that this was really a claim for an ERISA benefit that was preempted under section 502 and that characterizing it as a negligent treatment decision was inappropriate. The federal court denied the motion to remand the case to state court, leaving the consumer the limited remedies available in federal court.[138] Similarly, in *Garrison v. Northeast Georgia Medical Center, Inc.*,[139] the plaintiff alleged that the HMO was practicing medicine without a license when it made medical decisions to deny treatment. The court found that the denial of the request for a repeat caesarean section was really a denial of benefits subject to ERISA preemption.[140] The result of the ERISA preemption was that the court denied the request for remand to state court and granted defendant's motion to dismiss since the plaintiff had not stated a claim for which relief could be granted. Here the plaintiff was left with no forum or remedy.

Huss v. Greenspring Health Services[141] involved a benefit denial based on whether the plaintiff was covered by the health plan. The plan member was told that they were not covered by the health plan and later, without treatment, committed suicide. The plaintiffs alleged negligence, malpractice, negligent misrepresentation, and negligent infliction of emotional distress. The court relied on *Dukes* and found that this was not an issue about the quality of care but about the quantity of benefits

131. *Id.* at 941.
132. *Id.* at 943.
133. *Id.*
134. *Id.*
135. Holdsworth v. Allegheny, 2000 U.S. Dist. LEXIS 10744 (E.D. Pa. 2000). In this case the plaintiff sued for medical malpractice claiming that the physician failed to diagnose and treat the child's cancer. The child died from the cancer. The court re-characterized the claim as a claim for the denial of benefits resulting in preemption under ERISA.
136. 2000 U.S. Dist. LEXIS 13021 (N.D. Ill. 2000).
137. In this case, plaintiff had dental surgery, then received physical therapy to reduce the pain. Defendant's health plan denied physical therapy when requested, but covered it several months later. *Id.*
138. *Id.*
139. 66 F. Supp.2d 1336 (N.D. Ga. 1999).
140. *Id.* at 1341. The court found that this case was similar to *Jass* and *Tolton* in that the claim was really for benefits due under the benefit plan. *Id.* at 1342.
141. 1999 U.S. Dist. LEXIS 5101 (E.D. Pa. 1999).

under the health plan. The defendant had properly removed the case to federal court where ERISA preempted. Plaintiff was granted leave to amend the complaint to state an ERISA claim that could be reviewed in federal court.[142] The court's characterization of the claim as an issue about the quantity of benefits left the plaintiff with limited remedies in federal court. Similarly, *Brandon v Aetna Services, Inc.*[143] involved a person with anxiety disorder undergoing substance abuse treatment. In this case, treatment was rendered, but the health plan denied payment of the claims. The plaintiff alleged medical malpractice, but the court found that this was really a claim regarding payment of the claims that was preempted by ERISA. Defendant's motion to dismiss was granted and the plaintiff was left without remedy.[144]

D. Breach of Fiduciary Duty Claims and Mixed-Eligibility Decisions

In *Pegram v. Herdrich*,[145] the plaintiff sought to hold an HMO liable for damages beyond those specified in section 502 by bringing a state-law claim for breach of fiduciary duty.[146] The Supreme Court, however, determined that the HMO was not acting in its fiduciary capacity when making decisions regarding medical eligibility and therefore held that such a claim was not preempted by ERISA.[147] *Pegram* involved a health plan established by a physician group.[148] The physicians administered health plan benefits and provided medical services to plan members so that "each and every member of the benefit plan's administrative review board were the very owners of the plan, and the plan beneficiaries were without a single representative on the board."[149] The physicians, as claimed fiduciaries under the plan, performed "dual roles" as health plan administrators as well as medical service providers.[150]

The court differentiated the fiduciary duty[151] that arises from the common law of

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142. *Id.*

143. 46 F. Supp. 2d. 110 (D. Conn. 1999).

144. *Id.* at 114. In this case, however, treatment had already been rendered, so there was no access to care issue. *Id.*

145. 530 U.S. 211 (2000).

146. *Id.* at 215-17.

147. *Id.* at 229-31. The ERISA fiduciary statute was the basis of the lawsuit. It states:

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

29 U.S.C. § 1109 (a) (1999).

148. *Pegram*, 530 U.S. at 215.

149. Herdrich v. Pegram, 154 F. 3d 362, 379 (7th Cir. 1998), *rev'd by* Pegram v. Herdrich, 530 U.S. 211 (2000).

150. It has been suggested that physicians have a dual standard of care in the practice of medicine: (1) to meet the level of care of those with similar training and experience and (2) to manage and allocate resources efficiently. This second standard is obviously impacted by financial incentives of health care practitioners. *See* M. Gregg Bloche, *U.S. Health Care After Pegram: Betrayal at the Bedside? Are Physicians' Incentives to Withhold Care a Breach of Patients' Trust, or Are They Essential for Clinical Efficiency?*, HEALTH AFFAIRS (Sept. 2000–Oct. 2000).

151. In the unanimous Supreme Court decision that reversed the Seventh Circuit, the Justices did not distinguish between different types of HMO financial incentives, but broadly indicated that the "inducement to

trusts, which is a "duty of loyalty,"[152] from the ERISA fiduciary duty, which involves "someone acting in the capacity of manager, administrator, or financial advisor to a 'plan.'"[153] Mixed eligibility decisions that include both review of the contract coverage provisions and medical decision making were found to be so intertwined as to make them inseparable. Therefore, the threshold question in cases alleging that the ERISA fiduciary duty has been breached, is "not whether the actions of some person employed to provide services under a plan adversely affected a plan beneficiary's interest, but whether that person was acting as a fiduciary (that is, was performing a fiduciary function)."[154]

In determining that the mixed eligibility and treatment decisions were not fiduciary acts, the Supreme Court looked at the negative consequences of a contrary holding, including elimination of HMO incentives, creation of incentives to aggressively treat, holding HMO and physicians liable under ERISA, determining a standard of fiduciary responsibility, and duplication of existing state medical malpractice provisions and indicated a preference to a legislative solution to ERISA concerns.[155] In the meantime, the impact of the *Pegram* decision will be that mixed treatment decisions against HMO and physicians would be dismissed as not being ERISA fiduciary claims. It has been suggested that the defendant HMO in *Pegram* won the lawsuit, but the managed care industry lost. While *Pegram* protected the HMO and its agents from being ERISA fiduciaries when making medical treatment decisions, it removed the ERISA preemption protection for state law claims for medical malpractice and breach of state laws relating to fiduciary duty.[156] Nonetheless, *Pegram* left open the "possibility of plan liability under ERISA for failure to tell subscribers about physicians' financial incentives to limit care"[157] or other fiduciary responsibility by the employer who establishes the ERISA plan.

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ration care goes the very point of any HMO scheme." *Pegram*, 530 U.S. at 221. The court defined that the agreement between the HMO and the employer provide the elements of the ERISA plan that determines whether the beneficiaries are entitled to care, not the HMO documents themselves. Thus, the HMO was distinguished as a separate entity from the ERISA plan itself. *See id.* at 227.

152. *Id.* at 225.

153. While the common law trustee serves one role only as the fiduciary over financial matters, the ERISA fiduciary assumes multiple roles as plan administrator and decision maker as well as treating physician. Second, the common law trustee has no adverse interest to the beneficiary for whom he made decisions, while it is very likely that an ERISA fiduciary could have adverse incentives as plan sponsors may desire to control costs. Third, the common law trustee focuses primarily on financial interests, while the ERISA fiduciary may be involved in eligibility decisions based on the "plan's coverage of a particular condition or medical procedure for its treatment" as well as medical decisions based on medical diagnosis and treatment standards. *Pegram*, 530 U.S. at 225. Note that this differed from the approach taken by the circuit court. It found that the health plan through owner Carles was acting as a fiduciary in making decisions. The circuit court indicated that financial incentives do not automatically give rise to a breach of fiduciary duty. Rather, we hold that incentives can rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists (*i.e.*, where physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses). *See* Herdrich v. Pegram, 154 F.3d. 362 (7th Cir. 1998) *rev'd by* Pegram v. Herdrich, 530 U.S. 211 (2000).

154. *Pegram*, 530 U.S. at 226.

155. *Id.* at 232-34.

156. Thomas R. McLean & Edward P. Richards, *Managed Care Liability for Breach of Fiduciary Duty After* Pegram v. Herdrich*: The End of ERISA Preemption for State Law Liability for Medical Care Decision Making*, 53 FLA. L. REV. 1, 19 (2001).

157. *See generally* Bloche, *supra* note 150.

Lower courts have reached different results when applying *Pegram* to state law claims. The Illinois Supreme Court refused to allow a plaintiff to bring breach of fiduciary claim against a physician who failed to disclose finance incentives when a medical negligence claim already provided a remedy.[158] The case of *Neade v. Portes* involved a plaintiff with symptoms of coronary artery blockage.[159] Relying on test results, the physician denied further testing when the patient continued to complain of chest pain. Later the patient died of a myocardial infarction. Plaintiffs claimed that financial incentives limited access to care. The court stated that in order to uphold a breach of fiduciary claim the plaintiff must demonstrate (1) knowledge of the incentive fund; (2) that another physician would have ordered the test; (3) that the test would have detected the condition; and (4) that the treatment would have prevented the health problem and death.[160]

Similarly, in *Pryzbowski v. U.S. Healthcare, Inc.*,[161] the Third Circuit found that ERISA preempted state law claims for negligent delay in approving treatment by an out-of-network physician. *Pryzbowski* involved a request for surgery by an out-of-network neurosurgeon as well as non-participating support providers and facility.[162] The out-of-network surgery was eventually approved, but plaintiff claimed that there was a "negligent and careless" delay in approving the surgery.[163] The court reviewed the Third Circuit cases that distinguished quality of care from quantity of care decisions and noted that there might be times when "quality of the medical care provided would be so deficient that the beneficiary essentially would not have received any health care benefit at all."[164] The court noted that this was a mixed eligibility-treatment decision like that in *Pegram*, then went on to focus on whether the claim related to quality of care subject to state court review or quantity of care under plan administration, which was preempted by ERISA. The court found that the claims against U.S. Healthcare are completely preempted. In doing so, it noted that *Pegram* favored the congressional policy promoting HMOs and that to allow state court lawsuits for managed care practices such as favoring in-network providers would undermine this policy.[165] The court approved supplemental jurisdiction against Medemerge and the physician defendants but found that these claims were not expressly preempted and therefore would require further consideration after the district court determines the scope of malpractice law. Then, preemption will be determined.[166]

Conversely, in *Pappas v. Asbel*,[167] the Pennsylvania Supreme Court held that mixed eligibility and treatment decisions would fall under state medical malpractice

158. Neade v. Portes, 739 N.E.2d 496, 498 (Ill. 2000).
159. *Id.* at 497.
160. *Id.* at 502.
161. 245 F.3d 266 (3d. Cir. 2001).
162. *Id.* at 269.
163. *Id.* at 270.
164. *Id.* at 272-73.
165. *Id.* at 275. The court also noted that the claims against U.S. Healthcare for negligence did not involve negligence of medical treatment but focused on administration of plan benefits. *Id.*
166. *Id.* at 275-76.
167. 768 A.2d 1089 (Pa. 2001).

law.[168] In that case, the patient arrived at the emergency room with complaints of paralysis and numbness. In consultation with a neurologist and neurosurgeon, the physicians decided that this was a neurological emergency and that it was in the best interest of the patient to be treated at a university hospital. When the ambulance arrived, the physician found that the transfer was not authorized by the health plan. The health plan indicated two facilities to which the patient could be transferred. This resulted in a delay in transfer, resulting in permanent quadriplegia.[169] The HMO filed for summary judgment, claiming that ERISA preempted.[170] The trial court granted the summary judgment, but the appeals court found there was no ERISA preemption.[171]

The Supreme Court of Pennsylvania reviewed the *Pegram* decision and found that "[t]he Court held that Congress did not intend any HMO be treated as an ERISA fiduciary to the extent that it makes mixed eligibility and treatment decisions acting through its physicians."[172] The Pennsylvania court characterized the case as a mixed eligibility and treatment decision similar to *Pegram* to affirm its decision prior to *Pegram* reversing the grant of summary judgment to U.S. Healthcare.[173] The court found that this would fall under state law as a mixed eligibility and treatment decision.[174] The dissent, however, argued that the court should use caution in defining managed care administrative functions under ERISA and that a more precise duty should be defined under state tort law before the issue of conflict preemption can be resolved.[175]

E. Financial Disincentives Cases

Some plaintiffs have focused their claims on the financial incentive structures created by HMOs. Courts are split, however, on whether negligent financial incentives will be preempted by ERISA with limited federal forum remedies or will be allowed to sue in state with state court remedies. For these cases, the determining factor in the decision is the way the court characterizes the claim. While various causes of action have been alleged, courts have continued to focus on the distinction between quality of care issues that can be redressed in state court and quantity of care issues related to the denial of benefits subject to ERISA preemption.

The Eighth Circuit recently addressed whether a plaintiff could bring a state-law claim for negligent misrepresentation regarding the financial incentives that impacted physician decision making in *Shea v. Esensten*.[176] The court applied the

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168. *Id.* at 1090.
169. *Id.* at 1091.
170. *Id.* at 1091-92.
171. *Id.* at 1092.
172. *Id.* at 1094.
173. *Id.* at 1096.
174. *Id.*
175. *Id.* at 1097-98. The dissent also noted that the *Pappas* case was distinguishable from *Pegram* in two respects: (1) *Pegram* was more of a treatment decision since the treating physician also determined eligibility for treatment as an administrator in *Pegram*, while in *Pappas* the out-of-network decision making was primarily an eligibility determination and (2) in *Pegram* the plaintiff did not allege physical injuries while in *Pappas* physical injuries occurred because of the HMO decision making. *See id.* at 1100.
176. 208 F.3d. 712, 716 (8th Cir. 2000), *cert. denied*, 531 U.S. 871 (2000). In this case, the DOL amicus curiae brief claimed that the financial arrangements were part of the provision of medical services and not part of

Supreme Court "relates to" inquiry of whether the law "(1) expressly refers to an ERISA plan, or (2) has a connection with such a plan."[177] The court found that there was no express reference to an ERISA plan in the state law of negligent misrepresentation.[178] The court then looked at whether there was a connection with ERISA by looking at the objectives of the ERISA statute and the nature of the state law.[179] The court set out several factors to use in determining whether there was a connection with an ERISA plan:

> (1) whether the state law negates an ERISA plan provision, (2) whether the state law affects relations between primary ERISA entities, (3) whether the state law impacts the structure of ERISA plans, (4) whether the state law impacts the administration of ERISA plans, (5) whether the state law has an economic impact on ERISA plans, (6) whether preemption of the state law is consistent with other ERISA provisions, and (7) whether the state law is an exercise of traditional state power.[180]

The court then applied the factors and determined that there was no connection between the negligent misrepresentation claim and the ERISA plan to justify preemption.[181] The negligent misrepresentation claim was remanded to state court.[182]

Similarly, an Ohio district court characterized negligent incentives as relating to the quality of care so that the cases were remanded to state court with state court remedies.[183] The first, *Oulette v. Christ Hospital*, involved a claim for negligence when the hospital stay was limited to two days after surgery.[184] On the day of discharge, the petitioner developed pain, fever, and blood clots. The hospital staff discharged the woman. The physician claimed that he would not have discharged her if he had known of her condition.[185] Plaintiff claimed that the hospital staff members were negligent in the discharge and that this negligence was caused by the financial relationship between the HMO and the hospital.[186] The court followed the *Rice* test to hold that the negligent incentive claim was not preempted since it was based on a challenge to the quality of care, not the amount of care.[187] In this case the state court forum and remedies were available.

A second district court case, *Stewart v. Berry Family Health Center*, involved a claim of direct HMO negligence for failure to diagnose and treat as a result of HMO financial incentives.[188] The court found that there were no allegations of limited

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plan administration. *See* DOL Amicus Curiae Brief in Shea v. Esensten, Civil No. 3-96-406, *available at* http://www.dol.gov/dol/sol/public/info_about_sol/pbsbriefs/shea.txt.

177. *Shea*, 208 F.3d at 717.

178. *Id.* at 718.

179. *Id.*

180. *Id.* (citing Arkansas Blue Cross/Blue Shield v. St. Mary's Hosp., Inc., 974 F.2d 1341, 1344-45 (8th Cir. 1991)).

181. *Id.* at 718-19.

182. *Id.* at 721.

183. Oulette v. Christ Hospital, 942 F. Supp. 1160 (S.D. Ohio 1996); Stewart v. Berry Family Health Center, 105 F.Supp.2d. 807 (S.D. Ohio 2000).

184. *Oulette*, 942 F. Supp. at 1161.

185. *Id.*

186. *Id.* at 1163-64.

187. *Id.* at 1164-65.

188. *Stewart*, 105 F. Supp.2d. at 811.

treatment under utilization management and no denial of benefits under the plan to characterize the claim as one involving a denial of benefits, therefore it was not subject to ERISA preemption.[189] In making its determination, the court followed *Oulette*, holding that financial incentives were not subject to ERISA preemption. The court focused on the quality of care issues created by the financial incentives.[190]

In contrast, a federal district court in Virginia reviewed liability for HMO incentives and guidelines[191] and found they were preempted in *Lancaster v. Kaiser Foundation Health Plan.*[192] The plaintiffs had also brought claims for medical malpractice against the treating physicians and claims for vicarious liability against the HMO.[193] The court found that the malpractice claims were not subject to preemption. On the other hand, the court found that claims involving the financial incentives and false representations were more related to plan administration and therefore preempted.[194] The court noted that "[t]he Incentive Program, like pre-certification review, also affects the quantity of benefits delivered to a beneficiary."[195] The court dismissed the claims challenging the incentive program as preempted by ERISA.[196]

Reaching a similar result, the court in *Silva v. Kaiser Permanete*[197] re-characterized claims for medical malpractice and negligence when the patient was misdiagnosed as claims for ERISA benefits, since the alleged cost containment and utilization management procedures limited the testing and treatment options available that led to the misdiagnosis.[198] The court found the claims preempted by ERISA and denied the motion to remand to state court.[199] Even though the plaintiff had alleged medical malpractice and negligence, the plaintiff was left to pursue limited federal remedies in the federal forum because ERISA preempted the claim.

A more recent case involved failure to administer a test in a timely manner in order to diagnose prostate cancer. In the case of *Cristantielli v. Kaiser Foundation Health Plan,*[200] the plaintiff sued for medical malpractice for the misdiagnosis of cancer.[201] The court, however, re-characterized the claims as an administrative

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189. *Id.* at 812-13.

190. *Id.*

191. This case also involved claims that the HMO had negligently implemented an incentive fee structure. The DOL argued that all of the claims arose from the HMO's role as a medical service provider (subject to state law), not from its role as a plan administrator (subject to ERISA). *See* DOL Amicus Curiae Brief in Lancaster v. Kaiser Found. Health Plan of the Mid-Atlantic States, Case Nos. 97-1683 & 97-1690 (4th Cir.), *available at* http://www.dol.gov/dol/sol/public/info_about_sol/pbsbriefs/Lancaster.txt.

192. 958 F. Supp. 1137 (E.D.Va. 1997). This case involved an eleven-year-old with headaches who was treated with pain medications for four years, but received no diagnostic testing. Later a brain tumor was found. *Id.* at 1140.

193. *Id.* at 1140-41.

194. *Id.* at 1146-48.

195. *Id.* at 1147.

196. *Id.* at 1148. The direct negligent malpractice claims were state law claims to be remanded to state court to determine whether medical quality of care decisions were negligent. *Id.* at 1146.

197. 59 F. Supp. 2d. 597 (N.D. Tex. 1999).

198. *Id.* at 599. The patient was diagnosed as having Hepatitis C, but was correctly diagnosed a year later as having non-Hodgkin lymphoma. The patient died from the lymphoma. *Id.*

199. *Id.* This was despite plaintiff's claim that removal was improper for medical malpractice and negligence claims. *Id.*

200. 113 F. Supp.2d. 1055 (N.D. Tex. 2000).

201. *Id.* at 1057.

failure to provide a plan benefit of a diagnostic test, not as a medical malpractice claim resulting from a misdiagnosis.[202] The court viewed the failure to provide the test as a cost containment initiative of the HMO, which was an administrative failure to provide a plan benefit and therefore subject to ERISA preemption.[203] Even though the plaintiffs claimed this was a medical malpractice claim challenging the quality of medical care provided, the court found that artful pleading could not avoid complete preemption. Since the crux of the claim was considered to be the failure of the health plan to provide the PSA, the court found that this was a denial of benefits subject to preemption. The motion to remand to state court was denied.[204]

IV. ERISA PREEMPTION AND STATE LAW

Some states have attempted to provide an alternative to individual lawsuits against health plans by requiring independent review of health plan claims, establishing health plan liability through state right to sue legislation, and mandating minimum benefits for health plan members. Many of these statutes have faced challenges from health plans asserting that ERISA preempts such state laws. Some state laws have survived challenge, however, under an exception to ERISA preemption that allows states to regulate the insurance.

Typical state insurance regulations include solvency standards imposed through state insurance regulation, state mandated benefits for health coverage, and state consumer advocates in insurance departments. State regulation also offers consumer protection through investigation of consumer complaints against health plans. These protections are not available for ERISA plans.[205]

A. The Insurance Savings and Deemer Clauses

Federal preemption of state laws under ERISA is balanced against the traditional state authority to regulate insurance under the McCarran-Ferguson Act, which declares that

> (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such act specifically relates to the business of insurance.[206]

Thus, under the McCarran-Ferguson Act, states have the authority to regulate the business of insurance. The ERISA statute specifically indicates that the statute is not intended to "exempt or relieve any person from any law of any state that regulates insurance." In the "deemer clause," however, the ERISA statute also specifically

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202. *Id.* at 1063-64.

203. *Id.* at 1065-66.

204. *Id.* at 1066. The court also reviewed whether this was an employee benefit plan and found that since the family plan covered non-family members, it was an employee benefit plan. *Id.* at 1058-62.

205. Polzer & Butler, *supra* note 20.

206. 15 U.S.C. § 1012 (2001).

states that employee benefit plans, including welfare plans, are not in the business of insurance.[207] Therefore, employee welfare plans are thus subject to preemption and are not considered to be in the business of insurance subject to state court regulation.

Metropolitan Life v. Massachusetts,[208] which predates the *Travelers* decision, was the first Supreme Court case to interpret the insurance savings clause.[209] In this case, a Massachusetts statute established minimum mental health care benefits under insurance of employee health care plans that covered hospital and surgical expenses.[210] The Court looked at whether the statute applied to insurance policies purchased by employee health care plans regulated by ERISA. First, the Court reviewed whether the statute "relates to" welfare plans by looking at congressional intent.[211] It found that the mandated benefit statute related to an ERISA plan was preempted by section 514(a).

The Court then analyzed the insurance savings clause under section 514(b)(2). It first applied a "common sense" test and determined that the statute regulated the substantive content of insurance contracts and was therefore a law that regulates insurance.[212] Next, the Court examined three factors to determine whether the statute fell within the McCarran-Ferguson Act as regulating the business of insurance. These factors are the following: "First, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry."[213] The Court found that the mandated benefits were saved from preemption as a regulation of insurance.[214] In making its decision, the Court made a distinction between insured plans that were regulated by state insurance statutes and uninsured plans that were not subject to state regulation.[215] The Court found that Congress had made the distinction when it enacted the deemer clause. In this case, the statute was "saved" from preemption as it related to insured health care plans.[216]

In *FMC Corporation v. Holliday*,[217] the Court reviewed whether the deemer clause applied to self-funded plans.[218] In reviewing a state anti-subrogration law, the court found that the subrogration law related to an employee benefit plan because it "referred to" and was "connected with" the plan.[219] The state law was found to fall within the insurance savings clause as a law that regulated insurance.[220] The health

207. *Id.*
208. 471 U.S. 724 (1985).
209. *Id.* at 733.
210. *Id.* at 727.
211. *Id.* at 739.
212. *Id.* at 740.
213. *Id.* at 743.
214. *Id.* at 744.
215. *Id.*
216. *Id.*
217. 498 U.S. 52 (1990).
218. *Id.* at 54. In this case, the lawsuit was based on negligence and request for reimbursement of medical expenses after the child of the employee was injured in an automobile accident. *Id.*
219. *Id.* at 58-60.
220. *Id.* at 60.

plan in question, however, was a self-funded ERISA plan, as distinguished from an employee insurance plan. The Court held that the deemer clause exempted self-funded ERISA plans from state law.[221] The Court relied on the congressional intent in enacting ERISA to make its determination.[222] This decision effectively differentiated plans that are "self-funded" by the employer from those that are "purchased."[223] The result of the decision is that two individuals with a similar need for health care could receive two different remedies depending upon whether they were enrolled in a self-funded or insured health plan.[224] The effect of the *FMC* decision was that "state laws that require health plans to provide participants the right to choose their own doctors. . . are exempt from state attempts to regulate their financial practices."[225]

More recently, the Supreme Court reviewed two California laws to determine whether they related to the business of insurance. In *UNUM Health Life Insurance Co. v. Ward*,[226] an employer welfare plan established a long-term group disability plan for its employees.[227] The plan required proof of claims within a specified time frame.[228] The member became disabled, but did not apply for benefits until almost two years later and after the specified time period.[229] State law provisions that were reviewed were (1) a notice-prejudice rule[230] and (2) an agency rule.[231] The district court granted summary judgment, indicating that section 514 preempted the agency rule as relating to plan administration and was not saved from preemption under the insurance savings clause.[232] The Ninth Circuit court reversed the decision, stating that the notice-prejudice rule was preempted, but that it was saved from preemption as regulating the business of insurance and that the agency rule did not relate to the administration of benefits and was therefore not preempted.[233]

The Supreme Court relied on the California public policy favoring compensation for insured to determine that the California notice-prejudice rule was not preempted because it was a law that was saved from preemption under section 514(b)(2)(A) as related to the business of insurance.[234] It found that the common law agency rule was

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221. *Id.* at 61.

222. *Id.* at 63.

223. *Id.*

224. Dahlia Schwartz, *Breathing Lessons for the ERISA Vacuum: Toward a Reconciliation of ERISA's Competing Objectives in the Health Benefits Arena*, 79 B.U. L. REV. 631, 648 (1999).

225. Donald T. Bogan, *Protecting Patient Rights Despite ERISA: Will the Supreme Court Allow States to Regulate Managed Care?*, 74 TUL. L. REV. 951, 1004-05 (2000).

226. 526 U.S. 358 (1999).

227. *Id.* at 364.

228. *Id.*

229. *Id.* at 364-65.

230. Under the California notice-prejudice rule, "a defense based on an insured's failure to give timely notice requires the insurer to prove that it suffered substantial prejudice. Prejudice is not presumed from delayed notice alone. The insurer must show actual prejudice, not the mere possibility of prejudice." *Id.* at 366-67 (citing Shell Oil Co. v. Winterther Swiss Ins. Co., 12 Cal.App.4th 715, 760-61, 15 Cal.Rptr.2d 815, 841 (1st Dist. 1993)).

231. *Id.* at 368. The agency rule in this case was the "*Elfstrom* Rule" established by the California Supreme court, which held that the employer is the agent of the insurer in administering a group health insurance policy. *See* Elfstrom v. New York Life Ins. Co., 432 P.2d 731, 737 (Cal. 1967).

232. *UNUM*, 526 U.S. at 366.

233. *Id.*

234. In reviewing the McCarran-Ferguson factors to determine whether something was the business of insurance, the court noted that the factors were considerations to be weighed and that no one factor was

preempted under section 514(a) as relating to the employer benefit plan because it had an impact on plan administration by causing the plan to engage in activities it would not have otherwise engaged in.[235]

B. Independent Review Organizations

A number of states have passed laws requiring an independent, external review of health plan claims before proceeding to litigation.[236] Two circuit courts have reviewed whether or not ERISA precludes such mandatory review and reached opposite conclusions. The Fifth Circuit invalidated state independent review organization (IRO) provisions as preempted by ERISA,[237] while the Seventh Circuit upheld state IRO provisions as not conflicting with ERISA.[238]

The Fifth Circuit followed the Supreme Court trilogy of cases[239] and used ERISA objectives as a guide to determine if the liability provisions of the statute that created a right to sue in state court should be preempted.[240] The court distinguished two separate HMO functions. One is as a health care insurer that makes coverage decisions in the administration of the plan which are typically benefit determinations that are preempted by ERISA, while the other is in the role of a health care provider that is not protected from state liability for negligence under ERISA.[241] The court then found that the liability provisions of the statute did not "relate to" an ERISA benefit plan because they focused on the ability to sue in state court for medical negligence.[242] The court also noted that the Texas statute did not refer to an ERISA plan, but neutrally applied to both ERISA and non-ERISA plans.[243] Therefore, it found that the liability provisions of the act were not preempted by ERISA.[244] In Texas, state right to sue legislation for liability for negligence would be allowed as not preempted under ERISA.[245]

In reviewing the IRO provisions of the act, the court reviewed the act and determined that the provisions for appeal of adverse determinations to an external review organization could include appeals of determinations by managed care entities as well as negligent decisions by a physician.[246] Texas and the Department

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determinative of whether something was insurance. *See UNUM Health Life*, 526 U.S. at 373-75.

235. *Id.* at 378-79. The Court also found that section 502 civil enforcement procedures did not need to be reviewed because the plaintiff had sued under section 502 to recover benefits due under an ERISA plan and that the notice-prejudice law was the relevant rule of law. Further, section 503 requiring notice and review of denied claims did not create a conflict since the notice-prejudice rule created a longer time than the federal times under section 503. Therefore, the notice prejudice rule was found to complement, not contradict, ERISA. *Id.* at 376-77.

236. *See* Summary of State External Review Laws, March 2000, *available at* http://www.aahp.org.

237. Corp. Health Ins., Inc. v. Texas Dep't of Ins., 215 F.3d 526 (5th Cir. 2000).

238. Moran v. Rush Prudential HMO, Inc., 230 F.3d 959 (7th Cir. 2000), *cert. granted*, 121 S.Ct. 2589 (2001).

239. *See infra* notes 73-81 and accompanying text.

240. *Corp. Health*, 215 F.3d at 533-34.

241. *Id.* at 534.

242. *Id.* at 535.

243. *Id.*

244. *Id.*

245. *Id.* The court also found that the anti-retaliation provisions and anti-indemnification provisions of the statute were the type of quality regulations typically left to the state and were not subject to ERISA preemption. *Id.* at 535-36.

246. *Id.* at 536-37.

of Labor in its amicus brief argued that the liability provisions were saved from preemption under section 514(b) and that section 14(e) of the state statute made the utilization review provisions inapplicable to ERISA plans because it specifically excluded ERISA plans.[247] The Fifth Circuit applied the Supreme Court three-part test of the McCarran-Ferguson factors of insurance and found that two of the factors were present.[248] It then applied the *Pilots Life* requirement that the "savings clause must be informed by the legislative intent concerning civil enforcement provisions" to find that the IRO provisions establish "quasi-administrative procedure for the review of such denial and bind the ERISA plan to the decision of the independent review organization.[249] This scheme creates an alternative mechanism through which plan members may seek benefits due.[250] This created a conflict with ERISA that could not be saved by the savings clause.[251]

The impact of the Fifth Circuit decision was that it eliminated the ERISA "shield" for MCO's by allowing state court lawsuits for negligence under statutory liability provisions, while upholding the limited ERISA remedial provisions for coverage denials.[252] In doing so, the Fifth Circuit may have created an additional incentive for MCOs to refuse to reimburse care as an administrative benefit decision in order to limit liability for questionable treatment decisions that could result in state court

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247. In both cases, the DOL filed amicus curiae briefs addressing the issue of state mandated independent review organizations (IROs) and their relationship with ERISA preemption. The DOL claimed that IRO review, as a procedure available prior to filing a lawsuit, does not create an alternative remedy that conflicts with the intent of ERISA. *See* DOL Amicus Curiae Brief in Corp. Health Ins., Inc. v. Texas Dep't of Ins., App. No. 98-20949 & 98-20981 (5th Cir.), *available at* http://www.dol.gov/dol/sol/public/info_about_sol/pbsbriefs/corporatehealth.txt. It also claimed that the state statue providing for IRO did "relate to" ERISA under section 514 because it governed a core administrative function of ERISA plans, which is benefit determination. The DOL, however, claimed that the IRO provision was saved by the insurance savings clause as a state law "regulating insurance." Since HMOs spread risk, the HMO was considered to be in the business of insurance. *See* DOL Amicus Curiae Brief in Moran v. Rush Prudential HMO, NO. 99-222574 (7th Cir.), *available at* http://www.dol.gov/dol/sol/public/info_about_sol/pbsbriefs/moranrushprud.htm.

248. *Corp Health*, 215 F.3d at 537. The three McCarran-Ferguson factors are "(1) whether the practice has the effect of transferring or spreading the policyholder's risk; (2) whether it is an integral part of the policy relationship between the insured and the insurer; and (3) whether the practice is limited to entities in the insurance industry. The law need not satisfy each of these tests." *See infra* part III(a). The court found that the Texas act satisfied the second and third prongs of the McCarran-Ferguson test. *Id.* at 538.

249. *Id.* at 538-39.

250. The *Corp. Health* case was followed by *United Healthcare Insurance Co. v. Levy*, 114 F.Supp.2d 559 (N.D. Tex. 2000). In that case the plaintiff, a medical director employed by a third-party health care administrator for a self-funded plan, sued the Board of Medical Examiners and its Executive Director. *Id.* at 561. He sought a declarative judgment that the defendant medical examiners were making benefit determinations in their investigation and adverse determination against him in regard to his denial of services as plan medical director. He claimed that ERISA preempted their investigation and that their actions violated ERISA enforcement proceedings. The court looked at whether ERISA preempts the Board regulation of a coverage decision that was not based on medical necessity. The court found that ERISA preempted the Board's actions since the Board was acting as an "alternative enforcement mechanism" that was precluded under ERISA and was therefore preempted by ERISA. *Id.* at 564. In making its decision, the court relied on the Supreme Court trilogy of cases that carved out two instances where ERISA preempts state law: "(1) where state law mandates employee benefit structure or their administration, and (2) where state law provides alternative enforcement mechanisms to those provided by ERISA." *Id.* at 563. The court went on to say that ERISA does not insulate physicians from accountability to their state licensing agency in regards to medical decisions, but only preempts coverage determinations. *Id.* at 564.

251. *Corp. Health*, 215 F.3d at 539.

252. Christine Lockart, *The Safest Care Is to Deny Care: Implications of* Corporate Health Insurance, Inc. v. Texas Department of Insurance *on HMO Liability in Texas*, 41 S. TEX. L. REV. 621, 631 (2000).

liability.[253] Under Texas law, the MCO could expand benefit coverage exclusions or increase utilization management denials so that that there would be fewer possible negligence lawsuits under the liability statute.[254]

Conversely, the Seventh Circuit in *Moran v. Rush Prudential HMO* held that the Illinois IRO provisions were not an alternative remedy that conflicts with ERISA.[255] The Illinois statute required MCOs to "submit to independent physician review when there is a disagreement over whether a course of treatment is medically necessary between a patient's primary care physician and the MCO."[256] If the independent reviewer determined that the treatment was necessary, the HMO was required to cover the treatment.[257] The *Moran* case involved a woman who sought out-of-network surgery by a specialist for right shoulder problems. The out-of-network care was denied.[258]

The Seventh Circuit conducted a de novo review beginning with the question of complete preemption under section 502.[259] The court applied the *Jass* factors to determine that complete preemption was present under section 502. Next, the court reviewed whether the statute "related to" ERISA plans by reapplying the same Supreme Court trilogy of cases as the Fifth Circuit.[260] The court then found that because the law required HMOs to provide an independent review, it was a law that mandated "employee benefit structures or their administration" and therefore preempted under section 514.[261] Next, the court applied the same three savings-clause factors applied by the Fifth Circuit to find that two factors of the McCarran-Ferguson test were present and that the statute was saved as regulating insurance.[262] In looking at whether the "deemer clause" under section 514 (b)(2)(B) exempted the law from the savings clause exception, the court applied the *FMC* analysis that indicated that "the deemer clause exempts self-funded ERISA plans from state laws

253. Note, *Fifth Circuit Upholds State Statue Allowing HMO's to Be Sued for Doctor's Negligence*, 114 HARV. L. REV. 1406, 1409 (2001).

254. Even though the court upheld the right to sue in state court, the patient still may not have received a substantive protection since utilization management was left unrestricted and ERISA continued to preempt any utilization management decisions. *See* Kristin M. McCabe, *The Texas Health Care Liability Act: Texas Is the First State to Listen to the Concerns of Its Health Care Consumer, But How Much Has It Heard?*, 16 J. CONTEMP. HEALTH L. & POL'Y 565, 590-91 (2000).

255. Moran v. Rush Prudential HMO, Inc., 230 F.3d 959, 970 (7th Cir. 2000), *cert. granted*, 121 S. Ct. 2589 (2001).

256. *Id.* at 962.

257. *Id.*

258. *Id.* The health plan recommended that the woman undergo the standard surgery for her problems with an in-network physician. The out-of-network coverage denial was upheld after two physicians reviewed the claim. The appeal then went to an Appeal Committee of the health plan that also upheld the denial. The woman then went ahead with the out-of-network surgery by paying for the surgery herself. She also filed a written demand for independent physician review as required by the Illinois statute. She filed suit for reimbursement of her costs. An independent review was performed and the reviewer indicated that her surgery was medically necessary though the reviewer would have used a less intrusive process. The health plan medical director denied her request again after reviewing the report of the independent reviewer. *Id.*

259. *Id.* at 966.

260. *Id.* at 967-69 (relying on California Div. of Labor Standards Enforcement v. Dillingham Constr. N.A. Inc., 519 U.S. 316 (1997); New York Blue Cross Blue Shield Plans v. Travelers Ins., 514 U.S. 645, 656 (1995); Shaw v. Delta Air lines Inc., 463 U.S. 85, 96-97 (1983)).

261. *Id.* at 969.

262. *Id.* at 969-70.

that 'regulate insurance' within the meaning of the savings clause."[263] Because the health plan in the *Moran* case before the Seventh Circuit was not a self-funded plan, the court found that the deemer clause did not apply.[264]

The court then reviewed whether the Illinois Act conflicted with section 502 provisions for ERISA civil enforcement.[265] The *Moran* court characterized the state statute as incorporated into plaintiff's insurance contract, which created an additional "internal mechanism for making decisions about medical necessity and identifies who will make that decision" when there is a disagreement over the course of treatment.[266] The court found these provisions to be "mandated contract terms and treated as part of the insurance contract."[267] The court held that ERISA did not preempt the state law provisions and upheld summary judgment in favor of the plaintiff.[268] Thus, the *Moran* court found that the state could impose extra procedures for settling disputes between the HMO and the health care provider under the state regulatory goals of consumer protection, which would override the need for federal uniformity under ERISA.[269]

There were two distinguishing differences between the Fifth and Seventh Circuit Courts' treatment of IRO statutes. First, the courts characterized the IRO statutes differently. While *Corporate Health* viewed the statute as creating an alternative enforcement mechanism preempted by ERISA,[270] *Moran* viewed the statute as creating an additional dispute resolution mechanism that state law incorporated into the health plan contract.[271] Second, the courts differed in the application of the deemer clause. While *Corporate Health* did not distinguish between self-funded ERISA plans and other purchased insurance plans, thereby finding ERISA preemption of IRO provisions,[272] *Moran* found that the deemer clause only applied to self-funded ERISA plans and since the plan in question was not a self-funded plan, it was not subject to ERISA preemption.[273]

C. State Right to Sue Legislation

A number of state legislatures have focused on the right to sue in state court as well as other substantive consumer rights such as mandated benefits, claims and utilization processes, and external review requirements. States have taken these actions in spite of concerns that the very statutes enacted to protect consumer rights and enable access to the state law forum may be subject to ERISA preemption if they are found to "relate to" an employee benefit plan.[274]

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263. *Id.* at 970 (quoting FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990)).
264. *Id.* at 971.
265. *Id.* at 970-71.
266. *Id.*
267. *Id.* at 972.
268. *Id.* at 972-73.
269. Sapeika Tal, *ERISA: No Preemption of State's HMO Law Requiring Independent Physician Review*, 28 J.L. MED. & ETHICS 407 (2000).
270. *Corp. Health Ins. Co. v. Texas Dep't of Ins.*, 215 F.3d 526, 539 (5th Cir. 2000).
271. *Moran*, 230 F.3d at 971.
272. *Corp. Health*, 215 F.3d at 537.
273. *Moran*, 230 F.3d at 970.
274. Shaw v. Delta Air Lines Inc., 463 U.S. 85 (1983).

As a result of the *Corporate Health* case, the 1999 Texas legislature enacted new provisions regarding the Independent Review Organization.[275] These provisions took effect September 1, 1999.[276] They require notice of the claim[277] and give the health care entity the option to request review by an IRO within fourteen days from the notice.[278] If an IRO review is requested, the review must be completed prior to filing a claim in court.[279] If the enrollee does not comply with the notice requirements and review options, the court has discretion to order the parties to submit to an independent review, mediation, or other non-binding alternative dispute resolution. The court may abate proceedings for up to thirty days while this occurs.[280] The enrollee, however, is not required to comply with the IRO process if the pleading alleges that (1) harm has already occurred to the enrollee and (2) the review would not be beneficial. These allegations must be made in good faith.[281] In the first two and one-half years of the Texas IRO system, there were more than one thousand cases reviewed, of which fifty-seven percent were reversed in whole or part.[282]

In July 1998, a New Mexico statute with liability provisions went into effect. It was enacted as part of broader patient protection legislation in the state. The act establishes "private remedies to enforce patient and provider insurance rights."[283] The New Mexico statute establishes the right based on contract theory. It provides that

> an individual enrollee participating in or eligible to participate in a managed health care plan shall be treated as a third-party beneficiary of the managed health care plan contract between the plan and the party with which the plan directly contracts. An individual enrollee may sue to enforce the rights provided in the contract that governs the managed health care plan; provided, however, that the plan and the party to the contract may amend the terms of, or terminate the provisions of, the contract without the enrollee's consent.[284]

The New Mexico statute allows recovery of the greater of actual damages or $100.[285] It also provides for an injunction as needed and provides for awards to class members in class action lawsuits.[286] The statute indicates that the relief provided by statute is in addition to remedies available at common law or through other statutes of the state.[287] New Mexico is unique in that it does not combine the right to sue provisions with external review processes.

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275. TEX. CIV. PRAC. & REM. CODE § 88.003 (Vernon 1999).
276. *Id.* at § 88.003(a)(2)(B).
277. *Id.* at § 88.003(b).
278. *Id.* at § 88.003(c).
279. *Id.* at § 88.003(e).
280. *Id.* These alternative dispute resolution procedures are the sole remedy for the person complaining that the enrollee has not complied with the notice and optional IRO procedures. *Id.* at § 88.003(d) & (e).
281. *Id.* at § 88.003(e)(1) & (2).
282. 147 CONG. REC. H. 297-02 (daily ed. Feb. 13, 2001) (Statement of Rep. Green).
283. N.M. STAT. ANN § 59A-57-9 (2000).
284. *Id.* at § 59A-57-9.C.
285. *Id.* at § 59A-57-9.A.
286. *Id.* at § 59A-57-9.B & E.
287. *Id.* at § 59A-57-9.D.

Georgia has enacted broad Patient Protection provisions that include liability for managed care entities. The Georgia statute was effective July 1, 1999.[288] Like the other states, Georgia requires "ordinary diligence" in administering benefits or reviewing claims under a managed care plan.[289] The statute indicates that "any injury or death to an enrollee resulting from a want of such ordinary diligence shall be a tort for which a recovery may be had against the managed care entity offering such plan, but no recovery shall be had for punitive damages for such tort."[290] Georgia limits the remedy available by prohibiting punitive damages. The Georgia statute specifically prohibits waiver, delegation, or shifting of liability by contract or by other means.[291] It also protects an employer from liability.[292] Georgia also enacted provisions providing for independent review of claims.[293] Upon motion, the court may stay the legal action until the grievance procedure or independent review is conducted.[294]

In the fall of 1999, the governor of California signed bills reforming managed care that included right to sue provisions.[295] The Managed Health Care Insurance Accountability Act of 1999 became effective for services rendered after January 1, 2001. It specifies that health care service plans[296] or managed care entities have a duty of ordinary care to

> arrange for the provision of medically necessary health care service to its subscribers and enrollees, where the health care service is a benefit provided under the plan, and shall be liable for any and all harm legally caused by its failure to exercise that ordinary care when both of the following apply:
>
> (1) The failure to exercise ordinary care resulted in the denial, delay, or modification of the health care service recommended for, or furnished to, a subscriber or enrollee.
>
> (2)The subscriber or enrollee suffered substantial harm.[297]

The statute also indicates that the entity cannot seek indemnity from the provider for liability.[298] Employers are not liable for coverage purchases through self-funded

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288. GA. CODE ANN. § 51-1-48 (1999).

289. *Id.*

290. *Id.* at § 51-1-48(a).

291. *Id.* at § 51-1-48(b).

292. *Id.* at § 51-1-48(c).

293. Id. at § 51-1-48(a). Prior to filing a cause of action in court, the enrollee must either (1) exhaust the grievance as provided for by statute and give notice of intent to file a lawsuit and agree to submit the claim to independent review, *id.* at § 51-1-48(a)(1), or (2) file a pleading alleging that harm has already occurred to the enrollee for which the managed care entity may be liable and the grievance or independent review is not timely. § 51-1-48(a)(2).

294. *Id.* at § 51-1-48(a)(2)(B).

295. *Highlights*, 7 Health Care Policy Rep. (BNA) 1541, 1566 (Oct. 4, 1999).

296. Health service plans are defined as either "(1) Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees. (2) Any person, whether located within or outside of this state, who solicits or contracts with a subscriber or enrollee in this state to pay for or reimburse any part of the cost of, or who undertakes to arrange or arranges for, the provision of health care services that are to be provided wholly or in part in a foreign country in return for prepaid or periodic charge paid by or on behalf of the subscriber or the enrollee." CAL. HEALTH & SAF. CODE § 1345(f) (1999).

297. CAL. CIV. CODE § 3428 (1999).

298. *Id.* at § 3428(d).

employee benefit plans.[299] The California statute provides that any legally required independent medical review system must be completed prior to filing a cause of action in state court. Exceptions to this include situations where substantial harm has already occurred or is likely to occur imminently.[300] At the same time the liability provisions were enacted, California also enacted an external review statute that became operative January 1, 2001.[301] The statute provides for external independent review of health plan denials of experimental or investigational therapies when the person denied care has a life threatening or debilitating condition.[302]

In March 2000, the state of Washington enacted right to sue legislation. The legislation provides for independent review of health plan decisions prior to bringing a lawsuit unless the person has "suffered substantial harm."[303] The liability provisions indicate that "a health carrier shall be liable for any and all harm proximately caused by its failure to follow that standard of care when the failure resulted in the denial, delay, or modification of the health care service recommended for or furnished to, an enrollee."[304] It also creates vicarious liability for its employees, agents, or ostensible agents.[305] The provisions of the statute cannot be waived by contract or agreement.[306] Defenses to liability include assertions that the health care service is not a benefit of the plan, the health carrier nor its agent controlled or participated in the health care decision, and the health carrier did not deny or delay payment recommended by a participating health care provider.[307] The statute specifically excludes employers and employer group purchasing organizations from liability.[308]

In April 2000, Arizona passed right to sue legislation for "unreasonable denials, delays, or payments of covered health care."[309] The legislation requires the plaintiff to show that the health plan acted knowingly and purposefully in bad faith.[310] Arizona also passed independent review legislation that included provisions for independent review of claims disputes with expedited appeal requirements.[311]

Other states have proposed right to sue legislation that has not been enacted. Early proposals in Colorado were prevented by concerns about increased costs and

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299. *Id.* at § 3428(e).

300. *Id.* at § 3428(k).

301. *See id.* at §§ 3428(g) & (h). Any waiver of provisions of the statute is considered to violate public policy and be void. The statute is not intended to create new liabilities, nor to limit existing liability theories, but to provide an adequate state law remedy for people subject to wrongful acts by health care entities. The act also provides for the severability of any provisions declared invalid. *See id.* at § 3428(1).

302. *See* CAL. HEALTH & SAF. CODE § 1370.4 (1999). External independent review must be conducted based on medical and scientific evidence as specifically defined in the statute.

303. *See* WASH. STAT. ANN. § 43.70.235 (2000). Substantial harm is defined as a "loss of life, loss of significant impairment of limb, bodily or cognition function, significant disfigurement, or severe or chronic physical pain."

304. *Id.* at § 48.43.545(1)(a).

305. *Id.* at § 48.43.545(1)(l).

306. *Id.* at § 48.43.545(2).

307. *Id.* at § 48.43.545(4).

308. *Id.* at § 48.43.545(5).

309. *Arizona Legislature Approves Right to Sue Measure; Governor Has Not Promised to Sign*, Health Care Daily Rep. (BNA) (Mar. 28, 2000).

310. *Id.*

311. *Governor Signs Legislation Providing More Independent Review of Claims Disputes*, Health Care Daily Rep. (BNA) (Apr. 27, 2000).

negative impacts on consumers.[312] A total of seventeen states were considering whether to expand liability for managed care health plans during 2000, according to an annual survey by the Blue Cross and Blue Shield Association.[313]

Missouri took a different approach to the right to sue. As part of its managed care law in 1997, it expanded managed care liability by removing the corporate practice of medicine defense from suits against health plans. The idea was that a state prohibition on corporations practicing medicine will make it difficult for the health plans to be held liable either directly or vicariously for medical judgments.[314]

V. BEYOND THE RIGHT TO SUE: ERISA REDRESS IN NON-JUDICIAL FORUMS

While public attention has focused on the right to sue in state court as a remedy for the ERISA vacuum, other non-judicial forums have other options and remedies available to redress harm and protect consumer rights. The Department of Labor (DOL) strategies to protect consumers include promulgation of ERISA regulations as well as establishment of ERISA enforcement proceedings to protect consumers. Arbitration also provides a non-judicial forum for resolution of disputes in a manner that protects consumer rights. Other consumer protection activities promote consumer interest in cost effective, quality, accessible health care.

A. ERISA and Consumer Protection

While Congress was debating the various forms of the Patients' Bill of Rights, the Clinton administration was developing other means to improve patient access to care. In 1997, a Presidential Advisory Commission met to discuss consumer protection and quality in the health care industry. The Commission prepared a report to the President on Consumer Bill of Rights and Responsibilities.[315] The report established eight areas in which the consumer had rights and responsibilities. These are (1) information disclosure, (2) choice of providers and plans, (3) access to emergency services, (4) participation in treatment decisions, (5) respect and nondiscrimination, (6) confidentiality of health plan information, (7) complaints and appeals through an internal and external review process, and (8) consumer responsibilities. Within each of these areas, specific recommendations were made to ensure consumer protection in health care.[316]

In response to this report, the DOL filed a Report to the President summarizing its actions in each of the eight areas and indicating how consumer rights could be protected through ERISA.[317] The next day the President issued an Executive

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312. Tripp Baltz & Susan Webster, *States Slow to Move on Bills to Impose Health Plan Liability; Courts May Take Lead*, 7 Health L. Rep. (BNA) 649 (Apr. 23, 1998).

313. *Plan Liability, Physician Bargaining Bills Top List of Managed Care Bills in States*, 8 Health Care Policy Rep. (BNA) 287 (Feb. 21, 2000).

314. MO. REV. STAT. § 354.505 (1999).

315. *President's Advisory Commission on Consumer Protection & Quality in the Health Care Industry: Consumer Bill of Rights*, Report to the President of the United States by the Advisory Commission on Consumer Protection & Quality in the Health Care Industry (Nov. 1997), available at http://www.hcqualitycomm.gov.

316. *Id.*

317. *Implementing the Commission's Bill of Rights & Responsibilities through ERISA, The Department of Labor's Response to The Health Care Commission's Bill of Rights*, Report to the President & Vice President of the

Memorandum directing the Secretary of Labor to "propose regulations to improve the disclosure of health care benefits information and to strengthen the internal appeals process for ERISA-covered group health plans."[318] The Department implemented the requested regulations and filed a subsequent implementation report with the President.[319]

The first area of Consumer Rights was information disclosure. In this area, the Department issued interpretive guidelines clarifying the rights of plan participants to examine information about their plan. It also issued model language for summary plan description to use to disclose information about the Newborn & Mothers Protection Act of 1996 and noted that the Department had authority to propose regulations specifying information to include in Summary Plan Descriptions.[320] In September 1998, the Department published proposed amendments to regulations regarding the content of Summary Plan Descriptions. In November 2000 the final rule required Summary Plan Descriptions to describe cost-sharing provisions, any annual or lifetime caps or other limits on benefits under the plan, the extent of preventive services covered, existing and new drug coverage, and coverage for medical tests, devices, and procedures.[321] The DOL did not have authority to impact information disclosure by health facilities or health professionals.

The second consumer right was choice of providers. ERISA does not provide statutory authority for the Department to require health plans to provide a choice of providers or provide access to specialists. Discretion regarding choice of plan providers was left with the plan fiduciary under ERISA statutory provisions. Similarly, ERISA does not require standards for the sixth right of confidentiality of medical records. The Department, however, issued interpretive guidance on "quality considerations by plans when selecting health care service providers" to encourage plans to consider quality of care when selecting providers and to encourage confidentiality.[322]

Third and fourth were access to emergency care and participation in treatment decisions. ERISA does not require health plans to provide coverage for emergency services, nor set standards for access, nor does it generally require patient

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United States (Feb. 19, 1998), available at http://www.dol.gov/dol/pwba/public/whatsnew/meredith.htm. [hereinafter DOL Initial Implementation Report].

318. *Progress Report in Implementing the Patient's Bill of Rights at the Department of Labor*, Report to the Vice President of the United States (Nov. 2, 1998).

319. *Id.*

320. Information that the Commission proposed to include included benefits and limits of coverage, the extent of preventive service coverage, coverage of new and existing drugs, coverage for tests, devices and procedures, provider network composition, out of network coverage, access to specialty medical care, urgent care conditions, and pre-authorization and utilization review procedures. *See* DOL Initial Implementation Report, *supra* note 317, at 8.

321. Amendments to SPD Regs, Final Rule, 65 Fed. Reg. 70226-44 (Nov. 21, 2000).

322. *See* DOL Letter February 19, 1998, to Diana Ceresi from Bette Briggs, at ¶ 7, *available at* http://www.dol.gov/dol/pwba/public/programs/ori/advisory98/seiv5ltr.htm, in which the DOL encouraged plan selection of quality providers by looking at

> the scope of choices and qualifications of medical providers and specialists available to participants, ease of access to medical providers, ease of access to information concerning the operations of the health care provider, the extent to which internal procedures provide for timely consideration and resolution of patient questions and complaints, the extent to which internal procedures provide for the confidentiality of patient records, enrollee satisfaction statistics, and rating or accreditation of health care service providers by independent services or state agencies.

participation in treatment decisions. The ERISA statute does not require access to any care or any specific guidelines for implementing the plan.[323]

Fifth, the Bill of Rights required respect and nondiscrimination. While general ERISA provisions do not prohibit or address discrimination in the delivery or marketing of health services, the HIPPA requirements specifically prohibit group health plans from "establishing eligibility or contribution rules that discriminate against individuals on the basis of health related factors, including health status, medical condition, disability, genetic information and evidence of insurability."[324] The Department indicated that it would issue final rules regarding nondiscrimination[325] and issue interpretive guidance to fiduciaries regarding the quality of services provided. Interim final rules have now been issued. [326]Seventh, complaints and appeals procedures for ERISA plans are established by regulation.[327] At the time of the report, the DOL had proposed regulations for administration of claims that are now final.[328] The Department addressed the eighth area of consumer responsibility to act reasonably to promote their own health care by encouraging the provision of information to allow consumers to make informed decisions.[329]

B. Department of Labor Enforcement Strategies

The DOL has statutory authority to promulgate regulations as needed to enforce ERISA.[330] The DOL has also established regulations that relate to the administration and enforcement of ERISA violations as discussed under the enforcement section[331] as well as regulations regarding implementation of HIPPA requirements.[332] In response to consumer rights concerns, the DOL established proposed regulations relating to the administration of claims in an ERISA plan in 1998.[333]

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323. DOL Initial Implementation Report, *supra* note 317. The Newborn and Mother Health Protection Act amendment to ERISA, however, specifically prohibits health plans from providing incentives to physicians to discharge a mother or newborn early and the department published interim final rules regarding these provisions. *Id.*

324. *Id.*

325. On November 30, 2000, the DOL issued proposed rules prohibiting discrimination against participants and beneficiaries based on health status. 29 C.F.R. § 2590.702 (2000).

326. Interim Final Rules for Nondiscrimination in Health Coverage in Group Market, 66 Fed. Reg. 14076-14078 (Mar. 9, 2001) and Nondiscrimination in Health Coverage in Group Market Interim Final Rules & Regulations, 66 Fed. Reg. 1377-1420 (Jan. 8, 2001).

327. DOL Initial Implementation Report, *supra* note 317.

328. *Id. See also* 29 C.F.R. § 2560 (2000).

329. DOL Initial Implementation Report, *supra* note 317, at 15.

330. 29 U.S.C. § 1001-1461.

331. 29 C.F.R. § 2560, 2570, 2575 (1999).

332. *Announcement of Application of HIPPAA Group Market Rules to Individuals Who Were Denied Coverage Due to a Health Status-Related Factor*, ERISA Technical Release No. 97-02, U.S.D.O.L., *available at* http://www.dol.gov/dol/pwba/public/pubs/techrel/techrel2.htm.

333. The Consumer Bill of Rights was considered in establishing these proposed regulations. *See* 29 C.F.R. § 2560.503-1, 63 Fed. Reg. 48389 (Sept. 9, 1998). The proposed claims procedures incorporated review timelines and processes including decisions within seventy-two hours time for urgent care appeals, forty-five days to provide information needed to review a claim, and fifteen days for non-urgent benefit claims decisions. 29 C.F.R. § 2560.530-1(f)(2)(iii)(A). Denial notices were required to include statements of the right to appeal, give 180 days to appeal the claim, and render an appeal decision within thirty days. 29 C.F.R. § 2560.530-1(h)(3)(i). This compares with earlier final regulations that provide for ninety days to complete a decision. 29 C.F.R. § 2560.503-1(3)(1). The procedures also precluded arbitration prior to filing a claim under section 502 complete preemption. 29 C.F.R. § 2560.503-1(b)(3), 63 Fed. Reg. 48389, 48405 (Sept. 9, 1998). The Department estimated that

In November 2000 the claims procedure rule became final, with an effective date of January 20, 2001, to apply to claims filed after January 1, 2002.[334] The final rule establishes claims procedures that impact the timeliness and provide guidance to administrative processes that can be established prior to someone filing a lawsuit under ERISA. The procedures focus on patient rights by focusing on the timeliness of benefit determinations, access to information, and establish a full and fair review of denied claims. The rule applies to group health plans and plans providing disability benefits. The DOL differentiates pre-service claims that are characterized as creating an access to care issue from post service claims reimbursement, which create cost of care issues.[335] The regulations require urgent care decisions to be made within seventy-two hours,[336] pre-service claims to be decided within a reasonable period defined as fifteen days with one possible fifteen-day extension,[337] and post service claims to be decided within thirty days with one possible fifteen-day extension.[338] Mandatory appeals are limited to two levels of appeal.[339] If arbitration is used, it must be at one of these two levels and must include the right to file suit in court under section 502.[340] Thus, the right to sue in federal court as mandated by the ERISA statute is protected in the final rule.[341] Other substantive patient rights protected by the final rule include requirements that the health plan communicate its claim notice and disclosure requirements,[342] identify the reasons for the adverse benefit determination,[343] and require independent decision making on appeal[344] without any fees or costs to the claimant.[345] The final rule specifically states that state law governing review procedures for insurance plans is not preempted by the final rule.[346]

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establishment of the new claims and appeals procedures would add $30 million to annual costs in the year 2000 for 806 million claims. The cost was projected to be $.04 per claim and $0.09 per participant. 29 C.F.R. § 2560, 63 Fed. Reg. 48390, 48398 (Sept. 9, 1998).

334. 29 C.F.R. at § 2569.503-1 (2000).

335. *Id.* at § 2569, 65 Fed. Reg. 70245, 70248 (2000).

336. *Id.* at § 2569.503-1(f)(2)(i). Note that if information is not received, an additional twenty-four hours may be granted.

337. *Id.* at § 2569.503-1(f)(2)(iii)(A) & (i)(2)(1). If information is needed, the claimant can be given forty-five days to provide information.

338. *Id.* at § 2569.503-1(b)(6)(f)(2)(iii)(A). Similarly, if information is needed, the claimant can be given forty-five days to provide information.

339. *Id.* at § 2569.503-1(c)(2). Failure to follow the claim procedures is considered an exhaustion of administrative remedies. *Id.* at § 2569.503-1(1).

340. *Id.* at § 2569.503-1(b)(4)(i) & (ii). Health plans may also include a voluntary appeal process that includes arbitration, but they must provide information about the appeal process, they wave the right to claim failure to exhaust administrative remedies if the voluntary appeal process is not elected, the statue of limitations is tolled during the appeal process, and the voluntary appeal process must be implemented after the mandatory appeal process is complete. *Id.* at § 2569.503-1(b)(3)(i) to (b)(3)(v).

341. *Id.* at § 2569.503-1(c)(3)(i). *See also id.* at § 2569.503-1(k).

342. The health plan must give notice that the claimant has failed to follow health plan claim procedures within five days. *Id.* at § 2569.503-1(c)(1)(i) & (ii).

343. The health plan must refer to the rule or protocol used in making the decision. *Id.* at § 2569.503-1(g)(1)(v)(A). In medical necessity cases, the clinical judgment used must be referred to. Plans are required to consult a health professional in making decisions that involve medical judgments, and explain the scientific or clinical judgment used in making the determination. *Id.* at § 2569.503-1(g)(1)(v)(B).

344. *Id.* at § 2569.503-1(c)(3)(iv).

345. *Id.* at § 2569.503-1(c)(3)(v).

346. *Id.* at § 2569.503-1(k)(2)(i).

The DOL also has statutory authority to investigate and follow-up on ERISA violations.[347] It does this through the Office of Enforcement.[348] The Enforcement Manual provides guidance regarding agency policies that relate to enforcement. The agency can identify concerns through a variety of mechanisms and agency employees are encouraged to target reviews so that finite resources are focused towards plans and providers with the highest potential for abuse.[349] Once a potential case has been identified, the agency can conduct a limited review to determine whether the case may be closed or whether a complete review should be completed.[350]

In 1998, the agency indicated that more than fifty percent of its efforts were spent on health care issues that arose from managed care and cost containment.[351] In 2000, health care plans were one of the three priorities identified in the Pension and Welfare Benefits Administration (PWBA) Strategic Enforcement Plan (StEP).[352] Three enforcement initiatives were identified for health care: first, administrative service only (ASO) arrangements where the health plan bears the risk while the third party administrator handles plan administration;[353] second, the department is filing amicus briefs in medical malpractice claims that argue against ERISA preemption of negligence and malpractice claims.[354] It is also trying to curtail abuses in the claims processing area. The Department does this by arguing that if the claims process is unfair, then the "effect of that is to remove the deference given to plan administrators...and to allow courts to either grant de novo review or to send the case back for a fairer rehearing."[355] Third, the agency is focusing on fraudulent multiple employer welfare arrangements (MEWA).[356]

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347. 29 U.S.C. § 1132-1144.

348. DOL Enforcement Manual, Ch. 11, *available at* http://www.dol.gov/dol/pwba/public/programs/oemanual/chap11.htm.

349. Targeted review can be generated from computer compilations, analysis of annual reports, information available through other government agencies, information available through public sources, information received from complaints, or compilations of information from a variety of sources. *See* DOL Enforcement Manual Chapter 53: Targeting & Limited Review, *available at* http://www.dol.gov/dol/pwba/public/programs/oemanual/chap53.htm.

350. *Id.*

351. *Over 50 Percent of DOL Scrutiny Is on Health Benefits, Official Reports*, 7 Health Law Reporter (BNA) 9, 326 (Feb. 26, 1998) [hereinafter DOL Scrutiny].

352. Pension and Welfare Benefits Administration Strategic Enforcement Plan 4/6/00, 65 Fed. Reg. 18207-09.

353. *See* DOL Scrutiny, *supra* note 351. The concern is that large insurance companies serve as third party administrators and may not pass discounts along to the health plan. *See id.* Since this initiative began in 1993, the department has conducted about 118 investigations and recovered more than $31 million. *See Wellmark to Pay $8.25 Million to Settle Negotiated Discount Case*, Health Care Daily Rep. (BNA) (Mar. 1, 1999). In 1999, Wellmark of Iowa agreed to pay $6.9 million to health plan participants and sponsors for failing to pass on negotiated discounts with hospitals as well as $1.375 million in civil penalties. *See id.* In 1998, the Massachusetts Blue Cross Blue Shield plan was ordered to repay $10 million to participants and sponsors of health plans for failing to refund savings to self-insured health plans covered by ERISA. It was also required to pay civil penalties. See *Massachusetts Blues Ordered to Repay $10 Million to Plan Participants, Sponsors*, 7 Health Law Rep. (BNA) 211 (Feb. 5, 1998).

354. During the past five years, the Department of Labor has filed amicus curiae briefs with seventeen courts reviewing ERISA preemption issues regarding medical malpractice claims. The briefs repeatedly claim that ERISA does not preempt negligence or medical malpractice claims that occur outside the context of benefit denials. *The Secretary's Amicus Briefs on ERISA Preemption of Medical Malpractice Claims Against HMOs*, http:www.dol.gov/dol/pwba/public/pubs/ab/main.htm.

355. *Labor Official Outlines Litigation Efforts; Health Care Issues Becoming Predominant*, 8 Health Law Reporter (BNA) 24, 983 (June 17, 1999).

356. DOL Scrutiny, *supra* note 351. In December 1998, the DOL was granted a restraining order against International Workers Guild health plan, which was operating as a "sham union." It had $25 million in unprocessed

Other national enforcement activities include a Rapid ERISA Action Team or REACT, which targets plan participants potentially exposed to a great risk of loss such as when the employer has financial hardship and/or bankruptcy.[357] There is also an Orphan Plan Program in which the Pension & Welfare Benefits Administration (PWBA) identifies plans that have been abandoned by plan sponsors.[358] PWBA also encourages plan participant and beneficiary complaints through its field offices.[359] In 2000 there were 4311 civil investigations opened by PWBA and 2253 cases closed with violations for a total of $556 million dollars recovered.[360]

In March 2000, PWBA established a Voluntary Fiduciary Correction Program (VCCP) to encourage self-correction of ERISA violations.[361] When an agency review finds violations, the agency has discretion to coordinate voluntary compliance for most cases including "benefit disputes, bonding, reporting, and disclosure issues."[362] Voluntary compliance is not suitable for cases with losses over $500,000, cases in which the time for correction will exceed one year, cases involving fraud or criminal misconduct, cases in which removal of a fiduciary is warranted, or cases that involve individuals who have previously violated ERISA or other federal statutes.[363] Other cases that may not be appropriate for voluntary compliance include cases identified as significant for enforcement strategy or those involving interpretation of legal issues.[364]

The DOL also enforces criminal violations. These include false statements and influencing an employee benefit plan.[365] The HIPPA legislation created four new crimes related to health care benefit programs: (1) general health care fraud,[366] (2) theft and embezzlement,[367] (3) false statements regarding health plans,[368] and (4) obstruction of criminal investigations.[369] In the year 2000, there were 171 criminal investigations opened resulting in 151 cases closed with 90 indictments to recover 8.6 million dollars.[370]

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medical claims for 3600 participants. The fund administrator was removed under the order. Plan administrators had diverted plan assets and failed to reimburse participant health claims. *See Labor Department Obtains Order Freezing Assets of MEWA in New York*, 8 Health Care Policy Rep. (BNA) 1998 (Dec. 21, 1998).

357. PWBA Office of Enforcement Updated January 23, 2001, *available at* http://www.dol.gov/dol/pwba/public/program/oe/OE-pg2.

358. *Id.*

359. *Id.*

360. Note that this includes both retirement and health enforcement efforts. *Id.* The enforcement manual also provides for civil penalties for violation of the statute. The first level penalty is "five percent of the amount involved," while the second level penalty is up to one hundred percent of the amount involved if the prohibited transaction is not corrected within ninety days after a final agency order is issued. *See* DOL Enforcement Manual, Ch. 35: Civil Penalties, *available at* http://www.dol.gov/dol/pwba/public/prgrams/oemanual/chap35.htm.

361. Voluntary Fiduciary Correction Program, 65 Fed. Reg. 14164 (Mar. 15, 2000).

362. DOL Enforcement Manual, Chapter 34: Voluntary Compliance Guidelines, *available at* http://www.dol.gov/dol/pwba/public/prgrams/oemanual/chap34.htm.

363. *Id.*

364. *Id.*

365. 18 U.S.C. § 1027 (1999) & 18 U.S.C. 1995 (1974).

366. 18 U.S.C. § 1347 (1999).

367. 18 U.S.C. § 669 (1999).

368. 18 U.S.C. § 1035 (1999).

369. 18 U.S.C. § 1518 (1999).

370. PWBA Enforcement Updated Jan. 23, 2001, *available at* http://www.dol.gov/dol/pwba/public/programs/oe.

C. *ERISA Arbitration Cases*

The ERISA statute specifically provides that any disputes between employers and multiple employer plans are to be decided by arbitration.[371] Arbitration can also arise in the context of collective bargaining agreements that have been negotiated between union and employer regarding welfare plan benefits as well as through an arbitration clause in the contract provisions between health plan and doctor or plan participant or when employers include arbitration provisions in employment agreements.[372]

The Third Circuit addressed whether arbitration could be compelled in an ERISA plan in *Wood v. Prudential Insurance Co.*[373] This case involved an employee who sued his employer, Prudential Insurance, claiming that he was terminated because the employer wanted to avoid paying benefits.[374] The fifty-one-year-old plaintiff was eligible for full vesting of the company's ERISA benefit plan and retirement, which would have included payment of medical expenses for his disabled son. The son had suffered injuries from a car accident and the bills were in the millions of dollars.[375] The court found that section 502 completely preempted the state law claim, since a "benefit defeating" motive interferes with a right enforceable under section 502.[376] The court also found that section 502 preempted the state law claims of tort and emotional distress.[377] The court then reviewed whether dismissal of the action was appropriate to compel arbitration. It relied on the Supreme Court rule that any doubts should be decided in favor of arbitration.[378] It held that arbitration applied to the preempted claims of discrimination, defamation, and emotional distress as well as the other claims that had been raised.[379] The circuit court affirmed the denial of remand and ruled to compel arbitration according to the arbitration agreement.[380]

Once a case goes to arbitration, the process is private. Arbitration leaves discretion with the arbitrator to determine the admissibility of evidence and to determine the weight to give evidence to reach a fair decision.[381] Remedies under arbitration include "any remedy or relief that the arbitrator deems just and equitable and within the scope of the agreement of the parties, including, but not limited to, specific performance of a contract."[382] Arbitration is viewed as a non-judicial forum that allows for similar remedies otherwise available. Thus, the arbitrator has wide discretion to come to a remedy that is fair for the parties. While not all arbitration

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371. 29 U.S.C. § 1401 (1999).

372. *See* Circuit City Stores v. St. Clair Adams, 532 U.S. 105, 109, 121 S. Ct. 1302, 1306 (2001). In a non-ERISA opinion, the U.S. Supreme Court reviewed the application of the Federal Arbitration Act (FAA) to employment contracts to find that the FAA covers employment agreements. *Id.*

373. 207 F.3d 674 (3rd. Cir. 2000), *cert. denied*, 531 U.S. 927 (2000).

374. *Id.* at 676.

375. *Id.* at 677.

376. *Id.* at 677-79.

377. *Id.* at 679.

378. *Id.* at 680.

379. *Id.*

380. *Id.* at 681.

381. *Health Care Claims Settlement Procedures*, AAA Arbitration Rule 21 (July 1, 1992), *available at* http://www.adr.org.

382. AAA Arbitration Rule 32.

cases are reported, some ERISA arbitration cases are available that demonstrate the arbitration approach to ERISA.

The *Bethlehem Steel* arbitration award, decision number 3336, was an early arbitration award that dealt with ERISA preemption in the collective bargaining agreement context.[383] It involved a dispute over mental health benefits for a covered dependent of a welfare plan member. Initially, the plan paid the claims for treatment by a licensed psychologist; then the employee received word that the payment for services had been made in error and that future services were not reimbursable. Services continued for about a year, then a grievance was filed for coverage of the services under the collective bargaining agreement. Total charges for the services came to $3000. The plan benefit limited coverage to "reasonable and customary charges" and to $1500 per calendar year.[384] The *Bethlehem Steel* arbitrator, applying Supreme Court decisions, found that ERISA preempted the state statute because it related to an employee plan.[385] The arbitrator also found that the state's "equal basis" statute requiring all providers to be reimbursed equally[386] did not apply to the benefit plan language that required coverage as required by law because it was preempted by ERISA.[387] Because the parties may have relied on the previous arbitration decision, the decision was made effective prospectively. The effect of this was that psychotherapy claims prior to the date of the arbitration decision were reimbursable, while any future psychotherapy claims were not reimbursable because ERISA

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383. *In re* Bethlehem Steel Corporation & United Steelworkers of America, Local Union No. 6787, Decision No. 3336, 91 Lab. Arb. (BNA) 777 (Oct. 7, 1988).

384. *Id.*

385. The arbitrator followed Supreme Court opinions in *Shaw* and *Metropolitan Life*, *see infra* part II(A), which indicated that ERISA preemption displaces state laws that "relate to" an employee plan. In doing so, the arbitrator found that a prior arbitration decision, number 3253, had been overruled. That decision involved a dispute over coverage of chiropractic services. The chiropractic services had been covered by the Indiana Blue Cross plan for twenty years in its administrative services only (ASO) capacity for the welfare plan. The plan gave notice that as of a certain date services by a chiropractor would no longer be covered. X-ray benefits were covered when ordered by a licensed physician or as required by law. The benefit plan specificly excluded services by any other practitioners. The state, however, had a statute that required health plans to provide reimbursement for services provided by a number of health care practitioners including chiropractors. The union argued that the "as required by law" provision of the plan applied to require coverage of chiropractors. The company argued that "as required by law" includes federal and state laws including ERISA preemption language. The Administrative Board for the plan determined that the plan fell within the scope of the federal ERISA statute and preempted the state law provision so that the claims for chiropractic services would no longer be payable. The arbitrator construed ERISA preemption to only apply when the state statute directly conflicts with ERISA and found that the state statute requiring health care providers to be treated equally did not intrude on the federal provisions. The decision in 3253 was that ERISA did not preempt the state statute and therefore chiropractic services must be covered. See *Id.*

386. The union claimed that the state equal basis statute required coverage of individual psychotherapy visits whether they occurred in the physician's office or an outpatient psychiatric facility. The union interpreted the locations for treatment to include the psychotherapist's office; since the term physician is not defined in the coverage booklet, it should be interpreted broadly to include psychotherapists. The union further argued that its case differed from the earlier case, decision number 3253, involving chiropractic services because chiropractic services were not referred to in the benefit booklet, while the psychotherapy services in this case were. *Id.*

387. The company claimed that the health plan was a welfare benefit plan subject to the provisions of ERISA. The company also had a letter from the Insurance Commissioner that indicated that the Department of Insurance considered the plan a welfare plan subject to ERISA federal regulation, not state regulation. The company also contended that the benefit coverage does not cover treatment by a clinical psychologist, but only by a physician in the physician's office or in an approved facility and that a distinction must be made between a physician and a psychologist. The company also claims that as required by law language refers to both state and federal laws and that ERISA federal law is the appropriate law to apply. *Id.*

preempted the state law requirements.[388] The arbitrator had the flexibility in implementing the decision to effectuate this result.

A 1999 arbitration case involving a coverage denial applied the arbitrary and capricious standard to determine whether the welfare plan acted appropriately in denying a member's request for surgery.[389] The member had submitted a request for laser keratotomy to correct her myopia (near-sightedness). The request was forwarded to a physician advisor for a determination of medical necessity of the proposed procedure. The advisor noted that the vision was correctable with contacts or glasses, therefore the laser keratotomy was not medically necessary. The member appealed the decision to the appeal committee of the welfare fund Board of Trustees providing information that other plan members had been reimbursed for radial keratotomy surgery that was performed prior to the availability of the laser procedure. The committee conducted an investigation and found that at least two plan members had been reimbursed for the radial keratotomy surgery even though the surgery was normally considered a non-covered service. The appeals committee denied her request as not medically necessary. The claim was then submitted to arbitration where the arbitrator found that the medical necessity denial was supported by substantial evidence, and therefore, not arbitrary and capricious. The plan denial was upheld.[390]

Similarly, an arbitrator upheld a plan determination that a nicotine patch was not medically necessary, relying on plan language that gave the insurer discretion to make medical necessity determinations.[391] Another arbitrator upheld the denial of chelation therapy for atheroscloerosis, indicating that there were no scientific studies supporting the efficacy of chelation therapy for vascular treatment. The plan had found that the therapy was not medically necessary since it had not been demonstrated to be effective.[392] On the other hand, another arbitrator required a company to reimburse an optional hearing aid feature that was not considered medically necessary. The arbitrator based the decision on the fact that the plan providers agreed to accept the plan payment for services as payment in full unless the provider obtained a waiver indicating that the services were not medically necessary and the member will be responsible for the charges. The provider did not obtain a waiver in this case. The member's reliance on the provider recommendation was an important part of the decision.[393]

Other arbitration cases have looked at contractual coverage provisions to determine whether the plan complied with the provisions of the contract. Generally contract provisions have been upheld in arbitration. A request for cosmetic surgery was denied when the coverage provisions indicated that cosmetic surgery was only

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388. *Id.*

389. *In re* Alaska Elec. Health & Welfare Fund & Individual Grievant, AAA Case No. 75-320-00246-98, 113 Lab. Arb. (BNA) 17 (July 9, 1999).

390. *Id.*

391. *In re* Rubbermaid, Inc. & United Rubber, Cork, Linoleum and Plastic Workers of America Local 302, FMCS Case No. 93/12769, 103 Lab. Arb. (BNA) 667 (July 1, 1994).

392. *In re* Dana Corp., Spicer Axle Division & United Paperworkers International Union, Local 7903, FMCS Case No. 95/03575, 106 Lab. Arb. (BNA) 272 (Nov. 27, 1995).

393. *In re* Bethlehem Steel Corp. & United Steelworkers of America Local 6787, Grievance No. PIB-7509, 104 Lab. Arb. (BNA) 425 (Apr. 19, 1995).

available when it resulted from accident or injury. The woman had Bell's palsy which was not an accident or injury.[394] Other coverage provisions that have been upheld include: reduction of health benefits for services provided at a non accredited hospital where the plan had included notice of the limitation on benefits for twenty years in its printed materials;[395] nursing home reimbursement was discontinued as "convalescent care," which was excluded from coverage;[396] TMJ treatment, which was excluded from coverage;[397] and denial of pregnancy as a disability when there was no showing of illness so that the member could not work.[398]

Arbitrators have required the company to reimburse claims for excluded services when the member has relied on the plan statements in seeking treatment for services. In a claim requesting coverage for acupuncture the member asked the plan if it was covered and was told that it was. After receiving treatment, the reimbursement for acupuncture was denied. The arbitrator found that the member relied on the plan statement that it would be covered and that claims for acupuncture that had already been incurred should be reimbursed.[399] Another arbitrator award required reimbursement of orthodontic expenses when the member relied on plan documents and statements made upon plan enrollment to obtain orthodontic services.[400]

When employers have made changes in plan benefits, arbitrators have looked to see whether collective bargaining agreement provisions had been followed.[401] Arbitration decisions require the employer to comply with the collective bargaining agreement.[402]

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394. *In re* True Temper Corp. & United Steelworkers of America, Local 3417, Arbitration No. 2157, Grievance No. 4079, 73 Lab. Arb. (BNA) 1121, (Dec. 5, 1979).

395. *In re* Akro Co. & United Rubber, Cork, Linoleum, & Plastic Workers of America, Local 550, 79 Lab. Arb. (BNA) 1243 (Nov. 1982).

396. *In re* Dana Corp. & U.P.I.U. Local 7113, Grievance No. 94-17, 104 Lab. Arb. (BNA) 769 (Mar. 18, 1995).

397. *In re* Bethlehem Steel Corp. & United Steelworkers of America Local 6787, Grievance No. PIB-7695, 106 Lab. Arb. (BNA) 1299 (Oct. 2, 1995). The health provider initially filed a claim for TMJ services. After the services were denied as an exclusion of the contract, the provider resubmitted claims stating that the treatment was for cervical spine and muscular disorders that produced head and neck pain. These claims were also denied as still being for the excluded TMJ services. *Id.*

398. *In re* Whirlpool Corp., La Porte Division & United Automobile Workers, Local 1172, 77 Lab. Arb. (BNA) 1214 (Dec. 31, 1981).

399. *In re* Armco, Inc. & Armco Employees Independent Federation, AAA Case No. 52 30 0528 84, 86 Lab. Arb. (BNA) 928 (Dec. 9, 1985).

400. *In re* Morton Norwich Products, Inc., Texize Division & Int'l Chemical Workers' Union, Local 559, FMCS Case No. 80K/13422, 75 Lab. Arb. (BNA) 602 (Aug. 29, 1980).

401. *See* Riverside Osteopathic Hosp. & Service Employees Int'l Union, Local 79, AFL-CIO, AAA Case No. 54-30-1220-91, 98 Lab. Arb. (BNA) 1044 (Apr. 27, 1992). A union employee at a hospital suffered a seizure while driving in the spring and was injured. She was cleared to return to work a few weeks later. In the interim the employee applied for sick and accident benefits and the union to which she belonged went on strike. The member did not return to work, nor did she participate in the strike. In July, the member was diagnosed as having a brain tumor and began treatment for the tumor. The strike ended in October when a new contract, effective retroactively to March, was ratified. The hospital claimed that because the member did not return to work in October she was ineligible for plan benefits. The arbitrator found that the evidence demonstrated that she was disabled as of July when the brain tumor was diagnosed and that the disability dated back to May. The retroactive collective bargaining agreement would apply to the member who would be eligible for sickness and accident benefits for a period of time. *Id.*

402. *In re* Ad-Art, Inc. & Int'l Brotherhood of Electrical Workers, Local 591, FMCS Case No. 81K/19375 Grievance No. 21-H.W, 78 Lab. Arb. (BNA) 533 (Feb. 16, 1982). A change by the employer to replace a health carrier and plan when the bargaining agreement indicated that change could only be made by mutual consent was

D. Consumer Protection Activities

Other avenues of consumer protection have evolved to promote cost effective, quality, accessible health care through non-judicial forums. For example, other consumer protections have focused on methods to empower consumers and enhance procedural protections.[403] This would include use of a health care ombudsman to resolve complaints and improve access to care or dispute resolution processes such as mediation. These activities focus on (1) providing a forum for redress earlier in the process and in a less confrontational manner, (2) equalizing power differences between consumers and health plans, (3) simplifying the dispute resolution process and enhancing accessibility to the process, (4) ensuring access to procedures for uninsured, (5) incorporating elements of empowerment and fairness in court and non-court processes, and (6) ensuring legal accountability of health plans.[404] Thus, these methods of protecting substantive patient rights look beyond a specific forum for redress as recommended by the ERISA right to sue in state court to methods through which substantive consumer rights can be protected.

Other non-judicial activities address quality of care[405] concerns through processes such as quality improvement programs, risk management activities, ethics committees, customer relations, and ombudsman programs.[406] These processes usually occur within the organization and serve as a different method for ensuring quality distinct from the courts. If these processes can reduce medical error at an earlier stage, consumers may feel less need for the right to sue. The right to sue

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found to be improper and the employer was required to reinstate the prior health coverage. *Id.* An employer was not allowed to increase health plan co-payments when the collective bargaining agreement specified that co-payments were $5.00, nor could the employer raise premiums when the labor contract indicated that health and welfare policy would remain in effect for the duration of the contract. *See In re* Stuart Manufacturing, Inc., & Retail, Wholesale & Dep't Store Union, Local 835, FMCS File No. 92/21219, 100 Lab. Arb. (BNA) 100 (Nov. 23, 1992). Another employer was required to maintain two short-term disability plans when the bargaining agreement outlined short-term disability requirements. *See In re* Meadow Gold Dairies, Inc. & Int'l Brotherhood of Teamsters, Local 537, FMCS Case No. 981110-00298-A, 110 Lab. Arb. (BNA) 865 (June 2, 1998). Where the bargaining agreement provides that the parties may open negotiations for changes in health and welfare benefits, the employer could open negotiations for the express purpose of reducing or eliminating health plan benefits. *See In re* Northern Cal. Woodworking Manuf. Ass'n & United Brotherhood of Carpenters & Joiners of America, Local 1618, 79 Lab. Arb. (BNA) 946 (Sept. 10, 1982). An employer could recoup co-payment amounts retrospectively where the intent of the bargaining agreement was to hold employees responsible for co-payments. *See In re* Spartan Stores, Inc., & General Teamsters Local 406, Grievance No. 15321, 108 Lab. Arb. (BNA) 1159 (Aug. 5, 1997).

403. Eleanor Kinney, *Tapping and Resolving Consumer Concerns about Health Care*, 26 AM. J. L & MED. 335 (2000).

404. *Id.*

405. Two components of quality have been identified: (1) the need for technical competence that requires a balancing of the risks and benefits of applying science and technology to achieve favorable health outcomes. Failure to exercise technical competence deviates from the standard of care resulting in medical malpractice liability as a way to ensure adequacy of medical care. (2) Quality of care also requires interpersonal competence such as adequate communication, addressing bio-ethical concerns, and meeting the expectations of the customer. *See* Kinney, *supra* note 403, at 342-343. Negligence in this aspect of quality can result in medical malpractice claims, or other legal causes of action in attempts to remedy the discrepancy between the expectations of the customer and actual care provided. When the expected care is not received, the result is a quality of care concern. This also is a quantity of care issue when the unmet expectation is a result of limited benefits or denial of benefits under an ERISA benefit plan. Thus, whenever efforts are made to improve quality of care consumer interests are protected. *See* Francine S. Adler, *Corporate Health Insurance Inc. v. The Texas Dept. of Insurance: Is the Texas Act Holding HMOs Liable for Substandard Medical Care Preempted by ERISA?* 74 ST. JOHN'S L. REV. 209, 220 & 224 (2000).

406. Kinney, *supra* note 403, at 349-55.

provides remedies after poor care has been rendered but is limited in effectuating excellent medical care at the time services are rendered.

Access to health care has also been promoted through non-judicial activities. A number of states have legislated health care ombudsman or consumer advocates to facilitate health plan members' access to covered services. The ombudsman does this by providing and explaining health coverage requirements, "coaching" members on how to negotiate the managed care system by acting as a mediator between the consumer and the health plan, or by serving as a formal advocate for the consumer in discussions with the health plan.[407]

VI. CONCLUSION

The right to sue in state court focuses on the forum for enforcement of individual consumer rights while disregarding the substance of consumer rights and remedies that could be resolved in any forum. ERISA reform should incorporate substantive consumer rights rather than focusing on the forum for resolution through the right to sue. Substantive rights include insuring that consumer protections are in place in the administration and enforcement of benefit determinations. People need access to appropriate health care without contractual exclusions and medical necessity denials. The health care system should include processes to ensure quality of care. It should include a right to sue as a remedy in the forum one chooses. These patient protections go beyond the right to sue to include other processes and forums to encourage cost effective, quality, accessible health care.

Should harm occur, a forum that adequately redresses the harm should be in place to ensure a fair process of review, adequate remedies, and a quick resolution of the claim. The forum selected may be less important than the protection of rights and enforcement of remedies. This can occur in federal or state courts or through arbitration or other alternative procedures. Courts have begun to pierce the ERISA "shield of immunity" when lawsuits involve quality of care issues such as medical malpractice and negligence to allow lawsuits in state court. The outcome of the lawsuit, however, is dependent upon the cause of action alleged as well as the court's characterization of the claim based on the facts of the case. The Department of Labor has taken an active role in promoting this distinction through amicus curiae briefs in ERISA court cases. Federal legislative proposals would include the right to sue in state court if adopted, while state legislative proposals may be subject to ERISA preemption. The ERISA right to sue prescription needs to be broad enough to include consumer protections regardless of the forum for legal redress.

Finally, ERISA reform must address the following issues. First, it must occur through federal legislation, since any state legislation can potentially be preempted and court decisions are contingent upon statutory language. Second, the underlying cause of the right to sue discussion is an interest in obtaining access to needed health care that meets quality of care standards. There is no need to sue when adequate access to quality medical care exists. These issues of access and quality should be a primary focus of the health care system. Third, the right to sue involves the right to redress harm in a forum that will provide for adequate review of the issues and

407. Richard Cauchi, *Making the Best of Managed Care*, 27 STATE LEGISLATURES 6, 22 (2001).

provide remedies to compensate the actual harm. This can occur in multiple forums whether federal, state, or arbitration as long as the scope of review and breath of remedies provide fair review and adequate compensation. Fourth, the right to sue should be coupled with independent review organization (IRO) review of claims prior to filing a lawsuit. This serves as a screening function prior to filing a lawsuit and also provides for more expedient claims settlement when the timing of the decision may be important. Fifth, alternative dispute resolution techniques such as arbitration provide for alternative forums that at least currently have more discretion over the scope of claims review and available remedies. Last, court decisions should be more uniform in the characterization of claims subject to ERISA preemption in court, resulting in more consistent court decisions regarding the forum of redress.