

Indiana Law Review

Volume 32

1999

Number 4

NOTES

THE MANAGED CARE PLAN ACCOUNTABILITY ACT

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INTRODUCTION

Joy and anticipation overwhelmed Florence as she awaited the birth of her second child. She took comfort in the fact that her employer provided health insurance. Florence thought that if complications arose, as they did in her first pregnancy, she would have the best medical care. Florence's physician first recommended complete bed rest and then hospitalization to monitor the fetus. However, an administrator with Florence's health plan denied coverage for the recommended treatment and instead provided ten hours per day of in-home care as a less costly alternative. While Florence was home alone, during a period when the nurse was off duty, the fetus went into distress and died.

Distraught, Florence and her husband sued Florence's health plan, alleging that the child died because the plan would not authorize the hospital stay where the fetus could be monitored. Although the court agreed that the plan had engaged in a medical determination, it found that Florence had no claim because federal law did not provide for a cause of action against the health care provider.¹

Situations similar to Florence's have become all too common in this age of managed care. As health care costs rise, more employers enroll in managed care organizations ("MCOs") to meet the growing need for lower health insurance cost. As a result of the mechanics used by MCOs to control costs, health decisions are no longer made only by physicians. Often, when MCO administrators determine that treatment or testing is not necessary or covered under the MCO's health insurance plan, patients have little recourse against the MCO. Under current federal law, if an MCO denies an operation that could prevent a patient enrolled in a self-funded employer plan from going blind, and the patient subsequently goes blind, the MCO patient may only recover the cost of the operation that was previously denied.² The patient cannot sue for other

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1. Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1331 (5th Cir. 1992).

2. See Christine V. Bator, *Liability Issues in Managed Care—Who Should Bear the Risk of Loss*, 1995 NAT'L HEALTH L. ASS'N MANAGED CARE INST. 14.

damages resulting from the blindness itself.³ This seemingly unfair result is because most actions against MCOs are preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), leaving harmed individuals with limited recourse.⁴ Congress has raised viable solutions to this dilemma, such as the Managed Care Plan Accountability Act ("MCPAA") and others addressed in this Note, but has ultimately failed to pass such legislation. The MCPAA would create a federal right of action for individuals harmed by cost containment measures used by MCOs, allowing individuals to collect actual, consequential, and punitive damages.⁵

Part I of this Note discusses the emergence of managed care, why managed care has become so prevalent, and how managed care works. Part II examines the theories of managed care liability, including defenses raised by MCOs to avoid liability. Part III discusses ERISA preemption and its current application in today's legal environment. Part IV describes national reaction to managed care. Part V presents the MCPAA, explains how it could alleviate many of the current problems with MCOs, details legislative action, and explains why the MCPAA is an effective solution. Finally, Part VI introduces other managed care reform proposals that came before Congress in 1997.

I. THE EMERGENCE OF MANAGED CARE

Managed care developed during the late 1980s, when runaway inflation focused attention on the high cost of medicine and concerns over physicians overtreating patients for profit.⁶ Until the 1980s, under the traditional fee-for-service model, insurance would pay for virtually any physician the patient selected. The physician provided care for the patient and the patient's insurance company compensated the physician according to the physician's standard fee.⁷ In contrast, MCOs contract with employers who seek ways to reduce the cost of providing health care benefits to their employees.⁸ MCOs use a variety of techniques to accomplish this cost reduction, usually restructuring the manner in which physicians are paid and how they administer care.⁹

3. *See id.*

4. ERISA broadly states that federal law supersedes any and all state laws that relate to any employee benefit plan. 29 U.S.C. § 1144(a) (1994) ("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.").

5. *See infra* notes 159-64 and accompanying text.

6. *See* Jason Mark, *HMO Liability: Medical Decisions Made in the Corporate Boardroom*, MASS. LAW. WKLY., June 30, 1997, at B25.

7. *See* Laura H. Harshbarger, Note, *ERISA Preemption Meets the Age of Managed Care: Toward a Comprehensive Social Policy*, 47 SYRACUSE L. REV. 191, 194 (1996).

8. *See* Erik Larson, *The Soul of an HMO: Managed Care Is Certainly Bringing Down America's Medical Cost, But It Is Also Raising the Question of Whether Patients, Especially Those with Severe Illnesses, Can Still Trust Their Doctors*, TIME, Jan. 22, 1996, at 44.

9. *See* Gregg Easterbrook, *Healing the Great Divide: How Come Doctors and Patients End*

Managed care is experiencing widespread growth; an escalating number of Americans are affected by MCOs and their administration of health care. Today, over forty-five million Americans are enrolled in MCOs and ERISA governs the majority of those plans.¹⁰ Managed care health plans cover more than seventy percent of American workers and their families.¹¹ As health care costs continue to rise, more employers will likely choose MCOs to lower the cost of providing health care benefits to their employees. As more individuals receive their health care through employer-sponsored health benefit plans, more physicians will be forced to contract with managed care plans.¹² Because of the techniques managed care companies use to reduce health costs, physicians' treatment decisions are arguably affected by MCO's administrative choices.¹³ Managed care is different from traditional medical delivery services. Therefore, it needs new and innovative regulation to keep its development within the confines of responsible and responsive medical practices.

A. How Managed Care Works

Early MCOs employed physicians, however, most MCOs today simply contract with physicians who then act as independent contractors.¹⁴ In theory, the MCO serves only to administer the benefits and does not control the physician's delivery of care to the patient. Although physicians are often reluctant to enter into contracts with MCOs, as an increasing number of large employers in the physician's geographical area receive their health care benefits through an MCO, many physicians contract with MCOs for fear that their patient population will shift to another physician who contracts with the MCO.¹⁵ Most MCOs list contracted physicians as preferred providers. Preferred providers agree to a reduced fee in return for an increased volume of patients from area employers. As a disincentive to see non-contracted physicians, if a patient chooses to see a physician not listed in the MCO's preferred provider directory, the patient's care might not be covered or the patient may be asked to pay a larger copayment or deductible. This causes many patients to see only those physicians who have contracted with the MCO. In a geographic area where many large employers contract with MCOs, physicians who refuse to contract with MCOs may find their patient population significantly reduced. Physicians, though initially reluctant to contract with MCOs, now must contract with MCOs to maintain their

Up on Opposite Sides?, U.S. NEWS & WORLD REP., Oct. 13, 1997, at 64.

10. See Harshbarger, *supra* note 7, at 192.

11. See William Carlsen, *Bill Would Let Patients Sue HMOs for Denial of Services*, S.F. CHRON., May 23, 1997, at A4.

12. See James F. Henry, Comment, *Liability of Managed Care Organizations After Dukes v. U.S. Healthcare: An Elemental Analysis*, 27 CUMB. L. REV. 681, 684 (1996-1997).

13. See Barry R. Furrow, *Managed Care Organizations and Patient Injury: Rethinking Liability*, 31 GA. L. REV. 419, 423-26 (1997).

14. See *id.* at 422-23.

15. See *id.*

patient base.¹⁶

Despite the MCO's arguable success in reducing health care costs for employers, increasing access to care for employees, and providing a large pool of patients for some physicians, physicians and patients are often frustrated with MCOs.¹⁷ Their frustration stems from the two techniques central to managed care: utilization review and discounted or capitated physician fees.

B. Utilization Review

Utilization review is "a prospective or concurrent determination of whether the requested procedure is medically necessary and appropriate."¹⁸ Under an MCO's utilization review procedure, if a physician recommends a certain test or treatment, the physician's office often has to call a toll-free telephone number to get permission from the MCO to order the test or perform the treatment. The MCO representative then decides both whether the recommended treatment or testing is "medically necessary" in accordance with the plan and whether it is a covered service under the agreement with the patient. These MCO representatives are rarely physicians or even practicing health care professionals.¹⁹ Far from leaving treatment decisions to physicians, many MCO contracts actually state that whether a certain treatment will be provided is "in the sole judgment of the MCO."²⁰ "You can't do anything anymore without first calling an 800 number where someone with a high-school education asks you to spell out the diagnosis," says Quentin Young, a Chicago physician and president-elect of the American Public Health Association.²¹

There are four basic types of utilization review: retrospective review, concurrent review, prospective review, and case management.²² Under retrospective review, the MCO representative audits the patient's chart after the treatment is provided to determine whether the treatment was medically necessary.²³ Depending on the contract between the treating physician and the MCO, treatment that is determined not medically necessary after retrospective review may not be reimbursed or may be reimbursed at a reduced rate.²⁴

16. Ironically, some physicians who once resisted managed care now file lawsuits after being terminated from a managed care plan that covers a large portion of their patient base. See, e.g., *Harper v. Healthsource N.H., Inc.*, 674 A.2d 962 (N.H. 1996).

17. See *infra* notes 135-43 and accompanying text.

18. Harshbarger, *supra* note 7, at 195.

19. See Phyllis C. Borzi, *Managed Care and ERISA Healthplans*, in FIDUCIARY RESPONSIBILITY ISSUES UNDER ERISA—1996, Q245 A.L.I. - A.B.A 133, 137.

20. *Id.*

21. Easterbrook, *supra* note 9, at 65.

22. See Maureen E. Corcoran, *The Management of Managed Care*, in MANAGED CARE CONTRACTING: ADVISING THE MANAGED CARE ORGANIZATION § 1800.06(A) (BNA Health L. & Bus. Series No. 1700, 1996-1998).

23. See *id.*

24. See *id.*

Concurrent review programs constantly monitor the patient's treatment to determine whether continuation of treatment is necessary. This type of review is often used for inpatient hospital stays.²⁵

Prospective review programs are the most problematic. Prospective review requires authorization before the physician can provide the recommended treatment.²⁶ This often involves pre-hospital admission certification, hospital length-of-stay approvals, and second surgical opinions.²⁷ Prospective review programs concern physicians and patients alike because an erroneous decision could result in a denial of coverage by the patient's health insurance company. If the MCO will not pay for the care, the patient could pay out-of-pocket, but the high cost of most medical procedures would preclude many patients from choosing a treatment not covered by their MCO.²⁸ Therefore, an adverse prospective utilization review decision has the practical effect of denying treatment to the patient.

Case management entails the coordination of patient care by a patient's case manager (in a hospital setting) or primary care physician (e.g. family practitioner, internist, or pediatrician). This system is also known as a "gatekeeper system."²⁹ Under a gatekeeper system, the case manager or primary care physician determines whether a patient should see a specialist.³⁰ The patient's specialty care will not be covered by the MCO unless the patient first sees the gatekeeper, whose compensation may be adversely affected by frequent referrals. Under some payment mechanisms a primary care physician may lose money when that physician refers a patient to a specialist for expensive treatment.³¹ Some of the procedures typically performed by more expensive specialists, therefore, are performed by less expensive primary care physicians who may be paid on a capitated fee or a withhold basis.³² Specialists who are more extensively trained in particular areas of medicine may never have the chance to examine a patient and correctly diagnose their particular problem. The result for the patient is less choice in selecting a treating physician, a less qualified physician for the patient's particular problem, or withheld care.³³ A medical malpractice claim based on inadequate, delayed, or withheld treatment implicates both the treating physician and the MCO that established the utilization review system impacting the physician's decision.

25. *See id.*

26. *See Henry, supra* note 12, at 683, 697.

27. *See Corcoran, supra* note 22, § 1800.06(A).

28. *See Larson, supra* note 8, at 50.

29. *See Corcoran, supra* note 22, § 1800.06(B).

30. *See Bator, supra* note 2, at 7.

31. *See Easterbrook, supra* note 9, at 64.

32. *See infra* notes 34-44 and accompanying text.

33. *See Easterbrook, supra* note 9, at 64.

C. Payment Mechanisms

In addition to utilization review, MCOs' payment mechanisms are designed to impact how physicians treat patients. The traditional form of reimbursement for most providers was a straight fee-for-service model. The physician set his or her own fees and the patient paid the full amount out-of-pocket or through health insurance. The more physicians charged, the more the insurance companies paid. Consequently, health care costs and premiums for health insurance continued to rise.³⁴ MCOs changed this. MCOs pay providers using a variety of payment systems, all with the result of reducing health care expenditures for employers and employees.³⁵

Two predominant mechanisms used by MCOs are discounted fee-for-service and capitation.³⁶ A discounted fee-for-service system can either be a flat discount off a physician's scheduled fee (e.g. twenty percent) or a tiered-discount arrangement, where the physician's discount is tied to patient volume.³⁷ By reimbursing the physician less for the same services, physicians may be forced to spend less time with patients in order to maintain an income level necessary to run a viable practice.³⁸ In addition, physicians may treat patients under the MCO's health benefit plan differently than other patients paying the physician's full charges or receiving less of a discount.

However, it is the capitation payment mechanism that is most risky for physicians and MCOs.³⁹ While discounted fee-for-service payment arrangements may pay a physician a reduced fee, the physician still makes money on each service he provides. Under a capitation model, a physician may actually lose money by treating patients.⁴⁰ Under capitation, primary care physicians receive a flat fee per member per month regardless of whether they treat or even see the patient.⁴¹ Each time the primary care physician performs a service, admits a patient to a hospital, or refers a patient to a specialist, that cost is deducted from the primary care physician's capitated fee.⁴² Physicians spending less than the capitated fee, keep the surplus as profit. Physicians spending more than the fixed fee, are contractually obligated by the MCO to provide the care for free. Because of the impact of referrals on a primary care physician's income, there is a disincentive to refer patients to specialists, perform expensive tests, or order

34. See Harshbarger, *supra* note 7, at 194.

35. See Susan Brink & Nancy Shute, *Managed Care Is Pushing Aside the Private-Practice Doctors Typified by TV's Marcus Welby or Dr. Kildare. What's Replacing Them Isn't Making Anyone Smile*, U.S. NEWS & WORLD REP., Oct. 13, 1997, at 60-62.

36. See Easterbrook, *supra* note 9, at 64.

37. See Corcoran, *supra* note 22, § 1800.05.

38. See Furrow, *supra* note 13, at 433.

39. See *id.* at 431.

40. See Corcoran, *supra* note 22, § 1700.05(C); Larson, *supra* note 8, at 50.

41. See Easterbrook, *supra* note 9, at 64 (estimating that the median capitated rate is \$150 per patient per year).

42. See Mark, *supra* note 6, at B25.

inpatient hospital care.⁴³ Ironically, while proponents of managed care criticized the fee-for-service model because it led to overtreating patients, managed care now faces criticism for undertreating patients to maintain income and profits.⁴⁴

MCOs also interfere with the physician-patient relationship. Some MCOs, fearing that physicians may criticize their payment mechanisms and incentives to limit care and access to specialists, place language in their contracts to limit the ability of physicians to consult openly with patients.⁴⁵ "Doctors across the country say that health maintenance organizations routinely limit their ability to talk freely with patients about treatment options and HMO payment policies."⁴⁶ MCOs seek to limit this discussion by placing gag-clauses in physician contracts that limit the power of the physicians to tell their patients certain information such as treatment options and MCO policies.⁴⁷ Some contracts even forbid the physician to criticize the managed care plan, keeping health care consumers in the dark.⁴⁸ No doubt, MCOs want to limit the information available to patients so they will not request expensive treatment, unless the MCO can make the decision to pay for it in advance. Neither physicians nor patients benefit from gag clauses.

II. MANAGED CARE LIABILITY

Because of the utilization review programs used by MCOs and the incentives provided to physicians to limit care, treatment previously provided under fee-for-service health insurance is often denied to patients. When such denial results in harm or death to a patient or a patient's family, they often seek redress by filing suit against the MCO. Currently, plaintiffs who seek to hold MCOs liable for adverse treatment decisions assert multiple causes of action. Individual's claims of liability are often based on state or common law causes of action and include malpractice, vicarious liability (including respondeat superior and ostensible agency),⁴⁹ breach of contract,⁵⁰ breach of warranty, fraud and misrepresentation.⁵¹

43. See Robert Vilensky, *The Liability of Health Maintenance Organizations*, 69 N.Y. ST. B. J. 20 (1997). See also Furrow, *supra* note 13, at 423 (noting that in 1995, 70% of MCOs reported paying primary care physicians through capitation and 50% report paying specialists through a capitation model).

44. See Mark, *supra* note 6, at B25.

45. See generally Paul Gray, *Gagging the Doctors: Critics Charge That Some HMOs Require Physicians to Withhold Vital Information from Their Patients*, TIME, Jan. 8, 1996, at 50. See also Indiana Code section 27-13-15-1 for an example of a state law that prohibits gag clauses. IND. CODE § 27-13-15-1 (1998). "A contract between a health maintenance organization and a participating provider of health care services: . . . (2) may not prohibit the participating provider from disclosing: (A) the terms of the contract as it relates to financial or other incentives to limit medical services by the participating provider; . . ." *Id.*

46. Vilensky, *supra* note 43, at 20.

47. See *id.*

48. See Henry, *supra* note 12, at 705.

49. See Bator, *supra* note 2, at 2. Vicarious liability occurs when an employer becomes

MCOs, in turn, offer multiple theories to avoid liability.⁵² Despite the theory of liability individual plaintiffs employ, MCOs generally argue they cannot be held liable because (1) they do not engage in the practice of medicine and merely act as administrative plan interpreters, (2) they may not be found to engage in the practice of medicine due to the corporate practice of medicine doctrine,⁵³ or (3) such claims are preempted by ERISA.⁵⁴

The first argument MCOs raise is that they cannot be held liable for any treatment decisions because they do not engage in medical decision-making, diagnosis, or treatment. MCOs maintain that their determinations are only administrative ones, such as whether a certain test or treatment is covered under the terms of a plan, while the actual practice of medicine is left to the physicians. MCOs assert this defense even though MCO administrators—through utilization review—are authorizing or withholding payment for medical care and testing. These decisions have just as much effect on the patient as a physician's medical decision, because that decision determines whether the patient will receive the recommended care.⁵⁵ Of course, individuals who are denied coverage could pay the entire cost of the treatment out of their own pocket, but the cost is likely to be prohibitive. Still, MCOs argue that they are only involved in the administration of policies and not medical evaluations.

Second, MCOs raise the corporate practice of medicine doctrine as a defense against liability. MCOs charge that under the corporate practice of medicine doctrine, corporations, including MCOs, cannot practice medicine; therefore, MCOs cannot be held liable for any type of medical malpractice.⁵⁶ The corporate practice of medicine doctrine varies with the jurisdiction because it is founded in the common law, statutory law, and ethical rules established by the medical profession.⁵⁷ However, depending again on jurisdiction, a variety of exceptions

responsible for the actions of an employee (*respondeat superior*) or when a principle becomes responsible for the actions of its agent (*ostensible agency*). MCOs could be held vicariously liable for the actions of a physician through *respondeat superior* if the physician was actually employed by the MCO or works under conditions similar to an employee. MCOs could be held liable through *ostensible agency* if the physician was acting on behalf of the MCO, even though no employment relationship existed. *See id.*

50. *See* Bator, *supra* note 2, at 4 (explaining that breach of contract includes breach of implied covenant of fair dealing, false advertising, breach of fiduciary duty, and misrepresentation of the terms of a policy).

51. *See id.* at 2.

52. *See id.*

53. *See infra* notes 56-58 and accompanying text.

54. *See infra* notes 60-134 and accompanying text.

55. *See* Harshbarger, *supra* note 7, at 194.

56. *See, e.g.,* Dunn v. Praiss, 656 A.2d 413, 415-16 (N.J. 1995); Propst v. Health Maintenance Plan, Inc., 582 N.E.2d 1142, 1143 (Ohio Ct. App. 1990); Williams v. Good Health Plus, Inc., 743 S.W.2d 373, 375-77, 379 (Tex. App. 1987).

57. *See* George F. Indest III & Barbara A. Egolf, *Is Medicine Headed for an Assembly Line? Exploring the Doctrine of the Unauthorized Corporate Practice of Medicine*, 6 BUS. L. TODAY, 32,

exist permitting corporations to practice medicine.⁵⁸ While the corporate practice of medicine doctrine does not currently have a significant impact on MCOs, largely because the doctrine is not stringently enforced, it does exist and presents challenges to future recovery by patients.

The most used and most successful defense against MCO liability is ERISA preemption. MCOs most often raise this defense: Claims against them are preempted by a federal law. Specifically, ERISA regulates employee welfare plans, including employer-sponsored, self-funded health plans.⁵⁹

III. ERISA PREEMPTION

ERISA affirmatively preempts claims against MCOs based on state laws that “relate to” any employee benefit plan.⁶⁰ Because employer-sponsored, self-funded health care plans are considered employee welfare benefit plans covered by ERISA,⁶¹ claims based on state laws arising from such health plans—like medical malpractice claims—are preempted by ERISA.

Ironically, even though MCOs were almost nonexistent when Congress enacted ERISA, ERISA has become the saving grace for MCOs.⁶² MCOs use ERISA to limit their liability, even though this was not its original purpose.⁶³ Congress enacted ERISA to eliminate overlap and conflict between state and federal law as it applied to retirement plans and to protect the financial stability

34 (1997).

58. See Michael A. Dowell, *The Corporate Practice of Medicine Prohibition: A Dinosaur Awaiting Extinction*, 27 J. HEALTH & HOSP. L., 369, 370 (1994). Exceptions include “(1) professional medical corporations, partnerships, and group practices owned and operated by licensed professionals; 2) HMOs; 3) non-profit corporations such as medical foundations; and 4) fraternal, religious, hospital, labor, educational, and similar organizations.” *Id.* Most significant is the Federal HMO Act, which “incorporates many of the characteristics that the corporate practice of medicine doctrine was designed to protect against.” *Id.* at 371. See generally Federal HMO Act, 42 U.S.C. § 300e (1994 & Supp. II 1996) (supporting the prohibition of the corporate practice of medicine, allowing innovations in health care delivery systems to continue to develop and meet the changing needs of employers).

59. 29 U.S.C. § 1001 (1994 & Supp. II 1996).

60. *Id.* § 1144(a) (1994) (“[T]he provisions of [subchapter I] . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . .”).

61. See *id.* § 1002(1) providing:

The term[] ‘employee welfare benefit plan’ . . . mean[s] any plan, fund, or program . . . established or maintained by an employer or by an employee organization, or by both, to the extent that such plan . . . was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment. . . .

62. See Harshbarger, *supra* note 7, at 218 (noting that less than 40 MCOs existed when ERISA was enacted in 1974).

63. See *id.* at 216-17.

of such retirement plans.⁶⁴ ERISA protects participants in employee benefit plans and their beneficiaries by setting certain minimum standards that plans must meet, offering participants ready access to federal courts, and maintaining uniform sanctions and remedies that are available to all participants of benefit plans.⁶⁵

A. ERISA Does Not Cover All Plans

Despite its broad reach, regulating almost all employee benefit plans, ERISA also has its limitations. In order for ERISA to apply, the employee benefit plan must fall within the limits of ERISA's definition of a "covered plan."⁶⁶ In order to be a "covered plan," a plan must be "established or maintained by an employer or employee organization."⁶⁷ The plan must also be self-funded, meaning the employer, through direct employer funding and employee contributions, maintains the plan's reserves.⁶⁸ Even if an employer or employee organization does not intend to create an ERISA plan, does not distribute any materials, and does not comply with ERISA's other requirements, a court is still likely to determine that an employer-sponsored, self-funded plan providing health benefits is an ERISA plan.⁶⁹

However, some health plans are not covered by ERISA. The health plans of churches or church-operated businesses do not fall under ERISA.⁷⁰ Government employees and employees of public agencies are also not covered by ERISA.⁷¹ Independent contractors are not "employees" under ERISA,⁷² unless they are insured by the group plan that covers employees of the employer.⁷³ The scope of ERISA is also limited because it does not preempt state laws regulating insurance, banking, or securities.⁷⁴ However, because ERISA defines insurance so narrowly, this exception is not often implicated.⁷⁵

64. *See id.*

65. *See* Karen A. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Preemption*, 13 YALE J. ON REG. 255, 262-63 (1996).

66. 29 U.S.C. § 1003 (1994 & Supp. II 1996).

67. *Id.* § 1002(1) (1994).

68. *See id.*

69. *See* Scott v. Gulf Oil Corp., 754 F.2d 1499, 1503-04 (9th Cir. 1985); Donovan v. Dillingham, 688 F.2d 1367, 1371 (11th Cir. 1982).

70. 29 U.S.C. § 1003(b) (1994 & Supp. II 1996).

71. *See id.* § 1002(32) (1994).

72. *See* Nationwide Mut. Ins. Co. v. Darden, 503 U.S. 319, 327 (1992).

73. *See* Harper v. American Chambers Life Ins. Co., 898 F.2d 1432, 1434 (9th Cir. 1990).

74. 29 U.S.C. § 1144(b)(2)(A) (1994) ("[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities.").

75. *Id.* § 1144(b)(2)(B).

Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or

B. The Push for Federal Court

When an individual harmed by an MCO files a claim in state court, the defendant MCO typically moves to have the action removed to federal court, alleging that the state claim is preempted by federal ERISA law because the claim “relates to” an employee benefit plan.⁷⁶ Because MCOs face less potential liability under the provisions of ERISA than in state court, MCOs frequently raise the ERISA preemption defense, preferring to have federal ERISA law rather than state law govern claims against them.⁷⁷ ERISA’s remedy provisions provide only for recovery of health plan benefits—like the cost of a treatment or test and sometimes attorneys’ fees—while most state laws allow for recovery of consequential and punitive damages.⁷⁸ Further, jury trials are generally not available for claims against ERISA plans, an important advantage considering the highly emotional nature of many claims against MCOs.⁷⁹

MCOs frequently attempt to invoke both complete and substantive preemption. A state law is completely preempted by a federal law when the federal law so completely occupies the field that any complaint arising within the field is necessarily federal in character.⁸⁰ Therefore, if a state law claim falls under ERISA,⁸¹ the claim is considered federal in character and must be tried in

investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts.

Id.

76. Jurisdiction to remove the case to federal court for adjudication by federal law is based on 28 U.S.C. § 1441(b), which states that “[a]ny civil action of which the district courts have original jurisdiction founded on a claim or right arising under the Constitution, treaties or laws of the United States shall be removable.” 28 U.S.C. § 1441(b) (1994). *See also* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) (holding that ERISA preempts anyone from bringing an action in state court where they allege improper process of claims for benefits under any employee benefits plan regulated by ERISA because such claims “arise under the laws of the United States”).

77. 29 U.S.C. § 1132(a) (1994).

A civil action may be brought (1) by a participant or beneficiary (A) for the relief provided for in subsection (c) of this section, or (B) 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. . . .”

Id.

78. *See* Massachusetts Mut. Life Ins. v. Russell, 473 U.S. 134 (1985).

79. *See* Wardle v. Central States Pension Fund, 627 F.2d 820 (7th Cir. 1980).

80. *See* Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 63-64 (1987) (holding that there are areas of law, such as ERISA, that Congress has so completely preempted that any complaint raising this select group of claims is necessarily federal in character).

81. 29 U.S.C. § 1132(a)(1)(B) (1994) (stating that a civil action may be brought by a participant or beneficiary “to recover benefits due to him under the terms of the plan, to enforce his rights under the terms of his plan, or to clarify his rights to future benefits under the terms of the

federal court where damages are limited and a jury is unavailable. Because ERISA provides specified remedies, including enforcement of benefits, most negligence claims against MCOs fall under ERISA, thus forcing plaintiffs to adjudicate supplemental state claims in federal court.⁸²

However, if a plaintiff's claim is not one to recover benefits, enforce rights, or clarify rights to future benefits under ERISA's remedial provisions,⁸³ the claim is not completely preempted by ERISA and may not be removable to federal court.⁸⁴ State or federal courts will then examine whether the state claims are nevertheless substantively preempted by ERISA because the claim "relates to" an employee benefit plan governed by ERISA.⁸⁵ If the court finds that the state law claim "relates to" the benefit plan governed by ERISA, the claim is preempted by ERISA and the plaintiff is left without a cause of action, unless the claim may be brought under ERISA's enforcement provisions.⁸⁶ Courts frequently struggle with the "relates to" language, attempting to find a workable definition of how much contact or dependence the state laws have before they "relate to" an employee benefit and are preempted by ERISA.⁸⁷ The "relates to" language is therefore the focus of many ERISA cases involving MCOs.

Currently, circuits are split as to whether ERISA affirmatively preempts claims against MCOs.⁸⁸ Cases are generally judged solely on the specific facts, assuring no reliable outcome and offering no predictability to individuals or MCOs.⁸⁹ An analysis of previous cases, dealing more specifically with managed

plan").

82. See *Taylor*, 481 U.S. at 63-64.

83. 29 U.S.C. § 1132(a)(1)(B) (1994). For example, a plan participant might sue an MCO because the doctor they recommended as a preferred provider was practicing medicine without a license.

84. See 28 U.S.C. § 1441(c) (1994).

Whenever a separate and independent claim or cause of action within the jurisdiction conferred by section 1331 of this title is joined with one or more otherwise non-removable claims or causes of action, the entire case may be removed and the district court may determine all issues therein, or, in its discretion, may remand all matters in which State law predominates.

Id.

85. 29 U.S.C. § 1144(a) (1994) ("Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.").

86. See *Robinson v. Linomaz*, 58 F.3d 365 (8th Cir. 1995) (holding that if ERISA preemption leaves plaintiff with no cause of action such conclusion does not limit the scope of preemption).

87. See *infra* notes 93-134 and accompanying text.

88. See *infra* notes 95-134 and accompanying text.

89. Cases holding that malpractice claims against MCOs are not preempted by ERISA include: *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995); *Pacificare of Oklahoma v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Edelen v. Osterman*, 943 F. Supp. 75 (D.D.C. 1996). Cases holding that malpractice claims against MCOs are preempted by ERISA include: *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th

care liability, demonstrates the unresolved problems confronting courts.⁹⁰ State laws that are generally found to be preempted by ERISA are (1) laws that specifically apply to ERISA plans or which impose a duty on ERISA plans by referencing ERISA plans, (2) common law actions that are within the scope of ERISA's civil enforcement provisions, and (3) laws that mandate specific benefit structures or prohibit a method of determining the level of benefits.⁹¹

Congress, by enacting ERISA, sought to ensure that a uniform set of federal rules regulated employee benefit plans.⁹² Congress intended the "relates to" language to ensure that no state laws compromise the uniform federal laws by attempting to regulate or impact an employee benefit plan. Courts struggle with the "relate to" language, yet are unable to formulate a workable, cohesive doctrine of understanding.⁹³ For example, in *Ingersoll-Rand Co. v. McClendon*,⁹⁴ the Supreme Court held that the "relates to" language should be given broad meaning and that state laws could be preempted even if they did not directly address subjects covered under ERISA.⁹⁵ This broad definition of what "relates to" an ERISA plan has allowed MCOs to evade litigation in state court and keep awards limited to only compensatory damages.

C. ERISA Preempts Claims of Liability

Despite the mandate by the *Ingersoll* decision for broad interpretation of "relates to," courts continue to employ varying interpretations of the "relates to" language, perpetuating a split in the courts. Arguably, this causes inequitable outcomes for injured plaintiffs. For example, the inequity of allowing MCOs to use ERISA to avoid liability was illustrated all too clearly in *Corcoran v. United Healthcare, Inc.*⁹⁶ In *Corcoran*, the court held that ERISA preempted a claim of medical malpractice.⁹⁷ *Corcoran* had health insurance through an employer-sponsored ERISA plan administered by Blue Cross & Blue Shield of Alabama.

Cir. 1995); *Kuhl v. Lincoln National Health Plan*, 999 F.2d 298 (8th Cir. 1993); and, *Corcoran v. United Health Care, Inc.*, 965 F.2d 1321 (5th Cir. 1992).

90. See *infra* notes 95-134 and accompanying text.

91. See *Jordan*, *supra* note 65, at 266-67.

92. See *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers*, 514 U.S. 645, 657 (1995).

93. See *Harshbarger*, *supra* note 7, at 193.

94. 498 U.S. 133 (1990).

95. *Id.* at 138-42.

96. 965 F.2d 1321 (5th Cir. 1992).

97. *Id.* at 1332-33. Accord *Kuhl v. Lincoln Nat'l Health Plan*, 999 F.2d 298, 303 (8th Cir. 1993) (holding that a decision not to provide benefits and precertify payment for heart surgery was directly related to the administration of benefits and was therefore preempted by ERISA); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir. 1993) (holding that ERISA preempted a claim for negligent administration of benefits); *Butler v. Wu*, 853 F. Supp. 125 (D.N.J. 1994) (holding that claims of malpractice, negligence, breach of warranty, and wrongful death against a doctor and an MCO were all preempted by ERISA).

Blue Cross & Blue Shield contracted with United Healthcare, Inc. ("United"), an MCO, to provide utilization review.⁹⁸ While pregnant, Corcoran experienced complications and her physician recommended hospitalization and a Halter Monitor, but United determined that hospitalization was unnecessary.⁹⁹ Instead, United authorized partial day nursing care at Corcoran's home.¹⁰⁰ While the nurse was off duty, the fetus went into distress and died.¹⁰¹

When Corcoran brought a claim against United for medical malpractice, alleging that United had rendered a bad medical decision, United argued that the state law medical malpractice claim was preempted by ERISA.¹⁰² United contended that they had not engaged in a medical determination, but only evaluated what benefits Corcoran's plan covered.¹⁰³ Nevertheless, the court determined that because United's review was prospective rather than retrospective, United's utilization review constituted a medical decision.¹⁰⁴ In *Corcoran*, the court determined that prospective review was closer to a medical recommendation because it is more likely to affect health care decisions than retrospective review.¹⁰⁵

Even though the court in *Corcoran* found United at fault, it held that ERISA preempted the claim because it involved improper handling of a benefits claim.¹⁰⁶ The court characterized the medical decision to deny the inpatient stay and Halter Monitor as "part and parcel" of a benefits decision and sufficiently "related to" the ERISA plan to warrant preemption.¹⁰⁷

Another noted case, finding claims for medical malpractice, wrongful death, and negligence preempted by ERISA and allowed the MCO to avoid liability is *Tolton v. American Biodyne, Inc.*¹⁰⁸ Tolton held health insurance through his employer, United Way-Big Brothers/Big Sisters of Greater Cleveland, who contracted with American Biodyne to provide mental health services.¹⁰⁹ Tolton sought treatment for a drug addiction through Biodyne and, according to its protocol, Biodyne challenged Tolton to remain drug free for five days and then

98. See *Corcoran*, 965 F.2d at 1323; see also *supra* notes 18-33 and accompanying (describing utilization review).

99. See *Corcoran*, 965 F.2d at 1322-24.

100. See *id.* at 1324.

101. See *id.*

102. See *id.* at 1330.

103. See *id.* at 1329.

104. *Id.* at 1331-32. See *supra* notes 22-24 and accompanying text (discussing prospective and retrospective review).

105. *Corcoran*, 965 F.2d at 1331.

106. *Id.* See also *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987) (holding that a charge of improper processing of claims is within the scope of ERISA section 502(a) and therefore preempted).

107. *Corcoran*, 965 F.2d at 1332.

108. 48 F.3d 937 (6th Cir. 1995).

109. See *id.* at 939-40.

return for consultation, despite Tolton's request for inpatient care.¹¹⁰ After several unsuccessful attempts at rehabilitation in residential treatment facilities, Tolton appeared in a hospital emergency room seeking treatment for his suicidal thoughts and was again referred to a state sponsored crisis center.¹¹¹ Several days later, Tolton committed suicide.¹¹² When Tolton's wife filed suit against the MCO, the court found all claims preempted by ERISA because they arose from a refusal to treat under an ERISA plan. The court reasoned that American Biodyne simply determined benefits under Tolton's plan.¹¹³

D. ERISA Does Not Preempt Claims of Liability

While most courts hold that ERISA preempts any state regulation remotely related to an employer-sponsored, self-funded plan, as expressed in *Corcoran* and *Tolton*, some courts have taken a more narrow interpretation of ERISA's "relates to" language. These courts have found that ERISA does not preempt medical malpractice, negligence, and vicarious liability claims against MCOs.¹¹⁴ Courts deciding against MCOs evidence both a creative plaintiff's bar and a growing frustration of the judiciary in MCOs' use of ERISA to avoid liability for improper medical decisions. Although these cases are victories for the individual plaintiffs, the similarity with cases finding claims preempted adds to the confusion facing plaintiffs and the courts today.

For example, in *Rice v. Panchal*,¹¹⁵ the court limited ERISA's reach by finding that ERISA did not preempt a claim of medical malpractice against Prudential.¹¹⁶ In *Rice*, the plaintiff held insurance through his employer, Handy Andy, Inc., who obtained health insurance for its employees through

110. *See id.* at 940.

111. *See id.*

112. *See id.*

113. *Id.* at 942. Further, the court held that "[t]he fact that Tolton was refused benefits pursuant to utilization review does not alter our preemption analysis" and the fact "that ERISA does not provide the full range of remedies available under state law in no way undermines ERISA preemption." *Id.* at 942-43.

114. *See infra* notes 115-34 and accompanying text.

115. 65 F.3d 637 (7th Cir. 1995).

116. *Id.* *Accord* *Smith v. HMO Great Lakes*, 852 F. Supp. 669 (N.D. Ill. 1994) (holding that ERISA did not prevent a claim of medical malpractice arising out of the implementation of cost containment procedures against an HMO, because claims of negligence were not dependent on the employee benefit plan, but instead concerned the relationship between the HMO and the medical provider rather than the beneficiary of the plan); *Elsesser v. Hospital of Phila. College*, 802 F. Supp. 1286 (E.D. Pa. 1992) (holding an MCO liable when it failed to provide a competent physician because Congress did not intend for ERISA to proscribe standards of professional liability because it is an area traditionally under state control); *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983 (E.D. Pa. 1990) (holding that a state cause of action based on vicarious liability was not preempted by ERISA because the claim of vicarious liability had no relation to any denial of rights under the employee benefit plan, thus, the claim could exist outside of the scope of ERISA).

Prudential.¹¹⁷ Rice claimed Prudential's lengthy utilization review procedures delayed his treatment and resulted in permanent physical harm.¹¹⁸ Rice further alleged that Prudential was liable for the medical malpractice of the physicians included in his employer-sponsored benefit plan, based on the state law of respondeat superior, because they were selected by Prudential.¹¹⁹ The court held that ERISA did not preempt a respondeat superior claim against Prudential because the claim could be adjudicated without interpretation of the employee benefit plan at issue.¹²⁰

Similarly, in *Pacificare of Oklahoma, Inc. v. Burrage*,¹²¹ the Tenth Circuit found that ERISA did not preempt a vicarious malpractice claim even though it concerned the delivery of benefits under an ERISA plan.¹²² The plaintiff brought a vicarious malpractice and wrongful death suit against her husband's MCO, Pacificare, alleging that his death resulted from a Pacificare primary physician's malpractice.¹²³ The court held that ERISA did not preempt either claim because the issue of the physician's negligence could be decided without reference to the employee benefit plan.¹²⁴ The court reasoned that the malpractice claim did not "relate to" the employee benefit plan governed by ERISA because it "does not involve a claim for benefits, a claim to enforce rights under the benefit plan or a claim challenging administration of the benefit plan."¹²⁵

In the U.S. Supreme Court's most recent decision analyzing ERISA preemption and health care, *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*,¹²⁶ the Court adopted a narrow view of ERISA's "relates to" language. The Court held that ERISA did not preempt a state law that required the addition of surcharges to hospital bills of patients covered by ERISA.¹²⁷ In evaluating whether the regulations at issue in *Travelers* "related to" an employee benefit plan, the Court found that the surcharge regulations only had an indirect economic influence,¹²⁸ therefore, the surcharge did not rise to the level of "relating to" the employee benefit plan.¹²⁹ In *Travelers*, the Court found that Congress, in enacting ERISA, did not intend to supplant state laws.¹³⁰ The Court further stated that the purpose of the preemption clause "was to avoid a multiplicity of regulation in order to permit

117. *Rice*, 65 F.3d at 638.

118. *See id.*

119. *See id.* at 642.

120. *Id.*

121. 59 F.3d 151 (10th Cir. 1995).

122. *Id.* at 154-55.

123. *Id.* at 152.

124. *Id.* at 154.

125. *Id.*

126. 514 U.S. 645 (1995).

127. *Id.* at 649.

128. *Id.* at 659-60.

129. *Id.* at 662.

130. *Id.*

the nationally uniform administration of employee benefit plans.”¹³¹ The Court narrowed its previous interpretation of “relates to,” finding that a broad definition seemed to imply that few state laws would be valid because some small connection could always be maintained.¹³²

Although *Travelers* clearly applied a more narrow view of the “relates to” language, the holding spoke more to economic effects of regulations and not directly to MCO liability.¹³³ While *Travelers* narrowly interpreted ERISA, nothing in the Court’s opinion definitively included tort actions or claims for negligent administration of benefits.¹³⁴ Further, there is no indication that *Travelers* has led to a reevaluation of claims against MCOs in the lower courts. Because there is no direct language in *Travelers* calling for such a reevaluation, change is unlikely to come in a timely manner and correct the problems currently facing individuals enrolled in MCOs. While *Travelers* may call for reevaluation of the “relates to” doctrine based on economic effect, it is not a strong enough pronouncement to make a timely impact on heightened managed care liability. Plan participants who believe they have been harmed, as well as MCOs concerned about liability, are still forced to muddle through the confusion created by the split in the circuits.

IV. NATIONWIDE BACKLASH

Today, public criticism of MCOs is widespread. Accounts of denials of treatment, gag clauses prohibiting doctors from discussing treatment options with patients, shortened hospital stays, delays in testing, refusals to provide emergency care, along with the huge corporate bonuses earned by MCO executives, has brought managed care liability into the limelight.¹³⁵ Chronicles of managed care mismanagement even peaked the interests of Hollywood. In 1997, two blockbuster movies, *The Rainmaker*¹³⁶ and *As Good As It Gets*¹³⁷ dealt with issues of managed care liability. One health insurance executive recently reported that during a screening of *As Good As It Gets*, when one of the movie’s main characters harshly criticized the treatment her son received from his MCO, patrons in the theater actually stood up to applaud.¹³⁸

131. *Id.* at 657.

132. *Id.* at 655-56, 660.

133. *Id.* at 659-60.

134. One commentator argues that the decision in *Travelers* is an indication that courts should restrain the scope of the ERISA preemption defense. She states, “[t]he pragmatic and more delineated analytical framework could lead lower courts out of the current state of utter confusion. That is, if courts adopt a uniform approach to the [preemption] question, there is at least a greater potential for uniformity in the outcome.” Jordan, *supra* note 65, at 305.

135. See Brink & Shute, *supra* note 35, at 60.

136. *THE RAINMAKER* (Paramount 1997).

137. *AS GOOD AS IT GETS* (Tri-Star 1997).

138. *Outliers: Reform Plan Buried, Court Rules on Secrecy, and Battle Still Rages*, MOD. HEALTHCARE, Jan. 19, 1998, at 44.

Publicity from Hollywood, along with accounts of managed care mismanagement, are pervasive in the print media. A recent *Time Magazine* article exposed the frustrations many encounter with managed care and the enormous salaries earned by MCO executives.¹³⁹ The article detailed how one woman was denied a bone marrow transplant because her health plan deemed it experimental and was unwilling to pay for treatment where positive results were allegedly unlikely. Ironically, the \$92,000 cost of the transplant denied by the MCO was only 0.08% of the \$11.7 million that the MCO had available in its transplant pool.¹⁴⁰

MCOs have not escaped the effects of the bad publicity. Because of their poor public image, complicated acquisitions and mergers, rising medical costs, and a growing body of anti-managed care legislation, many MCOs are struggling with losses and slumping earnings.¹⁴¹ MCOs are likely to experience declining profits as lawmakers at both the federal and state levels, eager to demonstrate their willingness to fight for their constituents, seek to restrict the cost containment techniques used by MCOs. In 1998, President William J. Clinton made health care reform a national priority by widely promoting his Patient Bill of Rights.¹⁴² The Patient Bill of Rights advocates accessible emergency care, managed care liability, immediate review of coverage denials, and adoption of minimal standards of coverage.¹⁴³ While President Clinton's proposal was not passed by Congress into law, it demonstrates the prominence of health care reform in the national agenda.

State lawmakers have also jumped on the anti-managed care bandwagon. In 1997, states collectively passed 182 laws dealing with managed care.¹⁴⁴ Some state legislatures are so frustrated with the confusion over managed care liability and the success of MCOs in escaping liability, that they are proposing laws to create a state cause of action for individuals harmed by MCOs. In 1997, Texas passed a bill that allows patients to sue MCOs for injuries resulting from a

139. Larson, *supra* note 8, at 45. Larson recounts Chirsty deMeurers's unsuccessful three year battle with breast cancer along with her battle with her MCO, who constantly denied a bone marrow transplant. Larson also reports that while denying deMeurer's claims, the head of her MCO made a base salary of \$658,713, a bonus of \$815,000, and an additional \$300,000 from an incentive plan. *See id.*; *see also* George J. Church, et al., *Backlash Against HMOs Doctors, Patients, Unions, Legislators Are Fed Up and Say They Won't Take it Anymore*, *TIME*, Apr. 14, 1997, at 32; Paul Gray, *Gagging the Doctors: Critics Charge That Some HMOs Require Physicians to Withhold Vital Information from Their Patients*, *TIME*, Jan. 8, 1996, at 50 (discussing physician gag clauses).

140. *See* Larson, *supra* note 8, at 49.

141. *See* Louise Kertesz, *Managed Crisis—Bad Publicity, Slumping Earnings Hit HMOs*, *MOD. HEALTHCARE*, Jan. 5, 1998, at 30 (reporting large 1997 losses for Kaiser Permanente, PacifiCare, Aetna U.S. Healthcare, Oxford Health Plans, and Prudential HealthCare).

142. *See* Julius A. Karash, *Managed-Care Firms in Area Not Enthusiastic About Bill*, *KAN. CITY STAR*, Jan. 29, 1998, at A10.

143. *See id.*

144. *See* Brink & Shute, *supra* note 35, at 63.

refusal to cover necessary treatment.¹⁴⁵ A U.S. District Court recently upheld a challenge to this new law but limited its application.¹⁴⁶ The portion of the Texas law that created an independent review process to evaluate adverse benefit determinations was held to be preempted by ERISA, thereby limiting the impact of the legislation. Missouri also passed similar but less comprehensive legislation prohibiting MCOs from forcing providers to indemnify the MCO for damages incurred.¹⁴⁷ In addition, Florida,¹⁴⁸ Connecticut,¹⁴⁹ Pennsylvania,¹⁵⁰ Massachusetts,¹⁵¹ and several other states are working to pass laws heightening the liability of MCOs.¹⁵²

While many states report that anti-managed care legislation is on the agenda,¹⁵³ the proposed legislation may have little impact on heightening managed care liability because it can only apply to non-ERISA plans.¹⁵⁴ Further, state regulation could result in varying degrees of liability from state to state.

145. See Leslie Nicholson, *State HMO Liability Laws May be Stymied by ERISA Preemption*, 14 No. 8 MED. MALPRACTICE L. & STRATEGY, June 1997, at 1. The Texas bill became law on June 6, 1997 without Governor George W. Bush's signature. The bill eliminates the corporate practice of medicine doctrine as a defense against MCO liability, revises existing utilization review standards to provide for expedited appeal and independent review, and prohibits MCOs from requiring providers to be responsible for the plan's actions. See *Managed Care—Laws Expanding Health Plan Liability Pose Challenge to ERISA Preemption*, 5 HEALTH CARE POL'Y REP. (BNA) 1891 (Dec. 22, 1997) [hereinafter *Managed Care Laws*].

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

147. See *Managed Care Laws*, *supra* note 145, at 1891 (explaining the Missouri legislation passed on June 30, 1997). This legislation repeals the corporate practice of medicine doctrine, but it is limited because it applies only to licensed MCOs. See *id.*

148. The Florida legislature passed a bill allowing patients to sue MCOs but Governor Lawton Chiles vetoed the bill. See Nicholson, *supra* note 145, at 2.

149. "Connecticut Gov[ernor] John Rowland signed a measure tightening oversight of [MCOs] and giving consumers the right to appeal [MCO] decisions when they are denied coverage." *Id.*

150. The Pennsylvania legislature proposed the Quality Health Care Protection Act that would prohibit managed care provider contracts from including gag clauses, require managed care plans to cover emergency care, and increase patient access to specialist. See *Pennsylvania—Senate Panel Approves Safeguards for Managed Care Plan Subscribers*, 5 HEALTH CARE POL'Y REP. (BNA) 1897 (Dec. 22, 1997).

151. Massachusetts Governor Paul Cellucci proposed legislation to establish an accreditation board, a prohibition against physicians working for non-accredited MCOs, guaranteed coverage of emergency services, and a ban on gag-clauses. See *Massachusetts—Cellucci Seeks Managed Care Regulation, Predicts Passage of Consensus Legislation*, 6 HEALTH CARE POL'Y REP. (BNA) 132 (Jan. 19, 1998).

152. See Nicholson, *supra* note 145, at 2-3. The New York legislature also reports to be working on similar legislation for its next session. See *id.*

153. Forty states report anti-managed care legislation. See Constantine G. Papavizas & Norman F. Lent III, *HMO Legislation is Aimed at Protecting Patients: Consumers and Providers Call for Regulation; The Managed Care Industry Would Disagree*, NAT'L L.J., Apr. 7, 1997, at B8.

154. See *Managed Care Laws*, *supra* note 145, at 1892.

These state laws may only contribute to the already complex maze of state laws preempted by federal legislation that offer few guarantees to patients that their claims will be addressed fairly, regardless of the jurisdiction in which they reside. While the idea behind these state laws is noble, they may be preempted by ERISA and the same problems will continue.

V. THE MANAGED CARE PLAN ACCOUNTABILITY ACT OF 1997

The MCPAA represented an effort to eliminate much of the confusion, by offering a definitive answer as to when ERISA preemption applies to managed care. The bill's author and chief sponsor, Fortney "Pete" Stark, says the MCPAA "would clear up the legal confusion over ERISA by giving patients the right to sue their health plans in federal court for compensatory as well as punitive damages, which can run into the millions of dollars."¹⁵⁵ He goes on to state that "HMOs have tried to shirk their responsibility to their patients by arguing technicalities shielded them from malpractice suits."¹⁵⁶ Stark further states that the motivation behind the act is "to guarantee that plans are responsible for their actions. If HMOs make bad medical decisions, the HMOs should be liable for their actions, just like other health care providers are today."¹⁵⁷

Despite Stark's enthusiasm, the bill does have its critics, primarily those within the managed care industry. Don White, a spokesman for the American Association of Health Plans, which represents MCOs, states, "[i]t appears that the Stark legislation would do little to promote high-quality and reasonably priced health care but much to increase litigation and provide employment for trial attorneys."¹⁵⁸ Undoubtedly, many individuals in the managed care industry who profit from the various cost-cutting measures employed by most MCOs would suffer if MCOs were held legally and financially liable for those decisions.

Sentiment is so strong on both sides of the debate because passage of an act like the MCPAA could result in broad changes, thereby forcing MCOs to reevaluate the fundamentals of how they operate. The MCPAA would hold group health plans or health insurance issuers, including MCOs, liable for damages if they fail to provide benefits in accordance with the terms of the plan because of a clinically or medically inappropriate decision resulting from cost containment measures.¹⁵⁹

Specifically, the MCPAA amends both ERISA and the Internal Revenue Code of 1986 "to improve and clarify accountability for violations with respect to managed care group health plans."¹⁶⁰ The MCPAA would expand ERISA's civil enforcement provisions to provide a remedy for "cost driven violations of

155. *Bill Would Allow Patients to Sue Plans*, AM. POL. NET. INC. HEALTHLINE, May 23, 1997, at 3.

156. *Id.*

157. *Id.*

158. Carlsen, *supra* note 11.

159. H.R. 1749, 105th Cong. (1997).

160. *Id.*

plan[s].”¹⁶¹ Under the MCPAA, MCOs could be held liable if a negligent denial of care resulted from any cost containment procedure or from any medical care delivery policy that interfered with the ability of medical professionals to fully advise and treat patients.¹⁶² For example, such cost-cutting procedures and policies would include gag-clauses prohibiting physicians from communicating openly with patients, use of gatekeepers to limit patient’s use of specialty care, capitation, and utilization review.

The MCPAA also amends ERISA’s remedial provisions to include compensatory and punitive damages.¹⁶³ The MCPAA would hold MCOs liable for actual, compensatory, consequential, and, in some cases, punitive damages.¹⁶⁴ This substantial change would mean that individuals who were wrongly denied a certain medical treatment because of an MCO’s cost containment measures could collect more than just the cost of the denied treatment, unlike the current law. Under the MCPAA, harmed individuals could collect damages for further medical treatment, to correct any error made by the MCO, lost wages, lost consortium, and punitive damages meant to punish the MCO for its improper decision.¹⁶⁵

The MCPAA further contains a provision that defines the type of plans to

161. H.R. 1749 § 2(a)(1) provides:

(a) ADDITIONAL REMEDIES FOR COST-DRIVEN VIOLATIONS OF PLAN TERMS—

(1) IN GENERAL—Section 502(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(c)) is amended—

(A) by redesignating paragraph (6) as paragraph (7); and

(B) by inserting after paragraph (5) the following new paragraph:

(6)(A) In any case in which a group health plan, or a health insurance issuer offering health insurance coverage in connection with such plan, provides benefits under such plan under managed care, and such plan or issuer fails to provide any such benefit in accordance with the terms of the plan or such coverage, insofar as such failure occurs pursuant to a clinically or medically inappropriate decision or determination resulting from—

(i) the application of any cost containment technique,

(ii) any utilization review directed at cost containment, or

(iii) any other medical care delivery policy decision which restricts the ability of providers of medical care from utilizing their full discretion for treatment of patients

162. H.R. 1749 § 2(a)(1).

163. H.R. 1749 § 2(a)(1)(B) would amend ERISA to say:

each specified defendant shall be jointly and severally liable to any participant or beneficiary aggrieved by such failure for actual damages (including compensatory and consequential damages) proximately caused by such failure, and may, in the court’s discretion, be liable to such participant or beneficiary for punitive damages.

164. *Id.*

165. *Id.*

which the additional ERISA provisions will apply.¹⁶⁶ The MCPAA applies to those plans that provide benefits under a managed care plan either by providing care through participating providers, such as a list of physicians participating in the plan, or providing financial incentives, such as low copayments or deductibles to encourage participants to visit participating physicians, or both.¹⁶⁷

The MCPAA also offers protection for physicians against liabilities created by MCO's cost containment procedures.¹⁶⁸ The MCPAA provides full indemnification to physicians bound by plan restrictions, such as gag clauses, if the limitations in the provider's contract interfered with medical

166. H.R. 1749 §2(a)(1)(B) would amend ERISA to say:

For purposes of this paragraph—

(i) a group health plan, or a health insurance issuer offering health insurance coverage in connection with the plan, provides benefits under 'managed care' if the plan or the issuer—

(I) provides or arranges for the provision of the benefits to participants and beneficiaries primarily through participating providers of medical care, or

(II) provides financial incentives (such as variable copayments and deductibles) to induce participants and beneficiaries to obtain the benefits primarily through participating providers of medical care, or both.

167. H.R. 1749 § 2(a)(1)(B).

168. H.R. 1749 § 2(a)(2)(B) provides:

Section 502 of such Act (29 U.S.C. 1132) is amended further by adding at the end of the following new subsection:

(n)(1) In any such case in which a group health plan, or a health insurance issuer offering health insurance coverage in connection with such plan, provides benefits under such plan under managed care, the plan shall provide for full indemnification of any participating provider of medical care for any liability incurred by such provider for any failure to provide any such benefit in accordance with the terms of the plan or such coverage, if such failure is the direct result of a plan restriction on medical communications under the plan.

(2) For purposes of this subsection—

(A) the term 'plan restriction on medical communications under a group health plan means a provision of the plan, or of any health insurance coverage offered in connection with the plan, which prohibits, restricts, or interferes with any medical communication as part of—

(i) a written contract or agreement with a participating provider of medical care,

(ii) a written statement to a participating provider of medical care, or

(iii) an oral communication to a participating provider of medical care.

communications.¹⁶⁹ The MCPAA would fully indemnify a physician if he faced liability because a managed care contract kept him from freely advising his patient, resulting in harm to the patient.¹⁷⁰ This would not be a complete bar to physician liability, but would hold MCOs accountable for their policies.

The MCPAA also amends the Internal Revenue Code of 1986 by establishing an excise tax for cost-driven violations of benefit plans.¹⁷¹ The MCPAA would hold MCOs liable if the coverage provider fails to provide any benefit outlined in the plans terms.¹⁷² Excise tax fines could also be imposed if a MCO physician fails to provide a benefit due to a clinically or medically inappropriate decision resulting from cost containment, utilization review, or a medical care delivery policy decision restricting the ability of health care professionals to use full discretion in treatment and diagnosis.

A. An Act Whose Time Has Come

MCOs can provide much needed medical care through innovation in a market where the cost of quality medical care is steadily growing. MCOs can also provide quality care at a fair cost, allowing many employers to offer group health care coverage they may not otherwise be able to afford. Still, despite these advancements, the development and regulation of managed care has presented problems. Managed care does not fare well in public opinion.¹⁷³ The changes suggested in the MCPAA could improve both the overall quality and the image of available medical care.

First, the MCPAA would protect physicians from unfair lawsuits by making health plans responsible for the constraints they place on providers. This protection would improve patient-physician relations by freeing physicians from some of the constraints under which they currently practice. Physicians would

169. *Id.* See also *supra* notes 45-48 and accompanying text (discussing gag-clauses).

170. H.R. 1749 § 2(a)(2)(B).

171. H.R. 1749 § 3(a) provides:

Chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end of the following new subchapter:

(a) In the case of a group health coverage to which this section applies, there is a failure to meet the requirements of this chapter if—

(1) the provider of such coverage fails to provide any benefit in accordance with the terms of the coverage, and

(2) such failure occurs pursuant to a clinically or medically inappropriate decision or determination resulting from the application of—

(A) any cost containment technique,

(B) any utilization review directed at cost containment, or

(C) any other medical care delivery policy decision which restricts the ability of providers of medical care from utilizing their full discretion for treatment of patients.

172. *Id.*

173. See Easterbrook, *supra* note 9, at 60; see also *supra* notes 135-43 and accompanying text.

no longer be forced to ration health care by limiting treatment and referrals to specialists to preserve their capitated payments. Also, physicians would be able to communicate openly with their patients and prescribe the best treatment available, even if it is not the one endorsed as most cost efficient by the MCO.

Second, the MCPAA would create an incentive for MCOs to engage in responsible treatment decisions. Under the current civil enforcement provisions of ERISA, MCOs face little financial risk in denying treatment or testing because, outside of attorney's fees, MCOs likely will pay only the cost of the denied testing or treatment should the plaintiff succeed in a lawsuit.¹⁷⁴ Under current law, little incentive exists to err on the side of caution because a victory for a challenging plaintiff costs little more than the cost of withholding treatment, especially considering that not all patients who are wrongly denied treatment or testing are likely to pursue legal vindication of their rights. The MCPAA would force MCOs to be more aggressive in guarding against negligent decisions because the cost of litigation and the possibility of expensive compensatory and punitive damages would often not be worth the risk of denying coverage if the MCO's administration had any doubts.

Third, under current law there is a gross difference in the amount of compensation available for persons covered under an ERISA plan and those who are not when identical harms occur.¹⁷⁵ Persons whose health plans are not governed by ERISA can now collect actual as well as compensatory and punitive damages because they are not limited by ERISA's remedial provisions. In contrast, individuals who are covered by ERISA may not seek comparable damages.¹⁷⁶

For example, in *Fox v. Health Net*,¹⁷⁷ the plaintiff's health plan was not subject to ERISA, which meant she could seek greater damages and the jury awarded one of the largest known medical malpractice judgments against an HMO, \$89 million.¹⁷⁸ In *Fox*, the insured's physician diagnosed advanced breast cancer but her health plan refused to pay for bone marrow transplantation, largely

174. See Carlsen, *supra* note 11.

175. See Harshbarger, *supra* note 7, at 198.

176. See *supra* notes 96-113 and accompanying text.

177. No. 219692 (Cal. Super. Ct. Dec. 23, 1993).

178. Harshbarger, *supra* note 7, at 198 (citing David Leon Moore, *Can Your HMO Hurt You?*, USA TODAY, Jan. 22, 1996, at D2). In *Fox*, the plaintiff had insurance through a public school benefit plan. See Jake McCarthy & Jeremy Berzon, *HMO Award Sends "Shock Waves:" It Encourages Lawmakers Seeking to Rewrite Laws, Worries the Health-Insurance Industry and Buys Patient-Rights Activists*, PRESS-ENTERPRISE (Riverside, Cal.), Jan. 23, 1999. ERISA did not preempt state law claims for punitive damages because ERISA does not cover governmental plans. See Harshbarger, *supra* note 7, at 198.

In February 1999, a California jury awarded \$120.5 million in damages to Teresa Goodrich when Aetna U.S. Healthcare refused to treat her husband's cancer. This represents the largest known medical malpractice judgment against an HMO. Like the plaintiff in *Fox*, Goodrich's health plan was not subject to ERISA. See *Aetna Held Liable for Death of Insured*, NAT'L L.J., Feb. 1, 1999, at B4.

because they considered it “experimental.”¹⁷⁹ Yet, the court found that ERISA did not preempt her claim because the insured carried her health plan through a governmental plan *not* regulated by ERISA.¹⁸⁰

In contrast, in *Turner v. Fallon Community Health Plan Inc.*,¹⁸¹ Turner’s physician also diagnosed advanced breast cancer and her MCO, Fallon, refused to cover a bone marrow transplant.¹⁸² When Mr. Turner brought suit against Fallon on behalf of his deceased wife, the court found the plan was subject to ERISA and the claim was preempted.¹⁸³ Turner recovered no damages.

The discrepancy between *Fox* and *Turner* is unjust: One plaintiff collects the largest judgment against an MCO to date while the other collects nothing, simply because ERISA covered one plan and not the other. MCOs that operate under ERISA should be held to the same standards as those health care organizations that do not operate under ERISA and are open to a higher degree of liability because they operate in the same market. MCOs would be able to financially withstand the heightened liability created by the Act and would not place America’s retirement and employer sponsored group health plans in danger. Large MCOs often have in excess of \$1 billion in liquid assets and most midsize MCOs have in excess of \$500 million.¹⁸⁴

Fourth, MCOs should be held liable for inadequate utilization review because utilization review determines the medical appropriateness of treatment or testing for a certain patient. A physician would certainly be held liable for making such a decision and the MCO, if engaging in a medical determination, should be held to the same standard. Despite the MCOs argument that they are simply making an administrative determination of whether a certain treatment falls within the limits of an individual’s policy, the administrators do categorize some treatments as unnecessary, which is arguably a medical or clinical determination. MCOs, in an effort to contain cost, weigh the necessity of a medical procedure against its cost and engage in decisions outside of simple procedural ones.

Fifth, legislative action is needed because federal case law has not filled the void left by ERISA. Because ERISA preempts state laws that attempt to regulate MCOs, “a vacuum is created in which the states may not regulate and Congress has not—a vacuum that is slowly being filled by judge-made, federal common law. The result has been fragmented, inefficient, and inappropriate regulation of MCOs at both the state and federal levels.”¹⁸⁵ Congress could eliminate the

179. See Elizabeth C. Price, *The Evolution of Health Care Decision-Making: The Political Paradigm and Beyond*, 65 TENN. L. REV. 619, 633 (1998).

180. See *id.*; see also 29 U.S.C. § 1003(b)(1) (1994 & Supp. II 1996); *supra* note 71 and accompanying text.

181. *Turner v. Fallon Community Health Plan, Inc.*, 127 F.3d 196 (1st Cir. 1997). See also *First Circuit Affirms Ruling that ERISA Does Not Provide Damages Remedy for Plan’s Refusal to Cover Excluded Treatment*, HEALTH L. DIGEST (BNA), Nov. 1997, at 41.

182. *Turner*, 127 F.3d at 197.

183. *Id.* at 198-99, 200.

184. See Harshbarger, *supra* note 7, at 222.

185. Margaret G. Farrell, *ERISA and Managed Care: The Law Abhors a Vacuum*, 29 J.

vacuum by passing the MCPAA, which offers definitive answers where the courts have not by amending ERISA to create a right of action where none existed before. This would put an end to the uncertainty of judicial decisions regarding ERISA. Health care now exists in somewhat of an unregulated market¹⁸⁶ and the MCPAA would offer uniform federal regulation that would protect patients by holding an MCO responsible for its actions.

Sixth, the MCPAA would restore the regulation of health to its traditional position as a state function. The Court in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers* held that “in cases like this one, where federal law is said to bar state action in fields of traditional state regulation” such as regulation of health and welfare, “the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.”¹⁸⁷ The Court in *Travelers* examined the legislative history of ERISA and found nothing definitive in ERISA’s language indicating an intent to usurp state health regulation power.¹⁸⁸ The Court also pointed to a strong presumption against preemption where health care regulations within the traditional police power of the states are concerned.¹⁸⁹

Seventh, in the field of managed care, ERISA has not met its goal of uniform regulation. The goal behind ERISA was to provide uniform regulation for employer-sponsored retirement plans, yet liability of managed care provided by ERISA plans still remains in flux. While most courts hold that ERISA does preempt claims of negligence outside of ERISA, some courts have found such claims are not preempted. This confusion aggravates ERISA’s goal of uniformity and creates uncertainty. This uncertainty surrounding managed care liability could be solved by the passage of the MCPAA.

Finally, passage of legislation interpreting ERISA would allow Congress to speak regarding regulation of the managed care industry. Congress did not have this opportunity when ERISA was originally passed because managed care had not yet entered the health care market in the capacity it now holds. Because the traditional fee-for-service model was much more prevalent than managed care when Congress passed ERISA, the legislators did not consider the ramifications of limiting the liability of MCOs.¹⁹⁰ Congress now has the opportunity to provide for the uniform regulation of health care plans by clearly setting out what remedies are available to individuals harmed by the cost cutting measures that drive MCOs. The courts have indicated not only a need to reevaluate ERISA, but have allocated the job to Congress.¹⁹¹

HEALTH & HOSP. L. 268 (1996).

186. *See id.*

187. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers*, 514 U.S. 645, 655 (1995).

188. *Id.* at 656-57.

189. *Id.* *See also* Jordan, *supra* note 65.

190. *See* Harshbarger, *supra* note 7, at 216.

191. *See* Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992) (holding ERISA preempts state medical malpractice claims against an MCO). The court stated:

B. Where Did the MCPAA Go?

Representative Stark introduced the MCPAA on May 22, 1997.¹⁹² In his remarks to the House of Representatives, immediately after introducing the bill, he stated, “[o]ur legislation is fair and long overdue. Plans that actively manage the care of their enrollees must be held accountable for their decisions. Employees of ERISA-regulated health plans deserve the same rights and protections as people in non-ERISA plans.”¹⁹³ The bill was promptly referred to both the House Committee on Education and the Workforce and the House Committee on Ways and Means for consideration.¹⁹⁴ When subsequently referred to the Subcommittee on Employer-Employee Relations on June 17, 1997, the MCPAA died in committee.¹⁹⁵ The MCPAA attracted thirty-one cosponsors, the last of whom joined in mid-November 1997.¹⁹⁶ However, support for the MCPAA was diluted by the presence of several other managed care reforms also before Congress that are discussed in the next section. Despite the fact that the MCPAA did not pass, similar legislation is likely to appear before future Congresses and the MCPAA represents a first step in solving a

While we are confident that the result we have reached is faithful to Congress’s intent neither to allow state-law causes of action that relate to employee benefit plans nor to provide beneficiaries in the Corcorans’ position with a remedy under ERISA, the world of employee benefits has hardly remained static since 1974. Fundamental changes such as the widespread institution of utilization review would seem to warrant a reevaluation of ERISA so that it can continue to serve its noble purpose of safeguarding the interests of employees. Our system, of course, allocates this task to Congress, not the courts, and we acknowledge our role today by interpreting ERISA in a manner consistent with the expressed intentions of its creators.

Id. at 1338-39.

192. H.R. 1749, 105th Cong. (1997).

193. 143 CONG. REC. E1036 (May 22, 1997).

194. *See* H.R. 1749, Bill Tracking Report, 105th Cong. (1997).

195. *See id.*

196. Co-sponsors joining on May 22, 1997 included: Representatives Howard L. Berman (D-CA), Ronald V. Dellums (D-CA), George Miller (D-CA), Nancy Pelosi (D-CA), Ellen O. Tauscher (D-CA), Henry A. Waxman (D-CA), John Lewis (D-GA), Barney Frank (D-MA), James P. McGovern (D-MA), John F. Tierney (D-MA), Dale Kildee (D-Mich), Lynn N. Rivers (D-MI), Nita Lowey (D-NY), Charles B. Rangel (D-NY), Dennis J. Kucinich (D-OH), Peter A. DeFazio (D-OR), Patrick J. Kennedy (D-RI), Martin Frost (D-TX), Bernard Sanders (I-VT), Donna M. Christian-Green (D-VI), and Gerald D. Kleczka (D-WI). Co-sponsors joining on July 14, 1997 included: Representatives Lynn C. Woolsey (D-CA), David E. Bonior (D-MI), and Thomas M. Foglietta (D-PA). Representative Frank Pallone Jr. (D-NH) joined on October 28, 1997. Representatives Lane Evans (D-IL), Sidney R. Yates (D-IL), Jerrold Nadler (D-NY), and Eddie Bernice Johnson (D-TX) joined as cosponsors on November 6, 1997. Representative Robert A. Weygand (D-RI) joined on November 12, 1997 and Representative Marcy Kaptur (D-OH) joined on November 13, 1997. *See id.*

difficult problem.

VI. OTHER PROPOSED MANAGED CARE LEGISLATION

While the MCPAA of 1997 did not survive the 105th congressional session, it, along with other legislation, focused attention on the need for reform. There were four similar acts in Congress that would have specifically made ERISA preemption less viable as a defense against liability in the managed care setting. The four acts that proposed to limit ERISA preemption represent a clear indication that the problem will be addressed through federal legislation in a later session. Because so much legislation is aimed at correcting the confusion that currently exists, it is likely that a measure addressing managed care liability will soon become law.

Senator Edward M. Kennedy introduced the Health Insurance Bill of Rights Act of 1997 ("HIBRA"), on February 27, 1997.¹⁹⁷ In part, this bill would amend ERISA "to establish standards for protection of consumers in managed care plans and other health plans."¹⁹⁸ The HIBRA specifically provides for standard utilization review procedures, protection of confidentiality of patient records, establishment of a grievance procedure, prohibition of gag clauses and other limits on communications between physician and patient, easier access to specialty care, and coverage for emergency visits without pre-authorization.¹⁹⁹ The HIBRA was referred to the Committee on Labor and Human Resources in February 1997 but hearings were not held until May 1998.²⁰⁰ The Congressional session ended without any formal action being taken on the HIBRA.

Representative Charlie Norwood proposed the Patient Access to Responsible Care Act of 1997 ("PARCA"), on April 23, 1997.²⁰¹ Norwood introduced the PARCA as "[a] bill to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to establish standards for relationships between group health plans and health insurance issuers with enrollees, health professionals, and providers."²⁰² Specifically, the PARCA would require health insurance issuers to provide covered services to all enrollees, including full access to emergency and immediate care without prior authorization and access to specialized treatment.²⁰³ The PARCA would regulate utilization review and physician incentive plans that contain cost and limit communications between the physician and the patient.²⁰⁴ The PARCA also amends ERISA section 514 so that it no longer preempts state laws dealing with managed care liability.²⁰⁵ The

197. S. 373, 105th Cong. (1997).

198. *Id.*

199. *Id.*

200. *See* S. 373, Bill Tracking Report, 105th Cong. (1997).

201. H.R. 1415, 105th Cong. (1997).

202. *Id.*

203. *Id.*

204. *Id.*

205. H.R. 1415 § 4(a) provides: "[T]his section shall not be construed to preclude any State

bill had 234 cosponsors in the House.²⁰⁶ On April 24, 1997 Senator Alfonse D'Amato introduced a companion bill in the Senate. D'Amato's bill had four cosponsors.²⁰⁷ Subcommittee hearings were held in the House Subcommittee on Employer-Employee Relations, the House Subcommittee on Health and Environment, and the Senate Committee on Labor and Human Resources, but the legislation died in subcommittee before the end of the congressional session.²⁰⁸

Representative Marge Roukema introduced the Quality Health Care and Consumer Protection Act ("QHCCPA"), in the House on March 21, 1997.²⁰⁹ The QHCCPA is "[a] bill to amend the Employee Retirement Income Security Act of 1974 and the Public Health Service Act to require managed care group health plans and managed care health insurance coverage to meet certain consumer protection requirements."²¹⁰ Roukema's comprehensive legislation attacks managed care organizations and further requires them to cover emergency services, even when not pre-approved, when a "prudent layperson" would assume that immediate medical attention was necessary.²¹¹ The legislation also prohibits the use of physician gag clauses, requires disclosure of physician payment arrangements to all enrollees, imposes restrictions on denying coverage of experimental treatment, provides protection for confidentiality of medical records, and creates a structured grievance procedure.²¹² Similar to the other managed care legislation, the QHCCPA died in subcommittee.²¹³

Representative Charlie Norwood introduced the Responsibility in Managed Care Act of 1997 ("RMCA"), on November 8, 1997.²¹⁴ The RMCA is a bill that would amend ERISA "to clarify the preemption of State law by such title with respect to causes of action for damages for personal or financial injury of

cause of action to recover damages for personal injury or wrongful death against any person that provides insurance or administrative services to or for an employee welfare benefit plan maintained to provide health care benefits."

206. H.R. 1415, Bill Tracking Report, 105th Cong. (1997).

207. S. 644, 105th Cong. (1997); S. 644, Bill Tracking Report, 105th Cong. (1997).

208. H.R. 1415, Bill Tracking Report, 105th Cong. (1997); S. 644, Bill Tracking Report, 105th Cong. (1997).

209. H.R. 1222, 105th Cong. (1997).

210. *Id.*

211. *Id.*

212. *Id.* Representative Roukema also stated:

Medical professionals for generations have worked long and hard to give the United States the highest standard of medical care in the entire world. Our physicians, nurses, and medical researchers have performed miracles in combating dreaded disease, repairing ghastly injuries, and correcting infirmities. We cannot allow green-eyedshadded [sic] bean counters in insurance company accounting departments to throw that progress away. With a health care system that is the envy of the world, we must not allow the United States of America to slip to third world standards of medicine.

143 CONG. REC. E564 (Mar. 21, 1997).

213. *See* H.R. 1222, Bill Tracking Report, 105th Cong. (1997).

214. H.R. 2960, 105th Cong. (1997).

wrongful death resulting from failures to provide benefits under employee welfare benefit plans providing health care benefits.”²¹⁵ The RMCA had sixteen co-sponsors.²¹⁶ Like the MCPAA, the RMCA would increase the liability of managed care organizations by limiting the use of ERISA preemption as a defense against injury and wrongful death.²¹⁷

CONCLUSION

The time has come for reform. The MCPAA, or other similar legislation, could put an end to the confusion courts have created over the application of ERISA preemption. Such legislation would make equitable damages available to all plaintiffs injured by MCOs and heighten the standard of care available by creating a federal right of action holding MCOs liable for their cost containment measures.

Legislation limiting ERISA preemption would protect physicians from unfair lawsuits by making health plans responsible for the constraints they place on providers, creating an incentive for MCOs to engage in responsible treatment decisions, and making equal damages available to those individuals whose health plans are covered by ERISA. Legislation is vital because MCOs should be held liable for inadequate utilization review, as utilization review determines medical appropriateness of treatment or testing for a certain patient. Further, an act like the MCPAA could fill the void federal case law has created with ERISA preemption. Such change could bring uniformity to the field of managed care, a goal ERISA has not achieved. Legislative action would also allow Congress to speak regarding regulation of the managed care industry, an opportunity they did not have when Congress originally passed ERISA, because managed care had not yet entered the health care market with the force that exists today.

Remember Florence, the woman who lost her unborn child because her MCO determined inpatient care was not cost effective? Had the MCPAA, or comparable legislation, been the law when her child died, Florence could have sued her MCO to vindicate her rights. If MCOs are held accountable for their decisions, patient care may replace cost containment as a priority, leading to a better quality of healthcare for America’s workforce and their families.

215. *Id.*

216. *Id.*

217. The RMCA rewrites 29 U.S.C. § 1144(b) to provide that ERISA “shall not apply to any cause of action to recover damages for personal or financial injury or wrongful death against any person that provides insurance or administrative services to or for an employee welfare benefit plan maintained to provide health care benefits.” H.R. 2960, 105th Cong. (1997).