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**Comments**

ERISA Preemption of Medical Malpractice Claims Against Managed Care Organizations

The balance of power in the health care arena is shifting to managed care organizations and away from individual physicians and hospitals. Traditionally, courts applied tort theory to compensate patients proving harm caused by the incompetent practice of medicine. Plaintiffs seeking to sue managed care organizations for medical malpractice are often finding today, however, their claims are preempted by the Employee Retirement Income Security Act of 1974 ("ERISA").

**Emergence of Managed Care Organizations**

Due primarily to steadily increasing health care costs, managed care organizations have proliferated. Additionally, enrollment in managed care organizations has been continuously expanding. Managed care organizations began to appear in the early 1970's, covering approximately 3.6 million people. By 1995, almost 150 million Americans had enrolled in managed care organizations. Additionally, in 1997, almost 75% of people insured through their

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3. Harshbarger, supra note 2.
employers were enrolled in a managed care plan. The explosive growth of managed care is evidenced by the fact that just two years earlier, in 1995, managed care plans covered only 51% of Americans.

As a result of the increasing enrollment in managed care organizations, the health care market has consolidated substantially. Health insurers, physicians, and hospitals, once separate entities, are joining to form managed care organizations. Physicians and hospitals are joining managed care organizations, in part, out of fear of losing patients to the managed care plans. The pace of change is likely to continue at a high rate.

**WHAT IS A MANAGED CARE ORGANIZATION?**

A managed care organization is a "framework" for reducing and restraining costs for the provision of health care. Costs are controlled by providing care through alternative delivery systems and other cost-restricting methods such as pre-admission...
certification, concurrent review, discharge planning, case management, and utilization review.\textsuperscript{12}

A managed care plan combines financing (insurance) and health care delivery.\textsuperscript{13} The following features characterize managed care organizations:

(1) the organization delivering benefits assumes some or all of the financial risk for furnishing those benefits;
(2) the benefits are restricted to those designated in the contract;
(3) coverage is limited to services provided by a specified group of providers (physicians);
(4) benefits and coverage are constrained by assorted payment controls;
(5) network physicians typically must accept plan payments as payments in full for medical care provided (in addition to co-payments in some plans);
(6) benefits and coverage are subject to various utilization procedures (including pre-certification and utilization review);
(7) physicians are employed either by, or under contract with, the managed care organization;
(8) if plan enrollees receive treatment from a physician who is not in the managed care organization, the plan will likely not pay for the services.\textsuperscript{14}

A managed care plan is made up of "a series of interlocking and overlapping legal relationships — primarily those between the employer and the managed care organization ("MCO") and the MCO and its providers."\textsuperscript{15} Several types of managed care plans exist,
including the staff-model health maintenance organization ("HMO"), group-model HMO, network-model HMO, independent practice association ("IPA") HMO, preferred provider organization ("PPO"), exclusive provider organization ("EPO"), managed indemnity plan, and point-of-service Plan ("POS").

Managed care organizations limit health care costs by reducing the amount of care provided to the participants (fewer referrals to specialists, tests, and procedures) and by implementing payment schemes for physicians. Managed care organizations may reimburse physicians for their services by fee-for-service, capitation, or financial incentive arrangements.

Managed "fee-for-service" payment discounts the physician’s usual and customary payment. Payment by "capitation" generally reimburses the physician each month with a specific payment for each enrollee. "Financial incentive arrangements" are characterized by specific funds (risk pools) set aside for disbursement at the end of each year, allocated using performance goals or the physician's expenditure projections. Performance goals may be set for hospital referrals, emergency room referrals, consultative (specialist) services, tests and procedures, or quality improvement.

16. Physician Review Commission, supra note 8, at 190. The report listed the following types of Managed Care Plans:

Staff-Model HMO: A plan that directly hires its physicians.

Group-Model HMO: A plan that contracts with a single physician group, usually on an exclusive basis.

Network-Model HMO: A plan that contracts with several physician groups, usually on a nonexclusive basis.

Independent Practice: A plan that contracts with Association (PA) HMO individual physicians or physician groups, usually on a nonexclusive basis.

Preferred Provider: A plan that contracts with Organization (PPO) individual physicians for fee discounts, but which is usually not at risk.

Exclusive Provider: A type of PPO in which enrollees Organization (EPO) are only covered for services of network providers.

Managed Indemnity Plan: A plan that imposes some type of utilization review on the care delivered by any provider. Providers do not have contracts with the plan.

Point-of-Service: A managed care product, (POS) Plan sometimes called an open-ended HMO, in which the enrollee has the option of obtaining care from a non-network provider at a higher out-of-pocket cost.

Id. See also Battaglia, supra note 11, at 186.


18. Battaglia, supra note 11, at 176-77.

19. Id.

20. Id. A "capitation agreement" requires a physician to provide care to a patient, regardless of how many office visits are required. Consequently, the physician assumes the financial risk. The physician risks having a set of patients who require more than the average amount of care. Id.
assurance pools.\textsuperscript{21}

\textbf{MEDICAL MALPRACTICE AND MANAGED CARE ORGANIZATIONS}

Tort law "is a body of legal principles" which controls damaging behavior, allocates responsibility for harms that arise in social interaction, and provides compensation for those injured with valid claims.\textsuperscript{22} Tort liability, which is premised upon a breach of a duty owed by one party to another without regard to promises (contracts), embraces both intentional and unintentional acts.\textsuperscript{23} Medical malpractice is a form of negligence, which is an unintentional tort.\textsuperscript{24}

In the past, plaintiffs, when suing for medical malpractice, typically brought suit against the physician and/or the hospital. With their explosive growth and methods of making medical care decisions, managed care organizations have become the targets of plaintiffs' medical malpractice claims.\textsuperscript{25} MCOs may be liable for medical practice for their own actions, or corporate negligence.\textsuperscript{26} They may also be liable for the malpractice of their physicians under imputed or actual agency theories.\textsuperscript{27}

\begin{itemize}
\item \textsuperscript{21} \textit{Id.} \textit{See also} Council on Ethical and Judicial Affairs, \textit{supra} note 17.
\item \textsuperscript{22} W. PAGE KEETON ET AL., \textsc{Tort and Accident Law} 1 (2d ed. 1989).
\item \textsuperscript{23} \textit{Id.}
\item \textsuperscript{24} \textit{Id.} The elements of a cause of action of negligence are: (1) duty (recognized by law); (2) breach of duty; (3) actual (defendant's action or inaction actually caused the plaintiff's harm) and proximate cause (recognized by law); and (4) damage (actual loss or damage to the interests of the plaintiff). W. PAGE KEETON ET AL., \textsc{PROSSER AND KEETON ON THE LAW OF TORTS} \textsection 30, at 164-65 (5th ed. 1984).
\item The elements of a cause of action for medical malpractice have evolved to correspond to those of a negligence action. To be successful, the plaintiff in a medical malpractice action must establish: (1) that the physician owed her a legal duty; (2) that the physician breached that duty by failing to conform to an acceptable standard of care; (3) that the plaintiff suffered actual injury; and (4) that the physician's conduct caused the injury suffered. Mary S. Newbold, \textit{Medical Malpractice Law: Pennsylvania's "Two Schools of Thought,"} 66 \textsc{Temp. L. Rev.} 613, 628 n.28 (1993).
\item \textit{Id.}
\item Katherine Benesch, \textit{Managed Care Liability: An Expansion of Familiar Theories}, 9(3) \textsc{The Health Lawyer} 8 (Spring 1997).
\item \textit{Id.} supra note 2, at 136-37.
\item \textit{Id.} Imputed agency, or ostensible agency, occurs when (1) a patient looks to the institution (hospital or managed care organization) and not the individual physician for care; and (2) the institution holds out the physician as its employee. McClellan v. Health Maintenance Org. of Pa., 604 A.2d 1053, 1057 (Pa. Super. Ct. 1992). With ostensible agency, the physician is not an institution employee, but has arranged to care for patients at the hospital or patients enrolled with the managed care organization. The Restatement (Second) of Agency describes ostensible agency as: "One who represents that another is his servant or other agency and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of
In addition to medical malpractice, courts are finding managed care organizations liable for such non-tort causes of action as breach of contract, breach of fiduciary duty, breach of warranty, and misrepresentation/false advertising. Suits against MCOs have originated due to complaints about their decisions and rules, such as "the 24-hour-stay limitation for childbirths, breaches of patient confidentiality in patient records, the delays and hassles involved in obtaining specialist referrals," the availability, but non-use, of high-tech and high-cost therapies and negligent selection and retention of physicians. The conflicting goals of managed care (the reduction of health care costs and the provision of quality health care) are causing serious problems, however, for managed care plan enrollees.

ERISA

Many managed care plan participants have discovered that they cannot pursue claims against their managed care organization.
because ERISA often preempts those claims. Congress enacted ERISA in 1974 "to protect participants in employee benefit plans and their beneficiaries." The growth in size, scope, and number of employee plans provided the impetus for the Act. ERISA requires "the disclosure and reporting of financial and other information and the establishment of standards of conduct for fiduciaries of employee benefit plans." ERISA provides relief to plan beneficiaries for ERISA violations in the federal court system. The


34. Bales, supra note 7, at 643. "Preemption" is a doctrine adopted by the Supreme Court of the United States that holds that federal laws with a national character preempt, or take precedence, over state laws. A state may not enact a law which is inconsistent with federal law. Black's Law Dictionary 1177 (6th ed. 1990).

35. Battaglia, supra note 11, at 205-206. See also Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 90-91 (1983); Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 137 (1990). The Court was concerned that workers close to retirement were losing their pensions. Additionally, the Court found that pension plans were becoming more popular. Robert A. Cohen, Understanding Preemption Removal under ERISA § 502, 72 N.Y.U. L. Rev. 578, 588 (1997). "Thus, the central purpose of ERISA was to safeguard the benefit expectations of workers, while encouraging the growth of pension plans. Prior to ERISA, there was only an ineffective patchwork of state regulation covering this field; no federal remedy was available to workers who felt that they had been unfairly deprived of the pensions." Id. at 589.

36. 29 U.S.C. § 1001(a). The statute provides:

Congressional findings and declaration of policy.

(a) The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits. . . .

Id.

37. Battaglia, supra note 11, at 205-206.

38. Id. 29 U.S.C.A. § 1132 provides:

Civil enforcement.

(a) Persons empowered to bring a civil action

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 [supply requested information]

(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;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate
primary purpose of ERISA was to create a uniform national regulatory scheme pertaining to employee benefit plans, replacing conflicting state regulations. ERISA does not require employers to provide any specific benefits, however.

Pension plans and welfare plans are the two types of employee benefit plans subject to ERISA. Pension plans provide income to employees after retirement. Welfare plans provide various employee benefits, such as medical, health, accident, disability, death, unemployment, paid vacation, training programs, day-care services, scholarship funds, and legal services. ERISA covers pension and welfare plans offered by employers to their employees. ERISA medical plans cover more than one-half of all American workers.

ERISA PREEMPTION

ERISA preempts state law that "relates to" an employee benefit plan. However, laws that regulate insurance are exempt from...
ERISA preemption in the "savings clause" of the Act.\textsuperscript{47} "State law" includes "all laws, decisions, rules, regulations, or other State action having the effect of law."\textsuperscript{48} If ERISA preempts a claim against a managed care organization, it is likely that the plan participant will be without redress because ERISA remedies have been frequently interpreted to be limited to those provided by the statute.\textsuperscript{49} Under ERISA, remedies are limited to the recovery of benefits, enforcement of rights, or clarification of future benefits under the plan. The statute does not specifically provide for compensatory or punitive damages.\textsuperscript{50}

Four categories of laws relate to an employee plan.\textsuperscript{51} The first category consists of laws that regulate the types of benefits or

\textsuperscript{47} 29 U.S.C. § 1144(b) provides, in part:

\begin{itemize}
  \item \textsuperscript{(b)} Construction and application
    \begin{itemize}
      \item \textsuperscript{(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.}
    \end{itemize}
\end{itemize}

\textsuperscript{48} The traditional three step analysis to determine if a state law is preempted by ERISA is:

\begin{itemize}
  \item (1) does the law "relate to" an employee benefit plan?;
  \item (2) if so, is the state law "saved" from preemption under one of the specified exceptions to preemption (e.g., laws governing insurance, banking, security, generally applicable criminal laws, etc.)?;
  \item (3) even if apparently saved under the insurance exception, does the state law violate the "deemer" clause (i.e., is the state trying to circumvent preemption through the insurance exception by "deeming" a plan to be an insurer)?
\end{itemize}


\textsuperscript{50} 29 U.S.C. § 1132(a)(1)(B).

\textsuperscript{51} L. Frank Coan, Jr., \textit{You Can't Get There From Here — Questioning the Erosion of ERISA Preemption in Medical Malpractice Actions Against HMOs,} 30 GA. L. REV. 1023, 1049 (1996).
terms of ERISA plans. The second category includes laws that require ERISA plans to report, disclose, fund, or vest. Laws that provide parameters for the calculation of the quantity of benefits comprise the third category. Finally, laws and common-law rules that provide redress for misconduct arising from the administration of the ERISA plan constitute the fourth category.

State courts, federal district courts, and federal circuit courts are split concerning whether ERISA preempts negligence claims against managed care organizations. Some courts have distinguished negligence cases based upon failure to authorize treatment or administration of the plan (usually preempted) from medical malpractice claims against a physician (sometimes not preempted).

COURT DECISIONS ADDRESSING ERISA PREEMPTION

Some state courts have held that ERISA does not preempt a medical malpractice claim against a managed care organization. Pennsylvania and Minnesota have allowed plaintiffs to proceed with their medical malpractice suits. Other states, such as Texas and California, have held that ERISA does preempt such a claim.

Typically, defendant managed care organizations remove medical malpractice cases to federal court and allege preemption. Federal

52. Id.
53. Id.
54. Id.
55. Id.
56. Borzi, supra note 2, at 162. See also Harshbarger, supra note 2, at 192; Clifford, supra note 4, at 8.
57. Clifford, supra note 4, at 8. See also Liability: DOL Opposes Malpractice Preemption for Plans; Lawmakers, AMA Take Interest, BNA HEALTH CARE DAILY, Apr. 4, 1997, at d2.
59. Williams v. Good Health Plans, Inc., 743 S.W.2d 373 (Tex. App. 1988) (holding that a managed care organization is incapable of practicing medicine, so it cannot be held liable for medical malpractice); Wickline v. California, 228 Cal. Rptr. 661 (Cal. Ct. App. 1986) (holding that Medi-Cal, a state of California health plan, was not liable for harm caused by cost containment program when patient discharged from hospital too soon).
district courts, however, also have reached inconsistent decisions regarding ERISA preemption of negligence claims against managed care organizations.60 District courts in Connecticut, Mississippi, Texas, New Jersey, and New York have determined that ERISA preempts medical malpractice claims against managed care organizations.61 Conversely, district courts in Pennsylvania and Virginia have held that ERISA does not preempt such claims.62

Like the district courts, circuit courts have also reached conflicting decisions regarding ERISA preemption of medical malpractice cases against managed care organizations. The Third and Tenth Circuits have determined that ERISA does not preempt malpractice claims against HMOs.63 The Seventh Circuit has

60. Cohen, supra note 35. "Removal," or "removal of causes," is the transferring of a case from one court to another, such as from state to federal court. BLACK'S LAW DICTIONARY 1285, 1296 (6th ed. 1990). Generally, a defendant can remove a case filed in state court to federal court if the claim arises under federal law. Cohen, supra note 35, at 578. When ERISA preemption is asserted by a defendant as a defense to a state law claim brought in state court, the defendant may remove the case from state court to federal court. Id.


63. Dukes v. U.S. Healthcare, Inc., 57 F.3d 350, 353-54 (3d Cir. 1995). In Dukes, two cases were consolidated. Id. at 351. The two plaintiffs (the estates of Dukes and Visconti) brought medical malpractice actions in state court against HMOs organized by U.S. Healthcare, Inc. Id. The defendant HMOs removed the cases to federal court, arguing that ERISA preempted the claims. Id. The district court dismissed the claims, agreeing that ERISA preempted. Id. The Third Circuit reversed. Dukes, 57 F.3d at 352. The claim brought by appellant estate of Dukes alleged that the HMO refused to perform blood studies of the decedent who had an extremely high blood sugar level just before his death. Id. at 352. The claim brought by appellant estate of Visconti alleged malpractice in the care of her pregnancy. Id. at 353. The Third Circuit held that a well-pleaded complaint alleging negligence is not preempted by ERISA if it does not question a denial of benefits, but instead challenges the quality of benefits received. Id. at 356.

Pacifcare of Oklahoma v. Burrage, 59 F.3d 151 (10th Cir. 1995). In Pacifcare, the plaintiff filed a malpractice action in state court against Pacifcare of Oklahoma, Inc., an HMO. Pacifcare, 59 F.3d at 152. The action was removed to federal court where the district court held that ERISA preempted one of the claims and remanded the other two claims to the state court. Id. Pacifcare sought a writ of mandamus directing the district court judge to rescind his order remanding the two claims to state court and to find them also preempted by ERISA. Id. The Tenth Circuit denied the writ of mandamus. Id. at 155.
decided that ERISA preempts vicarious liability claims, but does not preempt medical malpractice claims brought under the theory of *respondeat superior.* The Fifth, Sixth and Eighth Circuits have held, without qualification, that ERISA preempts medical malpractice actions.

In an issue of first impression by a circuit court, the Tenth Circuit decided whether ERISA preempts a claim that an HMO is vicariously liable for the alleged malpractice of one of its physicians. *Id.* at 153. The district courts are divided on the issue. *Id.*

The *Pacificare* court explained that "ERISA does not preempt laws of general application — not specifically targeting ERISA plans — that involve traditional areas of state regulation and do not affect relations among the principal ERISA entities." *Id.* at 154. The Tenth Circuit held that ERISA does not preempt a vicarious liability claim against an HMO, as it does not preempt a malpractice claim against a doctor. *Id.* at 155.

64. *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996). In *Jass,* the plaintiff brought a medical malpractice claim against a managed care plan, alleging vicarious liability for the medical practice of a physician who was not a managed care plan employee. *Id.* at 1484. A claim was also brought against a nurse employed by the managed care plan. *Id.* The Seventh Circuit held that the vicarious liability negligence claim was preempted by ERISA. *Id.* at 1485. The court explained that the vicarious liability claim "relates to" a benefit plan. *Id.* at 1491. The *Jass* court characterized the negligence suit against PruCare as a denial of benefits claim. *Id.* at 1490.

65. *Rice v. Panchal,* 65 F.3d 637 (7th Cir. 1995). *Rice* brought a medical malpractice action against his physicians and his health plan administrator, the Prudential Insurance Company of America, under the theory of *respondeat superior.* *Id.* at 638. The Seventh Circuit found a factual issue as to whether the physician was an employee of the managed care organization. *Id.* at 645. The *Rice* court held that no preemption of a medical malpractice claim exists against a managed care organization under the theory of *respondeat superior.* *Id.* at 646. The claim was not preempted because it did not rest on the terms of the plaintiff's ERISA plan. *Id.* at 642.


In *Corcoran v. United Healthcare, Inc.*, the plaintiff was a member of a health plan funded by her employer and administered by defendant Blue Cross and Blue Shield of Alabama. *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1322-23 (5th Cir.), cert. denied, 113 S. Ct. 812 (1992). The plan, Medical Assistance Plan ("MAP"), refused to allow the plaintiff to be hospitalized for the final months of her pregnancy, and the unborn child died. *Id.* Under a portion of the Plan, "Quality Care Program" ("QCP"), participants of the plan had to obtain advance approval for hospital admissions and specified medical procedures. *Id.* at 1323. Continued approval had to be obtained for a hospitalized participant. *Id.* QCP, administered by defendant United HealthCare, was a form of cost-containment known as "utilization review," in which evaluations of care were made using established clinical criteria. *Id.*

Mrs. Corcoran and her husband, the plaintiffs, brought a wrongful death action in Louisiana state court, alleging that the death of their unborn child was the result of the negligence of Blue Cross and United HealthCare. Additionally, Mrs. Corcoran alleged aggravation of a pre-existing depressive condition and Mr. Corcoran sought damages for loss of consortium. *Id.* at 1324.

The defendants removed the case to federal court. *Id.* The district court granted the defendants' motion for summary judgment, holding that ERISA preempted the claims. *Id.* at 1325. The Fifth Circuit affirmed, holding that ERISA preempted the medical malpractice
The Supreme Court of the United States has not yet decided a case concerning the medical malpractice of a managed care organization. Other ERISA cases, however, provide guidance for predicting how the Supreme Court may rule. In Shaw v. Delta Air Lines, Inc., airlines and other employers sought a declaratory judgment that ERISA preempted New York's Human Rights law and disability benefit statutes. The laws prohibited discrimination in employment, including discrimination on the basis of pregnancy in employee benefit plans. The Supreme Court held that ERISA preempted the New York Human Rights law only insofar as it prohibited practices that were lawful under federal law. The Court further held that ERISA did not preempt the disability benefits law, although New York could not enforce its provisions through regulation of ERISA-covered benefit plans.

In describing preemption by ERISA, the Court held that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." However, many District and Circuit Courts determined after Shaw that medical malpractice claims were not

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68. Id.
69. Id. New York could not require an employer to amend its ERISA plan to comply with the law, however, New York could compel an employer to maintain a separate plan if necessary (for instance to provide pregnant employees with adequate disability benefits). Id. at 100 n.21.
“too tenuous, remote, or peripheral” to escape preemption by ERISA.\textsuperscript{71}

In \textit{Pilot Life Ins. Co. v. Dedeaux}, the Supreme Court held that ERISA preempts state common-law tort and contract actions, asserting improper processing of a claim for benefits under an insured employee benefit plan.\textsuperscript{72} The Court declared that the “question whether a certain state action is pre-empted by federal law is one of congressional intent. The purpose of Congress is the ultimate touchstone.”\textsuperscript{73} In favor of preemption, one could argue that Congress intended to create one uniform set of laws affecting benefit plans.\textsuperscript{74} However, in opposition to preemption, one could argue that Congress enacted ERISA to benefit employees, not to take remedies away for common-law torts.

The divergent views among state and federal courts regarding


\textsuperscript{72} Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 43-44 (1987). In \textit{Pilot Life}, the plaintiff, Everate Dedeaux, injured his back in an employee related accident. Dedeaux was covered by a long term disability employee benefit plan backed by a group insurance policy from Pilot Life Insurance Company ("Pilot Life"). After two years, Pilot Life terminated Dedeaux's benefits. During the next three years, Dedeaux's benefits were reinstated and terminated several times. Dedeaux brought a diversity action in the United States District Court for the Southern District of Mississippi against Pilot Life, alleging tortious breach of contract, breach of fiduciary duties, and fraud in the inducement. The district court granted Pilot Life's motion for summary judgment. The United States Court of Appeals for the Fifth Circuit reversed. \textit{Id.} The Supreme Court reversed, holding that ERISA preempts a state law claim which asserts improper processing of a claim for benefits under an ERISA regulated plan and is not “saved” by the “savings” clause that excepts state laws that regulate insurance from preemption (29 U.S.C. \S 1144(b)(2)(A)). \textit{Id.} at 57.

\textsuperscript{73} \textit{Pilot Life}, 481 U.S. at 45. \textit{See also} Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 137-38 (1990). Recently, in \textit{De Buono v. NYSA-ILA Med. and Clinical Serv. Fund}, 117 S. Ct. 1747, 1752 (1997), the Supreme Court reiterated that the objectives in enacting ERISA should be used as a “guide” in evaluating preemption of state law. Many are questioning whether ERISA was intended to be so broadly interpreted. Louise Kertesz, \textit{High Court Upholds HMO Suit Dismissal}, \textit{MODERN HEALTHCARE}, May 22, 1995, at 26.

\textsuperscript{74} One argument in favor of preemption is that managed care organizations would face financial ruin if medical malpractice liability were applied. Laura H. Harshbarger, \textit{ERISA Preemption Meets the Age of Managed Care: Toward a Comprehensive Social Policy}, 47 \textit{SYRACUSE L. REV.} 191, 222 (1996). However, “many HMOs often have in excess of \$1 billion dollars in liquid assets, and it is not uncommon for even midsize HMOs to have \$500 million in cash reserves.” \textit{Id.}
ERISA preemption is largely attributable to their interpretations of the phrase “relate to.” The Supreme Court explained that the words “relate to” were given a “broad common-sense meaning, such that a state law relates to a benefit plan in the normal sense of the phrase, if it has a connection with or reference to such a plan.” The Pilot Life Court clarified that the “preemption clause is not limited to state laws specifically designed to affect employee benefit plans.” Arguably, a medical malpractice claim does not “relate to” a benefit plan in the “normal sense of the phrase.”

In Mackey v. Lanier Collections Agency & Serv., the Supreme Court held that ERISA does not preempt “run-of-the-mill state-law claims.” The Court listed examples of state law claims that ERISA would not preempt: “unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan.” Certainly, one could argue that medical malpractice is a “run-of-the-mill state-law claim” and, therefore, should not be preempted by ERISA. However, even after Mackey, many circuit courts continued to hold that ERISA preempts a medical malpractice claim against a managed care organization.

Seven years after deciding Mackey, the Supreme Court presented a stronger pronouncement that medical malpractice claims against ERISA-covered managed care organizations may not be preempted by ERISA. The Court in New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co. held that all laws with indirect economic effects on ERISA plans may not be preempted by ERISA. The Court questioned whether all state law could be

75. Pilot Life, 481 U.S. at 47.
76. Id.
77. Mackey v. Lanier Collections Agency & Serv., 486 U.S. 825, 833 (1988). Mackey involved ERISA preemption of Georgia statutes which provided for the garnishment of funds from ERISA employee welfare benefit plans. Id. at 827. The Court held that ERISA preempts the Georgia statute which singles out ERISA employee welfare benefit plans for different treatment under state garnishment procedures. Id. at 830. Additionally, the Court found that ERISA does not forbid garnishment of an ERISA welfare benefit plan. Id. at 841.
78. Id. at 833. The Mackey court did not define “run-of-the-mill state-law claims,” but simply provided these examples.
79. See note 71 and accompanying text.
80. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 115 S. Ct. 1671, 1677 (1995). In New York State Conference, several commercial insurers acting as fiduciaries of ERISA plans joined with their trade associations to bring suit against state officials to invalidate a New York statute. Id. The statute required hospitals to collect surcharges from patients covered by a commercial insurer, but not from patients insured by a Blue Cross/Blue Shield plan. The Supreme Court held that the statutes were not preempted by ERISA. Id. at 1673-74.
81. Id. at 1681.
interpreted as relating to an employee benefit plan, such that all causes of action could be preempted; certainly Congress intended no such result.\textsuperscript{82}

The American Medical Association\textsuperscript{83} and the United States Department of Labor have filed amicus briefs in medical malpractice cases urging the courts to find that such cases are not preempted by ERISA.\textsuperscript{84} The American Medical Association asserts that ERISA preemption is unfair to both health care providers and their patients.\textsuperscript{85}

**FIDUCIARY LIABILITY**

ERISA imposes a fiduciary duty on plan administrators.\textsuperscript{86}

\textsuperscript{82} Id. at 1677. The Court reasoned:
The governing text of ERISA is clearly expansive. Section 514(a) [29 U.S.C. § 1144(a)] marks for pre-emption "all state laws insofar as they relate to any employee benefit plan" covered by ERISA, and one might be excused for wondering, at first blush, whether the words of limitation ("insofar as they relate") do much limiting. If "relate to" were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for really, universally, relations stop nowhere. . . . But that, of course, would be to read Congress's words of limitation as mere sham, and to read the presumption against preemption out of the law whenever Congress speaks to the matter with generality. Id. In United Wire v. Morristown Mem'l Hosp., 995 F.2d 1179, 1193 (3d Cir. 1993), cert. denied, 510 U.S. 944 (1993), the Third Circuit explained that if ERISA were interpreted to preempt all claims that affect a managed care organization, these companies would enjoy a unique status in the law. Id.

\textsuperscript{83} Liability: Court Set to Hear Oral Arguments on ERISA Preemption in Injury Suit, BNA HEALTH CARE DAILY, Apr. 30, 1997, at d3. The Supreme Court of Pennsylvania was scheduled to hear oral arguments in Pappas v. Asbel, 675 A.2d 711 (Pa. Super. Ct. 1996), to determine if a health plan can use ERISA to protect itself from a personal injury suit. Id. See also Liability: DOL Opposes Malpractice Preemption for Plans; Lawmakers, AMA Take Interest, BNA HEALTH CARE DAILY, Apr. 4, 1997, at d2.

\textsuperscript{84} Liability: DOL Opposes, supra note 83, at d2. The United States Department of Labor filed amicus briefs in eight cases, contending that ERISA does not preempt malpractice laws because these laws do not mandate benefit plan structure or administration. Professional Liability: Benefit Plan Law Does Not Supersede Claims of Medical Malpractice by HMO, BNA HEALTH CARE DAILY, Nov. 5, 1997, at d3.

\textsuperscript{85} Liability: Court Set, supra note 83, at d3. A member of the AMA Board of Trustees said:

It is a sad and disturbing irony that ERISA, the very law Congress enacted in 1974 to ensure that employees receive appropriate benefits, is now being subverted to shield health plans from liability when their decisions to deny care or to provide inadequate care result in patient injury. . . . Because of ERISA preemption, state courts are unable to hear personal injury suits against health plans, and patients are not able to seek redress for wrongful medical determinations made by plans. Id.

\textsuperscript{86} 29 U.S.C. § 1104. The statute provides:

A fiduciary is a person who has power over the affairs of another party and who is
Fiduciaries may be held liable to plan participants, or managed care enrollees, "for coverage determinations, treatment decisions, selection and monitoring of members of the provider network, and possibly, even for potential medical malpractice."87

The Supreme Court described ERISA’s fiduciary duty requirements in *Mertens v. Hewitt Assoc.*88 Under ERISA, fiduciary duties and responsibilities include “the proper management, administration, and investment of [plan] assets, the maintenance of proper records, the disclosure of specified information, and the avoidance of conflicts of interest.”89 ERISA provides remedies for breach of these fiduciary duties.90 A plan beneficiary (enrollee) may bring a civil suit to: (1) enjoin any act or practice that violates any provision of ERISA or the terms of the plan; (2) obtain other appropriate equitable relief to redress such violations or to enforce any provisions of this subchapter or the terms of the plan.91

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88. *Mertens v. Hewitt Assoc.*, 508 U.S. 248 (1993). In *Mertens*, the Supreme Court held that a nonfiduciary who knowingly participates in the breach of fiduciary duty imposed by ERISA is not liable for losses that an employee benefit plan suffers as a result of the breach.
89. *Id.* at 262-63.
90. *Id.* at 251-52. The Court explained: Section 409(a), 29 U.S.C. § 1109(a), makes fiduciaries liable for breach of these duties, and specifies the remedies available against them: The fiduciary is personally liable for damages (to make good to the plan any losses to the plan resulting from each such breach), for restitution (to restore to the plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary), and for such other equitable or remedial relief as the court may deem appropriate, including removal of the fiduciary.
91. *Id.* at 262-63. Title 29 U.S.C. § 1132(a)(3) permits plan participants to bring civil actions to obtain “appropriate equitable relief” to redress violations of the statute or the plan. The statute provides:

Civil enforcement.

(a) Persons empowered to bring a civil action

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

[supply requested information]
The fiduciary duties created by ERISA may be the basis for recovery by a plaintiff for the medical malpractice of a managed care organization. In Shea v. Esensten, the Eighth Circuit created a new avenue for obtaining relief, despite its holding that ERISA preempted the plaintiff’s claims for wrongful death.\textsuperscript{92} The Court validated the plaintiff’s claim that the defendant managed care

(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;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate
relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary
(A) to enjoin any act or practice which violates any provision of this
subchapter or the terms of the plan, or
(B) to obtain other appropriate equitable relief
   (i) to redress such violations or (ii) to enforce any provisions of this
       subchapter or the terms of the plan; . . . .

(g) Attorney’s fees and cost; awards in actions involving delinquent contributions
(1) In any action under this subchapter (other than an action described in
paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its
discretion may allow a reasonable attorney’s fee and costs of action to either
party . . . .

(l) Civil penalties on violations by fiduciaries
(1) In the case of —
   (A) any breach of fiduciary responsibility under (or other violation of)
       part 4 by fiduciary, or
   (B) any knowing participation in such a breach or violation by any other
       person, the Secretary shall assess a civil penalty against such fiduciary
       or other person in an amount equal to 20 percent of the applicable
       recovery amount.

(3) The Secretary may, in the Secretary’s sole discretion, waive or reduce the
penalty under paragraph (1) if the Secretary determines in writing that —
   (A) the fiduciary or other person acted reasonably and in good faith, or
   (B) it is reasonable to expect that the fiduciary or other person will not
       be able to restore all losses to the plan (or to provide the relief ordered
       pursuant to subsection (a)(9) of this section) without severe financial
       hardship unless such waiver or reduction is granted . . . .

\textit{Id.}

(1997). Patrick Shea was a member of the Medica health maintenance organization. At age
40, Mr. Shea had symptoms and a family history of heart disease. He was suffering chest
pains, shortness of breath, muscle tingling, and dizziness. Medica’s procedures required a
written referral from the assigned primary care physician before a patient could consult a
specialist. Mr. Shea’s doctor told him that a referral to a cardiologist was unnecessary. Mr.
Shea was unaware that Medica provided financial incentives to primary care physicians to
minimize referrals to specialists, docking a portion of their fees if they made too many.
When Mr. Shea offered to pay for the cardiologist’s services himself, he was told that he was
too young and did not have enough symptoms to justify a visit to a cardiologist. Mr. Shea
did not consult a cardiologist and died of heart failure a few months after first reporting the
symptoms to his primary care doctor. \textit{Id.} at 626.
organization violated its fiduciary duties under ERISA by attempting to reduce covered referrals and not disclosing to her and her deceased husband that his physician was offered financial incentives not to make specialist referrals. The circuit court reversed the district court's dismissal of the plaintiff's complaint.

One month after *Shea* was decided, the United States District Court for the District of New Hampshire, in *Drolet v. Healthsource, Inc.*, held that the plaintiff, in her class action complaint, stated a valid cause of action when she alleged that Healthsource New Hampshire, a managed care organization, breached its fiduciary duty in misrepresenting the nature of the relationship between the company and its contracting physicians. In *Drolet*, no medical malpractice was alleged, however, a new theory of fiduciary liability of a managed care organization was asserted. The district court denied the defendant's motion to dismiss.

Three months after *Drolet*, the District Court for the Southern District of New York, in *Weiss v. Cigna Healthcare, Inc.*, also held that the plaintiff, in a class action suit, stated a cause of action for breach of the defendant's fiduciary duty. The court explained that

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93. Id. The *Shea* court held that the duty of a fiduciary to disclose material information is "the core of a fiduciary's responsibility." *Id.* at 628-29. The court further explained that Mr. Shea had the right to know of the financial incentives that "could have colored his doctor's medical judgment about the urgency for a cardiac referral. . . . Health care decisions involve matters of life and death, and an ERISA fiduciary has a duty to speak out if it knows that silence might be harmful." *Id.*

94. *Id.* at 629.

95. *Drolet v. Healthsource, Inc.*, 968 F. Supp. 757, 757-58 (D.N.H. 1997). Robin Drolet, a beneficiary of a health care plan administered by the Mitre Corporation which contracted with Healthsource New Hampshire to provide the health care coverage, alleged that Healthsource made several false and misleading statements to plan beneficiaries. In the "Group Subscriber Agreement" issued by Healthsource, it explained that "the physician has a contractual relationship with Healthsource which does not interfere with the exercise of the physician's independent medical judgment." *Id.* at 758. Drolet contended that the doctor-patient relationship was actually compromised by several undisclosed financial incentives which cause physicians to reduce specialty referrals, including the "Referral Fund" which allows a physician to earn up to one-third more income by minimizing the "use of specialty services such as diagnostic tests, referrals, and hospitalizations." *Id.*

96. *Id.* The plaintiff sought a declaration that Healthsource had breached its fiduciary duties under ERISA, an injunction preventing further dissemination of materials containing the misrepresentations or omissions, an injunction preventing Healthsource from implementing or enforcing the provisions of its physician contracts, a return of premiums paid, and attorneys' fees and costs. *Id.*

97. *Id.* at 762.


Michelle Weiss was a participant in a health plan offered by her employer and managed by Cigna Healthcare of New York, a managed care organization. Weiss alleged that Cigna had breached the express and implied terms of the plan and various fiduciary duties required by
“ERISA requires plan fiduciaries to discharge their duties with respect to a plan solely in the interest of the participants and beneficiaries.”99 The court denied the defendant’s motion to dismiss the plaintiff’s claim of breach of fiduciary duty arising from Cigna Healthcare’s “gag order” policy.100

The Supreme Court has not yet addressed whether a plan beneficiary (or managed care enrollee) who brings suit for breach of fiduciary duty is limited to damages for the benefit not provided, or may recover compensatory damages.101 In Mertens v. Hewitt Assoc., the Supreme Court held that the relief described in ERISA section 502(a)(3) (codified at 29 U.S.C.A. § 1132(a)(3)) as “other appropriate equitable relief” is the type of relief typically available in equity (“injunction, mandamus, and restitution, but not compensatory damages”).102

In Massachusetts Mutual Life Ins. Co. v. Russell, the Supreme Court held that a fiduciary of an employee benefit plan could not be held personally liable to a plan beneficiary for extra-contractual compensatory or punitive damages caused by improper or untimely processing of benefits claims.103 Two years later, the Court, in Pilot Life Ins. Co. v. Dedeaux, found evidence that Congress did not authorize remedies other than those specifically listed in ERISA.104

In Mertens v. Hewitt Assoc., the Supreme Court held that

ERISA. Id. Weiss contended that Cigna had “an undisclosed policy” of “preventing its physicians from advising patients of treatment options which are not compensable by the HMO, and that it enforces this gag-order policy by reprimanding or even terminating physicians who disclose that Cigna will not cover particular forms of treatment that might be useful to the patient.” Id. The Court held that Weiss’ claim for breach of express and implied terms of the plan was preempted by ERISA, even though the claim for breach of fiduciary duty under ERISA stated a valid claim. Id. However, the Court also held that Cigna did not have an affirmative obligation to inform plan participants about the financial arrangements with participating physicians. Id. at 755.

99. Id. at 751.
100. Id. at 756.
101. See Karl J. Stoecker, ERISA Remedies After Varity Corp. v. Howe, 9 DEPAUL BUS. L. J. 237 (1997). The compensatory damages may include: actual loss, pain and suffering, emotional distress, deprivation of future earnings. It is uncertain whether punitive damages will be available.
102. Mertens, 508 U.S. at 257. See also Stoecker, supra note 101, at 246.
104. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987). "The six carefully integrated civil enforcement provisions found in § 502(a) [29 U.S.C. § 1132(a)] of the statute as finally enacted provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly." Id.
compensatory damages were not available under ERISA. However, three years after Mertens, in Varity Corp. v. Howe, the Court entertained the possibility of compensatory damages under ERISA, holding that ERISA authorized suits for individualized equitable relief. The Court held that Congress provided remedies for breaches of fiduciaries other than the interpretation of plan documents and the payment of claims. The Varity Court explained that the purposes of ERISA indicate that individual beneficiaries should have a remedy under ERISA.

The Supreme Court, in Varity, further provided that courts should determine the meaning of "appropriate equitable relief" by keeping "in mind" the "special nature and purpose of employee benefit plans" and the relief available elsewhere in ERISA. ERISA specifically provides that a plan beneficiary may recover benefits and may enjoin an act or practice that violates ERISA. Compensatory damages for harm other than those just mentioned (such as medical malpractice) may then be provided under 29 U.S.C. section 1132 (A)(3) to "obtain other appropriate equitable relief."

In Shea v. Esensten, the Eight Circuit "declined" to discuss remedies for the plaintiff because they were not part of the district court's ruling. In Drolet v. Healthsource, Inc., the district court held that Drolet could sue to enjoin Healthsource from making the allegedly false and misleading statements. However, the Drolet...
court explained that the plaintiff was not entitled to relief because
the plaintiff failed to claim that the alleged false and misleading
statements caused any harm.\(^\text{114}\) Although courts are now
considering breach of fiduciary claims under ERISA, the extent of
available damages is still unsettled.

**AMEND ERISA**

Injured enrollees of managed care organizations will be offered
an adequate remedy if Congress amends ERISA to clearly declare
that state law claims of medical malpractice against managed care
organizations are not preempted.\(^\text{115}\) Alternatively, Congress could
amend ERISA to conclusively provide damages for breaches of
fiduciary duty. Members of Congress have expressed interest in
amending ERISA to allow such suits.\(^\text{116}\) The Senate strategy
proposes a comprehensive plan to regulate managed care and

violated the express and implied terms of the plan; (3) an injunction preventing further
dissemination by Healthsource of materials containing misrepresentations or omissions; (4)
an injunction preventing Healthsource from implementing or enforcing the provisions of its
contracts with participating physicians; (5) a return of the fair value of premiums paid to
Healthsource; and (6) attorneys' fees and costs. *Id.* at 758. In *Weiss v. Cigna Healthcare,
Inc.*, the plaintiffs did not seek compensatory damages, only declaratory and injunctive relief.
*Weiss*, 972 F. Supp. at 750.

\(^{114}\) *Drolet*, 968 F. Supp. at 760. Retrospective relief is not available under ERISA. *Id.*

\(^{115}\) Kilcullen, *supra* note 45, at 7. The Court found:

The obstacle posed by ERISA can be effectively removed by amending it to allow
recovery for injuries shown to result from the provision or withholding of medical
treatment. Patients should not be required to show individual negligence of specific
parties. Rather, they should rely on the strict liability of the enterprise as the basis of
recovery on a factual showing of a causal relationship between the action or inaction
of the plan and the injuries they suffered.

*Id.* at 49. See also Shute, *supra* note 33.

\(^{116}\) *Liability: DOL Opposes*, *supra* note 83. "Rep. Charles Norwood (R-Ga) has said
he intends to introduce legislation later this month clarifying that health plans may be sued
for medical malpractice under state law." *Id.*

The Senate has also had proposals to Amend ERISA. "Two recent legislative proposals to
establish federal minimum standards for fair and reasonable health plan procedures are the
(D-Minn) and the Health Insurance Bill of Rights of 1997 (S. 373), introduced on Feb. 25,
1997 by Sen. Edward Kennedy (D-Mass.). Both bills have been referred to the Senate
Committee on Labor and Human Resources." *Id.*

Most recently, Democratic leaders in the House and Senate announced legislation for a
Patient Bill of Rights on March 31, 1998. The bills (S. 1890 and H.R. 3605) are based on an
provisions, the bill allows the decision of whether a plan enrollee can bring suit against a
managed care plan to be determined by state law, specifically overriding ERISA preemption.
protect the rights of patients.\textsuperscript{117}

Finally, injured enrollees' rights will be adequately protected if the Supreme Court decides the issue and finds that ERISA does not preempt medical malpractice actions against managed care organizations.

CONCLUSION

As managed care organizations continue to enroll more patients, their control over the provision of medical care correspondingly increases. Managed care enrollees who have been harmed by the medical malpractice of their managed care organizations have often been denied the right to recover damages. Congress enacted ERISA to aid plan participants but has actually become a substantial impediment to their recovery for injuries. The most expeditious and lucid remedy would be for Congress to amend ERISA to clearly provide that the medical malpractice of managed care organizations will not be shielded by ERISA. Certainly, Congress did not intend the preemption of these claims by ERISA. Even assuming that Congress intended preemption, leaving employees without a remedy clearly contradicts the spirit of ERISA. Congress enacted ERISA to provide protection for employee benefit programs. Unbelievably, that very legislation has often impeded recovery of damages in egregious situations.

State legislatures have recently enacted legislation to address liability of managed care organizations.\textsuperscript{118} However, courts may also find that ERISA preempts these laws. The rapidly changing American health care arena has created an urgent need for either Congress or the Supreme Court to mandate that ERISA does not preempt a medical malpractice claim brought by an enrollee against a managed care organization.

\textit{Julie K. Freeman}

\begin{footnotes}
\item[117] Robert Pear, \textit{Congress Weighs More Regulation on Managed Care}, \textit{N.Y. Times}, Mar. 10, 1997, § A, at 6. "H.M.O.'s have great potential to expand access to care and control costs, Mr. Kennedy said, but 'in too many cases, the priority has become higher profits, not better health.'" \textit{Id.} If H.M.O.'s block comprehensive federal regulation, piecemeal legislation will likely be passed. \textit{Id.}

\item[118] \textit{Liability: DOL Opposes . . .}, supra note 83. "Despite ERISA's restrictions, state legislatures have begun to look at regulating health plans more aggressively, and some of the proposed state laws do address health plan liability for patient injury stemming from actions by plan personnel and affiliated providers." \textit{Id.}
\end{footnotes}