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**CONTROL, QUALITY, AND COST:  
THE NEED FOR FEDERAL LEGISLATION  
AMENDING ERISA'S\* FAILURE  
TO PROTECT CONSUMERS  
FROM LIABILITY-FREE MCOS\*\***

*Eric M. Eusanio\*\*\**

*I thought I heard it all on the floor of the Senate about what the [MCOs] . . . were doing to American families, how health care was being compromised . . . . But when a doctor comes before me and says, "I had to call the [MCO] . . . for approval to admit a patient and they said, 'No, we won't go along with your suggestion, your medical advice, send the patient home,' this one doctor . . . said, "I finally asked the person on the other end of the line, 'Are you a doctor?'"*

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\* Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. §§ 1001-1461 (1994)) (regulating employer-provided: retirement, health plans, and other benefits by imposing reporting, disclosure, fiduciary, and administrative requirements on employers).

\*\* "Managed Care Organizations," for the purposes of this Note, are entities, such as health management organizations ("HMOs"), preferred provider organizations ("PPOs"), or independent practice associations ("IPAs") that integrate the financing and delivery of health care into a single organization by applying cost-containment devices, financial incentives, and risk-shifting techniques. See Daniel N. Burton & Michael S. Popok, *Managed Care 101*, 72 FLA. B.J. 26, 26 (1998); Peter D. Jacobson & Scott D. Pomfret, *Form, Function, and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence*, 35 HOUS. L. REV. 985, 991 (1998). See also *infra* notes 50-60 and accompanying text (discussing managed care organizations in greater detail, including the types of cost-containment devices, financial incentives, and risk-shifting techniques).

\*\*\* Brooklyn Law School Class of 2000; B.A., University of Rochester, 1995. The author wishes to thank his mother for always providing him unconditional love and support.

*He said, "No."*

*. . . "Are you a Nurse?"*

*He said, "No."*

*. . . "Do you have a college degree?"*

*The man said, "Well, no."*

*. . . "Well, what is your training?"*

*He said, "Well, I have a high school diploma, and I have the insurance company manual that I'm reading from."<sup>1</sup>*

## INTRODUCTION

While the doctor from Senator Durbin's statement on the Senate floor never mentioned whether his particular patient was suffering from a horrendous disease or whether a delay in treatment would impair his patient's chances for recovery, he did make an arguably more poignant point—that the doctor is no longer completely in control of the care he provides to his patient.<sup>2</sup> At first, this loss of control may seem advantageous, creating a check on an over-eager doctor who orders tests and operations at the first sign of trouble.<sup>3</sup> However, the picture portrayed by Senator Durbin's story casts doubt upon whether taking complete control away from doctors, at least when such control is placed in the hands of "managed care organizations" ("MCOs"), is truly advantageous. The Senator's statement suggests that giving MCOs control over a patient's treatment compromises the health care

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<sup>1</sup> 144 CONG. REC. S9733 (daily ed. Sept. 1, 1998) (statement of Sen. Durbin).

<sup>2</sup> See *infra* notes 61-62 and accompanying text (discussing the decision-making position that health plans have assumed with the advent of managed care).

<sup>3</sup> See *infra* notes 47-49 and accompanying text (discussing the moral-hazard problem raised by the independent physician within the fee-for-service health care system).

system because mere high school graduates, not experienced doctors, are often entrusted with the power to provide or deny treatment. Thus, there is a greater likelihood that an MCO will make erroneous decisions and deny necessary or life-saving treatment to consumers of pre-purchased health care.

This distrust of the managed care dominated health care market is a far cry from what was apparently the consensus view of MCOs less than five years ago, when both houses of Congress resoundingly defeated President Clinton's efforts to create nationalized health care that would provide universal coverage to America.<sup>4</sup> Senator Durbin's simple story of distrust of an MCO's ability to provide reasonable patient care illustrates both the quickness with which perceptions may change and the irony with which large scale, polycentric social reform may inhere since no one has found a way to predict the outcome of such reform with any certainty.<sup>5</sup> In particular, it is ironic that Americans voted to abandon comprehensive, government regulated health care seemingly to avoid an unattractive Canadian-styled system that subjects consumers to

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<sup>4</sup> See Robin Toner, *New Majority's Agenda: Substantial Changes May Be Ahead*, N.Y. TIMES, Nov. 10, 1994, at A26 (explaining that the push for comprehensive health care guarantying universal coverage ended even before the democrats lost their majorities in the 1994 elections, and implying that the new majority view focuses on an incremental approach which has effectively defeated any hope for a government-run health care system). See also Albert R. Hunt, *Health Care Is Issue of the Decade: Anger With System Fuels Pressure For "Patients' Bill of Rights,"* WALL ST. J., June 25, 1998, at A9 (explaining that the "waxing and waning" of the public's views on health care is illustrated by the defeat President Clinton's universal health care plan of 1993-94 because it was "too massive and too complex," while a "sizable margin of Americans [now] favor tougher managed care regulation" even if such regulation would raise costs and create a new bureaucracy); Steve Sternberg, *Finding the Health System Unfit Many Americans Fear the Care Won't Be There Study: Consumers Support Legislative Fix*, USA TODAY, Nov. 23, 1998, at 1D (implying that the defeat of the President Clinton's health care plan five years ago demonstrated that the consensus view favored private, for-profit managed care).

<sup>5</sup> See Lon L. Fuller, *The Forms and Limits of Adjudication*, 92 HARV. L. REV. 353, 401 (1978) (concluding that polycentric social issues are not amenable to judicial decision because such issues may lead to unworkable decisions with unexpected repercussions).

rationing.<sup>6</sup> Yet even with the chosen form of health care delivery—private, for-profit managed care—American consumers still endure the effects of rationing.<sup>7</sup>

Compounding the fact that MCOs subject their consumers to the detrimental effects of rationing, such as the delay or denial of life-saving treatment,<sup>8</sup> there is no vehicle through which consumers may seek to redress any injuries incurred as a result of this rationing by MCOs.<sup>9</sup> This result violates any concept of fairness rooted in law. In fact, it is a fundamental tenet of the law that culpable conduct which causes injury to a consumer may be redressed.<sup>10</sup> This principle is the cornerstone of a consumer's trust

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<sup>6</sup> See Patrick J. Monahan, *The Provinces, Ontario Caring for Medicare*, GLOBE AND MAIL (Toronto), July 15, 1998, at A15 (explaining that Canada's health care system rations the supply of health care services to reduce total spending, resulting in longer than clinically reasonable waits for routine surgical procedures and compelling Canadians to endure more prolonged physical pain and to be absent from work while awaiting treatment).

<sup>7</sup> See *infra* notes 56-60 and accompanying text (discussing the different cost containment mechanisms employed by the managed care system, with the net effect of compelling consumers to consume less health care than they want or need).

<sup>8</sup> See *infra* notes 60-61 and accompanying text (explaining that MCOs, by employing cost-containment mechanisms, compel consumers to consume less pre-purchased health care, producing similar detrimental effects as rationing, such as the delay or denial of necessary or live-saving treatment).

<sup>9</sup> See *infra* notes 73-74 and accompanying text (explaining that ERISA fails to provide substantive remedies and its preemption provisions preclude any possible recovery through state law).

<sup>10</sup> The principle that with every legal right violated there is a remedy at law was articulated best by the Supreme Court in *Marbury v. Madison*. 5 U.S. (1 Cranch) 137, 163 (1803) (stating that "[t]he very essence of civil liberty certainly consists in the right of every individual to claim the protection of the laws, whenever he receives an injury"). While this principle has been restricted since the time of *Marbury*, it is more instructive within the context of the ERISA health plan market in its descriptive sense rather than focusing on its prescriptive value. As this principle demonstrates, a consumer often will have an expectation before entering into a transaction that any injuries incurred will be redressed by an orderly, efficient market. The *Marbury* principle, however, has been limited by doctrine of the modern court, and has been expressly overruled in statutory construction cases that require courts to provide only that relief which was explicitly authorized by Congress within its statutory scheme. See *infra* notes

in the marketplace. When the legal system fails to afford the necessary remedies to maintain consumers' trust in the market,<sup>11</sup> legislative reform may be required to restore that trust. Legislative reform, as opposed to ad hoc court-imposed remedies, is preferred especially where prior legislation is the source of the failure to provide consumers with relief from marketplace injuries.<sup>12</sup> If such legislation is left unreformed, its unworkable provisions will continue to harm not only the trust of consumers, but also their access to an essential good: "reasonable health care."<sup>13</sup>

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169-170, 178-179, 187 and accompanying text (discussing Supreme Court cases that expressly hold that in cases of statutory construction, courts may only effectuate the remedial scheme desired by Congress and cannot base judgments or awards on their own notions of good-policy).

<sup>11</sup> See *infra* note 37 (discussing and providing examples of consumer distrust of the health care market, stemming from the immediate constraints and impediments created by MCOs).

<sup>12</sup> See *supra* note 10 (discussing consumers' expectation that their injuries incurred as market participants will be redressed under the law) and *infra* notes 169-170, 178-179 (asserting that in cases where a statutory scheme fails to provide a remedy, such as ERISA, courts cannot create a remedy). See also *infra* notes 187-193 and accompanying text (explaining that only Congress has the power to amend clearly expressed statutory rules, even when a statute has proven to be unworkable, and detailing the policy reasons underlying this requirement).

<sup>13</sup> For the purposes of this Note, the term "reasonable health care" is the "effective delivery" of pre-purchased "health care coverage," as measured by a "prudent lay-person" standard. See *infra* text accompanying notes 110-113 (describing the consumer protections provided by the Patients Bill of Rights Act of 1998 which are encompassed in the notion of "reasonable health care"). See also Patients Bill of Rights Act of 1998, H.R. 3605, 105th Cong. § 101(a)(2)(A) (defining a "prudent lay-person" as someone "who possesses an average knowledge of health and medicine").

The term "effective delivery" includes: (1) the receipt of adequate information prior to enrollment concerning the extent of coverage, limitations on coverage, and appeal processes for denials and delays of benefits, see *id.* § 121; (2) the receipt of pre-purchased "medical care" when deemed medically necessary according to a "prudent lay-person" standard for "emergency services," which are medical screening examinations within the capability of the emergency department of a hospital or other auxiliary services, see *id.* § 101, or when deemed necessary by a "reasonable doctor" for all other non-emergency services; and (3) an undeniable right to access an internal and external (independent) appeal process for denial or delay of any benefit within: (a) reasonable time for any non-life threatening or non-permanent impairment where there is no risk of

Specifically, the Employee Retirement Income Security Act of 1974 ("ERISA")<sup>14</sup> has failed to provide consumers with the ability to seek relief when harmed by their MCO in the private sector employer-provided health care market.<sup>15</sup> On March 31, 1998, House Bill 3605, The Patients' Bill of Rights Act of 1998 ("the Bill"),<sup>16</sup> was introduced in order to cure the defects flowing from ERISA's evisceration of a consumer's right under state law to obtain redress from the negligent conduct of MCOs.<sup>17</sup> The Bill

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a lost opportunity to effectively treat and restore functions as if care was received immediately; or (b) an expedited time period in accordance with the medical exigencies. *See id.* §§ 131-33.

The term "health care coverage" includes items and services paid for medical care or benefits consisting of medical care, which is provided directly, through insurance or reimbursement, or otherwise under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, and that is subject to ERISA as part of an employer-provided service or benefit. ERISA § 733(b)(1), 29 U.S.C. § 1191b(b)(1) (1994 & Supp. II 1996).

"Medical care" includes items and services paid for as medical care, such as: (1) a diagnosis, cure mitigation, treatment, or prevention of disease; (2) a purpose affecting any structure or function of the body; (3) transportation primarily for and essential to "medical care" as delineated in "(1)" and "(2)" above; (4) insurance covering "medical care" as defined in "(1)," "(2)" and "(3)" above. ERISA § 733(a)(2), 29 U.S.C. § 1191b(a)(2) (1994 & Supp. II 1996).

<sup>14</sup> Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. §§ 1001-1461 (1994)).

<sup>15</sup> *See infra* Part I.B.1, detailing how ERISA prevents consumers from redressing their injuries caused by the negligence of their MCOs. *See also* Corcoran v. United Healthcare, 965 F.2d 1321, 1333 (5th Cir. 1992) (asserting that while the court is "not unmindful of the fact that [its] . . . interpretation of [ERISA] . . . leaves a gap in remedies within the statute intended to protect participants in employee benefit plans . . . the lack of an ERISA remedy does not affect . . . preemption analysis").

<sup>16</sup> H.R. 3605, 105th Cong. (1998). The term "the Bill," as used in this Note, refers both to the Patients' Bill of Rights Act of 1998 and to any similarly crafted legislation that, at a minimum, adopts the essential provisions contained in H.R. 3605. *See infra* text accompanying notes 110-113 (noting four key consumer protections essential to effective federal legislative reform of the health care system).

<sup>17</sup> *See infra* notes 37-38 and accompanying text (discussing the harm or defects caused by MCOs, including: (1) distrust of the market; and (2) impaired ability to obtain effective access to reasonable health care).

was proffered in the hope of providing uniform consumer protections.<sup>18</sup> In order to restore the market position and confidence of consumers in obtaining reasonable health care, most of the Bill's protections borrowed provisions, in some form, from the "Consumer Bill of Rights and Responsibilities."<sup>19</sup>

In fact, the Bill was conceived and inspired by the work of the members of a non-partisan commission.<sup>20</sup> It provided, for the first time, unified and consistent federal protections for all American consumers of health care coverage, including consumers of individual private plans.<sup>21</sup> More importantly, however, the Bill,

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<sup>18</sup> See *infra* text accompanying notes 110-113 (discussing and enumerating the key federal consumer protections first introduced in the "Consumer Bill of Rights and Responsibilities").

<sup>19</sup> The "Consumer Bill of Rights and Responsibilities" was created as a result of the work of a 34-member commission appointed by President Clinton on March 26, 1997, to "recommend such measures as may be necessary to promote and assure health care quality and value and protect consumers and workers in the health care system." *President's Advisory Commission Releases Consumer Bill of Rights and Responsibilities* (last modified Nov. 20, 1997) <<http://www.hcqualitycommission.gov/press/cbor.html#head1>> [hereinafter *President's Advisory Commission*].

On February 20, 1998, President Clinton released "an Executive Memorandum directing all Federal health plans, which serve over 85 million Americans, to come into substantial compliance with the President's Quality Commission's Consumer Bill of Rights." *The White House at Work, President Clinton: Patient Bill of Rights* (last modified Feb. 20, 1998) <<http://www.hcqualitycommission.gov/press/pbor.html>>.

<sup>20</sup> The 34-member commission, consisting of a non-partisan group of experts in the field of health care, including insurance companies, federal regulators, medical care professionals and providers, recommended legislation to improve the often criticized health care delivery system, to restore consumer trust in the health care industry, and to educate consumers seeking redress for injuries caused by their MCOs on the variety and limitations of services, and appeal processes available from MCOs). *President's Advisory Commission, supra* note 19.

<sup>21</sup> *The White House, Remarks by the President on Health Care Quality: The East Room* (last modified March 13, 1998) <<http://www.hcqualitycommission.gov/press/final.html>> (noting that on March 13, 1998, President Clinton called for Congress to extend the protections of the Patients' (Consumers) Bill of Rights to all Americans that had been recently provided by executive order to the one-third of the nation's population covered by federal health care plans). See H.R. 3605, 105th Cong. §§ 201(a)'(a)' and 202(a)'(a)' (1998) (providing that each group health plan and health insurance issuer "shall comply with the patient



while generally claiming not to modify section 514 of ERISA,<sup>22</sup> actually amends section 514 and subtly carves out a narrow exception<sup>23</sup> to the doctrine of preemption, as applied to private sector employer-provided health care plans for over the past two decades.<sup>24</sup>

The Bill adjusts the incentives of both MCOs<sup>25</sup> and consumers<sup>26</sup> within the context of private sector employer-provided health

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protection requirements under title I of the Patients' Bill of Rights Act of 1998") (amended material in original contained within single quotation marks).

<sup>22</sup> 29 U.S.C. § 1144 (1994). The relevant provision of the Bill that cautions against construing title I as modifying section 514 of ERISA is H.R. 3605, 105th Cong. § 192(a)(2).

<sup>23</sup> H.R. 3605, 105th Cong. § 192(a)(1) (creating a statutory scheme announcing, in general, that the Bill "shall not supersede any provision of state law . . . except to the extent [it] prevents the application [of the standards of this title]"). This general scheme is subject to section 514 of ERISA, which effectively preempts state law remedies against health plans regulated thereunder. See H.R. 3605, 105th Cong. § 192(a)(2). This scheme, however, allows narrow exceptions to ERISA's preemption of state law negligence claims. See *infra* Part II.B, discussing the statutory scheme of the Bill in greater detail.

<sup>24</sup> Section 514 of ERISA has been held to preempt state law remedies that relate to the quantity and administration of services provided by an employer group health plan. Angela M. Easley, *A Call to Congress to Amend ERISA Preemption of HMO Medical Claims: The Dissatisfactory Distinction between Quality and Quantity of Care*, 20 CAMPBELL L. REV. 293, 299-300 (1998). See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47-48 (1987) (holding that a claim based on the alleged improper processing of benefits, essentially an action relating to the quantity of benefits provided, was preempted by section 514 of ERISA).

<sup>25</sup> See H.R. 3605, 105th Cong. § 302(a)(e)(1) (imposing immediate culpability on MCOs providing health care through private-sector employers for "any cause of action under state law to recover damages resulting from personal injury and wrongful death"). This provision of the Bill provides a strong incentive for MCOs to ensure that the administration of pre-purchased health care to the consumer is efficient, timely, and appropriate because, if not, consumers may seek redress through state law actions which could be costly to MCOs, both in terms of time, damage awards against them, and ruined reputation or loss of the good will of the public. See *id.*

<sup>26</sup> See H.R. 3605, 105th Cong. §§ 121-23 (encouraging consumers to inform themselves of the internal workings of the health care system, including: appropriate amounts and limitations of coverage, relevant appeal procedures, and available outside help).

plans, so as to encourage the administration of reasonable, quality care to a well-informed consumer. Under the Bill, a consumer may, when necessary, hold liable only the party actually responsible for the negligent conduct or defective delivery of pre-purchased health care.<sup>27</sup> As a result, the Bill effectively ensures that the consumers retain their right of redress under state law in discrete and appropriate situations,<sup>28</sup> while concomitantly guarding against the establishment of a Federal statutory tort system.<sup>29</sup> Further, the Bill has only slightly lifted the preemption blanket provided under ERISA,<sup>30</sup> which protects employer-provided health plans from direct liability,<sup>31</sup> in order to allow consumers to recover under available state law remedies protecting against essentially the same conduct prohibited by the Bill.<sup>32</sup> Thus, the Bill affords a unified

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<sup>27</sup> See H.R. 3605, 105th Cong. § 302(a)(e) (1998). See also *infra* note 108 (analyzing the provision of the Bill providing consumers the ability to hold MCOs liable when their negligent conduct causes them injury, but explaining that the Bill narrowly tailors this liability).

<sup>28</sup> See H.R. 3605, 105th Cong. § 302(a) (amending ERISA and imposing direct liability on any person, in connection with the provision of insurance, administrative services, or medical services, including arrangements made to recover damages resulting from personal injury or wrongful death).

<sup>29</sup> See *id.* (stating that the consumer can recover for damages directly caused by the MCO under state but not federal law). While the actual recovery will be under any state law that has analogous provisions to the Bill, the standards and requirements imposing liability under the Bill are often the model for the analogous state law provision. See *infra* notes 32 & 161 and accompanying text (comparing the Bill's function as a procedure to the traditional *Erie Railroad Co. v. Tompkins* interpretation of the relationship between federal and state law).

<sup>30</sup> See *infra* Part II.B, discussing the Bill's narrowly tailored statutory scheme.

<sup>31</sup> See Easley, *supra* note 24, at 305-09 (discussing that courts have held that ERISA preempts direct liability claims against MCOs for corporate negligence in the selection and retention of physicians, as well as for direct negligence claims arising from cost containment systems).

<sup>32</sup> See *infra* note 108 and accompanying text (discussing the liability structure of the Bill). The Bill affords the procedure and model standards by which to obtain relief, while the state law provides the substantive provisions through which the Federal procedures are enforced. See *Erie Railroad Co. v. Tompkins*, 304 U.S. 64, 78-80 (1938) (holding that Congress cannot declare substantive rules of law applicable in a state, but leaving open the use of procedural rules, such as the Federal Rules of Civil Procedure—adopted soon

and consistent Federal procedure for recovery under state law to the extent that private sector employer-provided health plans governed by ERISA are directly,<sup>33</sup> but not vicariously or incidentally,<sup>34</sup> liable for failing to comply with the consumer protection provisions of the Bill.<sup>35</sup>

This Note argues that because ERISA has effectively prevented consumers from redressing their marketplace injuries through the legal system,<sup>36</sup> federal legislation is necessary to cure the defects in the health care system flowing therefrom, such as consumers' distrust in the health care market<sup>37</sup> and their impaired ability to obtain effective, reasonable care.<sup>38</sup> In fact, Federal legislative

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after the Court's decision was issued—to ensure that Congress could protect Federal rights).

<sup>33</sup> See Easley, *supra* note 24, at 309-12 (discussing the lack of direct liability of MCOs).

<sup>34</sup> See Easley, *supra* note 24, at 311-12 (noting that liability of MCOs under ERISA is solely vicarious, creating incentives for inefficiency and harm to consumers).

<sup>35</sup> See *infra* text accompanying notes 110-113 (discussing the key protections provided by the Bill).

<sup>36</sup> See *infra* notes 116-118 and accompanying text (cataloguing examples of consumers impeded and injured by the negligence of their MCOs, but unable to obtain redress). While some courts have allowed consumers relief, the ability to seek redress has been prevented by ERISA preemption of state common law or the traditional mechanism utilized for consumer protection within the marketplace. ERISA § 502(a), 29 U.S.C. § 1132(a) (1994); ERISA § 514(a), 29 U.S.C. § 1144(a) (1994).

<sup>37</sup> Consumers' distrust in the health care market currently predominated by MCOs stems from the immediate "constraints" and "impediments" that prevent their access to timely, reasonable health care, such as the variety of people authorized to handle requests, treatment coverage decisions, and appeals, including: marketing or claims administrative staff; case workers; and medical professionals. See *Grievance Procedures for Health Care Quality, 1998: Hearing Before the Subcomm. on Labor of the Senate Comm. on Human Resources*, 105th Cong. (1998) [hereinafter *Hearing on Grievance Procedures*] (statement of Bernice Steinhardt, Director of Health Services Quality & Public Health Issues Group of the General Accounting Office). See also *infra* note 60 (discussing consumers' distrust of the health care market in greater detail).

<sup>38</sup> See ERISA § 502(a), 29 U.S.C. § 1132(a) (1994) (explaining that ERISA remedies, if any, merely provide recovery of the value or cost of the wrongfully denied benefit); *Hearing on Grievance Procedures, supra* note 37 (statement of

reform, creating a procedural vehicle through which consumers may obtain redress under state law substantive enforcement provisions, is the only approach that will provide consistent, uniform relief for consumers of private sector employer-provided health care injured by the negligence of their MCOs.<sup>39</sup>

Part I of this Note provides a brief overview of the recent rise in popularity of the MCO-structured health care system in contrast with the previously predominant fee-for-service system of delivering health care. Part I also examines the adverse effect of ERISA on the delivery of health care to consumers under the managed care system. Part II explores the incentives ERISA creates for an MCO to delay or deny coverage and to fail to adequately inform consumers of the extent and limitations of their coverage and their right to appeal those delays or denials.<sup>40</sup> In particular, this Part analyzes the Patients' Bill of Rights Act of 1998 and proposes that Congress enact the Bill or similar legislation adopting provisions that effectively allow consumers to obtain redress from MCOs.<sup>41</sup> Part II also argues that the key provisions of the Bill are crucial to reverse the incentive of MCOs to provide less than adequate coverage and to ensure the efficient delivery of health care. Finally, Part III suggests that the Patients' Bill of Rights Act, or other similar federal legislation, provides a superior method of reform to

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Olena Berg, Asst. Secretary of the Dep't of Labor's Pension and Welfare Benefits Admin.). *See also infra* note 60 (explaining that MCOs have impaired consumers' access to care and, in effect, have rationed their pre-purchased health care services). This unfortunate effect may only be cured by federal legislation expressly exposing MCOs to liability for tort damages and requiring MCOs to redress the injuries that result, as a practical matter, from their negligent decision-making. *See infra* Part III, discussing federal legislation as the best method to amend ERISA's failure to provide consumers relief from the negligence of their MCOs.

<sup>39</sup> *See infra* note 153 and accompanying text (analyzing the procedure utilized by the Bill and explaining its effects on ERISA).

<sup>40</sup> *See infra* notes 116-121 and accompanying text (asserting that because ERISA preempts direct liability against MCOs, it provided incentives for MCOs to deny or delay coverage, proffer inaccurate information and provide bureaucratic impediments to reasonable care).

<sup>41</sup> *See infra* text accompanying notes 110-113 (discussing and enumerating the federal consumer protections first introduced in the "Consumer Bill of Rights and Responsibilities").

other methods advocated by commentators.<sup>42</sup> This Note concludes that enactment of the Bill would eliminate the current defects<sup>43</sup> in the private sector employer-provided health care market and would begin to restore consumers' trust in the health care market by promoting a more efficient health care system.

## I. BACKGROUND OF THE MANAGED CARE SYSTEM AND ERISA

### A. *Managed Care versus the Fee-for-Service System*

Traditionally, health care has been delivered through the fee-for-service system.<sup>44</sup> In this system, insurers pay health care providers or reimburse patients upon completion of all medical treatment, and the decisions to perform a specific medical treatment and to incur the corresponding expense lie entirely within the providers' discretion.<sup>45</sup> This traditional method for delivering health care was purposefully structured "to avoid interference with doctors' relationships with patients or with doctors' styles of practice."<sup>46</sup> However, the standard application of the fee-for-service system creates a moral hazard for both the patient and the physician, where neither has any incentive to avoid unnecessary costs.<sup>47</sup> Often patients are fully covered for treatments that have

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<sup>42</sup> See *infra* note 166 and accompanying text (discussing other methods of reform suggested by commentators).

<sup>43</sup> See *supra* notes 37-38 and accompanying text (noting the defects in the health care system created by ERISA).

<sup>44</sup> See Suzanne M. Grosso, *Rethinking Malpractice Liability and ERISA Preemption in the Age of Managed Care*, 9 STAN. L. & POL'Y REV. 433, 434 (1998) (discussing the fee-for-service health care system).

<sup>45</sup> See Grosso, *supra* note 44, at 434 (asserting that under a fee-for-service system consumers were reimbursed or providers were paid upon completion of treatment, implicitly assuring consumers that needed care would be paid for by their insurer).

<sup>46</sup> David D. Griner, Note, *Paying the Piper: Third-Party Payor Liability for Medical Decisions*, 25 GA. L. REV. 861, 862 (1991).

<sup>47</sup> See J. Patrick Green, *Annual Survey of the United States Supreme Court and Federal Law Essay: Speculations on Managed Care*, 31 CREIGHTON L. REV. 679, 682 (1998); Grosso, *supra* note 44, at 434 (explaining that both providers and patients had little reason to question the propriety of a particular treatment).

only small incremental benefits, with doctors aware that they will be paid for their services in any case.<sup>48</sup> Patients then compound the moral hazard through their inability to monitor the quality of their medical care as well as their own lack of incentive to avoid ineffective care.<sup>49</sup>

Escalating health care costs caused a shift in the predominant form of health care delivery from fee-for-service to managed care.<sup>50</sup> Between 1970 and 1990, enrollment in the managed care system increased from 3.6 million to 35 million Americans.<sup>51</sup> In 1997, approximately 125 million people, half of all Americans, received their health care through a managed care organization sponsored by a private sector employer plan.<sup>52</sup> The vast majority of these plans are subject to ERISA, which preempts state law remedies against MCOs.<sup>53</sup> Although the primary impetus for this

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<sup>48</sup> In the traditional fee-for-service system, a third party payor reimbursed most services and treatment rendered to patients. This system provided incentive for physicians to increase services to patients because any test or procedure was not only a benefit for the patient, but also a profit for the physician. See Kenneth R. Pedroza, Note, *Cutting Fat or Cutting Corners, Health Care Delivery and its Respondent Effect on Liability*, 38 ARIZ. L. REV. 399, 401 (1996). Thus, the fee-for-service system of reimbursement increases the overall costs of health care coverage because there is no incentive to constrain consumption of the patient or spending by the doctor. *Id.*

<sup>49</sup> See Green, *supra* note 47, at 683.

<sup>50</sup> Alison Faber Walsh, Comment, *The Attack on Cost Containment: The Expansion Liability for Physicians and Managed Care Organizations*, 31 J. MARSHALL L. REV. 207, 213-15 (1997) (noting that increased health care costs forced insurers and employers to consider a new method of delivery and led to a new era of managed care).

<sup>51</sup> Deven C. McGraw, Note, *Financial Incentives to Limit Services: Should Physicians Be Required to Disclose These to Patients?*, 83 GEO. L.J. 1821, 1823 (1995).

<sup>52</sup> See *Hearing on Grievance Procedures*, *supra* note 37 (statement of Olena Berg, Asst. Secretary of the Dep't of Labor's Pension and Welfare Benefits Admin.). See also Robert Pear, *H.M.O.'s Using Federal Law to Deflect Malpractice Suits*, N.Y. TIMES, Nov. 17, 1996, at 24 (noting that, in 1996, 120 million Americans were subject to ERISA preemption).

<sup>53</sup> See *Hearing on Grievance Procedures*, *supra* note 37 (statement of Olena Berg, Asst. Secretary of the Dep't of Labor's Pension and Welfare Benefits Admin.) (noting that in most states about 70 to 80% of the private sector health market is subject to preemption of state law consumer protections).

change<sup>54</sup> in the way health care was delivered can be explained as a compelled response by insurers, policymakers, and employers to lower out of control health care costs, there is evidence that quality was an important factor in the shift from fee-for-service to managed care.<sup>55</sup>

Notwithstanding this concern for quality, the cost containment mechanisms employed by MCOs, such as utilization review,<sup>56</sup>

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<sup>54</sup> Unlike under the fee-for-service system of health care delivery that is based on a contract between the consumer and insurance carrier, the managed care method for delivering care depends on a contract between the health care provider and the MCO. See Walsh, *supra* note 50, at 215.

<sup>55</sup> See Walsh, *supra* note 50, at 215 (asserting that although the primary purpose of managed care plans is to lower medical costs, "managed care attempts to provide *quality* health care in a cost efficient manner") (emphasis added). From the beginning of the rise in popularity of managed care systems, cost reduction, while the primary goal, was not the only factor underlying the purpose of managed care. See Walsh, *supra* note 50, at 215 (stating that "[t]he United States introduced the concept of managed care to control the delivery of *quality* health care") (emphasis added). More specifically, when Congress introduced the Health Maintenance Organization Act of 1973, 29 U.S.C. §§ 300e to 300e-17 (1994), the purpose was to provide financial assistance and encourage the development of managed care organizations so long as they met federal requirements. See Diana Joseph Bearden & Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 BAYLOR L. REV. 285, 291 (1995). Under the HMO Act, MCOs must ensure that quality health care is provided and assume all responsibility for health care services delivered on a prospective or pre-paid basis. See William J. Bahr, Comment, *Although Offering More Freedom to Choose, "Any Willing Provider" Legislation is the Wrong Choice*, 45 U. KAN. L. REV. 557, 562 (1997).

<sup>56</sup> See Walsh, *supra* note 50, at 216 (stating that "[u]tilization review is a cost containment mechanism implemented by MCOs that attempts to lower health care costs by reducing the number of unnecessary medical procedures, hospital stays and tests" by hiring a board to review and screen each patient's records to determine if the treatment or care recommended by the patient's doctor is medically necessary). Utilization review can take three forms: "prospective," "concurrent," or "retrospective." See Walsh, *supra* note 50, at 217.

When MCOs make "prospective" decisions—i.e., before any care is administered—to delay or deny care, there is a potential that those decisions are negligent or represent culpable conduct. See *infra* notes 116-118 and accompanying text (providing examples of MCOs' negligent decision-making and failure to afford reasonable care). This analysis equally applies to MCOs when they make "concurrent" decisions—i.e., during the course of administering care.

capitation,<sup>57</sup> and payment incentives,<sup>58</sup> actually tend to sacrifice

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In contrast, when MCOs make “retrospective” decisions—i.e., after the care has been administered—to delay or deny coverage of such care, which is similar to fee-for-service approach, there is little opportunity for the MCO to cause injury because the care has been administered and only thereafter has its coverage been denied. Thus, under retrospective utilization review, even if the MCO wrongfully denies payment or coverage after the care was administered, the only damage will be pecuniary and is capable of recovery in an action for breach of contract under ERISA’s enforcement provisions. *See Hearing on Grievance Procedures, supra* note 37 (statement of Olena Berg, Asst. Secretary of the Dep’t of Labor’s Pension and Welfare Benefits Admin.). *See also* ERISA § 502(a), 29 U.S.C. § 1132(a) (1994) (providing that “[a] civil action may be brought . . . to recover benefits due . . . under the terms of . . . [a] plan, to enforce . . . rights under the terms of the plan, or to clarify . . . rights to future benefits under the terms of the plan”).

<sup>57</sup> Capitation is an alternative method of compensating physicians for their services, where the physician is paid a flat rate for each patient enrolled in the MCO regardless of the amount of care or services provided in a particular month. *See Walsh, supra* note 50, at 217-18. Thus, the financial risk of caring for patients is shifted to the primary care physician, because if a patient requires more care than allotted for any given month the doctor will lose the value of those services expended beyond the monthly budget. *See Walsh, supra* note 50, at 218. Should the patient need less medical care than the MCO has paid for in that month, the doctor will receive a windfall or greater value for the services actually provided. *See Walsh, supra* note 50, at 218. This shift in financial risk of caring for a patient creates an incentive for physicians to limit the direct medical services provided to their patient.

While this perceived incentive for doctors to limit the amount of service or care they provide their patients appears positive, it is often cited as the cause of many consumers discontent with and distrust of the managed care system. *See supra* note 37 (noting the sources of consumers’ distrust of MCOs). This is because the patient will never know whether care, in any given circumstance, is unnecessary or merely not recommended because the doctor wishes to protect his own pecuniary position, which ultimately increases the profits of MCOs. *See Walsh, supra* note 50, at 218-19 (asserting that a physician has a vested financial interest in the amount of medical care that exceeds the pre-set amount and implying that this creates incentive for a physician to under-utilize treatments). *See also* Bahr, *supra* note 55, at 566 (explaining that financial incentives for both MCOs and providers—i.e., physicians—to reduce services in order to reduce costs lead to “under-utilization” of health care).

<sup>58</sup> Payment incentives are employed by MCOs to further reduce health care costs by encouraging physicians to limit the amount of outside services, tests, or specialists that they recommend to their patients. *See Walsh, supra* note 50, at



quality in return for lower costs<sup>59</sup> by constraining and impeding

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219. MCOs may employ any of the following "payment incentives": (1) "withhold risk pools," where a portion of the physician's monthly capitated payment is withheld and placed in a pool that all outside services are paid from, and if there is a surplus the physician will keep it as a bonus, while any deficit will become a loss for the physician; (2) "bonuses," where rewards paid to physicians who maintain the amount of outside services they recommend below a preset level for the year; or (3) "expanded capitation," where the MCO includes the amount allotted for outside services in the monthly flat fees paid to the physicians for each patient, which is essentially the physician's own income paying for the outside services recommended. *See* Walsh, *supra* note 50, at 219-20.

Payment incentives that encourage limiting the amount of outside services recommended are often utilized in conjunction with utilization review or capitation. *See* Walsh, *supra* note 50, at 219. These create incentives to limit internal physician services provided, as both forms of incentive to limit internal or external health care expenditures ensure that overall health care costs decrease. *See* Walsh, *supra* note 50, at 219. These cost containment mechanisms are used together because when internal medical costs are reduced by employing only one type of cost reduction mechanism, the other unconstrained or external medical costs may increase overall costs. *See* Walsh, *supra* note 50, at 219.

<sup>59</sup> *See Hearing on Grievance Procedures, supra* note 37 (statement of Dr. Thomas McAfee, Chief Medical Officer, Brown & Tolland Medical Group) (stating that MCOs are committed to providing "high quality services" and that consumers do not want increased regulation at the expense of higher premiums). In fact, managed care was perceived as a way of reducing costs while retaining most benefits of a fee-for-service system. *See* Grosso, *supra* note 44, at 450-51. It was assumed that private managed care businesses, through their ability to operate efficiently in the free-market, could cut-the-fat while retaining quality services. *See* Walsh, *supra* note 50, at 215. Indeed, the lower costs were characterized as savings to the consumer and not as increased profits for the MCOs. Political lobbyists assumed and then convinced the public that the private sector could generate enough revenue to provide good medical service even though it spent less on such service. *See* Jack W. Germond & Jules Witcover, *Defeat of Tobacco Bill May Have Political Upside for Democrats*, BALTIMORE SUN, June 22, 1998, at A11 (implying that the fact that political strategists convinced the public that President Clinton's effort to provide universal health care coverage would create a new federal bureaucracy reveals that the public believed managed care, even though it reduced costs, would provide quality care). Even if this was true, the mere fact that the conduct of MCOs has reduced the costs of health care and made it more affordable for consumers does not excuse that same conduct if it happens to be negligent and cause injuries. By allowing MCOs to remain free of tort liability because the framers of ERISA

consumers access to care.<sup>60</sup> More specifically, these cost containment mechanisms are often employed by MCOs as a means to control the decision-making of physicians by either directly

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created federal legislation preempting all state law remedies, it is tantamount to Congress advocating the sacrifice of consumers lives and safety for the mere advantage of lower cost health care.

<sup>60</sup> In fact, it appears that the managed care system, within the context of the private sector employer-provided health care market, has rationed consumers' pre-purchased services without the fear of liability for negligent, culpable conduct. See *infra* note 155 (analyzing basic economic principles of free markets and concluding that MCOs have artificially reduced the supply of health care by denying consumers their pre-purchased services). This leaves open the question of whether MCOs are using the cost savings to enhance their own profits or whether ERISA merely has made liability-free MCOs complacent because they can still earn a profit by denying pre-purchased services. It is possible that MCOs planned to be innovative market providers by creating and exploiting new areas for profit through marketing or investment in other opportunities, so as to reduce costs and still provide reasonable health care coverage. But, it is more likely that a lack of liability under ERISA has left MCOs content to merely ration the pre-purchased services to consumers, often to the consumers' detriment. See *infra* notes 117-118 (detailing specific instances where MCOs' decisions have delayed or denied health care coverage and, as a result, injured or caused the death of a patient).

Consequently, consumers have become distrustful of the health care market and have little confidence in their MCOs. A national survey in 1998 by the Kaiser Family Foundation and Harvard University found that 55% of respondents said that they were worried that if they were sick their health plan would be more concerned with costs than about their care. Carol Marie Cropper, *In Texas, a Laboratory Test on the Effects of Suing H.M.O.'s*, N.Y. TIMES, Sept. 13, 1998, at C1. Often the persons making treatment decisions have insufficient information, expertise or information to properly refer consumers to the appropriate provider or to proffer accurate coverage information. *60 Minutes: "Managed or Mangled Care"* (CBS television broadcast, Sept. 6, 1998). Moreover, consumers are finding it very difficult to understand managed care given that MCOs often offer only very technical information materials or provide conflicting information on coverage, complaints, or appeal processes. See *Hearing on Grievance Procedures*, *supra* note 37 (statement of Bernice Steinhardt, Director of Health Services Quality & Public Health Issues Group of the General Accounting Office). In fact, 56% of consumers either did not know they were in managed care or did not know what that meant. See *Hearing on Grievance Procedures*, *supra* note 37 (statement of Bernice Steinhardt). Indeed, these problems are a large part of the concern that many policymakers have expressed with the apparent control that MCOs exercise over a patient's treatment decisions.

denying a doctor's recommended treatment or by discouraging doctors from providing certain beneficial treatments in an effort to reduce costs.<sup>61</sup> By utilizing these cost containment mechanisms, MCOs are in fact controlling treatment decisions.<sup>62</sup> When MCOs are negligent in making such decisions, by choosing to deny or delay coverage for appropriate treatment, they harmfully constrain consumers' access to reasonable care.

### *B. ERISA Preemption*

The predominance of MCOs in the health care market reveals the tremendous effect that their conduct has on a vast number of American consumers.<sup>63</sup> The expansive reach of an MCO's actions demonstrates the importance of allowing consumers to hold MCOs liable when their decisions preclude consumers from obtaining their pre-purchased health coverage and, as a result, injure those consumers by either denying or delaying their access to reasonable care. Unfortunately, however, consumers of employer-provided health care cannot seek redress for their injuries caused by the negligence of their MCOs because federal law, which regulates employer-provided health care, has failed to provide remedies for direct negligence and has expressly preempted any possible state law remedies.<sup>64</sup>

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<sup>61</sup> See Green, *supra* note 47, at 683 (asserting that "[i]n essence, the managed care provider becomes a final decision-maker"). See also *infra* notes 116-118 (noting that when MCOs make decisions to deny or delay care there is a potential that those decisions are negligent or represent culpable conduct, because if the care that was denied was actually medically necessary and part of the patient's pre-purchased health plan coverage, the patient could sustain injuries as a result of the MCOs negligent decision).

<sup>62</sup> See Green, *supra* note 47, at 683 (discussing the relationship between MCOs and providers and noting that MCOs are the final decision-maker with respect to treatment decisions for patient-consumers).

<sup>63</sup> See *supra* notes 51-53 and accompanying text (noting that enrollment in the managed care system exploded between 1970 and 1990 to include 125 million Americans enrolled in a managed care plan subject to ERISA as of 1997).

<sup>64</sup> See ERISA § 502, 29 U.S.C. § 1132 (1994); ERISA § 514(a), 29 U.S.C. § 1144(a) (1994). Indeed, where Congress acts pursuant to its plenary powers,

In 1974, ERISA was enacted by Congress pursuant to its commerce and taxing powers,<sup>65</sup> in part, to regulate employer-provided health care plans.<sup>66</sup> It was drafted with an express preemption provision barring state regulation "relate[d] to" employer-provided health plans.<sup>67</sup> However, ERISA was primarily enacted to establish standards of conduct for, and to impose reporting and disclosure requirements on, fiduciaries of employer pension plans to protect the financial interests of the employee plan participants.<sup>68</sup> By enacting ERISA, Congress intended to replace

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it may specifically prohibit parallel state legislation by employing an express preemption provision. See RONALD D. ROTUNDA & JOHN E. NOWAK, *TREATISE ON CONSTITUTIONAL LAW: SUBSTANCE AND PROCEDURE* § 12.1, at 62-63 (2d ed. 1992). In fact, when Congress may regulate an area of private sector activity, it may explicitly preempt and bar state regulation of that activity. *Id.* § 12.3, at 75.

<sup>65</sup> Section 2 of ERISA provides in pertinent part:

Congress finds that the growth in size, scope and numbers of employee benefit plans . . . has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; . . . that they are affected with a national public interest; . . . that they have become an important factor in commerce because of the interstate character of their activities[;] . . . that a large volume of the activities of such plans are carried on by means of the mails and instrumentalities of interstate commerce; . . . [and] that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment . . . .

29 U.S.C. § 1001(a) (1994).

<sup>66</sup> See ERISA § 3, 29 U.S.C. § 1002 (1994) (defining employee benefit plans regulated by ERISA to include, "any plan, fund, or program . . . established or maintained by an employer . . . to the extent [they are] . . . maintained for providing . . . their beneficiaries . . . medical, surgical, or hospital care or benefits").

<sup>67</sup> ERISA § 514(a), 29 U.S.C. § 1144(a).

<sup>68</sup> See Barry B. Cepelewicz et al., *Recent Developments in Medicine and Law*, 33 TORT & INS. L.J. 583, 583 (1998). The purpose of ERISA was to remove many of the barriers facing employees in trying to recover benefits from insufficiently funded pension plans by requiring disclosure and reporting of financial and other information and by providing remedies, sanctions, and ready access to the federal courts. See ERISA § 2, 29 U.S.C. § 1001(a) & (b) (1994). See also Larry J. Pittman, *ERISA's Preemption Clause and the Health Care Industry: An Abdication of Judicial Law-Creating Authority*, 46 FLA. L. REV. 355, 359 (1994) (citing 120 CONG. REC. 29,935 (1974) (statement of Sen. Javits))

a patchwork scheme of state regulation of pension plans with a uniform set of federal regulations and protections.<sup>69</sup> Seemingly, ERISA was made applicable to employer-provided health plans merely as an afterthought because, in contrast to its treatment of pension plans, it does not mandate minimum levels of benefits nor require that employees receive any such welfare plan.<sup>70</sup> Although ERISA's enforcement provisions provide judicial remedies to seek

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(stating that "at the time of enactment, ERISA, was heralded as nothing less than a *pension plan bill of rights* to which every worker . . . is entitled") (emphasis added)).

It is ironic that the very statute that vigilantly protects the rights of employees within the context of pension plans by affording remedies for injuries incurred as a result of their employers' or plan managers' negligence, has been interpreted to ignore the very same employees when their health care plan or managed care organization, through negligent decision-making, causes them injuries. *See, e.g., Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57 (1987) (holding that state law claim asserting negligent claim processing of benefits is preempted); *Dukes v. U.S. Healthcare*, 57 F.3d 350, 360-61 (3d Cir. 1995) (holding that employee's direct liability claim of negligence against his health benefit plan was preempted by ERISA); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 131-32 (9th Cir. 1993) (holding that ERISA preempted a state law claim for wrongful death because the claim asserted that a health plan was negligent in administering benefits).

<sup>69</sup> *See Pilot Life Ins.*, 481 U.S. at 46 (finding that the "'sole power to regulate the field of employee benefit plans [was] ERISA's crowning achievement [and] . . . [i]t should be stressed that . . . enforcement provisions . . . are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans'" (quoting 120 CONG. REC. 29,197, 29,933 (1974) (statements of Rep. Dent and Sen. Williams))). Congress intended to:

ensure that plans . . . would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among [s]tates . . . [to prevent] the potential conflict in substantive law . . . requiring the tailoring of plans . . . to the peculiarities of the law of each jurisdiction.

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

<sup>70</sup> *See Grosso, supra* note 44, at 441 (explaining that ERISA does not govern the substantive content of employee benefit plans and that the Department of Labor has not promulgated any meaningful regulations pertaining to the substance of employee benefit plans and has focused instead on pension plans).

relief for breaches of contractual or fiduciary obligations,<sup>71</sup> the statute has been interpreted as failing to provide a mechanism by which employee-consumers can seek redress for injuries caused by the direct negligence of their MCOs.<sup>72</sup>

### 1. *The Mechanics of ERISA's Dual Preemption Clauses*

The problem for consumers of employer-provided health care seeking relief for injuries caused by the direct negligence of their MCOs, is that ERISA essentially eliminates any opportunity for such relief, both because it fails to provide substantive remedies and because it creates a statutory scheme with dual preemption clauses that preclude recovery through state law remedies.<sup>73</sup>

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<sup>71</sup> ERISA § 502(a) provides in pertinent part:

A civil action may be brought—

(1) by a participant or beneficiary—

....

(B) to recover benefits due[,] . . . to enforce rights under the terms of the [health] plan, or to clarify rights to future benefits . . . .

....

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates . . . the terms of the [health] plan, or (B) to obtain other appropriate equitable relief . . . .

29 U.S.C. § 1132(a)(1)(B), (3)(A)-(B) (1994).

<sup>72</sup> See *infra* note 73 and accompanying text. But see *Corporate Health Ins. v. Texas Dep't of Ins.*, 12 F. Supp. 2d 597, 617-19 (S.D. Tex. 1998) (holding that a direct negligence claim against an MCO with respect to the quality of benefits actually provided, as opposed to a claim based on the denial of benefits, may be brought under state law and escape ERISA preemption).

<sup>73</sup> ERISA § 502(a), 29 U.S.C. § 1132(a)(1)(B), (3) (also known as "complete preemption"); ERISA § 514(a), 29 U.S.C. § 1144(a) & (b)(2)(A)-(B) (1994) (also known as "federal preemption").

Courts may utilize preemption, even in the absence of statutory authority, to displace a claim under state law by applying the preemption doctrine underlying the Supremacy Clause of the Constitution. See U.S. CONST. art. VI. However, the type of preemption that would displace a claim under state law is not a direct application of the Supremacy Clause because the intent of Congress is not sufficiently clear to show a direct conflict with a state law. Nevertheless, federal law overrides those state laws not directly conflicting when those state

ERISA's preemption clauses displace state law claims in two ways. First, a state law claim may be "completely preempted" if a federal court determines that such a claim can be characterized as requesting recovery for benefits due, enforcement of contractual rights, or clarification of rights to future benefits.<sup>74</sup> If the court determines

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laws "impair federal superintendence of the field." ROTUNDA & NOWAK, *supra* note 64, § 12.4, at 75-76.

Therefore, when legislators included health plans under the regime of ERISA without explicit remedies, the powerful preemption clauses, intended merely to maintain regulatory consistency and to encourage the formation of employee benefit plans, effectively obliterated the ability for employee-consumers of health care to seek redress for injuries caused by the direct negligence of their MCOs. *See* Corcoran v. United Healthcare, 965 F.2d 1321, 1333 (5th Cir. 1992) (asserting that while the court is "not unmindful of the fact that [its] . . . interpretation of [ERISA] . . . leaves a gap in remedies within the statute intended to protect participants in employee benefit plans . . . the lack of an ERISA Remedy does not affect . . . preemption analysis"). In fact, the Supreme Court has stated that ERISA's express preemption clauses:

Set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. *The policy choices reflected in the inclusion of certain and the exclusion of others under the federal scheme would be completely undermined if ERISA plan participants . . . were free to obtain remedies under state law that Congress rejected in ERISA.*

*Pilot Life Ins.*, 481 U.S. at 54 (emphasis added).

<sup>74</sup> ERISA § 502(a), 29 U.S.C. § 1132(a)(1)(B) (stating that "[a] civil action may be brought—by a participant or beneficiary . . . 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 terms of the plan"). *See also* Dukes v. U.S. Healthcare, 57 F.3d 350, 353-54 (3d Cir. 1995) (noting the Supreme Court's recognition that "complete preemption" is an exception to the well-pleaded complaint rule, which ordinarily does not allow removal to federal court merely because a defense of preemption may be established, since removal is proper only if a federal question is presented on the face of plaintiff's complaint. Thus, "complete preemption," as an exception to that rule, is justified by the Court as a mere effectuation of Congress' intent to so completely preempt a particular area that *any* civil complaint is "*necessarily federal in character*") (quoting *Metropolitan Life Ins. v. Taylor*, 481 U.S. 58, 63-64 (1987) (emphasis added)).

Within the context of ERISA, the Supreme Court has recognized that Congress intended the "complete preemption" doctrine to apply to any state law

that a plaintiff's state law claim is completely preempted, the claim is insulated from state law analysis and decided by the court solely under ERISA's provisions.<sup>75</sup> Consequently, when state law claims are determined to be completely preempted and a plaintiff's action is decided exclusively under ERISA, MCOs are effectively shielded from any liability for their negligent administration of health care.<sup>76</sup>

Second, even if a state law claim survives the court's complete preemption analysis, it may still be preempted under ERISA's "federal preemption" clause.<sup>77</sup> However, the claim, as a general matter, must first be heard in a state court to determine whether the claim is subject to federal preemption.<sup>78</sup> To make such a decision,

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causes of action that attempt to regulate conduct in appreciably the same manner as the ERISA enforcement provisions found in 29 U.S.C. § 1132(a). *See Taylor*, 481 U.S. at 66.

<sup>75</sup> *See* 28 U.S.C. § 1331 (1994) (providing the basis for the "well-pleaded complaint" rule, which requires that federal courts determine whether a plaintiff's complaint has established that the case arises under federal law—essentially the same inquiry necessary to determine whether a claim is "completely preempted"). Therefore, if a plaintiff's complaint establishes that a cause of action "arises under" ERISA, a federal court must decide the case solely under ERISA. *See id.* *See also* Grosso, *supra* note 44, at 442 (applying the well-pleaded complaint rule to ERISA cases).

<sup>76</sup> *See* Grosso, *supra* note 44, at 442.

<sup>77</sup> ERISA § 514 (a) & (b) providing that the provisions of ERISA shall:

Supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan[,] . . . nothing . . . shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities[, and] . . . an employee benefit plan . . . shall [not] be deemed to be an insurance company or other insurer, bank, trust, or investment company or to be engaged in the business of insurance or banking . . . .

29 U.S.C. § 1144(a)-(b) (emphasis added).

<sup>78</sup> *See Taylor*, 481 U.S. at 64 (finding that a prerequisite for the removal of a plaintiff's state law claim to federal court under the "complete preemption" doctrine is that the claim falls within the scope of an ERISA enforcement provision, irrespective of whether the claim may be preempted by ERISA's preemption clauses in 29 U.S.C. § 1144(a)). *See also* Federal Tax Board v. Construction Laborers Vacation Trust, 463 U.S. 1, 27-28 (1983) (finding that if complete preemption is not applicable, a federal court is without removal jurisdiction and can only remand the claim to state court for a resolution of the



the state court must make a three-step inquiry.<sup>79</sup> First, if the state law underlying the claim “relate[s] to” an employee benefit plan, the court should hold that the claim is preempted.<sup>80</sup> Second, if the state law on which the claim rests does not regulate insurance, banking, or securities, the claim will not be protected by the “savings” clause<sup>81</sup> and is preempted.<sup>82</sup> Finally, if a state law claim alleges that it is based on the regulation of insurance so as to be shielded from preemption by the savings clause, the claim will nonetheless be preempted under the “deemer” clause<sup>83</sup> when the claim’s alleged regulation of insurance rests on the characterization of an employee benefit plan as an insurance

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preemption issue).

<sup>79</sup> Grosso, *supra* note 44, at 444. See also Margaret G. Farrell et al., *Health Care Consumer Claims and Litigation*, SC04 ALI-ABA 271, 302 (1998) [hereinafter Farrell, *Consumer Claims*] (explaining that ERISA’s “federal preemption” clause preempts state laws that “relate to” an ERISA plan, then saving from preemption state laws that regulate insurance, and providing that state insurance laws may not regulate ERISA plans that are self-insured, sometimes called “fully-funded” plans).

<sup>80</sup> ERISA § 514(a), 29 U.S.C. § 1144(a) (also known as the “relate to” clause) (stating that “the provisions of this subchapter and subchapter III of this chapter *shall supersede any and all laws insofar as they may now or hereafter relate to any employee benefit plan*”) (emphasis added). See *infra* Part I.B., discussing judicial interpretation of the “relates to” phrase.

<sup>81</sup> ERISA § 514(b), 29 U.S.C. § 1144(b)(2)(A) (stating that “[e]xcept 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”) (emphasis added).

<sup>82</sup> Compare ERISA § 514(a), 29 U.S.C. § 1144(a) (preempting all state law claims which “relate to” an ERISA benefit plan), with ERISA § 514(b), 29 U.S.C. § 1144(b)(2)(A) (saving only those state law claims relating to a benefit plan which regulate insurance, banking, or securities).

<sup>83</sup> ERISA § 514(b), also known as the “deemer” clause, provides in pertinent part that:

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 investment company or to be engaged in the business of insurance or banking for the purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies . . .*

29 U.S.C. § 1144(b)(2)(B) (emphasis added).

company.<sup>84</sup> Therefore, the deemer clause instructs that a state law claim cannot be protected by the savings clause merely because the claimant's employee benefit plan provides insurance.<sup>85</sup>

## 2. *The Traditional Broad Interpretation of ERISA Preemption*

For over two decades, the Supreme Court of the United States has interpreted ERISA's dual preemption clauses broadly.<sup>86</sup> In particular, the Court has provided a broad interpretation of the ERISA's "federal preemption" clause. For example, in *Pilot Life Insurance Co. v. Dedeaux*, the Supreme Court, relying on two of its prior cases, stressed that ERISA's federal preemption clause has an expansive sweep and that the phrase "relate to" contained within that clause was intended to have its "broad common-sense meaning,"<sup>87</sup> such that a state law 'relate[s] to' a benefit plan . . . 'if it has a connection with or reference to such plan.'"<sup>88</sup>

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<sup>84</sup> See ERISA § 514(b), 29 U.S.C. § 1144(b)(2)(B).

<sup>85</sup> See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45 (1987) (finding that the "deemer" clause makes clear that an employee benefit plan cannot be "deemed" an insurance company for the purposes of asserting that a claim is not preempted because the state law on which the claim rests purports to regulate insurance). See also Farrell, *Consumer Claims*, *supra* note 79, at 302 (noting that the "deemer" clause provides that state insurance laws may not regulate ERISA plans that are self-insured, sometimes called "fully-funded" plans).

<sup>86</sup> See *Metropolitan Life Ins. v. Taylor*, 481 U.S. 58, 66 (1987) (recognizing that Congress intended the "complete preemption" clause to displace any state law causes of action that attempt to regulate conduct in appreciably the same manner as the ERISA enforcement provisions codified in 29 U.S.C. § 1132(a)).

<sup>87</sup> 481 U.S. at 47-48 (noting that the Court has interpreted the phrase "relate to" within the federal preemption clause broadly so that state laws have been preempted or displaced by ERISA when they have had a connection with or have made reference to an ERISA benefit plan). See *supra* note 72 and accompanying text (explaining that the interpretation of ERISA preemption by the federal courts, with the exception of the recent interpretation of a federal court from Texas, has effectively prevented consumers from bringing any direct negligence claims against MCOs).

<sup>88</sup> *Pilot Life Ins.*, 481 U.S. at 47 (quoting *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985); *Shaw v. Delta Air Lines*, 463 U.S. 85, 97 (1983)). See also *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138-39 (1990) (finding that Congress intended the "relate to" phrase to have a broad meaning to the extent that "a state law may relate to a benefit plan, and thereby

The Supreme Court has also interpreted ERISA's "complete preemption" clause broadly. Specifically, the Supreme Court and the lower federal courts have found that the detailed scheme of enforcement provisions contained in section 502(a) of ERISA—i.e., the "complete preemption" clause—reflects the policy choices of Congress to include and exclude certain remedies.<sup>89</sup> The *Pilot Life* Court noted that such a deliberate balancing of policies embodied in Congress' choice of remedies demonstrates that Congress intended that no other remedies undermine its clearly defined scheme.<sup>90</sup>

Indeed, the Supreme Court has found that ERISA's broad preemption provisions both proscribe interference with the benefit plans formed under ERISA and integrate a civil enforcement scheme, which is essential for accomplishing the stated purposes of ERISA.<sup>91</sup> In determining whether a state law is preempted or displaced, the Court has instructed that the inquiry begin with congressional intent, where the purpose of Congress is the ultimate touchstone.<sup>92</sup> In applying this mandate, the Supreme Court has found that the underlying congressional intent of ERISA was to "eliminat[e] the threat of conflicting or inconsistent State and local regulation" for the purpose of encouraging the formation of employee benefit plans.<sup>93</sup> More specifically, the *Pilot Life* Court,

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be preempted, even if the law is not specifically designed to affect such plans, or the effect is only indirect").

<sup>89</sup> See ERISA § 502(a), 29 U.S.C. § 1132(a) (1994) (providing that "[a] civil action may be brought . . . to recover benefits due[,] . . . to enforce . . . rights[,] . . . or to clarify . . . rights to future benefits"); *Ingersoll-Rand Co.*, 498 U.S. at 144-45 (explaining that exclusive remedies provided by section 502(a) of ERISA demonstrates that the preemptive effect of ERISA is complete); *Corcoran v. United Healthcare*, 965 F.2d 1321, 1333 (5th Cir. 1992) (noting that Congress may preempt state law causes of action that interfere with ERISA even if this preemption may leave a gap in remedies within a statute intended to protect ERISA plan participants).

<sup>90</sup> *Pilot Life Ins.*, 481 U.S. at 54.

<sup>91</sup> *Ingersoll-Rand Co.*, 498 U.S. at 137 (citing *Pilot Life Ins.*, 481 U.S. at 52, 54).

<sup>92</sup> *Id.* at 137-38 (citing *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 208 (1985)); *Pilot Life Ins.*, 481 U.S. at 45.

<sup>93</sup> *Pilot Life Ins.*, 481 U.S. at 46 (citing 120 CONG. REC. 29,933 (1974) (statement of Sen. Williams)).

employing ERISA's dual preemption clauses, held that a state cause of action based on an alleged improper failure to provide benefits under the ERISA plan was undoubtedly preempted.<sup>94</sup>

### 3. *The Judicial Narrowing of ERISA Preemption*

The Supreme Court's established interpretation of ERISA's preemption provisions, statutory scheme, and legislative history was recently narrowed in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*<sup>95</sup> In *Travelers*, the reach of the Court's broad understanding of the "relate to" clause<sup>96</sup> under the doctrine of ERISA preemption was limited to state law claims that affect the structure, administration, and type of benefits provided by a plan.<sup>97</sup> Even more recently, the Supreme

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<sup>94</sup> *Id.* at 45-48, 54-57. The *Pilot Life* Court found that the effect of the preemption clauses is not limited simply to state laws actually "designed to affect employee benefit plans." *Id.* at 47-48. See also *Ingersoll-Rand Co.*, 498 U.S. at 139 (explaining that preemption is not precluded simply because a state law is consistent with ERISA's substantive requirements).

<sup>95</sup> 514 U.S. 645, 658-60 (1995).

<sup>96</sup> ERISA § 514(a), 29 U.S.C. § 1144(a) (1994).

<sup>97</sup> See *Travelers*, 514 U.S. at 658-60 (adopting a narrower interpretation of the "relates to" ERISA preemption clause by applying a test, whereby a state law would not be preempted when the relationship between that law and the employee health plan was indirect and did not affect the structure, the administration, or the type of benefits provided by the plan). See also Margaret G. Farrell, *ERISA Preemption and Regulation of Managed Health Care: The Case for Managed Federalism*, 23 AM. J.L. & MED. 251, 261 (noting that *Travelers* narrowed the traditionally broad interpretation of the "relate[s] to" phrase). In addition, the Court in *Travelers* asserted in dicta that there is usually a presumption against preemption of areas of traditional state regulation, such as health and safety. 514 U.S. at 655. However, the Court made clear that ERISA will continue to preempt any state law regulation that binds the health plan or MCO to particular administrative requirements, yet preemption will be less likely where the state regulation has only an "indirect economic influence." *Id.* at 668 (holding that "a state law might produce such acute, albeit indirect economic effects . . . as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers[,] which would be preempted, but if the law does not fall into either that narrow category of laws that indirectly effect yet substantially constrain ERISA, or have a direct economic effect, the state law claim should not be preempted).

Court confirmed this clarification of the "relate to" clause in *De Buono v. NYSA-ILA Medical & Clinical Services Fund*.<sup>98</sup> The *De Buono* Court reiterated that the literal text of the "relate to" clause is "clearly expansive[, b]ut . . . the text could not be read to extend to the furthest stretch of its indeterminacy."<sup>99</sup> Ostensibly, the Court has left intact the traditional understanding of ERISA preemption,<sup>100</sup> while concomitantly recognizing a limitation on preemption where there is "so tenuous a relation [to an ERISA plan and the] . . . state law [is] in an area of traditional state regulation."<sup>101</sup> In particular, the Court acknowledged that the preemption clause clearly supersedes state laws where, for example, employers are required to provide certain benefits<sup>102</sup> or the existence of an ERISA plan is a critical element of the state law cause of action.<sup>103</sup>

However, recently the Court of Appeals for the Third Circuit, in contravention to the Supreme Court's established interpretation of ERISA preemption, narrowed the "complete preemption" clause.

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<sup>98</sup> 520 U.S. 806, 813-16 (1997).

<sup>99</sup> *Id.* at 813-14 (quoting *Travelers*, 514 U.S. at 655).

<sup>100</sup> *Id.* (explaining that in "earlier ERISA preemption cases, it had not been necessary to [interpret the outer edges or define the exact reach of preemption] . . . in order to find preemption because the state laws at issue . . . had a clear 'connection with' or 'reference to' ERISA benefit plans") (quoting *Shaw v. Delta Air Lines*, 463 U.S. 85, 96-97 (1983)).

<sup>101</sup> *Id.* at 814 n.9 (quoting *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 333-34 (1997)). The Court held that a state law imposing a tax on hospitals owned by ERISA plans is not preempted because it is a law of general applicability imposing minimal burdens on the administration of the ERISA plans, and hence does not "relate to" the ERISA plans. *Id.* at 814-16.

<sup>102</sup> *Id.* at 814-16 (citing *Shaw*, 463 U.S. at 96-97 (holding that ERISA preempted a state law requiring the provision of pregnancy benefits); *Metropolitan Life Ins. v. Massachusetts*, 471 U.S. 724, 739 (1985) (holding that a state law requiring benefit plans to include minimum mental health benefits "relate[d] to" ERISA and was preempted)).

<sup>103</sup> *Id.* (citing *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, at 139-40 (1990) (holding that because a particular state law was not a generally applicable statute and was dependent on the existence of an ERISA plan in establishing liability under its provisions, the state law "relate[d] to" ERISA and was preempted)).

In *Dukes v. U.S. Healthcare*,<sup>104</sup> the Third Circuit held that where a state law claim rests on the quality of treatment provided, and not on the quantity and administration of services or the decision by the MCO to deny coverage, the claim should not be preempted.<sup>105</sup> While this judicial narrowing of ERISA's dual preemption

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<sup>104</sup> 57 F.3d 350 (3d Cir. 1995).

<sup>105</sup> *Id.* at 358-59 & n.5, 360-61. The Third Circuit essentially relied on district court opinions that attempted to distinguish the nature and type of claims underlying the cases in which the Supreme Court decided the correct statutory construction of the ERISA preemption clauses, to avoid the Supreme Court's broad application of ERISA preemption of state law claims. *See Dukes*, 57 F.3d at 360 (citing *Kearney v. U.S. Healthcare*, 859 F. Supp. 182, 186-87 (E.D. Pa. 1994) (holding that ERISA preempts a direct negligence claim, but not a vicarious liability claim); *Independence HMO v. Smith*, 733 F. Supp. 983, 987-89 (E.D. Pa. 1990) (noting that ERISA does not preempt vicarious liability claims)). Dicta from the Supreme Court's opinion in *Travelers* appeared to modify the Court's historic position on the statutory construction of ERISA and the proper interpretation of the statute's legislative history. *See* 514 U.S. 645, 656-57, 659-61, 668 (1995). However, there is no support for the Third Circuit's decision to artificially narrow the reach of ERISA's preemption clauses by adopting a construction of ERISA that greatly departs from the traditionally accepted interpretation of Congress' intent in enacting ERISA with express and severe preemption clauses.

Relying primarily on lower court cases, the *Dukes* Court also expanded the Supreme Court's decision in *Travelers* by taking the narrow limitation the Supreme Court tried to carve out in the "relate to" preemption clause, ERISA § 514(a), 29 U.S.C. § 1144(a), and applying it to the "complete preemption" clause, ERISA § 502(a), 29 U.S.C. § 1132(a). *See Dukes*, 57 F.3d at 355, 361 (concluding that preemption of a state law claim was improper when based on the mere "quality" of benefits received because when "there [are] no allegation[s] . . . that the HMOs [either] denied anyone any benefits [or, in the rare case, breached any quality standards rising to the level of a denial of benefits] which were due under the plan" a state law claim should not be preempted). In essence, the Third Circuit expanded one of the Supreme Court's mere examples of state action—the setting of "quality standards"—which would affect cost, but would, in most circumstances, have only an indirect economic impact on a plan and preclude preemption of a claim rooted in such state action. *See Travelers*, 514 U.S. at 660-61. The Third Circuit in expanding the narrowly carved out exception to the "relate[s] to" preemption, noted that when "[n]othing in the record suggests . . . [displacement] of otherwise applicable state laws of agency and tort . . . [i]t would seem that . . . a plan . . . [which adopted] its own [quality] standard of acceptable health care . . . should [have to] provide . . . an

clauses is a welcomed trend for consumers who have been denied effective redress for injuries incurred from the negligence of their MCOs, federal legislation is still necessary to permanently and effectively amend ERISA preemption.<sup>106</sup> To implement consistent and effective health care reform, Congress must enact legislation that will protect Americans and free consumers in private sector employer-provided health plans from the impediments to relief contained in ERISA so as to promote the effective delivery of reasonable health care.

## II. PATIENT'S BILL OF RIGHTS ACT OF 1998

### A. Key Provisions

The best approach to cure the defects in the health care market, such as consumers' distrust and their inability to obtain relief for the injuries caused by the negligent conduct of MCOs, is for Congress to enact legislation. This legislation should not only reform the ERISA preemption clauses to provide a procedural mechanism by which consumers can seek redress for their injuries caused by the tortious conduct of their MCOs, but also to provide new consumer protections ensuring fair and appropriate treatment in an MCO-dominated health care market. The Patients' Bill of Rights Act<sup>107</sup> is narrowly tailored to provide such a procedural mechanism<sup>108</sup> and contains the necessary measures to reform the

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appropriate remedy to beneficiaries [according to the applicable state law]"). See *Dukes*, 57 F.3d at 359 & n.5. This distinction between quality and quantity made by the Third Circuit has placed further gloss on the established broad interpretation of ERISA preemption to the extent that almost any state law claim may be formulated by its language to avoid preemption, which has the effect of frustrating the express intent of Congress in creating an extensive statutory scheme with severe preemption clauses.

<sup>106</sup> See *infra* Part III.A.1, discussing the need for federal legislative reform of ERISA as opposed to ad hoc federal judicial relief.

<sup>107</sup> H.R. 3605, 105th Cong. (1998).

<sup>108</sup> Section 302 of the Patients' Bill of Rights Act of 1998 states:

(a) IN GENERAL- Section 514 of the Employment Retirement Income Security Act of 1974 (29 U.S.C. § 1144) is *amended* by adding at the

end the following subsection:

'(e) PREEMPTION NOT TO APPLY TO CERTAIN ACTIONS ARISING OUT OF PROVISION OF BENEFITS—

'(1) IN GENERAL- Except as provided in this subsection, *nothing in this title shall be construed to invalidate, impair, or supersede any cause of action under state law to recover damages resulting from personal injury or for wrongful death against any person—*

*'(A) in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health plan (as defined in section 733), or*

*'(B) that arises out of the arrangement by such person for the provision of such insurance, administrative services, or medical services by other persons.*

'(2) EXCEPTION FOR EMPLOYERS AND OTHER PLAN SPONSORS-

*'(A) IN GENERAL- Subject to subparagraph (B), paragraph (1) does not authorize—*

*'(i) any cause of action against an employer or other plan sponsor maintaining the group health plan, or*

*'(ii) a right to recovery or indemnity by a person against an employer or other plan sponsor for damages assessed against the person pursuant to a cause of action under paragraph (1).*

*'(B) SPECIAL RULE- Subparagraph (A) shall not preclude any cause of action described in paragraph (1) against an employer or other plan sponsor if—*

*'(i) such action is based on the employer's or other plan sponsor's exercise of discretionary authority to make a decision on a claim for benefits covered under the plan or health insurance coverage in the case at issue; and*

*'(ii) the exercise by such employer or other plan sponsor of such authority resulted in personal injury or wrongful death.'*

H.R. 3605, 105th Cong. § 302(a)(e) (emphasis added) (amended material in original included within single quotation marks). The Bill's statutory scheme explicitly amends section 514, ERISA's express preemption clause. *Id.* § 302(a). The Bill ensures that only the party actually or directly responsible for negligently causing injury to a consumer is held liable, by providing an express exception from liability for employers and other health plan sponsors, unless those entities directly cause injury to a consumer while exercising their discretionary authority to make a decision on the provision of benefits or health care coverage. *See id.* § 302(a)(e)(2)(A)-(B).

The Bill's intention to narrowly tailor liability is further illustrated by section 301(a)(b)(1), where a group health plan or health insurance issuer shall be treated as satisfying most of the Bill's consumer protection requirements



health care system in a manner that will allow both consumers and MCOs to benefit.<sup>109</sup>

The consumer protections advocated by the Bill that should, at a minimum, be adopted by Congress to effectively reform the ailing health care market, include: (1) mandatory disclosure of information by group health plans and health insurance issuers to health care consumers at the time of initial coverage or enrollment;<sup>110</sup> (2) assured consumer choice of varying plan options and providers offered by a plan or particular issuer;<sup>111</sup> (3) immediate emergency services access irrespective of whether the health care provider is a participating or nonparticipating server;<sup>112</sup> and (4)

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located in title I, *see id.* §§ 101-08, 143, 152-53, with respect to the benefits it is required to provide, and will *not* be considered as failing to meet such requirements so long as the plan or its *representatives* did not cause such a failure by the issuer. *Id.* § 301(a)(b)(1). However, an MCO's liability with respect to other consumer protections in title I, such as providing information, *see id.* § 121, and establishing an internal and external (independent) appeals process, shall be determined by the Secretary of Health and Human Resources. *See id.* § 301(a)(b)(2)-(4).

Consequently, as opposed to the current system of regulation under ERISA that preempts virtually all state law actions against MCOs, the Bill would hold MCOs liable for their direct conduct irrespective of the "quantity and quality" of services provided, but would not hold them liable for the negligence or failures of others. *See id.* § 302(a). *See also* Easley, *supra* note 24, at 301, 303-06 (discussing the narrowing of ERISA preemption by some courts recognizing a distinction between claims asserting a failure to provide a certain quantity of services that are preempted by ERISA, and those claims alleging a denial of quality service, which are not preempted). Moreover, unlike under ERISA, the Bill most likely would not hold an MCO liable for the torts of the doctors providing care to a consumer because doctors are usually not classified as representatives or agents of health plans. *See* Ronald Smothers, *Labor Board Orders Hearing on Doctor Union*, N.Y. TIMES, Sept. 10, 1998, at B6 (addressing the question of who constitutes a "representative" of an MCO for the purposes of determining liability and noting that doctors have been historically considered independent contractors and not agents or employees of MCOs).

<sup>109</sup> *See* H.R. 3605, 105th Cong. § 302(a) (amending ERISA and imposing direct liability on MCOs in discrete situations). *See also infra* Part II.B, discussing the Bill's narrowly tailored statutory scheme.

<sup>110</sup> H.R. 3605, 105th Cong. § 121 (1998).

<sup>111</sup> *Id.* §§ 102-103.

<sup>112</sup> *Id.* § 101.

a right to a timely and efficient appeal process, both internal and independent external review—including an expedited appeal for medical exigencies—for complaints concerning the plan or issuer's decisions not to provide coverage.<sup>113</sup>

These provisions are essential for several reasons. First, under current law,<sup>114</sup> MCOs contracting through private sector employer-provided health plans have escaped responsibility for their failures to provide appropriate coverage that has already been purchased<sup>115</sup> but denied or postponed because of bureaucratic impediments.<sup>116</sup> This, in turn, has created little incentive for MCOs to

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<sup>113</sup> *Id.* §§ 131-133.

<sup>114</sup> ERISA, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. §§ 1001-1461 (1994)).

<sup>115</sup> See Easley, *supra* note 24, at 305-09 (discussing the background of ERISA and lack of liability of MCOs).

<sup>116</sup> See *Hearing on Grievance Procedures*, *supra* note 37 (statement of Olena Berg, Asst. Secretary of the Dep't of Labor's Pension and Welfare Benefits Admin.) (detailing instances of the pervasive use of bureaucratic impediments by MCOs). For example, Ron Paulich, who had testicular cancer, was regularly receiving costly injections that were fully covered by his plan. Paulich's provider was changed by his plan, which had no effect on the pre-purchased benefits he was entitled to receive from his plan. He was notified, however, that his plan would no longer cover \$180 of the procedure cost. Paulich could not afford that additional expense and was compelled to undergo castration. Some time after the castration, Paulich received a letter from his plan informing him that it had been wrong and that he was actually entitled to the costly injections as part of his pre-purchased employer-provided health care plan. Because Paulich's MCO did not have adequate information about his plan nor adequate procedures to inform him of a right to appeal such denials of coverage, he was forced to suffer without a vital part of his anatomy and his only ERISA remedy would be to receive the injection which his plan had denied some time before he was compelled to undergo castration. See *Hearing on Grievance Procedures*, *supra* note 37 (statement of Olena Berg).

In another example, Cheryl Bolinger brought her daughter home from a complicated back surgery to combat scoliosis. 144 CONG. REC. H935-03 (daily ed. Mar. 10, 1998) (statement of Cheryl Bolinger). Pursuant to the surgeon's orders, Bolinger's daughter was to receive nursing care and physical therapy at home for at least twelve weeks. Nine days later, however, Bolinger's MCO decided to overrule the surgeon's orders and remove the nurse. When Bolinger initially complained to her MCO she was told only that a note would be made of her concern. After Bolinger sent several letters, made numerous phone calls, and procured many letters of justification, the MCO finally acquiesced and

reform their practices and provide timely, necessary care until, in some cases, the patient no longer can be effectively treated<sup>117</sup> or has died<sup>118</sup> waiting for coverage.

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provided her daughter only the care that one of their expert surgeons had ordered previously as vital treatment for her daughter's condition without any compensation for damages incurred as a result of the delay. *Id.*

Even to an objective observer, the conduct of the above MCOs seems beyond defense. Both consumers were contractually entitled to receive vital medical coverage, but were denied coverage because of bureaucratic impediments and injured as a result. Yet, because their health plans are subject to ERISA, neither consumer may seek relief beyond the value of the delayed service itself. *See Hearing on Grievance Procedures, supra* note 37 (statement of Olena Berg). *See also* ERISA § 502(a), 29 U.S.C. § 1132(a) (1994).

<sup>117</sup> For example, Willis Lester had been receiving blood pressure and cholesterol medications under his fee-for-service plan. *See* 144 CONG. REC. S11,103 (daily ed. Sept. 29, 1998) (statement of Sen. Kennedy). When Lester's employer switched to a managed care plan, the MCO ceased providing him these medications. Subsequently, Lester suffered a stroke. Lester's physician explained that the physical therapy plan was limited, making it apparent that the MCOs denial of care was "impairing" his recovery to an extent that Lester may no longer be as effectively treated as if he had received the "proper" care from the beginning. *Id.*

In another example, a boy's leg was seriously injured in an auto accident. 144 CONG. REC. S10,819 (daily ed. Sept. 23, 1998) (statement of Sen. Kennedy). At a nearby hospital, emergency doctors told the boy's parents that he needed vascular surgery immediately to save his leg and that a surgeon was available for such an operation. The boy's MCO, however, insisted that he be transferred to an "in-network" hospital for the surgery, otherwise it would not pay. By the time the boy was transferred, his surgery was delayed three hours after the doctors had advised immediate attention. As a result, the boy lost his leg. *Id.*

<sup>118</sup> Ms. Corklin, a pregnant woman, was advised by her doctor that she should have 24-hour care during her current pregnancy because she had a problem with a previous pregnancy. *See Hearing on Grievance Procedures, supra* note 37 (statement of Olena Berg, Asst. Secretary of the Dep't of Labor's Pension and Welfare Benefits Admin.). Instead, the MCO only allowed Corklin 10 hours of care and, as a result, while the care provider was not there her baby went into fetal distress and died. *See Hearing on Grievance Procedures, supra* note 37 (statement of Olena Berg).

There was also the case of Jim Bartee who had developed leukemia. 144 CONG. REC. H7560 (daily ed. Sept. 10, 1998) (statement of Rep. Strickland). He informed his MCO that he only had three weeks to live and his only recourse was a bone-marrow transplant. The MCO representative responded, "Oh, we could never get it approved that quickly." The transplant was not approved in

Second, the Bill will reverse the incentive of managed care providers to arbitrarily deny or delay coverage because they will no longer be immune from direct liability.<sup>119</sup> Further, they will be liable for more than just the cost of the coverage or benefit that was wrongly or negligently denied.<sup>120</sup> Indeed, under the Bill, MCOs would have to provide redress for injuries resulting from their defective administration of services.<sup>121</sup>

Third, the Bill, to the extent it increases the liability of MCOs, is drafted narrowly to address the consequences of their direct actions.<sup>122</sup> The Bill, however, does not impose liability, as under some interpretations of current law, for the indirect conduct of the managed care organization.<sup>123</sup> In fact, the Bill eliminates the need for consumers to assert a tenuous direct claim against their provider merely to ensure that they can also assert an indirect vicarious liability claim against their MCO.<sup>124</sup> Instead, under the Bill,

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time and Barteo died. *Id.*

<sup>119</sup> See H.R. 3605, 105th Cong. § 302(a) (1998) (amending ERISA and imposing direct liability under any state law or cause of action to recover damages resulting from personal injury or wrongful death against any person, in connection with the provision of insurance, administrative services, or medical services, including arrangements made by such person thereto). See also Easley, *supra* note 24, at 308-12 (discussing the background of ERISA and theories of direct and vicarious liability).

<sup>120</sup> See *supra* notes 71-73 and accompanying text (discussing the limited extent of remedies available under ERISA preemption of state law).

<sup>121</sup> H.R. 3605, 105th Cong. § 302(a).

<sup>122</sup> See *supra* note 108 and accompanying text (discussing the narrow construction of the Bill, which only imposes liability in specific circumstances for direct negligence).

<sup>123</sup> See Easley, *supra* note 24, at 311-12 (discussing that some courts have interpreted the liability of MCOs under ERISA as merely vicarious, creating incentives for inefficiency and harm to consumers). But see *supra* note 108 (analyzing the Bill and discussing the fact that its provisions narrowly tailor liability by providing express exceptions to liability which have the effect of holding liable only the parties actually responsible for their direct conduct which causes injury).

<sup>124</sup> See *infra* notes 195-204 and accompanying text (explaining the problems associated with allowing vicarious liability claims against MCOs to be attached to direct state law claims against providers).

consumers can hold their MCO directly accountable for damages flowing from negligent decision-making.<sup>125</sup>

This ability to file a direct claim against an MCO prevents the complication of asserting an insincere and merely strategic claim against a provider.<sup>126</sup> If a claim against a provider, such as physician malpractice, has merit, it can be effectively addressed without fear of preemption by a state law action against such provider individually.<sup>127</sup> Accordingly, there is no need to base liability on tenuous vicarious theories<sup>128</sup> because the Bill would

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<sup>125</sup> H.R. 3605, 105th Cong. § 302(a).

<sup>126</sup> See *infra* notes 195-197 and accompanying text (asserting that inefficiency and unfairness are the inevitable results of allowing vicarious liability claims against MCOs to be attached to direct claims against providers).

<sup>127</sup> See *infra* note 199 and accompanying text (discussing the fact that a direct state law malpractice claim against a provider is independent of ERISA and not subject to preemption).

<sup>128</sup> While virtually every court has found that direct negligence claims are preempted under ERISA, some courts have interpreted ERISA as allowing vicarious liability claims against MCOs. See *Pacificare of Okla. v. Burrage*, 59 F.3d 151, 154-55 (10th Cir. 1995); *Dukes v. U.S. Healthcare*, 57 F.3d 350, 361 (3d Cir. 1995) (holding that a vicarious liability claim against an MCO was cognizable because it found that a claim alleging that an MCO was liable in its role as an arranger for actual medical treatment for its plan members was not preempted); *Kearney v. U.S. Healthcare*, 859 F. Supp. 182, 186-87 (E.D. Pa. 1994) (holding that ERISA preempts a direct negligence claim, but not its vicarious liability claim). But see *Corporate Health Ins. v. Texas Dep't of Ins.*, 12 F. Supp. 2d 597, 616-19 (S.D. Tex. 1998) (holding that MCOs are subject to direct negligence claims brought under state law, but finding that such claims are limited to instances when consumers attack the quality of the services actually provided by the MCOs and not when MCOs merely deny benefits); *Ricci v. Gooberman*, 840 F. Supp. 316, 317-18 (D.N.J. 1993) (holding that vicarious liability claims were preempted).

Under the Bill, however, MCOs are not charged with incidental or vicarious liability, but still remain liable for the conduct of their representatives. See H.R. 3605, 105th Cong. § 301(a), (b). The term representative within the context of § 301(a), (b) seems not to include doctors, who are usually deemed independent contractors, or employers or other plan sponsors, who are not liable for the MCO's conduct. See *id.* § 302(a), (e)(2)(i)-(ii). See also Smothers, *supra* note 108, at B6 (asserting the historic view by classifying doctors as independent contractors and not employees). Moreover, the statutory scheme seems to belie any other interpretation because § 302(a), (e)(1)-(2) sets up a system where each party is liable for their own direct discretionary actions.

allow consumers to hold any culpable party accountable for its negligent conduct.<sup>129</sup>

More importantly, the Bill is structured to avoid the need for litigation at all. Specifically, the Bill employs a balance of front-end<sup>130</sup> and back-end<sup>131</sup> regulations to ensure timely delivery of medical services and to reserve costly court-imposed remedies for the unusual case that is missed by the health care system, yet deserving of redress.<sup>132</sup> While the incidence of injuries and need

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<sup>129</sup> H.R. 3605, 105th Cong. § 302(a). Essentially, the Bill maintains efficiency and fairness within the private sector employer-provided health care market, both because it provides an exception to ERISA preemption and because it preserves the traditional interpretation of ERISA preemption analysis for all other state law claims, such as physician malpractice, which are not "relate[d] to" and completely independent of ERISA. *See supra* note 108 (analyzing the Bill and detailing the provisions which clearly hold liable only the party actually responsible for negligent treatment).

<sup>130</sup> Front-end regulations are procedures or safeguards, such as disclosure requirements or internal appeal processes placed near the beginning of the formation of the relationship between MCOs and consumers to ensure that most complaints or problems are heard and hopefully solved before injury or substantial cost is imposed. *See Hearing on Grievance Procedures, supra* note 37 (statement of Dr. Margaret Hamburg, Asst. Secretary of Planning and the Evaluation Dep't of Health & Human Services). However, procedures alone are not enough to protect consumers because there will be always some instances where the procedure is either never activated or returns a wrong decision, which could still cause damage and should be compensated. *See Hearing on Grievance Procedures, supra* note 37 (statement of Olena Berg, Asst. Secretary of the Dep't of Labor's Pension and Welfare Benefits Admin.).

<sup>131</sup> Back-end regulations are remedial mechanisms, such as external appeal process or judicial review to ensure that damages are mitigated or obviated if front-end procedural safeguards fail. *See Hearing on Grievance Procedures, supra* note 37 (statement of Dr. Margaret Hamburg, Asst. Secretary of Planning and the Evaluation Dep't of Health & Human Services).

<sup>132</sup> By using both front-end and back-end regulations or procedural safeguards the need for litigation will be reduced because damages will be prevented and consumer trust will be increased. *See Hearing on Grievance Procedures, supra* note 37 (statement of Dr. Margaret Hamburg, Asst. Secretary of Planning and the Evaluation Dep't of Health & Human Services). While the procedural safeguards will not work in every case, the incidence of consumers having to avail themselves of the back-end or more costly remedial provisions will decrease when procedures are placed at the front-end to prevent any damages, in the first instance, occurring as a result of a delay or denial of health

for remedial protections will definitely decrease with the use of front-end procedural safe-guards, there is still a need for accountability in the system.<sup>133</sup> Remedial provisions are necessary to ensure that those injuries that are not addressed by front-end procedural protections can be remedied so as to eliminate the incentive for MCOs to reduce quality or quantity of care.<sup>134</sup> Indeed, the Bill minimally increases the liability of MCOs when analyzed within the context of the entire health care system.<sup>135</sup> But liability is only increased to the extent necessary to restore fairness to the private sector employer-provided health care market by providing consumers the ability to seek redress for injuries caused by the negligent decision-making of their MCO.

Finally, the Bill establishes uniform and consistent consumer protections on the federal level for every application of health care by allowing consumers to seek redress for the negligence of their MCOs.<sup>136</sup> While these federal protections are mostly procedural mechanisms to obtain potential relief under substantive state remedies,<sup>137</sup> the protections under this Bill often represent

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care coverage. *See Hearing on Grievance Procedures, supra* note 37 (statement of Olena Berg, Asst. Secretary of the Dep't of Labor's Pension and Welfare Benefits Admin.).

<sup>133</sup> *See Hearing on Grievance Procedures, supra* note 37 (statement of Olena Berg, Asst. Secretary of the Dep't of Labor's Pension and Welfare Benefits Admin.) (asserting that an effective health care system requires a safety valve, where consumers may hold MCOs liable for their negligent treatment decisions when the procedural protections fail).

<sup>134</sup> *See Hearing on Grievance Procedures, supra* note 37 (statement of Olena Berg, Asst. Secretary of the Dep't of Labor's Pension and Welfare Benefits Admin.). *But see* ERISA § 502(a), 29 U.S.C. § 1132(a) (1994) (allowing consumers to recover the value of treatments and to enforce and clarify rights under their plan).

<sup>135</sup> *See supra* note 108 and accompanying text (discussing the fact that the Bill imposes liability on MCOs, but only in situations where the direct conduct of an MCO caused the consumer's injury).

<sup>136</sup> *See supra* text accompanying notes 110-113 (detailing the consumer protections provided by the Bill).

<sup>137</sup> *See* H.R. 3605, 105th Cong. §§ 101-103, 121, 131-133, 302 (1998).

substantive standards that may serve as a model for underlying state laws or enforcement provisions.<sup>138</sup>

*B. The Procedural Mechanism to Reverse Adverse Incentives of MCOs*

The most important aspect of the Bill, or any newly drafted legislative reform of the health care system, is that it contains a procedure by which essential consumer protections may be implemented to provide narrowly tailored relief ensuring the delivery of reasonable care.<sup>139</sup> In contrast, a legislative scheme which merely adds federal remedies to ERISA, rather than amending the harsh effects of its preemption clauses to allow

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<sup>138</sup> The fact that recovery may be provided under analogous state law provisions will encourage those states that want reliable consumer protections in the health care system to draft legislation; whereas the states that desire less regulation and fewer protections can choose not to draft such legislation that could provide a vehicle for recovery under state law. *See supra* notes 32 and 161.

It is irrelevant to the present need for reform that some of the provisions of the Bill may overlap with other statutes that currently afford consumer protections or represent legislative reform of the health care system which has been already enacted. *See* Robert Pear, *Health Insurers' Skirting New Laws, Officials Report*, N.Y. TIMES, Oct. 4, 1997, at A1 (explaining that the Emergency Medical Treatment and Active Labor Act, for example, specifically targeted the need for emergency care to ensure that patients would receive it regardless of whether the hospital is a participating member of their MCO). Similarly, the Health Insurance Portability and Accountability Act of 1996 attacked the problem of coverage for pre-existing medical conditions. Robert Pear, *Move Under Way to Try to Block Health Care Bills*, N.Y. TIMES, Nov. 4, 1997, at A1 (asserting that "proposals [usually are] . . . an effort to accomplish, in an incremental way, some of the goals . . . pursued . . . in [a] plan for national health insurance"). Thus, while the problems addressed by the Bill may have been partially addressed, additional reform is necessary to cure the overall defects in the entire health care market, especially with respect to access to reasonable care and assurance that injuries caused by the negligence of MCOs will be redressed.

<sup>139</sup> *See supra* notes 25-26 and accompanying text (explaining that the incentives of MCOs to deny and delay care must be adjusted so as to encourage reasonable delivery of health care).



consumers to seek redress,<sup>140</sup> ignoring concerns of federalism<sup>141</sup>

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<sup>140</sup> See Jeffrey E. Shuren, *Legal Accountability for Utilization Review in ERISA Health Plans*, 77 N.C. L. REV. 731, 776-82 (1999) (arguing that Congress should create a duty of care requirement on MCOs and allow a direct cause of action against MCOs under federal statutory provisions, ignoring federalism and judicial economy concerns).

<sup>141</sup> As a general policy concern, federalism ideally instructs to balance power between the federal and state governments, where the federal government is delegated limited, enumerated powers while the states are provided the remainder, including general police powers to legislate so as to protect the "health and safety" of their citizens. See U.S. CONST. art. I, § 8 (granting Congress its enumerated legislative-powers), §§ 9-10 (proscribing state actions); *id.* amend. X (granting states all powers not reserved to the Federal government, nor prohibited by the Constitution).

Federalism is not a restraint on the judiciary only. It is a well accepted principle which counsels against interfering with a Republican form of government that diffuses power among the three branches of the Federal government and the several States. See GERALD GUNTHER & KATHLEEN M. SULLIVAN, *CONSTITUTIONAL LAW* pt. 2, at 87-89 (13th ed. 1997). Federalism concerns counsel against treading on the traditional powers exercised by either the federal or state governments. See, e.g., *Custer v. Sweeney*, 89 F.3d 1156, 1167 (4th Cir. 1996) (finding that ERISA, a federal law, usually does not preempt areas where states traditionally exercise authority, unless there is some clearly expressed direction under federal legislative power to set national, majoritarian policies); *Hook v. Morrison Milling Co.*, 38 F.3d 776, 781 (5th Cir. 1994) (finding ERISA preemption "remains subject to the traditional principle of federalism"). While federalism is not an absolute rule, it should be addressed when countenancing important legislative reform effecting both the federal and state governments. See, e.g., *Patsy v. Board of Regents*, 457 U.S. 496, 513 (1982) (reversing the decision below creating a new rule based merely on federalism concerns, and holding that "policy considerations alone cannot justify not following precedent unless it is consistent with congressional intent"). Congress should directly address federalism concerns, in areas of traditional import to state governments, and because of the important governmental and social policy concerns underlying the principle of federalism. See *Hearing on Grievance Procedures*, *supra* note 37 (statement of Dr. Margaret Hamburg, Asst. Secretary of Planning and the Evaluation Dep't of Health & Human Services) (recognizing the need for Congress to assess the impact of ERISA legislative reform on state powers). These policy concerns include: the states' interests in developing and enforcing policies which protect their citizens and comport with local needs, assured accountability and best possible representation for citizens of the several States, and a check on any arbitrary or capricious power. See, e.g., *Patsy v. Florida Int'l Univ.*, 634 F.2d 900, 911-12 (5th Cir. 1981) (finding that

and judicial economy.<sup>142</sup> Such a legislative scheme frustrates the efficient and effective delivery of private sector employer-provided health care.

Specifically, the Bill creates a statutory scheme that announces, in general, that it “shall not . . . supersede any provision of state

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federalism concerns address important social policies, such as: a “state[’s] . . . constitutionally based interest in autonomously running the . . . government to the fullest extent possible”), *rev’d on other grounds*, 457 U.S. 496, 513 (1982) (finding social policy concerns important, but noting that the Court should wait for Congress to act when there was clear precedent). These concerns suggest that a federal legislative plan that provides a universal and uniform procedure on the federal level, but allows state substantive law to provide redress, is better suited to cure the defects of ERISA than a plan providing relief on the federal level without counseling state interests. Moreover, Congress should follow the lead of the states that have already enacted comprehensive consumer protection provisions geared toward discouraging MCOs from ignoring the needs of their consumers. These innovative remedial schemes should be effectuated on the federal level so consumers in health care plans subject to ERISA may have equal protection from MCO negligence as the consumers of non-ERISA plans have.

<sup>142</sup> See *Hearing on Grievance Procedures*, *supra* note 37 (statement of Dr. Margaret Hamburg, Asst. Secretary of Planning and the Evaluation Dep’t of Health & Human Services) (asserting implicitly that judicial economy concerns are addressed by a legislative scheme that employs front-end procedural protections because those protections provide essential relief to consumers before damages occur and obviate the need for judicial review). See also *infra* note 191 and accompanying text (discussing the fact that it is unclear whether ERISA contemplated a federal common law).

Federal remedies by themselves are impractical because it is inefficient and expensive to administer a form of federal tort law requiring expansion, development, or redevelopment of a federal common law to address negligence claims solely under the ERISA framework covering over 125 million consumers of private sector employer-provided health care. See, e.g., *Patsy*, 634 F.2d at 911-12 (finding that state remedies are “generally simpler, speedier, and less expensive [and] improve [efficiency] . . . of the process itself”). In contrast, state courts are better equipped for the task, because these courts are more attuned to the needs of local citizens, they may utilize well developed common law in the area of consumer protection and health and safety, and they have practice interpreting various state laws addressing the same issues which sprout from litigation against MCOs. *Id.* (asserting that a state is “able to hone its [laws] . . . to comply with federal requirements . . . without losing the advantage of [its expertise,] . . . familiarity with the local conditions[,] and awareness of the impact of a particular action”).

law . . . [subject to paragraph (2) of the section and] except to the extent [it] prevents the application [of the standards of this title].”<sup>143</sup> This statutory scheme, however, does not appear to allow for any modification of section 514 of ERISA that preempts the application of state law remedies against employer-provided health plans.<sup>144</sup> In fact, paragraph (2) of the Bill explicitly asserts that “[n]othing in this title shall be construed to affect or modify . . . section 514 . . . with respect to group health plans.”<sup>145</sup> Thus, as a general rule, the Bill provides that state law remedies are applicable in conjunction with its own provisions, unless: (1) the state law contradicts the requirements of the Bill,<sup>146</sup> or (2) section 514 preempts the application of the state law to the employer-provided health plan.<sup>147</sup>

However, the exception allowing section 514 to preempt state law has its own limitations.<sup>148</sup> While this exception is derived from section 192(a)(2) of the Bill, stating that “nothing” shall affect or modify provisions of section 514 that have been found to preempt the applicability of state law remedies against health plans,<sup>149</sup> it must be interpreted and read within the context of the entire Bill. The term “nothing” as used within the context of the language of the Bill must mean there are “no” modifications made, in general, to the ability of section 514 to preempt state law remedies because the Bill expressly amends ERISA<sup>150</sup> in narrowly structured circumstances that provide for the specific situations where state law action against health care plans are not preempted.<sup>151</sup>

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<sup>143</sup> H.R. 3605, 105th Cong. § 192(a)(1) (1998).

<sup>144</sup> See 29 U.S.C. § 1144 (1994).

<sup>145</sup> H.R. 3605, 105th Cong. § 192(a)(2).

<sup>146</sup> *Id.* § 192(a)(1).

<sup>147</sup> *Id.* § 192(a)(2).

<sup>148</sup> *Id.* § 302 (ERISA Preemption Not to Apply to Certain Actions Involving Health Insurance Policyholders).

<sup>149</sup> *Id.* § 192(a)(2).

<sup>150</sup> *Id.* § 301(a) (asserting that ERISA “is amended by adding . . . the . . . new section: . . . ‘(a) . . . a group health plan[] and health insurance issuer . . . shall comply with the requirements [and standards imposed by] . . . title I’”).

<sup>151</sup> *Id.* § 302(a) (Preemption Not to Apply to Certain Actions Arising Out of Provision of Health Benefits). See also *supra* note 108 (analyzing the Bill and

There are three reasons demonstrating the importance of incorporating a narrowly tailored procedure, such as the one contained in the Bill, which employs consumer protections<sup>152</sup> to secure redress from the culpable conduct of MCOs.<sup>153</sup> First, such a procedure exposes MCOs to liability for their direct actions under state tort law and reverses the current incentive for MCOs to negligently deny or delay consumers' health care coverage in the name of cost containment and higher profits.<sup>154</sup> MCOs are therefore encouraged to become sensitive to the needs of consumers when developing business policies, so as to cure consumers' distrust of the private-sector employer-provided health care market and restore market efficiency.<sup>155</sup>

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discussing that its provisions narrowly tailor liability by providing express exceptions to liability which have the effect of holding liable only the parties actually responsible for their direct conduct which causes injury).

<sup>152</sup> The consumer protections are incorporated into the Bill in the following sections: H.R. 3605, 105th Cong. § 101 (Access to Emergency Care), § 102 (Offering Choice of Coverage Options under Group Health Plans), § 103 (Choice of Providers), § 121 (Patient Information), § 131 (Establishment of Grievance Process), § 132 (Internal Appeals and Adverse Determinations), and § 133 (External Appeals of Adverse Determinations).

<sup>153</sup> See H.R. 3605, 105th Cong. (providing procedural provisions, including: § 192(a)(1) which is the general rule recognizing the importance of federalism and respecting the legitimate interest that states have in enforcing their laws to deter tortious conduct and to compensate their citizens who are wrongfully injured, to the extent such laws do not frustrate the purpose of the federal statutory scheme; § 192(a)(2), the broad exception to the general rule, which practically swallows-up the rule, purports to honor and maintain the strong statutory preemption doctrine of ERISA, and ensures that the intent of Congress to replace a patchwork scheme of state regulations with a uniform set of federal regulations is preserved; and § 302(a), the narrowly tailored limitation on the broad-based exception—ERISA preemption—which provides the specific circumstances where state law actions are not preempted and respects the importance of the ability of the states to provide their injured citizens adequate relief within the context of the health care system).

<sup>154</sup> See *supra* notes 119-121 and accompanying text (explaining that the Bill reverses the incentive of MCOs to deny or delay coverage because it provides a procedure to seek redress for the direct negligence of MCOs under state law).

<sup>155</sup> In any ordered, free-market society, suppliers, such as MCOs, must be concerned with the needs or demand of their consumers to ensure efficiency. This efficiency, in theory, only occurs at the point where consumers' demand for

The next two reasons indicating the value of adopting a narrowly tailored procedure are derived from its narrow construction.<sup>156</sup> First, because health care has been historically under both state and federal control,<sup>157</sup> federalism concerns are addressed when consumer redress procedures are narrowly constructed and

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a good, such as health care, crosses the amount or supply of that good provided. See THE MIT DICTIONARY OF MODERN ECONOMICS 301 (David W. Pearce ed., 4th ed. 1992). Although a consumer's inability to hold a supplier liable, or, more appropriately, a consumer's lack of confidence in obtaining a satisfactory good, may be characterized as a transaction cost—not factored into neoclassical economic theory—it should be deemed reflected in the data which determines consumer demand because it is a controlling factor in any consumer's preference for a good. See PAUL A. SAMUELSON & WILLIAM A. NORDHAUS, ECONOMICS 459, 545 (13th ed. 1989). See also Kneave Riggall, *Comprehensive Tax Base Theory, Transaction Costs, and Economic Efficiency: How to Tax Our Way to Efficiency*, 17 VA. TAX REV. 295, 339 (1997) (describing transaction costs as the friction that prevents economic resources from flowing to their most productive uses and stating that “[m]any transactions costs are the *product of laws that, if changed would allow the economy to be more efficient . . .* [or] the absence of laws . . . that would foster economic activity”) (emphasis added). In a free market, if consumers are unsure of attaining reasonable health care and distrust the marketplace, they will demand less care on the market and either consume less or supplement traditional health care supplied by MCOs with alternatives. But, because ERISA preempts direct liability claims against MCOs for pre-purchased services, the supply of MCO provided health care has been artificially decreased, causing market inefficiency. See, e.g., David S. Peck, *Economic Analysis of the Allocation of Liability for Cargo Damage: The Case for the Carrier, Or is It?*, 26 TRANSP. L.J. 73, 83-84 (1998) (explaining that supply normally increases to meet demand and returns a price at equilibrium, but due to a supervening cause the supply may not increase, creating greater profits for the supplier). In effect ERISA preemption increases the profits of MCOs by denying consumers complete access to their pre-purchased health care. See *supra* notes 114-118 and accompanying text (asserting that MCOs subject to ERISA have failed to provide appropriate coverage and often deny or postpone coverage without fear of liability for negligence). Therefore, to restore consumer trust, market efficiency, and a sense of fair play, federal legislation must be enacted to amend ERISA's defects.

<sup>156</sup> See *supra* note 108 (discussing the Bill's narrow construction in greater detail).

<sup>157</sup> See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987) (discussing that the enactment of ERISA was for the purpose of replacing the patchwork of state law regulations with uniform federal law).

the power to regulate and enforce those procedures is allocated between the federal and state governments.<sup>158</sup> The federalism concern is arguably at its peak in circumstances where both the health and safety of states' citizens are at stake and the legislative powers of Congress to set national policies are threatened.<sup>159</sup> Because both the federal and state governments have legitimate interests in the subject of the federal legislation,<sup>160</sup> it is important that both bodies have input in the regulation process. Accordingly, the Bill is well suited to maintain federalism because it properly balances power between the federal and state governments. This balance, placing authority in the federal government to create the procedural consumer protections and power in the state governments to enforce these protections through substantive remedial laws,<sup>161</sup> is proper in light of the congressional intent under

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<sup>158</sup> See *supra* note 141 (discussing federalism).

<sup>159</sup> Where there is federal regulation in an area, such as health and safety, which is traditionally regulated by the states, the powers of the federal and state governments overlap. Both bodies have a legitimate interest in controlling or shaping the law in that area because Congress has a substantial interest in the adherence to its legislative pronouncements and clearly expressed policy objectives made pursuant to its Commerce Clause power, while the states have a substantial interest in protecting their citizens. See U.S. CONST. art. VI (guarantying that, to the extent that federal law is constitutional and legitimately enforced, states cannot contradict or frustrate its objectives); *id.* amend. X (guarantying that the states have the power to legislate in all areas other than those within the limited powers of Congress).

<sup>160</sup> However, depending on the intent of Congress to cover the field or completely preempt an area subject to federal law, states may regulate in the same area as a federal law. See, e.g., *Pacific Gas & Elec. Co. v. State Energy Resources Conservation & Dev. Comm'n*, 461 U.S. 190, 219-20 (1983) (holding that licensing or inspecting mandated by federal statute did not create a legislative scheme that occupied the entire area or field, nor prevented state regulation in that same area). The fact that Congress, even with limited powers, may, when expressly or implicitly provided by statute, so constrain states' power to regulate in one of its traditional areas, demonstrates that federal legislation is often necessary to correct or cure clearly expressed federal laws, such as the ERISA preemption clauses, which have become unworkable.

<sup>161</sup> This will encourage those states that want reliable consumer protections in the health care system to draft legislation, if not already in existence, that is analogous to the Bill. Conversely, states that desire less regulation and fewer protections can choose not to draft legislation that could provide a vehicle for

ERISA to maintain a uniform set of regulations.<sup>162</sup> Moreover,

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recovery under state law. *See, e.g.,* Mary Beth Denefe & Robert W. Brunner, *Managed Care Liability Under Illinois Law*, 86 ILL. B.J. 536, 536-37 (1998) (providing a good example of how states may afford consumers relief from their MCO's negligence by noting that Texas, in 1997, became the first state to establish a cause of action for negligence against an MCO and that Illinois may follow); Laurie McGiley, *Texas Law Allowing Patients to Sue Health Plans for Damages is Upheld*, WALL ST. J., Sept. 21, 1998, at B10 (noting same and that Missouri has adopted a similar law). Even though the Bill creates a procedure that determines the circumstances that will create liability for MCOs, the actual recovery may be obtained only through state law, not federal law. *See* H.R. 3605, 105th Cong. § 302(a)(e)(1). Hence, uniform consumer protection standards in the health care system would be available under federal law, but whether an actual remedy may be obtained is left to the discretion of each state legislature. *See id.* Therefore, the constitutional principle of federalism is maintained, while uniform federal protections are made available.

However, commentators may argue that because States have taken the lead recently in attempting to regulate the accountability of MCOs coupled with the holding of a federal district court in Texas that such a state law provision was not preempted by ERISA, federal legislation providing similar protections for consumers is not needed. *See, e.g.,* *Corporate Health Ins. v. Texas Dep't of Ins.*, 12 F. Supp. 2d 597, 614-20 (S.D. Tex. 1998) (holding that a Texas law imposing liability on MCOs was not preempted by ERISA because the State statute addresses the "quality" of benefits "actually" provided and not benefits denied). This argument is flawed because it would allow state law to infringe upon the clearly defined statutory interpretation and legislative history of ERISA, in contravention of the doctrines of stare decisis and separation of powers. It would also create divergent and inconsistent applications of federal law, which would unnecessarily tax judicial resources and fail to provide MCOs or consumers sufficient notice to conform their conduct to the law. *See infra* Part III.A.1, discussing the principles counseling against allowing ad hoc judicial remedies in greater detail. In addition, even the holding in *Corporate Health Insurance* encouraged Congress to refine ERISA. Charles Ornstein, *Judge Upholds State Law that Lets Patients Sue Over HMO Denials But Ruling Strikes Much of Independent Review Process*, DALLAS MORNING NEWS, Sept. 19, 1998, at A1 (quoting the federal judge upholding the Texas law against an ERISA preemption challenge, who stated that "[i]f Congress wants the American citizens to have access to adequate health care, then Congress must accept its responsibility to define the scope of ERISA preemption and to enact legislation that will ensure every patient has access to that care").

<sup>162</sup> *See Pilot Life*, 481 U.S. at 46 (discussing that the enactment of ERISA for the purpose of replacing the patchwork of state law regulations with uniform federal law).

under the Bill, federal law remains supreme because relief through state law is primarily necessary only in the unusual case that escapes the front-end consumer protections.<sup>163</sup>

Second, judicial economy is preserved when consumer redress procedures are narrowly tailored, even though they technically increase liability for MCOs. To the extent the liability of MCOs is increased, the Bill's consumer protection provisions employ a system with front-end and back-end regulations to address grievances before judicial review is necessary.<sup>164</sup> This eliminates the possibility that there will be a flood of litigation because the Bill's requirements for extensive information disclosure before enrollment, and an internal and external appeal, will address and resolve a number of complaints and appeals before any damage has occurred.<sup>165</sup> Consequently, in most cases, the narrow construction of the Bill and its system of protections will prevent or at least mitigate injury. This, in turn, will save the courts' resources for the rare cases where the system fails to address or remedy the complaint through both an internal or external, independent appeal process.

### III. EFFECTIVE UNIVERSAL REFORM OF THE HEALTH CARE SYSTEM

#### A. *A Superior Method of Reform*

The enactment of the Patients' Bill of Rights Act of 1998 or other federal legislation containing similar key provisions represents a superior method for reform when compared to other

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<sup>163</sup> See *supra* note 153 (noting the provisions of the Bill that create a narrowly tailored procedural mechanism).

<sup>164</sup> See *supra* text accompanying notes 110-113 & 130-131 and accompanying text (discussing the key protections provided by the Bill and asserting that the Bill places regulations in the front and back end of the relationship formed between consumers and MCOs, which will likely reduce most of the need for judicial review).

<sup>165</sup> See H.R. 3605, 105th Cong. § 121 (1998) (Patient Information), § 131 (Establishment of a Grievance Process), § 132 (Internal Appeals and Adverse Determinations), § 133 (External Appeals and Determinations).



approaches advocated by commentators. These alternative approaches include: (1) federal judicial review, which fashions relief on an ad hoc basis while completely abandoning the Supreme Court's precedent on the ERISA preemption clauses;<sup>166</sup> (2) creation of a system, whether legislatively or judicially created, which provides unjustified recovery for vicarious claims;<sup>167</sup> and (3) legislative reform, focusing solely on federalism ideals and thereby balancing federal and state authority too delicately with respect to health care, while failing to provide any governmental body with enforcement power allowing consumers the ability to seek redress.<sup>168</sup>

These alternative approaches do not provide effective methods of reform, because they encroach on the constitutional doctrines of stare decisis<sup>169</sup> and separation of powers.<sup>170</sup> In contrast, the Bill

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<sup>166</sup> Some commentators propose the radical narrowing or complete abandonment of both the Supreme Court's interpretation of ERISA's preemption clauses and its understanding of ERISA's legislative history to fashion relief for consumers on an ad hoc basis through federal judicial review. See Rebecca S. Fellman-Caldwell, New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.: *The Supreme Court Clarifies ERISA Preemption*, 45 CATH. U. L. REV. 1309, 1315-19, 1350 (1996) (asserting that the *Travelers* Court adequately narrowed the application of ERISA preemption, so as to allow ad hoc relief). See also Grosso, *supra* note 44, at 450-51.

<sup>167</sup> See Grosso, *supra* note 44, at 450-51 (advocating vicarious liability, whether judicially or legislatively created). See also Easley, *supra* note 24, at 313-14, 318 (asserting vicarious liability as necessary to ensure that MCOs are held liable for negligent conduct, and only advocating reform legislation because courts have been unwilling or unable to fashion ad hoc relief for consumers).

<sup>168</sup> See Farrell, *supra* note 97, at 252-54 (advocating legislation as the only effective method of reform while unrealistically insisting on a model of "managed federalism" poorly adapted to the private market for insurance).

<sup>169</sup> "[S]tare decisis is a principle of policy [which] . . . is a basic self-governing [mechanism] . . . within the Judicial Branch [that] is entrusted with the sensitive and difficult task of fashioning and preserving a jurisprudential system that is not based upon an arbitrary discretion." See *Patterson v. McLean Credit Union*, 491 U.S. 164, 172 (1989) (citing *Boys Markets Inc. v. Retail Clerks*, 398 U.S. 235, 241 (1970); *THE FEDERALIST* NO. 78, at 490 (Alexander Hamilton) (H. Lodge ed. 1888)).

<sup>170</sup> The separation of powers doctrine was originally derived from dicta in *McCulloch v. Maryland*, when Chief Justice Marshall pronounced that "where the law is not prohibited, and is really calculated to effect any of the objects

respects those doctrines. As an act of Congress, the Bill would properly amend the Federal Judiciary's precedents, thereby maintaining the credibility of the Federal Courts<sup>171</sup> and preserving stability, predictability, uniformity, efficiency, and fairness within the law.<sup>172</sup> It would also establish uniform, federal protections to provide relief through state law actions.<sup>173</sup> As a result, the Bill narrowly constructs the scope of liability and firmly allocates its enforcement regime to the states.

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entrusted to the government, to undertake here to inquire into the degree of its necessity, would be to pass the line which circumscribes the judicial department, and to *tread on legislative ground* [and t]his court disclaims all pretensions to such power." 17 U.S. (4 Wheat.) 316, 423 (1819) (emphasis added). This doctrine has since been applied in several circumstances which involve the interaction between the powers of Congress and the Judicial Branch. One such circumstance arises when a court is compelled to follow and interpret a statute enacted by Congress. In that circumstance, the court must be, when the statute is clear, bound by its normal or established application, unless, in the rare case, that plain language of the statute would lead to "patently absurd consequences." *Public Citizen v. United States Dep't of Justice*, 491 U.S. 440, 470 (1989) (citing *Holy Trinity v. United States*, 143 U.S. 457, 459 (1892)).

Moreover, just as it is the judicial department's duty to say what law is, *Marbury v. Madison*, 5 U.S. (1 Cranch) 137 (1803), "it is equally—and emphatically—the exclusive province of the Congress not only to formulate legislative policies and mandate programs and projects, but also to establish their relative priority for our Nation." *Tennessee Valley Authority v. Hill*, 437 U.S. 153, 194 (1978). Thus, once Congress has decided the order of priorities and extent of remedies in a certain area, it is for the courts to enforce those remedies when sought and it is not within the courts' power nor expertise to shape a remedy when Congress has acted in that area. *See id.*

<sup>171</sup> *See Planned Parenthood of S.E. Pa. v. Casey*, 505 U.S. 833, 864-69 (1992) (asserting that a court must take care to speak and act in ways that are grounded in principle and not merely in compromises that are the result of social and political pressures, because such principled decisions are upon what a court's credibility depends).

<sup>172</sup> *See EVA H. HANKS ET AL., ELEMENTS OF LAW* 174-180 (1994) (cataloguing defenses of the doctrine of precedent).

<sup>173</sup> *See supra* notes 32 & 161 (explaining that the Bill provides federal procedural protections and affords substantive remedies under state law).

### 1. Federal Judicial Review versus Federal Legislation

Commentators have advocated radically narrowing ERISA preemption analysis by abandoning over two decades of precedents<sup>174</sup> that broadly defined ERISA preemption<sup>175</sup> through the use of federal judicial review and the provision of ad hoc judicial remedies.<sup>176</sup> Utilizing this same federal judicial review to reform ERISA requires courts to abandon their prior decisions construing ERISA and its supporting legislative history and to reinterpret and narrow the established preemption analysis. This approach is inferior to federal legislative reform crafted with the essential mandates contained in the Bill<sup>177</sup> and it fails to afford a truly effective method of reform.

Such federal judicial review treads on the constitutional doctrines of stare decisis and separation of powers and thus is not the most effective method for reforming ERISA. There is no significant authority supporting the use of an approach, such as federal judicial review, which displaces an established statutory

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<sup>174</sup> See Caldwell, *supra* note 166, at 1315-19, 1350 (asserting that the Supreme Court in *Travelers* adequately narrowed the application of ERISA preemption, so as to allow courts to provide consumers ad hoc relief which implicitly rejects the need for legislation); Grosso, *supra* note 44, at 450-51 (advocating recognition of enterprise liability or allowing consumers to assert claims of vicarious and direct negligence whether judicially or legislatively created, and asserting that federal courts can and should narrow preemption analysis and fashion ad hoc remedies for consumers).

<sup>175</sup> See *supra* Part I.B.2, discussing the development of the judicial interpretation of ERISA's preemption analysis and statutory construction.

<sup>176</sup> The effects of the Supreme Court's abandonment of the previously broad construction of ERISA preemption implicitly necessitates that courts take a far greater role in employer-provided health care disputes by reviewing the merits of employees' state law claims, rather than simply giving effect to the traditional construction of ERISA's preemption clause and refusing to hear claims that would threaten the uniform application of ERISA regulations. See Caldwell, *supra* note 166, at 1347, 1350. See also Grosso, *supra* note 44, at 450 (advocating judicial review further narrowing ERISA preemption and entertaining vicarious liability claims on the basis of the Court's decision in *Travelers*).

<sup>177</sup> See *supra* text accompanying notes 110-113 (detailing the key consumer protections provided by the Bill).

scheme and abandons the traditional understanding of its legislative history.<sup>178</sup> The failure to comport with both the doctrines of *stare decisis* and separation of powers creates instability, unpredictability, inefficiency, and unfairness.<sup>179</sup> Thus, utilizing judicial review to reform ERISA unjustifiably distorts a statutory scheme which consumers depend on for the delivery of reasonable health care and

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<sup>178</sup> In contrast, most authority counsels against judicial interference with congressionally created statutory schemes, like ERISA, that are clearly intended to cover the field. *See, e.g.*, *United States v. National Treasury Employees Union*, 513 U.S. 454, 478-79 (1995) (asserting that a court should avoid “tampering” with a statute’s and modifying and crafting its own remedies, so as to avoid treading on the powers of the legislature); *Public Citizen v. United States Dep’t of Justice*, 491 U.S. 440, 470 (1989) (asserting that a court is bound to apply the normal or established application of a statute when the statute’s text is clear); *Northwest Airlines v. Transport Workers Union of America*, 451 U.S. 77, 91-95 (1981) (asserting that in matters of statutory construction, a court should examine the language, structure or coverage, and legislative history of the statute, and where its language is clear, the structure is comprehensive, or the history is informative, defer to Congress’ intention to cover the field); *Hanover Bank v. Commissioner of Internal Revenue*, 369 U.S. 672, 687-88 (1962) (asserting that where a statute uses plain and ordinary language or the legislative history is persuasive, it evidences a clear congressional intent to exclusively manage or control a certain field); *Chicago Truck Drivers, Helpers and Warehouse Union v. Steinberg*, 32 F.3d 269, 272 (7th Cir. 1994) (asserting that courts should be especially unwilling to overrule established statutory construction when the interpretation was dependent on a statute, like ERISA, with a clear congressional intention to cover the field).

<sup>179</sup> *See Payne v. Tennessee*, 501 U.S. 808, 827 (1991) (stating that “[s]tare decisis is the preferred course because it promotes the evenhanded [or fair], predictable, and consistent development of legal principles, fosters reliance on judicial decisions, and contributes to the actual and perceived integrity of the judicial process”). Moreover, “once Congress has addressed a national concern, [a court’s] fundamental commitment to the separation of powers precludes [it] from scrutinizing the sufficiency of the Congressional solution.” *Illinois v. Illinois Outboard Marine*, 680 F.2d 473, 478 (7th Cir. 1982). Therefore, when an approach to reform ERISA contravenes both the doctrines of *stare decisis* and separation of powers, consumers of employer-provided health care will be adversely affected because inconsistent, unfair, and unpredictable applications of ERISA’s statutory scheme will upset the delivery of health care.

prevents both consumers and MCOs from properly conforming their behavior to the law.<sup>180</sup>

Moreover, by overemphasizing the effect of the narrowing of ERISA preemption by the Supreme Court in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*,<sup>181</sup> commentators who support the use of judicial review to reform ERISA fail to justify completely abrogating the Supreme Court's understanding of ERISA.<sup>182</sup> In *Travelers*, the Court merely chose to treat the terms "relates to" and "connection with," which were utilized to assess the relationship between ERISA and state laws, as static and uninformative *without* breaking or departing from its traditional interpretation of ERISA's statutory construction and legislative history.<sup>183</sup> As the Court in *Travelers*

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<sup>180</sup> See, e.g., *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987) (noting that ERISA's purpose of fostering "uniformity of decision . . . is designed to . . . help administrators, fiduciaries, and participants to predict the legality of proposed actions").

<sup>181</sup> 514 U.S. 645 (1995). See also Caldwell, *supra* note 166, at 1341-42 (using language such as "stray from," "break with," and "departed from" when characterizing the effect the Court's decision in *Travelers* had on traditional preemption analysis).

<sup>182</sup> Commentators advocating judicial review to reform ERISA have attempted to narrow the previous interpretation of ERISA preemption based solely on the Supreme Court's decision in *Travelers*, which merely explained that the meaning of some of the terms underlying the traditional understanding of ERISA preemption were not informative in the Court's ratification of the traditional understanding of ERISA's statutory scheme. See *Travelers*, 514 U.S. at 655-57. See also *supra* notes 95-97 and accompanying text (discussing the Court's decision in *Travelers* in greater detail).

<sup>183</sup> See *Travelers*, 514 U.S. at 655-57 (noting that the terms "relate to" and "connection with," language utilized by the Supreme Court in its initial interpretation of ERISA, were not helpful in making the determination of which state law claims were or were not preempted; however, the Court did not have to look any farther than the "objectives" and intent underlying ERISA to make its determination). Any other interpretation of *Travelers* is untenable in light of the fact that Congress created a clear statutory scheme and express preemption provisions. See ERISA § 502(a), 29 U.S.C. § 1132(a) (1994); ERISA § 514(a), 29 U.S.C. § 1144(a) (1994). Moreover, unlike the difficulty of interpreting *congressional silence* and its various conflicting inferences, there are no possible interpretations of ERISA which could alter the clear statements and intentions of Congress to maintain a uniform, federal statutory scheme with minimal

expressly recognized in reasserting this traditional view, the framers of ERISA clearly intended to maintain regulatory consistency to reduce complexities in administering employee benefit plans, by expressly creating dual preemption clauses preventing the application of the many varied state and local restraints on such plans.<sup>184</sup> In fact, the Supreme Court, in *De Buono v. NYSA-ILA Medical & Clinical Services Fund*,<sup>185</sup> denied an opportunity to confirm these commentators' contention that the Court supports the abandonment of traditional preemption analysis and departure from the statutory construction of ERISA. In *De Buono*, the Court upheld the core understanding of ERISA preemption which has been followed for

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interference from state or local law. *See supra* notes 68-69 (asserting that the established statutory structure of ERISA was intended to preempt the field for federal regulations, thus eliminating the threat of conflicting or inconsistent state and local regulation of employee benefit plans). Commentators advocating reform through the federal judiciary, however, implicitly attempt to transform the enactment of ERISA into a situation of *congressional silence* merely because its language is broad. This argument is not persuasive considering that such language was made purposefully broad to effectuate its intent and not to allow courts to displace an expressly intended statutory scheme. *See supra* notes 68-69 (same). In fact, the Supreme Court has stated that ERISA's preemption clauses

Set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. *The policy choices reflected in the inclusion of certain and the exclusion of others under the federal scheme would be completely undermined if ERISA plan participants . . . were free to obtain remedies under state law that Congress rejected in ERISA.*

*Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987) (emphasis added). Consequently, the Supreme Court's established interpretation of ERISA compels that any substantive modification of this explicitly created statutory scheme must be undertaken by Congress, and not the courts, unless there is a special and compelling justification for an abrogation of clear legislative intent.

<sup>184</sup> *See Travelers*, 514 U.S. at 656-57 (finding that Congress intended "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with directives among the States"). *See also Cigna Health Plan of La. v. Louisiana*, 82 F.3d 642, 649 (5th Cir. 1996) (noting that the holding in *Travelers* limited and specifically avowed not to abandon the Supreme Court's prior understanding of ERISA preemption nor its underlying legislative intent).

<sup>185</sup> 520 U.S. 806 (1997).

over the last two decades.<sup>186</sup> This most likely signals the Court's reliance on its previous holdings that only Congress has the power to amend established rules based on statutory interpretation.<sup>187</sup>

Even assuming that the abandonment of precedent and established statutory construction derived from ERISA's legislative history is supported by a "special and compelling justification,"<sup>188</sup> utilizing federal judicial review to assess the status of state law claims under ERISA on a case-by-case basis is inefficient and provides unpredictable and divergent results.<sup>189</sup> In fact, abandoning the established broad, bright-line rule of preemption in favor of a preemption analysis which lacks any consistent underlying rules or standards to guide the determination of relief under state law<sup>190</sup> is very likely to tempt courts to create a federal common

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<sup>186</sup> See *id.* at 814 n.9 (quoting *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 333-34 (1997)). See also *id.* at 814-16 (holding that a state law imposing a tax on hospitals owned by ERISA plans is not preempted because it is a law of general applicability imposing minimal burdens on the administration of the ERISA plans, and hence does not "relate to" the ERISA plans).

<sup>187</sup> But see *Carlson v. Green*, 446 U.S. 14, 23-24 (1980) (recognizing that courts have ability to fashion remedies supplemental to Congressional statutory schemes based on sound judicial policy making if Congress did not expressly prohibit such relief). The *Carlson* holding was later abandoned by the Court. See *Schweiker v. Chilicky*, 487 U.S. 412 (1988) (declining to provide new substantive legal liability without legislative aid or common law). In fact, no case, including *Carlson*, has suggested that courts may completely abrogate established interpretations of statutory construction and legislative intent where Congress so clearly and directly manifested its intent to preempt the field and assume sole regulation of a particular subject matter. See *Carlson*, 446 U.S. at 23-24. The only proper recourse is to allow the political process and Congress to fashion reforms on a statute adopted with a clear purpose and specific scheme.

<sup>188</sup> See *Patterson v. McClean Credit Union*, 491 U.S. 164, 172 (1989) (quoting *Arizona v. Rumsey*, 467 U.S. 203, 212 (1984) (stating that "any departure from the doctrine of stare decisis demands special justification")).

<sup>189</sup> See, e.g., *Patsy v. Florida Int'l Univ.*, 634 F.2d 900, 911-12 (5th Cir. 1981) (explaining that state law is generally simpler and less expensive and noting that state courts, as opposed to federal courts, are more accustomed to dealing with legal remedies traditionally provided by state law), *rev'd on other grounds*, 457 U.S. 496, 513 (1982).

<sup>190</sup> See *supra* notes 169-170 and accompanying text (discussing the radical narrowing of ERISA preemption and the abandoning of previous precedents

law system of relief.<sup>191</sup> Such a system will tax more judicial resources than if the courts simply wait for Congress to amend the express statutory scheme and provide rules or standards from which to allow uniform, consistent relief.<sup>192</sup> Because courts have less expertise than Congress in providing broad based remedies not limited to the context of a particular case, ad hoc remedies created on a case by case basis will create inconsistencies and confusion in the law. Thus, efficiency and judicial economy concerns counsel against adopting the federal judicial review approach to reform the problems associated with ERISA preemption.

In contrast, the use of legislative reform is clearly superior to ad hoc judicial review because it corrects the problems with ERISA<sup>193</sup> without forcing the federal judiciary either to abandon precedents and established interpretations of statutory construction and legislative history, or to usurp legislative power. This prevents the contravention of the doctrines of stare decisis and separation of

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through the use of judicial review to reform ERISA are in contravention of the doctrines of stare decisis and separation of powers).

<sup>191</sup> There is conflicting case law as to whether ERISA even contemplates the creation of a "federal common law" by the judiciary to assist with administering the statutory scheme. *See, e.g.,* *Northwest Airlines v. Transport Workers Union of America*, 451 U.S. 77, 95 (1981) (emphasizing that the federal lawmaking power is vested in the legislative, not the judicial, branch of government; therefore "federal common law" is subject to the authority of Congress, the only exception being "admiralty law"); *City of Milwaukee v. Illinois*, 451 U.S. 304, 313-15 (1981) (holding that federal common law is subject to the paramount authority of Congress, and where Congress has occupied the field and established a comprehensive regulatory program, the courts will never be deemed to have been apportioned power to create federal common law); *Sanson v. General Motors Corp.*, 966 F.2d 618, 622 (11th Cir. 1992) (noting that a court cannot create a federal common law under ERISA on the sole authority of a congressional report). *But see* *Chemung Canal Trust Co. v. Sovran Bank*, 939 F.2d 12, 17-18 (2d Cir. 1991) (recognizing the courts' ability to develop "federal common law" under ERISA if the claim is against a "fiduciary" and involves traditional trust laws); *Petrili v. Gow*, 957 F. Supp. 366 (D. Conn. 1997) (same).

<sup>192</sup> *See supra* notes 169-170, 187 and accompanying text (discussing that Congress has the sole power to alter or amend statutory schemes when such statutes are clear and have acquired a general understanding as to their intent, structure, and legislative history).

<sup>193</sup> *See supra* notes 37-38 and accompanying text (noting the defects in the health care system created by ERISA).



powers, which inhere important policy concerns that preserve efficiency and fairness and maintain the credibility of the federal courts as a competent, independent body.

## 2. *The Inherent Problems with Vicarious Liability*

Certain commentators have proposed adopting a system to reform ERISA, irrespective of whether it is legislatively or judicially created, which will allow recovery for vicarious or derivative claims.<sup>194</sup> This approach is inferior to the enactment of the Bill because imposing vicarious liability without allowing direct liability can produce anomalous results. For example, under ERISA's preemption analysis, the actor directly liable and culpable for causing an injury is immune from punishment, while the party vicariously or indirectly liable is sanctioned instead of the primary tortfeasor.<sup>195</sup>

Moreover, indirect or vicarious claims are inherently inefficient and unfair because they often require the claimant to fashion a

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<sup>194</sup> See Easley, *supra* note 24, at 309-14 (advocating a system allowing for vicarious liability, irrespective of whether judicially or legislatively created); Grosso, *supra* note 44, at 450-51.

<sup>195</sup> See Ricci v. Gooberman, 840 F. Supp. 316, 317-18 (D.N.J. 1993) (asserting that allowing vicarious liability claims while denying direct negligence claims through preemption will lead to anomalous results, because an MCO's liability decreases the more directly involved it was in the harm caused to a patient). As the MCO's conduct becomes more direct, and arguably more severe, the less liability it will face in light of the fact that such MCO is immune from liability for its direct conduct and merely responsible for its indirect actions. See *id.* Any MCO decision centered on the negligent denial or delay of coverage, however, under current ERISA preemption analysis, would not attach liability for state claims or compensatory damages because MCOs are immune from state based suits which are "relate[d] to" the provision and administration of benefits. 29 U.S.C. § 1144(a). In addition, such benefit decisions are theoretically made pursuant to the parties' contractual relationship and capability of suit under ERISA's enforcement provisions. *Id.* § 1132(a). Therefore, the only remedies, if any, available are those expressly provided by ERISA, which merely allow recovery of the value or cost of the wrongfully denied benefit. See *id.* § 1132(a)(1)(B). This unfortunate effect may only be cured by federal legislation expressly exposing MCOs to liability for tort damages and requiring MCOs to redress the injuries that result from their negligent decision-making.

weak, and possibly fictitious, direct claim against the provider in an effort to hold the culpable party liable.<sup>196</sup> Indirect claims needlessly create litigation against the provider and, as found by the United States District Court of New Jersey in *Ricci v. Gooberman*, provide an incentive for the consumer-claimant to disingenuously aver that the MCO's conduct is merely indirect, when that conduct is actually the direct cause of the injury because the MCO is the negligent decision-maker.<sup>197</sup>

In practice, vicarious liability claims are often purposefully shaped and asserted merely to avoid ERISA preemption and to hold MCOs liable for their direct, negligent conduct.<sup>198</sup> For example, the claimant may characterize the MCO's cost containment policies, which allegedly provide strong incentives for physicians to negligently deny patients care, as the root of an indirect claim of negligence against the MCO that is attached to the main or direct state law malpractice claim against a physician.<sup>199</sup> Both the indirect and direct claims escape preemption under ERISA because they are not based on the administration of benefits by the MCO,<sup>200</sup> but are rather rooted in the negligent policies of the MCO which allegedly encourage physicians to engage in

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<sup>196</sup> See, e.g., *Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151, 154 (10th Cir. 1995) (noting that vicarious liability claims against MCOs for the malpractice of their physicians are attached to direct claims against providers, but these claims may also be determined independently of ERISA and without reference to the benefit plan).

<sup>197</sup> *Ricci*, 840 F. Supp. at 317-18. See also *supra* note 116-118 (discussing that consumer harm in the health care market often results from the negligent decision-making of MCOs).

<sup>198</sup> See *Ricci*, 840 F. Supp. at 317-18.

<sup>199</sup> See *Walsh*, *supra* note 50, at 232-33 (asserting that if financial incentives are a motivating factor in denying a patient's treatment and patient is injured, the physician can be held directly liable and the MCO can be held vicariously liable). See also *Easley*, *supra* note 24, at 309 (noting that courts have held that consumers injured by negligent treatment decisions controlled, arranged for, or provided by health plans should be permitted to pursue state remedies for negligence against an MCO).

<sup>200</sup> See *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 662-63, 668 (1995) (narrowing the scope of ERISA's broad preemption to state claims affecting the structure, administration, and type of benefits provided by a plan).

malpractice, a state law claim independent of ERISA.<sup>201</sup> In contrast, if such an indirect claim against the MCO was asserted directly, it would be preempted as "relat[ing] to" ERISA and the administration of benefits.<sup>202</sup> Federal legislation, however, would completely eliminate the need for that wasteful fiction because it would allow for direct recovery under state law for injuries sustained as a result of the negligence of an MCO.<sup>203</sup> Therefore, the Bill is a superior method to ensure that the culpable conduct of MCOs is redressed because it expressly amends the preemption clause and recognizes state law tort claims.<sup>204</sup> The Bill eliminates the need to attach an indirect claim against an MCO to a questionable direct claim against the provider, which could be, if meritorious, redressed by itself in a distinct state law action.

### 3. *The Impracticality of Focusing Legislative Reform Solely on Federalism*

Finally, some commentators advocate the adoption of federal legislation to cure the problems flowing from ERISA preemption. However, none of these commentators propose an effective legislative scheme.<sup>205</sup> In fact, one such commentator almost

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<sup>201</sup> Because doctors are independent contractors, separate from the health plan subject to ERISA regulation, a state law claim of physician malpractice coupled with an indirect claim against an MCO are immune from preemption because these claims do not affect the administration of benefits, but supposedly attack the competence of the service provided by the physician. *See* Walsh, *supra* note 50, at 232-33.

<sup>202</sup> ERISA § 514(a), 29 U.S.C. § 1144(a) (1994).

<sup>203</sup> *See* H.R. 3605, 105th Cong. § 302(a) (1998).

<sup>204</sup> *Id.*

<sup>205</sup> *See* Farrell, *supra* note 97, at 252-54 (asserting that a legislative scheme reforming ERISA should ensure shared federal and state enforcement authority, without providing practical provisions for allocating authority, and balancing federalism policy concerns too delicately, making relief impractical); Jose L. Gonzalez, *A Managed Care Organization's Medical Malpractice Liability for Denial of Care: The Lost World*, 35 HOUS. L. REV. 715, 790-99 (concluding that Congress should enact legislation amending ERISA without any discussion of an appropriate scheme or rationale); Shuren, *supra* note 140, at 776-82 (arguing that Congress should create a duty of care requirement for MCOs and allow a direct cause of action against MCOs under federal statutory provisions; however,

exclusively focuses on federalism concerns, and attempts to balance powers and responsibilities for health care between Congress and the states.<sup>206</sup> Indeed, this commentator appears to take a pragmatic approach to achieve the ultimate goal of managed federalism,<sup>207</sup> but merely focuses on the ideal of federalism without any analysis of the practical implications.<sup>208</sup>

Arguably, while creating a system of health care delivery which epitomizes federalism may ensure that the state and national governments only exercise the appropriate amount of authority, there is no indication whether this system, in perfectly adhering to federalism concerns, will function practically.<sup>209</sup> Moreover, the Bill, as opposed to managed federalism, is a superior method of reforming ERISA because it establishes uniform, practical federal protections which clearly places the enforcement power in the states, where consumers must file actions under state law to redress injuries incurred through the negligence of their MCOs.<sup>210</sup> In effect, the Bill provides practical, real relief to consumers who have been denied redress by the ERISA preemption regime, while addressing federalism concerns by narrowly tailoring liability<sup>211</sup> and encouraging states to participate in health care reform by drafting remedial programs through which consumers of employer provided health care can seek relief of violations of their federal rights.<sup>212</sup>

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ignoring federalism and judicial economy concerns).

<sup>206</sup> See Farrell, *supra* note 97, at 288-89.

<sup>207</sup> See Farrell, *supra* note 97, at 289 (defining "managed federalism" as a system that "coordinates state and federal legislative and judicial and private and public authorities based on their institutional competence to carry out necessary functions").

<sup>208</sup> See Farrell, *supra* note 97, at 288-99 (advancing a pragmatic approach to health care reform by balancing the policymaking strength of Congress with the administrative and enforcement strengths of the states, yet concluding that by simply constructing a system of "managed federalism" lawmakers will create an efficient and legitimate system of managed health care).

<sup>209</sup> See Farrell, *supra* note 97, at 289.

<sup>210</sup> See H.R. 3605, 105th Cong. § 302(a) (1998).

<sup>211</sup> See *supra* notes 25-38, 108 and accompanying text (discussing that the Bill narrowly tailors the liability of MCOs).

<sup>212</sup> See *supra* note 153 and accompanying text (discussing that states create

### B. Misguided Cries of Economic Troubles

Unfortunately, the issue of health care reform seems to evoke strong, emotional-laden positions from several commentators. The positions of these commentators include: those who want reform through legislation;<sup>213</sup> those who want reform through the judicial system;<sup>214</sup> and others who want anything but reform and contend that the market will adjust and correct any temporary problems.<sup>215</sup> But like most debates, the dialogue seems to merely reduce the topic of health care reform to a question of money: who has it, who wants it, and how much will the desired good truly cost? This debate often becomes bifurcated. For example, on one side of the spectrum commentators' arguments implicitly assume that quality of care is the ultimate goal of the health care system.<sup>216</sup> By contrast, the other side implicitly presumes that the

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the substantive law through which consumers can redress their injuries, while the federal government provides the protections, rights, and procedural mechanism through which consumers may recover under those state remedial laws).

<sup>213</sup> See *supra* note 205 (discussing commentator's positions).

<sup>214</sup> See Caldwell, *supra* note 166, at 1315-19, 1350 (asserting that the Supreme Court in *Travelers* adequately narrowed the application of ERISA preemption, so as to allow courts to provide consumers ad hoc relief which implicitly rejects the need for legislation); Grosso, *supra* note 44, at 450-51 (advocating recognition of enterprise liability or allowing consumers to assert claims of vicarious and direct negligence, whether judicially or legislatively created, and asserting that federal courts can and should narrow preemption analysis and fashion ad hoc remedies for consumers).

<sup>215</sup> See David A. Hyman, *Consumer Protection in a Managed Care World: Should Consumers Call 911?*, 43 VILL. L. REV. 409, 412-13, 459-65 (1998) (contending that legislative reform would only exacerbate the problems with managed care, which the market can correct).

<sup>216</sup> See Caldwell, *supra* note 166, at 1315-19, 1350 (asserting that the Supreme Court in *Travelers* adequately narrowed the application of ERISA preemption, so as to allow courts to provide consumers ad hoc relief which implicitly suggests judicial review is necessary to improve the quality of health care delivered to consumers); Farrell, *supra* note 97, at 252-54; Gonzalez, *supra* note 205, at 790-99; Grosso, *supra* note 44, at 450-51 (advocating recognition of enterprise liability or allowing consumers to assert claims of vicarious and direct negligence whether judicially or legislatively created, to improve the quality of health care delivery); Shuren, *supra* note 140, at 776-82 (arguing that

cost of health care is the most relevant variable to any discussion on the necessity for health care reform.<sup>217</sup> Both views, of course, do not address the key issues in the debate, and neither of the presumptions will bring us closer to achieving a system that provides the efficient delivery of reasonable health care while allowing redress for culpable conduct causing injury.<sup>218</sup> Advocates of the Bill, however, have devised a superior method of health care reform through federal legislation that not only addresses quality of care concerns,<sup>219</sup> but also narrowly constructs liability so as to ensure that the costs of providing health care do not dramatically increase.<sup>220</sup>

Those who oppose any form of health care reform, however, contend that consumer protection legislation in the area of managed care will inordinately increase costs by setting a floor on the permissible level of coverage or will decrease the quality of care through trade-offs and potential rent-seeking.<sup>221</sup> In fact, one critic ironically<sup>222</sup> asserts that by refraining from instituting any method

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Congress should create a duty of care requirement for MCOs and allow a direct cause of action against MCOs to improve the quality of the health care system).

<sup>217</sup> See Hyman, *supra* note 215, at 447 (asserting that economic issues are complex and determinative, in the sense that consumers—who include employers who choose the plans for their employees—will and should choose coverage based on costs rather than breadth of coverage, and as a result should be content with their cost-price choice).

<sup>218</sup> See *supra* notes 10 and 36 (discussing that remedies are traditionally available through state common law actions to redress injuries caused by culpable conduct within the marketplace).

<sup>219</sup> See *supra* text accompanying notes 110-113 (summarizing the substance of the Bill's consumer protection provisions).

<sup>220</sup> See *supra* note 108 and accompanying text (discussing the narrow construction of the Bill, which minimally increases liability).

<sup>221</sup> See, e.g., Hyman, *supra* note 215, at 412-13, 424-29 (asserting that such a reform of the health care market would increase health care costs without providing any benefit to consumers, because it encourages rent seeking by health care providers who want a system of health care delivery, hidden behind a concern for consumer protection, where the provision of services is not questioned).

<sup>222</sup> This contention is ironic because maintaining the status quo in the health care market does not leave the health care system free from regulation. See ERISA § 514 (a), 29 U.S.C. § 1144(a) (1994); ERISA § 502, § 1132(a) (1994)

of reform, the health care market will self-adjust to cure isolated problems while consumer legislation will not only exacerbate the health care system's more complex problems.<sup>223</sup>

The approach of leaving the future of the health care system to the market has little merit for several reasons. First, it is not feasible because the current defects in the health care market stem directly from previously enacted legislative reform—ERISA.<sup>224</sup> Even if Congress does nothing, the market cannot correct the systemic problems because one of the primary participants, the MCO, is not subject to the same market pressures as the rest of the industry. Under ERISA, the MCO is free from liability for all the marketplace injuries that are caused as a result of its negligent conduct.<sup>225</sup> There is no rational explanation or justification for MCOs to continue to be free from liability for their negligent decision-making. Even a corporation with substantially less interest

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(ERISA's preemption clauses regulate the health care market by allowing health plans subject to its provisions to be free from liability under most state laws). In fact, it merely preserves a severely regulated market where MCOs are free from market pressures that constrain most businesses and require them to earn their profits efficiently by staying sensitive to consumer needs or preferences, rather than denying or delaying coverage to reduce costs. *See supra* note 155 (discussing the effects of ERISA on the health care market).

<sup>223</sup> *See Hyman, supra* note 215, at 412-13.

<sup>224</sup> *See Hyman, supra* note 215, at 436 & n.96 (asserting that ERISA plans are beyond the scope of the author's discussion of the effects of "regulation" on the marketplace because most state regulations are preempted and not applicable to such ERISA plans). This assertion, however, is unpersuasive and avoids dealing with a more complex issue—what effect ERISA plans, which represent a large portion of the market-share, have on the health care marketplace as a whole. This is merely a means of framing the regulation debate as a traditional, linear issue of a cost versus quality tradeoff and allowing the author, who takes the anti-regulation position, to characterize the pro-regulation approach as the traditional pursuit of quality of care where price is no object. *See Hyman, supra* note 215 at 460. In essence, this commentator employs the same method of reasoning, a standard explanation lacking sufficient justification, to reject regulation of the health care market that he expressly criticized when utilized by pro-regulators. *See Hyman, supra* note 215, at 460. This reasoning does not explain why ERISA plans are not included in debating the merits of regulating MCOs.

<sup>225</sup> *See supra* note 73 and accompanying text (asserting that ERISA preemption effectively eliminated all remedies).

in doing business in a state is on notice that if it makes sufficient "contacts" with that state or its citizens, it will be subject to liability for any torts committed within that state or upon its citizens.<sup>226</sup>

Second, the costs of providing consumer protections are minimal, especially when compared to the benefits of such legislative reform.<sup>227</sup> For example, the cost of affording an independent appeal process is estimated to be merely seven cents a month, which is clearly a cost-effective method for providing consumers with an opportunity to obtain relief and for restoring the consumers' trust in the marketplace.<sup>228</sup> In addition, consumers would be secure in the knowledge that such relief was available if an emergency situation arose.<sup>229</sup> Furthermore, "[t]here are a number of studies that show that both external review and expanding remedies would result in only a minimal increase in costs."<sup>230</sup>

Finally, under the current private-sector employer-provided health care market, consumers and providers bear all the risks and costs associated with any erroneous or wrongful decision made by an MCO to delay or deny a consumer's pre-purchased health care coverage under an ERISA plan. There are more efficient and equitable methods of spreading the risk of loss in the marketplace than placing such risks solely on the consumers and physicians. For example, spreading the risk of loss among the three major participants-

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<sup>226</sup> See, e.g., *International Shoe Co. v. Washington*, 326 U.S. 310, 319-20 (1945).

<sup>227</sup> See *supra* notes 108, 122-132 and accompanying text (discussing the narrow construction of the bill).

<sup>228</sup> See *Hearing on Grievance Procedures*, *supra* note 37 (statement of Sen. Kennedy) (providing an estimate by the Congressional Budget Office that the cost of an independent appeal was seven cents a month).

<sup>229</sup> See, e.g., H.R. 3605, 105th Cong. §101 (1998) (mandating that MCOs provide access to emergency medical care irrespective of the available provider and additional cost).

<sup>230</sup> See *Hearing on Grievance Procedures*, *supra* note 37 (statement of Olena Berg, Asst. Secretary of the Dep't of Labor's Pension and Welfare Benefits Admin.) (explaining that even commentators critical of legislative reform estimate that expanded remedies in general would increase employer premium costs by only three-tenths of one percent).



in the health care market would eliminate any incentive for the risk-free market participant to assume risk with impunity. Discouraging moral hazard or unjustified risk-taking not only promotes efficiency because it eliminates added or needless risk, but also restores fairness and equity to the marketplace because the risk of loss due to wrongful or erroneous decision-making of the once immune party is spread among all the interested parties within a transaction.

## CONCLUSION

The Patients' Bill of Rights Act or legislation incorporating similar key provisions, if enacted, will ensure that all American consumers of health care services will have protection against their managed care organization's failure to properly administer health care. The Bill would protect against an MCO's failure to adequately inform the consumer of benefits and limitations of certain health plan options; failure to offer point-of-service coverage—where the consumer may purchase the option to use non-participating health care providers; failure to provide access to emergency services irrespective of whether the provider is a participating or nonparticipating server; and failure to provide a timely appeal process to address any delay or denial in health care coverage. This legislation will not impose a new, unmanageable federal tort system, but rather will inspire state legislators and courts to recognize these basic consumer protections and afford remedies under current state law tort principles for a managed care organization's negligent conduct in the delivery or administration of health care services resulting in personal injury or wrongful death. In the end, constitutional principles of stare decisis, separation of powers, federalism, and judicial economy will be satisfied—while improving and fostering a more efficient health care system.