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## ERISA Preemption of State Tort Law Claims Against Managed Care Entities

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# NOTE

## ERISA PREEMPTION OF STATE TORT LAW CLAIMS AGAINST MANAGED CARE ENTITIES\*

### INTRODUCTION

The recent proliferation of managed health care has dramatically affected the way most Americans receive their health care benefits.<sup>1</sup> At the heart of every managed care insurance plan is an emphasis on cost containment.<sup>2</sup> As a result, many patients have suffered poor health consequences because of decisions by managed care insurers to deny requested benefits.

Given the widespread use and effect managed care has had on health care, a health maintenance organization

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<sup>1</sup> The number of Americans using managed care plans is rapidly growing. A recent count estimated approximately one hundred million Americans are enrolled in some kind of managed care plan and the percentage of insured employees (working in firms with at least ten employees) with managed care plans was sixty-six percent. Saeid B. Aminib, *Discrimination of International Medical Graduate Physicians by Managed Care Organizations: Impact, Law, and Remedy*, 2 DEPAUL J. HEALTH CARE L. 461, n.63 (1999).

<sup>2</sup> The majority of managed care insurers have elements of quality and cost control systems that include practice reviews, guidelines, and advanced control over actual utilization of benefits by both providers and patients. RAND E. ROSENBLATT ET AL., *LAW AND THE AMERICAN HEALTH CARE SYSTEM* 20 (1997); Diana Joseph Bearden, *Emerging Theories of Liability in the Managed Care Industry*, 47 BAYLOR L. REV. 285, 294 (1995); Bryce A. Jensen, *From Tobacco to Health Care and Beyond: A Critique of Lawsuits Targeting Unpopular Industries*, 86 CORNELL L. REV. 1344, 1349-50 (2001); Eleanor D. Kinney, *The Brave New World of Medical Standards of Care*, 29 J.L. MED & ETHICS 323, 325 (2001); Jefferey Rugg, *An Old Solution to a New Problem: Physician Unions Take the Edge Off Managed Care*, 34 COLUM. J.L. & SOC. PROBS. 1, 7 (2000).

("HMO") or managed care organization ("MCO")<sup>3</sup> that is negligent in its delivery of health care to its policyholders should be held accountable for its actions. The most effective means of accomplishing this accountability is through state tort law claims.<sup>4</sup> However, in order for a plaintiff to maintain a tort law claim against an HMO, the claim must withstand the defense of Employee Retirement Income Security Act of 1974 ("ERISA") preemption.<sup>5</sup> Almost all MCOs are governed by ERISA when their plans are offered by an employer to an employee, and § 514 of ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" that is governed by ERISA.<sup>6</sup> Since the Supreme Court has yet to face the question of ERISA preemption of a state tort law claims against an HMO, it is important to analyze how the Court should treat such an issue if raised in the future.

This Note will discuss two main reasons why the Supreme Court should allow state tort law claims against HMOs to survive ERISA preemption. First, a recent trilogy of Supreme Court cases has begun to narrow the doctrine of ERISA preemption. In addition, the Court should analyze how lower courts have scrutinized the issue of ERISA preemption of state tort law claims against HMOs, and follow the reasoning of the Fifth Circuit which allowed claims to stand.

Second, the Court should view ERISA preemption of state tort law claims against HMOs in light of its treatment of the Federal Cigarette Labeling and Advertising Act's ("FCLAA")<sup>7</sup> preemption claims of breach of express warranty

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<sup>3</sup> Throughout this Note the terms HMO and MCO will be used interchangeably to refer to entities offering health insurance plans while maintaining some level of health care control with an emphasis on cost containment.

<sup>4</sup> See *infra* Part II.B. (illustrating the ineffective remedies under ERISA for claims of MCO negligence).

<sup>5</sup> 88 Stat. 829 (1974), (codified as amended 29 U.S.C. § 1001 *et seq.* (1988)). Employer sponsored benefit plans offered by governmental entities, churches, and plans established solely to comply with workers' compensation or unemployment compensation laws are excluded from ERISA regulation. 29 U.S.C. § 1003. I am assuming for the purposes of this note that the managed care entities discussed are governed by ERISA.

<sup>6</sup> 29 U.S.C. § 1144(a).

<sup>7</sup> Advertising in the tobacco industry is governed by the Federal Cigarette Labeling and Advertising Act of 1965, 15 U.S.C. §§ 1331-1341 (1982) [hereinafter FCLAA]. The Act's preemption provision states:

against the tobacco industry. FCLAA preemption is a useful guide for analyzing ERISA preemption because of the similarities between the tobacco industry and managed care entities. First, the decisions of both industries can have a marked affect on people's health. MCOs' decisions regarding the provision of benefits can result in policyholders not receiving necessary medical treatment. Likewise, given the negative effect of smoking on people's health, the tobacco industry's decisions also have a significant effect on individual health. In addition, both industries are governed by federal statutes which were enacted for similar purposes. Both ERISA and the FCLAA were enacted to reflect a balance between the regulation of major U.S. industries while promoting economic growth. Thus, the Court's treatment of FCLAA preemption should be used to view ERISA preemption of state law tort claims against MCOs.

Part I of this Note will trace the rise of managed care in the United States and illustrate its effect on the American health care system. Part II.A traces the Supreme Court's recent trend of narrowing the doctrine of ERISA preemption. Part II.B argues that a state tort law claim against an HMO for negligently adopting a benefits policy can help effectively ensure the quality of care in managed care. Part III.A argues that the Supreme Court's treatment of FCLAA preemption should be a guide to analyzing ERISA preemption because of the similarities between the tobacco industry and managed care entities, the similar objectives of the FCLAA and ERISA, and the fact that the Supreme Court has yet to face the issue of a MCO's liability for a common law tort claim. Part III.B analyzes the Court's treatment of FCLAA preemption of a claim of breach of express warranty against the tobacco industry and argues that the Court's analysis is a useful guide to analyze negligent adoption of a benefits policy by an HMO.

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(a) no statement relating to smoking and health, other than that which is required by section 133 of this title, shall be required on any cigarette package.

(b) no requirement or prohibition based on smoking and health shall be imposed under State law with respect to advertising or promotion of any cigarettes the packages of which are labeled in conformity with the provisions of this chapter.

In conclusion, given the Supreme Court's narrowing of ERISA preemption, the lower courts' treatment of state tort law claims against MCOs, and the Court's treatment of FCLAA preemption of breach of express warranty against the tobacco industry, the Court should allow state tort law claims against HMOs to survive ERISA preemption.

## I. THE RISE OF MANAGED CARE

Before the 1930s, patients paid directly for medical services under the traditional American health care system. But after the Great Depression drastically lowered middle class incomes, America's traditional health care payment system was undermined.<sup>8</sup> Since patients were no longer able to pay physicians directly, health care costs needed to be spread over a large number of people.<sup>9</sup> Thus, the rise of private health insurance was inevitable.

Indemnity benefit plans were the predominant form of early private health insurance.<sup>10</sup> Although the middle and upper classes enjoyed a host of benefits under these plans, the non-working class was largely left uninsured.<sup>11</sup> In the 1960s, the absence of health benefits for the growing number of

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<sup>8</sup> ROSENBLATT ET AL., *supra* note 2, at 8; ROBERT FABRIKANT ET AL., HEALTH CARE FRAUD: CRIMINAL, CIVIL, AND ADMINISTRATIVE LAW §1.02(2) (2002); David D. Griner, *Paying the Piper: Third Party Payor Liability for Medical Treatment Decisions*, 25 GA. L. REV. 861, 874 (1991).

<sup>9</sup> ROSENBLATT ET AL., *supra* note 2, at 8.

<sup>10</sup> *Id.* at 9. Indemnity benefit plans are ones in which patients pay their health care provider for services rendered and then seeks reimbursement from their insurance company. Under these plans, patients have their choice of health care providers, the plan pays for full service or a portion thereof, and the insurance company has no other relationship to the provider. *Id.*

<sup>11</sup> *Id.* at 10-11. The middle and upper classes were able to purchase indemnity health insurance such as Blue Cross Blue Shield and many employers began offering health insurance plans as an alternative to wage increases. *Id.* at 11. This resulted in a rise of private health insurance from 50.3% of the total population insured privately in 1950 to 81.1% of the total population insured privately in 1980. ROSENBLATT ET AL., *supra* note 2, at 12 (citing Randall R. Bovbjerg et al., *U.S. Health Care Coverage and Costs: Historical Development and Choices for the 1990s*, 21 J.L. MED. & ETHICS 141, 144, tbl. 2 (1993), reprinted with permission from the American Society of Law, Medicine & Ethics; drawing on Health Insurance Association of America, *Source Book of Health Insurance Data*, Washington, DC: HIAA, 25, tbl. 2.2 (1992)); Department of Commerce *Statistical Abstract of the United States*, Washington, DC: U.S. Government Printing Office, 8 tbl. 2 (1992).

elderly people created a powerful political group which, in part, resulted in the enactment of Medicare and Medicaid in 1965.<sup>12</sup> This federal legislation coupled with advances in expensive health care technology led to an enormous rise in national health care spending.<sup>13</sup> This set the stage for the emergence of managed care.

Managed care is a framework of financing and organizing health care.<sup>14</sup> The goal of managed care is to decrease costs by exercising more direct control over the provision of health care.<sup>15</sup> Although managed care may have been a necessary response to the increase in health care spending, it has significantly affected individual health care. For example, in a managed care system a patient seeking health care usually is limited to a select number of participating physicians.<sup>16</sup> Almost all MCOs today limit a patient's use of doctors to a selected group of physicians called participating physicians/providers. Although some MCOs do give patients the option to use a physician of their own choice, this option usually results in a penalty of higher prices to the insured. Additionally, in most MCOs, the participating physician agrees to follow certain treatment guidelines adopted by the MCO.<sup>17</sup> These guidelines are established in order to try

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<sup>12</sup> ROSENBLATT ET AL., *supra* note 2, at 14, FABRIKANT ET AL., *supra* note 8, at §102(2). Medicare, Title 18 of the Social Security Act, provides federal hospitalization and medical coverage for persons over sixty-five and Medicaid, Title 19 of the Social Security Act, provides federal matching funds for state medical assistance programs for the poor.

<sup>13</sup> ROSENBLATT ET AL., *supra* note 2, at 16-17. In 1960 the health care share of the Gross National Product ("GNP") was 5.3% while in 1990 it rose to 12.2%. *Id.* at 17, tbl. 2 (citing Bovbjerg et al., *supra* note 11, at 142, tbl. 1); Sally T. Burner et al., *National Health Expenditures Projections through 2030*, 14 HEALTH CARE FINANCING REV. 1, tbls. 3, 4, and 7 (1992).

<sup>14</sup> ROSENBLATT ET AL., *supra* note 2, at 19; Jensen, *supra* note 2, at 1349-50; Vickie Yates Brown, *Managed Care at the Crossroads: Can Managed Care Organizations Survive Government Regulation?*, 7 ANNALS HEALTH L. 25, 27-28 (1998); Bearden, *supra* note 2, at 289.

<sup>15</sup> ROSENBLATT ET AL., *supra* note 2, at 20. The function of insurance and delivery of health services are integrated into a single corporate entity that both insures groups and delivers covered benefits through a defined network of participating providers. *Id.* at 19.

<sup>16</sup> *See id.*

<sup>17</sup> *See id.* at 20; Susan O. Scheutzw, *A Framework for Analysis of ERISA Preemption in Suits Against Health Plans and a Call for Reform*, 11 J. L. & HEALTH 195, 200 (1996-97); James A. Duffy, *HMO Doctors as ERISA Fiduciaries: A Bankruptcy Perspective*, 8 AM. BANKR. INST. L. REV. 125, 128-29 (2000).

to contain treatment costs. The guidelines usually set the appropriate medical treatment based on the patient's diagnosis. Physicians are usually contractually bound to follow these guidelines and thus must seek approval from the MCO if a different course of treatment is believed to be necessary. Thus, individual health care in a managed care system is affected by giving the patient limited options in physician selection and requiring physicians to follow cost-containing guidelines. Since managed care is on the rise,<sup>18</sup> this effect is a concern for many Americans.

## II. ERISA PREEMPTION

### A. *Supreme Court's Narrowing of ERISA Preemption*

Congress enacted ERISA primarily to protect employees' pensions.<sup>19</sup> Congress was concerned with a system of unregulated employee pensions which often resulted in persistent underfunding. If major industries went into economic decline, such as the railroads in the 1930s and the automobile and steel industries in the 1960s and 1970s, many companies would not be able to pay promised pensions. In addition, pre-ERISA pension plan assets were supposed to be administered in trust for the benefit of employees, but because of the lack of effective state and federal law remedies, many pension assets were being utilized to benefit companies. This problem affected health benefits as well as pension plans.<sup>20</sup>

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<sup>18</sup> The percentage of the American population covered by private indemnity health insurance has fallen for the first time in fifty years, from 81.1 % in 1980 to 71.6% in 1990. ROSENBLATT ET AL., *supra* note 2, at 20. This drop in coverage has been caused by a combination of corporate layoffs and a shift to part time workers without benefits, a growing number of companies dropping health care benefits, the rising cost of individual policies, and the insurance companies' attempt to cut costs by excluding people with certain pre-existing conditions. *Id.*

<sup>19</sup> *Id.* at 159; Duffy, *supra* note 17, at 132; Bryron Done, *Health Care Reform and ERISA Preemption: Can the States Adopt Aspects of Germany's Health Care System to Achieve Universal Access and Cost Containment?*, 18 HASTINGS INT'L & COMP. L. REV. 745, 757-58 (1995).

<sup>20</sup> ROSENBLATT ET AL., *supra* note 2, at 159.

ERISA has also had a marked effect on health insurance. Since ERISA applies to an employee benefit plan maintained by "any employer engaged in commerce,"<sup>21</sup> it reaches almost all private employers who provide health insurance for their employees. Thus, ERISA affects many Americans' health insurance plans.

ERISA affects health insurance plans in two major ways. First, § 514(a) contains one of the most sweeping provisions preempting state law ever enacted in a federal statute,<sup>22</sup> and the ERISA remedies provision, § 502, has been interpreted by the Supreme Court as preempting any claim under an ERISA plan that falls within the scope of the remedies provision.<sup>23</sup> Second, ERISA's remedies are significantly more limited than remedies available under state laws.<sup>24</sup> As a result, ERISA has been interpreted as preempting much of state contract, insurance, and tort law which has left many employees and their families without adequate redress for perceived wrongdoing.<sup>25</sup>

In accordance with Supreme Court precedent stating that a federal law's preemptive control must be interpreted to reflect Congress' intent in enacting that statute,<sup>26</sup> ERISA preemption under § 514 has been interpreted broadly to follow Congress' intent to provide uniform regulation and supervision of employee benefit plans. The statute provides that ERISA "shall supercede any and all State laws insofar as they . . . relate to any employee benefit plan."<sup>27</sup> In *Shaw v. Delta Air*

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<sup>21</sup> 29 U.S.C. § 1003(a)(1).

<sup>22</sup> ROSENBLATT ET AL., *supra* note 2, at 160.

<sup>23</sup> See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (holding Congress intended ERISA's civil enforcement scheme to be the exclusive remedies available to ERISA beneficiaries).

<sup>24</sup> ROSENBLATT ET AL., *supra* note 2, at 161. See *infra* Section II.B. discussing the inadequacies of ERISA remedies.

<sup>25</sup> ROSENBLATT ET AL., *supra* note 2, at 160-61. For example, once a court has found a tort claim against an MCO preempted, claimants must pursue their grievance under ERISA's civil remedies provisions. Although one provision allows claimants to enforce benefits due under the plan, this is an inadequate remedy for a claimant who has already been injured by the denial of such benefit.

<sup>26</sup> *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 95 (1983); *Fid. Fed. Sav. & Loan Ass'n v. de la Cuesta*, 458 U.S. 141 (1982); *Jones v. Rath Packing Co.*, 430 U.S. 519 (1977).

<sup>27</sup> 29 U.S.C. § 1144(a).



*Lines, Inc.*,<sup>28</sup> the Supreme Court set forth the sweeping effect of ERISA preemption. The plaintiff employers challenged two New York state laws, as being preempted by ERISA, that dealt with discrimination in employee benefit plans on the basis of pregnancy and the provision of sick-leave benefits to pregnant employees.<sup>29</sup> The Court stated that the issue with ERISA preemption is whether the state laws "relate to" employee benefit plans subject to ERISA regulation.<sup>30</sup> The Court defined "relate to" broadly, holding that "a law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan."<sup>31</sup> In support of this broad interpretation, the Court referred to the legislative history of ERISA.<sup>32</sup> The Court observed that the bill originally contained a more limited preemption clause but Congress had chosen instead to adopt the present language to avoid the threat of conflicting and inconsistent state laws.<sup>33</sup> Therefore,

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<sup>28</sup> 463 U.S. 85 (1983).

<sup>29</sup> *Id.* at 88.

<sup>30</sup> *Id.* at 96. ERISA § 514(a) provides:

Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b). The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this title.

29 U.S.C. § 514(c)(1)-(2).

<sup>31</sup> *Shaw*, 463 U.S. at 96-97.

<sup>32</sup> *Id.* at 98-99.

<sup>33</sup> *Id.* Statements by the bill's sponsors stressed the breadth of federal preemption. Representative Dent stated:

Finally, I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation.

120 CONG. REC. 29,197 (1974) (quoted in *Shaw*, 463 U.S. at 99). Senator Williams echoed these sentiments:

It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute 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. This principle is intended

the Supreme Court initially embraced a broad ERISA preemptive effect because of its interpretation of Congress' intent.

However, in a recent trilogy of cases, the Supreme Court has retreated from such a broad reading of "relate to" and has thus narrowed ERISA's preemptive effect.<sup>34</sup> First, in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, the Supreme Court held that a New York statute imposing surcharges on hospital rates for patients covered by a commercial insurer did not "relate to" employee benefit plans under ERISA and thus was not preempted.<sup>35</sup> In analyzing the preemption challenge, the Court stated that "[i]f 'relate to' were taken to extend to the furthest stretch of indeterminacy, then for all practical purposes preemption would never run its course."<sup>36</sup> Rather than using a specific definition of "relate to," the *Travelers* Court looked to the objectives of ERISA to define the scope of the state law that would survive preemption.<sup>37</sup> Again, the Court stated that Congress' intent in enacting ERISA was to establish a uniform body of benefits law<sup>38</sup> in order to minimize the burdens of complying with conflicting state regulations.<sup>39</sup> The Court then found that the surcharges only imposed an indirect economic influence on the administrators of commercial insurers by increasing hospital costs, but did not bind them to any

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to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.

*Id.* at 29,933 (quoted in *Shaw*, 463 U.S. at 99).

<sup>34</sup> *De Bouno v. NYSA-ILA Med. and Clinical Servs. Fund*, 520 U.S. 806 (1997); *Cal. Div. of Labor Standards Enforcement v. Dillingham Const., N.A.*, 519 U.S. 316 (1997); *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) [hereinafter *Travelers*]; see also *Corporate Health Ins., Inc. v. Tex. Dep't of Ins.*, 215 F.3d 526 (5th Cir. 2000) (discussing the trilogy of Supreme Court preemption cases).

<sup>35</sup> *Travelers*, 514 U.S. at 654-68.

<sup>36</sup> *Id.* at 655.

<sup>37</sup> *Id.* at 656. The *Travelers* Court specifically stated that the definition of "connection with" set out in *Shaw* and the "relate to" text of the ERISA statute would be unhelpful in defining the key term. *Id.*

<sup>38</sup> Benefits laws are state and federal laws that govern the management of benefits gained by employees through their employment.

<sup>39</sup> *Travelers*, 514 U.S. at 656 (citing *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)).

particular choice of administration.<sup>40</sup> Such an indirect economic influence did not preclude a health insurer from offering a uniform interstate benefit package to employers because an insurer offering health plans to employers in different states, including New York, could still establish one plan. The statute would only affect the cost of the plan to employers in New York. The insurer could still offer the same plan, albeit at a higher cost, outside New York state.<sup>41</sup> The Court realized that if ERISA's preemptive clause was read too broadly, it would supercede all state laws affecting the cost of health insurance on the theory that those state laws indirectly relate to ERISA plans.<sup>42</sup> This broad reading would eliminate the limiting provision of "relate to."<sup>43</sup>

Although the Court states that a uniform interstate benefits plan is possible, the Court disregards one of the objectives of ERISA mentioned earlier in the opinion—minimizing the "financial burden of complying with conflicting directives among States."<sup>44</sup> A New York commercial insurance plan will inevitably have to charge its policyholders a higher premium given the hospital surcharge. If a New York commercial insurer wishes to provide an interstate-uniform policy, policyholders in all other states now face a higher premium because of the New York surcharges. Although New York voters may have supported the surcharges, policyholders in all other states with New York commercial carriers are now subject to its effects. As a result of unwarranted premium increases, many policyholders may elect to pursue intrastate insurers who would not be subjected to premium increases resulting from the New York surcharges. Thus, an interstate commercial insurer is facing a financial burden through conflicting state laws—one of the objectives that Congress sought to minimize by enacting ERISA.

The second Supreme Court case in the trilogy is *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*<sup>45</sup> The plaintiff challenged

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<sup>40</sup> *Id.* at 659.

<sup>41</sup> *Id.* at 660.

<sup>42</sup> *Id.* at 661.

<sup>43</sup> *Id.*

<sup>44</sup> *Travelers*, 514 U.S. at 656 (quoting *McClendon*, 498 U.S. at 142).

<sup>45</sup> 519 U.S. 316.

California's prevailing wage law,<sup>46</sup> which required a contractor on a public works project to pay its workers the prevailing wage, with an exception that permitted a contractor to pay a lower wage to workers participating in a state-approved apprenticeship program.<sup>47</sup> The issue was whether the preemption provision of ERISA supercedes the California law in that the law prohibits payment of the apprentice wage to an apprentice trained in an unapproved program. The Court found that the prevailing wage statute did not bind ERISA plans, but provided economic incentive to comport with State requirements.<sup>48</sup> Since no apprentice program is required to meet California standards, the economic incentive to comport with State requirements is that conforming apprentice programs can provide apprentices who can work at a lower wage. The Court concluded that the relationship between the California law and ERISA plans was too tenuous to allow ERISA preemption.<sup>49</sup> Again, the Court recognized the need for some limits to ERISA preemption of state laws.

The final case in the trilogy is *De Buono v. NYSA-ILA Medical and Clinical Services Fund*.<sup>50</sup> The Court held that New York's gross receipt tax on the income of medical centers operated by ERISA funds was not preempted.<sup>51</sup> Respondents, trustees of a medical fund which administers a welfare benefit plan, brought the action to enjoin future tax assessments.<sup>52</sup> Specifically, since the New York law taxed the income of medical centers, and respondents operated a medical center funded exclusively from funds generated from an employee benefit plan, the respondents alleged that the New York tax assessment is a state law that "relates to" a benefit plan under ERISA and is therefore preempted.<sup>53</sup> The Court started its analysis by noting that the traditional police powers of the State include regulation of health and safety.<sup>54</sup> In addition, the Court operated under a presumption that Congress did not

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<sup>46</sup> CAL. LAB. CODE ANN. § 1771 (West 1989).

<sup>47</sup> *Dillingham*, 519 U.S. at 319.

<sup>48</sup> *Id.* at 332.

<sup>49</sup> *Id.* at 334.

<sup>50</sup> 520 U.S. 806.

<sup>51</sup> *Id.* at 809.

<sup>52</sup> *Id.* at 810.

<sup>53</sup> *Id.*

<sup>54</sup> *Id.* at 814.

intend to supersede state law.<sup>55</sup> Thus, the Court concluded that respondents have a considerable burden to overcome.<sup>56</sup> The Court found that although the tax assessment imposes some burden on the administration of ERISA plans because any law that increases the cost of providing benefits to employees will have an effect on administration, that is not enough to render the state law preempted.<sup>57</sup> Here, as in *Travelers*, the Court seems to depreciate one of Congress' objectives in enacting ERISA—minimizing the burden on the administration of ERISA plans. An ERISA plan set up as a trust fund to administer health care would certainly be burdened by the imposition of a gross income tax. Nonetheless, the Court still found that this does not relate to ERISA plans within the meaning of the statute.<sup>58</sup> Therefore, from this trilogy of recent Supreme Court decisions it is evident that the Court has narrowed ERISA's § 514 preemption of state laws.

B. *ERISA Preemption of State Tort Law Claims Against HMOs*

As health care costs continue to grow in the United States, so will managed care and its emphasis on cost containment. When a health care provider and/or administrator has such a goal, it often jeopardizes the quality of care. Therefore, it is important that MCOs are not permitted to sacrifice quality health care for profit. One way to help ensure quality health care is to attach civil liability for negligent decision making by MCO. However, the doctrine of preemption poses a significant threat to the success of plaintiffs because of the significant difference between the damages recoverable in a state common law action and an action under ERISA.<sup>59</sup> Although the above trilogy illustrates the Court's trend toward narrowing ERISA's § 514 preemption, the Supreme Court has yet to address the question of ERISA

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<sup>55</sup> *De Buono*, 520 U.S. at 813.

<sup>56</sup> *Id.* at 814.

<sup>57</sup> *Id.*

<sup>58</sup> *Id.* at 816.

<sup>59</sup> See JOHN K. DIMUGNO & PAUL E.B. GLAD, CALIFORNIA INSURANCE HANDBOOK § 29.01 (2000).

preemption of state common law claims against MCOs. A MCO facing a tort action will likely assert that the claim seeks to recover benefits due under an ERISA plan. Since ERISA § 502 encompasses such an action, it may be preempted.

Section 502 of ERISA provides for six types of civil actions that may be brought to enforce the Act.<sup>60</sup> Although there are a "wide array of measures"<sup>61</sup> for ERISA participants to enforce their rights under a plan, none of these measures provide for extra-contractual damages. The Supreme Court in both *Massachusetts Mutual Life Insurance Co. v. Russel*<sup>62</sup> and *Mertens v. Hewitt Associates*<sup>63</sup> limited a claimant's recovery to policy proceeds.<sup>64</sup> For example, in *Massachusetts Mutual Life Insurance*, the Court held that a claimant suing under ERISA could not recover extra-contractual or punitive damages for improper benefits claim processing.<sup>65</sup> These decisions

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<sup>60</sup> Section 502(a) in full reads:

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

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

(3) by a participant, beneficiary, or fiduciary

(A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or

(B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of [section] 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary to enjoin any act or practice which violates any provision of this subchapter, or

(B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under subsection (c)(2) or (i) or (l) of this section.

29 U.S.C. § 1132(a) (1988).

<sup>61</sup> *Mass. Mut. Life Ins. Co. v. Russel*, 473 U.S. 134, 148 (1985) (Brennan, J., concurring) (citing as examples, an action to recover benefits due, enforce rights under a plan, or clarify future benefits under plan terms).

<sup>62</sup> 473 U.S. at 148.

<sup>63</sup> 508 U.S. 248 (1993).

<sup>64</sup> See DIMUGNO & GLAD, *supra* note 58.

<sup>65</sup> 473 U.S. at 148.

effectively foreclose the possibility of extra-contractual remedies under ERISA.<sup>66</sup>

As a result of these limited remedy provisions, insurers offering ERISA health plans have a perverse incentive to deny coverage or adopt policies limiting coverage. For example, since recovery under ERISA is constrained to the benefits contract, claimants are limited to enforcing rights that are specially provided under their plan. This allows an HMO to greatly limit the relief claimants may seek by drafting plans that establish guidelines and/or policies limiting the medical treatments that the entity will reimburse. If a coverage decision or policy is at minimum questionable, then an HMO committed to contain costs may deny the claim or adopt the policy without the fear of liability for tort damages.<sup>67</sup> Since a claimant can only recover under the contract, an HMO would only be responsible for the cost of the medical treatment that it refused to reimburse.<sup>68</sup> In this way an HMO really cannot lose by initially limiting treatments because the HMO can only be held liable for medical care sought. If policyholders' common law tort claims were preempted by § 504 of ERISA, recovery for injuries resulting from a denial of benefits or the negligent adoption of a policy limiting treatment would be greatly diminished. Thus, the one means to effectively protect a patient from the direct negligence of HMOs is to allow patients to bring state tort law direct liability claims against HMOs for their negligence.

In a series of cases, the Third Circuit has offered a glimmer of hope to the dilemma faced by HMO beneficiaries seeking to hold HMOs accountable. First, in *Dukes v. U.S.*

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<sup>66</sup> See DiMUGNO & GLAD, *supra* note 58.

<sup>67</sup> It seems likely that an HMO offering a plan under ERISA would not deny all questionable claims because of market competition. Although all HMOs emphasize cost-cutting techniques and profit, an HMO that denied too many questionable claims would certainly upset policyholders. Such dissatisfaction would likely cause the employer to offer another insurer or encourage policyholders to switch to another plan if multiple plans were offered. These market factors would likely curb some unwarranted denials, but not all.

<sup>68</sup> Section 503 of ERISA does provide that the court *may* award the claimant attorney's fees but this is much less threatening than facing a potential jury verdict for a tort claim. 29 U.S.C. §1132 (g)(1). In addition, the court is not required to award attorney's fees at all. Even if attorney's fees were awarded, the number of claimants who would hire an attorney to sue an HMO with only the hope of recovering the cost of treatment and the possibility of an attorney fee award would surely be small.

*Healthcare Inc.*,<sup>69</sup> the plaintiffs sued U.S. Healthcare, their HMO, for medical malpractice. In the first action, plaintiff Celicia Dukes brought a medical malpractice action under Pennsylvania state law's ostensible agency theory because her husband Darryl died after a hospital refused to perform a physician-ordered blood test.<sup>70</sup> In the second action, plaintiffs Ronald and Linda Visconti alleged that Linda's treating physician ignored her symptoms of preeclampsia, which led to the stillbirth of their child.<sup>71</sup> They sued U.S. Healthcare under direct negligence theory claiming that the HMO was negligent in the selection and supervision of their physician.<sup>72</sup> The court drew an important distinction between seeking recovery for benefits denied under an ERISA plan and claiming damages for the poor quality of care received.<sup>73</sup> The court concluded that both plaintiffs were claiming the latter, for which an HMO may be liable under agency or negligence principles.<sup>74</sup> The Third Circuit reasoned that § 502(a)(1)(B) of ERISA does not mention anything concerning the quality of benefits received.<sup>75</sup> Thus, the plaintiffs' claims were not preempted by ERISA as seeking to enforce an ERISA remedy.<sup>76</sup>

In the second case, *In re U.S. Healthcare Inc.*,<sup>77</sup> the plaintiff brought a state medical malpractice claim against her HMO, U.S. Healthcare, alleging direct and vicarious liability.<sup>78</sup> The claim was for damages arising from the death of the plaintiff's newborn baby.<sup>79</sup> The complaint alleged that after the plaintiff gave birth, Dr. Nemeh<sup>80</sup> discharged the mother and child after twenty-four hours under the HMO's pre-certification

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<sup>69</sup> 57 F.3d 350 (3d Cir. 1995).

<sup>70</sup> *Id.* at 352.

<sup>71</sup> *Id.* at 353.

<sup>72</sup> *Id.*

<sup>73</sup> *Id.* at 356-57.

<sup>74</sup> *Dukes*, 57 F.3d at 357.

<sup>75</sup> *Id.*

<sup>76</sup> *Id.*

<sup>77</sup> 193 F.3d 151 (3d Cir. 1999).

<sup>78</sup> *Id.* at 155. The plaintiffs also named as defendants: Kamilah Nemeh, M.D., the treating pediatrician, Kennedy Hospital, the hospital where the plaintiff's child was born, and The Health Maintenance Organization of New Jersey, Inc., a subsidiary of U.S. Healthcare, Inc. *Id.*

<sup>79</sup> *Id.*

<sup>80</sup> Dr. Nemeh is an independent health care provider contracting with U.S. Healthcare. *Id.* at 156.



discharge policy for newborns.<sup>81</sup> This policy required that newborns be discharged twenty-four hours after birth unless the treating physician obtained approval (pre-certification) from the provider for a longer stay. One day post-discharge, the plaintiff noticed that the baby was ill and contacted Dr. Nemeh, who did not advise her to bring the baby back to the hospital.<sup>82</sup> The plaintiff also contacted U.S. Healthcare and requested an in-home visit by a pediatric nurse, which was not provided. The plaintiff's child had contracted an undiagnosed strep infection that developed into meningitis; the baby died that same day.<sup>83</sup>

The plaintiff's complaints against U.S. Healthcare included direct liability for their adoption of the twenty-four hour, pre-certification discharge policy.<sup>84</sup> U.S. Healthcare contended that these claims were preempted by ERISA in that they sought recovery under state law for a denial of benefits under an ERISA plan. Following their previous decision in *Dukes*, the Third Circuit noted the distinction between claims directed to the quality of benefits provided, which are not preempted, and claims that a plan erroneously withheld benefits, which are completely preempted by ERISA.<sup>85</sup> In addition, the court distinguished between an HMO that acts solely as a benefits administrator and an HMO that acts as a health care provider by arranging for and providing medical treatment.<sup>86</sup> The Court held that the HMO's activity as a health care provider subjected the HMO to a state's standard of care.<sup>87</sup> Because the court found that the defendant HMO

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<sup>81</sup> *U.S. Healthcare*, 193 F.3d at 156.

<sup>82</sup> *Id.*

<sup>83</sup> *Id.*

<sup>84</sup> *Id.* at 156-57. Count One alleges that the policy "encouraged, pressured, and/or directly or indirectly required" the twenty-four hour pre-certification discharge used by the doctor and hospital. *Id.* at 156 (citation omitted). Count One also include a claim against U.S. Healthcare for vicarious liability for the negligence of its alleged agents Dr. Nemeh and Kennedy Hospital in their premature discharge of the newborn. *U.S. Healthcare*, 193 F.3d at 156. Count Five alleges that U.S. Healthcare negligently adopted the policy of hospital utilization that discouraged physicians from admitting infants after the discharge. *Id.* 157. Count Six alleges that after the discharge, the infant's condition required a home visit by a pediatric nurse. *Id.*

<sup>85</sup> *Id.* at 161-62. Once an action is completely preempted by ERISA, a claimant can only seek relief under the benefits contract.

<sup>86</sup> *Id.* at 162.

<sup>87</sup> *U.S. Healthcare*, 193 F.3d at 162.

essentially made a medical determination of the appropriate level of care when it adopted the twenty-four hour discharge policy,<sup>88</sup> the Court held that this was a claim involving the quality of care, which was not preempted by ERISA.<sup>89</sup>

In 2000, the Third Circuit reinforced the distinction between actions relating to the quality of care given and those involving claims for denying benefits. In *Lazorko v. Pennsylvania Hospital*,<sup>90</sup> Jonathon Lazorko alleged that the HMO U.S. Healthcare was directly and vicariously liable under state law for his wife's death. Lazorko claimed that the HMO imposed financial disincentives on his wife's physician which discouraged the doctor from recommending additional necessary treatment.<sup>91</sup> In holding that these claims were not preempted by ERISA, the court reasoned that challenging an HMO's financial incentive structure could relate to "the soundness of a medical decision by a health care provider rather than the administration of benefits under an ERISA plan."<sup>92</sup> As such, decisions to deny a request for additional treatment could be a claim about the quality of care given rather than the quantity of health benefits provided.<sup>93</sup>

The Third Circuit has recognized the need for holding HMOs accountable under state law. Giving a beneficiary a cause of action for challenging either the quality of benefits received or an HMO policy enables policyholders to seek recovery for HMO negligence and provides sound HMO regulation. Facing potential liability for policy decisions will certainly cause HMOs to more carefully research guidelines and benefits offered. Although pre-certification guidelines are an important tool to help contain the cost of health care, it is imperative that these guidelines are thoroughly researched to maintain high-quality health care delivery. The Third Circuit's decisions in *Dukes*, *U.S. Healthcare*, and *Lazorko* reflect a sensible balance between cost containment while allowing individuals a viable state law remedy.<sup>94</sup>

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<sup>88</sup> *Id.* at 163.

<sup>89</sup> *Id.* at 163.

<sup>90</sup> 237 F.3d 242 (3d Cir. 2000).

<sup>91</sup> *Id.* at 246.

<sup>92</sup> *Id.* at 249.

<sup>93</sup> *Id.*

<sup>94</sup> The Third Circuit in *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d

However, the Fifth, Sixth, and Eighth Circuits have been less willing to allow tort law claims to proceed against HMOs. The Fifth Circuit, in *Corcoran v. United Healthcare, Inc.*,<sup>95</sup> held that ERISA preempted the plaintiff's wrongful death claim against her HMO, U.S. Healthcare.<sup>96</sup> Plaintiff sued her HMO when she was denied temporary disability benefits.<sup>97</sup> Although her treating physician ordered complete bed rest for the remainder of her pregnancy, instead of providing hospitalization in accordance with the treating physician's order,<sup>98</sup> U.S. Healthcare only authorized in-home nursing care for ten hours per day.<sup>99</sup> During a period without nursing care, the plaintiff's fetus went into distress and died.<sup>100</sup> The court reasoned that even though U.S. Healthcare was making a medical decision concerning the plaintiff's health care, this decision had been made in the context of determining benefits under an ERISA plan.<sup>101</sup> Therefore, ERISA preempted her wrongful death claim.<sup>102</sup>

In *Tolton v. American Biodyne, Inc.*, the Sixth Circuit also held that ERISA preempted a state law claim for wrongful death based on an HMO's denial of benefits.<sup>103</sup> In *Tolton*, the administrator of the deceased patient's estate brought a wrongful death action against the decedent's HMO.<sup>104</sup> The decedent sought treatment from the HMO's psychologist on numerous occasions for his suicidal thoughts, but the HMO denied psychiatric benefits.<sup>105</sup> The decedent later committed suicide.<sup>106</sup> The court found that because the wrongful death

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Cir. 2001), recently used the quality/quantity approach and found that a challenge to an HMO's delay in the approval of a health treatment was preempted by ERISA. The court reasoned that underlying the delay was the HMO's decision to require beneficiaries to seek approval of out of network physicians. *Id.* at 273. This HMO policy related to the administration of benefits, rather than the quality of benefits received, and thus is distinguished from *Dukes, U.S. Healthcare*, and *Lazorko*. *Id.* at 272-73.

<sup>95</sup> 965 F.2d 1321 (5th Cir. 1992).

<sup>96</sup> *Id.*

<sup>97</sup> *Id.* at 1322.

<sup>98</sup> *Id.* at 1322-24.

<sup>99</sup> *Id.* at 1324.

<sup>100</sup> *Corcoran*, 965 F.2d at 1324.

<sup>101</sup> *Id.* at 1331.

<sup>102</sup> *Id.*

<sup>103</sup> 48 F.3d 937, 943 (6th Cir. 1995).

<sup>104</sup> *Id.* at 939.

<sup>105</sup> *Id.* at 939-40.

<sup>106</sup> *Id.* at 940.

claim arose from the HMO's refusal to provide psychiatric benefits, the claim "relate[d] to" the benefit plan and was thus preempted by ERISA.<sup>107</sup>

In addition, the Eighth Circuit held in *Thompson v. Gencare Health Systems, Inc.*<sup>108</sup> that ERISA preempted plaintiffs' medical malpractice claim against the HMO, Gencare Health Systems.<sup>109</sup> The plaintiff alleged that the HMO was negligent in its refusal to perform either high-dose chemotherapy or a bone marrow transplant to treat his wife's cancer.<sup>110</sup> The court reasoned that because this claim was a common law action for failing to provide benefits under an ERISA plan, it was preempted by ERISA.<sup>111</sup>

While the decisions of the Fifth, Sixth, and Eighth Circuits lead to disquieting results, the Third Circuit's acceptance of actions challenging an HMO's benefits policy is the best approach for regulating HMOs. If HMOs faced potential state tort liability for its policies on benefits decisions, HMOs would feel compelled to choose their policies with care and make proper decisions relating to plan benefits. This would better protect beneficiaries and ensure quality health care. However, if claims are preempted by ERISA, an HMO can adopt cost-cutting policies that would deny potentially necessary medical treatment recommended by a skilled practitioner. If the recommended treatment is truly necessary, the HMO can avoid a negligence claim through ERISA preemption. The beneficiary's sole recourse is the often-inadequate ERISA civil enforcement provisions. Without a tort claim challenging HMO policy, beneficiaries are left in a precarious position—they will either be treated by a thorough, competent physician whose medical decision may face administrative denial with little recourse,<sup>112</sup> or have recourse

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<sup>107</sup> *Id.* at 943.

<sup>108</sup> 202 F.3d 1072 (8th Cir. 2000).

<sup>109</sup> *Id.* at 1073.

<sup>110</sup> *Id.* The action was brought by Linda Thompson's husband.

<sup>111</sup> *Id.* at 1073.

<sup>112</sup> This is the situation under the Fifth, Sixth, and Eighth Circuits' approach.

through state tort law but only if their treating physician's treatment caused the alleged injury.<sup>113</sup> These are not desirable alternatives.

Additionally, the Supreme Court's decision in *Pegram v. Herdich*<sup>114</sup> lends support to the Third Circuit's reasoning.<sup>115</sup> Although *Pegram* involved the question of when an HMO owes a fiduciary duty to ERISA plan members, the Court's approach is useful in the ERISA preemption context. The Supreme Court distinguished between HMOs making "eligibility decisions," which are decisions concerning "the plan's coverage of a particular condition or medical procedure," and "treatment decisions," which entail "diagnosing and treating a patient's condition."<sup>116</sup> The former invokes a fiduciary duty under ERISA while the latter does not.<sup>117</sup> This terminology resembles the Third Circuit's quantity/quality distinction for ERISA preemption where quantity decisions refer to HMO decisions determining what benefits are appropriate while quality decisions refer to an HMO's role in arranging medical treatment. "Eligibility decisions" involve the coverage decisions in the administration of an ERISA plan while "treatment decisions" are more akin to actually providing health care to a beneficiary. Thus, "eligibility decisions" closely resemble the Third Circuit's decisions about quantity while "treatment decisions" are similar to decisions about the quality of medical care. Just as treatment decisions do not invoke ERISA in the fiduciary duty context, decisions concerning the quality of medical care should not invoke ERISA preemption.

Therefore, the Supreme Court should follow the decisions of the Third Circuit and allow state tort law claims to survive ERISA preemption that challenge HMO decisions effecting patient treatment because these claims do not fall within the remedies of ERISA's § 502.

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<sup>113</sup> This action would then be against the treating physician for medical malpractice thus avoiding the problem of ERISA preemption.

<sup>114</sup> 530 U.S. 211 (2000).

<sup>115</sup> See *Lazorko*, 237 F.3d at 273; *Pryzbowski*, 245 F.3d at 273.

<sup>116</sup> *Pegram*, 120 S. Ct. at 2154; *Pryzbowski*, 245 F.3d at 273.

<sup>117</sup> *Pegram*, 120 S. Ct. at 2155.

### III. FCLAA PREEMPTION AS A GUIDE TO ERISA PREEMPTION

#### A. *Similarities Between the Tobacco Industry and Managed Care Entities*

Tobacco companies and managed care organizations share an important similarity in that their actions have a direct impact on American health. Numerous actions of the tobacco industry have had a negative impact on public health. For example, early tobacco advertising campaigns promoted smoking as a healthy activity<sup>118</sup> and tobacco manufacturers include nicotine, an addictive substance, in their products. Similarly, managed care decisions affect public health. The denial of claims, the exclusion of certain conditions from coverage, and the selection of providers directly impact the course of treatment and thus the health of individuals.

The fact that the decisions of both industries affect public health should influence a court's acceptance of claims against the industries for individual harm stemming from such decisions. Since both industries are aware that their decisions directly affect public health,<sup>119</sup> this awareness should also favor making these entities accountable for their decisions.

In addition, both the tobacco industry and managed care organizations are significantly governed by federal statutes that share similar objectives. ERISA and the FCLAA are similar because they reflect a balance between industry regulation and the promotion of economic growth. ERISA was enacted primarily to protect employees' pensions.<sup>120</sup> The

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<sup>118</sup> See James C. Thornton, *The Liability of Cigarette Manufacturers for Lung Cancer: An Analysis of the Federal Cigarette Labeling and Advertising Act and Preemption of Strict Liability in Tort Against Cigarette Manufacturers*, 76 KY. L.J. 569, 571 (1988).

<sup>119</sup> It is common knowledge today that smoking directly affects individual health. It is also clear that managed care entities are aware that wrongful denials of care would adversely affect patient health because given the high cost of health care today it is unlikely that a patient would be able to pay for the needed treatment that a managed care organization wrongfully denied authorization for payment.

<sup>120</sup> ROSENBLATT ET AL., *supra* note 2, at 159. See also *supra* text accompanying note 20.

regulating aspect of ERISA lies in its stated purpose "to protect employees by requiring disclosure and reporting, setting forth standards of conduct for fiduciaries, requiring vesting of benefits, setting minimum standards of funding, and requiring plan termination insurance."<sup>121</sup> The aspect of ERISA that seeks to promote economic growth can be found in the preemption clause. By including ERISA's preemption provision, Congress also 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 conflicting directives among States."<sup>122</sup> This reflects Congress' intent to promote economic growth by minimizing the burdens to employers and insurers in setting up employee benefit plans.

Similarly, the FCLAA reflects these dual goals of industry regulation and the promotion of economic growth. The FCLAA was originally enacted in 1965 as a result of the awareness that cigarette smoking posed a health threat.<sup>123</sup> The Act's regulatory aspect can be found in its stated purpose to adequately inform the public that cigarette smoking may be hazardous to their health.<sup>124</sup> However, Congress was also concerned about promoting economic growth and protecting the national economy; thus, FCLAA allows tobacco companies to avoid the burdens of complying with different state-mandated warning labels.<sup>125</sup> In sum, ERISA and the FCLAA share the same dual purposes of protecting individuals through federal regulation and promoting the national economy through federal preemption of conflicting state laws. Given that the decisions of both the tobacco industry and managed care

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<sup>121</sup> Kristen M. McCabe, *The Texas Health Care Liability Act: Texas is the First State to Listen to the Concerns of its Health Care Consumers, But How Much Has it Heard?* 16 J. CONTEMP. HEALTH L. & POL'Y 565, 571 (2000) (citation omitted).

<sup>122</sup> *Ingeroll-Rand*, 498 U.S. at 142 (1990).

<sup>123</sup> *Pennington v. Vistrion*, 876 F.2d 414, 417 (5th Cir. 1989).

<sup>124</sup> 15 U.S.C. § 1331 (1982) ("It is the policy of Congress . . . to establish a comprehensive Federal program to deal with cigarette labeling and advertising . . . whereby: (1) The public may be adequately uninformed about any adverse health effects of cigarette smoking.").

<sup>125</sup> *Pennington*, 876 F.2d at 417.

entities directly impact public health and the Congressional purposes in enacting ERISA and FCLAA are so similar, the Court's treatment of FCLAA preemption provides a useful guide for viewing ERISA preemption of state tort law claims.

B. *The Supreme Court's Treatment of FCLAA Preemption*

Tobacco manufacturers have historically enjoyed civil immunity from product liability.<sup>126</sup> Since the 1950s, consumers have been informed by the Surgeon General of the association between cigarette smoking and lung cancer.<sup>127</sup> As a result, Congress enacted the FCLAA in 1965 to regulate the cigarette industry rather than prohibit smoking altogether.<sup>128</sup> The FCLAA requires tobacco manufacturers to post one of several specific labels on cigarette packages and advertisements warning of the health risks associated with smoking.<sup>129</sup> Thus, Congress assumed control of cigarette warnings and advertising. In addition, the FCLAA included a preemption provisions providing that "no statement relating to smoking and health," other than required by the FCLAA, "shall be required on any cigarette package."<sup>130</sup> Although Congress explicitly prohibited state laws relating to cigarette warnings, state common law damage actions concerning the adequacy of these warnings ensued.<sup>131</sup> The landmark decision, *Cipollone v. Liggett Group, Inc.*,<sup>132</sup> resolved this controversy.

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<sup>126</sup> Thornton, *supra* note 116, at 570 (citation omitted).

<sup>127</sup> *Id.* at 571 (citing Richard A. Wegman, *Cigarettes and Health: A Legal Analysis*, 51 CORNELL L.Q. 678, 680 (1966)). See Jonathan Turley, *A Crisis of Faith: Tobacco and the Madisonian Democracy*, 37 HARV. J. ON LEGIS. 433, 440 (2000).

<sup>128</sup> 15 U.S.C. §§ 1331-1340 (1982); see also Thornton, *supra* note 116, at 571. Congress amended certain provisions of the 1965 Federal Cigarette Labeling and Advertising Act by the Pub. Health Cigarette Smoking Act of 1969, Pub. L. No. 91-222, 84 Stat. 87 (1970), and again by the Comprehensive Smoking Education Act, Pub. L. No. 98-474, 98 Stat. 2200 (1984). *Id.* at n.40.

<sup>129</sup> See 15 U.S.C. § 1333 (1984).

<sup>130</sup> 15 U.S.C. § 1334(a) (1988).

<sup>131</sup> Thornton, *supra* note 116, at 577.

<sup>132</sup> 505 U.S. 504 (1992).



In *Cipollone*, an action was brought against cigarette manufacturers by the son of Rose Cipollone, who began smoking in 1942 and died of lung cancer in 1984.<sup>133</sup> The petitioner claimed that the cigarette manufacturers breached express warranties by failing to warn purchasers of the hazards of smoking.<sup>134</sup> The respondents' defense was that the FCLAA and its successor, the Public Health Cigarette Smoking Act of 1969<sup>135</sup> ("1969 Act"), preempted these state law claims.<sup>136</sup>

The Third Circuit held that a state law damage action that challenged the propriety of a party's actions with respect to the advertising of cigarettes was preempted by the 1969 Act.<sup>137</sup> On remand, the District Court, under the guide of the Court of Appeals, found the claim of breach of express warranty preempted.<sup>138</sup> The Supreme Court's decision marked a significant change from the Court of Appeals decision concerning FCLAA preemption. The Court held that with respect to the 1965 FCLAA preemption provision, "Congress spoke precisely and narrowly: 'No statement relating to smoking and health shall be required in the advertising of [properly labeled] cigarettes.'"<sup>139</sup> The Court reasoned that this provision on its face merely preempted positive laws mandating further cautionary statements at both the state and federal level.<sup>140</sup> In addition, the Court held that the preemption provision must be read to include a presumption against the preemption of state police power regulation.<sup>141</sup> Therefore, the plaintiff's state common law claims were not preempted by the FCLAA.<sup>142</sup> However, the 1969 Act broadened the scope of preemption.<sup>143</sup> The Act's preemption provision provides that: "No requirement or prohibition based on smoking and health

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<sup>133</sup> *Id.* at 508.

<sup>134</sup> *Id.* In addition, he claimed fraudulent misrepresentation, failure to warn, and conspiracy. *Id.*

<sup>135</sup> Pub. L. No. 91-222, 84 Stat. 88 (1970) (codified as amended, 15 U.S.C. §§ 1331-1340).

<sup>136</sup> *Id.* at 508, 510.

<sup>137</sup> *Cipollone v. Liggett Gr., Inc.*, 789 F.2d 181 (3d Cir. 1986).

<sup>138</sup> *Cipollone v. Liggett Gr., Inc.*, 649 F. Supp. 664 (D.N.J. 1986).

<sup>139</sup> *Cipollone*, 505 U.S. at 518 (quoting the FCLAA § 5 (b)).

<sup>140</sup> *Id.* at 518.

<sup>141</sup> *Id.*

<sup>142</sup> *Id.* at 519-20.

<sup>143</sup> *Cipollone*, 505 U.S. at 520.

shall be imposed under State law with respect to the advertising or promotion of any cigarettes the packages of which are labeled in conformity with the provisions of this chapter."<sup>144</sup> Thus, the Court examined each of the plaintiff's common law claims and asked "whether the legal duty that is the predicate of the common-law damages action constitutes a 'requirement or prohibition based on smoking and health . . . imposed under State law with respect to . . . advertising or promotion.'"<sup>145</sup>

The most significant analysis, for the purpose of this Note, is the claim of breach of express warranty<sup>146</sup> because it most resembles the claim of negligent adoption of benefits policy by an HMO. In an action for breach of express warranty, a plaintiff must allege a statement by the seller promising the goods are all in a certain condition and that the goods do not conform to the promised condition.<sup>147</sup> In an action against an HMO challenging the adoption of a benefits policy, a plaintiff must allege that the adoption of the policy was negligent and the damage sustained by the plaintiff was causally connected to such adoption. The claims are similar because both are grounded in state common law and are predicated on a voluntarily action by the defendant entity. In order to be liable for negligence of adoption of a benefits policy, an HMO must first voluntarily adopt such a policy. Likewise, liability for breach of express warranty stems from a manufacturer's claim that their product purports to be something. This claim is also voluntary on the part of the manufacturer.

In *Cipollone*, the Supreme Court found that a manufacturer's liability for breach of express warranty would not impose a requirement or prohibition based on state law

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<sup>144</sup> 15 U.S.C. § 1334(b).

<sup>145</sup> *Cipollone*, 505 U.S. at 524 (quoting 15 U.S.C. § 1334).

<sup>146</sup> The claim of failure to warn and fraudulent misrepresentation by neutralization of warnings were found to be preempted. *Cipollone*, 505 U.S. at 524, 527; see also Heather E. Klasing, *Federal Law Does Not Preempt Failure to Warn Claims by Nonsmokers: Why Big Tobacco May Get Burned*, 24 U. DAYTON L. REV. 119 (1998). The claim of fraudulent misrepresentation by false representation of material fact or concealment was held not to be preempted. *Cipollone*, 505 U.S. at 529. In addition, the claim of conspiracy to misrepresent or conceal material facts was not preempted. *Id.* at 530.

<sup>147</sup> Klasing, *supra* note 146, at 130.

because the requirement is imposed by the warrantor itself.<sup>148</sup> A common law remedy for a voluntarily taken, contractual commitment does not impose a requirement under state law.<sup>149</sup> Thus, the claim for breach of express warranty is not preempted by the 1969 Act.<sup>150</sup>

Following the *Cipollone* decision, federal district courts have allowed the breach of express warranty claim to survive preemption. In *Perez v. Brown & Williamson Tobacco Corp.*,<sup>151</sup> the Southern District of Texas found that the FCLAA did not preempt the claim of breach of express warranty against cigarette manufacturers because the claim was based on the duty not to deceive rather than on duties based on smoking and health.<sup>152</sup> Similarly in *Castano v. American Tobacco Co.*,<sup>153</sup> the Eastern District of Louisiana found that the claim of breach of express warranty was not preempted by the FCLAA for the reasons stated in *Cipollone*.<sup>154</sup> These cases show that after the *Cipollone* decision, the preemption defense was sufficiently narrowed to allow recovery under the claim of breach of express warranty against the tobacco industry.

As a result of the Supreme Court and other courts allowing the claim of breach of express warranty to survive FCLAA preemption, cigarette manufacturers may be held directly liable for their breach. The *Cipollone* Court held that since the duty that products conform to expressed warranties is voluntarily assumed by the tobacco industry, it is not a requirement imposed under state law.<sup>155</sup> Likewise, a negligently-drawn policy implemented voluntarily by an HMO should not be preempted by ERISA. A negligence claim challenging an HMO's policy relates most directly to the administration of the HMO, not to the employer's benefits plan. The effect on the plan stems from voluntary action taken by the HMO, adopting a policy to limit benefits. This voluntary

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<sup>148</sup> *Cipollone*, 505 U.S. at 525.

<sup>149</sup> *Id.* at 526.

<sup>150</sup> *Id.* at 527.

<sup>151</sup> 967 F. Supp. 920 (S.D. Tex. 1997).

<sup>152</sup> *Id.* at 928. In contrast, the court found that the plaintiff's claims of conspiracy, fraud, and misrepresentation, and breach of implied warranties stem from duties based on smoking and health and thus are preempted by the FCLAA.

<sup>153</sup> 870 F. Supp. 1425 (E.D. La. 1994).

<sup>154</sup> *Id.* at 1434.

<sup>155</sup> *Cipollone*, 505 U.S. at 526.

action should result in HMO liability for negligence just as the tobacco industry may be liable for its voluntary actions under breach of express warranty.

## CONCLUSION

Because of the prominence that managed care enjoys in today's health care system, many Americans are affected by its emphasis on containing health care costs. Although cutting health care cost may be warranted, negligently furthering this goal is unacceptable. To prevent such negligence in benefits decisions, HMOs must be held accountable for their actions. Because the presently enacted ERISA statute does not provide an effective remedy against HMO negligence, consumers should be able to bring a state tort law claim against HMOs.

Although the Supreme Court has yet to face the question of HMO liability for state tort law claims, its own precedent in federal statutory preemption cases and decisions of the Fifth Circuit provide a framework to allow such claims to survive ERISA preemption. Furthermore, given the similarities between the tobacco industry and managed care entities, the Supreme Court's decision to allow breach of express warranty claims to survive FCLAA preemption provides a useful guideline for allowing state tort law claims against HMOs to survive ERISA preemption.

Furthermore, there are sound policy reasons for allowing a state law tort claim against an HMO to survive ERISA preemption. First, none of the purposes that Congress was trying to accomplish with ERISA would be furthered by preempting this claim. An HMO would be subject to the same basic common law in all states—that of liability for injuries caused by negligence. So when an HMO adopts a multi-state policy, it should do so in compliance with a general standard of care. Thus, an HMO would not be subject to conflicting state laws, which was one of the policy considerations behind ERISA preemption.

In addition, the purpose of protecting employees' benefit plans is furthered by allowing this cause of action. If HMOs are not carefully adopting policies relating to their benefit plans, then policyholders should be able to hold them liable. This will

encourage HMOs to more carefully draft policies and ensure that money spent on benefit plans is providing quality health care. Thus, the ERISA objective of protecting employee benefit plans is better furthered by holding HMOs liable for negligently adopting their policies.

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