Health Care: ERISA Preemption and HMO Liability--A Fresh Look at ERISA Preemption in the Context of Subscriber Claims against HMOs

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COMMENT

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I. Introduction

In 1974, Congress enacted the Employee Retirement Income Security Act1 (ERISA) to secure the future of private employee pensions and welfare benefit plans. ERISA federalized the law of employee benefits and, in the process, overcame innumerable barriers to the reliable utilization of employee benefit plans.2 It displaced conflicting and duplicative state laws, and it provided minimum standards for the establishment, operation, and administration of employee benefit plans.3 ERISA also imposed special fiduciary obligations on employers and plan administrators.4 Most importantly, ERISA established a federal cause of action for plan participants to recover benefits or enforce rights granted to them under the terms of their benefit plans.5

To complete its goal of federalizing employee benefits law, Congress included section 514 of ERISA, which states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."6 Through this broadly worded provision, ERISA has been held to preempt a myriad of state statutes and the common law relating to employee benefit plans.7 For instance, a state motor vehicle law cannot preclude a benefit plan from requiring reimbursement for benefit payments from a claimant's tort recovery.8 ERISA also preempts state laws that prohibit employees' retirement pension benefits from being reduced by an award of workers' compensation benefits.9 For over twenty years, ERISA preemption has steadfastly protected employee benefit plans from direct and indirect state regulation.

2. See Frank Cummings, ERISA Litigation: An Overview of Major Claims and Defenses, in BASIC EMPLOYMENT AND LABOR LAW — IN DEPTH 255, 264 (ALI-ABA Course of Study, July 8, 1996), available in Westlaw, CB03 ALI-ABA 255.
4. See id. §§ 1101-1109.
5. See id. § 1132.
In 1997, however, the wall of ERISA preemption appears to be crumbling in the midst of the turbulent debate over the future of our nation's health care system. Over one-half of all American workers receive their health care coverage through ERISA-governed employee benefit plans. Consequently, almost every aspect of the national debate over health care reform implicates ERISA. On one front, ERISA preemption has stood as the primary obstacle to state health care reform initiatives. State governments have increasingly demanded that Congress grant ERISA waivers to allow the states to enact their own health care reform initiatives. In twenty years, Congress has granted only one ERISA waiver. However, the 105th Congress appears likely to reconsider waivers from ERISA preemption as a way of returning power to the states and fostering experimentation with health care cost containment.

An equally challenging issue in the health care debate involves ERISA preemption of legal claims brought under state law against health maintenance organizations (HMOs). HMOs are quickly displacing hospitals as the central players in the delivery of health care across the nation. These entities draw a large percentage of their subscribers from ERISA-governed employee benefit plans and, thus, operate as components of such plans. As a consequence, HMOs frequently invoke ERISA preemption as a defense to legal actions brought against them under state law.

Many courts have held that ERISA preempts claims against HMOs operating as part of employee benefit plans, including claims for breach of contract.

12. See id. at 785-86; see also 139 CONG. REC. E3126 (daily ed. Nov. 26, 1993) (statement of Rep. Wyden) (explaining the necessity of obtaining an ERISA waiver for Oregon's health care reform legislation). The call for ERISA waivers also comes from proponents of state bills to expand HMO liability in cases of medical negligence. In Texas, for example, the state senate is currently considering a bill that would prevent any health insurance carrier, HMO, or other managed care entity from including in its provider contracts a clause releasing it from liability or requiring indemnification from its providers. See Tex. S.B. 386, 75th Leg., Reg. Sess. (1997) (introduced Jan. 30, 1997). Governor George W. Bush has indicated that he will veto the bill if it passes. See Stephanie Anderson Forest & Mike McNamara, Revenge of the HMO Patients, BUS. WK., Mar. 17, 1997, at 30. However, even legislative consideration of the measure carries significant implications when taken in conjunction with the federal debate over ERISA waivers.
14. The actions of the 104th Congress with regard to welfare reform suggest a congressional focus on returning power from the federal government to state governments. The 1996 Election results seem to promise a similar focus from the 105th Congress.
15. See L. Frank Coan, Jr., You Can't Get There From Here — Questioning the Erosion of ERISA Preemption in Medical Malpractice Actions Against HMOs, 30 GA. L. REV. 1023, 1024 (1996).
16. This is true even if ERISA provides no alternative remedy. See Cannon v. Group Health Serv.,
fraud, negligence, and medical malpractice. Other courts, after finding that ERISA does not preempt these claims, have held HMOs liable to the subscribers that they have harmed. These courts differ dramatically in their interpretation and analysis of ERISA preemption.

Unfortunately, the United States Supreme Court has never addressed ERISA preemption of subscriber claims against HMOs that operate as part of employee benefit plans. Moreover, the thirteen existing Supreme Court opinions involving ERISA preemption in other contexts have failed to provide clear guidance to lower courts. In a series of early cases questioning the proper scope of ERISA preemption, the Supreme Court relied on a literalist approach that resulted in a remarkably broad interpretation of section 514. Subsequent to these cases, lower courts have struggled, in vain, to find a manageable framework within this expansive approach through which they could apply ERISA preemption to claims against HMOs. The result has been a panoply of confusion among courts, HMOs, physicians, and subscribers over what conduct is actionable, who is responsible for what services, and what remedies for injustice are available.

However, in *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co.*, a unanimous Supreme Court significantly narrowed its interpretation of ERISA preemption. The *Travelers* Court recognized the difficulties presented by its prior broad interpretations. The Court offered a new approach that focuses on defining the outer limits of ERISA’s preemptive scope by referring to congressional intent at the time of ERISA’s passage as well as the degree to

77 F.3d 1270, 1274 (10th Cir.), cert. denied, 117 S. Ct. 66 (1996).
17. See, e.g., Kuhl v. Lincoln Nat’l Health Plan, 999 F.2d 298, 302 (8th Cir. 1993).
23. Justice Scalia noted the lack of clarity in the Supreme Court’s ERISA jurisprudence in his concurring opinion in *Dillingham*. *Dillingham*, 117 S. Ct. 832, 843 (Scalia, J., concurring) ("[O]ur prior decisions have not succeeded in bringing clarity to the law.").
26. See id. at 1677.
which a state law affects employee benefit plans. Although Travelers did not specifically address the issue of subscriber claims against HMOs, the Court's opinion suggests that the scope of ERISA preemption may not encompass all such claims.

The Travelers opinion has sparked significant disagreement among courts and legal scholars over the proper scope of ERISA preemption in the context of claims against HMOs. Some legal scholars discount Travelers as a temporary departure from the earlier, more expansive approach to determining ERISA preemption. These scholars clearly favor a broad interpretation of section 514, citing the many "procedural ills" of pre-ERISA employee benefits law. Despite the attractiveness of some arguments in favor of broad preemption, other legal experts applaud the Travelers Court for taking a narrower view of ERISA's preemptive scope. These scholars argue that preemption has prevented beneficial state efforts at health care reform, unwisely shifted the balance of power from states to the federal government, and improperly shielded HMOs and other large corporate entities from taking legal responsibility for their wrongful actions. Even among these scholars, however, there is significant disagreement over the actual implications of Travelers on the development of a manageable framework by which to determine ERISA preemption. Indeed, few commentators have ventured to suggest a framework by which courts could determine the appropriate scope of section 514.

Many courts are in a similar disarray over the Travelers opinion. Subsequent to Travelers, the United States Courts of Appeals for the Third, Tenth, and Seventh Circuits reached different conclusions on whether ERISA preempts medical malpractice claims brought against HMOs under the theory of respondeat superior. The circuit court split over this single issue of ERISA preemption

27. See id.
28. See id. at 1683. The Travelers Court indicated that laws which affect only indirectly the relative prices of health insurance, including "myriad state laws in areas traditionally subject to local regulation, . . . Congress could not possibly have intended to eliminate." Id.
29. See, e.g., Cummings, supra note 2, at 302-04. This view has been weakened by the unanimous Supreme Court opinion in California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., 117 S. Ct. 832 (1997). The Dillingham Court reaffirmed Travelers' narrow interpretation of ERISA's preemption clause when it held that California's prevailing wage laws do not relate to employee benefit plans and are not preempted by ERISA. Id. at 842.
30. See, e.g., Cummings, supra note 2, at 302-04.
31. See, e.g., Schuler, supra note 11, at 793 (concluding that states will have more power to regulate in the health care arena after Travelers); Fisk, supra note 7, at 93 (arguing in favor of policy-oriented approach taken by Travelers over "textualist" approach of earlier preemption cases); Seema R. Shah, Loosening ERISA's Preemptive Grip on HMO Medical Malpractice Claims: A Response to Pacificare of Oklahoma v. Burmage, 80 MINN. L. REV. 1545, 1572 (1996) (approving narrower objective-based approach).
33. See, e.g., Coan supra note 15, at 1060 (recommending, without further suggestion, the need for a new interpretive framework).
34. In Dukes v. U.S. Healthcare, Inc., 57 F.3d 350 (3d Cir. 1995), the Third Circuit held that ERISA
reveals that, even after the Travelers Court refined its interpretation of section 514, the preemption borderline remains hazy and indistinct in the area of claims against HMOs.

This comment proposes a clear analytical framework for courts to follow in determining whether ERISA preempts a state law claim against an HMO. The proposed framework closely follows the statutory language of ERISA and the interpretive guidelines set forth in Travelers. It would not alter the substantive rights of any plan sponsor or beneficiary. However, the framework proposed in this comment would provide more clarity to the law of ERISA preemption as well as help define the appropriate role of HMOs in our nation's health care system.

The comment begins, in Part II, by discussing the emergence and operation of HMOs in the United States, including the legal quagmire in which HMOs have become enmeshed. Part III of the comment explores the application and importance of ERISA to the issue of HMO liability. This section also discusses the tortured interpretation of ERISA's preemption clause by the Supreme Court and suggests the need for a new interpretive framework for determining the scope of ERISA preemption. Part IV proposes a more definitive approach to determining the scope of ERISA preemption based on the plain meaning of section 514 and the reasoning set forth in Travelers. Part V studies the various theories of liability advanced against HMOs and discusses ERISA preemption of those legal claims, including how ERISA's preemption clause would apply under the proposed framework. Part VI concludes with an analysis of the beneficial effect this new approach would have on the issues of ERISA preemption and HMO liability.

II. The Emergence and Operation of HMOs

An understanding of HMOs requires recognition of the fact that health management arose not to restrain medical care but to contain medical costs. Thus, management of health care is only the means used to manage health costs. Ironically, the two entities most responsible for rising costs are the same entities most responsible for efforts to contain those costs — the health insurance industry and the federal government.

A. The Health Insurance Industry

The modern health insurance industry evolved slowly through the twentieth century. Prior to the 1930s, health insurance was something of an anomaly. Health problems did not qualify for insurance under traditional principles, which based the provision of insurance on three conditions: (1) the insured event must be definite

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might preempt vicarious liability claims for medical malpractice brought against HMOs. See id. at 361. In Pacificare of Oklahoma v. Burrage, 59 F.3d 151 (10th Cir. 1995), the Tenth Circuit held that vicarious liability claims against HMOs for medical malpractice do not relate to an employee benefit plan and are therefore not subject to preemption by ERISA. See id. at 153. In Jass v. Prudential Health Care Plan, 88 F.3d 1482 (7th Cir. 1996), the Seventh Circuit held that a claim for medical malpractice brought against an HMO under the theory of vicarious liability directly relates to an ERISA-governed employee benefit plan and is preempted. See id. at 1493-94.
and unambiguous; (2) the insured event must be outside of the insured's control; and (3) the insured event must be uncommon for individuals but have a predictable incidence among a group.55 These conditions made insurance profitable and publicly acceptable for destructive events of nature such as fires, floods, and storms.

By contrast, health issues ran contrary to traditional insurance principles. Health problems were societal mysteries, ambiguous and indefinite.56 An individual's health was deemed his own responsibility. Sickness, though not directly within an individual's control, was left to the personal sphere of family and friends.37 In addition, health problems were, and still are, common to every individual. For several reasons, these factors made health coverage unattractive, both as a business and as a public policy.38 The first reason involved the problem of adverse selection by consumers. Because most people believed that health was a matter within an individual's control, insurance companies were convinced that those individuals who purchased health insurance were also those most likely to have health problems.39 Insurers did not want to engage in what they thought would be a self-defeating financial risk. Second, there was the problem of how to avoid abuse of the insurance system. Insurers could not objectively measure the extent of an illness or curb excessive use of health services.40 In fact, insurers quickly realized that the existence of health insurance actually increases utilization of health services.41 Thus, insurance companies were hesitant to offer health coverage.

The Great Depression of the 1930s contributed significantly to the growth of commercial health insurance.42 Individuals could not pay for the health services they required. Undernourishment led to increased illness, and technological improvements of the 1920s kept the cost of health care services high.43 President Franklin D. Roosevelt's New Deal failed to address the problems of health care, and financially strapped communities could not provide needed aid to the poor.44 Private hospitals were dramatically affected by the Depression. Average hospital receipts fell from $236.12 per patient in the mid-1920s to only $59.26 per patient in 1930.45 Bed occupancy during that same time dropped from 71% to 64%.46 To recover lost income, hospitals and physicians began offering a certain amount of guaranteed care for a small monthly payment.47 One of the earliest organized

36. See id. at 294.
37. See id. at 296.
38. See id. at 294-98.
39. See id. at 294.
40. See id.
41. See id. at 298.
42. See id. at 270.
43. See id.
44. See id.
46. See id.
47. See Starr, supra note 35, at 307.
health plans, the Cooperative Health Association, was established in Oklahoma in 1929, by the Farmer's Union and Michael Shadid, M.D.\textsuperscript{48} Around the same time, the American Hospital Association developed Blue Cross plans to help ensure stable revenues for its members.\textsuperscript{49} These Blue Cross plans spread quickly, and Blue Shield plans were soon established to cover physician services.\textsuperscript{50} Private insurance companies soon entered the booming new market of commercial health insurance.\textsuperscript{51} From the 1930s, the number of individuals covered by health insurance grew steadily. Organized labor drove the expansion of private employee coverage.\textsuperscript{52} Federal measures, such as the GI bill, the Hill-Burton Act, and the creation of a national health research facility, contributed significantly to an explosion in health care services and new technology after World War II.\textsuperscript{53} In less than a quarter of a century, the percentage of Americans insured against health costs rose from near zero to 63%.\textsuperscript{54}

\textbf{B. The Federal Government}

The federal government played an important role in the postwar growth of health insurance. However, the government did not leap full force into the health care market until 1964, when President Lyndon B. Johnson announced his Great Society.\textsuperscript{55} In response to Johnson's mandate, Congress enacted Medicare and Medicaid to curb two major problems with the private-sector growth of health insurance.\textsuperscript{56} First, most employee-based health insurance ended upon retirement, leaving the elderly without health insurance at a time when, arguably, they needed it the most.\textsuperscript{57} Second, private health insurance failed to reach low-income individuals and families, who were more susceptible to illness than the average American population due to undernourishment and poor living conditions.\textsuperscript{58} These gaps were filled by Medicare and Medicaid, respectively, and the number of Americans demanding health care services jumped considerably.\textsuperscript{59}

\textbf{C. The Necessity of Cost Containment}

The growing demand for health care services led to an inevitable rise in the costs of health care delivery. National spending for health care increased from $12.7 billion to $41.9 billion in 1965 to $647 billion in 1990.\textsuperscript{60} Likewise, per capita

\textsuperscript{48} See id. at 302-03.
\textsuperscript{49} See Randall, supra note 45, at 11.
\textsuperscript{50} See STARR, supra note 35, at 307.
\textsuperscript{51} See id.
\textsuperscript{52} See id. at 311.
\textsuperscript{53} See KAREN DAVIS ET AL., HEALTH CARE COST CONTAINMENT 11 (1990).
\textsuperscript{54} See STARR, supra note 35, at 327.
\textsuperscript{55} See DAVIS ET AL., supra note 53, at 12.
\textsuperscript{56} See id.
\textsuperscript{57} See id.
\textsuperscript{58} See id.
\textsuperscript{59} See id. The creation of Medicare and Medicaid eventually added fifty million consumers to the health care market.
\textsuperscript{60} See BARRY R. FURROW ET AL., HEALTH LAW: CASES MATERIALS AND PROBLEMS 661 (2d ed.
spending for medical services skyrocketed from $82 per year in 1950 to $211 in 1965 to $2511 in 1990. Additionally, in its first twenty years, Medicare spending rose from $4.5 billion to $78 billion annually. From 1967 to 1970, Medicare hospital expenditures grew annually at an average rate of 18.1%.

The seemingly uncontrollable growth in the costs of health care delivery may be attributed to several factors. First, as expected, the emergence and growth of health insurance increased utilization of health services. Second, the progress of technology spurred cost increases. Health providers used more effective, but more expensive, methods of health treatment. Improved health care led to longer life, and an aging population contributed to overall costs as more elderly Americans required health services. Finally, the steady growth of economic inflation contributed to rising health costs.

By the early 1970s, cost containment had moved from a mere concern to an absolute necessity. Both private insurance companies and the federal government began taking steps to control costs through a practice of utilization management, which conditions payment for services on a certification of their necessity. Congress amended Medicare and Medicaid in 1972, giving both programs the authority to refuse payment for any procedures that were deemed unnecessary to efficient care. The Prospective Payment System was established to create an incentive for hospitals to operate in a more cost-efficient manner by fixing reimbursement on anticipated health needs and predetermined methods of cost-efficient treatment.

Prospective and concurrent utilization review, as those methods have come to be called in the modern lexicon of health management, evolved from a system of diagnosis related groups (DRGs). The Department of Health and Human Services, the government agency in charge of Medicare and Medicaid, used DRGs to categorize individuals according to their diagnoses, age, and health status. Payment for medical services was made prospectively based upon the anticipated needs for an individual's DRG. Similar payments were made to hospitals according to their size, location, and general patient base. Hospitals and providers

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1. See id.
2. See Davis et al., supra note 53, at 13.
3. See id. at 16.
4. See id. at 13.
7. See Feldstein, supra note 65, at 1311.
8. See Davis et al., supra note 53, at 20.
9. See id. at 21.
10. See id. at 35.
11. See id. at 36.
had to absorb any difference between the actual cost of the medical services provided and the DRG payment.\textsuperscript{72}

During the 1980s, private insurers adopted the prospective and concurrent methods of utilization review, either by forming internal utilization review committees or by contracting with independent utilization review organizations.\textsuperscript{73} Under most prospective and concurrent utilization review systems, subscribers must request precertification from an insurer for a particular treatment or procedure. The reviewer compares the treatment requested and the individual's diagnosis with a list of preapproved diagnoses and recommended treatments. If approved, the patient generally must justify an overnight hospital stay against another list of hospitalization criteria and averages for the length of stay required for a particular treatment. The ultimate decision to approve or disapprove payment for a requested medical treatment, procedure, or hospital stay usually lies in the hands of a physician and a medical director, not with the patient's treating physician.

\textit{D. Modern Health Management}

Health management principles now predominate in the modern health coverage market.\textsuperscript{74} Today, nearly every public and private health insurer includes certain cost-containment measures as part of an integrated health payment plan. These cost-containment mechanisms vary widely, from prospective, concurrent, and retrospective utilization review, to financial incentives that encourage doctors and patients to restrict utilization of health services. The wide variety and range of available health management mechanisms have come to rest primarily in two different types of managed care organizations: the preferred provider organization (PPO) and the health maintenance organization (HMO).

The PPO is a simple offshoot of the traditional health indemnity model, which operates on a fee-for-service basis.\textsuperscript{75} Under a fee-for-service plan, an insurer collects monthly premiums in exchange for coverage that guarantees reimbursement of all covered costs that an insured incurs from obtaining medical treatment. The physician is paid a fee for each service he or she provides. Thus, both the physician's income and the insurer's costs depend on the number of services performed and the fee amount associated with each service. Participants in a PPO pay lower premiums to the organization than they would to a traditional insurer. The PPO, in turn, contracts with physicians, hospitals, and other medical providers

\textsuperscript{72} See id.


\textsuperscript{74} The Institute of Medicine defines "managed care" as "a set of techniques used by or on behalf of purchasers of health benefits to manage health care by influencing patient care decision making through case-by-case assessment of the appropriateness of care prior to its provision." John Petrila, \textit{Ethics, Money, and the Problem of Coercion in Managed Behavioral Health Care}, 40 St. Louis U. L.J. 359, 363-64 (1996).

at a predetermined, reduced rate of reimbursement. Consumers are not required to see these "preferred providers" to obtain medical care, but they are strongly encouraged to do so through lower deductibles, discounted co-insurance rates, and higher benefit levels.76

While the legal responsibilities of PPOs to their subscribers are the subject of some controversy,77 the more prevalent and controversial form of managed care organization is the HMO.78 The HMO abandons the traditional fee-for-service indemnity model in favor of a more controlled structure based on the essential foundation of cost containment.79 Although all HMOs employ different methods of cost containment, all such methods are premised on two primary objectives: (1) eliminating physicians' incentives to overtreat patients by shifting the financial risk for such treatment to the medical provider80 and (2) coordinating patient utilization of medical services through a "gatekeeper" — a primary care physician — to restrict patients' freedom to self-select particular forms of treatment and services.81 These two objectives serve as the basic means by which HMOs contain health care costs and the essential foundations for all cost-containment measures.

Thus, like the PPO, the HMO contracts with physicians and other medical providers. However, the HMO requires its subscribers to call on these contracted providers in order to receive coverage. The HMO then makes fixed payments, per subscriber, to the assigned providers.82 For their part, providers must follow utilization procedures set by the HMO as a condition of participation.83 In many cases, an HMO's greater degree of control over the delivery of care blurs the thin line between an entity that simply pays for health services and an entity that actually provides health services.

76. See id.
77. See id.
78. Because of the degree of control an HMO has over physicians and other providers of medical care, and its stronger cost-containment measures, the HMO is more prevalent among managed care health plans. These same characteristics, however, make it controversial to patients and physicians.
79. "An HMO is an organized system of health care delivery for both hospital and physician services in which care delivery and financing functions are offered by one organization." Randall, supra note 45, at 20.
80. See id. "The traditional HMO structure completely shifts the financial risk from the third-party payer to the provider. This shift means that HMOs can obtain cost savings by controlling both utilization and expenses." Id.
81. See id. By placing control over hospital admissions, outpatient procedures, and referrals to specialists in the hands of a primary care physician, HMOs centralize control over patient utilization. See id.
82. This method of payment is called capitation. Capitation is, in essence, a mechanism for shifting the risk of overtreatment of services to contracting physicians. Faced with fixed prepayments for each subscriber, physicians have an incentive to practice cost-efficient medicine.
83. This requirement is generally known as utilization management and comes in three forms: (1) prospective utilization review, in which providers must precertify each procedure to ensure payment; (2) concurrent utilization review, in which providers must consult with a payment review team during ongoing treatment; and (3) retrospective utilization review, in which the provider's treatment is reviewed and payment may be denied. See Vemellia R. Randall et al., Section 1115 Medicaid Waivers: Critiquing the State Applications, 26 SETON HALL L. REV. 1069, 1130 (1996).
The HMO model may be further categorized into three general types: (1) the staff model; (2) the Independent Practice Association (IPA) model; and (3) the group model. Each of the three models employs different methods of cost containment and various levels of organizational control. The staff model HMO directly employs salaried providers at its own health care facilities. Because of its structure, the staff model HMO generally exercises the greatest amount of control over utilization and costs. The IPA model HMO is less structured than the staff model. Under the IPA model, the HMO contracts with an association of physicians to provide services to HMO subscribers. The members of the physician association utilize their own facilities and are paid by the association, which is, in turn, reimbursed by the HMO on a fixed, "capitated" rate for each HMO subscriber. Member physicians also have the freedom to provide services to non-HMO patients through their own financial arrangements. In contrast, the group model HMO directly contracts with physicians or groups of physicians, without an intervening association. The HMO selects each physician, group, or other provider and reimburses or prepays them directly. Plan subscribers have a limited number of providers within each physician group to call upon for medical treatment.

These three categories — staff, IPA, and group model HMOs — only serve as general classifications. Because of the wide variety of cost-containment mechanisms utilized by HMOs, some organizations include characteristics of two or three models combined. All three of these general models employ the basic features of capitation and utilization review. All HMOs also focus on preventive medicine as a means to less expensive health care. However, some HMOs provide additional risk-sharing financial incentives, such as bonus or withholding arrangements geared toward discouraging overutilization of medical services. In addition, HMOs employ different methods of utilization review either prospectively, concurrently, or retrospectively.

Although the various managed care organizations are controversial, especially the HMO, they have all received multiple endorsements from the federal and state governments. The Federal HMO Act, enacted in 1973, established national guidelines for the safe and efficient operation of HMOs. The HMO Act formally recognized the various cost-containment measures used by HMOs, including

85. See id. The staff model HMO uses the strictest control and cost-containment mechanisms, and is subsequently most controversial of all HMO models. No staff model HMOs operate in Oklahoma. OKLA. STATE DEPT. OF HEALTH, 1995 ANNUAL REVIEW: HEALTH MAINTENANCE ORGANIZATIONS 1-2 (1995).
86. See Chittenden, supra note 84, at 452.
87. See Davis et al., supra note 53, at 131. The term "health maintenance organization" was coined in 1970 to stress managed care's focus on preventive medicine.
88. See Randall et al., supra note 83, at 1130.
90. See generally 42 U.S.C. §§ 300e to 300e-17 (1994).
organizational structures such as the staff, IPA, and group models,91 capitation arrangements,92 utilization review mechanisms,93 and financial risk-sharing incentives.94 In addition, many state governments have passed their own HMO Acts.95 Some of these state laws characterize HMOs as health care financiers rather than as health care providers.96 But the basic premise in every state and federal HMO Act remains the same: HMOs should be encouraged to operate within the health care market to promote efficiency and economy.

E. Disputing the Potential Liability of HMOs

Today, more than sixty million Americans are enrolled in HMOs.97 This figure represents nearly one-third of all Americans who are covered by some form of health insurance, and is up 60% from only five years ago.98 In the State of Oklahoma, HMOs have seen enormous growth. From 1981 to 1995, state enrollment in HMOs increased from 4,386 to 304,899 Oklahomans.99 The number of HMOs operating in the state during that same time sprang from one to nine.100 In 1993, the Oklahoma legislature passed the Health Care Authority Act,101 which specifically endorsed "alternative health care delivery systems and strategies for the procurement of health care services in order to maximize cost-containment."102 Since the commencement of the Oklahoma Health Care Authority, HMOs operating in the state have increased their total revenues by over $45 million.103

The swift growth of HMOs across the country, fueled by rising health care costs,104 has sparked a national debate over the virtues and defects of health

91. See id. § 300e(b)(3)(A).
92. See id. § 300e(b)(1)(A), (B).
93. See id. § 300e(c)(6).
94. See id. § 300e(c)(2)(D).
96. The Federal HMO Act defines health maintenance organization as an entity "which provides basic and supplemental health services to its members." 42 U.S.C. § 300e(a) (1994). By contrast, the Illinois HMO Act authorizes HMOs to furnish "health care services through providers which are under contract with or employed by the [HMO]." 215 ILL. COMP. STAT. ANN. 125/2-3(c) (West Supp. 1996).
97. See Robert Perx, His Eye on 2d Term, Clinton to Name Panel, N.Y. TIMES, Sept. 25, 1996, at A11.
98. See id.
99. See OKLA. STATE DEPT OF HEALTH, supra note 85, at 3.
100. See id. at 3.
102. 63 OKLA. STAT. § 5003(B)(2) (Supp. 1997).
104. According to the Consumer Price Index for Medical Care, spending for health care in the United States rose 7.8% in 1993 and 4.8% in 1994. See Richard Rinkunas et al., Congressional Research Report, Health Care: Price Increases for 1995 (1996), abstract available in 1996 WL 11259340. These figures represent the lowest annual increases in 21 years. See id. Health spending represents approximately 14% of the nation's gross domestic product. See Richard Price & Richard
management by HMOs. For some Americans, membership in an HMO means lower health insurance premiums, reduced medical costs, and a necessary focus on preventive medicine. For many others, HMOs provoke fears of health rationing, poor-quality medical care, and a world in which financial considerations take priority over patient care.

Recent years have seen an explosion of lawsuits in which HMOs have defended against claims by disgruntled patients who allege that they have been denied access to quality medical care. These lawsuits are far from uniform. Plaintiffs allege many different theories of liability, ranging from breach of contract and breach of warranty to negligence, fraud, and medical malpractice. Each lawsuit has its own defenses, its own facts, and a maze of legal issues. However, a common thread runs through every lawsuit against an HMO: Plaintiffs argue that HMOs cause injury by placing financial considerations ahead of patient care. Thus, every case against an HMO calls into question the inherent characteristics and policy considerations of health management.

The flood of suits against HMOs, and the important questions on which they focus, has engendered a critical debate over the extent to which an HMO should be held liable for a patient's substandard medical care. The essential role that health management plays in the delivery of modern health care services has aroused many different, and often conflicting, public interests. Most consumers place great significance on patient care and argue that HMOs remain accountable to patients when they are held liable for patient harm.105 Physician advocates complain of the growing control HMOs have over the practice of medicine.106 These advocates argue that with control must come responsibility, and that HMOs should be held liable for injurious patient care over which they have responsibility.107 By contrast, HMOs and large employers contend that potential unlimited liability would cripple cost-containment mechanisms and force physicians to practice "defensive medicine," driving up health care costs. This, in turn, would eliminate the availability of affordable, long-term coverage for many Americans.108

III. The Application and Importance of ERISA Preemption

A. ERISA Preemption and its Impact on HMOs

One of the most important and complex facets of the dispute over HMO liability involves ERISA. More than one-half of all American workers receive their health


106. See id. At least one-third of all medical practitioners have capitated contracts with HMOs. Capitation accounts for approximately 19% of revenues for doctors with those contracts. Nearly 50% of all physicians are subject to some form of financial withholding for overutilization of services. See Julie Johnson, Trial Focus: Public Unease with Physician Incentives, AM. MED. NEWS, Aug. 12, 1996, at 1.
108. See id.
care coverage through ERISA-governed employee benefit plans.\textsuperscript{109} For several reasons, HMO subscribers constitute a large and growing percentage of this market. First, employers with employee welfare benefit plans have increasingly turned to HMOs as a means of restricting the rising costs of such plans.\textsuperscript{110} Second, HMOs have actively courted employer-sponsored benefit plans. By contracting with a few large employers, HMOs are able to access thousands of potential subscribers. Thus, employee benefit plans offer HMOs easy access to the health care market as well as a large subscriber base with which to operate. In addition, by cultivating members through large employee organizations, HMOs avoid the risks of adverse selection by individual consumers, who might choose a particular health plan on the basis of a high-risk illness already diagnosed. Third, ERISA has attracted the participation of HMOs, as it did other insurers and organizations, by allowing them to escape burdensome and varying state mandates. Thus, a number of factors have combined to create a situation in which ERISA significantly impacts HMOs by encouraging their swift expansion into the provision of employee health benefits.

The provision of ERISA that gives HMOs their greatest advantage is section 514, commonly known as ERISA's preemption clause.\textsuperscript{111} Pursuant to the Supremacy Clause of the United States Constitution,\textsuperscript{112} any comprehensive federal statute implicitly preempts state laws that affect similar subjects.\textsuperscript{113} In section 514, however, Congress explicitly mandated that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."\textsuperscript{114} This broad language bars direct state regulation of employee benefit plans as well as any state laws that, although not directly aimed at the regulation of employee benefits, relate in their application to ERISA-governed benefit plans. To restrict the preemptive scope of section 514, Congress included a "savings clause" that exempts from preemption the law of "any State which regulates insurance, banking or securities."\textsuperscript{115} However, the "deemer clause" in the same section prohibits states from arbitrarily deeming ERISA-organized plans to be insurance companies, banks, or trust and investment companies.\textsuperscript{116}

The language of section 514 has been interpreted to preempt a host of state law claims advanced against HMOs that operate as elements of employee benefit plans. For example, HMOs have successfully invoked ERISA preemption as a defense to claims for breach of contract.\textsuperscript{117} Similarly, ERISA has preempted claims against HMOs for fraud and misrepresentation,\textsuperscript{118} breach of fiduciary duty,\textsuperscript{119} tortious

\textsuperscript{109} See Kilcullen, \textit{supra} note 10, at 9.
\textsuperscript{110} See id. at 40.
\textsuperscript{112} U.S. CONST. art. VI, § 2.
\textsuperscript{114} 29 U.S.C. § 1144(a) (1994).
\textsuperscript{115} Id. § 1144(b).
\textsuperscript{116} See id. § 1144(b)(2)(B).
\textsuperscript{117} See, e.g., Kuhl v. Lincoln Nat'l Health Plan, 999 F.2d 298, 302 (8th Cir. 1993).
\textsuperscript{118} See, e.g., Settles v. Golden Rule Ins. Co., 927 F.2d 505, 509 (10th Cir. 1991); Elsesser v.
interference with contractual relations,120 negligence,121 and medical malpractice.122

Thus, ERISA's preemption clause has extended broad protection to HMOs against liability under state laws. However, the extent of this protection remains unclear. One major reason that courts have struggled in vain to provide a definitive test for ERISA preemption involves the confusion over the term "preemption." As it is used in the context of ERISA, preemption applies to two distinct legal concepts — complete and conflict preemption. These two concepts involve different sections of ERISA. However, many state and federal courts have confused the two concepts and misapplied the legal tests involved. Therefore, to apply a more definitive test for preemption of a claim against an HMO, courts must properly define and separate the two concepts of complete and conflict preemption.

B. Distinguishing Between Complete and Conflict Preemption

1. Complete Preemption

The first concept involving the term preemption is the doctrine of "complete preemption." The complete preemption doctrine is not exclusive to ERISA. Rather, the doctrine has a broader application arising from the concept of federal removal jurisdiction under 28 U.S.C. § 1441.123 In general, a claim may not be removed from state court to federal district court unless diversity of citizenship exists between the parties to the action,124 or a federal question is presented on the face of the plaintiff's well-pleaded complaint.125 An exception to the well-pleaded complaint rule is the doctrine of complete preemption, which derives from the reasoning that "Congress may so completely preempt a particular area that any civil complaint raising this select group of claims is necessarily federal in character." 126

Thus, although a plaintiff's complaint may not explicitly state a federal question, it may implicate a particularly comprehensive federal law that would displace the plaintiff's state law claims. Such state claims are then said to be completely preempted by the federal law, allowing removal of the plaintiff's complaint to federal court.

120. See, e.g., Kuhl v. Lincoln Nat'l Health Plan, 999 F.2d 298, 302 (8th Cir. 1993).
121. See, e.g., Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1331 (5th Cir. 1992).
123. Title 28, section 1441 provides that defendants may remove a case from state court to federal district court if the district court would have original jurisdiction. See 28 U.S.C. § 1441 (1994).
124. See id. § 1332.
125. See id. § 1331 (providing that district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws or treaties of the United States); see also Franchise Tax Bd. v. Construction Laborers Vacation Trust, 463 U.S. 1, 9-12 (1983) (discussing well-pleaded complaint rule).
The Supreme Court invoked the doctrine of complete preemption in Metropolitan Life Insurance Co. v. Taylor, when it held that a plaintiff's common law breach of contract and tort claims were completely preempted by ERISA. The Metropolitan Life Court reasoned that Congress intended section 502(a) of ERISA, commonly known as ERISA's civil enforcement provision, to be the exclusive means for a plan participant to recover benefits from an ERISA-governed plan. Section 502(a) states 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 the terms of the plan." Thus, whenever a plaintiff's cause of action falls within the scope of section 502(a), that cause of action is subject to complete preemption under ERISA. Moreover, the Metropolitan Life Court recognized that while the civil enforcement scheme of section 502(a) may displace a plaintiff's state law claims, the section does not necessarily replace those state claims with a federal remedy. Therefore, a plaintiff's claims may be subject to complete preemption even in the absence of a remedy under section 502(a), leaving the plaintiff with no remedy at all.

As indicated, the doctrine of complete preemption arises in the context of ERISA when a defendant HMO removes a plaintiff's state action to federal court. If the plaintiff's complaint against the HMO only alleges claims that are cognizable under state law, a court must determine whether: (1) the plaintiff is a participant or beneficiary of a covered employee benefit plan and thus is eligible to bring a claim under section 502(a) of ERISA and (2) the plaintiff's state law claim falls within the subject matter of that section. To satisfy the second element, a court must determine that the plaintiff's state law claim rests upon the terms of the ERISA-governed plan and requires an interpretation of those terms. If the court finds that both requirements are met by the plaintiff's state law claims, then those claims are completely preempted, and the action is subject to removal.

A state law claim that is completely preempted under ERISA is not only subject to removal but also to dismissal. Section 502(a) constitutes the plaintiff's exclusive remedy for a claim falling within the scope of that section. Thus, a plaintiff's state law claim that falls within the section's civil enforcement scheme may be removed by a defendant HMO and then dismissed for failure to state a claim upon which relief may be granted. If any of the plaintiff's claims against an ERISA-governed

128. See id. at 62-63.
130. See Metropolitan Life, 481 U.S. at 63.
132. See Metropolitan Life, 481 U.S. at 63.
133. See id. at 62-53. The Court held that both claims were completely preempted, even while noting that only the contract action to recover benefits fell directly under § 502(a). See id.
134. See Rice v. Panchal, 65 F.3d 637, 641-42 (7th Cir. 1995) (discussing Supreme Court jurisprudence on complete preemption under ERISA).
135. See id. at 642
health plan do not fit within the scope of section 502(a), those claims may not form the basis of a removal motion, nor may they be dismissed pursuant to the doctrine of complete preemption.  

2. Conflict Preemption

The second concept incorporating the term preemption is what this comment, and some courts, refer to as "conflict preemption." Even if state law claims are not completely preempted under ERISA's civil enforcement provision, they may still be subject to "conflict preemption" under ERISA's preemption clause, section 514. As indicated earlier in this comment, if a court finds that a plaintiff's state law claims against an HMO relate to an ERISA-governed health plan within the meaning of section 514, then the court must dismiss those claims as preempted.

Thus, the ultimate effect of both conflict preemption under section 514 and complete preemption under section 502 is the same: dismissal of the plaintiff's state law claim. However, a significant difference exists between the two concepts that has important practical consequences. Complete preemption justifies removal to federal court and then dismissal of the state law claims. Conflict preemption only justifies dismissal of those claims. Thus, HMOs that wish to remove cases against them to federal court must show that the plaintiffs' claims satisfy the standards of complete preemption under section 502. Proving that a plaintiff's state law claim fits into the narrow enforcement scheme of section 502 is considerably more difficult for defendants than proving that the claim "relates to" an ERISA-governed plan under ERISA's broadly worded preemption clause.

Therefore, it remains important for courts to keep the concepts of complete and conflict preemption analytically distinct. Unfortunately, courts often confuse complete and conflict preemption. This confusion has contributed significantly to the courts' failure to provide a clear test for whether a claim is preempted under either doctrine.

C. The Legislative Origins of ERISA Preemption

Another major reason why courts have failed to establish a cohesive framework for interpreting section 514 of ERISA is the lack of a clear direction from Congress. Ironically, ERISA's preemption of state law claims against HMOs was an

136. In other words, it is possible for a plaintiff with several state law claims to see one of those claims form the basis of removal to district court and then be dismissed, while the other claims either remain in the district court or get remanded back to state court.

137. See Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482, 1487 (7th Cir. 1996) (using term "conflict preemption" to refer to "ordinary preemption" under § 514).


139. See Jass, 88 F.3d at 1487.

unintended consequence that neither Congress nor the health care industry foresaw. The preemption clause initially employed language that simply prevented state legislation about "the subject matters regulated by this Act." This language sailed through both the Senate and House of Representatives unchanged, but was amended in a Joint Conference Committee to mandate preemption of "any and all state laws relating to any employee benefit plan." The Committee disclosed the new language only ten days before Congress took final action on the bill.

After passage, House and Senate members disagreed on the desirability of the preemption clause. The House sponsor, Rep. John Dent (D.-Pa.), called the preemption clause the "crowning achievement of the legislation" because it "eliminated the threat of conflicting and inconsistent state and local regulation." Senator sponsor Jacob Javits (R.-N.Y.) took a different view, suggesting that the "desirability of further regulation" necessitated a refining of ERISA preemption.

Sen. Harrison Williams (D.-N.J.), cosponsor of ERISA, was less restrained when describing the Conference Committee's change of ERISA's preemption language. Senator Williams suggested in no uncertain terms that the preemption clause was obviously the result of interest group politics. Despite the varying opinions on the desirability of the preemption clause, there is little doubt that no member of Congress could foresee the impact that ERISA preemption would have on the delivery of health care and specifically on HMOs.

D. Supreme Court Interpretation of ERISA Preemption

Congress' inability to foresee the full effects of ERISA preemption prevented it from providing any meaningful direction for the appropriate interpretation of section 514. In the absence of legislative direction, the basic interpretive guidelines for determining the scope of ERISA preemption have come from a series of United

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141. See Daniel M. Fox & Daniel C. Schaffer, Semi-Preemption in ERISA: Legislative Process and Health Policy, 7 AM J. TAX. POL'Y 47, 49 (1988). A Blue Cross Association official recalled that the health insurance industry failed to notice the significance of ERISA preemption. See id. at 51.
142. See id.
143. H.R. 2, 93d Cong. § 699(a) (1974).
147. Id.
148. Id. at 29,942 (statement of Sen. Javits).
149. See id. at 29,533 (statement of Sen. Williams).
150. See Fox & Schaffer, supra note 141, at 52 (noting that neither the Senators nor the staff of the Senate Committee on Labor and Public Welfare discussed the implications of preemption with the members of the House Subcommittee on Health).
States Supreme Court decisions. Unfortunately, these decisions have failed to provide a consistent analytical framework for lower courts to follow.

The Supreme Court has focused on one basic question in all of its ERISA preemption cases: When does a state law "relate to" employee benefit plans? To answer this question, the Court has spent the vast majority of its time defining the words "relate to." Early cases interpreting this vague terminology relied on a "value neutral" approach, in which the Court attempted to replace "relate to" with more definitive language of its own. By using this approach, the Court avoided the need to analyze the state law at issue or the constitutional and policy implications of ERISA preemption. Instead, the Court concentrated on a textual interpretive analysis of the language used by Congress.

The benchmark case using the value neutral, textualist approach to interpreting ERISA's preemption clause is Shaw v. Delta Air Lines. In Shaw, the Supreme Court applied ERISA to preempt New York's Human Rights and Disability Benefits Laws, which prohibited sex discrimination in employment and required employers to pay sick leave benefits to employees who were temporarily disabled or pregnant. The Shaw Court began its analysis by stating that it must decide whether the state laws "relate to" employee benefit plans within the meaning of § 514(a). From this point, the Court focused solely on the meaning of "relate to" and avoided any analysis of the state laws and their effect on employee benefit plans.

Specifically, the Shaw Court noted that "Congress used the words 'relate to' in § 514(a) in their broad sense," concluding that a narrower interpretation of these words would make subsequent provisions of section 514 superfluous. The Court also provided an analysis of ERISA preemption's brief legislative history to support its reasoning that Congress must have intended an expansive interpretation of that clause. Finally, the Shaw Court relied upon Black's Law Dictionary to find that a state "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. Under this broad interpretation of ERISA's preemption clause, the Court had "no difficulty in concluding that the Human Rights Law and Disability Benefits Law 'relate to' employee benefit plans."

The expansive interpretation offered by Shaw promised little certainty in interpretation of section 514. The words "connection with or reference to" in Shaw

151. The Supreme Court has written thirteen opinions on the scope of ERISA preemption. See supra note 22.
152. For a more in-depth discussion of the textualist approach to ERISA preemption, see generally Fisk, supra note 7.
154. See id. at 108.
155. Id. at 96.
156. Id. at 98.
157. See id. at 98-99.
158. Id. at 96-97.
159. Id. at 96.
are no more clear than the ambiguous terminology of the statute itself. The *Shaw* Court recognized that the scope of ERISA preemption was limited when it noted that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan."\(^{160}\) However, the Court failed to define when a law's effect would be too tenuous, remote, or peripheral to justify preemption. In fact, the *Shaw* Court made no attempt at all to analyze the state laws at issue or judge their impact on employee benefit plans. Despite the uncertainty that was apparent in the Court's application of section 514, *Shaw* marked the beginning of an expansive approach to determining the scope of ERISA preemption — one which centered entirely on interpreting the text of section 514 and ignored the actual impact of challenged state laws upon employee benefit plans or the policy implications of federal preemption.

The Supreme Court reaffirmed its broad interpretation of section 514 in *Pilot Life Insurance Company v. Dedeaux.*\(^{161}\) The *Pilot Life* Court held that ERISA preempted the Mississippi common law tort of bad faith when it was applied against a self-funded employee health plan.\(^{162}\) The Court further held that the bad faith claim was not exempted from ERISA preemption as a regulation of insurance.\(^{163}\) In its reasoning, the *Pilot Life* Court noted that, to be exempted from ERISA preemption under the insurance exception of the savings clause, a state law must not only "have an impact on the insurance industry, but must be specifically directed toward that industry."\(^{164}\) The *Pilot Life* Court reconfirmed the *Shaw* Court's broad reading of ERISA preemption and found that the plaintiff's state law claims were unquestionably preempted.\(^{165}\) Indeed, the *Pilot Life* Court reasoned that any common law tort or contract action seeking damages for improper processing of a benefits claim would be preempted by ERISA.\(^{166}\)

The Supreme Court appeared to depart from its broad interpretation of ERISA preemption in *Fort Halifax Packing Co. v. Coyne,*\(^{167}\) when it held that ERISA did not preempt a state law that required large employers to provide a one-time severance payment to employees in the event of a plant closing.\(^{168}\) While the *Fort Halifax* Court initially relied on the expansive language of *Shaw* and *Pilot Life*, the Court also analyzed the state statute at issue and found that it did not raise "the types of concerns that prompted preemption."\(^{169}\) Specifically, the *Fort Halifax* Court reasoned that "Congress intended preemption to afford employers the advantages of a uniform set of administrative procedures governed by a single set

160. *Id.* at 100 n.21.
162. *See id.* at 47.
163. *See id.* at 51.
164. *Id.* at 50.
165. *See id.* at 47-48.
166. *See id.*
168. *See id.* at 4.
169. *Id.* at 11.
of administrative regulations." The state statute did not require or interfere with the administration of a benefit plan and, consequently, did not implicate the congressional purpose behind ERISA's preemption clause.

Fort Halifax represents a more narrow approach to determining ERISA preemption than the framework which emerged from Shaw and Pilot Life. The Fort Halifax Court looked beyond a basic, textual interpretation of section 514 to analyze the state law and its impact on employee benefit plans. The Court recognized that a state law does not relate to an employee benefit plan simply through its connection with or reference to employee benefits but requires a careful examination of its purpose and effect with regard to the administration of benefit plans. Thus, the Fort Halifax Court reasoned that the scope of ERISA preemption is ultimately limited by the underlying purpose behind Congress' passage of section 514.

However, like Shaw and Pilot Life, the Fort Halifax Court failed to clearly define the limitations that it found in section 514. In subsequent cases, the Supreme Court returned to a broad interpretation of ERISA's preemption clause. For instance, the Court in FMC Corp. v. Holliday held that ERISA preempted a state motor vehicle law that precluded reimbursement for benefit payments from a claimant's tort recovery. The FMC Corp. Court reasoned that the law referred to employee benefit plans in its statutory language and had a connection with benefit plans in its application. A similarly broad application of ERISA preemption resulted in Ingersoll-Rand Co. v. McClendon, in which the Court found that a plaintiff's suit for wrongful discharge was preempted by ERISA. The Court reasoned that because the plaintiff claimed that his employer fired him to prevent his pension from vesting, the plaintiff's lawsuit related "not merely to pension benefits, but to the essence of the pension plan itself."

The Court in District of Columbia v. Greater Washington Board of Trade provided the most expansive application of section 514 when it held that ERISA preempted a workers' compensation statute which required employers who provided health insurance for their employees to provide equivalent coverage to injured employees. According to the Court, section 514 applied to the statute because it set compensation levels for injured employees' health coverage by reference to the amount of benefits each employer pays to full-time employees.

170. Id.
171. See id.
172. See id.
173. See id.
175. See id. at 59.
176. See id.
178. See id. at 139.
179. Id. at 140.
181. See id. at 130.
182. See id.
Greater Washington Board of Trade, Ingersoll-Rand, FMC Corp., Pilot Life, and Shaw reflect an expansive interpretation of section 514 centered upon a value-neutral, plain meaning approach to the words "relate to" of the preemption clause. However, Fort Halifax represents a narrower approach based on the rationale that ERISA's preemption clause has implicit limits grounded in the policy implications of preemption. The Supreme Court returned to these implicit limits in 1995 when it decided New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.183

In Travelers, a New York statute required hospitals to collect surcharges from patients covered by commercial insurers and from certain HMOs.184 Several commercial insurers and HMOs challenged the validity of the state law, arguing that the law interfered with the administrative decision making of ERISA-governed employee benefit plans and imposed significant costs on such plans.185 Both the district court and United States Court of Appeals for the Second Circuit agreed with this argument and held that the New York law related to employee benefit plans under the Supreme Court's prior interpretation of section 514 and was preempted by ERISA.186

The Supreme Court reversed and held that the law was not subject to ERISA preemption.187 The Travelers Court began its analysis by recognizing that Congress must have intended section 514 to retain certain limits for the phrase "relate to" to have any substantive meaning.188 The Court indicated that its prior attempts to construe the phrase "relate to" were of little help in determining the limitations of ERISA's preemption clause, noting that the statute at issue made no "reference to" employee benefit plans, and that the phrase "connection with" was as unhelpful as the phrase "relate to" in determining the scope of section 514.189 Ultimately, the Court reasoned that state laws which only affect the costs of providing employee benefits, and therefore exert an indirect economic influence on the administration of benefit plans, do not fall within the reach of ERISA's preemption clause.190

The reasoning in Travelers is significantly more narrow than the Court's traditionally expansive interpretation of section 514. However, the Supreme Court may have further confused lower courts by disclaiming in Travelers the analytical approach that it had developed in previous cases. A number of ERISA preemption cases decided after Travelers do not even mention the case, but rely instead on interpretive analyses firmly grounded in the Shaw approach.191 Unfortunately,

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184. See id. at 1673.
185. See id. at 1676.
186. See id.
187. See id.
188. See id. at 1677.
189. See id.
190. See id. at 1679.
analyses based on the Shaw approach are far from "firm" when they are applied to claims against HMOs. The following sections discuss the inadequacy of the current interpretive frameworks based on Shaw and then return to the Supreme Court's opinion in Travelers to propose a new, more definitive framework for determining the scope of ERISA preemption.

E. Deceptive and Artificial Tests for Preemption

In an attempt to develop a manageable framework from Shaw's expansive interpretation of section 514, courts that have addressed subscriber claims against HMOs have developed a number of deceptive and artificial tests for determining whether ERISA preempts such claims. These tests may be grouped into three major types: (1) a quality of care versus denial of benefits classification; (2) a direct versus indirect claim classification; and (3) a physical versus nonphysical loss classification. The following section examines these three types of tests and explains how they have become an obstacle to elucidation of a definitive test for ERISA preemption.

1. Claims Based on Quality of Care Versus Claims Based on Denial of Benefits

Under a quality of care versus denial of benefits theory of claim classification, courts have reasoned that ERISA was only intended to secure the right of employees to receive benefits promised to them under an employee benefit plan. These courts reason that ERISA was not intended to guarantee a certain standard within the medical profession. Thus, claims against an HMO that are based on a complaint about the delivery of substandard medical care are not preempted by ERISA, while claims arising from an HMO's refusal to pay for that medical care would be preempted as an alleged improper denial of benefits. As this comment will show through a review of case law, the quality of care versus denial of benefits classification may or may not result in a finding of preemption, depending on which type of preemption doctrine is being considered (complete or conflict preemption) and under which legal theory the plaintiff chooses to characterize her claim.

Additionally, the distinction between a claim based on a substandard quality of care and one founded on an improper denial of benefits is often hazy and difficult for courts to determine. For example, it is reasonable to argue that an HMO's prospective or concurrent utilization review decision to deny payment for a requested medical treatment directly affects a physician's medical determination of whether to proceed with the treatment, and, thus, that prospective or concurrent utilization review affects the quality of care provided. Yet these de facto medical determinations are also benefit decisions. Some courts may find that claims arising from utilization review decisions are preempted as claims for an improper denial of benefits, while other courts reject ERISA preemption on the basis that the claim is really one for the delivery of substandard medical care. Thus, the quality of care versus denial of benefits classification is inadequate for forming a determinative test for ERISA preemption.
2. Direct Versus Indirect Claims

Under another general classification theory, courts have attempted to define the scope of ERISA by distinguishing state claims that directly implicate an ERISA-governed health plan from those claims that only affect such plans indirectly. This reasoning derives from a statement made by the Supreme Court in *Shaw v. Delta Air Lines*, which recognized that a state law is not subject to ERISA preemption if it affects employee benefit plans in "too tenuous, remote or peripheral a manner to warrant a finding that the law 'relates to' the plan." Thus, courts weigh the degree to which a legal claim invades the realm of ERISA, finding some claims sufficiently invasive to justify preemption and others too remote to qualify.

The direct versus indirect theory of classifying claims hardly seems adequate, for it leaves many important questions unanswered. Where do the boundaries of ERISA lie when analyzing claims against HMOs, which were unforeseen elements of employee benefit plans when Congress drafted the statute? What degree of invasiveness is required before a claim is no longer tenuous, remote, or peripheral to an ERISA plan? In addition, it seems that a direct versus indirect classification might incorporate a classification based on the quality of care versus denial of benefits distinction. A claim based on the quality of care might also be said to have only an indirect effect on an ERISA plan. Moreover, the *Travelers* Court explicitly recognized that ERISA might preempt state laws that indirectly affect employee benefit plans if the effects were sufficiently acute to interfere with administration of those plans. Despite the Supreme Court's recognition that ERISA might preempt direct and indirect claims alike, courts have continued to rely on the direct versus indirect distinction as a manageable approach to determining ERISA preemption.

3. Physical Versus Nonphysical Loss

At least one legal scholar has suggested a third general theory for classifying claims used by the courts — a classification based on physical versus nonphysical loss. Under this theory, courts group claims for recovery from physical injury apart from those claims seeking recovery for economic loss. The former would not be subject to ERISA preemption, while the latter group would be preempted by ERISA. The premise underlying this theory is twofold. First, ERISA provides a remedy for economic loss of benefits through its civil enforcement scheme, while recovery for physical injuries is not provided for under ERISA. Second, courts are less inclined under equitable considerations to find a claim preempted when the plaintiff has suffered physical injury or less than when a plaintiff's damages are merely financial. Thus, state law claims seeking recovery for economic damage are

193. Id. at 100 n.21
194. See *Travelers*, 115 S. Ct. at 1683.
195. See *Chittenden*, supra note 84, at 486-92.
more likely to be preempted by ERISA than claims for recovery from physical injury.

Several problems exist with the physical versus nonphysical loss classification. First, it is unsupported by case law. Few courts have explicitly considered whether or not a plaintiff’s claim was related to physical injuries or economic damages.\(^{196}\) Indeed, many of the courts that have faced a claim for physical injuries have found that ERISA preemption still applies.\(^{197}\) Second, the existence of a federal remedy is not a requirement for preemption of a state claim.\(^{198}\) Third, the conduct producing the injury remains the same, regardless of whether that injury is physical or economic. Therefore, it must be argued that if ERISA governs a claim concerning economic loss resulting from an HMO’s conduct, then ERISA should also govern identical conduct that results in physical injury.\(^{199}\) Thus, the usefulness of the physical versus nonphysical loss distinction is severely limited in determining ERISA preemption of claims against HMOs.

F. The Need for a Review of ERISA Preemption

Clearly, a new approach to determining ERISA preemption is needed. From the beginning, courts have entangled the two separate concepts of complete and conflict preemption. In addition, courts have invented deceptive and artificial classifications for claims to simplify the issue of ERISA preemption. The result is a myriad of confusion: Does a claim relate to the quality of care provided under a plan or to a denial of plan benefits? Is the claim directly related to the plan or does it affect the plan in only an indirect way? Did the allegedly improper activity forming the basis for the claim result in physical injury or economic loss? The obvious confusion in the courts over which of these questions to ask and what answers to accept has served to erode the public trust of HMOs, government, and the judicial system. Justice Stevens recognized the devastating effects of the chaos surrounding ERISA preemption in his dissenting opinion in District of Columbia v. Greater Washington Board of Trade.\(^{200}\) Justice Stevens noted the existence of over 2800 judicial opinions addressing ERISA preemption and suggested the need for a fresh look at the scope of ERISA’s preemption clause.\(^{201}\)

IV. Travelers: Clearing the Path for a New Approach to ERISA Preemption

A. The Travelers Approach

Although it has not magically cleared the confusion surrounding interpretation of section 514, Travelers provides the starting point from which a fresh approach to determining ERISA preemption may emerge. The Travelers Court implicitly

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197. See id.


199. See Chittenden, supra note 84, at 488.


201. See id. (Stevens, J., dissenting).
disclaimed the expansive view supported in past cases.\textsuperscript{202} Moreover, the Court clearly indicated a preference toward nonpreemption of state laws that fall within areas traditionally regulated by the states,\textsuperscript{203} including general health care regulation.\textsuperscript{204} Most importantly, however, the Travelers Court suggested a new borderline for the scope of ERISA preemption.

According to Travelers, state laws that mandate employee benefit structures or their administration, or which provide alternative enforcement mechanisms to recover benefits, sufficiently relate to ERISA to trigger section 514.\textsuperscript{205} These state laws need not constitute a direct regulation of ERISA plans, for "a state law might produce such acute, albeit indirect effects . . . as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers."\textsuperscript{206} Under the reasoning in Travelers, state laws with such an effect on employee benefit plans would likely be subject to ERISA preemption.\textsuperscript{207}

\textbf{B. The First Step to a New Framework: Defining the Benefit}

Thus, according to Travelers, courts must determine whether, directly or indirectly, a state law forces a plan to adopt (or disclaim) a certain employee benefit structure, mandates a method of plan administration, or circumvents ERISA's enforcement mechanisms. The first step to applying this new approach to claims against HMOs requires an understanding that HMOs are not, in themselves, "employee benefit plans." In many cases, an HMO is simply the means by which an employee benefit plan provides health care coverage to its members. Even when an HMO is designated as a plan administrator or fiduciary, state laws that affect the HMO do not necessarily relate to the plan itself.\textsuperscript{208} In addition, the medical care provided to HMO subscribers is not the "benefit" secured by ERISA. The benefit provided by an employee benefit plan is affordable health care coverage for specified medical expenses. In effect, the benefit is membership in the HMO. The following discussion sets forth the rationale behind these two assertions.

\textbf{1. Why the HMO Is \textit{Not} the Employee Benefit Plan}

Under ERISA, an "employee welfare benefit plan" includes "any plan, fund, or program . . . established or maintained by an employer or by an employee

\begin{itemize}
\item \textsuperscript{202} See Travelers, 115 S. Ct. at 1677 ("That said, we have to recognize that our prior attempt to construe the phrase 'relate to' does not give us much help in drawing the line here.").
\item \textsuperscript{203} See id. at 1676.
\item \textsuperscript{204} See id. at 1680 ("[N]othing in the language of [section 514] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern.'").
\item \textsuperscript{205} See id. at 1676.
\item \textsuperscript{206} Id. at 1683.
\item \textsuperscript{207} See id.
\item \textsuperscript{208} This fact is seen most clearly in Travelers. The HMOs in that case were named plan fiduciaries, yet the Travelers Court held that the state surcharge imposed on these entities was not preempted by ERISA. See id. at 1679. Thus, the designation of an HMO as a plan administrator or fiduciary is not controlling in a determination of ERISA preemption of a claim against it.
\end{itemize}
organization, or by both, . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, or hospital care or benefits.209 ERISA plans are nonprofit, tax-exempt entities. By contrast, HMOs are independent organizations that are generally organized as for-profit corporations. HMOs are not established by employers or employee organizations pursuant to ERISA. Rather, HMOs emerged in the nation's health care system as an alternative to traditional health insurance. With this in mind, it becomes clear that HMOs are not the plans themselves but, instead, are the "otherwise" that Congress referred to in the above definition of an employee benefit plan.210

In Travelers, the Supreme Court recognized the distinction between ERISA plans and HMOs that operate in conjunction with those plans. The Court held that ERISA did not preempt a New York law imposing a surcharge on HMOs operating as elements of employee benefit plans.211 In fact, the Travelers Court explicitly noted that plans may "purchase insurance policies or HMO memberships."212 State laws that impose costs or otherwise affect HMOs do not automatically relate to an employee benefit plan, but might simply affect the purchasing decisions of such plans.213 However, the Travelers Court also recognized that a state law affecting HMOs "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."214 Any state law that produced such effects might be preempted under section 514.215 Thus, an effective preemption analysis cannot end with the conclusion that the defendant HMO is not the employee benefit plan. Courts must also analyze whether the state law claim relates to the plan established by the employer to provide benefits. Such an analysis requires a careful interpretation of the "benefit" in an employee benefit plan.

2. Why the Benefit Is Membership in the HMO

The term "benefit" is never explicitly defined in ERISA. ERISA does not mandate that employees provide specific payments or services to employers, or that they provide any benefits at all. Employers have the discretion to determine if and what benefits they choose to offer. Consequently, the "benefit" has been difficult for courts to define. HMOs argue that the health benefit in an employee benefit plan is the actual medical care provided to plan participants.216 On the other hand, plaintiffs argue that the health benefit is affordable health care

210. See id.
211. See Travelers, 115 S. Ct. at 1676.
212. Id. at 1679.
213. See id.
214. Id. at 1683.
215. See id.
coverage secured through membership in an HMO. 217 This latter interpretation of the term "benefit" is supported by the United States Department of Labor, the agency in charge of ERISA enforcement, which argued for this interpretation as amicus curiae in Dukes v. U.S. Healthcare, Inc. 218 The agency contended that "HMOs are separate from . . . ERISA plans and that the sole benefit that participants and beneficiaries receive from each plan is . . . membership in the HMOs." 219

The rationale behind the Labor Department's interpretation of benefit is supported by the text of ERISA and its plain meaning. First, in ERISA's opening section, Congress stated its finding that "the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered." 220 This statement suggests an understanding of the term "benefit" in its financial sense. Employers establish plans to provide important benefits such as pensions funds, funds to pay for accidental death, accident, or disability, and funds to pay for necessary health care. Thus, through financial benefits, plans provide participants with important security against injury, age, and loss of work.

In addition, the civil enforcement provision of ERISA also indicates that the term "benefit," with regard to claims against HMOs, is best defined as health care coverage secured through HMO membership. 221 Section 502 allows a plan participant to bring an action under the statute "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." 222 If benefits are defined as medical care, as HMOs argue, then section 502 would allow plan participants to bring state medical malpractice claims into federal court. ERISA would preempt innumerable state laws relating to medical care simply because that care was provided pursuant to an employee benefit plan. The interpretation urged by HMOs would thus result in preemption of an area that has historically and traditionally been left to the states. As the Supreme Court has noted, such an effect cannot be justified unless "that was the clear and manifest purpose of Congress." 223

If the benefit is defined as HMO membership, however, then section 502 provides plan participants with a remedy for loss of promised health care coverage. In this respect, it is important to remember that Congress intended to provide for the financial stability of workers. Congress drafted ERISA to ensure that plan participants would have financial security, not to mandate a certain national standard for the provision of insurance, the quality of medical care, or the regulation of securities. 224 Thus, the plain meaning of the term "benefit" and

217. See Dukes, 57 F.3d at 356.
218. See id.
219. Id.
221. See id. § 1132(c)(1)(B).
222. Id.
224. In fact, ERISA's preemption clause specifically exempts state laws that regulate insurance,
the legislative history behind the statute support an interpretation that would define the term as health care coverage secured by membership in an HMO.

This reading is also consistent with the idea that ERISA extends protection to all participants equally. Thus, a plan participant who chooses to participate in a traditional indemnity plan provided by the employer has the same ERISA-enforced benefits as the HMO subscriber — the right to receive contracted health insurance provided by an entity funded through the plan. Clearly, the health benefits provided to an employee who has chosen to utilize traditional health insurance are the funds to purchase such insurance and the coverage received. Likewise, the health benefits available to an employee who has chosen to subscribe to an HMO is the health coverage guaranteed by membership in the HMO. Thus, the term "benefit" is best defined as HMO membership.

C. A Manageable Framework: Intrinsic Versus Singular Claims

The proposed interpretations of the terms "employee benefit plan" and "benefit" would not alter the statutory language of ERISA, nor would they change the substantive rights of any plan sponsor or beneficiary. However, they would clarify the scope of ERISA preemption in the context of subscriber actions against HMOs. Moreover, the proposed interpretations would serve to: (1) bind the two concepts of complete and conflict preemption in the context of claims against HMOs and (2) eliminate the artificial classifications invented by courts to determine ERISA preemption of claims against HMOs. Ultimately, the proposed interpretations would provide a single, unified test for preemption. Under that one test, ERISA would preempt state law claims that challenge the inherent structure of HMOs, while claims that focus on the particularized actions of a single HMO would escape the defense of ERISA preemption. This comment refers to the former type of state law claim as an "intrinsic claim" and the latter type of claim as a "singular claim."

As previously indicated, the doctrine of complete preemption would justify the removal and dismissal of any state law claim that fell within the scope of ERISA's civil enforcement provision.225 This provision, section 502, allows plan participants to recover benefits due to them under the terms of their plans.226 By defining the term "benefit" as the coverage secured by HMO membership, section 502 would completely preempt any state law claim that attempts to recover the rights of membership in an HMO. In this respect, the rights of HMO membership are defined by two basic elements: (1) the HMO subscriber contract with the Plan and (2) the cost-containment structure inherent in all HMOs.

For example, a contract between plan members and their HMO usually indicates what medical services are covered under the terms of the HMO membership agreement. Thus, the subscriber contract defines the rights of HMO membership with regard to specific types of covered medical care. Similarly,

225. See supra text accompanying notes 123-36.
226. See 29 U.S.C § 1132(a) (1994).
plans purchase HMO coverage for their members because of the cost-containment structure inherent in all HMOs. As mentioned earlier, the essential purpose behind HMOs is to contain costs by preventing physician overtreatment and patient overutilization. The necessity of these central objectives requires that all HMOs be structured to retain a certain degree of control over the provision of medical care. Thus, cost-control measures such as utilization review and financial risk-sharing arrangements typify the inherent structure of HMOs.

The rights of HMO membership are defined by this structure, for a member may not receive coverage for health care that is not provided by an HMO physician, or is not certified by a claims administrator. Thus, complete preemption would only apply to those state law claims that arise from the subscriber contract or that challenge the inherent structure of HMOs. The doctrine would not apply to those claims which simply allege that particular, individualized actions of an HMO were improper.

A similar analysis can be applied to conflict preemption under section 514. Once it is clear that ERISA only preempts those state laws that relate to a plan's provision of health care coverage through HMO membership, it becomes clear that conflict preemption only applies to state law claims that challenge the nature and rights of that membership. In this respect, the nature and rights of HMO membership are defined just as they were above, by an HMO's subscriber contract and the inherent structure of HMOs in general. Therefore, the proposed interpretations of ERISA would lead to a single test for both complete and conflict preemption based on those intrinsic claims that challenge the inherent structure of HMOs. Singular claims — those state law claims that focus on the allegedly improper activities of a single HMO — would not be preempted by ERISA.

V. Analyzing the Claims Against HMOs and ERISA
Preemption of Those Claims

The distinction between singular claims and intrinsic claims may not be immediately clear. However, a review of the various legal claims advanced against HMOs reveals the logic and rationale behind the proposed framework. The following section examines the numerous theories of liability under which plaintiffs have sued their HMOs and discusses the application of ERISA preemption to each type of claim under both the traditional interpretive analyses and the framework proposed by this comment.

A. Breach of Contract Claims

1. Theories of Contractual Liability

Numerous courts have addressed breach of contract claims leveled against HMOs by injured patients. These claims are by no means uniform among the litigation on this issue. To the contrary, plaintiffs have alleged a number of different theories to support their breach of contract claims. While courts have held that the vast majority of these claims are preempted by ERISA, the
traditional preemption analyses differ significantly according to the contractual theories advanced by plaintiffs. Thus, a discussion of the various theories of contractual liability is important to understanding preemption of these claims.

a) Failure to Provide Access to Quality Medical Care

Under the first and most frequently used breach of contract theory, a plaintiff may allege that her HMO breached its contractual duty to provide access to quality medical services. The plaintiff must first show that her subscriber contract with the HMO expressly or impliedly requires a certain standard of quality medical care. The plaintiff must then prove that the treatment she received through her HMO failed to meet the required standards of quality. Finally, the plaintiff must show that the substandard quality of care that was provided proximately caused her injuries. These last two elements pose an obvious barrier to recovery and plague many breach of contract claimants.

b) Failure to Provide Coverage

A second theory on which plaintiffs rest their breach of contract claims involves an HMO's failure to provide the coverage required under its subscriber contract. The plaintiff bears a lighter burden of proof under this theory than under a contractual claim dealing with the quality of medical care. However, there are several important limitations to this type of contractual claim. First, this theory only operates under a specific set of facts — those in which a patient pays for treatment out of her own pocket and then sues to recover for the economic loss. Few patients can afford to risk paying for their treatment with the scant hope that they might later recover from their HMO in the courts. Second, a plaintiff must still overcome the deference that courts give to medical experts. An HMO employing physicians to perform its utilization review has the advantage of this traditional deference in arguing that the plaintiff's treatment was not truly necessary. Thus, a plaintiff bringing a claim for failure to provide contractual coverage must come forward with credible medical experts to refute the HMO's denial of certification. This places severe evidentiary and financial limitations on plaintiffs.


228. See Steineke v. Share Health Plan, 518 N.W.2d 904, 908 (Neb. 1994) (granting summary judgment against breach of contract plaintiff who failed to prove that HMO's requirement that surgery be performed in approved hospital proximately caused injuries).

229. See Robert J. Conrad, Jr. & Patrick D. Seiter, Health Plan Liability in the Age of Managed Care, 62 DEF. COUNS. J. 191, 193 (1995) (discussing Fox v. Health Net, No. 219692 (Cal. Super. Ct. Riverside County 1993). The plaintiff in Fox successfully relied on a breach of contract claim against an HMO that provided health care coverage to public employees. The HMO had denied precertification of the plaintiff's requested bone marrow transplant on the grounds that the treatment was investigational. The plaintiff and her husband proceeded with the transplant, paid for it with their own funds, and then brought suit against the HMO. A jury awarded the plaintiff and her husband approximately $89 million. The HMO appealed, but the case was settled prior to appellate review. See id.
c) **Failure to Deal in Good Faith**

A third breach of contract theory addresses an HMO's failure to follow established procedures when handling a subscriber's claim. Courts have generally recharacterized this narrow contractual theory as a claim for failure to deal in good faith.\(^{230}\) Bad faith claims against insurance companies provide two characteristics favorable to plaintiffs. First, bad faith claims are familiar to courts and, thus, easier to litigate. Second, although these claims sound in contract, they support tort recovery of punitive damages.\(^{231}\)

However, under bad faith claims, a plaintiff must come forward with evidence of more than a "mere omission to perform a contract obligation."\(^{232}\) Instead, the plaintiff must show a breach of "a positive legal duty" through a course of conduct by an HMO that evidences a disregard for its contractual duties to a subscriber.\(^{233}\) This evidentiary burden limits bad faith claims to relatively few factual situations.

d) **Subscribers as Third-Party Beneficiaries**

A fourth theory supporting contractual liability against HMOs involves third party enforcement of HMO-physician agreements, or group master contracts between HMOs and employers. Under this theory, subscribers, as third-party beneficiaries, may state a cause of action in contract when an HMO-physician agreement or group master contract provides contractual assurances of quality medical care and that quality care is not provided.\(^{234}\) This theory gives plaintiffs more leeway to bring suit against their HMOs. However, a third party beneficiary claim also compels the same evidentiary burdens as a straightforward breach of contract claim involving the quality of care.\(^{235}\)

e) **Breach of Warranty**

A fifth theory of liability arising out of an HMO's contract with its subscribers is breach of warranty.\(^{236}\) Under a breach of warranty theory, an HMO may be held liable to subscribers injured by poor quality medical care if the organization warranted a higher quality of medical services than it actually provided.\(^{237}\)

Generally, plaintiffs bringing a warranty claim point to representations in an


\(^{231}\) Bad faith insurance claims involve questions of contractual duty and breach of that duty. The difference lies with the tortious intent of an insurer when breaching its contract with an insured.

\(^{232}\) Williams, 535 N.E.2d at 721.

\(^{233}\) See id. at 726-21.

\(^{234}\) See id. at 722.

\(^{235}\) See supra text accompanying notes 227-28.


HMO's promotional literature that "guarantee" or "assure" a high standard of quality medical service.\textsuperscript{238}

Generally, warranty claims are infrequent and inadequate methods of recovery against HMOs. Seldom are health care providers considered guarantors of medical treatment; physicians rarely warrant a cure or assure a specific result.\textsuperscript{239} In fact, the court in \textit{Pulvers v. Kaiser Foundation Health Plan}\textsuperscript{240} recognized that the language upon which the plaintiffs relied for their breach of warranty theory amounted to nothing "more than . . . generalized puffing to the effect that the Foundation's doctors would exercise good judgment in their care."\textsuperscript{241} As \textit{Pulvers} suggests, few courts are likely to entertain a warranty cause of action against an HMO unless the organization's literature or agents expressly guarantee a specific and unequivocal outcome.

2. \textit{Traditional Preemption Analysis of Claims for Breach of Contract}

An analysis of the five contractual theories discussed above reveals the folly behind the various classifications currently used by courts to determine the scope of ERISA preemption. With regard to breach of contract claims, the classification based on quality of care versus denial of benefits is virtually identical to a classification based on physical versus economic loss. For example, in a situation whereby a patient abides by an HMO's prospective coverage decision, she may subsequently suffer physical injury as a result of substandard medical care. The patient might then bring a breach of contract or warranty claim, and the court could classify that claim either under a quality of care analysis or under a physical injury theory. Under either of these classifications, the plaintiff's claim relates to subject matter outside the scope of ERISA and would not be preempted. Likewise, if a patient disagrees with an HMO's certification of coverage decision and ventures beyond the HMO to receive quality medical care at her own financial risk, then her subsequent contractual claim would seek recovery for an improper denial of benefits or economic loss. ERISA would preempt her claim under either classification.

Thus, application of these two classification theories to contractual claims seems fundamentally opposed to the very concept of health coverage, which stems from the idea that a third party will share the financial risk of an uncontrollable and potentially damaging event. Under the scenario outlined above, HMO subscribers who are forced to abandon the safety net of health coverage to protect their own health would be prevented from recovering from the very entities who agreed to bear the financial risk of providing such treatment. In addition, conditioning ERISA preemption on such artificial distinctions invites plaintiffs to artfully plead their breach of contract claims to avoid ERISA preemption.\textsuperscript{242}

\textsuperscript{239} But see Sorokolit v. Rhodes, 889 S.W.2d 239 (Tex. 1994) (holding as actionable plaintiff's claim that plastic surgeon warranted results of breast augmentation surgery).
\textsuperscript{240} 160 Cal. Rptr. 392 (Ct. App. 1979).
\textsuperscript{241} Id. at 393.
\textsuperscript{242} See Kuhl v. Lincoln Nat'l Health Plan, 999 F.2d 298, 302-03 (8th Cir. 1993) (noting futility
For these reasons, courts do not use the denial of benefits versus quality of care distinction or the physical versus economic loss distinction to address preemption of claims based on breach of contract theories. Instead, courts that have addressed breach of contract or warranty claims against HMOs operating under ERISA-governed plans have characterized those claims as directly relating to an ERISA plan and, thus, subject to ERISA preemption.243

For example, in Kuhl v. Lincoln National Health Plan,244 the plaintiff's breach of contract claim alleged that the HMO's coverage decision resulted in delayed surgery and the subscriber's death. The Kuhl court recognized that the HMO's decision may have constituted a breach of its contractual duty to provide quality medical care.245 In fact, the court suggested that other HMOs which venture into medical decision making might be held liable for breach of contract if their decisions result in poor quality medical care.246 However, in the final analysis, the Kuhl court abandoned the quality of care categorization. The court reasoned that resolution of the plaintiff's claim required interpreting the HMO contract made pursuant to the employee benefit plan governed by ERISA.247 Thus, the plaintiff's claim directly related to the ERISA-governed plan and was preempted.248

Likewise, in Settles v. Golden Rule Ins. Co.,249 the court abandoned the physical versus economic loss distinction to hold that ERISA preempted a breach of contract claim against an HMO.250 In Settles, the widow of an employee sued an insurer for breach of contract, among other claims, alleging that its action in terminating her husband's insurance coverage caused him to have a heart attack. The Settles court explicitly recognized that the widow's claim was not for economic loss but rather for physical injury — in this case, death.251 Nevertheless, the Settles court disregarded the categorization of physical loss claims to hold that the plaintiff's breach of contract claim was preempted.252

As Kuhl and Settles demonstrate, courts selectively use the various tests available to determine the scope of ERISA preemption depending on the type of claim involved. Case law suggests that courts are likely to apply ERISA preemption to all breach of contract claims brought against HMOs operating as part of an employee benefit plan.253 However, the analysis and classifications

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244. 999 F.2d 298 (8th Cir. 1993).

245. See id. at 303.

246. See id.

247. See id.

248. See id.

249. 927 F.2d 505 (10th Cir. 1991).

250. See id. at 509.

251. See id.

252. See id.

253. See Kuhl v. Lincoln Nat'l Health Plan, 999 F.2d 298, 302 (8th Cir. 1993) (holding ERISA to
employed by the courts vary significantly and are likely to confuse future questions about preemption of contractual claims.

3. ERISA Preemption of Contract Claims Under the Intrinsic Test

Under the intrinsic claims test proposed in this comment, subscriber claims against HMOs for breach of contract would automatically be preempted by ERISA. Breach of contract claims depend upon an interpretation of the subscriber contract from which HMO membership arises. The HMO subscriber contract is an essential element of employee benefit plans that offer health insurance coverage to members. A plan participant may only receive HMO coverage through signing a subscriber contract provided by the plan. In other words, under all of the aforementioned contractual theories, a plaintiff essentially alleges that the coverage guaranteed by the HMO subscriber contract is different or greater than the coverage that was actually provided. Because health coverage through an HMO is the benefit provided by a plan, state law claims for breach of contract challenge the method by which plans administer health coverage through the HMO. As indicated in Travelers, state laws that mandate a method of plan administration would be preempted by ERISA.254

B. Intentional Tort Claims

1. Fraud and Misrepresentation

Under facts similar to those that support breach of contract and warranty claims, a plaintiff may bring claims of misrepresentation or fraud against an HMO. These claims involve allegations that an HMO intentionally misrepresented the quality of care or scope of coverage that it provides to subscribers, thereby inducing new subscribers to join.255 Like warranty claimants, plaintiffs alleging misrepresentation or fraud point to language in subscriber contracts and promotional literature to support their claims. Thus, as HMOs wage more aggressive marketing campaigns to compete for the remainder of America's potential subscribers, misrepresentation and fraud claims are likely to increase in number.256 However, these claims are necessarily limited by the difficult evidentiary burdens of proving intentional misrepresentation and justifiable

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254. See New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 115 S. Ct. 1671, 1678 (1995) ("In each of these cases, ERISA pre-empted state laws that mandated employee benefit structures or their administration.").


256. The results of Pulvers and McClellan suggest this likelihood. Whereas the Pulvers court rejected the plaintiff's fraud claim as legally insufficient, 160 Cal. Rptr. at 393-94, the McClellan court, sitting twelve years after Pulvers was decided, entertained a plaintiff's allegations of fraud by an HMO, 604 A.2d at 1060.
reliance. In addition, fraud and misrepresentations claims are limited by the umbrella defense of ERISA preemption.

In general, plaintiffs allege fraud and misrepresentation theories on the basis of a substandard quality of care, not on the basis of fraud in the administration of plan benefits. Despite these bases of liability, most courts that have addressed ERISA preemption of fraud and misrepresentation claims have rejected a quality of care versus denial of benefits analysis. For instance, in Elsesser v. Hospital of the Philadelphia College of Osteopathic Medicine the court recognized that the plaintiff’s fraud claim was “based on representations over the extent of and nature of the care provided under the benefit plan.” Despite the fact that the plaintiff’s fraud claim was based on the delivery of medical care, a matter outside the scope of ERISA, the Elsesser court held that ERISA preempted the claim. Thus, the court rejected a quality of care analysis. Ironically, the Elsesser court relied on a quality of care classification, in the very same opinion, to hold that ERISA does not preempt medical malpractice claims against HMOs. The Elsesser court’s selective reasoning was further confused by the fact that the court interpreted the statute’s preemption clause to permit both removal and dismissal improperly combining the two concepts of complete and conflict preemption.

Like the court in Elsesser, the court in Settles v. Golden Rule Insurance Co. concluded that ERISA preempted a plaintiff’s fraud claim. However, the Settles court reasoned that fraud claims do not deal with the quality of care provided under a plan, but rather require findings that a defendant HMO improperly administered the subscriber’s insurance coverage. Thus, the Settles court classified the plaintiff’s fraud claim as an alleged improper denial of benefits that is preempted by ERISA. The inconsistencies between Settles and Elsesser indicate that, although courts are likely to apply ERISA preemption to fraud and misrepresentation claims, the reasoning used may vary drastically. If fraud claims against HMOs become more prevalent in the courts, then the varying rationales for determining ERISA preemption may result in conflicting holdings that will add more confusion to the issue of HMO liability.

However, the framework proposed in this comment would help clarify the scope of ERISA preemption in the context of fraud and misrepresentation claims.

258. Id. at 1292.
259. See id.
260. See id. at 1290. The Elsesser court noted that allegations of vicarious liability rely upon principles of professional malpractice, which implicate the quality of care classification, rather than on the HMO's contractual obligations as an employee benefit plan administrator. See id.
261. See id. at 1292. The Elsesser court only considered ERISA section 514 in determining the motion to remand. Id. at 1289. As discussed previously, the proper determination of a covert's preemption jurisdiction requires consideration of section 502. See text accompanying notes 123-36.
262. 927 F.2d 505 (10th Cir. 1991).
263. See id. at 509.
264. See id.
265. See id.
Such claims do not arise from activities that are related to the inherent structure of an HMO, nor do they depend on the existence of a subscriber contract.\(^{266}\) Not all HMOs must intentionally misrepresent their claims process or the quality of doctors with whom they contract. Fraud is not fundamental to the cost-containment structuring of an HMO.\(^{267}\) Rather, claims of fraud and misrepresentation relate to the particular actions of a single HMO toward its subscribers. While a judgment that a particular HMO committed fraud against an employee benefit plan participant might indirectly raise the costs of HMO membership for benefit plans, the Travelers Court recognized that such indirect economic effects do not constitute plan regulation that would trigger preemption.\(^{268}\)

2. Breach of Fiduciary Duty

Another potential state law claim against HMOs involves an organization's breach of its fiduciary duties to a subscriber. This state law claim must be carefully distinguished from a fiduciary duty claim cognizable under ERISA.\(^{269}\) Although few states currently recognize a fiduciary relationship between an HMO and its subscribers, the conceptual basis for such a claim under state law derives from the special relationship between a patient and physician and, in some states, between an insurer and insured.\(^{270}\) The subscriber in an HMO places her absolute trust and confidence in the organization to provide total health services at a high quality. In addition, because an HMO restricts a subscriber's choice of physicians, facilities, and providers, the HMO has a heightened duty of care — a fiduciary duty.

By contrast, ERISA imposes separate statutory obligations and liabilities on specified "fiduciaries" for the benefit of a plan.\(^{271}\) Unlike fiduciaries under state law, ERISA fiduciaries must either be explicitly designated as such in the plan instrument or, pursuant to a procedure specified in the plan, be identified as a fiduciary by the employer, the employee organization, or both.\(^{272}\) ERISA fiduciaries "have authority to control and manage the operation and administration

\(^{266}\) Although many fraud and misrepresentation claims may refer to a statement made in the subscriber contract, the essence of the fraud claim relies on the statement and the intent behind it, not on the existence of the contract itself.

\(^{267}\) Some plaintiffs might choose to base their fraud claims on the alleged intentional nondisclosure by HMOs that they use cost-containment measures such as utilization review. Even these claims would not be preempted because the alleged nondisclosure constitutes the underlying conduct, not the use of cost-control mechanisms. Intentional nondisclosure does not arise from a contractual relationship or from the cost-containment structure of HMOs, and thus would not be preempted.


\(^{269}\) See 29 U.S.C. §§ 1101-1109 (1994) (sections of ERISA defining plan "fiduciaries" and setting forth obligations to the plan).

\(^{270}\) Oklahoma does not recognize the existence of a fiduciary relationship between insurer and insured. See Silver v. Slusher, 770 P.2d 878, 883 (Okla. 1988). However, the dissent in Silver urged the Court to recognize the special duties that adhere to the insurer. See id. at 886 (Wilson, J., dissenting).


\(^{272}\) See id. § 1102(a)(2).
Similarly, they are required to discharge their duties "solely in the interest of the participants and beneficiaries[,]" using "care, skill, prudence, and diligence." An ERISA plan fiduciary "who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by [ERISA] shall be personally liable to make good to [the] plan any losses ... resulting from each such breach." Thus, a plan participant may sue certain individuals in their capacity as ERISA fiduciaries on behalf of the plan itself — the statute does not provide a private right of action for breach of fiduciary duty.

Despite the differences between an ERISA fiduciary and a fiduciary relationship under state law, most courts have held that ERISA preempts state law fiduciary duty claims. However, case law suggests that a finding of preemption may depend upon whether: (1) the defendant HMO is an ERISA fiduciary and (2) the state law claim arises out of a complaint about administration of the benefit plan. For example, in Santitoro v. Evans, the court held that ERISA did not completely preempt a plaintiff's fiduciary duty claim against an HMO because the claim related to a duty to provide "medical care imposed by state tort law" rather than to a contractual duty imposed by the employee benefit plan. Similarly, in Glaziers & Glassworkers Union Local 252 Annuity Fund v. Newbridge Securities, the United States Court of Appeals for the Third Circuit held that ERISA only preempted a state law fiduciary duty claim under section 514 if that claim related to administration of the employee benefit plan. In concurring, Judge Stapleton added his opinion that when a defendant is not a designated ERISA fiduciary of a benefit plan, a state law fiduciary duty claim does not relate to the benefit plan within the meaning of section 514 and is not preempted.

The reasoning of both Santitoro and Glaziers illustrates the complexity of applying the Supreme Court's current test for ERISA preemption to suits against HMOs. Courts that use the quality of care classification are likely to reject the ERISA preemption defense as inapplicable to a fiduciary duty claim. By contrast, a direct versus indirect claim categorization would lead to a finding of preemption, because an interpretation of the HMO contract would be necessary to determine the existence of a fiduciary duty. The physical versus economic loss distinction creates further confusion, as a fiduciary duty claim could fit into either category, depending upon whether or not the plaintiff received care from the HMO.

273. Id. § 1102(a)(1).
274. Id. § 1104(a)(1).
275. Id. § 1109(a).
276. See, e.g., Kramer v. Smith Barney, 80 F.3d 1080, 1084 (5th Cir. 1996) (finding state law claims of breach of fiduciary duty completely preempted by ERISA).
278. See id. at 736.
279. 93 F.3d 1171 (3d Cir. 1996).
280. See id. at 1185.
281. See id. at 1186 (Stapleton, J., concurring).
Thus, the traditional approaches to ERISA preemption are inadequate to determining the proper scope of section 514. However, an intrinsic claims test would definitively result in a finding of preemption. The reasoning is simple: The inherent structure and purpose of HMOs is to provide health care coverage at an affordable price through careful management of costs. It is this inherent structure that allows HMOs to operate as alternatives to traditional health insurance and, thus, gives rise to a fiduciary obligation under state law, if one exists at all. Consequently, claims for breach of fiduciary duty challenge the inherent structure of all HMOs. ERISA clearly preempts such claims under the intrinsic test.

3. Tortious Interference with Contract

A number of plaintiffs have brought claims for tortious interference with a contract against their HMOs. Under a tortious interference claim, a plaintiff alleges that her HMO has intentionally and tortiously engaged in misconduct to interfere with contractual relations between the plaintiff and her physician or employer. More specifically, tortious interference claims typically question an HMO's utilization review procedures or financial risk-sharing arrangements. The plaintiff alleges that the HMO purposefully designed its review procedures or risk-sharing arrangements to discourage doctors from performing costly medical services or prescribing expensive methods of treatment, which might be necessary to properly care for the patient. Tortious interference claimants may also allege that this interference prevents employers from providing promised benefits to their employees.

Courts have generally been unwilling to recognize an HMO's utilization review procedures or risk-sharing financial arrangements as intentional misconduct—a required element of a tortious interference claim. One court even noted that utilization review and risk-sharing are inherent characteristics of HMOs that are encouraged by the federal HMO Act. In addition, courts have held, without much analysis, that ERISA preempts tortious interference claims against HMOs operating under employee benefit plans.

For example, in *Kuhl v. Lincoln National Health Plan*, a physician and hospital had recommended immediate bypass surgery for the plaintiff, an HMO subscriber. The HMO denied their requests for precertification, and the physician canceled the plaintiff's surgery. On review of its decision, the HMO agreed to pay for the surgery. By that time, however, the plaintiff's heart had deteriorated beyond repair. The plaintiff sued his HMO, claiming tortious interference with the doctor-patient contract. The *Kuhl* court held that ERISA preempted the claim because it was based on the contention that the HMO improperly processed the

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283. See *Reazin*, 899 F.2d at 977 (stating that wrongful intent to interfere is required element of tortious interference claim).

284. See *Pulvers*, 160 Cal. Rptr. at 394.

285. 999 F.2d 298 (8th Cir. 1993).
plaintiff’s request for benefits.\textsuperscript{286} The court noted that, while the HMO’s benefit determination resulted in cancellation of the claimant’s surgery and, thus, affected the quality of care provided to the plaintiff, the decision was actually a benefit determination that was not subject to state law claims.\textsuperscript{287} Thus, the \textit{Kuhl} court followed a quality of care versus denial of benefits analysis to find that ERISA preempted the tortious interference claim.\textsuperscript{288}

The intrinsic claims test proposed in this comment would result in a finding of nonpreemption. Like fraud and misrepresentation claims, claims for tortious interference with a contract do not arise from the subscriber contract between the plan members and the HMO or to the inherent structure of HMOs in general. While HMOs have a certain degree of indirect control over their physicians, not all HMOs use that control to intentionally interfere with the doctor-patient relationship to such an extent that medical care is jeopardized. Therefore, a tortious interference plaintiff is not challenging the structure of the HMO itself or the inherent existence of an HMO-physician relationship. Instead, a tortious interference complaint arises from the intentional misconduct of a particular HMO toward its subscribers. Under the interpretive framework proposed, ERISA would not preempt such a claim.

\textbf{C. Negligence Claims}

By far the greatest number of claims advanced against HMOs by patients concern direct negligence liability. All negligence claims against HMOs are premised on the four basic elements of duty, breach of duty, causation, and damages. However, they also support vastly different theories and involve varying factual allegations. In addition, negligence claims have received varying analyses in the courts with regard to both the merits of a claim and ERISA preemption. The following section separates negligence claims into three major categories and discusses ERISA preemption of each different category.

\textbf{1. Negligent Affiliation}

The most common type of negligence claim is what this comment refers to as a "negligent affiliation" claim. Under a negligent affiliation theory, a plaintiff may allege that her HMO breached its duty to select, credential, retain, or supervise quality medical providers. Plaintiffs level these claims directly against an HMO and do not rely on any theory of respondeat superior.\textsuperscript{289}

The general thrust of a negligent affiliation claim is that an HMO was negligent in its affiliation with a member physician or other medical provider. However, negligent affiliation claims spring from two different theoretical bases. The

\textsuperscript{286} See id. at 302-03.
\textsuperscript{287} See id. at 303.
\textsuperscript{288} See id.
\textsuperscript{289} Respondeat superior is the legal term meaning, literally, "let the master answer," \textsc{Black's Law Dictionary} 1311-12 (6th ed. 1990). The doctrine as applied means that in some cases, the master will be liable for the tortious acts of his servant.
The difference between these two underlying theories have significantly affected courts' preemption analyses and led to confusion over the scope of ERISA preemption with respect to negligent affiliation claims.

The first basic theory underlying the negligent affiliation claim is that an HMO's duty to use reasonable care in affiliating with medical providers depends on the underlying duty of its providers.290 Under this view, the HMO's duty is still separate and runs directly to its subscribers. However, the HMO's liability for negligent affiliation relies upon a finding that the member physician or provider with whom it affiliated was knowingly incompetent in performance of its duty.291 The second conceptual basis for the negligent affiliation claim is that an HMO's duty to reasonably select, credential, retain, and supervise quality medical providers stems directly from its independent relationship with its subscribers, not from the underlying duties of its providers.292 This underlying theory also supports the theory of corporate negligence293 and forms the basis for section 323 of the Restatement (Second) of Torts.294

Both rationales support the same legal conclusion — that an HMO may be liable to a subscriber for negligent affiliation with incompetent providers. However, the distinction between the reasoning of the two courts is crucial under the current analytical approaches to determining ERISA preemption. If a court determines that the HMO's duty of reasonable affiliation with member physicians depends on its physicians' underlying duties to their patients, then an HMO's breach of reasonable affiliation gives rise to a negligence claim involving the quality of care provided to patients. Courts applying a quality of care versus denial of benefits classification are unlikely to find that ERISA preempts such claims. On the other hand, if a court determines that the HMO has a separate and independent duty to use reasonable care in affiliating with its physicians, then liability for breach of that duty arises out of the HMO's responsibilities under the ERISA-governed plan. Courts using this rationale are likely to find such claims preempted by ERISA.

A review of recent case law involving negligent affiliation claims against ERISA-governed HMOs reveals the confusion surrounding these two, different rationales and their effect on ERISA preemption. In Corcoran v. United...

290. See Harrell v. Total Health Care, Inc., 781 S.W.2d 58, 60-61 (Mo. 1989) (en banc).
291. See id. at 60.
293. See id. at 1058-59; see, e.g., Thompson v. Nason Hosp., 591 A.2d 703, 706 (Pa. 1991) ("T]he corporate hospital of today has assumed the role of a comprehensive health center, with responsibility for arranging and coordinating the total health care of its patients.").
294. Section 323 of the Restatement (Second) of Torts provides:

One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if

(a) his failure to exercise such care increased the risk of harm, or
(b) the harm is suffered because of the other's reliance upon the undertaking.

RESTATEMENT (SECOND) OF TORTS § 323 (1965).
Healthcare, Inc., the Fifth Circuit Court of Appeals held that because the plaintiff's negligent affiliation claim related to supervision of benefits administrators, it implicated the plaintiff's relationship with the HMO and was preempted by ERISA. The Sixth Circuit followed suit in Tolton v. American Biodyne, holding that a claim for negligent retention of a utilization review administrator was preempted because it arose out of an alleged improper denial of benefits. Although the courts in Corcoran and Tolton both held the negligent affiliation claims to be preempted without much analysis of their conceptual bases, the holdings of both courts suggest a belief that HMOs' duties of reasonable affiliation derive from the duties of those with whom they affiliate. In other words, the benefits administrators in both cases had a duty to administer benefits competently, and the HMOs' duties to retain and supervise their administrators arose from the same responsibilities. Thus, the duties breached by the HMOs related to a denial of benefits and were subject to ERISA preemption.

In this respect, the courts were simply applying the familiar quality of care versus denial of benefits classification to determine the scope of ERISA preemption. For instance, the Tolton court stressed that the basis of the plaintiff's claim was for an alleged improper denial of benefits. Similarly, the court in Corcoran stated that the plaintiff's "attempt to distinguish United's role in paying claims from its role as a source of professional medical advice was unconvincing." Ultimately, the Corcoran court concluded that "United makes medical decisions — indeed, United gives medical advice — but it does so in the context of making a determination about the availability of benefits under the plan."

Following in the footsteps of Corcoran and Tolton, the Third Circuit in Dukes v. U.S. Healthcare, Inc. also applied the quality of care versus denial of benefits classification to a negligent affiliation claim. But unlike the two previous courts, the Dukes court held that the plaintiff's negligent affiliation claim was not preempted by ERISA. The essential difference between the three cases is that, in Dukes, the plaintiff alleged that the defendant HMO failed to use reasonable care in selecting, screening, monitoring, and evaluating medical providers rather than claims administrators. Because the HMO's duty arose from its providers' duties to their patients, breach of that duty constituted negligence involving the quality of care rather than the administration of benefits. Under the quality

295. 965 F.2d 1321 (5th Cir. 1992).
296. See id. at 1332.
297. 48 F.3d 937 (6th Cir. 1995).
298. See id. at 942.
299. See id.
300. Corcoran, 965 F.2d at 1325.
301. Id. at 1351.
302. 57 F.3d 350 (3d Cir. 1995).
303. See id. at 361.
304. See id. at 360.
305. See id. at 361 ("The plaintiffs here are attempting to hold the HMO's liable for their role as
of care distinction applied by Dukes, ERISA did not preempt the plaintiff's negligent affiliation claim.\textsuperscript{306} The reasoning in Dukes stands in contrast to the analysis in Pomeroy v. Johns Hopkins Medical Services,\textsuperscript{307} in which a plaintiff alleged that his HMO was negligent in selecting, employing, contracting, and retaining unqualified medical providers. Whereas the Dukes court found that ERISA does not reach such claims, the Pomeroy court held that the plaintiff's claim was predicated on a duty "created and defined by the relationship between [the HMO] and the Plaintiffs through the Plan."\textsuperscript{308} Reasoning that the HMO's duty existed independently of its physicians' responsibilities to provide quality care, the Pomeroy court applied a direct liability classification to the plaintiff's negligent affiliation claim and held it to be preempted by ERISA.\textsuperscript{309}

Pomeroy, Dukes, Tolton, and Corcoran reveal the morass of confusion over the issue of ERISA preemption. All four courts addressed negligent affiliation claims against HMOs. However, the reasoning and results of the four courts differed significantly. Dukes only addressed the issue of whether ERISA completely preempted the plaintiff's claim.\textsuperscript{310} The other courts incorrectly combined the concepts of complete and conflict preemption.\textsuperscript{311} Corcoran, Tolton, and Dukes placed significance on the underlying duty of the allegedly incompetent actor.\textsuperscript{312} If the claim was for an HMO's negligent affiliation with an unqualified benefits administrator, the claim related to a denial of benefits and was preempted by ERISA.\textsuperscript{313} On the other hand, if the plaintiff alleged an HMO's negligent affiliation with an unsatisfactory medical provider, then the claim dealt with the unreasonable quality of care and was not preempted.\textsuperscript{314} By contrast, Pomeroy relied upon the reasoning that the plaintiff's claim directly related to the HMO's independent duties under the employee benefit plan.\textsuperscript{315} Application of this reasoning would undoubtedly result in the preemption of all negligent affiliation claims, regardless of whether they involved medical providers or benefits administrators.\textsuperscript{316} Clearly, the different reasoning and outcomes of the four cases

\begin{footnotesize}
\begin{enumerate}
\item the arrangers of the decedent's medical treatment.
\item Santitoro v. Evans, 935 F. Supp. 733, 737 (E.D.N.C. 1996) (remanding negligent affiliation claim and other claims after finding complete preemption under ERISA does not apply to claims involving quality of care).
\item Dukes, 57 F.3d at 361; see also Lupo v. Human Affairs Int'l, Inc., 28 F.3d 269, 272-73 (2d Cir. 1994).
\item 868 F. Supp. 110 (D. Md. 1994).
\item Id. at 113 n.4.
\item See id. at 113.
\item Dukes, 57 F.3d at 361.
\item See Dukes, 57 F.3d at 360-61; Tolton, 48 F.3d at 942; Corcoran, 965 F.2d at 1331.
\item See Tolton, 48 F.3d at 942; Corcoran, 965 F.2d at 1332.
\item See Dukes, 57 F.3d at 361.
\item See Pomeroy, 868 F. Supp. at 113.
\item An HMO's duties to a plan subscriber arise from the plan. Thus, the HMO's activities,
\end{enumerate}
\end{footnotesize}
illustrate that the traditional analyses for determining the scope of ERISA preemption are inadequate.

Applying the intrinsic test to negligent affiliation claims would definitively result in a finding of nonpreemption. As indicated earlier in this section, negligent affiliation claims are based either on the underlying duty of the provider with whom an HMO affiliates or on the HMO's independent relationship with its subscribers.\textsuperscript{317} Neither theory relies on the terms of the HMO subscriber contract. Nor does either theory implicate the inherent structure of HMOs in providing health coverage and containing costs.

While it is true that the HMO-physician relationship is defined by the cost-containment mechanisms inherent in HMOs, a negligent affiliation claim does not challenge the existence of this relationship.\textsuperscript{318} Rather, the duty of reasonable affiliation arises for an HMO when it decides to selectively choose its physicians. If the HMO allowed its subscribers to visit any medical provider willing to accept capitated payments and submit to utilization review, then no duty of reasonable affiliation would arise.\textsuperscript{319} Thus, a negligent affiliation claim results from an HMO's voluntary decision to screen and select only certain medical providers. Under the proposed framework, which separates claims that challenge the inherent structure of HMOs generally from those based on the singular actions of a particular HMO, negligent affiliation claims would fit into the latter category and would not be preempted by ERISA.

2. Negligent Design or Implementation of Utilization Review Procedures

Another claim against HMOs that reveals the limitations of the current interpretive approaches and the benefits of the proposed framework for determining ERISA preemption is a claim for negligence in the design or implementation of utilization review procedures. Utilization review is one of the most essential cost-containment mechanisms employed by an HMO.\textsuperscript{320} Organizations generally implement utilization review in one of three ways: prospectively, concurrently, or retrospectively.\textsuperscript{321} The utilization review method employed by the HMO also affects the classification of the plaintiff's claim for purposes of determining ERISA preemption. Thus, negligent utilization review claims provide

\textsuperscript{317} See supra text accompanying notes 290-94.

\textsuperscript{318} A challenge to the inherent existence of the HMO-physician relationship is one which questions the amount of control an HMO exercises over its physician's practice of medicine. By contrast, the negligent affiliation claim challenges the apparent lack of control an HMO has over the quality of its physicians.

\textsuperscript{319} This is true because the provider would not be restricted to a specified list of physicians approved by the HMO. It is this restriction on consumer choice that results in a duty of reasonable affiliation.

\textsuperscript{320} See Kilcullen, supra note 10, at 23.

\textsuperscript{321} See Randall et al., supra note 83, at 1130.
an interesting look at the difficulties in determining the scope of ERISA's preemption clause.

Under a negligent utilization review theory, the plaintiff alleges that the defendant HMO or its agent followed improper review procedures, resulting in a denial of benefits and injury to the plaintiff. The plaintiff's injury might be physical, economic, or both, depending upon the utilization review method employed by the HMO. If the HMO utilized the traditional retrospective system, then the patient might have a claim for recovery of the coverage owed to him under the plan. Under a prospective or concurrent utilization review scheme, in which the HMO requires precertification or concurrent certification for all procedures, treatments, and referrals, the plaintiff might very well have a state cause of action for both physical and economic damages resulting from an improper decision.

Negligent utilization review claims are controversial for several reasons. First, they reach to the heart of the managed care system. If an HMO can be held liable for improperly administering one of its key components, or if the mere existence of that component might be deemed negligent, then the basic existence of HMOs is essentially called into question. Second, utilization review claims vary widely in both factual allegations and analysis. Many HMOs have contracted with outside companies to provide utilization review for its subscribers, so a number of utilization review cases also address questions of vicarious liability and corporate negligence.

By far the most controversial aspect of negligent utilization review claims is the question of ERISA preemption. As discussed above, courts may fit negligent utilization review claims into every analytical approach used to determine the reach of ERISA's preemption clause. In addition to the physical versus economic loss classifications, courts may choose to categorize all negligent utilization review claims as direct claims requiring interpretation of the ERISA-governed plan. Prospective and concurrent utilization review claims might also be classified as either quality of care claims or benefit determinations, while retrospective review claims would fall solely into the category of a benefit administration decision. Thus, courts may select whatever classification they wish to determine whether ERISA preempts negligent utilization review claims. Most often, utilization review decisions, even concurrent and prospective review determinations, have been cast as benefit determinations preempted by ERISA.

322. See, e.g., Wickline v. State, 228 Cal. Rptr. 661, 670 (Ct. App. 1986) (noting in dicta that third party payors such as HMOs might be held liable for patient harm if plaintiff proves causation), appeal dismissed, 741 P.2d 613 (Cal. 1987); Wilson v. Blue Cross, 271 Cal. Rptr. 876, 883 (Ct. App. 1990) (denying summary judgment motion on grounds that HMO could be held liable for patient harm).


This has resulted in very few utilization review claims being decided on their merits.

Under the proposed framework, claims for negligent utilization review would clearly qualify as intrinsic claims because they challenge the utilization review process inherent in all HMOs. Utilization review is an essential element of cost containment. It is required by the federal HMO Act, and every HMO employs some form of utilization review. Unlike the duty of reasonable affiliation, the duty of reasonableness in utilization review arises from the inherent structure and purpose of all HMOs—not from the voluntary decisions of a single HMO. Thus, claims for negligent utilization review directly implicate the employee benefit structure referred to in *Travelers* and would be preempted by ERISA section 514.

3. Negligent Formulation of Risk-Sharing Financial Incentives

Under a theory of negligent risk-sharing, a plaintiff may allege that her HMO breached its duty of reasonable care by providing financial incentives that encourage its physicians to refrain from utilizing costly medical services such as referrals, medical tests, or inpatient hospital stays. While all HMOs utilize some form of risk-sharing, the forms vary according to the HMO-physician contract. In general, an HMO's financial arrangements shift some or all of the insurer's risk to the physician, encouraging the physician to utilize fewer services and maximize his profit. The incentives range from a simple capitation system, in which a physician is paid a flat-rate per subscriber, to bonus and penalty arrangements. Under these latter arrangements, a physician either receives a percentage of the HMO's profits from his client base or he must contribute to any deficit the HMO suffers from his client base.

As a result of the difference in risk-sharing plans, plaintiffs face varying degrees of evidentiary burdens in proving breach of duty and causation. Many courts may be unwilling to hold that simple capitation arrangements, the staple of HMOs, constitute a breach of duty and legal cause of injury. However,

327. See, e.g., Bush v. Dake, No. 86-25767 NM-2, slip. op. at 3 (Mich. Cir. Ct. Saginaw County 1989), reprinted in BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS, AND PROBLEMS 719 (2d ed. 1991). In *Bush*, the plaintiff claimed that his HMO was negligent in formulating risk-sharing arrangements and financial incentives that subsequently affected a member physician's medical determination. The HMO argued on summary judgment that it could not be liable for its risk-sharing financial arrangements because those arrangements were encouraged by state and federal law such as the federal HMO Act. The *Bush* court agreed that the HMO's cost-containment mechanisms were supported by public policy. However, the court also held that a jury should determine whether the HMO's financial arrangements proximately caused the plaintiff's injuries and imposed negligence liability.
328. See Johnsson, supra note 106, at 1 (discussing bonus arrangements).
329. This is especially true when one considers that capitation arrangements apply generally to all patients and are not patient-specific, thus making the element of causation particularly difficult to prove. See Chittenden, supra note 84, at 483.
courts may be more inclined to believe that bonus arrangements specifically designed to limit utilization of services might unreasonably create an unhealthy medical atmosphere for HMO subscribers.

The problems of applying ERISA's preemption clause are no less tedious when it comes to negligent risk-sharing claims. Under a quality of care versus denial of benefits classification, a court may determine that the existence of financial incentives and risk-sharing arrangements have no relation to determination of coverage under an ERISA-governed plan. This reasoning would result in the conclusion that negligent risk-sharing claims relate to the quality of care provided by an HMO and, therefore, would not be preempted by ERISA.

For example, in *Ouellette v. Christ Hospital*,\(^{330}\) a plaintiff sued her HMO for "limiting the hospital stays of its subscribers and enforcing those limitations by an unreasonable system of financial incentives to hospitals."\(^{331}\) The *Ouellette* court held that ERISA did not completely preempt the plaintiff's claim because it focused on the relationship between the HMO and its physicians instead of on the relationship between the HMO and the plaintiff.\(^{332}\) The court reasoned that the claim related to the quality of care received and, thus, was "separate and distinct from a claim for benefits under a plan."\(^{333}\)

However, a direct versus indirect classification analysis is likely to lead courts to the opposite conclusion. Under this analysis, a court is likely to find that the HMO's risk-sharing arrangements directly involve a subscriber's contract with his employee benefit plan. Thus, any claim arising from these financial arrangements would relate to the plan and be preempted by ERISA. The difficulty for a court, therefore, is determining which classification to use.

However, the intrinsic claims analysis encompasses the traditional approaches to determining ERISA preemption and would eliminate unnecessary confusion for future courts. Under the intrinsic claims test, claims for negligent risk-sharing would be preempted just like claims for negligent utilization review. Risk-sharing is a fundamental aspect of all HMOs. It arises from the inherent need to contain costs by shifting financial risk to medical providers. While no HMO is forced to engage in the most precarious forms of risk-sharing, such forms are basic elements in the structural composition of HMOs. Claims that challenge the existence of these structural elements would be preempted by ERISA under the intrinsic claims test.

**D. Vicarious Liability Claims**

1. Basis of Vicarious Liability

In addition to direct negligence claims, plaintiffs have also alleged that HMOs are vicariously liable for the negligent acts of their agents.\(^{334}\) The principle for

\(^{331}\) *Id.* at 1163-64.
\(^{332}\) *See id.* at 1165.
\(^{333}\) *Id.*
bringing a vicarious liability claim against an HMO derives from a recent trend in the law that holds hospitals liable for the acts of physicians and other providers within the hospital's authority. Under vicarious liability claims, plaintiffs must prove the underlying action against the medical provider or benefits administrator as well as the existence of an agency, apparent agency, or agency by estoppel relationship between the provider and the HMO. Thus, an HMO must have authorized or apparently authorized its medical providers to act as its agents in providing medical care to subscribers.

Like other types of claims against HMOs, vicarious liability claims have many different facets and factual bases. For instance, plaintiffs can generally establish the existence of an agency relationship in a staff model HMO because a direct employment relationship exists between the HMO and its physicians. In the case of IPA and group model HMOs, in which physicians and physician groups independently contract with the HMO, the existence of an agency relationship is more difficult for the trier of fact to determine.

However, an HMO may still be held vicariously liable under the doctrines of "apparent agency" and "agency by estoppel." To prove the existence of an apparent agency relationship, a plaintiff must prove: (1) that the HMO held out certain physicians as its agents and (2) that the plaintiff looked to the HMO to provide medical care, not to the providers alone. To prove agency by estoppel, a plaintiff must establish the two elements of apparent agency as well as a third element — that the plaintiff reasonably and justifiably relied on the HMO's representations to her detriment.

The elements of both types of ostensible agency relationships seem fairly easy for a plaintiff to prove given the current status of HMOs in the nation's health care system. To establish the elements of either, HMO subscribers may point to the fact that the HMO provides a limited list of available physicians from which to choose and generally forces subscribers to see a primary care physician before

335. See Boyd, 547 A.2d at 1231-32 (discussing nature of vicarious liability theory applied to HMOs).
340. See RESTATEMENT (SECOND) OF AGENCY § 267 (1958); Chittenden, supra note 84, at 458-59.
seeing any specialist. By placing limitations on patient freedom, patients reasonably believe that an HMO acts as a provider of health care services. In addition, HMOs regularly hold themselves out to be health care providers in their advertisements, leading the general public to see them as such. Thus, plaintiffs argue, HMOs should be held vicariously liable for the tortious acts of their providers.

2. Traditional Approaches to ERISA Preemption of Vicarious Liability Claims

The more difficult question is whether ERISA preempts vicarious liability claims against HMOs operating as elements of employee benefit plans. Because vicarious liability claims are based on the theory of respondeat superior, plaintiffs have argued that these claims relate solely to the quality of care provided and the physician-HMO relationship, not to the administration of benefits under the plan. Under this argument, vicarious liability claims do not implicate ERISA and are not preempted. On the other hand, HMOs have argued that the medical care provided is the benefit under the plan. Therefore, ERISA would preempt all claims relating to the quality of care provided under the plan, including vicarious liability claims for medical malpractice. Not surprisingly, courts have disagreed over the issue of ERISA preemption of vicarious liability claims. A series of cases decided between February 1995 and July 1996 reveals the extent of this disagreement.

In Jackson v. Roseman, a plaintiff brought a medical malpractice claim against his HMO, alleging that the organization was vicariously liable for the negligence of one of its contracted physicians. The Jackson court analyzed both conflict preemption under ERISA section 514 and complete preemption under section 502. In its analysis of the plaintiff's claim, the Jackson court recognized two opposing views as to whether ERISA preempts vicarious liability claims. According to one view, a vicarious liability theory requires the plaintiff to show that "the HMO held out a supposedly negligent doctor or facility as its employee, thereby necessitating an examination of the benefits plan, and consequently, triggering ERISA preemption." Under the other view, a law only relates to an ERISA plan, and thus is subject to ERISA preemption, if it is designed to affect such plans, singles them out, predicates rights or obligations on their existence, impairs their operation in multiple states, or restricts their effectiveness with regard to structure or administration. The Jackson court adopted the latter view, holding that a medical malpractice claim founded on the theory of vicarious liability is an inappropriate target for ERISA's preemption.

342. See id. at 823. Complete and conflict preemption involve two separate concepts and are often confused by courts. See discussion supra notes 123-40 and accompanying text.
344. See id.
clause.\textsuperscript{345} Furthermore, the plaintiff's vicarious liability claim did not directly relate to section 502, ERISA's civil enforcement provision, and thus was not subject to complete preemption.\textsuperscript{346} Therefore, in its analysis of both conflict and complete preemption, the \textit{Jackson} court used an indirect liability classification to find that the claim was beyond ERISA's scope and not preempted.

The court in \textit{Dukes v. U.S. Healthcare, Inc.}\textsuperscript{347} reached the same conclusion as the \textit{Jackson} court with regard to complete preemption of a plaintiff's vicarious liability claim.\textsuperscript{348} However, the reasoning of the \textit{Dukes} court differed from that of \textit{Jackson} in several important ways. First, the \textit{Dukes} court distinguished between complete preemption and conflict preemption, holding that it could not address the latter unless it first found that removal to federal court was proper through the doctrine of complete preemption.\textsuperscript{349} Second, the \textit{Dukes} court noted that a claim of medical malpractice really involves the quality of medical care provided under the plan.\textsuperscript{350} Therefore, a vicarious liability claim for medical malpractice falls outside of ERISA's scope.\textsuperscript{351} Thus, where \textit{Jackson} applied a direct versus indirect liability classification to find that the plaintiff's claim was subject to neither complete nor conflict preemption,\textsuperscript{352} the \textit{Dukes} court used a quality of care analysis to hold only that complete preemption under section 502 did not apply.\textsuperscript{353} Third, the \textit{Dukes} court specifically left open the possibility that conflict preemption might apply to vicarious liability claims.\textsuperscript{354}

The Tenth Circuit Court of Appeals rejected that possibility less than one month later in \textit{Pacificare of Oklahoma, Inc. v. Burrage.}\textsuperscript{355} The court held that the plaintiff's vicarious liability claim against the defendant HMO for medical malpractice did not "relate to" the employee benefit plan and, thus, was not subject to ERISA's preemption clause.\textsuperscript{356} The \textit{Pacificare} court applied two different classifications to the plaintiff's vicarious liability claim before subjecting it to ERISA's preemption clause. First, the court applied a direct versus indirect liability classification, stating that "the effect of the malpractice action on the plan is too tenuous, remote or peripheral . . . to warrant a finding that the law 'relates to' the plan."\textsuperscript{357} Second, the \textit{Pacificare} court noted that a malpractice claim does not involve the benefits under a plan.\textsuperscript{358} Instead, a vicarious liability claim for medical malpractice only alleges "negligent care by the doctor and an agency

\begin{itemize}
\item \textsuperscript{345} See id. at 526.
\item \textsuperscript{346} See id.
\item \textsuperscript{347} 57 F.3d 350 (3d Cir. 1995).
\item \textsuperscript{348} See id. at 356.
\item \textsuperscript{349} See id. at 355.
\item \textsuperscript{350} See id. at 356.
\item \textsuperscript{351} See id.
\item \textsuperscript{352} See \textit{Jackson}, 378 F. Supp. at 824-26.
\item \textsuperscript{353} See \textit{Dukes}, 57 F.3d at 356.
\item \textsuperscript{354} See id. at 361.
\item \textsuperscript{355} 59 F.3d 151 (10th Cir. 1995).
\item \textsuperscript{356} See id. at 155.
\item \textsuperscript{357} Id. at 154 (quoting Shaw v. Delta Air Lines, 463 U.S. 85, 100 n.21 (1983)).
\item \textsuperscript{358} See id. at 155.
\end{itemize}
relationship between the doctor and the HMO."\textsuperscript{359} Thus, the \textit{Pacificare} court also reasoned that ERISA's preemption clause did not apply under a quality of care versus denial of benefits distinction.

Only two months later, the court in \textit{Rice v. Panchal}\textsuperscript{360} addressed a similar claim of vicarious liability for medical malpractice. The \textit{Rice} court noted that "[t]he Supreme Court has not yet had an opportunity to . . . distinguish carefully between ordinary preemption and complete preemption."\textsuperscript{361} Attempting to fill that void, the \textit{Rice} court explained that where the application of a state law creates a qualitative standard by which the performance of an ERISA-governed HMO is evaluated, then that law is completely preempted.\textsuperscript{362} The court further explained that determining whether an agency or apparent agency relationship exists does not involve interpretation of the benefit plan or establish a qualitative standard by which to evaluate such a plan.\textsuperscript{363} Thus, vicarious liability claims are not subject to complete preemption under ERISA.\textsuperscript{364}

The \textit{Rice} court's holding is important for several reasons. First, the court expressly accepted the argument offered by HMOs that the "benefit" of an employee benefit plan involves the medical care provided.\textsuperscript{365} HMOs argue that because medical care is a benefit of the plan, ERISA preempts all claims relating to the provision or quality of that care. Acceptance of this definition by the \textit{Rice} court stands in contrast to the court in \textit{Dukes}, which declined to decide the issue.\textsuperscript{366} Second, the \textit{Rice} court appeared to find the quality of care classification irrelevant to determining whether ERISA completely preempts vicarious liability claims. Complete preemption would apply to any claim falling under a quality of care classification, so long as the plaintiff leveled the claim directly at the HMO.\textsuperscript{367} In fact, the court specifically mentioned the probability that ERISA would completely preempt negligent selection of provider claims.\textsuperscript{368} Third, language in the \textit{Rice} court's decision suggests that the court would apply conflict preemption under ERISA to vicarious liability claims because such claims affect the structure of the HMO through their inquiry into the existence or nonexistence of an agency relationship between the HMO and its physicians.\textsuperscript{369}

\begin{footnotes}
\footnotetext{359}{\textit{Id.}}
\footnotetext{360}{65 F.3d 637 (7th Cir. 1995).}
\footnotetext{361}{\textit{Id.} at 643.}
\footnotetext{362}{See \textit{Id.} at 644.}
\footnotetext{363}{See \textit{Id.} at 645.}
\footnotetext{364}{See \textit{Id.}}
\footnotetext{365}{See \textit{Id.} at 644. The court stated that case law indicates that where state law has the effect of creating a qualitative standard by which performance of a Plan contract is evaluated, then that state law is completely preempted. See \textit{Id.}}
\footnotetext{366}{See \textit{Dukes v. U.S. Healthcare, Inc.}, 57 F.3d 350, 356 (3d Cir. 1995).}
\footnotetext{367}{See \textit{Rice}, 65 F.3d at 643.}
\footnotetext{368}{See \textit{Id.}}
\footnotetext{369}{See \textit{Id.} at 645.}
\end{footnotes}
Similar to *Rice*, the court in *Prihoda v. Shpritz*\(^{370}\) also held that complete preemption did not apply to a vicarious liability claim against an HMO.\(^{371}\) However, the *Prihoda* court cited reasoning virtually opposite to that used in *Rice*. Whereas the *Rice* court disregarded the quality of care classification as grounds for not applying complete preemption, the *Prihoda* court expressly relied on the quality of care approach. In concluding that the claim was not completely preempted and that removal was improper, the *Prihoda* court stated:

The distinction between the quantity of benefits due under a welfare plan and the quality of those benefits will not always be clear. In this case, however, the distinction is clear. The plaintiff is challenging only the quality of the treatment . . . received. Thus, the case is not removable and must be remanded to state court.\(^{372}\)

Thus, *Prihoda* and *Rice* applied contrasting reasoning to reach the same conclusion. In fact, although *Jackson, Dukes, Rice*, and *Prihoda* all concluded that ERISA does not completely preempt vicarious liability claims for provider malpractice, all four courts applied different reasoning to reach that conclusion. In addition, none of the four courts agreed on the issue of whether vicarious liability claims are subject to conflict preemption under ERISA section 514. *Prihoda* does not address the issue. *Jackson* and *Pacificare* stand for the proposition that vicarious liability claims do not fall within the scope of ERISA's preemption clause. *Dukes* recognizes the possibility that vicarious liability claims may be preempted; *Rice* suggests that such a holding is probable.

The obvious disparities between the various analyses and conclusions become even more apparent in *Jass v. Prudential Health Care Plan, Inc.*,\(^{373}\) which was decided by the same court that decided *Rice*. In contrast to its previous analysis in *Rice*, however, the *Jass* court applied a quality of care versus denial of benefits classification to the plaintiff's two vicarious liability claims. The *Jass* court held that ERISA completely preempted the plaintiff's first claim, which asserted that the defendant HMO was vicariously liable for the improper actions of a benefits administrator employed directly by the HMO.\(^{374}\) However, the court held that the plaintiff's second claim of vicarious liability for the malpractice of a contracted physician was not subject to complete preemption.\(^{375}\) The same plaintiff had brought the claims against the same HMO for the same injury. The only difference between the two vicarious liability claims involved the underlying negligence — one involved an alleged improper denial of benefits, the other involved failure to provide quality care. Thus, the *Jass* court abandoned the

\(^{370}\) 914 F. Supp. 113 (D. Md. 1996).

\(^{371}\) See *id.* at 117-18.

\(^{372}\) *Id.* at 118.

\(^{373}\) 88 F.3d 1482 (7th Cir. 1996).

\(^{374}\) See *id.* at 1489.

\(^{375}\) See *id.* at 1488.
reasoning of *Rice* and applied a quality of care analysis to distinguish between the two claims.

In addition, the *Jass* court held that, although ERISA did not completely preempt the plaintiff's vicarious liability claim against the HMO for medical malpractice, the claim was subject to conflict preemption under ERISA section 514.\(^{376}\) The court applied ERISA's preemption clause to the plaintiff's claim for two reasons. First, the *Jass* court reasoned that the question of whether an agency or apparent agency relationship exists directly relates to the structure of an HMO under an ERISA-governed plan.\(^{377}\) Second, the court reasoned that the underlying claim against the physician was not for "negligent treatment," but rather for "negligent failure to treat."\(^{378}\) To the *Jass* court, this meant that the claim did not relate to the quality of care provided under the plan, but instead related to the provision of that care.\(^{379}\) Thus, the claim actually related to an alleged improper denial of benefits rather than failure to provide quality care.

This last reason is most interesting for its hypocrisy. The *Jass* court had rejected complete preemption of the plaintiff's vicarious liability claim for medical malpractice on grounds that the claim involved delivery of poor quality of care rather than any benefits owed under the plan.\(^{380}\) Then, later in the same opinion, the court rejected that quality of care analysis and found that the very same claim related to a denial of benefits and was preempted under section 514.\(^{381}\) Clearly, *Jass* demonstrates the striking disparities of applying ERISA preemption under the current interpretive approaches.

3. **The Proposed Framework: Preemption of Vicarious Liability Claims**

Perhaps the most surprising implication of the intrinsic claims framework is the definitive preemption of vicarious liability claims against HMOs operating as part of employee benefit plans. As indicated, vicarious liability claims are based on the law of agency.\(^{382}\) Each claim, whether it is against a staff, IPA, or group model HMO, is based on the HMO-physician relationship and the degree of control the HMO has over that relationship. Even under apparent agency and agency by estoppel theories, a plaintiff challenges the HMO based on her reasonable belief that the physician was the actual agent of the HMO.\(^{383}\) Thus, every vicarious liability claim against an HMO implicates the existence of an agency relationship between the HMO and its physicians.

The agency relationship between an HMO and its physicians, or the appearance of such a relationship, is created by the control that the HMO retains over the provision of medical care to its subscribers. In this respect, it is important to

\(^{376}\) See *id.* at 1492.

\(^{377}\) See *id.*

\(^{378}\) *Id.* at 1493.

\(^{379}\) See *id.*

\(^{380}\) See *id.* at 1488.

\(^{381}\) See *id.* at 1492.

\(^{382}\) See discussion *supra* notes 333-39 and accompanying text.

\(^{383}\) See discussion *supra* notes 338-39 and accompanying text.
remember that all HMOs maintain some degree of control over the provision of care so as to achieve effective cost containment. It is this control — an inherent aspect of HMOs — that lies at the heart of a vicarious liability claim. Such a claim directly relates to the inherent structure and purpose of HMOs as unique providers of affordable health care coverage. Thus, vicarious liability claims are essentially attempting to mandate the structure of HMOs and would be preempted by ERISA under the proposed framework.

**VI. Conclusion**

In 1974, Congress passed ERISA to provide a comprehensive federal solution to a major national problem with the law of employee benefits. Now, in 1997, ERISA has become entangled by the relatively new and turbulent controversy over the potential liability of HMOs. The current analytical methods for determining whether ERISA preempts a state law claim against an HMO are inadequate and confusing. Moreover, these analytical methods have led to a seemingly arbitrary application of ERISA that is damaging the public trust of our health care and legal systems.

In an effort to halt the madness that has inflicted the law of ERISA preemption, courts should step back from the confusing array of legal interpretations for the phrase "relates to" in ERISA's preemption clause and refocus on the limitations of the term "benefit." This approach closely follows the reasoning of the Supreme Court in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, in which the Court indicated that ERISA preempts state laws that force plans to adopt certain employee benefit structures or change their administration, or which provide alternative enforcement mechanisms to recover plan benefits.

A proper understanding of the term "benefit" with respect to subscriber claims against HMOs leads to the conclusion that ERISA only preempts those state law claims that challenge the inherent nature and structure of HMOs, for it is that inherent structure that guarantees the benefit of employee health care coverage through HMO membership. This new approach would bind the twin concepts of complete and conflict preemption and eliminate the artificial and deceptive tests that have confused courts in the past. Most importantly, the new approach outlined in this comment would serve to protect the wall of ERISA preemption from further decay while helping to define the appropriate role of HMOs in our nation's health care system.

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385. See id. at 1678.