

Spring 2000

## Coverage Denials in ERISA Plans: Assessing the Federal Legislative Solution

Karen A. Jordan

Follow this and additional works at: <https://scholarship.law.missouri.edu/mlr>



Part of the [Law Commons](#)

---

### Recommended Citation

Karen A. Jordan, *Coverage Denials in ERISA Plans: Assessing the Federal Legislative Solution*, 65 Mo. L. REV. (2000)

Available at: <https://scholarship.law.missouri.edu/mlr/vol65/iss2/2>

This Article is brought to you for free and open access by the Law Journals at University of Missouri School of Law Scholarship Repository. It has been accepted for inclusion in Missouri Law Review by an authorized editor of University of Missouri School of Law Scholarship Repository. For more information, please contact [bassettcw@missouri.edu](mailto:bassettcw@missouri.edu).

# Coverage Denials in ERISA Plans: Assessing the Federal Legislative Solution

Karen A. Jordan\*

## TABLE OF CONTENTS

I.	INTRODUCTION .....	406
II.	THE SCOPE OF THE PREEMPTION PROBLEM IN CASES INVOLVING COVERAGE DENIALS .....	409
A.	<i>Coverage Denials Before Managed Care—Contractual in Nature</i> .....	411
B.	<i>Coverage Denials in Managed Care Plans</i> .....	412
1.	The Basics of Managed Care .....	412
2.	Managed Care—The Injection of Medical Decision Making into the Coverage Decision ...	415
3.	Discerning the Basis for the Coverage Denial .....	417
4.	Why the Distinction Is Important .....	420
III.	PREEMPTION OF STATE LAW CHALLENGES ARISING FROM COVERAGE DENIALS .....	421
A.	<i>Pilot Life and the Traditional Broad View of ERISA Preemption</i> .....	421
B.	<i>The Corcoran Decision</i> .....	425
C.	<i>Most Courts Steadfastly Continue to Follow Corcoran</i> .....	428
IV.	THE FEDERAL LEGISLATIVE SOLUTION: THE NORWOOD-DINGELL PROVISIONS .....	432
V.	GIVEN THE EMERGING VIEW OF PREEMPTION, IS FEDERAL LEGISLATION NECESSARY? .....	435
A.	<i>The Supreme Court Trilogy</i> .....	435
1.	The Narrowing of § 514(a) Preemption .....	436
2.	The Trilogy Undermines <i>Corcoran</i> —The Implied Preemption Analysis .....	440
a.	A <i>Corcoran</i> -Type Claim Would Not Infringe on Employer Interests .....	442
b.	A <i>Corcoran</i> -Type Claim Promotes Employee Interests .....	445
3.	Why Have Lower Courts Continued To Follow <i>Corcoran</i> ? .....	447
4.	The Demise of <i>Corcoran</i> Does Not Completely Resolve the Preemption Problem .....	449
B.	<i>Courts of Appeals Decisions Narrowing the Scope of § 502(a)(1)(B)</i> .....	451
1.	Suits to Recover Benefits Due Under the Terms of the Plan .....	453
a.	The <i>Dukes</i> Analysis:	

A Quantity-Quality Test . . . . .	453
b. The Impact on the Reasoning	
Underlying <i>Corcoran</i> . . . . .	455
(i) A Simple Quality Test Is	
More Justifiable . . . . .	456
(ii) Application to Coverage Denials . . . . .	460
2. Suits to Enforce Rights Under the Terms of the Plan . . . .	461
a. The <i>Dukes &amp; Rice</i> Analyses . . . . .	461
b. Application to Coverage Denials . . . . .	463
C. <i>Despite a Narrower View of Preemption, Some Claims Arising</i>	
<i>from Coverage Decisions Would Still Be Preempted—</i>	
<i>and a Federal Legislative Solution Is Thus Preferable</i> . . . . .	464
VI. ASSESSMENT OF THE SOLUTION PROPOSED	
IN THE NORWOOD-DINGELL BILL . . . . .	467
VII. CONCLUSION . . . . .	471

## I. INTRODUCTION

Whether patients who obtain their health coverage through private employment ought to be able to sue managed care plans for injuries resulting from coverage denials has been a significant health policy issue for years. The debate became more intense as recent judgments against major managed care plans highlighted the inequity caused by the preemption provisions in federal employment law.<sup>1</sup> A Kentucky jury awarded \$13 million to Karen Johnson after finding that Humana Health Plan, Inc. wrongfully denied insurance coverage for a hysterectomy recommended by her doctor.<sup>2</sup> In California, a jury awarded \$116 million in punitive damages to Teresa Goodrich, whose husband died of cancer after Aetna U.S. Healthcare of California refused to pay for a bone marrow transplant.<sup>3</sup> Karen Johnson and Teresa Goodrich could sue their managed care plans because their health coverage was not obtained through a benefit plan governed by the Employee Retirement Income Security Act of 1974

---

\*Associate Professor of Law, Louis D. Brandeis School of Law at the University of Louisville.

1. See, e.g., Julie Marquis, *Jury's Huge Award in HMO Case Renews Debate on Patients' Rights*, L.A. TIMES, Jan. 22, 1999, at A23.

2. See *Kentucky Jury Delivers Blow to HMO, Awards Cancer Patient \$13 Million*, MEALEY'S MANAGED CARE LIABILITY REP., Oct. 28, 1998, at 5. The jury awarded Johnson \$13 million in punitive damages, as well as \$100,000 in damages for pain and suffering and \$14,046.82 for the amount she paid for the hysterectomy.

3. See *Plan Liability: California Jury Awards Record Damages Against Aetna for Treatment Decisions*, BNA'S HEALTH CARE DAILY REP. (BNA), Jan. 22, 1999, at d3, available in WL 1/22/1999 HCD d3. The jury also awarded Teresa \$4.5 million in compensatory damages for medical expenses and loss of companionship.

("ERISA").<sup>4</sup> In contrast, ERISA plan participants and beneficiaries, comprising roughly forty-four percent of the population of the United States,<sup>5</sup> have been and continue to be precluded from bringing comparable suits. Indeed, although courts have narrowed the scope of preemption in recent years and have allowed some negligence claims to proceed against managed care plans, courts continue to hold that ERISA insulates managed care plans from liability arising from any aspect of a benefit determination.<sup>6</sup>

Appropriately, the issue has garnered significant attention in Congress. In 1998, several federal proposals surfaced that addressed the public's concerns stemming from the prevalent shift to managed care plans. However, only one bill would have amended ERISA's preemption provisions to expressly permit negligence suits against managed care plans.<sup>7</sup> Congress pledged to revisit the

4. 29 U.S.C. §§ 1001-1461 (Supp. III 1997). ERISA was enacted to help ensure that employee benefit plans are established on financially sound principles and to ease the burdens that could arise from plans serving employees in more than one state. See Michael Cohen, Note, *No Faith in Bad Faith*, 41 HASTINGS L.J. 201, 216 (1989).

5. See Jana K. Strain & Eleanor D. Kinney, *The Road Paved With Good Intentions: Problems and Potential for Employer-Sponsored Health Insurance Under ERISA*, 31 LOY. U. CHI. L.J. 29, 32 (1999) (citing U.S. GENERAL ACCOUNTING OFFICE, EMPLOYER-BASED HEALTH PLANS: ISSUES, TRENDS, AND CHALLENGES POSED BY ERISA 2 (1995)).

6. See, e.g., Hull v. Fallon, 188 F.3d 939 (8th Cir. 1999), cert. denied, 120 S. Ct. 1242 (2000); Parrino v. FHP Inc., 146 F.3d 699 (9th Cir. 1998); Turner v. Fallon Community Health Plan, 127 F.3d 196 (1st Cir. 1997); Tolton v. American Biodyne, Inc., 48 F.3d 937 (6th Cir. 1995); Huss v. Green Spring Health Servs., Inc., 18 F. Supp. 2d 400 (D. Del. 1998); Benoit v. W.W. Grainger, Inc., No. Civ.A 98-1315, 1998 WL 749444 (E.D. La. Oct. 21, 1998); Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49 (D. Mass 1997). See also Karen A. Jordan, *Tort Liability for Managed Care: The Weakening of ERISA's Protective Shield*, 25 J. L. MED. & ETHICS 160, 167 & 169 (1997) (explaining that, regardless of the reason for a denial of coverage, the trend is and has been that any and all claims arising from benefit determinations are generally found to be preempted). But see *infra* note 14 (noting that courts are more receptive to claims challenging negligent selection of providers in the plan network, negligent policies that affect the provision of medical care, and negligent provision of medical advice by agents of the managed care plan. See, e.g., Crum v. Health Alliance-Midwest, Inc., 47 F. Supp. 2d 1013 (C.D. Ill. 1999); Delucia v. St. Luke's Hosp., No. Civ.A 98-6446, 1999 WL 387211 (E.D. Pa. May 25, 1999)).

7. The Democratic leadership proposal would have amended § 514(a) of ERISA by adding a subsection providing generally that ERISA shall not:

[S]upersede any cause of action under state law to recover damages resulting from personal injury or for wrongful death against any person: (A) in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health plan; or (B) that arises out of the arrangement by such person for the provision of such insurance, administrative services, or medical services by other persons.

S. 1890, 105th Cong. (1998); H.R. 3605, 105th Cong. (1998).

The proposal included an express exception for employers or other plan sponsors.

issue of managed care legislation in 1999. This time, several bills emerged that would have allowed suits (of varying scope) against managed care plans.<sup>8</sup> On October 7, 1999, the House passed the Norwood-Dingell bill, which broadly exempts from ERISA preemption state law causes of action arising from managed care activities, including denials of coverage.<sup>9</sup> However, the fate of the Norwood-Dingell bill is uncertain because the Senate passed a managed care reform bill in July 1999 that did not contain any provision allowing suits against managed care plans.<sup>10</sup> Further, the Norwood-Dingell bill never won the support of House leadership.<sup>11</sup> It is thus unclear whether the House provision will survive the conference committee process.

The purpose of this Article, in part, is to provide some guidance to the debate. The Article first explains the scope of the preemption problem for ERISA plan participants and beneficiaries in cases involving coverage denials and introduces the reader to the legislative solution passed by the House. The Article then explores whether federal legislation is necessary to address the problem, in light of narrowing interpretations of the scope of ERISA preemption by the judiciary. This question necessarily requires an assessment of the soundness of the narrower view of preemption, as well as of the extent to which

---

Specifically, the proposal provided that the amendment would not authorize "(i) any cause of action against an employer or other plan sponsor maintaining the group health plan, or (ii) a right of recovery or indemnity by a person against an employer or other plan sponsor for damages assessed against the person pursuant to [the state cause of action exempted from § 514(a) preemption]." In contrast, none of the Republican proposals would have changed the current scope of ERISA preemption. *See* H.R. 4250, 105th Cong. (1998) (House Republican Leadership Bill); S. 2330, 105th Cong. (1998) (Senate Republican Leadership Bill); S. 2416, 105th Cong. (1998) (Senate Centrists Bipartisan Plan). An early version of federal managed care regulation proposed to amend ERISA to create a federal action under § 502(a). This proposal disappeared from the more intense debates during the summer of 1998. *See* H.R. 1749, 105th Cong. (1998) (sponsored by Rep. Pete Stark (D-Cal.)).

8. For a discussion of the 1999 proposals, see *infra* notes 112-27 and accompanying text.

9. *See* H.R. 2723, 106th Cong. (1999). The bill is titled "Bipartisan Consensus Managed Care Improvement Act of 1999." H.R. 2723 § 1(a). After passage of the Norwood-Dingell bill, the House passed a Republican package of tax breaks and insurance reforms, H.R. 2990, 106th Cong. (1999), designed to increase access to health care coverage. Following that vote, the Norwood-Dingell bill was merged with the access bill. The combined bill kept the bill number of the access measure. *See Plan Regulation: GOP Leaders Fail to Name Norwood, Ganske to Conference on Managed Care Legislation*, HEALTH CARE DAILY (BNA), Nov. 4, 1999, at d3, available in WL 11/4/1999 HCD d3.

10. *See Plan Regulation: Managed Care Reform Faces Next Hurdle: Conferees Likely to Oppose House-Passed Bill*, HEALTH CARE DAILY (BNA), Oct. 12, 1999, at d2, available in WL 10/12/1999 HCD d2.

11. *See infra* note 125 and accompanying text.

the narrower view resolves the preemption problem. The analysis concludes that a federal legislative solution is preferable because, although the emerging view of preemption might permit state law claims challenging coverage decisions based on medical decision making, state law claims that would provide an incentive for managed care plans to act fairly would likely remain preempted.

In addition to contributing to the debate regarding the proposed federal legislation, this Article seeks to explain in detail why, in contrast to the prevalent trend, courts should now find that Congress did not intend for ERISA to preempt all state law claims challenging any aspect of coverage decisions by managed care plans. Rather, case law now supports the argument that a common law claim seeking recovery for harms arising from a negligent medical decision represents a distinct type of state law claim that does not warrant preemption. If the House bill does not survive the conference committee process, the analysis presented in this Article may be useful to courts as they continue to grapple with the scope of ERISA preemption.

## II. THE SCOPE OF THE PREEMPTION PROBLEM IN CASES INVOLVING COVERAGE DENIALS

Coverage denials are an inevitable consequence of the financing systems used by Americans to pay for health care services. Even under the traditional indemnity model of health insurance, coverage denials were an integral part of the system. However, concern over coverage denials has dramatically increased due to the shift to managed care because managed care has changed the nature of the claims denial process. Under managed care, physical injury is more likely to be a consequence of a coverage denial. The problem for ERISA plan participants and beneficiaries has been their inability to hold managed care plans accountable when coverage decisions have caused harm, even when the denial was based on an exercise of medical judgment as opposed to mere contractual interpretation.

As noted, ERISA plan participants and beneficiaries, unlike Karen Johnson and Teresa Goodrich, have been precluded from bringing lawsuits against their managed care plans for injuries stemming from coverage decisions. The preclusion of such lawsuits is a consequence of a provision in ERISA that expressly preempts state laws that “relate to” ERISA plans.<sup>12</sup> ERISA’s preemption provision has historically been viewed expansively. Consequently, any state tort or contract claim that in any way arises from a health benefit determination for a participant or beneficiary in an ERISA plan has been held to

---

12. Section 514(a) of ERISA prescribes that ERISA “shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.” 29 U.S.C. § 1144(a) (Supp. III 1997). For an overview of ERISA’s preemption provisions, see generally Karen A. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption*, 13 YALE J. ON REG. 255 (1996).

be preempted.<sup>13</sup> Although courts have narrowed the scope of preemption in recent years—thereby permitting some tort claims against managed care plans<sup>14</sup>—most courts continue to find preempted any state law claim involving, in any way, a coverage denial.<sup>15</sup> And this is true notwithstanding the fact that coverage denials can be based on different reasons or the fact that some tort claims effectively regulate the quality of health care. Thus, appreciating the scope of the preemption problem in cases involving coverage denials requires an explanation of the different types of coverage denials in managed care plans, as well as an explanation of the leading preemption cases involving state common law actions arising from coverage denials.<sup>16</sup>

13. See Jordan, *supra* note 12, at 261-70 (discussing the scope of ERISA's preemption provisions prior to 1995).

14. For example, because they are further removed from the processing of claims for benefits, courts have become receptive to the argument that ERISA does not preempt claims challenging negligent selection of providers in the plan network, negligent policies that affect the provision of medical care, and negligent provision of medical advice by agents of the managed care plan. See, e.g., Crum v. Health Alliance-Midwest, Inc., 47 F. Supp. 2d 1013, 1018 (C.D. Ill. 1999) (holding that ERISA does not preempt state common law claims arising from advice provided by the managed care plan's "advisory nurse"); Delucia v. St. Luke's Hosp., No. Civ.A 98-6446, 1999 WL 387211 (E.D. Pa. May 25, 1999) (holding that ERISA does not preempt state common law claims challenging a managed care plan's policies that caused a treating physician to negligently fail to order a breathing monitor).

15. See, e.g., Hull v. Fallon, 188 F.3d 939, 943 (8th Cir. 1999) (holding preempted state law claims arising from the plan administrator's decision to deny coverage for a thallium stress test, and to recommend a treadmill test instead), *cert. denied*, 120 S. Ct. 1242 (2000); Parrino v. FHP, Inc., 146 F.3d 699, 704-05 (9th Cir. 1998) (holding preempted state law claims arising from a managed care entity's allegedly wrongful initial denial of coverage for proton beam therapy upon a utilization review finding that the treatment was experimental and unnecessary); Turner v. Fallon Community Health Plan, Inc., 127 F.3d 196, 199-200 (1st Cir. 1997) (holding preempted a state law claim that a managed care entity wrongfully denied coverage for a type of bone marrow transplant and high dose chemotherapy treatment—although this case may not have given rise to a tort claim); Huss v. Green Spring Health Servs., Inc., 18 F. Supp. 2d 400, 408-09 (D. Del. 1998) (holding preempted a state tort claim that a managed care plan negligently failed to verify coverage and refused to cover treatment for a psychiatric disorder); Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49 (D. Mass. 1997) (holding preempted claims that a managed care entity repeatedly and negligently refused to authorize inpatient rehabilitation and detoxification treatment).

16. Notably, some decisions suggest that the crucial factor in the preemption analysis is how the plaintiff has pleaded her claim. For example, in *Delucia*, 1999 WL 387211, at \*1, the plaintiff sought to hold a managed care plan vicariously liable for injuries caused by the treating physician's decision to discharge an infant from the hospital without a breathing monitor. *Id.* The physician advised Delucia that the infant's condition did not meet the managed care plan's criterion for discharging a newborn on a breathing monitor. The defendant managed care plan argued that the plaintiff's claim was for a "denial of benefits" and thus preempted. *Id.* The court disagreed, noting:

### A. Coverage Denials Before Managed Care—Contractual in Nature

Historically, health coverage was predominantly provided through Blue Cross and Blue Shield service benefit plans or commercial indemnity insurance plans. Under Blue Cross plans, providers elected to participate in the plan, and thus to provide services for enrollees and to accept the plan's payments for services.<sup>17</sup> Blue Cross and Blue Shield plans, then, have always involved a relationship or agreement with "participating providers," but the plans did not attempt to influence the provision of health care.<sup>18</sup> Blue Cross reimbursed hospitals on the basis of "reasonable costs." Costs included virtually any expense, and Blue Cross rarely questioned the reasonableness of costs.<sup>19</sup> Blue Shield reimbursed physicians on the basis of "customary fees" for particular procedures in particular areas.<sup>20</sup> Under traditional indemnity plans, patients selected a health care provider, paid the provider's bill, and then sought reimbursement from the plan. In contrast to Blue Cross and Blue Shield plans, indemnity plans had no financial or other relationship with the providers.<sup>21</sup> To ensure provider cooperation in commercial plans, insurers tracked the

When a plaintiff fails to allege that the denied or omitted medical treatment or service was due under the plan, preemption does not apply. Plaintiffs here nowhere allege that Aetna denied a request for a breathing monitor. Nor do they allege either that the [infant's] condition, in fact, met the plan's criterion . . . or even that a breathing monitor was covered by the plan.

*Id.* at \*3 (citation omitted).

However, preemption is not a matter of pleading. Rather, the crucial factor is whether the claim arises from a coverage denial. In *Delucia*, no one ever presented to Aetna a request for a breathing monitor for the infant. Thus, a denial of coverage did not occur. The fact that a claim results from a coverage denial is the crucial factor in the preemption analysis.

17. Whereas indemnity plans viewed themselves as selling insurance, Blue Cross plans viewed themselves as selling "prepaid health care." See RAND E. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 9 (1997).

18. Blue Cross plans were controlled by the American Hospital Association, and Blue Shield plans were controlled by state medical societies. See ROSENBLATT ET AL., *supra* note 17, at 10.

19. See ROSENBLATT ET AL., *supra* note 17, at 469 (explaining that Blue Cross determined only whether costs were "allowable"; and that allowable costs included "salaries, costs of medical education, capital costs, depreciation, interest, legal fees, public relations, bad debts, and a plus factor for items that might have been omitted from the list of allowable costs").

20. See ROSENBLATT ET AL., *supra* note 17, at 514-15 (explaining that physicians historically were paid on a fee-for-service basis, often using a fee schedule; and that Blue Shield would pay the lesser of the individual physician's actual billed charge, the customary charge, or the prevailing charge in the community).

21. See ROSENBLATT ET AL., *supra* note 17, at 553-54.



reimbursement policies of Blue Cross and Blue Shield.<sup>22</sup> Both plans limited benefits to “medically necessary” care, but in practice the companies rarely questioned the medical judgment of providers.<sup>23</sup>

Under the historical system, then, coverage decisions were made retrospectively, after the health care had been provided to the patient. In commercial indemnity plans, the decision was made when the claimant sought reimbursement from the plan. In Blue Cross and Blue Shield plans, the decision was made when the provider submitted a claim for payment. Because commercial insurers and Blue Cross and Blue Shield rarely questioned medical necessity, there was no advantage in making coverage decisions before or during the course of the treatment. Further, the fact that medical necessity was rarely questioned meant that denials resulted only if the claim was improperly filed or if the service was not “covered”—for some reason other than medical necessity. For example, a claim might be denied if (1) the service did not fall within a category of services covered by the policy, (2) the service fell within the scope a specific exclusion in the policy, or (3) the service exceeded the quantity allowed under the policy. Thus, the reasons underlying a coverage denial before managed care tended to be more purely contractual in nature.

## B. Coverage Denials in Managed Care Plans

### 1. The Basics of Managed Care

It is well recognized that managed care plans have become a dominant force in our health care system.<sup>24</sup> Managed care has proliferated because of its promise to contain the costs associated with health care delivery under the traditional “reasonable cost” and “fee-for-service” paradigms.<sup>25</sup> Cost savings in

22. See ROSENBLATT ET AL., *supra* note 17, at 13.

23. See ROSENBLATT ET AL., *supra* note 17, at 13 (explaining that, in the era of provider-dominated financing, “[t]here was no serious, independent review of doctors and hospitals regarding which patients they chose to serve, or for quality or volume of care, and private insurers would pay doctors and hospitals pretty much what they asked”).

24. It has been reported that, as of 1995, 78% of all privately insured persons were members of managed care plans. Further, by 1996, one third of the nation’s nearly 36 million Medicaid beneficiaries, and 9% of the Medicare population, were enrolled in some form of managed care. See ROSENBLATT ET AL., *supra* note 17, at 544; see also Gail A. Jensen et al., *The New Dominance of Managed Care: Insurance Trends in the 1990s*, 16 HEALTH AFFAIRS 125 (1997).

25. Managed care has been broadly defined as any system:

[T]hat integrates the financing and delivery of appropriate health care services to covered individuals [by] arrangements with selected providers to furnish a comprehensive set of health care services . . . explicit standards for selection of health care providers; formal programs for ongoing quality assurance and

managed care result from the integration of health care financing and delivery. This is often explained by noting that managed care plans act in a dual capacity:

First, [plans assume] the role of an insurance company by defining and determining the parameters as to the level and extent of health care that will be provided in exchange for the 'premiums,' 'dues,' or 'membership fees.' Second, [plans establish] the 'network' or system of medical care providers to actually render the medical care covered under the established parameters.<sup>26</sup>

More specifically, however, cost savings are achieved because of the controls that managed care plans can exert over health care providers in exchange for allowing providers to be part of the network.<sup>27</sup> The primary objectives of the controls are to prevent the provision of "unnecessary" medical care.<sup>28</sup> Utilization review ("UR") is the most notorious practice used by managed care plans to stem the provision of unnecessary care.<sup>29</sup> UR involves a

---

utilization review; and significant financial incentives for members to use providers and procedures associated with the plan.

HEALTH INSURANCE ASS'N OF AMERICA, SOURCE BOOK OF HEALTH INSURANCE DATA 18 (1991).

26. See Sharon J. Arkin, *A Litigator's Perspective on HMO Liability: The View from the Plaintiff's Side*, 22 AM. J. TRIAL ADVOC. 131, 134 (1998). Professor Furrow has explained:

Managed care is usually distinguished from traditional indemnity plans by the existence of a single entity responsible for integrating and coordinating the financing and delivery of services were once scattered between providers and payers. This entity provides comprehensive health care services to an enrolled membership for a fixed per capita fee, thus becoming both an insurer and a provider of medical care. This risk bearing is then distributed downstream to physician providers through capitation contracts.

See Barry R. Furrow, *Managed Care Organizations and Patient Injury: Rethinking Liability*, 31 GA. L. REV. 419, 430 (1997) (footnotes omitted).

27. To date physicians, out of fear of being left out of networks and thus of losing access to significant volumes of patients, have entered into contracts with managed care organizations "almost indiscriminately." See William M. Sage, *Enterprise Liability and the Emerging Managed Health Care System*, 60 LAW & CONTEMP. PROBS. 159, 193 (1997).

28. Practices include UR, capitation payment, and financial incentives. For a description of UR, see *infra* notes 29-31 and accompanying text. Capitation refers to a reimbursement system in which a managed care plan compensates a contracting physician at a flat rate for each patient enrolled in the plan for a specified period of time. Financial incentives include strategies such as risk pools, bonuses, and expanded capitation to decrease the use of referrals, diagnostic tests, and other services. See generally Stephen R. Latham, *Regulation of Managed Care Incentive Payments to Physicians*, 22 AM. J. L. & MED. 399 (1996).

29. UR is a subset of the broader concept of utilization management ("UM"). As

comparison of services being provided or proposed to be provided to a patient “with established criteria developed from information obtained from comparable patients in order to determine if . . . health care services are medically necessary.”<sup>30</sup> Thus, in contrast to the historical approach to coverage, a central tenet of managed care is to question the medical judgment of providers.

UR can be prospective, concurrent, or retrospective. Prospective UR is performed prior to the administration of the recommended treatment; concurrent UR occurs during the course of the treatment; and retrospective UR occurs after medical treatment is rendered. As noted, retrospective review, even if based on the issue of medical necessity, tends to impact only a question of coverage because the health care has already been provided to the patient.

In contrast, prospective and concurrent UR often impact whether the recommended health care services are actually provided to the patient because patients often cannot afford the medical care recommended by their treating physician but denied by their managed care plan. Hence, concurrent and prospective UR are the linchpins of managed care. Most managed care plans follow a similar process in conducting concurrent or prospective UR.

[The UR] process entails a review of the subscriber’s case, usually by a registered nurse, who analyzes the care or procedures proposed or provided in order to determine whether they fall within the managed care entity’s utilization standards. After this initial analysis has been completed and it has been determined that the treatment is not within the standards, the case is presented to a [UR] physician or medical director for further analysis. If, after consultation with the subscriber’s physicians, it is determined that the care is not medically necessary, payment will not be authorized. In the event it is determined that the requested service is not medically necessary and thus not covered under the policy, the subscriber can elect to pay for the service out of pocket or pursue an appeal of the decision.<sup>31</sup>

---

one article has explained:

Today, UM is conducted by insurance companies, third party administrators, managed care entities, and private companies that provide specialized UM services. UM in these areas involves a myriad of functions. Techniques include monitoring the practice patterns of providers, case management of high cost cases, referral management, and service and coverage authorization.

Brian P. Battaglia, *The Shift Toward Managed Care and Emerging Liability Claims Arising from Utilization Management and Financial Incentives Arrangements Between Health Care Providers and Payers*, 19 U. ARK. LITTLE ROCK L.J. 155, 170-71 (1997) (footnotes omitted).

30. *Id.* at 171 (citing PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, HEALTH CARE FINANCING ADMINISTRATION, 104TH CONG., MEDICARE AND THE AMERICAN HEALTH CARE SYSTEM, REPORT TO CONGRESS 80-81 (1995)).

31. *Id.* at 172. Battaglia states:

Managed care plans stress that policyholders can elect to pay for the service out of pocket in order to support their position that the UR determination is simply a “coverage issue” and not medical decision making. But, the essence of the UR determination in many cases is whether the recommended medical service or treatment is medically necessary; and, thus, the reviewer is engaging in medical decision making. Further, because prospective and concurrent UR often impact whether the enrollee actually proceeds with recommended treatments, managed care plans’ medical decision making has a great potential to cause harm.

## 2. Managed Care—The Injection of Medical Decision Making into the Coverage Decision

With the advent of managed care, then, the reasons for coverage denials have multiplied. Coverage denials before managed care generally resulted only if the claim was improperly filed or if the service was not “covered” for some contractual reason. For example, a claim might be denied if (1) the service did not fall within a category of services covered by the policy, (2) the service fell within the scope a specific exclusion in the policy, or (3) the service exceeded the quantity allowed under the policy. In contrast, coverage denials in managed care health plans may be based on conduct involving an application of medical judgment in addition to conduct involving contractual interpretation or application.

More specifically, a denial by a managed care plan generally still is based on one of two reasons: the claim for coverage was improperly filed, or the service is not covered by the policy. The three contractual reasons noted in the prior paragraph which tended to underlie a coverage decision before managed care remain as possible reasons for a denial after managed care. But managed care gives rise to additional reasons: Under managed care, a service may not be covered because (1) the service was improperly accessed, *e.g.*, the claimant obtained the service from a nonparticipating provider or without pre-approval, or (2) the service, although falling within a covered category of services generally, is not covered in a given case because it is deemed to be “not medically necessary” or “experimental.”

A denial based on a finding that the service is not medically necessary is distinct from all of the other noted reasons. A decision that a service is not covered in a given case because it is deemed to be “not medically necessary” or

---

Sources relied upon in [UR] include the Appropriateness Evaluation Protocol, Intensity of Service, Severity of Illness, Discharge and Appropriateness Screening Criteria, and the Standardized Medreview Instrument. These standards evolved from programs funded by the government to develop criteria for the [Medicare peer review organizations]. In addition, databases have been developed commercially for use in the [UR] process.

*Id.*

“experimental” involves medical decision making.<sup>32</sup> As other scholars have aptly explained, a medical necessity determination also involves the injection of a value judgment, *i.e.*, a judgment as to whether a particular procedure is worth performing given the cost and expected health outcome.<sup>33</sup> But the essence of the decision involves medical decision making.

Indeed, recent judicial decisions have specifically recognized that persons making UR determinations are making medical decisions. In *Murphy v. Board of Medical Examiners*,<sup>34</sup> the Court of Appeals of Arizona held that an individual who made decisions authorizing or denying pre-certification of medical procedures was engaged in the practice of medicine and thus subject to the jurisdiction of the Arizona Board of Medical Examiners.<sup>35</sup> According to the court,

Dr. Murphy evaluated information provided by both the patient’s primary care physician and her surgeon. He disagreed with their decision that gall bladder surgery would alleviate her ongoing symptoms. S.B.’s doctors diagnosed a medical condition and proposed a non-experimental course of treatment. Dr. Murphy substituted his medical judgment for theirs and determined that the surgery was “not medically necessary.” There is no other way to characterize Dr. Murphy’s decision: it was a “medical decision.”<sup>36</sup>

32. For purposes of clarity, this Article will henceforth speak only in terms of determinations of medical necessity, rather than continuing to reference determinations of whether particular treatment or care should be deemed “experimental.” As with determinations of medical necessity, whether medical care or treatment is experimental often involves an exercise of medical knowledge and judgment.

33. Professor Patricia Danzon has explained:

At best, medical science may be able to tell us the probability distribution of health outcomes and risks from a given treatment. To decide whether a particular procedure is worth performing requires comparing the value of the expected health outcomes to costs. Valuation of medical services ultimately depends on consumer preferences for alternative outcomes, including tolerance for risk and discomfort, preferences for health care versus other goods, and so forth. Thus, ‘medical judgment’ alone cannot provide a basis for evaluating a particular cost containment mechanism or coverage decision.

Patricia M. Danzon, *Tort Liability: A Minefield for Managed Care?*, 26 J. LEGAL STUD. 491, 508 (1997) (footnotes omitted); *see also* Peter A. Glassman et al., *The Role of Medical Necessity and Cost-Effectiveness in Making Medical Decisions*, 126 ANNALS OF INTERNAL MEDICINE 152 (1997).

34. 949 P.2d 530 (Ariz. Ct. App. 1997).

35. *Id.* at 535-36; *cf.* *Morris v. D.C. Bd. of Med.*, 701 A.2d 364 (D.C. 1997).

36. *Murphy*, 949 P.2d at 536. The court recognized the significant policy issues arising as a result of its holding. On the one hand, its decision might prompt a “flood of complaints by disgruntled doctors and patients who dispute the insurer’s denial of benefits as ‘not medically necessary.’” On the other, a failure to find that Murphy

In a different context, the court in *Long v. Great West Life & Annuity Insurance Co.*,<sup>37</sup> similarly held that UR involves “medical decision making” and thus is distinguishable from the traditional process of determining “insurance claims and coverage.”<sup>38</sup>

Therefore, health care coverage denials in the managed care environment can be characterized as falling into two distinct categories: (1) denials arising from conduct that involved an exercise of medical judgment, and (2) denials arising from conduct that involved contractual interpretation or application, but not an exercise of medical judgment.

### 3. Discerning the Basis for the Coverage Denial

Unfortunately, the categorization just described is complicated by the realities of health coverage contracting. Managed care plans generally define the term “medical necessity” in their policies. As a result, coverage denials based on a finding that the recommended treatment is “not medically necessary” could fall into either category. Some health coverage policies do not define the phrase medically necessary and simply cover certain medical services as long as a utilization reviewer agrees with the treating physician’s determination that a certain covered service is “medically necessary” or “reasonable and necessary.”

---

engaged in the practice of medicine might “frustrate consumers who purchase health insurance yet find themselves facing a stone wall when their insurer opposes their physicians’ treatment recommendations.” *Id.* The court left the policy issues to the legislature.

37. 957 P.2d 823 (Wyo. 1998). In *Long*, one issue was whether the plaintiff, a state employee who obtained coverage through his employment, was required to exhaust the administrative procedures set forth in the statutory provisions and administrative rules governing state insurance programs. An administrative rule stated that the grievance procedures established through the rules and regulations “provide the exclusive administrative remedy available to state employees . . . in adjudicating disputes concerning insurance claims and coverage.” *Id.* at 832. The court held that the rule did not preclude the plaintiff’s judicial action against the insurance company that administrated the state health plan.

38. *Id.* However, Ohio’s attorney general recently issued an opinion finding that “actions taken by a health-insuring corporation are not considered to constitute the practice of medicine,” under Ohio law, and thus the Ohio State Medical Board could not discipline a medical director employed by an insurance company as a result of a medical necessity determination. See *Doctors Doing UR Not Practicing Medicine, Ohio AG Rules; Medical Board in Quandry*, HEALTH L. REP. (BNA), Sept. 16, 1999, at 1500. Interestingly, the attorney general noted that, as a result of her opinion, the Ohio legislature may want to revisit the issue of whether patients should be able to sue their HMOs for denying coverage: “If these doctors aren’t accountable to the medical board, and patients can’t sue their HMOs, what other course of action does a physician or patient have? I can see light bulbs popping up in a lot of legislators’ minds about this.” *Id.*

When such policies are involved, all denials based on a finding that, in a given case, the recommended treatment is “not medically necessary” would involve an exercise of medical judgment. Other policies, however, may have specialized definitions of what constitutes “medically necessary” or “reasonable and necessary.” For example, in one well known case, the coverage policy defined “medically necessary” as that care or treatment

[(i)] required and appropriate for care of the Sickness or Injury; and that [(ii)] are given in accordance with generally accepted principles of medical practice in the U.S. at the time furnished; and that [(iii)] are approved for reimbursement by the Health Care Financing Administration; and that [(iv)] are not deemed to be experimental, educational or investigational in nature by any appropriate technological assessment body established by any state or federal government; and that [(v)] are not furnished in connection with medical or other research.<sup>39</sup>

A tort action arising in connection with a denial of coverage under this definition of medical necessity could be characterized as an action challenging conduct that involved contractual interpretation or application. Further, application of some of the clauses of the provision would not require an exercise of medical judgment, e.g., clauses (iii) and (iv). However, application of some of the clauses would require an exercise of medical judgment, e.g., clauses (i), (ii), and perhaps (v).<sup>40</sup>

The Goodrich and Johnson suits aptly illustrate that there are differences in the types of suits which may arise from a coverage denial. Karen Johnson, a thirty-five year old woman, was diagnosed with IN-SITU carcinoma of the cervix with endocervical gland extension. Her physicians recommended a hysterectomy, as this treatment more dramatically reduced the risk that the cancer might return. Johnson’s insurer, Humana, disagreed that a hysterectomy was medically necessary. Humana approved payment for a cheaper, less invasive procedure called a cervical conization. Johnson appealed twice to Humana for coverage for the treatment recommended by her physicians, but was denied both times.<sup>41</sup> She therefore used \$14,000 of her family’s money to pay

39. See *Fuja v. Benefit Trust Life Ins. Co.*, 18 F.3d 1405, 1408 (7th Cir. 1994).

40. Thus, because the theory explained in Part V of this Article is that ERISA does not preempt state tort actions challenging a managed care plan’s negligent medical decision making, litigants must carefully develop the relevant facts and courts must carefully discern exactly what type of conduct is being challenged when the defense of ERISA preemption is raised in tort actions.

41. During the trial, Humana argued that three independent board-certified gynecologists reviewed Johnson’s claim and determined that a hysterectomy was not medically necessary. However, Johnson’s attorneys argued that Humana’s claims reviewer, Value Health Systems in California, determined that the hysterectomy was not

for the hysterectomy.<sup>42</sup> In this type of scenario, a tort suit challenging the denial would be aimed at conduct involving an exercise of medical judgment.<sup>43</sup>

Teresa Goodrich's suit arose from different circumstances. Her husband, David, was diagnosed with a rare type of stomach cancer. Because no Aetna physicians were equipped to treat David's cancer, his primary care physician authorized out-of-network visits with cancer treatment specialists who eventually recommended that he undergo a bone marrow transplant. Aetna refused to pay for the procedure or for any of David's visits to out-of-network physicians, purportedly because David sought treatment outside the Aetna plan without first obtaining approval from Aetna's medical director. Aetna recommended that David begin chemotherapy supervised by in-plan physicians,<sup>44</sup> even though Aetna conceded that its network physicians were inexperienced with the rare form of stomach cancer involved.<sup>45</sup> But Aetna made other statements: first, that David's policy explicitly excluded the bone marrow transplant<sup>46</sup> and, second, that David was never an appropriate candidate for high-dose chemotherapy due to the progression of the disease.<sup>47</sup> Thus, it is not entirely clear to what extent the denial of coverage may have been attributable to an exercise of medical judgment. However, some of the noted reasons, such as David's alleged failure to obtain plan approval, would give rise to a claim challenging conduct involving contract interpretation or application other than an exercise of medical judgment. That type of claim is distinguishable from the type of claim in the Johnson case.

---

medically necessary without properly examining Johnson's medical file or her health care contract. *See Kentucky: Humana to Pay Patient \$13 Million For Denying Hysterectomy, Jury Decides*, HEALTH L. REP. (BNA), Oct. 29, 1998, at 1723-24.

42. *See Kentucky Jury Delivers Blow to HMO, Awards Cancer Patient \$13 Million*, MEALEY'S MANAGED CARE LIABILITY REP., Oct. 28, 1998, at 5; *Humana Asks Judge to Throw Out \$13.1 Million Verdict; HMO Did Nothing Wrong in Woman's Case*, COURIER-JOURNAL (Louisville), Dec. 22, 1998, at 01B.

43. Professor Danzon has advocated pursuing denials under contract rather than tort principles. *See supra* note 33. However, the premises underlying her argument do not reflect the reality of the relationship between the managed care plan and the policyholder/patient.

44. *See California HMO Case Moves Toward Trial After Surviving Arbitration, ERISA Hurdles*, MEALEY'S MANAGED CARE LIABILITY REP., Nov. 25, 1998, at 13.

45. *See Julie Marquis, Sending a Signal: HMO Hit With Nation's Largest Verdict: California Cancer Victim's Widow is Awarded \$120 Million*, SEATTLE TIMES, Jan. 21, 1999, at A15.

46. *See California HMO Case, supra* note 44, at 13 (noting that Aetna explained that "[s]ervices from non-participating providers, including self-referral to participating providers, are excluded from coverage, except in the case of medical emergency or when authorized in advance by the plan's medical director").

47. *See Aetna U.S. Healthcare, Aetna Responds to Goodrich Verdict* (visited Jan. 21, 1999) <[http://www.aetnaushc.com/about/press/jan21\\_99.html](http://www.aetnaushc.com/about/press/jan21_99.html)>.



#### 4. Why the Distinction Is Important

The distinction between types of denials may seem unimportant if ERISA precludes plan participants and beneficiaries from holding managed care plans accountable for harm caused by coverage decisions—even when the denial was based on an exercise of medical judgment as opposed to mere contractual interpretation. However, understanding that different types of conduct underlie coverage denials helps one appreciate the scope of the preemption problem. Further, understanding the distinction helps one understand the evolution of preemption case law. An early Supreme Court case held that ERISA preempted state common law actions challenging the processing of a claim for benefits; however, in that case, the conduct did not involve an exercise of medical judgment.<sup>48</sup> The Fifth Circuit extended preemption to actions challenging coverage denials based on conduct that *did* involve an exercise of medical judgment.<sup>49</sup> Today, most courts steadfastly continue to follow the Fifth Circuit view and hold that ERISA preempts any state tort or contract claim which in any way arises from a health coverage determination—even if the denial was based on an allegedly negligent exercise of medical judgment.

In light of more recent Supreme Court decisions delimiting the scope of ERISA preemption, however, the issue becomes whether preemption should continue to be extended to cases arising from denials based on determinations of medical necessity.<sup>50</sup> Indeed, under an emerging view of preemption, courts may find that ERISA does not preempt tort actions challenging a managed care plan's failure to use reasonable care when making medical decisions, or other tort actions constituting state regulation of the quality of health care. If this view of ERISA preemption is valid—thereby opening the door to at least some lawsuits that arise from coverage denials that result in harm—the issue then

---

48. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); see also *infra* notes 65-75 and accompanying text.

49. See *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992); *infra* notes 77-93 and accompanying text.

50. These developments include a trilogy of Supreme Court cases which, among other things, have prompted lower courts to take a more pragmatic or purposive approach to preemption rather than viewing ERISA as broadly preempting any state law with any "relation to" ERISA plans. Additionally, lower courts have modified their approach to the question of preemption of state common law tort actions against managed care plans by recognizing that actions challenging the quality of medical care are not preempted. However, courts have continued to follow *Corcoran* and thus continue to find that ERISA precludes tort suits challenging the *quality* of a UR decision that medical care or treatment recommended by a treating physician is not "medically necessary"—because those actions also involve a benefit determination and thus challenge the *quantity* of benefits received as well. Importantly, the defendant in such cases generally would be the managed care organization or an entity that engages in UR, and not the ERISA plan or the employer.

becomes whether a federal amendment to ERISA is necessary. Before addressing those questions, however, it is first helpful to review why lower courts so readily extended ERISA preemption to state tort actions seeking damages for injuries caused by allegedly negligent coverage denials based on conduct involving an exercise of medical judgment.

### III. PREEMPTION OF STATE LAW CHALLENGES ARISING FROM COVERAGE DENIALS

Understanding why ERISA has been construed as preempting all state common law suits arising in any way from a coverage denial requires an understanding of the Supreme Court's early preemption cases, especially *Pilot Life Insurance Co. v. Dedeaux*,<sup>51</sup> as well as an understanding of the Fifth Circuit's landmark decision in *Corcoran v. United Healthcare, Inc.*,<sup>52</sup> which extended ERISA preemption to state tort actions seeking damages for injuries caused by allegedly negligent coverage denials based on conduct involving an exercise of medical judgment. Importantly, *Corcoran* was decided at a time when the Supreme Court precedent suggested an expansive and practically unlimited view of ERISA preemption.<sup>53</sup>

#### A. *Pilot Life and the Traditional Broad View of ERISA Preemption*

ERISA was enacted in 1974 to protect the interests of participants and their beneficiaries in employee benefit plans, primarily by establishing standards for disclosure and reporting, and various fiduciary responsibilities.<sup>54</sup> Congress included a preemption provision to ensure uniform regulation of plans administered in more than one state, arguably because this would facilitate the formation and maintenance of plans.<sup>55</sup> Section 514(a) of ERISA ("§ 514(a)") prescribes that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ."<sup>56</sup> While the full

---

51. 481 U.S. 41 (1987).

52. 965 F.2d 1321, 1334 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992).

53. *See infra* notes 54-75 and accompanying text.

54. *See* 29 U.S.C. § 1001(b) (1994).

55. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9-11 (1987).

56. 29 U.S.C. § 1144(a) (1994).

scope of ERISA preemption is modified by the savings and deemer clauses,<sup>57</sup> the outer boundary of ERISA preemption is guided by the “relates to” language.

The history of ERISA preemption and the early Supreme Court construction of the “relates to” language has been well chronicled, and there is no need for an expansive treatment of the subject in this Article.<sup>58</sup> It is sufficient to emphasize a few key points about how courts viewed ERISA preemption at the time *Corcoran* was decided. Prior to 1995, Supreme Court cases broadly interpreted the phrase “relates to” as encompassing any state law that had “a connection with or reference to” an ERISA plan.<sup>59</sup> The Court had stated that ERISA preemption extends beyond state laws specifically directed at employee benefit plans or laws dealing with the subject matters covered by ERISA<sup>60</sup> to reach even state laws that are consistent with ERISA’s purpose.<sup>61</sup> The Court left room for some limitation on the breadth of ERISA preemption by noting that preemption would not result if a state law has only a “tenuous, remote, or peripheral” connection with covered plans.<sup>62</sup> However, until 1995, when the Supreme Court decided *New York State Conference of Blue Cross & Blue Shield Plans v.*

57. ERISA’s savings clause exempts from preemption any law that regulates insurance, banking, or securities. 29 U.S.C. § 1144(b)(2)(A) (1994). ERISA’s deemer clause modifies the savings clause by prescribing that employee benefit plans may not be characterized as an insurance company and regulated by the state through insurance laws. 29 U.S.C. § 1144(b)(2)(B) (1994). Because of the savings clause, states can regulate health care coverage to some extent through insurance reform. However, the deemer clause limits the reach of such reforms by precluding application of insurance laws to self-insured plans. For a discussion of how the savings clause could be applied to permit greater regulation of health care coverage concerns, see Karen A. Jordan, *ERISA Pre-emption: Integrating Fabe into the Savings Clause Analysis*, 27 RUTGERS L. J. 273-342 (1996).

58. See generally Jordan, *supra* note 12. See also Peter D. Jacobson & Scott D. Pomfret, *Form, Function, and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence*, 35 HOUS. L. REV. 985 (1998); Vicki Lawrence MacDougall, *The “Shared Risk” of Potential Tort Liability of Health Maintenance Organizations and the Defense of ERISA Preemption*, 32 VAL. U. L. REV. 855 (1998); Karla S. Bartholomew, Note, *ERISA Preemption of Medical Malpractice Claims in Managed Care: Asserting a New Statutory Interpretation*, 52 VAND. L. REV. 1131 (1999).

59. *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990); *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 96-97 (1983). See generally Daniel A. Engel, *ERISA: Where’s the Preemption Now?*, 27 TORT & INS. L. J. 523-54 (1992).

60. *FMC Corp.*, 498 U.S. at 58-59 (limiting the preemption clause to state laws imposing reporting, disclosure, and fiduciary duties would be incompatible with Congress’s rejection of both House and Senate bills that contained such a limitation).

61. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990) (citing *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985)); *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 829 (1988) (ERISA preempted state garnishment statute even though it was enacted to help effectuate ERISA’s underlying purposes).

62. See *Shaw*, 463 U.S. at 100.

*Travelers Insurance Co.*,<sup>63</sup> its decisions shed little light on the outer bounds of the phrase “relates to.”<sup>64</sup>

Because the phrase “state laws” includes judicial decisions, the Supreme Court had held, in *Pilot Life Insurance Co. v. Dedeaux*,<sup>65</sup> that ERISA preempts state common law tort and contract claims arising out of improper processing of claims for benefits and brought against ERISA plans or their administrators.<sup>66</sup> In *Pilot Life*, the defendant administered the employee disability benefit plan for Dedeaux’s employer. After Dedeaux became disabled in a work-related accident, Pilot Life Insurance Company approved, terminated, and then reinstated Dedeaux’s disability benefits several times. With little discussion, the Court held that Dedeaux’s state law claims for tortious breach of contract, breach of fiduciary duties, and fraud “related to” ERISA plans and were preempted.<sup>67</sup>

However, in assessing whether Dedeaux’s claims were exempt from preemption by the insurance savings clause,<sup>68</sup> the Court explained that saving the state claims would be inconsistent with ERISA Section 502(a) (“§ 502(a”).<sup>69</sup> Section 502(a) is ERISA’s civil enforcement provision. Section 502(a) sets forth a comprehensive scheme regulating who may bring a civil enforcement action and the type of actions which may be brought.<sup>70</sup> Section 502(a) of ERISA has come to play a significant role in determining the scope of ERISA preemption

63. 514 U.S. 645 (1995).

64. Only two Supreme Court cases prior to *Travelers* involved state laws that the Court held did not “relate to” ERISA plans. See *Mackey*, 486 U.S. at 833-41 (holding that ERISA does not bar a state garnishment proceeding against the plan, even though the proceeding would inflict substantial burdens on the plan administrator because ERISA prescribes that plans may sue and be sued, but does not prescribe a method for execution of judgments); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 4 (1987) (holding that ERISA did not preempt a state law requiring employers to provide a one-time severance payment to employees because, although the law related to benefits, it did not relate to a “benefit plan”).

65. 481 U.S. 41 (1987).

66. See, e.g., *Pilot Life*, 481 U.S. at 44 (holding that ERISA preempted tort and contract claims based on allegedly improper processing of a claim for benefits under an insured plan); *Ingersoll-Rand*, 498 U.S. at 145 (holding that ERISA preempted a common law claim for wrongful discharge). At the same time, ERISA contains virtually no substantive regulation of health or welfare plans, thereby creating a regulatory vacuum which in reality often fails to protect plan participants and beneficiaries. See generally William K. Carr & Robert L. Liebross, *Wrong Without Rights: The Need for a Strong Federal Common Law of ERISA*, 4 STAN. L. & POL’Y REV. 221-29 (1992-93); Norman Stein, *ERISA and the Limits of Equity*, 56 LAW & CONTEMP. PROBS. 71-110 (1993).

67. *Pilot Life*, 481 U.S. at 44.

68. See *supra* note 57.

69. See *Pilot Life*, 481 U.S. at 57.

70. Other subsections set forth details such as whether the plan may sue or be sued, jurisdiction and venue, attorney’s fees and costs, etc. See 29 U.S.C. §§ 1132(d), (e)(1), (e)(2), (g) (1994).

of state common law claims.<sup>71</sup> In addition to *Pilot Life*, other Supreme Court cases have looked to § 502(a) in determining the scope of ERISA preemption.<sup>72</sup> As in *Pilot Life*, the Supreme Court has held certain state common law causes of action preempted when the actions were used to challenge conduct regulated by ERISA, or to pursue a remedy authorized by ERISA.<sup>73</sup> In such cases, the Court has viewed the state tort or contract action as being inconsistent with § 502(a) because the action was being used by the plan participant as an alternative means of enforcing ERISA.<sup>74</sup>

After *Pilot Life*, lower courts readily held that ERISA preempted state law contract and tort claims brought by plan participants or beneficiaries against health care providers or plan administrators, or brought by health care providers against plan administrators.<sup>75</sup> Often, preemption was found merely because of a trickle-down economic effect on ERISA plans.<sup>76</sup> Lower courts could reach that conclusion only by drawing upon the Supreme Court's generally broad approach to ERISA preemption. It was in this context that the United States Court of Appeals for the Fifth Circuit held, in *Corcoran v. United Healthcare, Inc.*, that

71. See, e.g., *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 354-55 (3d Cir.), cert. denied, 516 U.S. 1008 (1995). See also *infra* notes 179-92 and accompanying text.

72. See, e.g., *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 145 (1990) (holding that ERISA preempted a Texas common law cause action for wrongful termination to preclude access to employee benefits because ERISA itself authorizes a civil suit arising from such a scenario).

73. *Id.* (holding preempted a Texas common law action for wrongful discharge arising out of an employer's desire to avoid contributing to or paying benefits under the employee's pension fund because ERISA regulates such conduct).

74. Accordingly, the Court later explained that such state laws had been found preempted because the laws constituted an "alternative enforcement mechanism." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995).

75. Various rationales have been used by lower courts in finding that ERISA preempted state law claims: (1) the claim is really a claim for benefits or a claim for improper processing of the claim, see, e.g., *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1332 (5th Cir. 1992); (2) the claim effects plans by causing pass-through costs that will result in the plan having to choose between higher costs or a reduction in benefits, see, e.g., *Ricci v. Goberman*, 840 F. Supp. 316, 318 (D.N.J. 1993); (3) the claim regulates the administration of the plan, see, e.g., *Dearmas v. Av-Med, Inc.*, 865 F. Supp. 816, 818 (S.D. Fla. 1994); (4) the claim arises from the provision of benefits pursuant to an ERISA plan, see, e.g., *Dukes v. United States Health Care Sys., Inc.*, 848 F. Supp. 39, 42-43 (E.D. Pa. 1994), *rev'd on other grounds*, 57 F.3d 350 (3d Cir.), cert. denied, 516 U.S. 1009 (1995); or (5) the claim requires an examination of plan documents, see, e.g., *Nealy v. H.S. Healthcare HMO*, 844 F. Supp. 966, 972-73 (S.D.N.Y. 1994). In cases involving contract or tort claims, courts often use several of these rationales. See, e.g., *Nealy*, 844 F. Supp. at 966.

76. See, e.g., *Ricci v. Goberman*, 840 F. Supp. 316, 318 (D.N.J. 1993) (finding preemption because trickle-down economic effect of the law might cause employers to reduce benefits or to refrain from creating plans).

ERISA preempts a state law wrongful death action brought to recover damages arising out of a denial of coverage involving an exercise of medical decision making.

### B. *The Corcoran Decision*

*Corcoran* involved a claim by Florence and Wayne Corcoran for damages resulting from the alleged negligence of a company hired to conduct UR. Florence obtained her health coverage through a self-funded ERISA benefit plan which was administered by Blue Cross and Blue Shield of Alabama.<sup>77</sup> The plan had a UR program that required participants and beneficiaries to obtain pre-certification for overnight hospital admissions and certain other medical procedures.<sup>78</sup> United Healthcare agreed to perform UR services for Blue Cross.<sup>79</sup>

Due to her high risk pregnancy, Florence's obstetrician ordered her hospitalized as her delivery date neared so that the fetus could be monitored around the clock. The obstetrician sought pre-certification from United. United disagreed with the obstetrician's recommendation for hospitalization and instead authorized ten hours per day of home nursing care. During a period when no nurse was on duty, the unborn child went into distress and died.<sup>80</sup> The Corcorans brought a wrongful death action against United, alleging that United negligently denied the medical care recommended by Florence's obstetrician and negligently determined that home nursing care was adequate for her condition.<sup>81</sup>

The Corcorans argued that their claim was not preempted by ERISA because they were challenging a medical decision made by United, not merely an administrative decision about benefit entitlements.<sup>82</sup> There was substantial evidence suggesting that United's contemplated role was to make independent medical judgments regarding the need for recommended health care. A booklet provided to plan members explained that the purpose of United's review was to "assess the need for surgery or hospitalization and to determine the appropriate length of stay for hospitalization, based on nationally accepted medical

---

77. *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1323 (5th Cir.), *cert. denied*, 506 U.S. 1033 (1992).

78. *Id.* The plan used both prospective and concurrent UR. This aspect of the plan was referred to as the "Quality Care Program." *Id.*

79. *Id.*

80. *Id.*

81. *Id.* at 1326. The Corcorans also named Blue Cross and Blue Shield as a defendant, but appealed only the district court's determination that their claim against United was preempted. Although not clear, this may have been due to a belief that the claim against Blue Cross was more clearly within the scope of ERISA preemption since Blue Cross administered the plan. However, under the view of preemption presented in this Article, the negligent acts of the plan administrator are not shielded from liability for that reason alone.

82. *Id.* at 1330.

guidelines.”<sup>83</sup> It further noted: “United’s staff includes doctors, nurses, and other medical professionals knowledgeable about the health care delivery system. Together with your doctor, they work to assure that you and your covered family members receive the most appropriate medical care.”<sup>84</sup> Indeed, the Fifth Circuit agreed that United made medical decisions.<sup>85</sup>

Nonetheless, the Fifth Circuit held that the Corcorans’ action was preempted by ERISA because the medical decision was made in the context of a benefits determination under an ERISA plan.

In our view, United makes medical decisions as part and parcel of its mandate to decide what benefits are available under the [ERISA] plan . . . . When United’s actions are viewed from this perspective, it becomes apparent that the Corcorans are attempting to recover for a tort allegedly committed in the course of handling a benefit determination. The nature of the benefit determination is different than the type of decision that was at issue in *Pilot Life*, but it is a benefit determination nonetheless. The principle of *Pilot Life* that ERISA preempts state-law claims alleging improper handling of benefit claims is broad enough to cover the cause of action asserted here.<sup>86</sup>

Thus, the Fifth Circuit viewed ERISA preemption, as construed in *Pilot Life*, as insulating from liability all aspects of any benefit determination.

Notably, the *Corcoran* court supported its finding of preemption by noting the financial impact on ERISA plans that might occur if the Corcorans’ suit were allowed to proceed. The court explained that a holding that the action was not preempted would create a “significant risk that state liability rules would be applied differently to the conduct of utilization review companies in different states.”<sup>87</sup> According to the court, that would in turn cause a financial impact on

83. *Id.* at 1323 (quoting from a booklet providing a more complete description of United’s Quality Care Program, under the heading: “What QCP Does”).

84. *Id.* at 1324 (quoting from United’s Quality Care Program, under a paragraph headed: “Independent, Professional Review”).

85. *Id.* at 1331. The court stated: “[W]e conclude that United makes medical decisions—indeed, United gives medical advice . . . .” *Id.* (citing Robert C. Macaulay, Jr., *Health Care Cost Containment and Medical Malpractice: On a Collision Course*, 21 SUFFOLK U. L. REV. 91, 106-07 (1986) (noting that an adverse prospective determination on medical necessity involves “complex medical judgment”).

86. *Id.* at 1332.

87. *Id.* at 1333. The court apparently viewed possible liability, stating: It is foreseeable that state courts, exercising their common law powers, might develop different substantive standards applicable to the same employer conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. Such an outcome is

ERISA plans: “The cost of complying with varying substantive standards would increase the cost of providing utilization review services, thereby increasing the cost to health benefit plans of including cost containment features . . . (or causing them to eliminate this sort of cost containment program altogether) and ultimately decreasing the pool of plan funds available to reimburse participants.”<sup>88</sup>

The court also expressly rejected the Corcorans’ argument that their state law tort claim involved the regulation of medical decision making, an area traditionally reserved for state regulation. The court noted: “we [are] ‘not convinced’ that the traditional or nontraditional nature of the state law properly bears upon the initial question whether it is pre-empted by § 514(a), because the distinction [has] no support in the statutory language.”<sup>89</sup> Thus, the court gave little if any weight to the presumption against preemption of state laws involving the exercise of traditional state authority.

Further, in addition to holding that the Corcorans’ state law claims were preempted, the court rejected the alternative argument that the Corcorans were entitled to recover damages under § 502(a)(3) of ERISA.<sup>90</sup> The court found that the type of damages the Corcorans sought, money for emotional injuries,<sup>91</sup> would not be available under the trust and contract law principles governing the issue.<sup>92</sup> The court, however, was troubled by the prospect of leaving the Corcorans without a remedy. The court concluded the opinion by noting:

---

fundamentally at odds with the goal of uniformity that Congress sought to implement.

*Id.*

88. *Id.* Notably, although the court also purported to support its finding of preemption on the basis of the objectives underlying ERISA preemption, its logic faltered. The court noted that allowing the suit to proceed would interfere with Congress’s goal of ensuring that plans and plan sponsors would be subject to a uniform body of law. However, the court quoted a Supreme Court passage that only expressed concern regarding the imposition of varying state substantive standards on “employer” conduct—not the conduct of a UR entity providing services for an ERISA plan. Thus, the preemption holding was supported only by the potential economic impact.

89. *Id.* at 1334 (citing *Sommers Drug Employee Profit Sharing Trust v. Corrigan Enters., Inc.*, 793 F.2d 1456, 1468 (5th Cir. 1986), *cert. denied*, 479 U.S. 1034 (1987)).

90. *Id.* at 1335. That is, the Corcorans argued in the alternative that if their state law claims were preempted, they had stated a claim under § 502 of ERISA, ERISA’s civil enforcement provision. Section 502(a)(3) authorizes suits to obtain “other appropriate equitable relief” to redress violations of, or to enforce, any provisions of ERISA or of the terms of a plan. *See* 29 U.S.C. § 1132(a) (1994).

91. *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1324 (5th Cir.), *cert. denied*, 506 U.S. 1033 (1992). The Corcorans sought damages for the lost love, society, and affection of their unborn child. Additionally, Florence sought damages for the aggravation of a pre-existing depressive condition and the loss of consortium caused by the aggravation, and Wayne sought damages for loss of consortium. *Id.*

92. *Id.* at 1335.



While we are confident that the result we have reached is faithful to Congress' intent neither to allow state-law causes of action that relate to employee benefit plans nor to provide beneficiaries in the *Corcorans'* position with a remedy under ERISA, the world of employee benefit plans has hardly remained static since 1974. Fundamental changes such as the widespread institution of utilization review would seem to warrant a reevaluation of ERISA so that it can continue to serve its noble purpose of safeguarding the interests of employees. Our system, of course, allocates this task to Congress, not the courts, and we acknowledge our role today by interpreting ERISA in a manner consistent with the express intentions of its creators.<sup>93</sup>

Thus, the court's harsh stance was grounded in its conviction that, because of the expansive scope of ERISA preemption, the *Corcorans'* state law cause of action was barred. However, that conviction was premised on the court's belief that (1) *Pilot Life* mandated preemption of any claim arising from any aspect of the benefit determination process, (2) allowing the claim to proceed would have a trickle-down financial effect on ERISA plans caused by increased costs associated with providing UR, (3) the presumption against preemption was not applicable in ERISA cases, and (4) any delimitation on the scope of preemption was solely within the province of Congress.

### C. Most Courts Steadfastly Continue to Follow *Corcoran*

In the years since the Fifth Circuit decided *Corcoran*, lower courts have steadfastly followed its reasoning, thereby creating—until very recently—an impenetrable barrier for ERISA plan participants and beneficiaries who have been harmed by coverage decisions made by managed care plans. For example, in *Tolton v. American Biodyne, Inc.*,<sup>94</sup> the Sixth Circuit followed *Corcoran* and held that ERISA preempted wrongful death and medical malpractice claims brought against an HMO that refused to authorize certain psychiatric benefits to Henry Tolton prior to his suicide because the HMO determined that the treatment was unnecessary.<sup>95</sup> The court, like others, simply viewed *Corcoran* as governing the issue. Moreover, lower courts have continued to follow *Corcoran* even after recent Supreme Court and courts of appeals decisions which, as explained in the next section, have greatly undermined *Corcoran's* reasoning. For example, in *Hull v. Fallon*,<sup>96</sup> the Eighth Circuit in 1999 followed *Corcoran* and held that ERISA preempted a state tort claim against a managed care plan challenging the plan administrator's decision that a thallium stress test

---

93. *Id.* at 1338-39.

94. 48 F.3d 937 (6th Cir. 1995).

95. *See* 48 F.3d 937 (6th Cir. 1995).

96. 188 F.3d 939 (8th Cir. 1999).

recommended by the treating physician was not necessary, and authorizing a treadmill test instead.<sup>97</sup> Other cases reinforce the continued adherence to *Corcoran*.<sup>98</sup>

Unfortunately, many courts have elected to follow *Corcoran* without independent analysis of the continued soundness of the reasoning used by the *Corcoran* court. One exception is the decision in *Corporate Health Insurance Inc. v. Texas Department of Insurance*,<sup>99</sup> in which a federal district court held that ERISA does not preempt a Texas legislative provision that authorizes civil suits against managed care entities. The managed care entities' strongest argument supporting preemption was the fact that the civil action authorized by the statute constituted a state common law suit akin to the suit in *Corcoran*, thereby warranting preemption. The court in *Corporate Health* expressly opined that, if decided today, *Corcoran* would "perhaps be decided differently."<sup>100</sup> Nonetheless, the court felt compelled to remain consistent with *Corcoran* and thus construed the Texas provision as authorizing a suit distinguishable from that at issue in *Corcoran*.<sup>101</sup>

97. *Id.* at 943; *see also* *Thompson v. Gencare Health Sys., Inc.*, 202 F.3d 1072 (8th Cir. 2000).

98. *See, e.g.*, *Parrino v. FHP, Inc.*, 146 F.3d 699, 704-05 (9th Cir. 1998) (holding preempted state law claims arising from a managed care entity's alleged wrongful initial denial of coverage for proton beam therapy upon a UR finding that the treatment was experimental and unnecessary); *Turner v. Fallon Community Health Plan*, 127 F.3d 196, 200 (1st Cir. 1997) (holding preempted a state law claim that a managed care entity wrongfully denied coverage for a type of bone marrow transplant and high dose chemotherapy treatment (although this case may not have given rise to a tort claim)); *Huss v. Green Spring Health Servs.*, 18 F. Supp. 2d 400, 405 (D. Del. 1998) (holding preempted a state tort claim that a managed care plan negligently failed to verify coverage and refused to cover treatment for a psychiatric disorder); *Benoit v. Grainger, Inc.*, No. 98-1315, 1998 WL 749444, at \*3 (E.D. La. Oct. 21, 1998) (holding preempted a medical malpractice claim against an HMO challenging the HMO's allegedly negligent initial decision not to authorize immediate surgery for the plaintiff following a motorcycle accident); *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 54-55 (D. Mass. 1997) (holding preempted claims that a managed care entity repeatedly and negligently refused to authorize inpatient rehabilitation and detoxification treatment).

99. 12 F. Supp. 2d 597 (S.D. Tex. 1998).

100. *Id.* at 617.

101. *Id.* The Texas provision authorizes individuals to sue managed care entities for damages proximately caused by the entity's failure to exercise ordinary care when making a health care treatment decision. *Id.* at 602. The statute defines "health care treatment decision" as "a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees." *Id.* at 617 (quoting TEX. CIV. PRAC. & REM. CODE ANN. § 88.001(5) (West 1998)). The court in *Corporate Health* construed the Act as authorizing a suit challenging the "quality" of medical care received (e.g., a direct or vicarious claim arising from provider malpractice); and thus as authorizing a suit distinguishable from a *Corcoran*-type claim which arises because

Even courts that strongly believe that the result in *Corcoran* was unjustifiably inequitable have felt constrained to follow *Corcoran*. In *Andrews-Clarke v. Travelers Insurance Co.*,<sup>102</sup> Judge Young of the United States District Court for the District of Massachusetts made an impassioned plea for congressional attention to the problem of ERISA preemption.<sup>103</sup> The case involved a managed care entity's repeated denials of coverage for inpatient rehabilitation and detoxification treatment for an individual covered by an ERISA plan. The court noted

[Clarke's] policy expressly provided coverage for certain medical and psychiatric treatments, including enrollment in a thirty-day inpatient alcohol detoxification and rehabilitation program. Doctors at several hospitals, and even the courts of the Commonwealth of Massachusetts, determined that Clarke was in need of such treatment, but the insurer and its agent, the utilization review provider, repeatedly and arbitrarily refused to authorize it.<sup>104</sup>

The plaintiff's suit included, among other claims, a negligence claim challenging the managed care plan's "failure to diagnose the severity of Clarke's condition

coverage for recommended medical care has been denied and the patient is injured as a consequence of not receiving the recommended care.

102. 984 F. Supp 49 (D. Mass. 1997).

103. Judge Young stated: "Under any criterion . . . the shield of near absolute immunity now provided by ERISA simply cannot be justified." *Id.* at 63. Judge Young also stated:

A more efficient approach is to allow insurers and utilization review providers to make benefit determination on a case-by-case basis, but hold them legally accountable for the consequences of their decisions. By ensuring that bad medical judgments made during the utilization review process do not 'end up being cost-free to the plans that rely on [UR] to contain medical costs,' plan administrators will have more incentive to 'seek out those [UR providers] that can deliver both high quality services and reasonable prices.'

*Id.* at 62. Judge Young further stated:

Unfortunately, to date, 'ERISA [has proven] an excellent example of the classic observation that it is a great deal more difficult for Congress to correct flawed statutes than it is to enact them in the first place . . . because interests coalesce around the advantageous aspects of the status quo.' Although the alleged conduct of Travelers and Greenspring in this case is extraordinarily troubling, even more disturbing to this Court is the failure of Congress to amend a statute that, due to the changing realities of the modern health care system, has gone conspicuously awry from its original intent.

Does anyone care?

Do you?

*Id.* at 64-65.

104. *Id.* at 52.

during the utilization review process.”<sup>105</sup> Despite the judge’s deep conviction that preemption was unjust, the court nonetheless followed *Corcoran* and held the claims preempted because the claims—including the malpractice claim—“go right to the heart of the benefit determination process.”<sup>106</sup>

Importantly, and despite the definite tendency of lower courts to continue following *Corcoran*’s rationale, at least one federal court has moved in the opposite direction due to recent Supreme Court and courts of appeals decisions which arguably narrow the scope of preemption. In *Moscovitch v. Danbury Hospital*,<sup>107</sup> state law claims were brought against Physician Health Services (“PHS”), the entity that administered the group medical plan covering the plaintiff’s son. PHS first authorized admission for the plaintiff’s son to Danbury Hospital after two suicide attempts; but seven days later terminated the inpatient coverage and required the child to be transferred to Vitam Center, an allegedly inappropriate facility because Vitam was only prepared to treat adolescents with substance abuse problems.<sup>108</sup> The plaintiff’s son committed suicide on the day of the transfer. The plaintiff’s complaint included direct and vicarious tort claims against PHS.<sup>109</sup> In finding that ERISA did not preempt the claims, the court focused on the fact that the claims challenged the appropriateness of the medical and psychiatric decisions of PHS. The court noted: “[The claim] does not assert that PHS was making wrong decisions about whether certain care would be covered by its plan, but instead challenges the decision made by PHS with respect to the quality and appropriate level of care and treatment for the decedent.”<sup>110</sup> Thus, although the claim at issue clearly also could have been characterized as arising from the denial of further coverage for inpatient hospital care, the court decided that the fact that the claim challenged a medical care decision pulled it outside the reach of ERISA preemption.<sup>111</sup>

The *Moscovitch* case clearly raises the question whether, in light of more recent precedent, ERISA preemption should continue to be extended to cases

105. *Id.* at 56 n.23.

106. *Id.* at 58 (“As all of her common law claims arise out of denial of benefits under an ERISA plan, they fall squarely within the scope of ERISA’s civil enforcement provision, section 502(a) . . .”).

107. 25 F. Supp. 2d 74 (D. Conn. 1998); *see also infra* notes 207-09 and accompanying text (discussing further the analysis used in this decision).

108. *Id.* at 76. Claims were also brought against Danbury Hospital and Vitam Center, Inc.

109. *Id.* The claims against PHS in the plaintiff’s original complaint were grounded in state statutory provisions. The plaintiff amended the complaint to include, against PHS, only state common law tort theories grounded in direct and vicarious liability. *Id.* at 77.

110. *Id.* at 80. The court pointed to allegations that PHS failed to properly diagnose and assess the decedent’s psychiatric condition, failed to properly monitor, care, and treat him, and failed to properly oversee his treatment. *Id.*

111. *Id.* at 81-82.

arising from denials based on determinations of medical necessity. If this view of ERISA preemption is valid, the courthouse door will be opened to at least some lawsuits that arise from coverage denials that result in harm, thereby raising the issue of whether a federal amendment to ERISA allowing suits against managed care plans is necessary. Accordingly, the issues to be considered are (1) whether the approach to preemption used by the court in *Moscovitch* is sound and (2) if so, to what extent does that approach to preemption eviscerate the preemption problem for ERISA plan participants and beneficiaries. Before addressing those issues, however, it is useful to understand the basics of the federal provisions passed by the House.

#### IV. THE FEDERAL LEGISLATIVE SOLUTION: THE NORWOOD-DINGELL PROVISIONS

On October 7, 1999, the House passed a managed care reform bill sponsored by Representatives Charlie Norwood (R-Ga.) and John Dingell (D-Mich.).<sup>112</sup> The Norwood-Dingell bill includes provisions that would exempt from ERISA preemption state law claims against managed care plans by patients injured by denials of or delays in medical care. The Norwood-Dingell bill was selected over three other bills that emerged in the final weeks before the House vote.<sup>113</sup> Those bills also contained provisions allowing suits against managed care plans, but would have limited the scope of claims allowed.<sup>114</sup> In contrast, the Norwood-Dingell provisions are notable for their breadth, although they include some restrictions which are described in the following paragraphs. The Norwood-Dingell bill amends § 514 of ERISA by adding a subsection which states that:

[N]othing in this title shall be construed to invalidate, impair, or supersede any cause of action by a participant or beneficiary . . . under State law to recover damages resulting from personal injury or for wrongful death against any person—(i) in connection with the provision of insurance, administrative services, or medical services by

---

112. See H.R. 2723, 106th Cong. (1999). The bill is titled “Bipartisan Consensus Managed Care Improvement Act of 1999.” H.R. 2723 § 1(a). After passage of the Norwood-Dingell bill, the House passed a Republican package of tax breaks and insurance reforms designed to increase access to health care coverage. Following that vote, the Norwood-Dingell bill was merged with the access bill. The combined bill kept the bill number of the access measure. See *GOP Leaders Fail to Name Norwood*, *supra* note 9, at d3.

113. Alternative bills were offered by Tom Coburn (R-Okla.) and John Shadegg (R-Ariz), H.R. 2824, 106th Cong. (1999) (the Coburn-Shadegg bill); by Amo Houghton (R-N.Y.), H.A. 515, 106th Cong. (1999); and by John Boehner (R-Ohio), H.R. 2926, H.R. 2089, 106th Cong. (1999).

114. See *infra* notes 121-24 and accompanying text.

such person to or for a group health plan, or (ii) that arises out of the arrangement by such person for the provision of such insurance, administrative services, or medical services by other persons.<sup>115</sup>

Thus, the bill does not attempt to delimit in any way the types of state law claims that are exempt from preemption, or the type of conduct that could give rise to a claim.<sup>116</sup> An action could arise from any aspect of a managed care plan's operation, *e.g.*, providing health insurance benefits, administering health benefit plans, providing medical services pursuant to a plan, or arranging any of these services. Further, by authorizing suits against "any person," any managed care plan or UR entity could be held liable, regardless of its organizational structure, as long as the plan provides services for an ERISA plan.<sup>117</sup>

Therefore, the liability provisions in the Norwood-Dingell bill would eliminate, in part, the preemption problem posed by *Corcoran*. As explained, courts have steadfastly followed *Corcoran*'s view that any claim intertwined with a benefit determination is preempted.<sup>118</sup> The Norwood-Dingell bill would represent an explicit statement by Congress that ERISA does not preempt suits arising from coverage denials that result in personal injury or wrongful death. Moreover, the Norwood-Dingell bill would do more than eviscerate the impact of *Corcoran*. All suits arising from coverage denials would be free from the constraints of ERISA preemption—not just those involving an exercise of medical judgment. Thus, state law actions arising from both categories of coverage denials would be permitted, and claims akin to those in the Johnson and Goodrich cases could be brought by ERISA plan participants and beneficiaries.

At the same time, the preemption problem is only partially eliminated because the Norwood-Dingell bill contains a significant restriction on the availability of punitive damages. The bill provides that the plan would not be

115. See H.R. 2723 § 302(a) (amending § 514 of ERISA by adding § 514(e)(1)(A)(i)-(ii)).

116. Further, House Bill 2723 would not require ERISA plan participants and beneficiaries to exhaust the plan's administrative process where the injury or death occurred before completion of the process. H.R. 2723 § 302(a) (amending § 514 of ERISA by adding § 514(e)(3)).

117. The provision uses the definition of group health plan established in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). HIPAA defines group health plan as an employee welfare benefit plan to the extent the plan provides medical care to employees or their dependents directly or through insurance, reimbursement, or otherwise. See 29 U.S.C. § 1191b(a)(1) (Supp. III 1997). The bill appropriately notes that the provision generally does not authorize any cause of action or any right of indemnity against "an employer or other plan sponsor maintaining the group health plan (or against an employee of such employer)." H.R. 2723 § 302(a) (amending § 514 of ERISA by adding § 514(e)(2)(B)(i)-(ii)); see also *infra* note 234 and accompanying text.

118. See *supra* notes 94-106 and accompanying text.

liable for punitive damages if the claim relates to an “externally appealable decision”; the external appeal was initiated in a timely manner and completed; and the plan complied with the determination resulting from the external appeal.<sup>119</sup> Under the bill, an “externally appealable decision” is a coverage denial arising from conduct involving an exercise of medical judgment.<sup>120</sup> Thus, although ERISA plan participants and beneficiaries with claims akin to those in the Johnson and Goodrich cases could bring suit, they would be limited to compensatory damages.

Whether the Norwood-Dingell bill has struck the right balance as a matter of health policy is explored in Part VI of this Article. As noted, other bills advanced in the House would have restricted even further the liability of managed care plans. One bill would have allowed suits against managed care plans only upon a showing of “substantial harm,” and would have restricted punitive damages to cases where the managed care plan showed “conscious, flagrant indifference to the rights or safety of others.”<sup>121</sup> Further, the bill would have limited noneconomic damages to the lesser of \$500,000 or twice the economic damages, while punitive damages would have been capped at the greater of \$250,000 or twice the economic damages.<sup>122</sup> The bill also would have imposed court costs on the plan participant or beneficiary if an external review board ruled that the patient was not actually injured and the patient sued anyway.<sup>123</sup> Another bill would have allowed lawsuits only against the person making the “sole final decision” to deny care and would have banned punitive damages altogether if the plan’s denial of coverage was upheld by the external reviewers.<sup>124</sup>

Because the Norwood-Dingell bill passed by a substantial margin, despite the availability of more limited liability options, it might seem as though the House membership broadly supports substantially curtailing the scope of ERISA preemption with regard to state common law claims against managed care plans. In reality, the future of the bill is uncertain for two key reasons. First, the Norwood-Dingell bill never won the support of House leadership, and thus

119. H.R. 2723 § 302(a) (amending § 514 of ERISA by adding § 514(e)(1)(B)(i)-(iv)).

120. The term is defined as:

[A] denial of claim for benefits . . . (i) that is based in whole or in part on a decision that the item or service is not medically necessary or appropriate or is investigational or experimental; or (ii) in which the decision as to whether a benefit is covered involves a medical judgment.

H.R. 2723 § 103(a)(2).

121. *See Plan Regulation: Norwood-Dingell Managed Care Bill Sails Through House in Massive Bipartisan Vote*, HEALTH CARE DAILY (BNA), Oct. 8, 1999, at d2, available in WL 10/8/1999 HCD d2 (describing the Coburn-Shadegg bill).

122. *Id.*

123. *Id.*

124. *Id.* (describing the Houghton amendment).

conference committee members from the House may not fight to save the provision.<sup>125</sup> Second, the managed care legislation passed in the Senate does not expand a patient's right to sue a plan, and the Senate legislation is significantly different in other respects as well.<sup>126</sup> Predictions of difficult negotiations make it far from clear that the House provision will survive the conference committee process.<sup>127</sup> Accordingly, as noted in Part I, while one purpose of this Article is to contribute to the debate regarding the need for a federal amendment to ERISA, another purpose is to provide guidance to courts and litigants regarding the proper preemption analysis in the event the House bill does not survive the conference process.

## V. GIVEN THE EMERGING VIEW OF PREEMPTION, IS FEDERAL LEGISLATION NECESSARY?

The House provision addresses the problem posed by *Corcoran*, namely the preemption of all state law claims, by ERISA plan participants or beneficiaries, against a managed care plan arising out of a denial of coverage. However, federal legislation may not be necessary if the approach used by the court in *Moscovitch* is sound. Subparts V(A) and V(B) therefore assess the soundness of arguments that recent precedent has greatly undermined the reasoning used by the Fifth Circuit in *Corcoran*. The analysis concludes that the *Moscovitch* approach is sound. But the analysis does not end there. Even if the *Moscovitch* approach is sound, it is essential to analyze the extent to which the emerging view of preemption will allow courts to deviate from *Corcoran* and, ultimately, whether a federal amendment to ERISA is unnecessary. That is, the analysis must also consider whether *Corcoran*'s obstacle can be completely eviscerated or whether some state law claims against managed care plans will remain barred notwithstanding a narrower approach to preemption. The analysis shows that some claims arising from a coverage denial would remain preempted and, thus, a federal legislative solution may be preferable to the judicial solution.

### A. The Supreme Court Trilogy

Since 1995, the Supreme Court has decided several cases that have caused lower courts to approach the ERISA preemption analysis differently than when

125. Indeed, only one of the 13 Republican conferees actually voted for the Norwood-Dingell bill, although 68 Republicans in the House defied their leadership and voted for the bill. Interestingly, the House approved a motion to instruct the House conferees to "insist" on the Norwood-Dingell liability provisions during the conference with the Senate. However, the instruction is advisory only and thus is not binding on the conferees. See *GOP Leaders Fail to Name Norwood*, *supra* note 9, at d3.

126. See S. 1344, 106th Cong. (1999).

127. See *Norwood-Dingell Managed Care Bill*, *supra* note 121, at d2.



*Corcoran* was decided. Three cases are particularly noteworthy: *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, *California Division of Labor Standards Enforcement v. Dillingham Construction Inc.*, and *DeBuono v. NYS-ILA Medical & Clinical Services Fund*.<sup>128</sup> This trilogy of cases has prompted lower courts to take a more pragmatic or purposive approach to preemption, rather than simply viewing the language of § 514(a) as broadly preempting any state law with any “relation to” ERISA plans. The result has been a narrowing of the range of state laws that should be found to be within the scope of ERISA preemption.

### 1. The Narrowing of § 514(a) Preemption

The most significant case in the Supreme Court trilogy is *New York State Conference of Blue Cross & Blue Shield v. Travelers Insurance Co. Travelers*.<sup>129</sup> *Travelers* addressed preemption of New York’s inpatient hospital rate-setting system.<sup>130</sup> In upholding the state law, the Court shed substantial light on several aspects of the preemption analysis.<sup>131</sup> Foremost, the Court in *Travelers* stressed what lower courts had increasingly overlooked—that the resolution of preemption claims must be premised on a presumption against preemption, especially in cases where federal law would be supplanting state action in a field of traditional state regulation.<sup>132</sup>

128. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995); *California Div. of Labor Standards Enforcement v. Dillingham Constr. Inc.*, 519 U.S. 316 (1997); *DeBuono v. NYS-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997). Another important case is *Boggs v. Boggs*, 520 U.S. 833 (1997). See *infra* note 136 and accompanying text (discussing *Boggs*).

129. 514 U.S. 645 (1995).

130. New York’s rate-setting system establishes the rates that hospitals may charge various payers. Payers are categorized into three groups. The first group, including the state as payer for Medicaid, Blue Cross and Blue Shield plans, and HMOs, may be charged only a base “diagnostic-related” rate (“the DRG rate”). The second group, including some self-insured plans and commercial insurers, may be charged the DRG rate plus a 13% surcharge. The third group consisting of all other payers may be charged actual hospital charges up to a statutory limit of 120% of the rate charged payers in group two. See N.Y. PUBLIC HEALTH LAW § 2807-c (McKinney 1994).

131. For a more detailed discussion of a broad interpretation of the Court’s opinion in *Travelers*, see Jordan, *supra* note 12, at 255. For other perspectives of the *Travelers* decision, see generally Catherine L. Fisk, *The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 HARV. J. ON LEGIS. 35 (1996); Paul J. Ondrasik, *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.—Back to the Future?*, ERISA LITIG. REP., Fall 1995, at 4.

132. *Travelers*, 514 U.S. at 655. In *Travelers*, the Court noted:

[I]n cases like this one, where federal law is said to bar state action in fields of traditional state regulation, we have worked on the “assumption that the historic police powers of the States were not to be superseded by the Federal

The Court also moved away from its open-ended view of the scope of ERISA preemption. The Court noted that, although the “relates to” language of the preemption clause is clearly expansive, its meaning must be limited.<sup>133</sup> The Court then observed that its previously established standard for analyzing preemption—whether the law has a “connection with or reference to” an ERISA plan—was, without more guidance, similarly unhelpful.<sup>134</sup> The Court stated: “We simply must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.”<sup>135</sup> The Court thus, in essence, suggested that ERISA preemption analysis should resemble implied preemption analysis.<sup>136</sup>

Additionally, the Court provided a benchmark for determining when state laws frustrate congressional purposes. The Court looked to legislative history and found that the “basic thrust of the pre-emption clause was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.”<sup>137</sup> Then, after reviewing its prior cases, the Court concluded that laws it had found preempted due to a connection with ERISA plans were laws that either mandated employee benefit structures or administrative practices of ERISA plans<sup>138</sup> or constituted alternative enforcement mechanisms.<sup>139</sup> The Court’s holding that the New York rate-setting provisions were not preempted hinged on the fact that the system caused only an “indirect economic influence” on protected ERISA plans that did “not bind plan

Act unless that was the clear and manifest purpose of Congress.”

*Id.* (citations omitted).

133. *Id.* The Court stated that “if ‘relate to’ were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for ‘[r]eally, universally, relations stop nowhere.’” *Id.* (quoting H. JAMES, RODERICK HUDSON xli (New York ed., World’s Classics 1980).

134. *Id.* at 656 (noting that “[f]or the same reasons that infinite relations cannot be the measure of pre-emption, neither can infinite connections”). The Court did not elaborate on the “reference to” prong of the test because the Court found that New York’s rate-setting legislation did not reference ERISA plans at all. *Id.* *But see* District of Columbia v. Greater Washington Bd. of Trade, 506 U.S. 125 (1992).

135. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995).

136. *Accord* *Boggs v. Boggs*, 520 U.S. 833 (1997). In *Boggs*, the Supreme Court used an implied preemption analysis. This was significant because, prior to *Boggs*, the Court had appeared to follow an express preemption analysis—albeit one that looked beyond the text of the preemption provision. *See generally* Karen A. Jordan, *The Shifting Preemption Paradigm: Conceptual and Interpretive Issues*, 51 VAND. L. REV. 1149 (1998).

137. *Travelers*, 514 U.S. at 657.

138. *See, e.g.*, *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983).

139. *See, e.g.*, *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

administrators to any particular choice and thus function as a regulation of an ERISA plan itself."<sup>140</sup>

Lastly, and most significantly for purposes of this Article, the Court implied that it was clear that it would frustrate congressional purposes to find that ERISA preempts state laws regulating the quality of health care. In observing how unlikely it was that Congress intended ERISA to preempt the rate-setting provisions at issue, the Court explained:

Quality standards, for example, set by the State in one subject area of hospital services but not another would affect the relative cost of providing those services over others and, so, of providing different packages of health insurance benefits. . . . Quality control . . . regulation, to be sure, [is] presumably less likely to affect premium differentials among competing insurers, but that does not change the fact that such state regulation will indirectly affect what an ERISA or other plan can afford or get for its money. Thus, in the absence of a more exact guide to intended pre-emption than § 514, it is fair to conclude that mandates for rate differentials would not be pre-empted unless other regulation with indirect effects on plan costs would be superseded as well.<sup>141</sup>

Thus, the decision readily can be construed as supporting the view that Congress did not intend for ERISA to preempt state laws regulating the quality of health care.

The Supreme Court affirmed *Travelers's* more restrictive view of when a state law has a sufficient "connection with" an ERISA plan to warrant preemption in the other two cases in the trilogy:<sup>142</sup> *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*,<sup>143</sup> and *DeBuono*

140. *Travelers*, 514 U.S. at 659-60. The Court further explained that the system: [S]imply bears on the costs of benefits and the relative costs of competing insurance to provide them. It is an influence that can affect a plan's shopping decisions, but it does not affect the fact that any plan will shop for the best deal it can get, surcharges or no surcharges.

*Id.* at 660.

141. *Id.* at 660-61.

142. When a state law conflicts with an ERISA provision, the conflict alone is sufficient to warrant preemption. *See, e.g.*, *Boggs v. Boggs*, 520 U.S. 833 (1997). This would be true under traditional preemption doctrine even absent ERISA's specific preemption provisions.

143. 519 U.S. 316 (1997). In *Dillingham*, the Court upheld California's prevailing wage law, which permits contractors to pay a lower wage for workers participating in approved apprenticeship programs. As in *Travelers*, the prevailing wage law regulated an area traditionally governed by states and was consistent with federal law. But the key to the analysis was the Court's finding that the state law "does not bind ERISA plans to anything." *Id.* at 332. Rather, the Court found that the law merely provides an economic

*v. NYS-ILA Medical & Clinical Services Fund*.<sup>144</sup> At issue in *DeBuono* was a New York tax on gross receipts for patient services imposed on certain health care entities. The law was challenged by a self-funded ERISA plan which owned and operated medical clinics on which the tax was imposed. The Court held that although New York's provider tax affected plans that own and operate medical centers more directly, the law nonetheless merely caused an increase in costs, which influences choices made by employers or plan administrators.<sup>145</sup> Thus, whether direct or indirect, a mere economic effect on ERISA plans is insufficient to trigger preemption.<sup>146</sup>

The trilogy of Supreme Court cases, then, has established a more pragmatic or purposive approach to preemption, rather than an approach that simply views the language of § 514(a) as broadly preempting any state law with *any* "reference to or association with" ERISA plans. More specifically, the cases re-established the relevance of a strong presumption against preemption in an analysis involving a state law in an area of traditional state regulation, and they established that ERISA preemption analysis is akin to implied preemption analysis, which hinges on frustration of congressional purpose. At the same time, the Court did not displace its largely categorical approach to preemption. The test is still whether a state law has an impermissible connection with or

---

incentive to encourage employers or plan sponsors to set up apprentice programs that comport with state requirements. *Id.* at 333-34. Thus, the Court's approach in *Dillingham* confirmed *Travelers*'s more restrictive standard for determining whether a state law is preempted because of its effect on ERISA plans. Characteristically, lower court decisions since *Travelers* have not interpreted the decision uniformly. Compare *NYS Health Maintenance Org. Conference v. Curiale*, 64 F.3d 794 (2d Cir. 1995) (upholding a state law requiring HMOs to engage in open enrollment and community rating by applying *Travelers*'s restrictive standard), with *Boyle v. Anderson*, 68 F.3d 1093 (8th Cir. 1995) (upholding a two percent provider tax, but applying *Travelers* very narrowly).

144. 520 U.S. 806 (1997).

145. *Id.* at 815-16. The Court stated:

If the Fund had made the other choice, and had purchased health care services from a hospital, that facility would have passed the expense of the [tax] onto the Fund and its plan beneficiaries through the rates it set for the services provided. The Fund would then have had to decide whether to cover a more limited range of services for its beneficiaries, or perhaps to charge plan members higher rates. Although the tax in such a circumstance would be "indirect," its impact on the Fund's decisions would be in all relevant respects identical to the "direct" impact felt here.

*Id.* at 816.

146. Notably, the Court qualified its holding in *Travelers* by acknowledging that "a state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and that such a state law might indeed be preempted under § 514." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 668 (1995).

reference to ERISA plans. But the Court has provided two specific benchmarks for when a state law's effect on ERISA plans frustrates congressional purposes: (1) an economic effect on ERISA plans, whether direct or indirect, is generally insufficient to trigger preemption; and (2) the effect on ERISA plans of state laws regulating the quality of health care is generally insufficient to trigger preemption. The result therefore has been a narrowing of the range of state laws that should be found to be within the scope of § 514(a).

## 2. The Trilogy Significantly Undermines *Corcoran*—The Implied Preemption Analysis

The modifications to the preemption analysis suggested by the trilogy of Supreme Court cases have greatly undermined the *Corcoran* approach. As noted, the *Corcoran* holding was premised on the Fifth Circuit's belief that (1) *Pilot Life* mandated preemption of any claim arising from any aspect of the benefit determination process, (2) allowing the claim to proceed would have a trickle down financial effect on ERISA plans caused by any increased costs associated with providing UR, (3) the presumption against preemption was not applicable in ERISA cases, and (4) any delimitation on the scope of preemption was solely within the province of Congress.<sup>147</sup>

Several points made by the Supreme Court in the trilogy are directly inconsistent with the Fifth Circuit's premises. First, the court in *Corcoran* specifically opined that the traditional or nontraditional nature of the state law did not bear on the preemption issue. This aspect of *Corcoran* is undermined by the Supreme Court's recognition of the strong presumption against preemption of state laws in a field of traditional state regulation. Second, the *Corcoran* court supported its holding of preemption by pointing to the trickle-down economic effect that might result from imposing tort liability on entities that perform UR for ERISA plans. Yet the Supreme Court trilogy holds that an economic effect on an ERISA plan, whether direct or indirect, is generally insufficient to trigger preemption. Third, the Supreme Court's shift to a pragmatic or purposive approach to preemption reflects a recognition that delimitation of the scope of preemption is not solely within the province of Congress, as believed by the Fifth Circuit. A purposive approach to statutory interpretation is premised on the judiciary's involvement in the lawmaking process.<sup>148</sup> Fourth, the *Corcorans'*

---

147. See *supra* note 93 and accompanying text.

148. See, e.g., Jordan, *supra* note 136, at 1202-05, & 1219-20 (explaining, in part, that a purposive approach to statutory interpretation views the judiciary's role as one of effectuating the purpose embodied in legislation; thus, a court using a purposive approach to interpretation puts itself in the place of a reasonable legislature, strives to ascertain the underlying reason for the provision, looks beyond the text of the statute to the context of its enactment when necessary, and interprets the statute in a way that best harmonizes fundamental policies and fits the provision into the general fabric of the law). See also Jordan, *supra* note 136, at 1210 n.285 (listing of useful law review articles

claim constituted an attempt to hold the UR entity accountable for a negligent medical decision and therefore constituted a state law regulating the quality of health care. Thus, the *Corcoran* court's view that its holding was mandated by *Pilot Life* is undermined by the Supreme Court's strong implication that the effect on ERISA plans of state laws regulating the quality of health care is generally insufficient to trigger preemption.<sup>149</sup> A tort suit challenging an allegedly negligent medical decision is, of course, distinguishable from the types of "quality-control" regulation explicitly referred to in *Travelers*.<sup>150</sup> But the logic of the *Travelers* opinion suggests that these suits are sufficiently analogous to warrant similar treatment.

More fundamentally, the Supreme Court in *Travelers* signaled that the ERISA preemption analysis is akin to an implied preemption analysis, and implied preemption analysis supports the view that a tort suit challenging an allegedly negligent medical decision is not preempted. Implied preemption analysis turns on whether the state law at issues frustrates congressional purposes.<sup>151</sup> Allowing a claim challenging an allegedly negligent medical determination would not frustrate congressional purposes.<sup>152</sup> In enacting ERISA and its preemption provisions, Congress sought to balance several interests: the protection of employees and their rights to benefits, the formation and maintenance of employee benefit plans, and the avoidance of a multiplicity of state laws that would prevent employers from operating interstate benefit plans.<sup>153</sup> As the following analysis shows, allowing negligence suits to proceed

---

addressing statutory interpretation).

149. Notably, the federal district court in *Corporate Health Ins. Inc. v. Texas Dep't of Ins.*, 12 F. Supp. 2d 597 (S.D. Tex. 1998), reached the same conclusion. The court noted: "In light of the Supreme Court's recent mandate regarding ERISA preemption analysis, perhaps the Fifth Circuit would reach a different decision in *Corcoran* today." *Id.* at 617. However, as noted *supra* note 101, the court avoided the issue by construing the relevant Texas liability provision as reaching conduct distinguishable from the conduct at issue in *Corcoran*. *Corporate Health*, 12 F. Supp. 2d at 617.

150. The Court in *Travelers* noted:

Quality standards, for example, set by the State in one subject area of hospital services but not another would affect the relative costs of providing those services over others and, so, of providing different packages of health insurance benefits. Even basic regulation of employment conditions will invariably affect the costs and price of services.

*Travelers*, 514 U.S. at 660-61.

151. For a greater discussion of the nature of the implied preemption analyses, see Jordan, *supra* note 136, at 1165-76.

152. See *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987).

153. See ROSENBLATT ET AL., *supra* note 17, at 195-96 (providing an overview of the genesis of ERISA). In addition to being concerned with the difficulties faced by employers wanting to establish benefit plans for employees in several states, Congress also was concerned with the employer practice of underfunding pension plans and with plan administrators who regularly breached fiduciary obligations. See ROSENBLATT ET

against managed care plans would not disrupt the balance established by Congress.

a. A *Corcoran*-Type Claim Would Not Infringe on Employer Interests

A tort suit against a managed care plan challenging a negligent medical decision would only indirectly and insubstantially affect ERISA plans or employers operating ERISA plans, and thus would not overly burden employer interests. Understanding this point requires an understanding of the structure of ERISA plans, and how coverage decisions generally are made. Private employers may establish health plans in several different ways. Sponsors of smaller plans generally choose not to underwrite the risk of health care and instead purchase coverage for plan participants. These employers contract with a traditional insurance company, a health care service corporation such as a Blue Cross or Blue Shield company, a preferred provider organization ("PPO"), a health maintenance organization ("HMO"), or any other entity licensed to bear risk.<sup>154</sup> ERISA plans created through such arrangements are referred to as "insured" ERISA plans because the risk of the participants' health care expenses is borne by the entity with whom the employer contracts. In contrast, sponsors of larger health plans generally choose to be "self-insured" in whole or in part.<sup>155</sup> As the label implies, employers who self-insure elect to assume the risk of health care expenses themselves.<sup>156</sup>

---

AL., *supra* note 17, at 195-96.

154. See Clifford A. Cantor, *Fiduciary Liability in Emerging Health Care*, 9 DEPAUL BUS. L.J. 189, 194 (1997).

155. See Cantor, *supra* note 154, at 195 nn.23-24 (noting that in 1994 74% of employers with 500 employees or more self-insured their health plans) (citing *Group Health Care Covers Most Americans, Takes Larger Piece of Compensation Pie*, HEALTH CARE DAILY (BNA), Aug. 29, 1995, at d2); G. Jensen et al., *The New Dominance of Managed Care: Insurance Trends in the 1990s*, 15 HEALTH AFFAIRS 125 (1997) (noting that 46% of employees were covered by self-insured health plans in 1995); *Number of Self-Insured Plans Declines Due to Rise in Managed Care, Study Says*, HEALTH CARE DAILY (BNA), Aug. 9, 1996, at d8 (noting that 51% of employees were covered by self-insured plans in 1995). The prevalence of self-insured plans is due to the cost savings which inure to the employer by not paying another party to accept underwriting risk, through lower administrative costs, and due to exemption from state insurance regulation pursuant to ERISA's deemer clause.

156. However, all but the largest employers purchase some level of reinsurance or stop-loss insurance to protect against unexpectedly high losses to the plan. See Cantor, *supra* note 154, at 195. There is some debate as to whether employers should be entitled to the advantages of self-insurance when stop-loss insurance attaches at a low dollar amount. See Dennis K. Schaeffner, Comment, *Insuring the Protection of ERISA Plan Participants*, 47 BUFF. L. REV. 1085 (1999) (discussing cases addressing the effect of stop-loss insurance). Both insured and self-insured plans are subject to ERISA's requirements.

Coverage decisions in ERISA plans are within the purview of the plan administrator.<sup>157</sup> In insured ERISA plans, the risk-bearing entity with whom the employer contracts generally also contracts to assume some administrative duties, such as record keeping and notification, eligibility determinations, and review of claims for benefits. Employers who self-insure typically delegate many administrative functions relating to the management and operation of the plan to third-party administrators (“TPAs”), including duties relating to claims determinations. TPAs are often insurance companies or other managed care organizations that administer, for the self-insured employer, plans virtually identical to their plans offered to employers who sponsor *insured* plans—the only real difference being that the self-insured employer retains the risk of coverage. Thus, in the health benefit context, for both insured and self-insured plans, the employer generally contracts with a distinct entity that administers claims for benefits—the TPA or the risk-bearing entity that underwrites insured plans.<sup>158</sup>

The procedures for claims administration may take a multitude of forms. Nonetheless, the procedures for claiming benefits in most plans are but variations of a standard model.<sup>159</sup> The initial coverage decision is made by a claims manager (often a nurse) who is an employee of the administrator. Denials generally must be referred for special consideration to a physician or other appropriate health professional, also employed by the administrator.<sup>160</sup> In one variation on this model, as in the *Corcoran* case, some administrators may contract with a distinct UR entity that makes the coverage determination and sometimes handles appeals. Thus, the typical claims process for claims in ERISA plans involves only employees or agents of the TPA or the risk-bearing

---

157. ERISA plans generally involve four parties: “(1) the employer, who makes the contributions to the plan; (2) the plan administrator, who administers the plan; (3) the trustee, who invests the plan’s funds; and (4) the employee/beneficiary, who receives the benefits.” George Lee Flint, Jr., *ERISA: The Arbitrary and Capricious Rule Under Siege*, 39 CATH. U. L. REV. 133, 137 (1989). The plan administrator is the key party in health coverage plans. The role of plan administrator can be performed by different persons or entities: the employer, a management employee (or a committee of management employees), a service provider, such as an insurance company operating under an administrative contract with the plan, or a committee of equal numbers of representatives from management and from the rank and file employees. *Id.* at 137-38.

158. Indeed, TPAs are often insurance companies that have contracted solely to perform administrative functions.

159. See, e.g., *Crocco v. Xerox Corp.*, 956 F. Supp. 129 (D. Conn. 1997), *aff’d in part, rev’d in part*, 137 F.3d 105 (2d Cir. 1998).

160. Indeed, some states are beginning to require that medical necessity determinations made by HMOs or other managed care plans be performed only by physicians licensed to practice medicine within the state. See *Medical Necessity Decisions Must Be Made By Licensed Physician, Attorney General Says*, HEALTH L. REP. (BNA), June 3, 1999, at 903.



entity with whom the employer has contracted, or a distinct entity contracted to provide UR services.

Upon a denial of coverage, the plan participant or beneficiary has several options. One option is to initiate an internal appeal.<sup>161</sup> Alternatively, if the plan beneficiary believes the denial resulted from a negligent medical determination, a state tort suit would be an option—if the suit is not preempted by ERISA. The proper defendant in such a suit would be the TPA or the managed care entity with whom the plan sponsor contracted to perform UR services. Thus, any tort duty to use care arising as a result of a claim challenging a negligent medical decision would fall directly on those entities conducting UR—and not on employers or ERISA plans.<sup>162</sup> The only effect on the employer or plan sponsor would be costs passed through to ERISA plans in the form of higher premiums or higher administrative costs. The Supreme Court in *Travelers* held that this type of indirect economic effect is generally insufficient to trigger preemption.

Further, any difference in state tort law that might emerge would have only a minimal effect on benefit structure or plan administration and thus would not hinder interstate ERISA plans. First, any difference in the substantive tort law would be minimal. The tort duty likely to be imposed would require utilization reviewers to use reasonable care in making determinations of medical necessity. What evolves as being “unreasonable” may differ slightly from jurisdiction to jurisdiction depending on the standard of care applied and any resulting jury verdicts. But, as in the case of malpractice suits against physicians, although

161. The internal appeal may be to a medical director employed by the administrator or an “appeals committee” comprised of persons with some medical expertise and selected by (and often compensated by) the administrator.

162. Notably, the federal district court in *Corporate Health Ins. Inc. v. Texas Dep’t of Ins.*, 12 F. Supp. 2d 597 (S.D. Tex. 1998), held that managed care plans are not ERISA plans. In *Corporate Health*, managed care entities affected by the Texas liability provision brought suit challenging the law as being preempted by ERISA. See *supra* note 101; *infra* note 200 (describing the Texas liability provision). The State of Texas argued that the plaintiffs:

[B]lurr[ed] the distinction between an ERISA plan (established by an employer to provide benefits to an employee) and a health plan (established by health insurance entities as a vehicle for bearing the risks of health insurance and providing coverage to an ERISA plan for those employees). Aetna admits plaintiffs ‘offer products in the form of managed health care coverage to employees who are enrolled in ERISA . . . plans in Texas.’ Aetna may operate as a ‘health plan,’ but Aetna is not an ERISA plan established by an employer.

*Id.* at 609. The court agreed, stating that the plaintiffs are “medical service providers to ERISA plans and their members. Plaintiffs operate health plans rather than ERISA employee benefit plans.” *Id.*

such differences may affect litigation,<sup>163</sup> they likely would have only a negligible effect on conduct.<sup>164</sup>

Second, it is implausible that any differences that might emerge would cause any significant changes in plan administration or benefit structure. Employers or plan sponsors could, and would, continue to contract for plans using UR and other managed care practices.<sup>165</sup> Similarly, even if there would be a minimal effect on what medical services would be covered by the ERISA benefit plan, the Court in *Travelers* made clear that preemption is not warranted when a state law results in some increased costs being passed through to the employer, causing the employer to reduce coverage. Thus, allowing suits arising from allegedly negligent medical decisions to proceed would only indirectly and insubstantially affect employers or ERISA plans.

#### b. A *Corcoran*-Type Claim Promotes Employee Interests

At the same time, allowing suits against managed care plans for negligent medical decision making is consistent with the congressional interest in protecting employees' interests. In enacting ERISA, Congress sought to protect

---

163. Cf. Jacobson & Pomfret, *supra* note 58, at 1066 (noting that differences in tort law may lead to procedural differences and differences in methods of proof, such as the standard for expert witnesses).

164. Cf. Jacobson & Pomfret, *supra* note 58, at 1066-67 (noting (1) that although the standard by which the medical decision will be judged may differ slightly across state lines, the burden imposed on utilization reviewers would not interfere with uniform policies, and (2) that many commentators have pointed to the growing trend toward a national standard of care). In justifying the trend toward a national standard of care for judging the exercise of medical decision making, one court aptly explained:

Medical school admission standards are similar across the country. Curricula are substantially the same. Internship and residency programs for those entering medical specialties have substantially common components. Nationally uniform standards are enforced in the case of certification of specialists. Differences and changes in these areas occur temporally, not geographically.

Physicians are far more mobile than they once were. They frequently attend medical school in one state, do a residency in another, establish a practice in a third and after a period of time relocate to a fourth. All the while they have ready access to professional and scientific journals and seminars for continuing medical education from across the country. Common sense and experience inform us that the laws of medicine do not vary from state to state in anything like the manner our public law does.

Hall v. Hilburn, 466 So. 2d 856, 870 (Miss. 1985), *quoted in* Jacobson & Pomfret, *supra* note 58, at 1066 n.511.

165. Cf. Jacobson & Pomfret, *supra* note 58, at 1066 (noting that, even if there is some difference in state tort law, the differences do not suggest that the coverage policy for which an employer or ERISA plan sponsor contracts in order to provide health benefits must be different).

employees in several ways.<sup>166</sup> The preemption provision itself was intended to protect employees as much as employers. By preempting state laws that impermissibly effect ERISA plans, the provision encouraged employers to create or maintain benefit plans by permitting multistate employers to offer a single plan to all employees without the cost and inconvenience of complying with contradictory state regulations. Other provisions allow plan participants and beneficiaries to bring a federal civil action to recover benefits due and to enforce terms of the plan; and they require plan fiduciaries, in carrying out their functions, to act solely in the interests of plan participants and beneficiaries.<sup>167</sup> Thus, Congress intended to do more than simply create a bare right to benefits; Congress also tried to ensure that benefits would be provided in a reasonable manner.<sup>168</sup>

Allowing tort suits challenging negligent medical decisions is consistent with the protection Congress sought to ensure for employees. Tort suits would protect employees' legitimate expectations that managed care plans will use reasonable care in exercising medical judgment and that plans can be held accountable for deviations that cause injury. At the same time, the resulting costs to managed care plans, which are passed on to employers, are not likely to

166. See Dahlia Schwartz, Note, *Breathing Lessons for the ERISA Vacuum: Toward A Reconciliation of ERISA's Competing Objectives in the Health Benefits Arena*, 79 B.U. L. REV. 631, 635-36 (1999). Schwartz explains:

Congress enacted ERISA in response to three related problems that attained national prominence in the early 1970s. First, in the absence of comprehensive national or state regulation, many employers underfunded employee pension plans. . . . Second, pension plan administrators, although obligated to act as fiduciaries of the trusts they administered, faced few and inadequate remedial consequences for breaches of their fiduciary duty. . . . Third, corporations engaged in interstate commerce faced complex and myriad state regulations designed to address the previous two concerns.

*Id.* at 636.

167. For ERISA's civil enforcement provisions, see § 502(a) of ERISA, codified at 29 U.S.C. § 1132 (1994). Some have noted that protecting employees' interests in their benefits was the primary purpose underlying the ERISA provisions that apply to health plans. See Jacobson & Pomfret, *supra* note 58, at 999-1001.

168. Congress explicitly noted that its policy objectives in enacting ERISA included the protection of:

[T]he interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

29 U.S.C. § 1001(b) (1994).

dissuade a significant number of employers from offering plans or to cause employers to discontinue plans.<sup>169</sup>

In sum, an implied preemption analysis suggests that *Corcoran*-type claims—claims against managed care plans for negligent medical decision making—should not be preempted. Congressional purposes would not be frustrated, and the balance established by Congress would be maintained.<sup>170</sup> The modifications to the preemption analysis established by the trilogy of Supreme Court cases have therefore greatly undermined the reasoning of the *Corcoran* decision.

### 3. Why Have Lower Courts Continued to Follow *Corcoran*?

As noted, most lower courts have continued to follow *Corcoran* despite the Supreme Court trilogy. A distinct issue, then, is why: Why have lower courts steadfastly clung to the reasoning in *Corcoran* if the trilogy suggests that *Corcoran* was wrongly decided? The answer to this question is, of course, multifaceted. But two reasons seem most likely. In part, the reluctance to deviate from *Corcoran* may stem from the fact that the state laws involved in the Supreme Court trilogy were not state common law actions, but instead were provisions enacted by state legislatures. Thus, lower courts may believe that the Supreme Court holdings do not directly govern the issue of preemption of state common law actions, and that common law actions must continue to be governed by *Pilot Life* and *Corcoran*.<sup>171</sup>

However, nothing in the Supreme Court cases suggests that the modified preemption analysis applies only to state legislative provisions. Rather, the trilogy broadly governs an analysis of preemption under § 514(a) of ERISA. Under § 514(a), state laws are preempted if there is a sufficient “connection with or reference to” ERISA plans. The trilogy, as discussed in this Article,

169. In 1998, the General Accounting Office (“GAO”) criticized widely quoted estimates, used by health insurance and business groups, that suggested that 400,000 individuals would lose health coverage for every one percent increase in premium costs. See *Insurance Regulation: GAO Criticizes Lewin Group’s Prediction on Coverage Loss Due to Premium Hikes*, HEALTH CARE DAILY REP. (BNA), Aug. 6, 1998, at d9, available in WL 8/6/1998 HCD d9. The GAO was hesitant to produce its own estimates, noting the many unknown factors that could affect the estimates. *Id.*

170. *But see* *Huss v. Green Spring Health Servs., Inc.*, 18 F. Supp. 2d 400 (D. Del. 1998) (concluding, with little discussion, that preemption of a state tort claim, “although regrettable, necessarily furthers” the congressional goal of uniformity and minimization of administrative and financial burdens on ERISA plans).

171. *Cf.* *Benoit v. Grainger, Inc.*, No. Civ.A. 98-1315, 1998 WL 749444, at \*3 (E.D. La. Oct. 21, 1998) (noting that the facts in the Supreme Court’s *Dillingham* decision were not sufficiently analogous to the case at hand to warrant disregarding *Corcoran*, and stating that “nothing in *Dillingham* . . . directly or indirectly suggests that *Corcoran* is no longer good law”).

established a different focus for resolving the issue of whether a state law is preempted due to a "connection with" ERISA plans.<sup>172</sup> And the Court in *Travelers* expressly included in this category of laws that may be preempted, state common law actions that the Court had found to be preempted.<sup>173</sup> Thus, it is reasonable to conclude that the modified preemption analysis applies to state common law actions as well as to state legislative provisions.

A second reason for the reluctance to deviate from *Corcoran* may stem from the fact that lower courts are unsure how to distinguish *Pilot Life*, which purportedly dictated the holding in *Corcoran*.<sup>174</sup> In *Travelers*, the Court purportedly did not overrule any of its prior preemption decisions, and lower courts may feel constrained by the prior Supreme Court holding. However, a tort suit arising from an allegedly negligent medical decision can be distinguished from the claims involved in *Pilot Life*. In *Pilot Life*, Dedeaux's claims for tortious breach of contract, breach of fiduciary duties, and fraud arose from the fact that Pilot Life granted, terminated, reinstated, and terminated again Dedeaux's claim for disability benefits.<sup>175</sup> Dedeaux's claims were characterized as arising from "improper processing of his claims for benefits."<sup>176</sup> Unfortunately, the facts in the case are sparse, and it is unclear why Dedeaux's

---

172. However, the *Dillingham* decision also addressed preemption due to a "reference to" ERISA plans. See *California Div. of Labor Standards Enforcement v. Dillingham Constr. Inc.*, 519 U.S. 316, 324-25 (1997).

173. Specifically, the Court in *Travelers* cited to *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990). In *Ingersoll-Rand*, the Court held that ERISA preempted a common law cause of action recognized by the Texas Supreme Court that permitted plaintiffs to recover in a wrongful discharge action if the plaintiff could show that the principal reason for the termination was the employer's desire to avoid contributing to or paying benefits under the employee's pension fund. According to the Court, the state cause of action was preempted because it directly conflicted with § 510 of ERISA, which protects employees from termination motivated by an employer's desire to prevent a pension from vesting. *Id.* at 143-44. Thus, the Texas cause of action represented an "alternate enforcement mechanism" to ERISA § 510. A secondary reason for preemption also existed: the cause of action was premised on the existence of an ERISA plan (i.e., an ERISA plan was critical to the law's operation), and thus the law impermissibly "referenced" ERISA plans.

174. *Cf. Parrino v. FHP, Inc.*, 146 F.3d 699, 705 n.3 (9th Cir. 1998) (noting that the Supreme Court has not overturned its prior substantive holdings and finding the state claims at issue preempted because the claims were based "upon alleged improper handling of this claim for treatment"); *Turner v. Fallon Community Health Plan, Inc.*, 127 F.3d 196, 199 & n.1 (1st Cir. 1997) (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52-57 (1987) and noting that "[h]owever [the] general language [of § 514(a)] might otherwise have been read, the Supreme Court has construed it to preclude state claims to enforce rights under an ERISA plan or to obtain damages for the wrongful withholding of those rights . . . and this construction has been repeatedly followed").

175. See *Pilot Life*, 481 U.S. at 43-44.

176. *Id.* at 48, 57.

disability benefits were provided in an “on-again, off-again” manner. However, there are two likely possibilities. First, Pilot Life may have had in place a faulty process for administering disability benefits, e.g., perhaps claims for benefits were neglected, or perhaps authorized benefits automatically expired after a certain period of time. Second, because disability benefits were at issue, the termination and reinstatement likely stemmed from findings regarding whether Dedeaux was in fact “disabled.” Whether an individual is “disabled” and thus qualifies for disability benefits hinges on the individual’s ability to work.<sup>177</sup> Regardless of which reason formed the basis of the denial in *Pilot Life*, it is clear that Dedeaux was not challenging a decision about what medical care or treatment was necessary or reasonable. The claim at issue in *Pilot Life* is therefore distinguishable from the type of claim at issue in *Corcoran*.

Accordingly, because the recent trilogy of Supreme Court cases substantially undermines the reasoning underlying the *Corcoran* decision rather than steadfastly following *Corcoran*, lower courts should conduct a careful reevaluation of whether Congress intended ERISA to preempt tort actions arising from coverage denials in which the conduct being challenged involved an exercise of medical judgment.

#### 4. The Demise of *Corcoran* Does Not Completely Resolve the Preemption Problem

This Article explained the scope of the preemption problem for ERISA plan participants and beneficiaries as being largely shaped by *Corcoran*. Thus, it might seem logical to assume that, if recent Supreme Court precedent has undermined the reasoning underlying *Corcoran*, the preemption problem has been completely eviscerated and a federal amendment to ERISA is unnecessary. But that conclusion does not automatically follow. Although it is accurate to describe *Corcoran* as establishing that ERISA preempts all state and contract claims arising in any way from a health-benefit determination, *Corcoran* itself involved only a wrongful death action based on an allegedly negligent determination that hospitalization was not medically necessary. Thus, the

---

177. A disability benefit plan provides income-replacement benefits to employees who are unable to work because of illness or accident. Because the benefit is “income” and not reimbursement for medical services, the amount of disability income an employee collects depends on his or her pre-disability income level and not on the type or severity of the disability suffered. The type or severity of a disability is relevant to whether benefits are due because disability plans typically provide benefits only for individuals who become totally disabled and unable to work. See Stephen F. Befort, *Mental Illness and Long-Term Disability Plans Under the Americans With Disabilities Act*, 2 U. PA. J. LAB. & EMP. L. 287 (1999). The focus of the inquiry in determining benefits, then, is whether the plan participant or beneficiary is able to work. See, e.g., *Garner v. Heckler*, 745 F.2d 383 (6th Cir. 1984); *Giampa v. Trustmark Ins. Co.*, 73 F. Supp. 2d 22 (D. Mass 1999).

demise of *Corcoran* actually eviscerates the preemption problem only as to coverage denials involving an exercise of medical judgment, and it may have little bearing on the preemption of actions based on the other type of coverage denial, *i.e.*, denials arising from conduct that involves contractual interpretation or application, but not from an exercise of medical judgment.

As this Article explained in Part II, a denial arising from conduct that involves contractual interpretation or application, but not an exercise of medical judgment, is more akin to the traditional process of determining insurance claims and coverage. The basis for a denial would include reasons such as (1) the service did not fall within a category of services covered by the policy, (2) the service fell within the scope a specific exclusion in the policy, (3) the service exceeded the quantity allowed under the policy, or (4) the service was improperly accessed. Thus, a state common law action seeking damages arising from a more traditional coverage denial is predominately contractual in nature and less like a negligence-based, *Corcoran*-type claim. A distinct issue, therefore, is whether, under a narrower view of preemption, it continues to be appropriate to construe ERISA as preempting claims arising from coverage denials based on conduct involving contractual interpretation or application, but not exercises of medical judgment.

A more contractually based cause of action would similarly benefit from the presumption against preemption. However, a contract-based cause of action is not readily characterized as a regulation of the "quality" of health care; even if the claim asserted is "tortious" breach of contract, the tort aspect of the claim is premised on the plan's violation of the contractual duty of good faith and fair dealing.<sup>178</sup> Thus, *Travelers* cannot as readily be construed as bearing on the question of preemption of a more contractually based claim. A contract-based claim also is less easily distinguished from the type of claim at issue in *Pilot Life*. Indeed, the plaintiff in *Pilot Life* asserted a tortious breach of contract claim, and the Supreme Court found that the claim was preempted.

Significantly, however, the Court's analysis in *Pilot Life* focused largely on the fact that Dedeaux's claim was inconsistent with § 502(a)(1)(B) of ERISA, a subsection of ERISA's civil enforcement provision. Thus, actions arising from a denial of coverage based on conduct that does not involve an exercise of medical judgment may have more than mere economic effects on ERISA plans. These actions may be inconsistent with § 502(a)(1)(B) and, if so, they would be preempted for that reason. Accordingly, in assessing the need for a federal legislative solution to the preemption problem, it is necessary to also consider the recent case law developments relating to § 502(a) of ERISA. The following

---

178. Most states have recognized that insurers are subject to a duty to act in good faith and to deal fairly with their insureds. An insurer's breach gives rise to a cause of action for tortious breach of contract. The cause of action is intended to compensate the insured for injury caused by the insurer's wrongful conduct, not for benefits covered by the policy. See *infra* notes 224-29 and accompanying text (discussing preemption of a claim for tortious breach of contract).

section of this Article explains the interaction between § 502(a)(1)(B) of ERISA and § 514(a) of ERISA and analyzes the extent to which the emerging § 502(a)(1)(B) case law has eviscerated the preemption problem for ERISA plan participants and beneficiaries in cases involving coverage denials.

*B. Courts of Appeals Decisions Narrowing the Scope of  
§ 502(a)(1)(B)*

While ERISA § 514(a) contains Congress's express statement regarding preemption, § 502(a) of ERISA also plays a significant role in determining the scope of ERISA preemption. The Court noted in *Travelers* that some state laws it had previously found to be preempted because of their "connection with" ERISA plans were state laws that constituted "alternative enforcement mechanisms."<sup>179</sup> Thus, a state law may be preempted under § 514(a) because the law is inconsistent with § 502(a).<sup>180</sup> Because of this relationship between § 514(a) and § 502(a), a distinct issue is whether that type of action could be preempted due to a conflict with § 502(a)(1)(B) of ERISA even though the foregoing section of this Article concluded that tort actions challenging an allegedly negligent medical decision should not be found preempted under the more pragmatic approach to § 514(a) preemption. This section analyzes the question of preemption due to a conflict with § 502(a)(1)(B) as to both types of coverage denials.

As noted, the plaintiff in *Pilot Life* asserted claims for tortious breach of contract, breach of fiduciary duties, and fraud. The Court in *Pilot Life* supported its holding that Dedeaux's state law claims were preempted because they "related to" ERISA plans by noting that allowing a state action based on the "improper processing of his claims for benefits" would be inconsistent with § 502(a)(1)(B). More specifically, the Court in *Pilot Life* explained that Congress intended § 502(a)(1)(B) to be the exclusive vehicle for actions by ERISA plan participants and beneficiaries asserting improper processing of a claim for benefits.<sup>181</sup> One way of assessing whether a claim is preempted due to

---

179. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995). The Court was referring to cases in which state common law actions had been found preempted because the actions were inconsistent with suits authorized by § 502(a). *Id.* (citing *Ingersoll-Rand Co. v. McClenden*, 498 U.S. 133 (1990)).

180. Section 502(a), ERISA's civil enforcement provision, is so central to ERISA preemption analysis that some scholars and courts distinguish between § 514(a) preemption and § 502(a) preemption. *See, e.g.*, ROSENBLATT ET AL., *supra* note 17, at 65, 71, 187 (distinguishing between preemption under § 514(a) and preemption due to a conflict with § 502(a)).

181. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987). Further, the Court stressed that courts should not find, in claims brought under § 502(a), any implied right to remedies; rather, according to the Court, § 502(a):



the scope of § 502(a)(1)(B), then, would be to focus on the phrase “improper processing of a claim for benefits.” This language is sufficiently open-ended that it could be construed as encompassing any action arising from any aspect of a benefit determination—and thus as requiring preemption of actions arising from both categories of coverage denials. Indeed, the *Corcoran* court viewed the phrase in that way.

Yet, as this Article has pointed out, a tort suit arising from a negligent medical determination is readily distinguishable from the type of claims involved in *Pilot Life*. Thus, although a tort suit challenging a negligent medical determination arises from one distinct aspect of the benefit determination process, such a claim should not necessarily be characterized as falling within the scope of the phrase “improper processing of a claim for benefits” as that phrase was used in *Pilot Life*. Accordingly, if the phrase “improper processing of a claim for benefits” is not sufficiently refined to identify the claims that should be preempted, then the phrase is not the appropriate focus for the preemption analysis. Rather, the focus of the preemption analysis should simply be whether a claim is inconsistent with the language of § 502(a)(1)(B).

Section 502(a)(1)(B) of ERISA authorizes suits “to recover benefits due . . . under the terms of [the] plan, [and] to enforce . . . rights under the terms of the plan . . . .”<sup>182</sup> Because the Supreme Court has never clarified when a state common law suit constitutes an action within the scope of § 502(a)(1)(B), it becomes appropriate to look to recent circuit courts of appeals decisions that have narrowed the scope of state common law claims that fall within § 502(a)(1)(B), namely, *Dukes v. U.S. Healthcare, Inc.*<sup>183</sup> and *Rice v. Panchal*.<sup>184</sup> Although the claims in these cases did not involve allegedly negligent coverage determinations, the decisions are instructive.<sup>185</sup> The analysis in each was limited

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

*Id.* at 42.

182. See 29 U.S.C. § 1132(a) (1994). Section 502(a)(1)(B) also authorizes an action “to clarify . . . rights to future benefits under the terms of the plan.” This part of the provision, however, is unlikely to be triggered by a state tort suit.

183. 57 F.3d 350 (3d Cir.), *cert. denied*, 516 U.S. 1009 (1995).

184. 65 F.3d 637 (7th Cir. 1995).

185. In *Dukes*, the plaintiffs alleged that their HMOs were vicariously liable for the negligence of participating providers and directly liable for negligent selection, retention, and oversight of the HMOs’ participating providers. In *Rice*, the plaintiff alleged only a vicarious liability claim against the insurer that administered the plaintiff’s managed care plan for injuries sustained in the course of medical treatment.

to the question of whether the common law claims at issue were preempted by virtue of § 502(a)(1)(B).<sup>186</sup>

The court in *Dukes* focused on whether the alleged vicarious liability and direct negligence claims could constitute suits “to recover benefits due.” In contrast, the court in *Rice* analyzed whether a vicarious liability claim could constitute a suit “to enforce rights under the terms of the plan.” The following subsections explain the approaches used by these courts in determining whether state common law actions fall within the scope of § 502(a)(1)(B) and consider their impact on claims rising from denials based on an exercise of medical judgment as well as on claims based on denials not involving an exercise of medical judgment.

## 1. Suits to Recover Benefits Due Under the Terms of the Plan

### a. The *Dukes* Analysis: A Quantity-Quality Test

At issue in *Dukes* were two types of claims against HMOs: a vicarious liability claim arising from the negligent provision of medical care by providers within the HMO network, and a direct negligence claim challenging the selection

186. In both cases, the plaintiffs originally had filed common law tort claims in state court. The defendants raised the issue of ERISA preemption and then removed the actions from state court to federal court. Removal to federal court is authorized if, on the face of the complaint, it appears that the plaintiff could have filed the action in federal court. See 28 U.S.C. § 1441 (1994); *Louisville & Nashville R.R. v. Mottley*, 211 U.S. 149, 153-54 (1908) (establishing the parameters of the well pleaded complaint rule). The issue in both cases therefore was whether the actions were properly removed by virtue of the doctrine of complete preemption. Both courts explained that actions alleging state law tort claims are not automatically removable to federal court when a defendant raises the defense of ERISA preemption. Rather, under the doctrine of complete preemption, the actions would be removable only if the plaintiffs’ claims could be recharacterized as federal claims; namely, claims within the scope of § 502(a). See *Rice*, 65 F.3d at 640. The Supreme Court recognized the doctrine of complete preemption in ERISA cases in *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987).

Thus, rather than questioning the “effect” on ERISA plans, the courts addressed only whether the state tort claims were within the scope of § 502(a)(1)(B). Notably, a state law claim that is not within the scope of § 502(a) of ERISA may nonetheless be preempted because of its effect on an ERISA plan. In such a case, the generally recognized practice is to remand the action to state court for determination of the question of ERISA preemption on a basis other than § 502(a). The decisions in *Rice* and *Dukes* should go a long way toward clarifying the distinction between preemption and the doctrine of complete preemption and whether an action involving a state tort claim against a managed care plan is removable. However, they have also highlighted the inefficiencies associated with removal since the ERISA preemption analysis becomes split between federal and state courts. See generally Karen A. Jordan, *The Complete Preemption Dilemma: A Legal Process Perspective*, 31 WAKE FOREST L. REV. 927, 927-99 (1996).

and retention of providers in the HMO network. The issue was whether these claims could constitute suits “to recover benefits due.” A threshold issue in resolving whether a state common law claim may be characterized as a suit to “recover benefits due” is what constitutes “benefits” under the plan. The court in *Dukes* assumed, without deciding, that medical care is a benefit for purposes of a § 502(a)(1)(B) analysis when the health benefits are provided through an HMO.<sup>187</sup> In reaching its decision that the claims did not constitute a suit to recover benefits due, the court in *Dukes* created a test seemingly based on whether the suit challenges the “quality” or “quantity” of benefits provided under the ERISA plan.

The court’s conclusion that the claims did not constitute a suit to recover benefits due hinged on the fact that the claimants in the case were not alleging that the HMOs had withheld some “quantum” of medical care due. The court held that a suit “to recover benefits due . . . is concerned exclusively with whether or not the benefits due under the plan [medical care] were actually provided.”<sup>188</sup> As noted, the claims at issue were a vicarious liability claim arising from negligent provisions of medical care by providers within the HMO network and a direct negligence claim challenging the selection and retention of providers in the HMO network. As to both claims, the court found that the plaintiffs were challenging the low “quality” of the medical care and treatment they received rather than the “quantity” of care received.<sup>189</sup> The court in *Dukes* thus held that a suit against a managed care plan is not a suit to “recover benefits due” when the claim stems from medical care received, and the plaintiff is challenging either the quality of the medical care itself or certain conduct by the managed care plan that directly affects the quality of medical care provided under the plan.<sup>190</sup>

In addition to creating a “quantity-quality” test, the court in *Dukes* suggested that the quantity prong of the test could trump the quality prong. This aspect of the *Dukes* decision is derived from the court’s attempt to distinguish *Corcoran*. The court explained that the direct negligence claim involved in *Corcoran* challenged only the managed care function of UR whereas the claims in *Dukes* challenged only the function of “arranging” medical care for plan

187. *Dukes*, 57 F.3d at 356.

188. *Id.* at 357. In *Rice*, the plaintiff similarly alleged a vicarious liability claim based on negligent treatment received. The court merely made a conclusory statement that the plaintiff had not alleged that he did not receive the benefits (payments) due under the plan, and thus the claim was not “to recover benefits.” *Rice*, 65 F.3d at 642.

189. *Dukes*, 57 F.3d at 356-57.

190. However, the court in *Dukes* noted that an exception might exist. For example, if the quality of the medical care rendered is so low that the treatment does not qualify as health care at all, then the distinction between the “quantity” of benefits due and the “quality” of benefits becomes a distinction without a difference. *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 358 (3d Cir.), *cert. denied*, 516 U.S. 1009 (1995). In such a case, a suit challenging the quality of care could be characterized as a suit for benefits.

beneficiaries, by selecting and supervising the physicians who comprised the HMO's network. According to the court, that distinction was crucial because "only in a utilization-review role is an entity in a position to deny benefits due under an ERISA welfare plan."<sup>191</sup> Like other courts striving to remain consistent with *Corcoran*, the *Dukes* court also suggested that characterizing challenged conduct as medical decision making is not determinative. Thus, *Dukes* can be construed (and some courts have construed it) as implying that an action challenging conduct involving an exercise of medical judgment (e.g., arranging for care) still might be preempted if it also involves a challenge to conduct involving a denial of care.<sup>192</sup> Thus viewed, the quantity prong of the test seems to be determinative. In other words, a challenge to the quality of benefits due (e.g., medical care) is nonetheless preempted if the action arises from a coverage denial.

#### b. The Impact on the Reasoning Underlying *Corcoran*

At first blush, it may appear that the *Dukes* decision does little to undermine the reasoning underlying *Corcoran* if the test is a "quality-quantity" test with the quantity prong being determinative. This is because the claim in *Corcoran* could be described as a claim challenging the "quantity" of benefits since the claim arose from United's denial of coverage for hospital benefits. Indeed, as noted, the court in *Dukes* explicitly attempted to harmonize its decision with the *Corcoran* opinion. However, it is important to emphasize that the holding in *Dukes* was that certain state law claims were *not* inconsistent with § 502(a)(1)(B). Further, because the claims at issue in *Dukes* did not arise from a coverage denial, the issue before the court did not require the court to consider or evaluate the correctness of *Corcoran*. Like other courts, the court in *Dukes* simply supported its decision by pointing out that it was not inconsistent with *Corcoran*.

Understanding that the aspect of *Dukes* which suggested that the quantity prong of the test would trump the quality prong was dicta is important. Because it was dicta, the essence of the *Dukes* decision is that state law actions challenging the quality of benefits due under the plan (e.g., medical care) are not inconsistent with § 502(a)(1)(B), and whether the fact that the action also arises from a benefit denial (the "quantity" prong of the test) should trump the quality prong is a distinct issue. If not, rather than a "quantity-quality" test, the test

---

191. *Id.* at 360-61.

192. *See, e.g.,* *Delucia v. St. Luke's Hosp.*, No. Civ.A. 98-6446, 1999 WL 387211, at \*3 (E.D. Penn. May 25, 1999). Notably, although the court in *Dukes* suggested that the "UR" function and the "arranging for care" function were distinct, it may be more accurate to describe the UR function as a subset of the overarching function of arranging for care. Thus, rather than thinking that some HMOs perform one function and other HMOs perform the other, it is better to perceive all HMOs as arranging for care for their enrollees, but that some also perform the function of UR.

should simply be whether a state common law action constitutes a challenge to the quality of benefits.

The following subsections explain why a “quality” standard is more justifiable for preemption purposes than a “quantity-quality” distinction, identify emerging case law supporting use of a simple quality test, and apply a “quality” standard to a state actions challenging coverage denials. The analysis shows that actions arising from coverage denials involving an exercise of medical judgment are not inconsistent with § 502(a)(1)(B), but that actions arising from coverage denials that do not involve an exercise of medical judgment may be inconsistent with § 502(a)(1)(B).

### (i) A Simple Quality Test Is More Justifiable

In light of recent Supreme Court precedent, it is unwarranted to allow the “quantity” prong of the *Dukes* test to trump the fact that a state common law claim is challenging the quality of medical decision making. Rather, the fact that a state claim challenges conduct involving medical decision making should trump the fact that the suit may also involve a benefit denial. This conclusion flows from the relationship between § 514(a) and § 502(a) of ERISA.

As explained, because of the relationship between § 514(a) and § 502(a), a state law may be preempted under § 514(a) because the law is inconsistent with § 502(a).<sup>193</sup> Understood this way, preemption due to a conflict with § 502(a) is but a subset of the preemption set forth in § 514(a). This is consistent with the view that § 514(a) reflects Congress’s expression of the outer bounds of preemption by ERISA. But if these premises are correct, preemption due to a conflict with § 502(a) cannot logically reach state laws that the Supreme Court has suggested are not preempted under § 514(a). In *Travelers*, the Supreme Court explained that Congress did not intend § 514(a) of ERISA to preempt state laws regulating the quality of health care. If § 514(a) should not be construed as preempting state laws regulating the quality of health care, then it is also logical to conclude that § 502(a)(1)(B) should not be construed as preempting state laws regulating the quality of health care.

The essence of medical decision making occurring in the context of UR is fundamentally no different than medical decision making by a managed care enrollee’s treating physician.<sup>194</sup> Both represent clinical decisions, *i.e.*, individualized application of medical knowledge and judgment to clinical symptoms in order to determine whether a particular medical treatment or service is medically necessary.<sup>195</sup> Permitting a state tort action challenging medical decision making thus represents regulation of the quality of health care delivery, and this seems especially evident when the medical decision is made

193. See *supra* notes 179-80 and accompanying text.

194. See *supra* notes 32-38 and accompanying text.

195. Cf. Jacobson & Dorfman, *supra* notes 58, at 1064-65.

in the context of UR, where resource considerations are admittedly more influential.<sup>196</sup> Thus, when a tort suit is seeking to challenge conduct involving medical decision making, the fact that the suit may also arise from facts which may be characterized as a denial of benefits should not suffice to cause preemption. Accordingly, the better approach is to focus on the essence of the *Dukes* decision—that a state common law cause of action regulating the quality of medical decision making is not inconsistent with § 502(a)(1)(B) and should not be preempted.

The justification for making the quantity prong determinative flows from concerns about permitting a plaintiff to recover damages for personal harm caused by a coverage denial. The Supreme Court has held that a § 502(a)(1)(B) suit to “recover benefits due” authorizes ERISA plan participants and beneficiaries to recover just that—benefits—but no extracontractual damages.<sup>197</sup> For example, Florence Corcoran was denied coverage for hospitalization. Under § 502(a)(1)(B), the only remedy she could seek would have been coverage for hospitalization, which she of course no longer needed. Further, the Court has similarly held that other § 502(a) actions do not authorize recovery of monetary damages to individuals.<sup>198</sup> Lower courts have used these Supreme Court holdings to justify the view that any state law cause of action that allows claimants to recover “damages” for harm caused by a coverage denial is inconsistent with § 502(a)(1)(B) and thus preempted.<sup>199</sup> But an inconsistency exists only if it is true that Congress intended to preempt all state common law actions arising from a coverage denial—including actions that represent a state law regulation of the quality of medical decision making.

Thus, courts have been approaching the issue backwards. That is, courts have allowed their view that Congress intended § 502(a) to provide the exclusive remedies for ERISA plan participants and beneficiaries to effect the scope of § 514(a) preemption. But, § 514(a) is Congress’s expression of the outer bounds of preemption. The scope of § 514(a) preemption should therefore impact the courts’ view of what actions should be found inconsistent with § 502(a)(1)(B), rather than the other way around. And given *Travelers’s* clarification of the scope of the laws Congress intended to preempt, actions arising from coverage denials involving medical decision making should not be found preempted.

196. Resource considerations enter into the clinical decision in both situations, but especially when the clinical decision is being made in the context of UR for a managed care health plan.

197. *See, e.g., Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985).

198. *See, e.g., Varsity Corp. v. Howe*, 516 U.S. 489, 512-13 (1996); *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 260 (1993).

199. *See, e.g., Hull v. Fallon*, 188 F.3d 939 (8th Cir. 1999), *cert. denied*, 120 S. Ct. 1242 (2000); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995); *supra* note 98 (discussing additional cases).

Fortunately, there is some evidence that lower courts are beginning to recognize the prominence of the “quality” prong of the *Dukes* decision in assessing the preemption issue.<sup>200</sup> In the long-awaited case of *Pappas v. Asbel*,<sup>201</sup> the Supreme Court of Pennsylvania focused on the fact that the state tort claim against an HMO constituted a regulation of the quality of health care.<sup>202</sup> *Pappas* involved an action arising from an HMO’s allegedly negligent delay in authorizing the transfer of the plaintiff to a university hospital with greater capabilities and resources to treat his medical condition.<sup>203</sup> Relying on the trilogy of Supreme Court cases, the Pennsylvania Supreme Court held that the tort claim was not preempted. The court focused on the fact that *Travelers* cautioned that Congress did not intend to displace general health care regulation (historically a matter of local concern)<sup>204</sup> and especially state laws governing the provision of “safe medical care.”<sup>205</sup> The court found that ERISA did not preempt the tort claim because “[c]laims that an HMO was negligent when it provided contractually-guaranteed medical benefits in such a dilatory fashion that the

200. There is also evidence that litigants are focusing on the “quality” aspect of the *Dukes* test. In the *Corporate Health* case, the State of Texas also focused on “quality” in arguing against preemption of the Texas liability provision. See *Corporate Health Ins. Inc. v. Texas Dep’t of Ins.*, 12 F. Supp. 2d 597, 603 (S.D. Tex. 1998). As noted, the Texas law allows individuals to sue an HMO or other managed care entity for damages proximately caused by the entity’s failure to exercise ordinary care when making a health care treatment decision. The State of Texas argued that “Senate Bill 386 regulates the quality of care provided by HMO[s] operating in Texas. . . . The plain meaning of the statute shows that the purpose of [the bill] is to prevent plans from escaping liability for the medical decisions they ‘make,’ ‘control’ or ‘influence.’” *Id.*; see *supra* notes 99-101 and accompanying text (discussing in more detail the *Corporate Health* decision and the challenged liability provision).

201. *Pappas v. Asbel*, 724 A.2d 889 (Pa. 1998). Those interested in ERISA preemption issues anxiously awaited the *Pappas* decision because it was one of the first cases involving the issue of ERISA preemption of a negligence claim against an HMO to be decided by a state’s highest court in the post-*Travelers* era.

202. *Id.* at 893. *Pappas* initially brought suit against his primary care physician and Haverford Hospital, the hospital which attempted to transfer *Pappas*. The original defendants implead the HMO. The Pennsylvania Supreme Court addressed the issue of ERISA preemption of the tort claim against the HMO. *Pappas* did not involve an HMO’s “medical necessity” determination; rather, the denial at issue was due to the HMO’s limited provider network and its failure to timely authorize treatment at a non-participating hospital.

203. *Id.* at 890. *Pappas* was diagnosed as suffering from an epidural abscess which was pressing on *Pappas*’s spinal column. Although not entirely clear from the facts in the case, *Pappas*’s transfer to a more capable hospital was delayed at least three hours. *Pappas* now suffers from permanent quadriplegia resulting from compression of his spine by the abscess. *Id.*

204. *Id.* at 892 (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers*, 514 U.S. 645, 661 (1995)).

patient was injured indisputably are intertwined with the provision of safe medical care.<sup>206</sup> Thus, with focus on the fact that the claim constituted a state regulation of the quality of medical care, it became irrelevant that the claim also could have been characterized as a challenge to the HMO's UR or pre-certification process or the HMO's transfer authorization denial.

As explained in Part III(C), a similar analysis was used by the federal district court in *Moscovitch v. Danbury Hospital*.<sup>207</sup> In finding that ERISA did not preempt the claims against the managed care plan, PHS, the court focused on the fact that the claims challenged the appropriateness of the medical and psychiatric decisions of PHS. The court noted: "[The claim] does not assert that PHS was making wrong decisions about whether certain care would be covered by its plan, but instead challenges the decision made by PHS with respect to the quality and appropriate level of care and treatment for the decedent."<sup>208</sup> Although the claim at issue clearly also could have been characterized as arising from the denial of further coverage for inpatient hospital care, the court decided that the fact that the claim challenged a medical care decision pulled it outside the reach of ERISA preemption.<sup>209</sup>

In each of these cases, though, the courts suggested that their analyses were consistent with *Dukes*.<sup>210</sup> Thus, even these courts have not expressly shifted to

206. *Id.*

207. 25 F. Supp. 2d 74, 80-83 (D. Conn. 1998). In *Moscovitch*, state law claims were brought against Physician Health Services ("PHS"), the entity which administered the group medical plan covering the plaintiff's son. PHS first authorized admission for the plaintiff's son to Danbury Hospital after two suicide attempts; but seven days later terminated the inpatient coverage and required the child to be transferred to Vitam Center, an allegedly inappropriate facility because Vitam was only prepared to treat adolescents with substance abuse problems. Claims also were brought against Danbury Hospital and Vitam Center, Inc. The plaintiff's son committed suicide on the day of the transfer. The plaintiff's complaint included direct and vicarious tort claims against PHS. The claims against PHS in the plaintiff's original complaint were grounded in state statutory provisions. The plaintiff amended the complaint to include, against PHS, only state common law tort theories grounded in direct and vicarious liability.

208. *Id.* at 80. The court pointed to allegations that PHS failed to properly diagnose and assess the decedent's psychiatric condition, failed to properly monitor, care, and treat him, and failed to properly oversee his treatment. *Id.*

209. *Id.* at 82; see also *In re U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir. 1999); *Tiemann v. U.S. Healthcare, Inc.*, No. CIV. 99-5885, 2000 WL 62304, at \*1 (E.D. Pa. Jan. 11, 2000). In both cases, the courts found that because the plaintiff's complaints challenged the quality of a medical determination their claims were protected from ERISA preemption. However, neither case clearly involved an allegation that the harm arose from a benefit determination.

210. The concurring opinion in *Pappas* attempted to expressly explain that the outcome was consistent *Dukes*. The concurring judge did explain that the HMO's refusal to transfer "constituted, in effect, an individual medical decision or judgment as opposed to a decision affecting the administration of an employee benefit plan," and thus



a quality test. Nonetheless, the cases reflect the subtle shifting that is the product of case law development. The quality test is emerging because a focus on whether the state law constitutes a regulation of the quality of health care ensures a preemption result more in line with recent Supreme Court signals regarding congressional intent.

(ii) Application to Coverage Denials

If the quantity-quality test of *Dukes* gives way to a simple quality test, the determinative issue in assessing whether a state common law action is inconsistent with § 502(a)(1)(B) would be whether the state law action challenges the quality of benefits due under the plan (or, stated more broadly, whether the state law action challenges the quality of medical decision making). The fact that the action arises in the context of a benefit determination should not impact the analysis. Using a quality standard, some state common law actions arising from coverage denials likely would still be found inconsistent with § 502(a)(1)(B). But some would not.

An action arising from a coverage denial that did *not* involve an exercise of medical judgment, for example, *cannot* readily be characterized as a regulation of the quality of health care. The essence of such a claim is that benefits were withheld for some more purely contractual reason. Thus, the claim can be more readily characterized as a challenge to the quantity of “benefits due.” When a claim does not challenge quality, the fact that it does involve quantity is determinative; and this is true even if a plaintiff is seeking remedies other than the benefits, such as damages for emotional distress or punitive damages arising from a breach of contract. A claim challenging a coverage denial that did not involve medical decision making is more analogous to the claims in *Pilot Life* and would be found inconsistent with § 502(a)(1)(B) and preempted.

In contrast, a *Corcoran*-type claim is not inconsistent with § 502(a)(1)(B) under a test based on the quality prong of the *Dukes* analysis. Although the *Corcorans*' claim arose from a denial of benefits, the suit in *Corcoran* was essentially a malpractice claim against the UR entity.<sup>211</sup> A judgment for a plaintiff in a suit challenging a negligent medical necessity determination by a utilization reviewer would impose, on the entity making the UR decision, a duty to use reasonable care in exercising medical judgment. Thus, the suit would represent a challenge to the quality of health care and would not be preempted due to § 502(a)(1)(B). Under a simple quality test, then, the courthouse door

---

constituted a challenge to the quality of benefits received. *Pappas v. Asbel*, 724 A.2d 889, 894 (Pa. 1998) (Nigro, J., concurring). But the concurring judge did not mention that the claim also could have been characterized as a denial of benefits claim. Similarly, the court in *Moscovitch* expressly explained that its conclusion was consistent with *Dukes*, but failed to address that the claim also could have been characterized as a denial of benefits claim. *Moscovitch*, 25 F. Supp. 2d at 80-81.

211. See *supra* notes 77-85 and accompanying text.  
<https://scholarship.law.missouri.edu/mlr/vol65/iss2/2>

should be open to at least some suits against managed care plans arising out of a coverage denial.

## 2. Suits to Enforce Rights Under the Terms of the Plan

### a. The *Dukes* and *Rice* Analyses

In addition to a suit to recover benefits due, § 502(a)(1)(B) authorizes a suit to “enforce rights” under the ERISA plan. The courts in *Dukes* and *Rice* both addressed the question of whether a state law tort claim against a managed care plan was inconsistent with this part of § 502(a)(1)(B). The Third Circuit in *Dukes* interpreted this language in § 502(a)(1)(B) very narrowly. *Dukes* held that a state tort claim could be characterized as a § 502(a)(1)(B) suit only if the claim would enforce a contract right other than the right to benefits; and, indeed, something to which plan participants would not otherwise be entitled.<sup>212</sup> The court readily concluded that neither a vicarious liability claim based on negligent provision of care nor a direct negligence claim alleging negligent selection and retention of providers would fall within the scope of § 502(a)(1)(B) because “patients enjoy the right to be free from medical malpractice regardless of whether or not their medical care is provided through an ERISA plan.”<sup>213</sup> Thus, the key inquiry under *Dukes* is whether permitting the state tort claim to proceed would result in the enforcement of a right that is distinct from a right to benefits and accorded to the plaintiff only by the contractual terms of the plan.

The court in *Rice* took a broader view. Because evidence of the agency relationship required for vicarious liability would be found in plan documents, the *Rice* court decided that it was necessary to conduct a more complex analysis of whether this rendered the plaintiff’s vicarious liability claim a suit to enforce his rights under the plan.<sup>214</sup> The court elected to follow the rule developed for determining the preemptive scope of Section 301 of the Labor Management Relations Act (“LMRA”).<sup>215</sup> Under that approach, the key inquiry is whether

212. *Dukes v U.S. Healthcare, Inc.*, 57 F.2d 350, 358 (3d Cir.), *cert. denied*, 516 U.S. 1009 (1995).

213. *Id.* It is not absolutely clear that the court was referring to both the direct and vicarious claims since a claim for negligent credentialing generally is not considered a “malpractice” claim. But it is a reasonable conclusion since throughout the opinion the court essentially treated the two claims as one.

214. *Rice v. Panchal*, 65 F.3d 637, 642 (7th Cir. 1995).

215. The Labor Management Relations Act (“LMRA”), codified in scattered sections of 29 U.S.C., was enacted as an amendment to the National Labor Relations Act (“NLRA”). Although the NLRA was the first federal law recognizing the right of workers to form a union, the LMRA was intended to limit the power of organized labor. The Supreme Court has often analogized ERISA’s preemption with § 301 preemption. Section 301 of the LMRA recognizes collective bargaining agreements as enforceable contracts and grants federal district courts original jurisdiction over suits involving

resolution of the state law claim will require an interpretation of the ERISA plan.<sup>216</sup>

The issue raised by the plaintiff's claim in *Rice* was whether the physician's status as a "participating provider" rendered the defendant insurer/administrator liable for the physician's malpractice under the law of respondeat superior. Under state law, resolution of the case would have hinged on issues such as whether the plaintiff justifiably relied on the physician, whether the physician was authorized to act, and whether the plaintiff was put on notice of the lack of the physician's authority.<sup>217</sup> The court explained that, due to the factual nature of the inquiry, *Rice*'s claim would not require interpretation of the ERISA plan; further, the fact that the plan might serve as some evidence of the agency relationship did not meet the Section 301 standard.<sup>218</sup> Thus, the court found that the vicarious liability claim was not a suit to enforce rights under the terms of the plan.<sup>219</sup>

violations of those agreements. See LMRA § 301, 29 U.S.C. § 185(a) (1994). Because of the importance of uniform interpretation of § 301 collective bargaining agreements, courts scrutinize suits brought by a party to a collective bargaining agreement even if the complaint alleges a state law claim that does not, on its face, allege a breach of a § 301 agreement. A body of case law is devoted to determining whether a state law claim that does not allege a breach of a § 301 contract is nonetheless properly considered a claim within the scope of § 301. See, e.g., *Rice*, 65 F.3d at 643 (citing *Lingle v. Norge Div. of Magic Chef, Inc.*, 486 U.S. 399 (1988); *Livadas v. Bradshaw*, 512 U.S. 107 (1994); *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202 (1985)). The court in *Rice* held that this § 301 case law should inform the analysis of whether a state law claim that does not allege a breach of an ERISA plan is nonetheless properly recharacterized as a § 502(a)(1)(B) suit to enforce rights under the terms of the plan. Thus, the Seventh Circuit believes that the need for uniform interpretation of ERISA plans is so strong that any state law claim whose resolution depends on an interpretation of the terms of the ERISA plan (i.e., the terms of the coverage policy) becomes a federal ERISA claim "to enforce the terms of the plan." Interestingly, the *Dukes* and *Rice* approaches to the question of what claims can be characterized as claims to enforce the terms of an ERISA plan can be harmonized. One view of when the § 301 standard is met is whether the state law claim is "independent"—in that it does not depend on the existence of a collective bargaining agreement. See Mark L. Adams, *Struggling Through the Thicket: Section 301 and the Washington Supreme Court*, 15 BERKELEY J. OF EMP. & LAB. LAW, 106, 106-40 (1994) (citing Stephanie R. Marcus, Note, *The Need for a New Approach to Federal Preemption of Union Members' State Law Claims*, 99 YALE L. J., 209, 209-230 (1989-90)). This is in essence the test articulated by the court in *Dukes*. However, the case law articulating the scope of preemption under § 301 of the LMRA is itself the subject of considerable dispute. Thus, the Seventh Circuit's approach to the ERISA preemption analysis is bound to muddy the waters considerably more than the Third Circuit's more straightforward approach.

216. *Rice*, 65 F.3d at 644.

217. *Id.* at 645.

218. *Id.*

219. This is a narrower view than some lower courts had previously taken. See,

### b. Application to Coverage Denials

The analyses used in *Dukes* and *Rice* similarly show that some state common law actions arising from coverage denials may be found inconsistent with § 502(a)(1)(B), but that some would not. First, a state common law action challenging a denial of coverage based on conduct that did not involve an exercise of medical judgment might be found to constitute a suit “to enforce rights” due under the terms of the plan. The essence of such a claim is that benefits were withheld for a reason more contractual in nature. Thus, the claim would not satisfy the test articulated by the *Dukes* court because it would be enforcing the right to benefits due under the plan terms—not a contract right *other than* the right to benefits. However, because resolution of the claim would require the interpretation of the plan, the claim would seem to satisfy the *Rice* test. If so, the claim could be found preempted due to an inconsistency with § 502(a)(1)(B).

A state law claim arising from a coverage denial involving an exercise of medical judgment, however, is not a suit “to enforce rights” under an ERISA plan under either test. A policyholder’s right to be free from negligent medical decision making is independent from the ERISA plan. Thus, such a claim generally would not enforce a right conferred by the contract and, under the *Dukes* approach, the claim would not fall within the scope of § 502(a)(1)(B). Similarly, a state law claim challenging conduct involving an exercise of medical judgment generally would not constitute a suit “to enforce rights” under the approach established in *Rice*. However, a fuller analysis of the outcome under the approach used in *Rice* is necessary.

Under *Rice*, whether a state law tort suit constitutes a suit to enforce rights under the terms of the plan depends on whether resolution of the state law suit will require an interpretation of the ERISA plan. When the suit involves health benefits, the relevant plan document is the policy setting forth health coverage. Some policies simply cover certain medical services, as long as a utilization reviewer agrees that the treating physician’s recommendation is for a covered service that is “medically necessary” or “reasonable and necessary.” In that case, the issue raised by a claim challenging an allegedly negligent UR decision is whether the review failed to conform to accepted medical standards. Resolving that issue would not—and should not—require interpretation of the coverage policy.

Other policies, however, may go further and have specialized definitions of what constitutes “medically necessary” or “reasonable and necessary.” In such a case, it is less clear whether resolution of the state law suit will require an interpretation of the ERISA plan. As explained in Part II(B), some tort actions

---

*e.g.*, *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966, 972 (S.D.N.Y. 1994) (holding a state tort claim preempted in part because resolution would require scrutiny of plan documents).

arising in connection with a denial of coverage under a more detailed definition of medical necessity could be characterized as actions challenging conduct that involved contractual interpretation or application but not an exercise of medical judgment. For example, what if the policy stated that, to be medically necessary, a treatment must be approved for reimbursement by the Health Care Financing Agency, and a denial of coverage was based on a finding that the treatment was not so approved? In such a case, resolution of the plaintiff's claim that the coverage denial was wrongful and that the managed care plan should be accountable for the resulting harm may well involve an interpretation of the health coverage policy. Thus, under the *Rice* approach, the state law claim would be inconsistent with § 502(a)(1)(B) and would be preempted. Other than that type of situation, however, a state tort action arising in connection with a denial of coverage involving medical decision making generally would not be found to be inconsistent with § 502(a)(1)(B).

*C. Despite a Narrower View of Preemption, Some Claims Arising from Coverage Decisions Would Still Be Preempted—and a Federal Legislative Solution Is Thus Preferable*

This necessarily lengthy and complex analysis shows that, even under the emerging, narrower view of preemption, some state claims against managed care plans arising from a coverage denial would remain preempted. The analysis strongly supports the argument that, under the emerging approach, courts should find that Congress did not intend for ERISA to preempt those claims arising from coverage denials that involve medical decision making and that would constitute state regulation of the quality of health care. Because recent Supreme Court precedent has undermined the rationale used by the Fifth Circuit in *Corcoran*, such a claim should not be found to have a sufficient effect on ERISA plans to warrant preemption under § 514(a) of ERISA. Partly because of that, such a claim also should not be found to be preempted for inconsistency with § 502(a)(1)(B). Additionally, that view is supported by tests articulated by recent circuit courts of appeals decisions for use in determining whether such a claim falls within the scope of § 502(a)(1)(B). In contrast, however, state claims arising from a coverage denial that did not involve medical decision making stand on different footing. Claims that do not challenge medical decision making cannot be characterized as state regulation of the quality of health care. Thus, under both the Supreme Court trilogy and the appellate court tests, this type of suit may still be found to be preempted.

The issue becomes, of course, what does this mean in terms of the debate over a federal legislative solution to the preemption problem. That is, is a federal amendment to ERISA necessary if the courthouse door is being opened for at least some claims against managed care plans? The answer to that question depends on whether the permissible claims would provide sufficient regulation of coverage denials by managed care plans.

Under the emerging judicial view of preemption, permissible claims would be those that regulate the quality of medical necessity determinations made by managed care plans. That is, claims that would hold managed care plans accountable for medical decision making and that are akin to the types of suits used to hold health care professionals liable for their negligence, such as claims for managed care plan “medical malpractice liability” or claims holding plans vicariously liable for medical decisions made by their “medical directors.”<sup>220</sup> Because of ERISA preemption, few cases exist that directly support extension of medical malpractice liability to managed care plans.<sup>221</sup> Significantly, however, sufficient case law exists to warrant the assumption that, if the ERISA preemption barrier is removed, courts will fill the void.<sup>222</sup>

220. In *Moscovitch*, the plaintiff asserted a medical malpractice claim directly against the managed care plan. *See supra* notes 107-11 and accompanying text. In other cases, plaintiffs have sought to hold the plan vicariously liable for medical decision making by plan administrator or other agent. *See, e.g.*, *Hull v. Fallon*, 188 F.3d 939, 941 (8th Cir. 1999), *cert. denied*, 120 S. Ct. 1242 (2000); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1484 (7th Cir. 1996); *Crum v. Health Alliance-Midwest, Inc.*, 47 F. Supp. 2d 1013, 1016 (C.D. Ill. 1999).

221. Medical malpractice claims arising from allegedly negligent determinations of medical necessity involve “coverage denials” and, thus, historically have been viewed as preempted. *See supra* notes 94-106.

222. The foundation for such a claim was laid in two landmark cases out of California. *See Wickline v. California*, 228 Cal. Rptr. 661, 670 (Ct. App. 1986); *Wilson v. Blue Cross of Southern California*, 271 Cal. Rptr. 876, 886 (Ct. App. 1986). *Wickline* recognized several important principles: (1) that an erroneous prospective or concurrent UR decision likely results in the withholding of necessary care and potential injury to the patient; (2) that patients injured when care is not provided should recover from all those responsible for the wrongful deprivation of care; (3) that a UR decision often involves an exercise of medical judgment; and (4) that payers can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms. *Wilson* confirmed the view that the imposition of tort liability on a private managed care plan is appropriate when warranted by the facts.

More recently, two state supreme courts have implicitly recognized the applicability of a malpractice type of claim against a managed care plan. *See McEvoy v. Group Health Coop.*, 570 N.W.2d 397, 402-03 (Wis. 1997); *Long v. Great West Life & Annuity Ins. Co.*, 957 P.2d 823, 832 (Wyo. 1998). In *McEvoy*, the court held that the theory of tortious breach of contract could apply to HMOs. Specifically, the court held that, when the UR decision is a nonmedical, coverage-related decision, the “HMO should be held to the same level of responsibility for its actions as a traditional insurance company.” *McEvoy*, 570 N.W.2d at 404. Logically, the *McEvoy* opinion also stands for the converse proposition; namely, that, the more closely the decision at issue resembles an exercise of medical judgment made by a health care provider, the more appropriate the tort of malpractice becomes; and the HMO should be held accountable to the same extent as health care providers, through the tort of medical malpractice.

Thus, under the emerging view of preemption, ERISA plan participants and beneficiaries could bring tort suits that would create an incentive to use reasonable care in making medical decisions that are part and parcel of benefit determinations. Lack of accountability for negligent medical necessity determinations is viewed by many as the most egregious aspect of the preemption problem.<sup>223</sup> Accordingly, a significant component of consumer concerns could be addressed without a federal legislative provision amending the scope of ERISA preemption.

Yet, many likely believe that other managed care practices need to be addressed as well. For example, what if a managed care plan denies a claim for benefits for the stated reason that the enrollee did not have a referral from the enrollee's primary care physician, but the enrollee really did have the referral? Or what if a claim for benefits is denied because the enrollee went to her physician's office twice in one calendar year as purportedly permitted by the policy, but the visits were not exactly six months apart as the managed care plan interpreted the policy to require? Further, what if the managed care plan denied these claims knowing that, if appealed, they would be paid, but hoping that they would not be appealed so that the plan would never have to pay the claims? Denials such as these would be based on contract language and not on determinations of medical necessity.

Thus, rather than a "medical malpractice" type of claim, a suit challenging denials based on managed care practices other than medical decision making would likely take the form of a suit for bad faith or tortious breach of contract.<sup>224</sup> Courts developed the bad faith breach of contract claim to encourage fair treatment of insureds and to penalize unfair and corrupt insurance practices.<sup>225</sup>

223. See, e.g., David Mechanic, *Managed Care as a Target of Distrust*, 277 JAMA 1810 (1997). See also National Coalition on Health Care, *Survey, A Reality Check: The Public's Changing View's of Our Health Care System* (1996), available in <<http://www.nchc.org/emerg/exec0498.html>>. One commentator states:

Patients and physicians are concerned—quite justifiably—about the effect that a system riven by economics will have on quality of care and professional independence. Patients fear that care managers will pay insufficient attention to the clinical consequences of their actions and will engage in de facto rationing of expensive services. Physicians fear they will be caught between a rock and a hard place, beset on one side by arbitrary contracting policies and administrative requirements and on the other by legal responsibility for sub-optimal clinical outcomes.

Sage, *supra* note 27, at 162.

224. Most states have recognized that insurers are subject to a duty to act in good faith and to deal fairly with their insureds. An insurer's breach gives rise to a cause of action for tortious breach of contract. The cause of action is intended to compensate the insured for injury caused by the insurer's wrongful conduct, not for benefits covered by the policy. See generally John H. Bauman, *Emotional Distress Damages and the Tort of Insurance Bad Faith*, 46 DRAKE L. REV. 717 (1998).

225. See *McEvoy*, 570 N.W.2d at 402 (citing cases). The tort of bad faith is a

Although traditionally applied to insurance companies, courts have extended the tort to managed care plans.<sup>226</sup> Indeed, both Karen Johnson and Teresa Goodrich pursued and successfully obtained compensatory and punitive damages through bad faith breach of contract claims against their managed care plans.<sup>227</sup> Because a bad faith breach of contract claim regulates unfair insurance practices or analogous managed care plan activities, the claim does not constitute state regulation of health care.

Suits challenging managed care plan practices other than medical decision making therefore would not represent state regulation of the quality of care and thus would continue to be found preempted.<sup>228</sup> ERISA plan participants could bring a suit under § 502(a)(1)(B), but would be barred from any extracontractual damages. Thus, a claimant would be limited to recovery of benefits due (*e.g.*, payment of the claim) notwithstanding any bad faith in the coverage denial.<sup>229</sup> Accordingly, many ERISA plan participants and beneficiaries would likely think it preferable to have a federal legislative solution to the preemption problem that would not only permit suits against managed care plans for malpractice-type claims, but would also permit suits involving claims for bad faith breach of contract in order to provide an incentive for managed care plans to act fairly. If a federal legislative solution is preferable in order to satisfactorily emasculate the shield of ERISA preemption, the issue becomes whether the Norwood-Dingell bill represents a sound legislative solution.

## VI. ASSESSMENT OF THE SOLUTION PROPOSED IN THE NORWOOD-DINGELL BILL

As explained in Part IV of this Article, the Norwood-Dingell bill<sup>230</sup> would broadly open the door to state common law claims against managed care plans.

---

hybrid claim, based on both contract and tort principles. The theory recognizes that “bad faith by one party to a contract toward another is a tort separate and apart from a breach of contract and that separate damages may be recovered for the tort.” *Id.*

226. *Id.*

227. *See supra* notes 1-3 & 41-47 and accompanying text.

228. *See, e.g.*, *Buters v. Royal Maccabees Life Ins. Co.*, 174 F.3d 1207, 1213 (11th Cir. 1999) (holding that claims asserting breach of contract and bad faith refusal to pay are within the scope of § 502(a)(1)(B) of ERISA). Further, although a bad faith breach of contract claim arguably represents “state regulation of insurance,” such a claim is not likely to be found to be exempt from preemption under ERISA’s saving clause. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50-52 (1985) (holding that a state common action for bad faith breach of contract, although developed in the context of insurance contracts, was not a state law “regulating insurance” and thus saved from preemption because the cause of action evolved from general principles of tort and contract law).

229. *See supra* note 181 and accompanying text. *But see Jordan, supra* note 57, at 273.

230. H.R. 2723, 106th Cong. (1999).



The Norwood-Dingell bill amends § 514 of ERISA by adding a subsection which states that:

[N]othing in this title shall be construed to invalidate, impair, or supersede any cause of action by a participant or beneficiary . . . under State law to recover damages resulting from personal injury or for wrongful death against any person—(i) in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health plan, or (ii) that arises out of the arrangement by such person for the provision of such insurance, administrative services, or medical services by other persons.<sup>231</sup>

The provision does not attempt to delimit in any way the types of state law claims that are exempt from preemption, or the type of conduct that could give rise to a claim.<sup>232</sup> An action could arise from any aspect of a managed care plan's operation that results in personal injury or wrongful death. The provision, therefore, would satisfy consumer concerns about managed care plan accountability by allowing both malpractice-types of claims and claims for bad faith breach of contract. But, whether the Norwood-Dingell bill represents a sound legislative solution depends on whether the provision goes too far in opening the door to managed care plan liability.

Notably, the Norwood-Dingell bill does contain some significant limitations which seem to address many of the concerns reflected in the alternate bills that surfaced in the House. The publicized limitations in the bills offered as alternatives to the Norwood-Dingell bill involved only "who" could be held accountable (*e.g.*, the person making the sole final decision), the degree of harm necessary to support a claim (*e.g.*, upon a showing of substantial harm), and "how much" could be recovered (*e.g.*, only up to designated dollars caps on noneconomic and punitive damages).<sup>233</sup> The Norwood-Dingell bill, if examined closely, contains similar limitations.

First, the Norwood-Dingell bill has a restriction regarding who would be a proper defendant to a claim brought by a plan participant or beneficiary. Although the Norwood-Dingell provisions would allow a state suit against any managed care plan, regardless of its organizational form, the bill would not authorize any claim (including a claim for indemnity) against "an employer or other plan sponsor maintaining the group health plan (or against an employee of

231. See H.R. 2723 § 302(a) (amending § 514 of ERISA by adding § 514(e)(1)(A)(i)-(ii)).

232. Further, the bill would not require ERISA plan participants and beneficiaries to exhaust the plan's administrative process where the injury or death occurred before completion of the process. H.R. 2723 § 302(a) (amending § 514 of ERISA by adding § 514(e)(3)).

233. See *supra* notes 121-24 and accompanying text.

such employer).”<sup>234</sup> This seems like an appropriate balance given consumer concerns regarding managed care plans generally. Protecting employers or unions from lawsuits will allay concerns that the provision may cause employers to discontinue health coverage. On the other hand, the alternative of requiring an ERISA plan participant or beneficiary to identify the person making the “sole final decision” seems an unnecessary complication.

Second, the Norwood-Dingell bill also has a limitation on the degree of harm necessary to support a claim. The bill encompasses only claims resulting in wrongful death and personal injury.<sup>235</sup> Personal injury is defined as “personal injury,” although it includes “an injury arising out of the treatment (or failure to treat) a mental illness or disease.”<sup>236</sup> Again, this seems to strike an appropriate balance. The limitation precludes lawsuits based on state claims when enrollees are simply disgruntled by the strategies or coverage decisions of a managed care plan, even if their disgruntlement rises to the level of emotional distress. Yet, the bill permits recovery when harm is tangible and does not complicate the action with an ambiguous requirement of “substantial harm.”

Third, the bill has a restriction on the availability of punitive damages. However, the Norwood-Dingell limitation on punitive damages would not provide as much protection from punitive damages to managed care plans as some of its alternatives. The Norwood-Dingell bill provides that the plan would not be liable for punitive damages if the claim relates to an “externally appealable decision”; the external appeal was initiated in a timely manner and completed; and the plan complied with the determination resulting from the external appeal.<sup>237</sup> As noted, an “externally appealable decision” under the bill is a coverage denial arising from conduct involving an exercise of medical judgment.<sup>238</sup> Thus, the Norwood-Dingell bill limitation would apply only to

234. However, this exemption from liability is not available if the action is based on “the employer’s or other plan sponsor’s (or employee’s) exercise of discretionary authority to make a decision on a claim for benefits covered under the plan or health insurance coverage” and if that exercise of authority results in personal injury or wrongful death. H.R. 2723 § 302 (amending § 514 of ERISA by adding § 514(e)(2)(B)(i)-(ii)). Further, the bill defines the phrase “an exercise of authority” to protect certain types of decisions: a decision to include or exclude from the plan any specific benefit, a decision to provide extracontractual benefits, and a decision to refrain from making any decision about the provision of a benefit while internal or external review is being conducted. H.R. 2723 § 302(A) (amending § 514 of ERISA by adding § 514(e)(2)(C)(i)-(iii)).

235. H.R. 2723 § 302(a) (amending § 514 of ERISA by adding § 514(e)(1)(A)).

236. Although physical injury “includes an injury arising out of the treatment (or failure to treat) a mental illness or disease.” H.R. 2723 § 302(a) (amending § 514 by adding § 514(e)(1)(C)). Where no physical injury has occurred, plan enrollees will still have available a cause of action under ERISA for recovery of “benefits due.”

237. H.R. 2723 § 302(a) (amending § 514 of ERISA by adding § 514(e)(1)(B)(i)-(iv)).

238. The term is defined as:

claims arising from coverage denials involving an exercise of medical decision making<sup>239</sup> and, therefore, it would not apply to suits based on the tort of bad faith breach of contract. As the Johnson and Goodrich cases show, large punitive damages verdicts can result in cases based on bad faith claims.<sup>240</sup> Thus, the provision reflects a compromise: The potential for liability would address consumer concerns about the accountability of managed care plans, and the restriction on punitive damages if an external appeals process is properly used would protect both consumers (as it is likely to encourage proper use of an external appeals process) and managed care plans.

The question becomes whether the Norwood-Dingell restriction on punitive damages is sufficient. The alternate bills would have gone further. One bill would have capped punitive damages at the greater of \$250,000 or twice the economic damages.<sup>241</sup> Another would have banned punitive damages altogether if the plan's denial was upheld by external reviewers.<sup>242</sup> On the one hand, the more limited restriction in the Norwood-Dingell bill is arguably more appropriate than the broader ban on punitive damages offered in the alternative bills. To recover punitive damages in bad faith claims, plaintiffs generally must show that the defendant acted maliciously or with reckless or gross disregard of the plaintiff.<sup>243</sup> If a plaintiff has strong evidence of such conduct by the managed care plan in relation to a coverage denial, should the managed care plan be protected to the extent that it would be with a broader ban on punitives?

A denial of claim for benefits . . . (i) that is based in whole or in part on a decision that the item or service is not medically necessary or appropriate or is investigational or experimental; or (ii) in which the decision as to whether a benefit is covered involves a medical judgment.

H.R. 2723 § 103(a)(2).

239. The House Bill provides that the plan would not be liable for punitive damages if the claim relates to an "externally appealable decision"; the external appeal was initiated in a timely manner and completed; and the plan complied with the determination resulting from the external appeal. *See* H.R. 2723 § 302(a) (amending § 514 of ERISA by adding § 514(e)(1)(B)(i)-(iv)). An "externally appealable decision" would be a coverage denial arising from conduct involving an exercise of medical judgment.

240. *See also* Bauman, *supra* note 224, at 749-54 (exploring the appropriateness of allowing recovery of damages for emotional distress in bad faith breach of contract claims).

241. *See Norwood-Dingell Managed Care Bill, supra* note 121, at d2 (describing Coburn-Shadegg bill).

242. *Id.* (describing the Houghton amendment).

243. *See, e.g.,* Anderson v. Continental Ins. Co., 271 N.W.2d 368, 376-77 (Wis. 1978) (explaining that a plaintiff must show the "absence of a reasonable basis for denying benefits of the policy" plus the insurance company's "knowledge or reckless disregard of the lack of a reasonable basis for denying the claim"). Professor Bauman has noted that judicial formulations such as this one require the plaintiff to show that the tort was an intentional one. *See* Bauman, *supra* note 224, at 741-42.

Arguably no: Because without the possibility of punitive damages, there is no real incentive to avoid “bad faith” denials in the future.

On the other hand, a broader limitation on punitive damages in all cases against managed care plans, including bad faith breach of contract claims, may lessen the financial consequences of allowing suits arising out of coverage denials and thereby help ensure that any federal legislative solution will not result in employers discontinuing the provision of health benefits. The legitimacy of that concern is debatable,<sup>244</sup> and indeed, perhaps it represents a factor that is truly unquantifiable.<sup>245</sup> Nonetheless, if a broader ban on punitive damages is crucial in order to get a federal solution to the ERISA preemption problem, supporters of the Norwood-Dingell bill should make the compromise.

The result would still leave ERISA plan participants and beneficiaries in better position than they are without a federal legislative solution. Without a federal legislative solution, courts can open their doors only to suits challenging coverage denials involving an exercise of medical decision making (*i.e.*, managed care plan medical malpractice claims). If the Norwood-Dingell bill is enacted, plan participants and beneficiaries would also be able to challenge other coverage denials—those not involving an exercise of medical judgment, but involving some other questionable managed care tactic (*e.g.*, bad faith breach of contract claims). Even if punitive damages are not allowed, plan participants and beneficiaries would be able to recover compensatory damages for physical injuries.<sup>246</sup> This is a remedy currently unavailable to ERISA plan participants and beneficiaries, and is definitely a step in the right direction. Most legislative solutions involve a balancing of competing interests. Adopting the Norwood-Dingell provision, with a compromise on the issue of punitive damages, seems an appropriate balance to strike in this area.

## VII. CONCLUSION

Most lower courts have continued to find that ERISA plan participants and beneficiaries are barred from pursuing any suit against a managed care plan for injuries sustained as a result of the plan’s wrongful denial of benefits. Suits arising from coverage denials are found to be preempted whether the denial is based on a more purely contractual reason or on conduct involving the exercise of medical judgment. This Article concludes that a federal legislative solution to the preemption problem in cases involving coverage denials is appropriate

---

244. See *supra* note 169 and accompanying text.

245. See *Rand Study on ERISA Health Plan Liability Yields Mixed Results*, MEALEY’S MANAGED CARE LIABILITY REP., July 28, 1999, at 19 (reporting that a study by the RAND Institute for Civil Justice found that support for claims on both sides of the debate is weak “as most of the necessary data for accurate estimates are not available”).

246. In addition, in appropriate cases plan participants and beneficiaries may be able to recover damages for emotional distress in claims based on bad faith breach of contract. See Bauman, *supra* note 224, at 752.

because, although the emerging judicial view of preemption might permit state law claims challenging coverage decisions based on medical decision making, state law claims that would provide an incentive for managed care plans to act fairly would likely remain preempted.

Further, the Article concludes that the liability provisions in the Norwood-Dingell bill reflect a basically sound solution to the preemption problem. First, the liability provision in the Norwood-Dingell bill would largely eviscerate the preemption problem by carving out from the scope of ERISA preemption any state law causes of action against plans when coverage denials result in personal injury or wrongful death, including malpractice-types of claims and claims for bad faith breach of contract. Second, the Norwood-Dingell bill contains significant limitations on the right to sue which arguably reflect a meaningful balancing of the interests at stake. The provisions would protect employers and plan sponsors from liability and restrict suits to cases involving physical injury. Further, the bill would ban punitive damages in cases involving coverage denials based on an exercise of medical judgment if the appeals process is properly accessed and complied with by the managed care plan.

However, punitive damages would be available and unrestricted in other coverage denial cases, thereby providing fuel for the arguments that the liability provisions will cause costs to rise and employers to drop health coverage. Thus, further compromise on the issue of punitive damages may be prudent if necessary to ensure enactment of patient protection legislation that includes a right to sue.