

JUDICIAL INTERPRETATION OF MANAGED CARE POLICY

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For the past twenty-five years, the federal and state courts have been very active in adjudicating controversies over: (a) the role of the federal and state levels of government in designing and regulating the American health care system, which involves fundamental issues of federalism; (b) critical issues related to managed care benefits determinations, which involves interpretation of ERISA; and (c) critical issues related to the future of managed care plans and organizations.

This article is based on a comprehensive empirical examination of the federal and state court cases related to managed care law. This analysis supports the notion that our judicial institutions cannot make up their minds about whether to support or restrain managed care.

There are three special features of this article: (1) it is based on an examination of all federal and selected state court cases since 1990; (2) we have included an analysis of the critical 2003 and 2004 unanimous Supreme Court cases (Kentucky v. Miller and Aetna v. Davila)—one of which is supportive of managed care plans and one of

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which is not; and (3) it contains a special appendix which is divided into six tables displaying all of the Supreme Court, circuit court, and state court cases relevant to managed care since 1990.

The judicial interpretation of ERISA, over time, makes it clear that Congress and/or the Supreme Court needs to take steps to develop a more just, consistent, and fair system of administration and regulation of health insurance and health care benefits.

From 1985 to the present, the American health care system has been undergoing a fundamental transformation from a service delivery system financed primarily through fee-for-service mechanisms to one which is dominated by managed care plans. In 2004, more than 177 million Americans were enrolled in a managed care organization.¹ This represents a transformation of the American health care system from one dominated by fee-for-service plans to one in which “more than ninety percent of all persons with employer-based health insurance coverage [in 2000] were enrolled in some form of managed care . . .” plan.² Only a decade earlier, fewer than three out of ten people with health insurance coverage were enrolled in managed care plans.³ Moreover, by the mid 1990s, over eighty percent of the practicing physicians in the United States had entered into a contractual arrangement with at least one managed care plan, which represents a one-third increase from the previous five years.⁴ From the provider perspective, participation in a managed care plan has become essential to practicing medicine.⁵

With the rise of managed care organizations (MCOs), there has also been a rise in judicial proceedings involving these organizations. These cases have focused on the benefits that MCOs offer through employers, which necessitates judicial interpretations of the Employee Retirement Income Security Act of 1974 (ERISA).⁶ The increased litigation involving managed care organizations is part of the “backlash”

1. MCOL, MANAGED CARE FACT SHEETS: MANAGED CARE NATIONAL STATISTICS at <http://www.mcareol.com/factshts/factnati.htm> (last visited Mar. 7, 2005).

2. Sara Rosenbaum & Brian Kamoie, *Managed Care and Public Health: Conflict and Collaboration*, 30 J.L. MED. & ETHICS 191, 192 (2002).

3. FAMILIES USA FOUND., HIT AND MISS: STATE MANAGED CARE LAWS 1 (1998), at <http://www.familiesusa.org/site/DocServer/hitmiss.pdf>.

4. Rosenbaum & Kamoie, *supra* note 2, at 193.

5. *Id.*; see also David Segal, *Doctors Who Dodge a Managed Care Stampede*, WASH. POST, May 20, 1996, at F5.

6. The Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001–1461 (2004).

from the general public, physicians, and the media against managed care.⁷

Over the past twenty-five years, the federal and state courts have been very active in adjudicating controversies over: (a) the role of the federal and state levels of government in designing and regulating the American health care system, and the extent to which federal initiatives in health policy preempt state actions; (b) critical issues related to managed care benefits determination and key components of managed care plans (e.g., the use of incentive systems, selective contracting, the quality/quantity distinction); and (c) critical issues related to the future of managed care plans and organizations (e.g., a series of lawsuits against HMOs put the question of MCO liability on the top of the health policy agenda).⁸ In other words, the courts have dealt explicitly with controversial issues related to the implementation of managed care theory and implicitly with the role of the states and federal government in regulating health insurance and employee benefit plans in general and managed care organizations in particular.

The “jurisprudence” of managed care, as exemplified by federal and state court decisions interpreting the congressional intent behind the Health Maintenance Organization Act of 1973,⁹ ERISA,¹⁰ and various state statutes and regulations is inconsistent and even confusing.¹¹ The primary issues discussed by the circuit courts include common-law claims, cases involving specific state statutes and some claims that fall outside of the ERISA preemption analysis undertaken by the courts.¹² The cases include claims for: breach of contract; malpractice; vicarious liability; breach of duty of good faith; unfair trade practices;

7. See generally Robert J. Blendon et al., *Understanding the Managed Care Backlash*, HEALTH AFF., July–Aug. 1998, at 80 (describing the nature of the backlash and its origins in patient and provider dissatisfaction with changes in their health insurance arrangements); see also Mollyann Brodie et al., *Media Coverage of Managed Care: Is There a Negative Bias?*, HEALTH AFF., Jan.–Feb. 1998, at 9 (describing the media’s relation of high-profile, but uncommon, examples of managed care “horror stories” to the public).

8. See Douglas A. Hastings, *Patients’ Rights Meet Managed Care: Understanding the Underlying Conflicts*, 31 J. HEALTH L. 3, 241 (1998).

9. Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (codified at 42 U.S.C. §§ 300e–300e-14a (2004)).

10. ERISA §§ 1001–1461 (2004).

11. See generally Russell Korobkin, *The Failed Jurisprudence of Managed Care, and How to Fix It: Reinterpreting ERISA Preemption*, 51 UCLA L. REV. 457 (2003) (detailing the convoluted history of judicial interpretation of ERISA as it relates to managed care).

12. See, e.g., Penny/Ohlmann/Niemen, Inc. v. Miami Valley Pension Corp., 399 F.3d 692 (6th Cir. 2005).

control over the MCO-provider relationship; surcharges on MCOs; regulations of MCOs by states; disclosure of MCO incentive structures; and abuse of discretion.¹³

The case history surrounding managed care supports the notion that our judicial institutions cannot decide whether to support or restrain managed care.¹⁴ Court interpretations of the relevant sections of ERISA have served both to restrict and protect MCOs. Between 1990 and 2004, at the Supreme Court level, there were three cases that were supportive and five cases that were restrictive of managed care plans or practices;¹⁵ at the federal circuit court level, there were seventy-four supportive and sixty-four restrictive cases;¹⁶ and at the state court level, there were nine supportive and ten restrictive cases.¹⁷ These simple statistics reinforce our argument that court decisions have been inconsistent and even contradictory with respect to managed care policy.

Part I of this article provides an overview of the debate in the courts over the appropriate role of government in regulating the American health care system. Interpretation of ERISA¹⁸ represents a major part of the tension between the federal and state levels of government over what constitutes appropriate regulation of the health care system. Part II focuses on how the federal and state courts have dealt with key controversies and critical issues surrounding managed care plans. Part III concludes the article by looking at the trends in judicial interpretation as they relate to the future of managed care organizations. In addition, there is a comprehensive appendix which covers federal and state court cases relevant for managed care plans between 1990 and 2004. The appendix consists of six tables, which are

13. *Id.*

14. This is consistent with the executive and legislative branches of government who have also been inconsistent, and even contradictory, in their support of managed care theory and managed care organizations. See Robert F. Rich & Christopher T. Erb, *The Two Faces of Managed Care Regulation and Policy-Making*, 16 STAN. L. & POL'Y REV. 233 (2005).

15. See *infra* App. tbl. 1.

16. See *infra* App. tbl. 2.

17. These numbers are based on a sampling of cases which dealt primarily with managed care and ERISA and are deemed by the authors to have significant implications for the operation of managed care plans; the assignment of the classification 'supportive' or 'restrictive' is based on the authors' interpretation of the courts' holdings and interpretations in each case. See *infra* App. tbl. 3.

18. See 29 U.S.C. §§ 1001-1461 (2004).

organized around the issue of whether they are supportive or restrictive of managed care.

I. The Role of the Federal and State Governments in Health Care Regulation

Legal controversies in American health care policy, in the broadest sense, can be seen in the context of judicial interpretation of ERISA. ERISA was originally passed in 1974 to ensure for uniformity in the administration of pension plans and retirement benefits.¹⁹ Representative John Dent, who was one of the authors of ERISA, noted:

I wish to make note of what is to many the crowning achievement of this legislation: reserving of Federal authority the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation.²⁰

The legislative intent behind ERISA was also, in part, to allow multi-state employers to avoid the administrative burden of having to comply with multiple, different state regulations.²¹

There are three main parts of ERISA that have been important in the jurisprudence surrounding this law. The first, section 514(a), provides that ERISA shall “supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.”²² This section establishes the supremacy of the federal statute in regulating employee benefits. The second most important part of ERISA as it is applied to health insurance benefits has proven to be section 514(b)(2)(A), which provides that nothing in ERISA “shall be construed to exempt or relieve any person from any law of any State which regulates insurance.”²³ This section, known as the “saving clause,” maintains for the states their traditional role as regulators of

19. Margaret G. Farrell, *ERISA Preemption of Managed HealthCare: The Case for Managed Federalism*, 23 AM. J.L. & MED. 251, 260 (1997).

20. 120 CONG. REC. 29, 197 (1974).

21. Farrell, *supra* note 19, at 260 n.53.

22. 29 U.S.C. § 1144(a) (2004). Citations to ERISA are complex, and, while most judicial opinions refer to the U.S. Code numbering (29 U.S.C. § 1144(a) (2004)), many judicial scholars refer to the numbering in the Act e.g. § 514(a). See RAND E. ROSENBLATT ET AL., *LAW AND THE AMERICAN HEALTH CARE SYSTEM* 160 (1997). Throughout the text of this paper the various sections of ERISA will be referred to by the section numbers given in the original legislation, as passed by Congress (e.g., § 514(a)). For clarity and for the reader's convenience, we provide footnote citations to the U.S. Code where appropriate.

23. 29 U.S.C. § 1144(b)(2)(A).

insurance.²⁴ One exception to the saving clause has been important as well. The “deemer clause” (section 514(b)(2)(B)) states that no employee benefit plan “shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts.”²⁵ This clause precludes states from attempting to regulate employee benefit plans by disguising their laws as “insurance regulation,” and is particularly important in protecting organizations which have become self-insured.²⁶ A final section of ERISA that has created some significant litigation is section 502(a)(1)(B), which provides for complete preemption by ERISA of any claims “to recover benefits due . . . under the terms of the plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.”²⁷ This section specifically brings under the purview of ERISA any dispute about the nature of insurance benefits provided by an insurance company, and it ensures that any awards or damages will be standardized at the federal level and not by so-called piecemeal state legislation.

The hallmark of ERISA, as it applies to health care policy and regulation, is the broad preemption provision which stipulates that all state laws which “relate to” employee benefit plans are preempted.²⁸ The Supreme Court has consistently endorsed its view of the intent behind the original legislation: “[t]he 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.”²⁹ Consequently, state initiatives to regulate health policy became a major source of legal controversy: was this a regulation which “relates to” an employee benefit plan (and is, therefore, preempted) or is it, instead, a health insurance regulation which is appropriately within the jurisdiction of the states (i.e., “saved” from federal preemption)?

24. *Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039, 1043 (9th Cir. 1998).

25. 29 U.S.C. § 1144(b)(2)(B).

26. See Edward Albuoro Morrissey, *Deem and Deemer: ERISA Preemption Under the Deemer Clause as Applied to Employer Health Care Plans with Stop-Loss Insurance*, 23 J. LEGIS. 307, 308–09 (1997).

27. 29 U.S.C. § 1132(a)(1)(B).

28. See *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657 (1995).

29. *Id.*

Judicial interpretation of ERISA has, in large part, focused on these controversial issues of federalism. The underlying question has been: what is the appropriate role of the federal and state governments in developing health care law, policy, and regulation? Despite a long tradition of considering health insurance regulation and public health to be matters in the states' jurisdiction,³⁰ ERISA has recently been used to assert broad, national standing in the area of health care.³¹ As a result, over the past thirty years, there has been a strong tension between the states' assertion of its jurisdiction and the intent of Congress to provide or create uniformity in the administration of employee benefits.³²

A. Preemption Analysis over Time: An Overview

The Supreme Court has interpreted the ERISA preemption provision in a substantial number of cases since its enactment in 1974. Initially, the interpretation of the provision was particularly broad.³³ In 1983, in *Shaw v. Delta Airlines, Inc.*, the Court stated, "[t]he breadth of § 514(a)'s pre-emptive reach is apparent from that section's language."³⁴ The *Shaw* decision basically invited preemption of any state regulation or policy dealing with employee benefits, including health benefits.³⁵ On the other hand, in 1985, in *Metropolitan Life Insurance Co. v. Massachusetts*,³⁶ a state law requiring health insurance companies to provide mental health benefits was held to be saved from ERISA preemption under § 514(b)(2)(A) because it was a law that regulated insurance.³⁷ Despite this early ambiguity, a general pattern in Supreme Court decisions ensued from *Shaw* up to *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*; in 1995 this pat-

30. JILL MARSTELLAR & RANDALL BOVBJERG, THE URBAN INST. FEDERALISM AND PATIENT PROTECTION: CHANGING ROLES FOR STATE AND FEDERAL GOVERNMENT, OCCASIONAL PAPER 28 (1999), at <http://www.urban.org/url.cfm?Id=309099> (last visited Mar. 28, 2005).

31. See, e.g., *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Shaw v. Delta Airlines*, 463 U.S. 85 (1983).

32. Compare *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), with *Shaw*, 463 U.S. at 85.

33. See *Shaw*, 463 U.S. at 98 (the first Supreme Court case finding ERISA to have broad preemption power over states' efforts to enact health care laws in the managed care era).

34. *Id.* at 96.

35. See *id.* at 96-98.

36. *Metro. Life Ins. Co.*, 471 U.S. at 724.

37. See *id.* at 744.

tern allowed for complete preemption of state health care regulations.³⁸ The Court's consistent assumption, starting with *Shaw*, was that health insurance is an "employee benefit," as defined by ERISA, if an employee received this insurance through an employer.³⁹ Hence, before *Travelers*, one merely had to invoke the phrase "relates to" (employee benefits) to ensure an almost automatic finding of preemption by the federal courts.⁴⁰ Indeed, the Court's approach from 1983 (*Shaw*) to 1995 (*Travelers*) held that state law was preempted unless its relationship to an ERISA plan was "too tenuous, remote, or peripheral."⁴¹ The presumption was, in other words, for preemption of any state laws related to health care policy. This prevailing point of view was a key component in *Pilot Life Insurance Co. v. Dedeaux*⁴² in which ERISA was found to preempt a state common-law tort, breach of contract claim for damages, for failure to provide benefits due under an insurance policy.⁴³ In *Pilot*, the Supreme Court noted: "We have observed in the past that the express preemption provisions of ERISA are deliberately expansive."⁴⁴

However, in the seminal case of *Travelers*⁴⁵ the Court initiated what many today perceive to be a sea change in ERISA preemption policy and interpretation.⁴⁶ The Court held that a New York law requiring hospitals to collect surcharges from patients covered by a commercial insurer did not "relate to" employee benefit plans within

38. N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995).

39. *Shaw*, 463 U.S. at 91-92; Christopher Oster, *The ERISA Trap: When Employees Can't Win*, THE WALL ST. J. VIA DOW JONES, available at http://www.bourhis-wolfson.com/press/erisa_trap_2003.htm (last visited Mar. 28, 2005).

40. Larry D. Weiss et al., *Employee Retirement Income Security Act and Managed Care: Current Issues and Their Impact on Medical Practice*, 92 S. MED. J. 1049, 1052 n.11 (1999).

41. *Shaw*, 463 U.S. at 100 n.21.

42. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

43. *Id.* at 47, 57.

44. *Id.* at 45-46.

45. N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995).

46. Since *Travelers* was decided in 1995, the Supreme Court has decided additional cases construing the "relates to" provision of ERISA. See, e.g., *Boggs v. Boggs*, 520 U.S. 833 (1997); *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997); *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., Inc.*, 519 U.S. 316 (1997). While neither *Dillingham* nor *Boggs* are cases regarding MCOs, and thus not included in the appended tables of cases, they provide thorough discussions of ERISA's "relate to" clause, which provides useful background information. *De Buono* is included in the tables as a case supportive of managed care, and also as a case with an extensive discussion of the "relate to" clause.

the meaning of ERISA's preemption provision.⁴⁷ The Court reasoned that the "relates to" test for preemption set forth in their previous cases was not helpful in setting the limits on preemption envisioned by Congress when ERISA was enacted.⁴⁸ Justice Souter noted that the surcharge provisions neither made reference to ERISA plans in any manner⁴⁹ nor bore the requisite connection with ERISA plans to trigger preemption,⁵⁰ thus "any conclusion other than the one we draw would bar any state regulation of hospital costs."⁵¹ Justice Souter went on to further develop this point: "Congress never envisioned ERISA pre-emption as blocking state health care cost control."⁵² The Court noted: "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.'"⁵³ In addition, the Court acknowledged that previous cases interpreting the preemption provision were not insightful because the statutes or policies previously challenged under the "relates to" provision fell clearly within the preemption category.⁵⁴

The circuit courts at that time also began to consider the view that the Supreme Court adopted in the *Travelers* case, that only those state laws that either directly or indirectly adopt a minimum level of benefits, that have an effect on the administration of a plan, or that preclude the uniform administration and coverage of interstate employee benefit plans are preempted.⁵⁵ In *Travelers*, the Supreme Court stipulated that Congress only intended to preempt three categories of state laws: (a) those that "mandate employee benefit structures or their administration"; (b) those that "provide alternative administration mechanisms"; and (c) those that "bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself."⁵⁶ The majority opinion in *Travelers* further notes, that "*nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically*

47. *Travelers*, 514 U.S. at 656, 662.

48. *See id.* at 655.

49. *See id.* at 656.

50. *See id.* at 662.

51. *Id.* at 664.

52. *Id.* at 667 n.6.

53. *Id.* at 655 (quoting HENRY JAMES, RODERICK HUDSON XLI (New York ed., World's Classics 1980).)

54. *See id.* at 658.

55. *Id.* at 646.

56. *Id.* at 646, 659.

has been a matter of local concern.”⁵⁷ In other words, the Court is noting that the traditional legal perspective *should have* been one of a presumption against preemption of state laws. As already alluded to, prior to *Travelers*, the strength of this presumption, or even the existence of the presumption, in the context of ERISA preemption, was unclear. For example, in *Metropolitan Life Insurance Co. v. Massachusetts*,⁵⁸ the Court concluded that a Massachusetts statute requiring certain minimum mental health care benefits be provided to Massachusetts residents insured under a general health policy “relate[d] to” employee benefit plans within the meaning of the Act.⁵⁹ The majority opinion, in reviewing the preemption analysis, made no mention of the presumption against preemption of state laws: “The pre-emption provision was intended to displace all state laws that fall within its sphere, even including state laws that are consistent with ERISA’s substantive requirements.”⁶⁰ However, because the Massachusetts law was clearly designed to regulate insurance, the unanimous Court found that it was saved from ERISA preemption, and ruled that the state law was to remain in effect.⁶¹ This case illustrates the balancing act that the courts have been required to perform when deciding ERISA preemption cases. By shifting the presumption analysis, *Travelers* has required the courts to review ERISA preemption cases in a much more nuanced fashion.

The Court in *Travelers* emphasized that the presumption against preemption remained despite the language of the ERISA Act.⁶² The presumption since *Travelers*, therefore, shifts the burden from one in favor of preemption to one against preemption, and courts have emphasized the new presumption more heavily since *Travelers*. For ex-

57. *Id.* at 661.

58. *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

59. *Id.* at 739.

60. *Id.*

61. *Id.* at 739–40. In an opinion by Justice Blackmun, expressing the unanimous view of the eight participating members of the Court, it was held that while the state statute clearly related to pension plans governed by ERISA so as to fall within the broad preemption provision of section 514(a) of ERISA (29 U.S.C. § 1144(a)), the state statute was saved from preemption by section 514(b)(2) of ERISA (29 U.S.C. § 1144(b)(2)) as a law “which regulates insurance.” The Court further held that while the statute, like many laws affecting terms of employment, potentially limited an employee’s right to choose one thing by requiring that he be provided with something else, it did not limit the rights of self-organization or collective bargaining protected by the NLRA, and was thus not preempted by that Act. *Id.* at 758.

62. *See Travelers*, 514 U.S. at 655–56.

ample, in *Emard v. Hughes Aircraft Co.*,⁶³ the Ninth Circuit concluded that a widower's claim, pursuant to California's community property laws, to proceeds of life insurance policies issued as part of an ERISA benefit package was not preempted by ERISA.⁶⁴ The Court concluded: "We recognize that, in the circumstances of a case such as this, the plan administrator must take certain steps to answer the complaint and either disburse the . . . funds to the prevailing claimant or deposit the funds. . . . But this burden on the administrator is too slight to overcome the presumption against preemption of state family and family property law."⁶⁵

Since *Travelers*, when a state has legislated in an area of traditional health insurance regulation, the typical analysis begins with a presumption against preemption of that state law. For example, in *California Division of Labor Standards Enforcement v. Dillingham Construction*,⁶⁶ the Court states: "As is always the case in our pre-emption jurisprudence, 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 Act unless that was the clear and manifest purpose of Congress."⁶⁷

Some courts have even acknowledged that prior to *Travelers* the outcome of a case would have been different. For example, in *Operating Engineers Health & Welfare Trust Fund v. JWJ Contracting Co.*,⁶⁸ the Ninth Circuit held that an Arizona act requiring public works contractors to issue payment bonds through sureties was not preempted by ERISA.⁶⁹ The court acknowledged that if the case had been presented before *Travelers*, the court would likely have concluded that ERISA barred the operation of the state act.⁷⁰ Even to the more cautionary courts it is clear that the "relates to" provision is no longer to be con-

63. *Emard v. Hughes Aircraft Co.*, 153 F.3d 949 (9th Cir. 1998).

64. *Id.* at 962.

65. *Id.* at 959.

66. *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., Inc.*, 519 U.S. 316 (1997).

67. *Id.* at 325 (citations omitted).

68. *Operating Eng'rs Health & Welfare Trust Fund v. JWJ Contracting Co.*, 135 F.3d 671 (9th Cir. 1998).

69. *Id.* at 678.

70. *Id.* at 679.

strued with the same breadth as prior Supreme Court precedent had suggested.⁷¹

B. The Post-Travelers Era

Federal and state courts did not interpret *Travelers* as an unambiguous signal regarding the interpretation of ERISA. *UNUM Life Insurance v. Ward*⁷² is perhaps the most important ERISA-related Supreme Court decision in the post-*Travelers* era. In a unanimous opinion written by Justice Ginsburg, the Court analyzed the preemption and saving clauses in a suit involving disability benefits offered in a UNUM Life Insurance Company of America (UNUM) policy.⁷³ The Court addressed two issues; first, whether California's "notice-prejudice rule" satisfied the requirements of ERISA's saving clause and, second, whether California's agency law was preempted by ERISA.⁷⁴

Under California's notice-prejudice rule an insurance company such as UNUM would have to prove they suffered substantial prejudice if an insured, such as Ward, failed to give timely notice of a claim.⁷⁵ Under the terms of UNUM's policy with Ward, through his employer, Ward filed his disability claim five months past the deadline and was denied coverage, prompting the action.⁷⁶ In analyzing whether the notice-prejudice rule regulates insurance, and therefore satisfies the saving clause, the Court first asked "whether, from a 'commonsense view of the matter,' the contested prescription regulates insurance."⁷⁷ The Court then examined whether the rule fits within the business of insurance as defined under the three McCarran-Ferguson factors.⁷⁸ The Court opined that the notice-prejudice rule

71. See, e.g., *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 57 (D. Mass. 1997) (noting that the "catastrophic consequences of overbroad interpretation of 'relates to' preemption would thus appear to be waning").

72. *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999).

73. *Id.* at 363. As noted earlier, the 1998 *O'Connor v. UNUM Life Insurance Co. of America* decision was a precursor to this Supreme Court case. In the 1998 case, Justice Ginsburg sat on the D.C. Circuit and also wrote the majority opinion.

74. *Id.* at 364.

75. *Id.* at 366.

76. *Id.* at 365.

77. *Id.* at 367 (citing *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985)).

78. *Id.* The so-called McCarran-Ferguson factors have been used by the courts to determine if a state law fits the test of being "health insurance." Three factors are used to make this determination: (1) whether the practice has the effect of transferring or spreading a policyholder's risk; (2) whether the practice is an inte-

appeared to satisfy the commonsense view because it was directed at the insurance industry and applied only to insurance contracts.⁷⁹

In defending against the commonsense finding, UNUM argued that “disproportionate forfeiture should be avoided in the enforcement of contracts.”⁸⁰ UNUM went on to argue that the notice-prejudice rule resembled the Mississippi law at issue in *Pilot Life Insurance Co. v. Dedeaux*,⁸¹ where the roots of that law were planted in Mississippi tort and contract law, therefore falling outside of the saving clause.⁸² In dismissing UNUM’s argument the Court acknowledged UNUM’s concern that the “law abhors a forfeiture” but distinguished the notice-prejudice rule “because it is a rule firmly applied to insurance contracts, not a general principle guiding a court’s discretion in a range of matters.”⁸³ The Court concluded its commonsense discussion by noting California’s desire for insurers to show prejudice is grounded in that state’s public policy and was a key to their decision.⁸⁴

The Court next applied the McCarran-Ferguson factors to the notice-prejudice rule to determine the saving clause issue, noting that the factors were “considerations [to be] weighed” and not determinative in and of themselves.⁸⁵ The Court did not analyze the first factor regarding transferring or spreading a policy holder’s risk because the other two factors and the commonsense view were satisfied.⁸⁶ Under the second factor—whether the rule is an integral part of the relationship between insurer and insured—the Court held the notice-prejudice rule “dictates the terms of the relationship . . . and consequently, is integral to that relationship.”⁸⁷ The third factor, regarding

gral part of the policy relationship between the insurer and insured; and (3) whether the practice is limited to entities within the insurance industry. For further discussion of the Supreme Court’s interpretation of the McCarran-Ferguson factors as they relate to the regulation of managed care, see *Kentucky Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 339–42 (2003).

79. *UNUM Life Ins.*, 526 U.S. at 368.

80. *Id.* (quoting Brief of Amici Curiae for American Council of Life Insurance et al., at 13; Brief of Amici Curiae Association of California Life and Health Insurance Companies, at 5).

81. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987).

82. *UNUM Life Ins.*, 526 U.S. at 368–69.

83. *Id.* at 370–71.

84. *Id.* at 368.

85. *Id.* at 373 (citing *Pilot Life*, 481 U.S. at 49 and *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)).

86. *Id.* at 374.

87. *Id.* at 374–75.

whether the rule is limited to the insurance industry, was also met because the rule is aimed at the insurance industry.⁸⁸

It is important to note that the Court also rejected several other arguments made by UNUM. First, UNUM argued that the notice-prejudice rule, by altering the contract provisions, conflicts with ERISA's requirement that fiduciaries act in accordance with the plan.⁸⁹ The Court rejected this argument noting that they have repeatedly found similar laws saved and that UNUM's interpretation of section 1104(a)(1)(D)⁹⁰ would render States "powerless to alter the terms of the insurance relationship in ERISA plans."⁹¹ Next, UNUM argued that section 502(a) prohibits state causes of action like notice-prejudice, but the Court quickly rejected this because Ward brought his suit under section 502(a)(1)(B).⁹² UNUM also argued that notice-prejudice conflicted with 29 U.S.C. § 1133, requiring plans to provide notice and the opportunity to review denied claims, and conflicted with Department of Labor regulations.⁹³ The Court rejected these arguments because notice-prejudice provides longer filing times and therefore compliments the federal requirements.⁹⁴

Finally, the Court addressed the second issue of California's agency rule and whether Ward's employer acted as UNUM's agent when it received his disability claim.⁹⁵ The Court held that based on the rule laid down in *Elfstrom v. New York Life Insurance Co.*,⁹⁶ the California law did relate to an ERISA plan and was, therefore, preempted by ERISA.⁹⁷ To rule otherwise "would 'forc[e] the employer, as plan administrator, to assume a role, with attendant legal duties and consequences, which it has not undertaken voluntarily.'"⁹⁸

In a similar analysis of the balance between the preemption clause and the saving clause, the Ninth Circuit discussed these two ERISA provisions in *Washington Physicians Service Ass'n v. Gregoire*.⁹⁹ At issue was "whether Washington's so-called Alternative Provider

88. *Id.* at 375.

89. *Id.* (citing 29 U.S.C. § 1104(a)(1)(D) (2004)).

90. 29 U.S.C. § 1104(a)(1)(D) (2004).

91. *UNUM Life Ins.*, 526 U.S. at 376.

92. *Id.* at 376-77.

93. *Id.* at 377.

94. *Id.*

95. *Id.*

96. *Elfstrom v. N.Y. Life Ins. Co.*, 432 P.2d 731 (1967).

97. *UNUM Life Ins.*, 526 U.S. at 379.

98. *Id.*

99. *Wash. Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998).

Statute [was] preempted by . . .” ERISA where the statute “requires that [MCOs] cover . . . ‘alternative’ medical treatments.”¹⁰⁰ On motions for summary judgment the district court ruled for the plaintiffs holding that the Alternative Provider Statute (Statute) was preempted by ERISA and not saved under the saving clause.¹⁰¹ On appeal, the Ninth Circuit examined both the “relates to” clause, finding the Act was not preempted, and the “saving clause” noting that the law would have been saved from ERISA preemption if it had not met the ‘relates to’ clause.¹⁰²

In its analysis of the “relates to” clause, the court applied the rule established in *Travelers*,¹⁰³ which stated that a law was not preempted unless it produced particular economic effects such that the ERISA plan had to adopt certain coverage or the choice of insurers was limited.¹⁰⁴ The court stated that the Statute referred only to plans offered by health carriers such as HMOs, not to benefit plans offered by employers, thus not operating directly on ERISA plans.¹⁰⁵ The court reversed the lower court ruling of summary judgment because “the mere fact that the Act regulates a product that ERISA plans often choose to buy does not mean that it ‘relates to’ an ERISA plan.”¹⁰⁶ The Ninth Circuit concluded that “ERISA plans no longer have a Midas touch that allows them to deregulate every product they choose to buy as part of their employee benefit plan.”¹⁰⁷

Despite finding that the statute was not preempted, the court examined the saving clause to decide whether it regulated insurance.¹⁰⁸ The court applied a two-part test; first reviewing whether the statute fit a commonsense understanding of insurance regulation, and then applying the McCarran-Ferguson factors.¹⁰⁹ The court found that the statute was specifically directed toward insurance,¹¹⁰ and that it conferred a benefit on the insured because the statute expanded the avail-

100. *Id.* at 1042.

101. *Id.* at 1043.

102. *Id.*

103. *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995).

104. *Gregoire*, 147 F.3d at 1043.

105. *Id.*

106. *Id.* at 1045.

107. *Id.*

108. *Id.*

109. *Id.* (citing *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740–44 (1985)).

110. *Id.*

able treatments, which affected the spreading of risks.¹¹¹ Thus, the commonsense prong was satisfied.¹¹² The court also found all three of the McCarran-Ferguson factors were satisfied because the statute spread risk, affected the carrier-insured relationship and was limited to the insurance industry because it did not reach self-insured ERISA plans.¹¹³ Thus the saving clause of ERISA was met.¹¹⁴

Following *Travelers*, the imposition of fees and surcharges established by the states on MCOs or their patients has not been found to be preempted by the circuit courts that have encountered them. The Second Circuit has heard four such cases and found all four not to be preempted¹¹⁵ and the Seventh Circuit held that the one case it reviewed was likewise not preempted.¹¹⁶ Primary among the circuits' reasons for not preempting the laws was that the laws did not "relate[] to" ERISA plans based on the Supreme Court's holding in *Travelers*.¹¹⁷ Courts have also noted the limited impact that such surcharge laws would have on the provision of services by the MCO as further support for not preempting the laws.¹¹⁸ The laws at issue tend to require that the money from the fees and surcharges be used to assist those who do not have insurance, in essence, to spread the risk of providing health care throughout the states in question.¹¹⁹ The limited effect of the costs is significant because it demonstrates that these are not attempts to change the structure of the services provided by the MCOs that must pay the costs, but altruistic desires to help those who are underinsured.

Several states have passed a variety of laws that directly regulate MCOs and these laws have met with mixed results when circuit courts considered whether they should be preempted.¹²⁰ The laws that have

111. *Id.* at 1046.

112. *Id.* at 1047.

113. *Id.*

114. *Id.*

115. See *Conn. Hosp. Ass'n v. Weltman*, 66 F.3d 413 (2d Cir. 1995); *New England Health Care Employees Union v. Mt. Sinai Hosp.*, 65 F.3d 1024 (2d Cir. 1995); *NYS Health Maint. Org. Conference v. Curiale*, 64 F.3d 794 (2d Cir. 1995); *Travelers Ins. Co. v. Pataki*, 63 F.3d 89 (2d Cir. 1995).

116. See *Safeco Life Ins. Co. v. Musser*, 65 F.3d 647 (7th Cir. 1995).

117. See *id.*; *Travelers Ins. Co.*, 63 F.3d at 89.

118. See *Curiale*, 64 F.3d at 794.

119. *Id.* at 797.

120. See *Singh v. Prudential Healthcare Plan, Inc.*, 335 F.3d 278 (4th Cir. 2003); *Prudential Ins. Co. of Am. v. Nat'l Park Med. Ctr., Inc.*, 154 F.3d 812 (8th Cir. 1998); *Plumb v. Fluid Pump Serv., Inc.*, 124 F.3d 849 (7th Cir. 1997); *Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500 (4th Cir. 1993).

been preempted have been more expansive than allowed by ERISA and could not be “saved” as regulating only the insurance industry.¹²¹ However, the majority of such laws have been found not to be preempted. Laws such as Virginia’s law prohibiting insurers from discriminating in the creation of Preferred Provider Organizations,¹²² or Maryland’s HMO Act¹²³ were saved as laws that regulate insurance due to the narrow focus and specificity regarding health insurance.¹²⁴ Furthermore, two Missouri laws, one regarding the continuation of coverage for the disabled after termination of an insurance plan,¹²⁵ and another limiting the incentives an HMO could provide for insureds to order drugs through the mail,¹²⁶ were also not preempted. The Eighth Circuit found those laws also saved from preemption due to their narrow focus on the regulation of health insurance.¹²⁷

Overall, in the post-*Travelers* era, as illustrated in Table 5 and summarized here, the circuit courts have upheld the states’ health insurance regulatory role in a series of important cases:

- In *Safeco Life Insurance Co. v. Musser*,¹²⁸ the Seventh Circuit found that a Wisconsin law imposing fees on insurers was not preempted because it did not “relate to” an ERISA plan;
- In *NYS Health Maintenance Organization Conference v. Curiale*,¹²⁹ the Second Circuit found that a New York state law requiring health insurance pools to equalize risk of coverage of high risk claims was not preempted because it did not “relate to” an ERISA plan nor did it have any connection to the plan;
- In *Plumb v. Fluid Pump Service, Inc.*,¹³⁰ the Seventh Circuit found that an Illinois law limiting pre-existing condition re-

121. See *Prudential Ins. Co.*, 154 F.3d at 812 (finding the Arkansas Patient Protection Act preempted because it was not sufficiently directed at the insurance industry).

122. See *Stuart Circle Hosp.*, 995 F.2d at 500.

123. See *Singh*, 335 F.3d at 278.

124. See *Plumb*, 124 F.3d at 849 (finding an Illinois law restricting preexisting condition requirements and expanding portability of health insurance saved from preemption).

125. See *Express Scripts, Inc. v. Wenzel*, 262 F.3d 829 (8th Cir. 2001) (creating incentives for mail order drugs).

126. See *United of Omaha v. Bus. Men’s Assurance Co. of Am.*, 104 F.3d 1034 (8th Cir. 1997) (continuing insurance for the disabled).

127. *Id.* at 1041.

128. *Safeco Life Ins. Co. v. Musser*, 65 F.3d 647 (7th Cir. 1995).

129. *NYS Health Maint. Org. Conference v. Curiale*, 64 F.3d 794 (2d Cir. 1995).

130. *Plumb v. Fluid Pump Serv., Inc.*, 124 F.3d 849 (7th Cir. 1997).

quirements and portability of health insurance for small businesses was not preempted by ERISA because it was “saved” as a law regulating insurance;

- In *O’Connor v. UNUM Life Insurance Co. of America*,¹³¹ the D.C. Circuit Court found that the California “notice-prejudice” rule was not preempted by ERISA because it was a law that regulates insurance;
- In *Transitional Hospitals Corp. v. Blue Cross & Blue Shield of Texas, Inc.*,¹³² the Fifth Circuit found that state law claims for misrepresentation regarding payment of bills and breach of contract were not preempted under ERISA because the claims did not depend on benefits due to the insured.

At the same time that the federal courts have been more inclined to limit the preemptive powers of ERISA since *Travelers*, they have, nevertheless, continued to reinforce the strong preemption provisions of ERISA in certain areas. This is illustrated fully in Table 2 and summarized here:

- In *Dowden v. Blue Cross & Blue Shield of Texas, Inc.*,¹³³ the Fifth Circuit found that state claims for breach of insurance policy obligation to provide benefits were preempted by ERISA because they were an eligibility decision made under the plan and interpreted by the provider. In other words, the court found that this was not a matter of insurance regulation;
- In *McNeil v. Time Insurance Co.*,¹³⁴ the Fifth Circuit found that state law claims for breach of contract and breach of duty of good faith were preempted under ERISA’s 514 conflict preemption section because they involved the right of the insured to receive medical benefits,¹³⁵

131. *O’Connor v. UNUM Life Ins. Co. of Am.*, 146 F.3d 959 (D.C. Cir. 1998). This case was a precursor to the Supreme Court “Ward” case, *UNUM Life Insurance Co. of America v. Ward*, 526 U.S. 358 (1999).

132. *Transitional Hosps. Corp. v. Blue Cross & Blue Shield of Tex., Inc.*, 164 F.3d 952 (5th Cir. 1999).

133. *Dowden v. Blue Cross & Blue Shield of Tex., Inc.*, 126 F.3d 641 (5th Cir. 1997).

134. *McNeil v. Time Ins. Co.*, 205 F.3d 179 (5th Cir. 2000).

135. The cases involving state law claims for breach of contract and breach of duty were regularly preempted because they were found to relate to an employee benefit plan. See, e.g., *Transitional Hosp. Corp.*, 164 F.3d at 952; *Mass. Cas. Ins. Co. v. Reynolds*, 113 F.3d 1450 (6th Cir. 1997); *Zuniga v. Blue Cross & Blue Shield of Mich.*, 52 F.3d 1395 (6th Cir. 1995); *Kuhl v. Lincoln Nat’l Health Plan of Kan. City*,

- In *Prudential Insurance Co. of America v. National Park Medical Center, Inc.*,¹³⁶ the Eighth Circuit held that Arkansas' "Patient Protection Act" was preempted in its entirety by ERISA and was not "saved" as a regulation of insurance because it was not sufficiently directed at the insurance industry;
- In *Johnston v. Paul Revere Life Insurance Co.*,¹³⁷ the Eighth Circuit found Nebraska's state law regarding the alteration of policy without written consent to be preempted by ERISA as a law that "related to" an ERISA plan. The law was not "saved" as a regulation of insurance because it was not sufficiently directed at the insurance industry;¹³⁸
- In *Hotz v. Blue Cross & Blue Shield of Massachusetts, Inc.*,¹³⁹ the First Circuit found that state claims regulating delays by MCOs in approval of payment for treatment are not saved as regulating insurance because they were so broad, they awarded damages, and did "relate to" an ERISA plan.

The federal courts have struggled over the interpretation of the preemption provisions of § 514 (a), (b) and (c).¹⁴⁰ The issue has largely focused on whether state laws and regulations are considered to directly regulate an employee benefit plan or whether they legitimately constitute health insurance regulation.¹⁴¹ Since 1995, the courts have also considered the impact—primarily the *economic* impact—of surcharges, fees, and other regulations.¹⁴² The "broader" the impact of the regulation, the more likely it is that the initiative will be preempted. While there has been some movement toward allowing for more state flexibility and discretion in the post-*Travelers* era, the courts

Inc., 999 F.2d 298 (8th Cir. 1993); *Swerhun v. Guardian Life Ins. Co. of Am.*, 979 F.2d 195 (11th Cir. 1992); *Gahn v. Allstate Life Ins. Co.*, 926 F.2d 1449 (5th Cir. 1991); *Perkins v. Time Ins. Co.*, 898 F.2d 470 (5th Cir. 1990); *see also infra* Part I.D.

136. *Prudential Ins. Co. of Am. v. Nat'l Park Med. Ctr., Inc.*, 154 F.3d 812 (8th Cir. 1998).

137. *Johnston v. Paul Revere Life Ins. Co.*, 241 F.3d 623 (8th Cir. 2001).

138. *Id.* at 630–33.

139. *Hotz v. Blue Cross & Blue Shield of Mass., Inc.*, 292 F.3d 57–59 (1st Cir. 2002).

140. 29 U.S.C. § 1144(a)–(c) (2004).

141. *Hotz*, 292 F.3d at 57–61.

142. *See, e.g., Travelers Ins. Co. v. Pataki*, 63 F.3d 89 (2d Cir. 1995).

have continued to uphold what they consider to be the core principles of section 514.¹⁴³

C. Developing the Concept of Complete Preemption

In addition to this analysis of the history of federal preemption and the debate over what the “presumption” for preemption should or should not be, the next step in our analysis is to examine the concept of “complete preemption” as it relates to § 502 of ERISA (as distinct from the § 514 analysis presented in the previous section).

In this context, the Third Circuit issued an extraordinarily important decision in *Dukes v. U.S. Healthcare, Inc.*¹⁴⁴ The plaintiff filed medical malpractice claims against U.S. Healthcare, an HMO, and the court had to determine whether the claims presented fell under the “complete preemption” exception to the “well-pleaded complaint” rule, which is central to section 502 of ERISA.¹⁴⁵ In this case, the court underscored the distinctions between “complete preemption,” which permits a case to be removed to federal court, and the express preemption of section 514(a).¹⁴⁶ Section 514(a) clearly defines ERISA’s preemption, whereas complete preemption is

concerned with a more limited set of state laws, those which fall within the scope of . . . § 502. State law claims which fall outside of the scope of § 502, even if preempted by § 514(a), are still governed by the well-pleaded complaint rule and, therefore, are not removable under the complete preemption principles established in *Metropolitan Life*.¹⁴⁷

Thus, a district court cannot resolve a state claim that may be preempted if that claim is not first “completely preempted.”¹⁴⁸

The circuit courts’ interpretation of the complete preemption section has also been very important over the last fifteen years. This is illustrated in Table 2 and summarized here:

- In *Danca v. Private Health Care Systems, Inc.*,¹⁴⁹ the First Circuit found that a denial by an MCO for a request to be placed in a specific hospital was “completely preempted”

143. See, e.g., *DeBuono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997).

144. *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995).

145. *Id.* at 354.

146. *Id.* at 355.

147. *Id.*

148. *Id.*

149. *Danca v. Private Health Care Sys., Inc.*, 185 F.3d 1 (1st Cir. 1999).

even though the decision was “quasi-medical” in nature. The court was concerned about “inconsistent state action” that would be inconsistent with the intent of ERISA;

- In *Haynes v. Prudential Health Care*,¹⁵⁰ the Fifth Circuit found that an MCO decision that an insured’s doctor was not his primary care physician was “expressly preempted” by ERISA because the decision was an administrative decision. The court reasoned that such decisions should fall under one regulatory scheme as opposed to state-by-state regulation;
- In *Marks v. Watters*,¹⁵¹ the Fourth Circuit found that state claims for negligence and vicarious liability for premature release of a mental health patient were “completely preempted” under ERISA’s “remedial scheme” (§ 502) because the decisions made were administrative in nature;
- In *Fink v. DakotaCare*,¹⁵² the Eighth Circuit found that state law claims for breach of contract and violation of South Dakota Unfair Trade Practices law were “completely preempted” by § 502 of ERISA. The court noted that it was important to establish a uniform regulatory scheme nationwide.¹⁵³

D. Circuit Court Tests

Overall, the bulk of the circuit courts’ time has been spent determining the issue of preemption for State common law and State statutes, as they relate to sections 514 and 502 of ERISA. The State statutes at issue in the majority of the preemption-related circuit court cases can be classified into four groups. First there are those laws that seek to prevent unfair trade practices, typically titled [STATE] Unfair Trade Practices Act.¹⁵⁴ Second, states have passed legislation involving the relationship between the MCO and the healthcare providers they employ.¹⁵⁵ Third, states have passed laws regarding surcharges,

150. *Haynes v. Prudential Health Care*, 313 F.3d 330 (5th Cir. 2002).

151. *Marks v. Watters*, 322 F.3d 316 (4th Cir. 2003).

152. *Fink v. DakotaCare*, 324 F.3d 685 (8th Cir. 2003).

153. *Id.* at 688.

154. *See, e.g., Custer v. Pan Am. Life Ins. Co.*, 12 F.3d 410 (4th Cir. 1993) (evaluating the West Virginia Unfair Trade Practices Act).

155. *See, e.g., Wash. Physicians Serv. Ass’n v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998) (evaluating Washington Alternative Provider Law); CIGNA Healthplan of

fees or other obligations imposed on MCOs and used for other health related services.¹⁵⁶ The fourth group includes statutes that deal directly with the MCOs.¹⁵⁷

Certain common-law claims have met with consistent results before the circuit courts. Claims for breach of contract against MCOs brought by individual insureds or insured companies have almost always been held preempted by ERISA in the circuit courts.¹⁵⁸ The most common reasoning for the preemption typically offered by the courts was that the charges brought by the plaintiff “relate[d] to” an ERISA plan because they were cases brought for benefits due under the terms of the ERISA plan.¹⁵⁹ These are cases regarding the eligibility of the insured for treatment, which directly related to the terms of the plan. Despite this consistency, two circuit court cases remanded breach of contract claims back to state court after failing to find grounds for preemption.¹⁶⁰ Fortunately, the reasoning behind the preemption of typical breach of contract cases is consistent with these two cases. In *Sonoco Products Co. v. Physicians Health Plan*,¹⁶¹ the employer brought a claim against the MCO to vindicate the company’s rights when the MCO attempted to modify the benefits contract after the first year of a two-year contract. Because they were not acting in their fiduciary duty to their employees by bringing suit, the case did not fall under the complete preemption requirements of § 502 and thus did not involve the ERISA plan.¹⁶² Similarly, in *Providence Health Plan v. McDowell*,¹⁶³ a suit was brought by an MCO to be reimbursed for payments to an insured due to a payment the insured had received from a third-party for the same injuries. The claims were simple state law contract claims, irrelevant to the terms of the medical plan, and thus were not preempted.¹⁶⁴

La., Inc. v. Louisiana, 82 F.3d 642 (5th Cir. 1996) (discussing State of Louisiana Any Willing Provider law).

156. See, e.g., NYS Health Maint. Org. Conference v. Curiale, 64 F.3d 794 (2d Cir. 1995) (evaluating New York law requiring pooling of health insurance funds to equalize coverage for high-cost claims).

157. See, e.g., Kariotis v. Navistar Int’l Trans. Corp., 131 F.3d 672 (7th Cir. 1997) (involving Illinois Health Insurance Claim Filing Act).

158. See, e.g., Transitional Hosps. Corp. v. Blue Cross & Blue Shield of Tex., Inc., 164 F.3d 952 (5th Cir. 1999).

159. *Id.* at 955.

160. See *infra* notes 161, 162.

161. *Sonoco Prods. Co. v. Physicians Health Plan*, 338 F.3d 366 (4th Cir. 2003).

162. *Id.* at 374.

163. *Providence Health Plan v. McDowell*, 361 F.3d 1243 (9th Cir. 2004).

164. *Id.* at 1248.

In the context of the post-*Travelers* era, some circuits have developed ERISA preemption tests or checklists to assist them in the difficult task of determining when a law or cause of action is preempted.¹⁶⁵ The tests reveal how the federal courts perceive the present reach of ERISA's preemption provision. For example, drawing from Supreme Court cases, the Tenth Circuit considers a state claim preempted if the case involves, "(1) laws regulating the types of benefits or terms of ERISA plans; (2) laws creating reporting, disclosure, funding or vesting requirements for such plans; (3) laws providing rules for calculating the amount of benefits to be paid under such plans; (4) laws and common-law rules providing remedies for misconduct growing out of the administration of such plans."¹⁶⁶ The Ninth Circuit employs a similar test in order to assist the court in determining whether a state law has a "connection with" ERISA benefit plans.¹⁶⁷ This examination of circuit court decisions illustrates that, even when the preemptive scope of ERISA is reduced, the reach of ERISA preemption is still fairly broad. States remain constrained from legislating in a manner that will reach many individuals receiving benefits through their employer. Laws that regulate the type of benefits or terms of an ERISA plan provide for alternative enforcement mechanisms already established in ERISA, whereas laws that would act to interfere with plan administration remain subject to preemption.¹⁶⁸ For example, in *Parrino v. FHP, Inc.*,¹⁶⁹ the Ninth Circuit held that ERISA preempted an insured's state law causes of action for breach of the implied covenant of good faith and fair dealing and for civil conspiracy against the administrator of his ERISA-governed HMO plan where both actions were predicated on alleged defects in claims processing. The court concluded that, "one of the principal goals of ERISA is to establish a uniform body of federal law governing the administration of employee benefit plans. ERISA therefore preempts 'state laws providing alternative enforcement mechanisms' for ERISA plan benefits, as well

165. See, e.g., *Metro. Life Ins. v. Petit*, 164 F.3d 857, 862 (4th Cir. 1998); *Gweke Ford v. St. Joseph's Omni Preferred Care, Inc.*, 130 F.3d 1355, 1361 (9th Cir. 1997). Traditionally courts considering ERISA preemption challenges utilize the test initially set forth in *Shaw*. The test is simply that a law "relates to" an employee benefit plan "if it has a connection with or reference to such a plan." *Shaw v. Delta Airlines*, 463 U.S. 85, 96-97 (1983).

166. *Woodworker's Supply, Inc. v. Principal Mut. Life Ins. Co.*, 170 F.3d 985, 990 (10th Cir. 1999).

167. *Emard v. Hughes Aircraft Co.*, 153 F.3d 949, 958 (9th Cir. 1998).

168. Weiss et al., *supra* note 40, at 1050 n.11.

169. *Parrino v. FHP, Inc.*, 146 F.3d 699 (1998).

as ‘state laws that mandate employee benefits structures or their administration.’”¹⁷⁰ In addition, in *Eklecco v. Iron Workers Locals 40, 361, & 417 Union Security Funds*,¹⁷¹ the Second Circuit concluded that a New York State Lien Law that provided for liens on employee benefits was preempted by ERISA as the law “impermissibly supplements the limited enforcement mechanisms enumerated in ERISA.”¹⁷²

E. Summary of Preemption and Complete Preemption Issues

In sum, the Court’s interpretation of ERISA’s preemption provision has changed fairly significantly from preemption of almost all causes of action or laws relating to ERISA to a more restrained approach, far more similar to traditional preemption analysis.¹⁷³ Despite this more restricted interpretation of ERISA’s preemption provision, the core of ERISA’s preemptive scope still acts to restrict any state seeking to effectuate wholesale health care reform. In *Aetna Health, Inc. v. Davila*¹⁷⁴ the Supreme Court reinforces the preemptive powers of ERISA and underscores its unanimous interpretation that ERISA contains “expansive preemption provisions” that are fully legitimate and were the intent of Congress.¹⁷⁵ The Court is explicit in stating that the “[p]urpose of ERISA is to provide a uniform regulatory regime over employee benefit plans. To this end, ERISA includes expansive pre-emption provisions, which are intended to ensure that employee benefit plan regulation would be ‘exclusively a federal concern.’”¹⁷⁶

In an effort to round out the discussion of the § 514 and § 502 provisions of ERISA, the Court goes on to state that “any state law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted.”¹⁷⁷

Thus, the ERISA civil enforcement mechanism is one of those provisions with such “‘extraordinary pre-emptive power’” that it “‘converts an ordinary state common law complaint into one stat-

170. *Id.* at 705.

171. *Eklecco v. Iron Workers Locals 40, 361 & 417 Union Sec. Funds*, 170 F.3d 353 (2d Cir. 1999).

172. *Id.* at 356.

173. See generally *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., Inc.*, 519 U.S. 316, 334 (Scalia, J., concurring).

174. *Aetna Health, Inc. v. Davila*, 124 S. Ct. 2488 (2004).

175. *Id.* at 2495.

176. *Id.*

177. *Id.*

ing a federal claim for purposes of the well-pleaded complaint rule.” *Metropolitan Life*, 481 U.S., at 65–66. . . . Hence, “causes of action within the scope of the civil enforcement provisions of § 502(a) [are] removable to federal court.” *Id.* at 66. . . .¹⁷⁸

Finally, the Court is even more explicit in recognizing the federal role in specifying that “[t]he 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 and that Congress rejected in ERISA.”¹⁷⁹

II. Key Controversies Surrounding Managed Care Plans and Organizations

The debate over the appropriate roles for the federal and state levels of government in health care policy making and regulation sets the stage and provides the context for litigation over the specifics of managed care plans. ERISA preemption represents implicit, if not explicit, support for managed care plans and organizations by virtue of preventing effective state-level regulation of the health care system.¹⁸⁰ Preemption can, in effect, be interpreted as a policy stance that signals an intention to support managed care organizations and allow them to continue doing business. Legal interpretations of ERISA and the HMO Act of 1973 can be interpreted as being both supportive and un-supportive of managed care theory as implemented in managed care plans and organizations.¹⁸¹ This part of the article is divided into federal and state court decisions which support managed care and those which restrict its implementation. Within this context, we examine specific issues taken up by the courts as they relate to managed care plans and managed care organizations.

A. Supportive Federal and State Court Decisions

1. THE QUALITY-QUANTITY MIXED ELIGIBILITY DEBATE

As illustrated in Tables 1 and 2, there have been a series of federal court cases in support of some of the key principles of managed

178. *Id.* at 2496.

179. *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 64 (1987).

180. Rich & Erb, *supra* note 14, at 240.

181. *Id.* at 251.

care theory.¹⁸² One of the most controversial issues over time has been the so called quality-quantity debate, which later evolved into a discussion of “mixed eligibility-treatment” issues. The mixed eligibility-treatment concept stems from the fact that MCOs make utilization review (UR) decisions that they deem to be based on a beneficiary’s eligibility for services per the contract agreement.¹⁸³ Because these UR decisions typically result in denial or modification of treatment options, it has been difficult to distinguish whether MCOs are actually making treatment decisions, or whether their UR decisions are based solely on plan eligibility.¹⁸⁴

The quality-quantity debate first became salient in the 1995 *Dukes v. U.S. Health Care*¹⁸⁵ decision of the Third Circuit, which, as noted in the previous section, was focused on the issue of complete preemption. In this case, the plaintiff filed medical malpractice claims against U.S. Healthcare, an HMO, and the court had to determine whether the claims presented fell under the “complete preemption” exception to the “well-pleaded complaint” rule which is central to § 502 of ERISA.¹⁸⁶ In finding that the plan was not subject to “complete preemption,” the court pointed to the fact that the plaintiff’s claim was about the quality of care and had nothing to do with withholding benefits, enforcing their rights under the plan, or defining benefits.¹⁸⁷ For support of this view, the court pointed to the ERISA statute, which says nothing about the quality of benefits, and the legislative history, which also does not indicate any support for quality claims to be covered under ERISA.¹⁸⁸ The court then acknowledged that the distinction between quality of care and quantity of care may not always be clear:

We recognize that the distinction between the quantity of benefits due under a welfare plan and the quality of those benefits will not always be clear in situations like this where the benefit contracted for is health care services rather than money to pay for such services. There well may be cases in which the quality of a patient’s medical care or the skills of the personnel provided to administer

182. See, e.g., *FMC Corp. v. Holliday*, 498 U.S. 52 (1998); *Pryzbowski v. U.S. Healthcare*, 245 F.3d 266 (3d Cir. 2001); *Danea v. Private Health Care Sys., Inc.*, 185 F.3d 1 (1st Cir. 1999).

183. *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 448 (3d Cir. 2003).

184. *Id.* at 447.

185. *Dukes v. U.S. Health Care*, 57 F.3d 350 (3d Cir. 1995).

186. *Id.* at 351.

187. See *id.* at 356.

188. *Id.* at 357.

that care will be so low that the treatment received simply will not qualify as health care at all.¹⁸⁹

The court was distinguishing between the “quality of benefits” provided and the wholesale “denial of benefits” and stated that “[q]uality control of benefits, such as . . . health care benefits . . . is a field traditionally occupied by state regulation and we interpret the silence of Congress as reflecting an intent that it remain such.”¹⁹⁰ *Dukes* was explicitly distinguished from *Corcoran v. United Healthcare, Inc.*¹⁹¹ The court noted that unlike the case before them, United Healthcare in *Corcoran* had “not provide[d], arrange[d] for, or supervise[d] the doctors who provided the actual medical treatment for plan participants.”¹⁹² United Healthcare had simply performed an administrative function, which was critical to distinguishing *Corcoran* from *Dukes*.¹⁹³

The quality versus quantity distinction developed in *Dukes* is one which is cited in subsequent circuit court and Supreme Court cases as a way to distinguish between decisions which are related to employee benefits and, therefore, in federal jurisdiction (quantity) and those which refer to quality of services, treatments, or benefits and, therefore, fall within the state jurisdiction directly connected to insurance regulation, such as medical malpractice.¹⁹⁴

The most visible of the decisions extending the quality-quantity debate is *Pegram v. Herdrich*.¹⁹⁵ In this unanimous decision, the Supreme Court focused on what the essential functions of a managed care organization (MCO) are: administrative, financial (as an insurer),

189. *Id.* at 358.

190. *Id.* at 360.

191. *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1325, 1332 (5th Cir. 1992). The district court found that the negligence claim in this case was based on a benefits determination and was, therefore, preempted by ERISA. In upholding the District Court’s ruling in the Corcorans’ appeal, the Fifth Circuit Court was clearly reaffirming congressional support for the development of HMOs: “Allowing the Corcorans’ suit to go forward would contravene Congress’s goals of ‘ensur[ing] that plans and plan sponsors would be subject to a uniform body of benefit law’ and ‘minimiz[ing] the administrative and financial burdens of complying with conflicting directives among States or between States and the Federal Government.’”

192. *Dukes*, 57 F.3d at 360.

193. *Id.* at 360–61.

194. *See, e.g., Pegram v. Herdrich*, 530 U.S. 211 (2000).

195. *Id.*

and providing treatment.¹⁹⁶ It dealt with several key questions: Were physicians, as owners of the HMO, negatively influenced in their treatment decisions?¹⁹⁷ Were physicians limiting treatment because of financial incentives offered by the MCO?¹⁹⁸ The Court reasoned that rationing health care is integral to all HMOs and that drawing a line between good and bad HMOs is best left to the legislative process.¹⁹⁹ The Court examined Herdrich's claim that Dr. Pegram's judgment was compromised by Carle Care's incentive system of year-end payment provisions given to doctors for the purpose of reducing costs.²⁰⁰ The Court parsed out "two sorts of arguably administrative acts", the first being "eligibility decisions" which involve a plan's coverage of conditions or treatments, and the second being "treatment decisions" which are choices about how to treat a condition.²⁰¹ The Court found that Dr. Pegram's decision that Herdrich's condition did not warrant immediate care was a combination eligibility-treatment decision.²⁰² Because of Dr. Pegram's judgment, Herdrich was not eligible for immediate care.²⁰³ The Court held that "Congress did not intend Carle or any other HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians."²⁰⁴

To solidify their holding, the Court examined the consequences of affirming Herdrich's view that Pegram limited treatment because of the institutional incentive system affecting her as a physician/owner.²⁰⁵ It noted that attacking the profit structures of HMOs would essentially destroy for-profit MCOs, which is contrary to the congressional intent (in the original 1973 HMO Act) to allow HMOs to exist in the first place.²⁰⁶ The Court next reasoned that by allowing a breach of duty claim whenever (1) a doctor did not treat aggressively when there was some doubt regarding treatment, or (2) the doctor's reason for not treating was only for financial gain, they would be

196. *Id.* at 214 ("The question in this case is whether treatment decisions made by a health maintenance organization, acting through its physician employees, are fiduciary acts within the meaning of . . . (ERISA).").

197. *See id.* at 223.

198. *See id.*

199. *See id.* at 231.

200. *Id.* at 227.

201. *See id.* at 228.

202. *See id.* at 229.

203. *See id.*

204. *Id.* at 231.

205. *See id.* at 233-34.

206. *See id.* at 234.

using ERISA in place of simple malpractice claims.²⁰⁷ The Court did not feel there was any reason ERISA was intended to replace state malpractice law.²⁰⁸ With this decision, the Supreme Court was clearly reaffirming congressional support for the development of HMOs.

2. QUALITY-QUANTITY EXTENDED TO OUT-OF-NETWORK REFERRALS

The issue of differentiating between MCO decisions regarding quality of treatment (which would not be preempted by ERISA) versus quantity or eligibility has resulted in several opinions defining the boundary.²⁰⁹ Chief among these is *Pryzbowski v. U.S. Healthcare, Inc.*,²¹⁰ in which the Third Circuit found that managed care plans have the discretion of whether or not to refer patients to “out of network” providers.²¹¹ In this case, suit was brought based on a delay in treatment “caused” by waiting for authorization to use an “out of network” physician.²¹² Underlying these allegations of delay is the policy adopted by U.S. Healthcare (and many other HMOs) requiring beneficiaries either to use in-network specialists or to obtain approval from the HMO for out-of-network specialists.²¹³ These activities fall within the realm of the “administration of benefits,”²¹⁴ and are, as such, completely preempted.

In this case, the court recognized that its circuit had developed a rule in which issues regarding the *quality* of benefits are not completely preempted, but issues involving the *quantity* of benefits are completely preempted.²¹⁵ The court analogized their distinction to the distinction made by the Supreme Court in *Pegram v. Herdrich* between “treatment decisions” which are not preempted and “eligibility decisions” which are preempted.²¹⁶ Thus the relevant question became

207. *See id.* at 234–35.

208. *See id.* at 235–36. This interpretation was based on the Court’s finding that Dr. Pegram’s decision to delay treatment was solely her own and not made under the influence of the MCO’s financial incentive structure. In the Court’s judgment, Herdrich was still free to pursue a state medical malpractice claim against Dr. Pegram.

209. *See, e.g., Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001); *In re U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir. 1999).

210. *Pryzbowski*, 245 F.3d at 266.

211. *Id.* at 273–74.

212. *Id.* at 269–70.

213. *Id.* at 269.

214. *Id.* at 273.

215. *See id.*

216. *Id.*

whether the claim made by Pryzbowski challenges the administration or eligibility of benefits, and is thus preempted, or challenges the quality of care, and is not preempted.²¹⁷ The court upheld the lower court decision that Pryzbowski's claims were completely preempted because the claims involved the delay in providing benefits, which are administrative functions.²¹⁸

The *Pegram* decision has not only set a precedent for future cases alleging MCO liability, but has also prompted at least one instance of a court reexamining an old decision on the issue. In light of the Supreme Court's decision in *Pegram*, the Pennsylvania Supreme Court had to reconsider its decision regarding a summary judgement in *Pappas v. Asbel*,²¹⁹ where it had held that medical negligence claims, asserted under state law against third-party defendants, were not preempted by ERISA.²²⁰ In this case, the plaintiff sued the doctor and hospital for malpractice due to a delay in transferring him to a different hospital, which he claimed resulted in his injury.²²¹ The doctor and hospital then brought the third-party claims against the insurer, U.S. Healthcare.²²²

After an analysis of the relevant portions of *Travelers* and *Pegram*, the court surmised that "if [the hospital's] third party claim against U.S. Healthcare arose out of a mixed decision, it is, according to *Pegram*, subject to state . . . law . . . [and] [m]oreover, under *Travelers*, it is not preempted by ERISA."²²³ The court delved into the decision making process of the HMO to determine if this was a mixed decision, stating:

[At 11:00 a.m.] Dr. Dickter, the physician who first saw Pappas in the emergency room of [the hospital] . . . received permission from Jefferson [Hospital] to admit Pappas to its spinal cord trauma center. . . . When Dr. Dickter learned at 12:40 p.m. from ambulance personnel that Pappas' transfer to Jefferson was not HMO approved, he telephoned U.S. Healthcare at 12:50 p.m. and asked that it reconsider its decision. Dr. Dickter spoke to Elaine Norman, a U.S. Healthcare representative, and told her that Pappas' condition constituted a neurological emergency that needed immediate attention, and for which he had made arrangements with Jefferson. Ms. Norman advised Dr. Dickter that

217. *See id.*

218. *Id.* at 274.

219. *Pappas v. Asbel*, 724 A.2d 889 (Pa. 1998).

220. *Pappas v. Asbel*, 768 A.2d 1089, 1090-91 (Pa. 2001).

221. *Id.* at 1091.

222. *Id.*

223. *Id.* at 1095.

she was not authorized to take action one way or the other, but that she would consult with someone who was. At 1:05 p.m., Dr. Dickter spoke with Carol DeLark, another U.S. Healthcare representative. She told him that Dr. Liebowitz, one of U.S. Healthcare's physicians who had the authority to decide such matters, reviewed Pappas' case; that the referral to Jefferson, a non-HMO hospital, continued to be denied; and that a referral to [other] facilities affiliated with [the hospital] . . . was approved.²²⁴

The court then held that the decision by U.S. Healthcare was a mixed decision because its determination went beyond deciding whether the treatment was covered under the terms of the plan. Instead, it decided where, when, and under what circumstances [the plaintiff] would be treated.²²⁵ The decision, therefore, was a mixed eligibility-treatment decision that should be covered under state law, as *Pegram* mandates, and was also not preempted, as *Travelers* requires.²²⁶

3. LIMITS ON THE MIXED-ELIGIBILITY PRINCIPLE

The use of the mixed-eligibility principle has not supplanted the preemption analysis that the courts have used in the post-*Travelers* era. Subsequent to *Pappas II*, in *DiFelice v. Aetna*,²²⁷ the Third Circuit further defined the quality-quantity distinction in a case challenging an MCO's decision concerning "medical necessity" in the use of a tracheostomy tube. It found that preemption was not limited to simple "eligibility" decisions.²²⁸ The court reasoned that without movement away from the pure eligibility decision required for preemption, any decision having a remote connection with the quality of medical care could not be preempted.²²⁹

The critical issue of what constitutes a "mixed-eligibility decision" was also taken up by the Supreme Court in *Aetna Health, Inc. v. Davila*.²³⁰ The Court attempts to further define the boundary between quality and quantity, noting that in *Pegram*,

[T]he plaintiff's treating physician was also the person charged with administering the benefits; it was she who decided whether certain treatments were covered.²³¹ We reasoned 'that

224. *Id.* at 1095–96.

225. *Id.* at 1096.

226. *Id.*

227. *DiFelice v. Aetna*, 346 F.3d 442, 446–47 (3d Cir. 2003).

228. *See id.* at 447–48.

229. *Id.* at 450.

230. *Aetna Health, Inc. v. Davila*, 124 S. Ct. 2488 (2004).

231. *Id.* at 2501.

the physician's eligibility decision and the treatment decision were inextricably mixed.²³² We concluded that Congress did not intend (the defendant HMO) or any other HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians."²³³

The Court further clarifies the definition of what constitutes a mixed eligibility decision when it finds:

[I]t was essential to *Pegram's* conclusion that the decisions challenged there were truly 'mixed eligibility and treatment decisions,' medical necessity decisions made by the plaintiff's treating physician *qua* treating physician and *qua* benefits administrator. Put another way, the reasoning of *Pegram* 'only makes sense where the underlying negligence also plausibly constitutes medical maltreatment by a party who can be deemed to be a treating physician or such a physician's employer.' Here, however, petitioners are neither respondents' treating physicians nor the employers of respondents' treating physicians. Petitioners' coverage decisions, then, are pure eligibility decisions, and *Pegram* is not implicated.²³⁴

Although the jurisprudence related to mixed-eligibility decisions is complex, pure eligibility decisions seem to be straightforward. In *Dowden v. Blue Cross & Blue Shield*,²³⁵ for example, the Fifth Circuit found that eligibility decisions fall squarely under the provisions of ERISA and its singular regulatory scheme.²³⁶ "The district court correctly concluded that the contested plan grants Blue Cross 'the exclusive and conclusive authority to determine coverage and benefits, and to interpret provisions of the plan, including whether treatment is medically necessary.'"²³⁷

4. KEY COMPONENTS OF MANAGED CARE PLANS

In addition to the landmark decisions in *Pegram* and *Davila*, which help to define the role and functions of MCOs, other major federal and state court decisions have supported the development of some key components of managed care plans.²³⁸

232. *Id.*

233. *Id.*

234. *Pegram v. Hedrich*, 530 U.S. 211, 229–30 (2000); *see also Cicio v. Does*, 321 F.3d 83, 109 (2d Cir. 2003).

235. *Dowden v. Blue Cross & Blue Shield*, 126 F.3d 641 (5th Cir. 1997).

236. *Id.* at 643–44.

237. *Id.* at 644 (quoting the opinion from the United States District Court for the Western District of Texas).

238. *See infra* App. tbls. 1, 2, 3.

In *Jones v. Kodak Medical Assistance Plan*,²³⁹ the Tenth Circuit upheld the discretion of managed care plans to pre-certify treatment that is being sought by a consumer/patient.²⁴⁰ Moreover, the plan administrator has the right to approve or deny treatment at a particular facility.²⁴¹ The court held that the criteria used to make these judgments could not be reviewed “[b]ecause we consider the . . . criteria a matter of [p]lan design and structure, rather than implementation,” therefore upholding the summary judgment on this point.²⁴² Lastly, the court reviewed whether the plan administrator was arbitrary or capricious and applied a reasonable standard to their review.²⁴³ It held that the insurer’s decision was reasonable because an independent reviewer agreed and because the criteria were part of the plan and the plaintiff could not present evidence that those criteria were applied in a discriminatory manner.²⁴⁴ Thus the court affirmed all parts of the district court’s decision.²⁴⁵

In addition, the courts have also found that managed care plans have the discretion to offer financial incentives to providers as part of a managed care contract,²⁴⁶ and that managed care plans have no “duty to reveal financial incentives to patients.”²⁴⁷ A number of circuits have ruled on cases involving financial incentives and found that MCOs do not have a fiduciary duty under ERISA to disclose the underlying incentives in the plan.²⁴⁸ *Ehlmann v. Kaiser Foundation Health Plan of Texas*²⁴⁹ illustrates the courts’ typical reasoning in these financial incentive cases. In *Ehlmann*, the Fifth Circuit found that ERISA does not impose a duty on MCOs to reveal the compensation plan that the MCOs provide their doctors. It believed that a broad duty to disclose was unwarranted because previous courts’ decisions, such as

239. *Jones v. Kodak Med. Assistance Plan*, 169 F.3d 1287 (10th Cir. 1999).

240. *See id.* at 1292; *see also* *Danca v. Private Health Care Sys., Inc.*, 185 F.3d 1 (1st Cir. 1999) (similarly holding on precertification).

241. *Jones*, 169 F.3d at 1290.

242. *Id.* at 1292.

243. *Id.*

244. *See id.*

245. *Id.*

246. *See* *Lancaster v. Kaiser Found. Health Plan of Mid-Atl. States, Inc.*, 958 F. Supp. 1137, 1138–39 (E.D. Va. 1997).

247. *Id.* at 1150.

248. *See* *Horvath v. Keystone Health Plan E., Inc.*, 333 F.3d 450 (3d Cir. 2003); *Ehlmann v. Kaiser Found. Health Plan of Tex.*, 198 F.3d 552 (5th Cir. 2000); *Weiss v. Cigna Health Care, Inc.*, 972 F. Supp. 748 (S.D.N.Y. 1997). *But see* *Shea v. Esenstein*, 107 F.3d 625 (8th Cir. 1997).

249. *Ehlmann*, 198 F.3d at 552; *infra* App. tbl. 2.

Shea v. Esensten,²⁵⁰ were too broad in their interpretation of MCO plan administrators' duties under ERISA.²⁵¹ *Ehlmann* takes a deliberate stand on the issue of disclosure of financial incentives and, in doing so, restricts information that must be provided to participants which they could then use as a basis for suits alleging a breach of duty based on the compensation schemes used by the MCO.

The circuit courts have, over time, also ruled on other key elements of managed care theory in a manner which is supportive of MCOs:²⁵²

- In *Haynes v. Prudential Health Care*,²⁵³ the Fifth Circuit found that MCOs could make decisions designating an insured's "primary care physician."²⁵⁴ These are purely "administrative decisions" that are expressly preempted by ERISA,²⁵⁵
- This parallels the 1991 case, *Miller v. Metropolitan Life Insurance Co.*,²⁵⁶ in which the Sixth Circuit ruled that the trustees of health care organizations have the discretion to terminate benefits as long as their actions are not "arbitrary and capricious;"
- Similarly, in *Shiple v. Arkansas Blue Cross & Blue Shield*,²⁵⁷ the Eighth Circuit found that the plan administrator acted reasonably and did not "abuse" its discretion in canceling policies which control benefits paid as a method for controlling costs;
- Finally, in *Lefler v. United Health Care of Utah*,²⁵⁸ the Tenth Circuit held that MCOs could calculate consumer co-payments based on a percentage of providers' charges. Although the court recognized that the practice of charging based on a percentage of a provider's charges was a conflict of interest, it found that the practice was reasonable under ERISA as a method for MCOs to allocate costs.²⁵⁹

250. *Shea*, 107 F.3d at 625; *infra* App. tbl. 2.

251. *Ehlmann*, 198 F.3d at 556.

252. See, e.g., *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001); *Danca v. Private Health Care Sys., Inc.*, 185 F.3d 1 (1st Cir. 1999); *Aloha Airlines, Inc. v. Ahue*, 12 F.3d 1498 (9th Cir. 1993).

253. *Haynes v. Prudential Health Care*, 313 F.3d 330 (5th Cir. 2002).

254. *Id.*

255. *Id.* at 337.

256. *Miller v. Metro. Life Ins. Co.*, 925 F.2d 979 (6th Cir. 1991).

257. *Shiple v. Ark. Blue Cross & Blue Shield*, 333 F.3d 898 (8th Cir. 2003).

258. *Lefler v. United Health Care of Utah*, No. 01-4228 (10th Cir. Aug. 14, 2003).

259. *Id.* slip op. at 4.

B. Restrictive Federal and State Court Decisions

1. UTILIZATION REVIEW

Tables 4, 5, and 6 illustrate the cases that have served to significantly limit the full implementation of managed care theory. Some of these cases also explicitly focus on what the appropriate function and roles of MCOs should be.²⁶⁰ They pose the question: to what extent is an MCO a provider and insurer and not just an administrator of benefits? For example, in *Rush Prudential HMO v. Moran*,²⁶¹ the Supreme Court, in a five to four decision, found that states could require external review of unfavorable utilization review decisions, because this requirement is legitimately part of state insurance regulation and is, therefore, “saved” from ERISA preemption.²⁶² The Court, in the majority opinion written by Justice Souter, acknowledged that an HMO is both a health care provider and an insurer.²⁶³ Therefore, it argued, “as long as providing insurance fairly accounts for the application of state law, the savings clause may apply.”²⁶⁴ Justice Souter next pointed out that “HMOs actually underwrite and spread risk among their participants . . . a feature distinctive to insurance.”²⁶⁵ He also noted that the insurance component of HMOs has been understood by Congress since the creation of the phrase “‘Health Maintenance Organization’ was established and defined in the HMO Act of 1973.”²⁶⁶

The dissent in this decision views the Illinois statute (providing for the external review) as a binding determination upon Rush (the provider) of whether certain benefits are due.²⁶⁷ Justice Thomas, writing on behalf of the dissenters, points out that allowing independent review statutes, such as the one used in Illinois, will undermine

260. See *infra* App. tbls. 4, 5, 6.

261. *Rush Prudential HMO v. Moran*, 536 U.S. 355 (2002).

262. Forty-two states and the District of Columbia have provisions for independent review of medical necessity determinations. See generally E. Haavi Morreim, *ERISA Takes a Drubbing: Rush Prudential and its Implications for Health Care*, 38 TORT & INS. L.J. 933, 933–61 (2003) (discussing the implications of independent review laws for the future of ERISA preemption).

263. *Rush Prudential*, 536 U.S. at 367.

264. *Id.*

265. *Id.*

266. *Id.* at 367.

267. The majority view was that the review represents a “second opinion” which is still open to judicial review. *Id.* at 386. The dissent sees the review as arbitration and, hence, an alternative to further litigation. *Id.* at 388–402.

HMO's ability to manage cost, thereby undermining the ability of employers to provide health care coverage.²⁶⁸

Managed care plans, from a theoretical perspective, must be in a position to predict and control the cost of care. To the extent that the *Rush* decision empowers independent reviewers to make binding decisions, this will challenge the ability of MCOs to control cost and will further weaken the ability of these managed care plans to enforce pre-authorization procedures.

2. "ANY WILLING PROVIDER" STATUTES

In this insurance framework, the Supreme Court took up the case of *Kentucky Association of Health Plans, Inc. v. Miller*²⁶⁹ in June of 2003. The question before the Court was whether Kentucky's "Any Willing Provider" (AWP) statute was preempted by ERISA.²⁷⁰ The Kentucky law required "a health insurer [not to] discriminate against any provider who . . . is willing to meet the terms and conditions for participation" in the insurer's plan.²⁷¹ The Court's decision unanimously upheld the Kentucky law and held that this was clearly a matter of regulation of insurance which is "saved" from ERISA preemption.²⁷² Justice Scalia reasoned that "[b]y expanding the number of providers from whom an insured may receive health services, AWP laws alter the scope of permissible bargains between insurers and insureds" such that the Kentucky law "substantially affects the type of risk pooling arrangements that insurers may offer."²⁷³ The Court also

268. See *id.* at 402. Justice Thomas's reasoning here is informative of the dilemma the courts have faced in deciding ERISA-related cases as they relate to managed care:

[E]fforts to expand the variety of remedies available to aggrieved beneficiaries beyond those set forth in ERISA are obviously designed to increase the chances that patients will be able to receive treatments they desire, and most of us are naturally sympathetic to those suffering from illness who seek further options. Nevertheless, the Court would do well to remember that no employer is required to provide any health benefit plan under ERISA and that the entire advent of managed care, and the genesis of HMOs, stemmed from spiraling health costs. To the extent that independent review provisions such as § 4-10 make it more likely that HMOs will have to subsidize beneficiaries' treatments of choice, they undermine the ability of HMOs to control costs, which, in turn, undermines the ability of employers to provide health care coverage for employees.

269. *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003).

270. See *id.* at 332.

271. *Id.* at 330-33.

272. See *id.* at 342.

273. *Id.* at 338-39.

noted that “Kentucky health-care providers are still capable of entering exclusive networks with insurers who conduct business outside” of Kentucky.²⁷⁴ Justice Scalia recognized that “as a consequence of Kentucky’s AWP laws, entities outside the insurance industry (such as health care providers) will be unable to enter into certain agreements with Kentucky insurers.”²⁷⁵

This landmark decision has the consequence of substantially limiting the ability of MCOs to “selectively contract,” which represents a core element of managed care theory.²⁷⁶ As noted above, the Court found that expanding the network of providers altered “the scope of permissible bargains between” the insured and the insurance provider “in a manner similar to the mandated benefit laws we sustained in *Metropolitan Life*, the notice-prejudice rule we sustained in *UNUM*, and the independent review provisions we approved in *Rush Prudential*.”²⁷⁷ These recent decisions, and *Miller* in particular, are blows to the managed care industry, which has continued to rely heavily on restricted provider networks as a strategy to control costs, despite the fact that twenty-six states have enacted AWP laws.²⁷⁸

Miller’s significance goes beyond its focus on any willing provider laws. The Supreme Court used this decision to comment on the traditional McCarran-Ferguson criteria that have been used to determine whether a particular issue falls within the jurisdiction and realm of “state health insurance.”²⁷⁹ The Court broke from the previous doctrine of applying the McCarran-Ferguson factors in evaluating a saving clause claim.²⁸⁰ Justice Scalia, explaining the change in doctrine, stated that the “use of the McCarran-Ferguson case law . . . has misdirected attention, failed to provide clear guidance to lower federal courts, and . . . added little to the relevant analysis.”²⁸¹ In overturning the Court’s previous interpretation of these factors, Justice Scalia explained:

Our holdings in *UNUM* and *Rush Prudential*—that a state law may fail the first McCarran-Ferguson factor yet still be saved from pre-

274. *Id.* at 335.

275. *Id.*

276. See Rich & Erb, *supra* note 14, at 236.

277. *Miller*, 538 U.S. at 330.

278. See NAT’L CONFERENCE OF STATE LEGISLATURES, MANAGED CARE STATE LAWS AND REGULATIONS INCLUDING CONSUMER AND PROVIDER PROTECTIONS (Feb. 2003), at <http://64.82.65.67/health/hmolaws.htm> (last visited Mar. 7, 2005).

279. See *Miller*, 538 U.S. at 339–40.

280. See *id.*

281. *Id.* at 330.

emption under [section 514](b)(2)(A)—raise more questions than they answer and provide wide opportunities for divergent outcomes. May a state law satisfy any two of the three McCarran-Ferguson factors and still fall under the savings clause? Just one? What happens if two of three factors are satisfied, but not “securely satisfied” or “clearly satisfied,” as they were in *UNUM* and *Rush Prudential*?²⁸²

Justice Scalia went on to point out that “confusion arises from the question whether the state law itself or the conduct regulated by that law is the proper subject to which one applies the McCarran-Ferguson factors.”²⁸³ An example of the confusion can be demonstrated by comparing *Pilot Life*,²⁸⁴ where the inquiry focused on the law at issue, with *Rush Prudential*,²⁸⁵ which “focused the McCarran-Ferguson inquiry on the conduct regulated by the state law.”²⁸⁶ Finally, Scalia pointed out a last reason for the doctrinal change: the Court has “never held that the McCarran-Ferguson factors are an essential component” of any savings clause inquiry.²⁸⁷

Given these arguments, the Court laid down a new rule to satisfy the savings clause under § 514(b)(2)(A) which required: (1) the state law to be “specifically directed toward entities engaged in insurance,” and (2) “the state law must substantially affect the risk pooling arrangement between the insurer and the insured.”²⁸⁸ In applying their new rule the Court held that the Kentucky statute satisfied its requirements and fell under ERISA’s savings clause.²⁸⁹

For the first prong, Scalia found that “[n]either of Kentucky’s AWP statutes . . . imposes any prohibitions or requirements on health-care providers,” and that “Kentucky health-care providers are still capable of entering exclusive networks with insurers who conduct business outside” of Kentucky.²⁹⁰ Scalia recognized that “as a consequence of Kentucky’s AWP laws, entities outside the insurance industry (such as health care providers) will be unable to enter into certain agreements with Kentucky insurers.”²⁹¹ However such concerns were not

282. *Id.*

283. *Id.*

284. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

285. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002).

286. *Miller*, 538 U.S. at 341.

287. *Id.*

288. *Id.* at 341–42.

289. *Id.* at 342.

290. *Id.* at 334–35.

291. *Id.* at 335.

enough to prevent other state laws from being saved from preemption in *FMC Corp.*²⁹² and *Miller*.²⁹³ Thus the first prong was satisfied.

Under the second prong, Scalia initially points out that the savings clause is not concerned “with how to characterize conduct undertaken by private actors, but with how to characterize state laws in regard to what they ‘regulate.’”²⁹⁴ The Kentucky law prevents health insurers from discriminating against willing providers and thus “‘regulates’ insurance by imposing conditions on the right to engage in the business of insurance.”²⁹⁵ Thus the second prong of the new rule was satisfied and the Kentucky law met the requirements of the savings clause.

Prior to *Miller*, states’ any willing provider laws had been struck down as preempted by ERISA in both the Fifth and the Eighth Circuits.²⁹⁶ It was reasoned that these laws require plans to purchase benefits of a specific structure when a managed care plan is purchased.²⁹⁷ The Louisiana and Texas statutes were not saved because they referred to “entities outside of the insurance industry.”²⁹⁸ In *Prudential Insurance Co. of America v. National Park Medical Center*, the Eighth Circuit concluded that Arkansas’ Patient Protection Act, which included an any willing provider provision, was preempted by ERISA and could not be “saved” pursuant to ERISA’s insurance-saving provision.²⁹⁹ The court stated: “We believe that this conclusion is compelled by applicable precedent. Although we recognize that various courts have expressed concern about the scope of ERISA preemption, it is for Congress, not the courts, to reassess ERISA in light of modern insurance practices and the national debate over health care.”³⁰⁰

In contrast, several cases moved against the trend of striking down any willing provider laws. In *Washington Physicians Service As-*

292. *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

293. *Miller*, 538 U.S. at 333–35.

294. *Id.* at 330.

295. *Id.* at 338.

296. See *Prudential Ins. Co. of Am. v. Nat’l Park Med. Ctr., Inc.*, 154 F.3d 812 (8th Cir. 1998); *Tex. Pharmacy Ass’n v. Prudential Ins. Co.*, 105 F.3d 1035 (5th Cir. 1997); *CIGNA Healthplan of La., Inc. v. Ieyoub*, 82 F.3d 642 (5th Cir. 1996); see also *Cnty. Health Partners v. Kentucky*, 14 F. Supp.2d 991 (W.D. Ky. 1998).

297. See *Prudential*, 154 F.3d at 812; *Tex. Pharmacy Ass’n*, 105 F.3d 1035; *CIGNA*, 82 F.3d at 642; see also *Prudential Ins. Co. of Am. v. Nat’l Park Med. Ctr., Inc.*, 964 F. Supp. 1285 (E.D. Ark. 1997).

298. See *Prudential*, 154 F.3d at 812; *CIGNA*, 82 F.3d at 642.

299. See *Prudential*, 154 F.3d at 829.

300. *Id.* at 830.

*sociation v. Gregoire*³⁰¹ the Ninth Circuit held that the Washington any willing provider statute was not preempted by ERISA.³⁰² The court noted that: “The statute operates directly upon ‘health plans,’ but it also makes clear that this term refers to the plan offered by the health carrier . . . not the benefit plan offered by the employer.”³⁰³ This was consistent with an earlier Fourth Circuit decision involving an AWP law in Virginia.³⁰⁴ Another exception is found in *American Drug Stores, Inc. v. Harvard Pilgrim Health Care*, which held the state’s AWP statute fell within an area of traditional state regulation and the Act did not interfere with the administrative functions and responsibilities “related to” administration of an ERISA plan.³⁰⁵ The court further reasoned that the Act merely regulates insurance and is directly saved from ERISA preemption.³⁰⁶

3. SELECTION AND DE-SELECTION

Another key aspect of managed care plans is the selection/de-selection of physicians as part of a network or panel. In California, a physician working within an HMO brought suit under “the common-law right to fair procedure, which forbids arbitrary expulsions from private organizations under certain circumstances.”³⁰⁷ The majority opinion in *Potvin v. Metropolitan Life Insurance Co.* concluded that “the relationship between insurers and their preferred provider physicians significantly affects the public interest” thereby falling under the right to fair procedure.³⁰⁸ However, the court qualified that conclusion by saying that insurers only have to comply with the right to fair procedure if “the insurer possesses power so substantial that the removal [from a provider list] significantly impairs the ability of an ordinary, competent physician to practice medicine . . . in a particular geographic area, thereby affecting an important, substantial economic interest.”³⁰⁹ In defining conditions that would significantly impair a

301. Wash. Physicians Serv. Ass’n v. Gregoire, 147 F.3d 1039 (9th Cir. 1998).

302. *Id.* at 1042–43.

303. *Id.* at 1043.

304. The Fourth Circuit held that Virginia’s AWP law was not preempted by ERISA in *Stuart Circle Hospital Corp. v. Aetna Health Management*, 995 F.2d. 500, 501 (4th Cir. 1993).

305. *Am. Drug Stores, Inc. v. Harvard Pilgrim Health Care*, 973 F. Supp. 60, 69 (D. Mass. 1997).

306. *Id.* at 72.

307. *Potvin v. Metro. Life Ins. Co.*, 997 P.2d 1153, 1155 (Cal. 2000).

308. *Id.* at 1160.

309. *Id.*

physician's practice of medicine, the court stated if "participation in managed care arrangements is a practical necessity for physicians generally and if only a handful of health care entities have a virtual monopoly on managed care, removing individual physicians from preferred provider networks . . . could significantly impair those physicians' practice of medicine."³¹⁰ In this decision, the California Supreme Court specifically limited the discretion of HMOs in delisting a physician.³¹¹

4. OTHER LIMITING PROVISIONS

The courts have also been involved in limiting other aspects of the standard operations of managed care plans. A variety of Federal court decisions all represent restrictions on the implementation of managed care theory.³¹² The following list is a summary of the specific ways in which court decisions have limited MCOs' management practices.

1. MCOs do have a duty to disclose the underlying incentives in their managed care plan.³¹³ And MCOs' physician incentive plans may be revealed and challenged in State court.³¹⁴ Specifically, the Eighth Circuit found in *Shea v. Esensten* that an MCO "was offering financial incentives that could have colored the doctor's medical judgement . . . Health care decisions involve matters of life and death, and an ERISA fiduciary has a duty to speak out if it knows that silence may be harmful" to a patient.³¹⁵
2. MCOs may have a duty to use their discretionary authority to *provide* a benefit, rather than *deny* it.³¹⁶

310. *Id.*

311. Other courts have dealt with the issue of physician deselection procedures, with similar results. See *Tex. Med. Ass'n v. Aetna Life Ins.*, 80 F.3d 153 (5th Cir. 1996); *Ambrosino v. Metro. Life Ins. Co.*, 899 F. Supp. 438 (N.D. Cal. 1995); *Delta Dental v. Banasky*, 33 Cal. Rptr. 2d 381 (Ct. App. 1994); *Napoletano v. CIGNA Healthcare of Conn.*, 680 A.2d 127 (Conn. 1996); *Harper v. Healthsource N.H.*, 674 A.2d 962 (N.H. 1996).

312. See *infra* App. tbls. 5, 6.

313. See *Shea v. Esensten*, 107 F.3d 625 (8th Cir. 1997).

314. See *Fritcher v. Health Care Serv. Corp.*, 301 F.3d 811 (7th Cir. 2002); *Lazorko v. Pa. Hosp.*, 237 F.3d 242 (3d Cir. 2000).

315. *Shea*, 107 F.3d at 629.

316. See *Chiera v. John Hancock Mut. Life Ins. Co.*, 248 F.3d 1147 (6th Cir. 2001); *Milone v. Exclusive Healthcare, Inc.*, 244 F.3d 615, 619 (8th Cir. 2001); *Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287, 302 (5th Cir. 1999); *McGraw v. Prudential Ins. Co. of Am.*, 137 F.3d 1253, 1263 (10th Cir. 1998); *Bellaire Gen. Hosp. v. Blue Cross & Blue Shield of Mich.*, 97 F.3d 822, 832 (5th Cir. 1996); *Lee v. Blue Cross & Blue Shield of Ala.*, 10 F.3d 1547, 1551 (11th Cir. 1994); *Heasley v. Belden & Blake Corp.*, 2 F.3d 1249, 1262 (3d Cir. 1993); *Doe v. Group Hospitalization & Med. Servs.*, 3 F.3d 80, 89 (4th Cir. 1993); *Glocker v. W.R. Grace & Co.*, 974 F.2d 540, 544

3. MCOs may be “vicariously liable” for care provided by network providers.³¹⁷
4. There can be state law malpractice suits against MCOs in the form of “vicarious liability.”³¹⁸
5. Managed care plans are obligated to include certain, specific health care benefits (e.g., alternative medicine or chiropractic).³¹⁹

III. The Future of Managed Care Organizations

Given the legal controversies over the appropriate roles for the federal and state levels of government and the controversies over specific managed care plan elements, what will be the key legal issues for the future development of managed care plans? Legal liability of managed care organizations as compared with individual provider malpractice claims is among the most controversial of all issues currently on the agenda. The use of external, independent review procedures, discussed earlier in the context of the *Rush Prudential HMO v. Moran* decision, and strict use of practice guidelines, also represent challenges for the future. However, the liability issue is by far the most controversial of these three.

A. Legal Liability

The question of MCO legal liability is directly related to defining what the core functions of such organizations are: administrators of an employee benefit plan, insurance plan, and/or service provider. In the *Rush-Prudential*, *Pegram*, *Miller*, and *Davila* decisions, the Supreme

(4th Cir. 1992); *McGee v. Equicor-Equitable HCA Corp.*, 953 F.2d 1192 (10th Cir. 1992); *Masella v. Blue Cross & Blue Shield of Conn.*, 936 F.2d 98, 107 (2d Cir. 1991); *Kunin v. Benefit Trust Life Ins. Co.*, 898 F.2d 1421, 1428 (9th Cir. 1990).

317. See *Corp. Health Ins., Inc. v. Tex. Dep't of Ins.*, 215 F.3d 526, 534 (5th Cir. 2000); see also Clark C. Havighurst, *Vicarious Liability: Reallocating Responsibility for the Quality of Medical Care*, 26 AM. J.L. & MED. 7, 20 (2000) (discussing the implications of assigning vicarious liability to MCOs). The issue of liability and vicarious liability will be discussed further in part three of this article.

318. See *Land v. CIGNA Healthcare of Fla.*, 339 F.3d 1286 (11th Cir. 2003); *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995); *Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3rd Cir. 1995); see also James F. Henry, Comment, *Liability of Managed Care Organizations After Dukes v. U.S. Healthcare: An Elemental Analysis*, 27 CUMB. L. REV. 681, 689 (1996/1997) (interpreting *Dukes* as a sea-change in ERISA law surrounding managed care liability: “However, the *Dukes* decision buttresses the emerging rule that ERISA will not pre-empt ostensible agency claims based on quality of care. Under the *Dukes* reasoning, ERISA operates to pre-empt only claims based on denial of benefits.”).

319. See *Wash. Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998).

Court has recognized this controversy over the functions of MCOs. In *Rush-Prudential*, the Court went so far as to acknowledge that an HMO is both a health care provider and an insurer.³²⁰ Other courts have dealt with the critical question of whether managed care organizations make treatment decisions or whether these medical decisions are, instead, made only by physicians.³²¹ These distinctions were also at the center of the decisions about quality-quantity and mixed eligibility that were discussed previously.

The 2004 *Davila* decision is particularly relevant with respect to the liability of managed care organizations. The respondents in this case argued that the Managed Care Organization's refusal to cover requested services violated their "duty to exercise ordinary care when making health care treatment decisions" and that these refusals "proximately caused" their injuries.³²² Consequently, *Davila* and *Calid*—the respondents—argued that the MCO was liable in state court for these injuries.³²³ Moreover, they contended that under the Texas Health Care Liability Act (THCLA)³²⁴ the MCOs "controlled, influenced, and participated in and made decisions that affected the quality of diagnosis, care, and treatment provided in a manner that violated the duty of ordinary care."³²⁵ It was also asserted that "this duty of ordinary care arises independently of any duty imposed by ERISA . . . [and that] any civil action to enforce this duty is not within the scope of the ERISA civil enforcement mechanism."³²⁶

The Supreme Court rejected this argument and found that while THCLA does impose a duty of ordinary care, and liability, when making *treatment* decisions, if an MCO correctly concluded a treatment was not covered, their denial of coverage could not be a proximate cause of any injury.³²⁷ Any injury would have been caused by a fail-

320. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 366–67 (2002). "Rush contends that seeing an HMO as an insurer distorts the nature of an HMO, which is, after all, a health care . . . provider, too The answer to Rush is, of course, that an HMO is both: it provides health care, and it does so as an insurer."

321. *See, e.g.*, *Pegram v. Herdrich*, 530 U.S. 211 (2000); *Pappas v. Asbel*, 724 A.2d 889 (Pa. 1998); *Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229 (Pa. Super. Ct. 1988).

322. *Aetna Health, Inc. v. Davila*, 124 S. Ct. 2488, 2493 (2004).

323. *Id.*

324. Texas Health Care Liability Act (THCLA), TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001–.003 (2004).

325. *Davila*, 124 S. Ct. at 2497.

326. *Id.*

327. *Id.*

ure in the design of the plan to cover the treatment itself.³²⁸ “The design of a plan is administrative in nature and completely preempted by ERISA.”³²⁹

The Court also acknowledged that Texas was attempting to create a state cause of action to authorize remedies beyond those authorized by § 502 (a) of ERISA.³³⁰ But, it asserted that “the limited remedies available under ERISA are an inherent part of the ‘careful balancing’ between ensuring fair and prompt enforcement of rights under a plan and the encouragement or the creation of such plans.”³³¹

This decision is particularly important in light of the strong beliefs by consumers and providers that managed care organizations do indeed strongly influence (if not make) treatment decisions.³³² Consequently, they argue, MCOs should be legally liable for medical error and malpractice in the same way that physicians and hospitals are currently liable.³³³ From this perspective, medical errors are caused by system failures and not by individual errors.³³⁴ Managed care organizations and insurers, on the other hand, argue that legal liability of this type would significantly increase the costs of managed care plans and would not increase the overall quality of care provided.³³⁵ This issue is at the core of the difference between the House and Senate versions of the Patient Bill of Rights statute.³³⁶

328. *Id.*

329. *Id.* at 2498.

330. *Id.* at 2499.

331. *Id.*

332. See, e.g., Allison Faber Walsh, *The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability for Physicians and Managed Care Organizations*, 31 J. MARSHALL L. REV. 207, 209 n.2, 3 (1997) (describing a hypothetical situation based on the Pennsylvania case, *McClellan v. Health Maintenance Organization of Pennsylvania*, 686 A.2d 801 (Pa. 1996), in which a medical treatment decision by a provider was overridden in the MCO’s utilization review process, effectively taking the treatment decision out of the hands of the provider and locating it squarely with the MCO’s utilization review team).

333. *Id.*

334. James F. Blumstein, *The Legal Liability Regime: How Well Is It Doing in Assuring Quality, Accounting for Costs, and Coping with an Evolving Reality in the Health Care Marketplace?*, 11 ANNALS HEALTH L. 125, 138 (2002).

335. *Id.* at 131.

336. For example, in 2001 the U.S. Senate passed Senate Bill 1052 (one version of a Patients’ Bill of Rights). S. 1052, 107th Cong. (2001). The U.S. House of Representatives debated but did not pass its version of such legislation. H.R. 2563, 107th Cong. (2001). As of this writing, Congress has not adopted a Patient Bill of Rights. See George J. Annas, *A National Bill of Patients’ Rights*, 338 NEW ENG. J. MED. 695, 697–99 (1998) (summarizing the rights that have been discussed as critical to patient protection, including rights to information, privacy, treatment refusal, emergency care, advocates, and the more controversial right to sue one’s health plan).

Prior to *Davila*, there were a variety of cases in which the courts held that ERISA preempts a state law medical malpractice³³⁷ or medical negligence³³⁸ claim. ERISA has also been found to preempt a state law wrongful death claim.³³⁹ For example, the Eighth Circuit found that an MCO's decision to cancel heart surgery previously authorized was not malpractice, but rather the denial was that of a benefit due under the plan and, therefore, the state law claims were completely preempted.³⁴⁰ In other cases, courts have reasoned that a successful malpractice claim would require the court to analyze the "underlying" health plan (i.e., the nature of the benefits package provided), and the claim would, consequently, be preempted.³⁴¹

In *Corcoran v. United Healthcare, Inc.*,³⁴² the MCO denied the physician's hospitalization order for the then pregnant plaintiff and, instead, only authorized home nursing care.³⁴³ During a time in which the nurse was not present, the plaintiff's fetus went into distress and died.³⁴⁴ The court found that the negligence claim in this case was based on a benefits determination and was, therefore, preempted by ERISA.³⁴⁵

Malpractice claims against MCOs have not met with uniformity in their preemption holdings by the circuit courts.³⁴⁶ Malpractice claims against MCOs tend to be analyzed under the quantity-quality rubric and are preempted because they have been found to be decisions involving quantity or eligibility for benefits.³⁴⁷ However, six circuit court decisions have held malpractice claims not to be preempted based on their particular facts, where the courts found that those particular facts fell on the quality side of the quantity-quality line.³⁴⁸ In

337. *Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th Cir. 1993); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992).

338. *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 927 (6th Cir. 1995).

339. *See, e.g., Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir. 1993); *Settles v. Golden Rule Ins. Co.*, 927 F.2d 505 (10th Cir. 1991).

340. *Kuhl*, 999 F.2d 298, 303 (8th Cir. 1993).

341. *Pomeroy v. Johns Hopkins Med. Servs., Inc.*, 868 F. Supp. 110, 113 (D. Md. 1994); *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966, 974 (S.D.N.Y. 1994).

342. *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992).

343. *Id.* at 1324.

344. *Id.*

345. *Id.* at 1325.

346. *See infra* notes 348–51 and accompanying text.

347. *See, e.g., Pryzbowski v. U.S. Healthcare*, 245 F.3d 266 (3d Cir. 2001).

348. *See, e.g., Land v. CIGNA Healthcare of Fla.*, 339 F.3d 1286 (11th Cir. 2003); *Roark v. Humana, Inc.*, 307 F.3d 298 (5th Cir. 2002); *Corp. Health Ins., Inc. v. Tex. Dep't of Ins.*, 215 F.3d 526 (5th Cir. 2000); *Rice v. Panchal*, 65 F.3d 637 (7th Cir.

those cases, the courts held that the claims brought by the injured plaintiffs were not claims for benefits due, but claims based on the poor quality of care they received.³⁴⁹ For instance, claims for the failure to run blood tests,³⁵⁰ or for poor treatment of an infected finger resulting in amputation,³⁵¹ were not preempted. Cases where the doctors have clearly provided negligent treatment place the MCOs under the scope of state malpractice laws because such claims do not involve the terms of an ERISA plan, but instead involve the execution of those plans by the doctors hired by the MCO.³⁵²

Tied closely with the malpractice claims are the common-law vicarious liability claims, which have also been met with mixed results before the circuit courts. Typically, MCOs have not been held liable for the actions of others when the decisions made were administrative in nature or involved the medical plan terms.³⁵³ The reasoning for vicarious liability claims that are not preempted mirrors the reasoning in malpractice claims. Malpractice claims that encompass the quality of care given by doctors also open up the MCO for vicarious liability when the MCO has held their provider out as their agent.³⁵⁴

In some instances, courts have begun to hold MCOs “vicariously accountable” based on “agency” or “enterprise” liability theory.³⁵⁵ “Enterprise medical liability” is a term used to describe a system in which health care organizations bear responsibility for medical malpractice in addition to, or instead of, individual health professionals.³⁵⁶ “Courts reason that the business entity arranging for the care is most capable of being able to ensure quality medical care.”³⁵⁷ Some would argue that enterprise liability “flows logically from the most

1995); *Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995).

349. *Land*, 339 F.3d at 1293; *Corp. Health Ins.*, 215 F.3d at 534; *Rice*, 65 F.3d at 645; *Pacificare*, 59 F.3d at 154; *Dukes*, 57 F.3d at 356.

350. *See Dukes*, 57 F.3d at 352.

351. *See Land*, 339 F.3d at 1288.

352. *Corp. Health Ins.*, 215 F.3d at 534; *Rice*, 65 F.3d at 642.

353. *See, e.g.*, *Marks v. Watters*, 322 F.3d 316 (4th Cir. 2003); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996).

354. *See Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995).

355. *See generally* CLARK C. HAVIGHURST ET AL., *HEALTH CARE LAW AND POLICY: READINGS, NOTES, AND QUESTIONS* 1185–91 (2d ed. 1998); *see also* Hastings, *supra* note 8, at 241.

356. *See generally* Jack K. Kilcullen, *Groping for the Reins: ERISA, HMO Malpractice, and Enterprise Liability*, 22 AM. J.L. & MED. 7 (1996); William M. Sage & James M. Jorling, *A World That Won't Stand Still: Enterprise Liability by Private Contract*, 43 DEPAUL L. REV. 1007 (1994).

357. Hastings, *supra* note 8, at 241.

promising features of managed care itself: pre-selection of physicians, use of financial incentives and utilization management techniques.³⁵⁸ Circuit courts have also found that ERISA does not preempt state law malpractice suits against managed care plans.³⁵⁹ In the area of vicarious liability, the district and circuit courts have been inconsistent in their decisions.³⁶⁰

The courts also distinguish between direct and vicarious liability on the one hand, and plan liability on the other.³⁶¹ Many MCO plans have introduced provider incentive programs designed to control costs by reducing utilization of the most expensive services.³⁶² One of the controversies surrounding MCOs is whether these “incentive plans” influence physicians to make treatment decisions based on financial rather than clinical or therapeutic considerations. *Lancaster v. Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.*³⁶³ raises a series of very important questions for managed care organizations: does the MCO-designed incentive plan encourage physicians to make treatment decisions for financial rather than medical reasons?³⁶⁴ Can the MCO be held liable if the treatment decisions are influenced by the incentive plan?³⁶⁵ In other words, the structure and design of the medical plan is being questioned in this case. The district court found any direct liability claim against the Kaiser plan was preempted by ERISA and, therefore, dismissed state law liability claims.³⁶⁶ The court’s decision stated that the MCO’s administrative decision “had the effect of denying benefits to Lancaster as a plan participant . . .” and, as such, falls centrally into the purview of ERISA.³⁶⁷ In this case, ERISA is being used as a direct instrument of support for the management practices of MCOs.

358. Clark C. Havighurst, *Vicarious Liability: Reallocating Responsibility for the Quality of Medical Care*, 26 AM. J.L. & MED. 7, 20 (2000) (discussing the implications of assigning vicarious liability to MCOs).

359. *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995); *Pacificare of Okla., Inc. v. Barrage*, 59 F.3d 151 (10th Cir. 1995); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995).

360. *Dukes*, 57 F.3d at 357.

361. Rich & Erb, *supra* note 14, at 272.

362. See *Lancaster v. Kaiser Found. Health Plan of Mid-Atl. States, Inc.*, 958 F. Supp. 1137 (E.D. Va. 1997).

363. *Id.*

364. *Id.* at 1141.

365. See *id.*

366. *Id.* at 1146.

367. *Id.* at 1150.

It is clear that the liability of MCOs and the possible need to reform ERISA seem to be the most controversial dimensions of the legal and public policy discussions concerning managed care. This is true because Congress, and to a great extent the Supreme Court, continues to believe in the intent of ERISA to insure uniformity in the administration of employee benefits plans.³⁶⁸ The courts have, however, voiced their concern over the broad preemption of state health care law. For example, on appeal in the 1992 *Corcoran* case, the Fifth Circuit took the opportunity to editorialize about the implications of its decision, noting:

The result that ERISA compels us to reach means that the *Corcorans* have no remedy. . . . This is troubling for several reasons. First, it eliminates an important check on the thousands of medical decisions routinely made in the burgeoning utilization review system. . . . 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 expressed intentions of its creators.³⁶⁹

It has also been difficult for courts to interpret ERISA preemption issues because the practice of managed care often makes the distinction between claims determinations and medical care decisions less than clear. *Andrews-Clarke v. Travelers Insurance Co.*³⁷⁰ noted that the courts at that time had “no choice but to pluck [claims] out of the state court . . . and then . . . slam the courthouse doors in [the plaintiffs’] face . . . without any remedy.”³⁷¹ In response to the numerous ERISA cases it has heard, the Supreme Court has similarly and repeatedly invited Congress to reevaluate the preemption clauses.³⁷² Indeed, the Court has queried whether Congress might not want to address the very intent behind ERISA and whether the original intent is still applicable in the context of managed care.³⁷³ Controversy in this area

368. PATRICIA BUTLER, NAT’L ACAD. FOR STATE HEALTH POLICY, ERISA PREEMPTION MANUAL FOR STATE HEALTH POLICY MAKERS 6 (2001), available at http://www.nashp.org/Files/GNL30_ERISA_Preemption_manual.pdf.

369. *Corcoran v. United Healthcare*, 965 F.2d 1321, 1338–39 (5th Cir. 1992).

370. *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49 (D. Mass. 1997).

371. *Id.* at 53.

372. See BUTLER, *supra* note 368, at 19.

373. This call for reappraisal of ERISA preemption has been echoed in the medical and legal literature on a number of occasions in the past decade, most notably by legal scholar Wendy K. Mariner in a series of articles beginning in 1996 and continuing through 2002. See, e.g., Wendy K. Mariner, *Independent External Re-*

is heightened because of employers' strong opposition to expanded liability. To an MCO, a claim denial may simply represent an efficient business decision.³⁷⁴

Given the backdrop of these mixed decisions, we might expect an increasing number of malpractice claims against MCOs because "managed care organizations combine medical and financial functions in ways that make it difficult to separate vicarious³⁷⁵ from direct responsibility for patient care."³⁷⁶ As already noted, the courts have found it difficult to separate direct responsibility for patient care from benefit determinations related to reimbursement decisions, and this is likely to become even more difficult as new forms of MCOs arise and new contractual arrangements are developed. These issues of MCO legal liability are also at the core of the difference between the House and Senate versions of the "Patient Bill of Rights," which, as we have noted, has not reached resolution in over four years of active debate in Congress.

B. External Appeals/Review Procedures

Consumers maintain that some kind of appeal procedure is required when MCOs deny a claim for reimbursement of services.³⁷⁷ Forty-two states and the District of Columbia have provisions for independent review of "medical necessity determinations" which are at the core of approval or denial of a particular claim.³⁷⁸ *Rush Prudential*³⁷⁹ helps to underscore the critical issue for the future of managed care plans: to what extent is the opinion of the "reviewer" binding?

view of Health Maintenance Organizations' Medical Necessity Decisions, 347 NEW ENG. J. MED. 2178 (2002); Wendy K. Mariner, *State Regulation of Managed Care and the Employee Retirement Income Security Act*, 335 NEW ENG. J. MED. 1986 (1996) [hereinafter *State Regulation*]; Wendy K. Mariner, *What Recourse?—Liability for Managed-Care Decisions and the Employee Retirement Income Security Act*, 343 NEW ENG. J. MED. 592 (2000) [hereinafter *What Recourse*].

374. See generally *What Recourse*, *supra* note 373.

375. Vicarious liability is defined as the "imposition of liability on one person for the actionable conduct of another person based solely on a relationship between the two persons." BLACK'S LAW DICTIONARY 1566 (6th ed. 1990).

376. See generally *State Regulation*, *supra* note 373, at 1987 (providing examples of how ERISA has created a regulatory 'vacuum' in which health plans operate, "[T]he result is an anomalous law that precludes state regulation of ERISA health plans without substituting federal standards, leaving the plans in a regulatory vacuum.").

377. See Morreim, *supra* note 262.

378. *Id.* at 939.

379. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002).

Rush offered to cover the “standard” treatment for Moran, but not the experimental treatment she desired.³⁸⁰ By upholding the Illinois statute, Moran essentially was entitled to receive reimbursement for treatment which was not preauthorized (an essential feature of managed care plans).³⁸¹ To the extent that this kind of review becomes more common, it will constrain a MCO’s ability to rein in costs and maximize efficiency. And given the controversy that this case engendered, the courts will certainly revisit this issue in the near future.

C. Practice Guidelines

In the context of cost control and “evidence-based medicine,” there is increasing pressure to use a standard set of “practice guidelines.”³⁸² This is a relatively recent development which can be seen as augmenting or replacing the way in which managed care plans seek to gain control over treatment practices of physicians and other providers.³⁸³ MCOs have accomplished this through utilization review and review of individual treatment decisions by physicians.³⁸⁴ “Managed care focuses on the basic issue of physician practice style and essentially seeks to minimize individual physician judgment in favor of greater levels of standardization.”³⁸⁵

From the perspective of the future of managed care, such initiatives to achieve standardization may or may not lead to cost control, efficiency, and quality of care. MCO enrollees have a legal right to be reimbursed for the specific benefits defined in their plan.³⁸⁶ Providers may seek to minimize utilization of services through specific incentive-disincentive schemes. Managed care organizations may also establish treatment guidelines in an attempt to help control costs while maintaining quality. These guidelines could, however, become incorporated into a contract of insurance which specifies a fixed standard

380. *Id.* at 361.

381. *Id.* at 367.

382. See Barry R. Furrow, *Broadcasting Clinical Guidelines on the Internet: Will Physicians Tune In?*, 25 AM. J.L. & MED. 403, 405 (1999).

383. Donald R. Farquhar, *Recipes or Roadmaps?*, 157 CAN. BUS. & CURRENT AFF. 403 (1997).

384. *Id.*

385. Sara Rosenbaum & Brian Kamoie, *Managed Care and Public Health: Conflict and Collaboration*, 30 J.L. MED. & ETHICS 191, 194 (2002).

386. *Jones v. Kodak Med. Assistance Plan*, 169 F.3d 1287, 1292 (10th Cir. 1999).

of care.³⁸⁷ The fixed standard of care could legally leave little room for discretion or review by the MCO or healthcare providers and negatively affect cost control initiatives.

Others have argued, alternatively, that such “standard of care” guidelines when imposed on MCOs (i.e., through the use of mandated benefits laws) may set a minimum standard that becomes a maximum over time.³⁸⁸ In this context, it is argued that MCOs could potentially be constrained from offering new or innovative treatment options as they become available.³⁸⁹ Clearly, treatment guidelines, whether they set a minimum or a maximum standard of care, are controversial and will continue to play a role in managed care litigation in the foreseeable future.

IV. Conclusion

Since 1990, managed care has had a profound effect on federal and state health policy.³⁹⁰ It has also, however, been widely criticized as having failed in its goal of improving the quality of health care and reducing the costs of that care.³⁹¹ This criticism has led to a backlash against managed care that has been fueled by claims that it has not reduced costs or increased efficiency,³⁹² has led to patient dissatisfac-

387. See *id.* at 1289–90. The MCO (APM) used a treatment guideline protocol it had developed to determine the medical appropriateness of inpatient substance abuse treatment. Of the six criteria laid out in the protocol, the patient must meet three before being eligible for inpatient services.

388. Aetna Health, Inc. v. Davila, 124 S. Ct. 2488, 2493 (2004).

389. See, e.g., Carrie J. Gavora, *How Health Insurance Mandates Misdiagnose the Disease*, THE HERITAGE FOUNDATION, Policy Backgrounder # 1108, (Apr. 10, 1997), at <http://www.heritage.org/Research/HealthCare/BG1108.cfm> (last visited Mar. 28, 2005) (raising concerns that state-mandated benefits laws could create a standard of care that may be difficult to change as medical advances enhance our ability to treat disease, and even stifle the innovation that might lead to those medical advances).

390. See, e.g., John D. Blum, *Overcoming Managed Care Regulatory Chaos Through a Restructured Federalism*, 11 HEALTH MATRIX 327, 349 (2001); Marilyn Denny, *Managed Care: Increasing Inequality & Individualism*, 3 QUINNIPIAC HEALTH L.J. 59 (1999–2000) (suggesting that the current regulatory environment in health care is tantamount to a constitutional crisis because of the ways in which the federal and state roles have been confused: “At the core of the current health care regulatory dysfunction is a system of federalism in which the respective levels of government are acting in a competitive, duplicative, and ultimately financially irresponsible manner.”).

391. See Elizabeth D. Schulman et al., *Primary Care Case Management and Birth Outcomes in the Iowa Medicaid Program*, 87 AM. J. PUB. HEALTH 80 (1997); Kip Sullivan, *On the ‘Efficiency’ of Managed Care Plans*, HEALTH AFF., Jul.–Aug. 2000, at 139.

392. See Dana P. Goldman et al., *The Effects of Benefit Design and Managed Care on Health Care Costs*, 14 J. HEALTH ECON. 401 (1995); Sullivan, *supra* note 391.

tion,³⁹³ and its management techniques or practices have resulted in adverse medical outcomes.³⁹⁴ At the same time, managed care has been credited with slowing down or controlling health care inflation³⁹⁵ without having a significant effect on the quality of care delivered.³⁹⁶

There also continues to be a “market demand” for managed care, which dominates the health care market as the major accepted form for financing, organizing, and delivering health care services.³⁹⁷ The fact that the “demand” is not only coming from the “free market” but also from the “captive market” of Medicare and Medicaid, suggests that managed care continues to be an accepted and viable option for the organization, finance, and delivery of health care.

There is also little doubt that the public policy approach in the area of health policy has changed over the last thirty years. In 1973, for example, when the original HMO statute was enacted, Congress’ intent was clearly to support the development of a new and innovative system that could control the rising costs of health care.³⁹⁸ In contrast, the intent of the new federal and state regulations and legislation (e.g., HIPAA³⁹⁹) is to limit the managed care system’s ability to apply particular management practices that are viewed as undesirable by consumers and providers. Public policy makers who once supported

393. Robert J. Blendon et al., *Americans Views on Children’s Health*, 280 JAMA 2122 (1998); Steven R. Simon et al., *Views of Managed Care*, 340 NEW ENG. J. MED. 928 (1999); Atul A. Gawande et al., *Does Dissatisfaction with Health Plans Stem from Having No Choices?*, HEALTH AFF., Sept.–Oct. 1998, at 184.

394. Schulman et al., *supra* note 391, at 80.

395. See Paul B. Ginsberg & Jon R. Gabel, *Tracking Health Care Costs: What’s New in 1998?*, HEALTH AFF., July–Aug. 1998, at 141.

396. Robert H. Miller & Harold S. Luft, *Managed Care Plan Performance Since 1980: A Literature Analysis*, 271 JAMA 1512 (1994); Robert H. Miller & Harold S. Luft, *Does Managed Care Lead to Better or Worse Quality of Care?*, HEALTH AFF., July–Aug. 1997, at 5.

397. Marsteller & Bovbjerg, *supra* note 30 (describing the rise of managed care and the rapid increase in state regulatory activity in response to managed care in the mid-1990s).

398. *Aetna Health, Inc. v. Davila*, 124 S. Ct. 2488, 2493 (2004).

399. Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified in scattered sections of 26 U.S.C., 29 U.S.C., & 42 U.S.C.). The sections of HIPAA that have had the greatest effect on the operations of managed care organizations are those that set restrictions on the use of preexisting condition exclusions and waiting periods and guarantee renewability of health coverage, both of which have been controversial because of the fact that while they provide a certain measure of security and protection for patients vis à vis managed care organizations, these provisions may have the effect of limiting managed care plans’ ability to encourage or discourage certain kinds of service options. The feared result may be increased accessibility for some patients, but higher costs and fewer choices for all.

managed care practices, because of their promise for reducing costs, became the strong advocates for consumer rights and protection against the MCOs.⁴⁰⁰ New legislation and regulations became the vehicle for protecting the consumer against what was widely perceived as “overt abuses.”⁴⁰¹

Managed care is, however, continuing to develop in response to shifts in market conditions.⁴⁰² Traditional HMO roles are changing through the development of alternative strategies to address the issues of access and cost.⁴⁰³ The types of MCOs that dominate the industry are changing as a result of employer and employee dissatisfaction with the sometimes stringent guidelines imposed by the traditional HMOs.⁴⁰⁴

In this context, an examination of judicial interpretation of general health care policy, on the one hand, and managed care regulations on the other, shows an inconsistent pattern along two key dimensions: (a) a federalism dimension—the questions of what are the appropriate roles of the federal and state levels of government and who has what type of jurisdiction and why, and (b) a managed care policy dimension—to what extent should the continued implementation of managed care theory be supported?

Interpretation of ERISA as it applies to health care plans and benefits is at the heart of this pattern of inconsistent judicial interpretation. This is, however, only one component of a more general pattern that can be thought of as the two faces of managed care policy and regulation.⁴⁰⁵ As a consequence of ERISA’s structure and the record of judicial interpretation over the last twenty-plus years, states interested in strict health care regulation or health care reform must either design their health care reform efforts within the framework of “general legislation” having indirect effects on ERISA entities, or operate within the “insurance” regulation framework provided by the Act. For example, in *United of Omaha v. Business Men’s Assurance Co. of*

400. Blum, *supra* note 390.

401. Hastings, *supra* note 8.

402. See HCFO News & Progress, *HCFO/Health Tracking Grant Awards: Results of the Community Tracking Study Household Survey Solicitation* (May 1999), available at www.hcfo.net/pdf/news599.pdf (last visited Mar. 28, 2005).

403. See BARRY R. FURROW ET AL., *HEALTH LAW* 500–01 (2d ed. 2000).

404. *See id.*

405. *See generally* Rich & Erb, *supra* note 14.

America,⁴⁰⁶ the Eight Circuit concluded that a Missouri statute that required group health insurance plans to provide an extension of benefits to qualifying beneficiaries was not preempted by ERISA because the statute was directed specifically toward insurance companies, and thus was “saved” from preemption by the savings clause.⁴⁰⁷ If the state had attempted to regulate health benefits offered by a self-funded plan, the statute would not have survived ERISA preemption. Thus, it appears that states are confined by the structure of the “relates to” and “savings” clause provisions, and must await congressional action before being able to affect change through an ERISA entity.

Since ERISA was enacted in 1974 the federal and state courts have struggled in their effort to interpret the ERISA preemption provision consistently. While the preemptive reach of ERISA has been limited in the post-*Travelers* era, ERISA remains an effective barrier to states that seek to fully regulate health care entities outside the traditional state-regulated insurance field.

Over the last ten years, Congress, state legislatures, and the federal courts have seen a need, based primarily on the consumer and provider backlash, for regulating and reforming managed care plans and managed care organizations. This is evident in the number of statutes and regulations which have been enacted.⁴⁰⁸ Government regulation of the managed care industry has become more prevalent and restrictive of its activities⁴⁰⁹ as protection of consumers has become an important governmental role.⁴¹⁰ However, the liability of MCOs and the possible need to reform ERISA seem to be the most controversial dimension of the legal and public policy discussions concerning managed care. This is true because Congress continues to believe in the intent of ERISA to insure for uniformity in the administration of employee benefit plans.⁴¹¹ It is also because the practice of

406. *United of Omaha v. Bus. Men's Assurance Co. of Am.*, 104 F.3d 1034 (8th Cir. 1997).

407. *Id.* at 1040.

408. See NAT'L CONFERENCE OF STATE LEGISLATURES, *supra* note 278.

409. See generally Alice A. Noble & Troyen A. Brennan, *The Stages of Managed Care Regulation: Developing Better Rules*, 24 J. HEALTH POL., POL'Y & L. 1275 (1999) (characterizing managed care regulation as an historical progression of government intervention from fully supportive early on (1970s and 1980s) to more and more restrictive and prescriptive over time as the patient and provider backlash increased (mid to late 1990s)).

410. See generally REGULATING MANAGED CARE: THEORY, PRACTICE, AND FUTURE OPTIONS (Stuart H. Altman et al. eds., 1999).

411. *Aetna Health, Inc. v. Davila*, 124 S. Ct. 2488, 2493 (2004).

managed care often makes the distinction between claims determinations and medical care decisions less than clear. From the patient's perspective a claim denied often means that needed access to treatment is out of reach.⁴¹² However, as noted earlier, a claim denial may simply represent an efficient business decision to an MCO.⁴¹³

The state and federal courts continue to try to sort out the extent to which core elements of managed care theory can be supported as well as the extent to which the federal or state levels of government should be regulating the design and delivery of health care plans. They have yet to develop a consistent framework in which to judge managed care plans. There have been a set of major decisions which support managed care and others which restrict its future development. The areas which are most controversial and will receive the most attention in the future are managed care liability, the use of independent external reviewers, and the use of practice guidelines.

In a concurring opinion in *Davila*, Justice Ginsburg underscores some of the difficulties that have been involved in ERISA interpretation as it relates to managed care organizations.⁴¹⁴ Justice Ginsburg writes: "I . . . join the 'rising judicial chorus urging that Congress and [this] Court revisit what is an unjust and increasingly tangled ERISA regime.'"⁴¹⁵ In explaining why ERISA is "unjust," she states: "virtually all state law remedies are preempted, but very few federal substitutes are provided."⁴¹⁶ Justice Ginsburg points to a series of court decisions which identify problems with ERISA's permitted remedies and calls for "fresh consideration of the availability of consequential damages under § 502(a)(3)."⁴¹⁷

The plethora of managed care related legislation and regulations, as well as the outcomes of considerable litigation, points to a confused and disjointed health policy at the federal and state levels of government. "In very broad terms, the positions which government leaders have taken toward managed care are fundamentally schizophrenic, promoting the concept as a type of cost-effective, market-based salvation for health care, but simultaneously . . . government leaders are railing against the very vehicles of care and coverage they are promot-

412. See *supra* notes 369–71 and accompanying text.

413. See *supra* note 375 and accompanying text.

414. *Davila*, 124 S. Ct. at 2503.

415. *Id.*

416. *Id.*

417. *Id.*

ing . . . ”⁴¹⁸ The judicial interpretation of ERISA makes it clear that Congress and/or the Supreme Court needs to develop a more just, consistent, and fair system for the administration and regulation of health insurance and health care benefits.

418. Blum, *supra* note 390, at 349.

Appendix

Appendix Overview

The federal and state courts have, since 1990, been very active in judicial interpretation of ERISA, the Health Maintenance Organization Act, and state law focusing on the American health care system in general, and managed care organizations in particular. Between 1990 and 2004, at the Supreme Court level there were three cases that were supportive and five cases that were restrictive of managed care plans or practices; at the Federal Circuit court level, there were seventy-one supportive and sixty-five restrictive cases; and at the State court level, there were eight supportive and ten restrictive cases.⁴¹⁹

We have organized Tables 1–6 around the issue of whether a given court decision is supportive or restrictive of managed care. We have attempted to be comprehensive in including all cases which are relevant for managed care organizations:

- Table 1 covers the three Supreme Court decisions supportive of MCOs between 1990 and the present;
- Table 2 covers the seventy-four cases supportive of MCOs before the eleven circuit courts between 1990 and 2003;
- Table 3 covers the nine most important state court cases which have been supportive of MCOs between 1990 and 2003;
- Table 4 covers the five Supreme Court decisions restrictive of managed care between 1990 and the present;
- Table 5 covers the sixty-four cases restrictive of MCOs before eleven circuit courts between 1990 and 2003; and
- Table 6 covers the ten most relevant state court cases restrictive of MCOs between 1990 and 2003.

For each of these tables, we have cited the case, identified the issue dealt with in the case, and summarized the court's holding. The holding column focuses specifically on how the case is either supportive or restrictive of MCOs and managed care plans.

419. These numbers are based on a sampling of cases which dealt primarily with managed care and ERISA and are deemed by the authors to have significant implications for the operation of managed care plans. The assignment of the classification 'supportive' or 'restrictive' is based on the authors' interpretation of the courts' holdings and interpretations in each case.

Table 1
ERISA and Managed Care Cases Supportive of MCOs Before the Supreme Court (1990–Present)

CASE	ISSUE	HOLDING
FMC Corp. v. Holliday, 498 U.S. 52 (1990)	Application of state law to self-funded health care plan.	Preempted by ERISA's "deemer clause" which exempts self-funded health plans from state insurance laws. Employers can establish MCO-like plan that will receive ERISA protection.
Pegram v. Herdrich, 530 U.S. 211 (2000)	Definition of fiduciary duty within ERISA regarding MCO payment and incentive structure.	MCO is not a fiduciary to the extent that the MCO's physician makes a mixed eligibility/treatment decision. Supports MCOs by not holding them accountable for acts by their physicians possibly based on the incentive structure of the MCO.
Aetna Health, Inc. v. Davila, 124 S. Ct. 2488 (2004)	Plaintiffs sued their HMOs for a failure to exercise ordinary care in the handling of their benefit determination because of the denial of benefits.	The claims were completely preempted under ERISA's remedial scheme. Because their complaints were only for a denial of coverage the duty of ordinary care imposed by the State law did not arise independently of ERISA. Additionally the State law duty of ordinary care made the HMOs liable if they proximately caused injury but a correct denial of benefits, based on plan terms, was not the cause of injury, it was the fact that the plan never covered the desired treatment. Supportive of MCOs because preemption leads to only one, federal, regulatory scheme for MCOs.

NUMBER 1

MANAGED CARE POLICY 143

Table 2
ERISA and Managed Care Cases Supportive of MCOs Before Circuit Courts (1990–Present).

CASE	ISSUE	HOLDING
<u>First Circuit</u>		
Turner v. Fallon Cmty. Health Plan, Inc., 127 F.3d 196 (1st Cir. 1997)	Claim for damages under ERISA and state law claims for denial of benefits.	ERISA does not provide damages and none should be inferred. State claims preempted because they “relate to” a benefit plan. Supports MCOs by confirming that ERISA does not provide damages and courts will not infer them.
Danca v. Private Health Care Sys., Inc., 185 F.3d 1 (1st Cir. 1999)	Denial by MCO of requested placement in specific hospital.	Claims regarding processing claim for benefits was “completely preempted” despite being quasi-medical in nature. Other state claims preempted because they would subject MCOs to inconsistent state action against the intent of ERISA. Supports MCOs by preempting claims regarding methods of evaluating claims.
Mass. Ass’n of Health Maint. Orgs. v. Ruthardt, 194 F.3d 176 (1st Cir. 1999)	State law requiring Medicare supplement insurers to provide prescription drugs.	State law was preempted by Medicare + Choice plan. Supportive of MCOs by not allowing states to add onto federally mandated programs thus subjecting MCOs to the requirements of every state.

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Table 2—Continued

Hotz v. Blue Cross & Blue Shield of Mass., Inc., 292 F.3d 57 (1st Cir. 2002)	Delay by MCO in approval of payment for treatment brought under state law.	State laws “relate to” an ERISA plan and are not “saved” as regulating insurance because they were so broad and awarded damages. Supportive of MCOs because laws at issue contained insurance regulation language but could also be applied to other businesses and award damages, which are not allowed under ERISA.
Second Circuit		
Maltz v. Aetna Health Plans of N.Y., Inc., 152 F.3d 919 (2d Cir. 1998)	MCO changing compensation method for physicians from fee-for-service to capitation.	MCO changing compensation method for physicians from fee-for-service to capitation.
Cicio v. Does, 321 F.3d 83 (2d Cir. 2003)	Timeliness of response regarding treatment and misleading nature of information provided about plan.	Both state law claims were preempted by ERISA since they could have been brought through ERISA’s remedial scheme. Supportive of MCOs by staying with ERISA’s intent of not subjecting MCOs to varying remedial obligations of the several states.
Third Circuit		
Travitz v. N.E. Dep’t ILGWU Health and Welfare Fund, 13 F.3d 704 (3d Cir. 1994)	State law precludes insured from recovering damages from a tortfeasor in an auto accident if they can receive benefits via their health insurance policy.	Law “related to” health plan and was preempted. Prevents state law from imposing different requirements on ERISA plans. Reduces burden on MCO because insured can pursue claim against tortfeasor.
<i>(Continued on next page)</i>		

Table 2—Continued

Pryzbowski v. U.S. Healthcare, 245 F.3d 266 (3d Cir. 2001)	Delay in treatment waiting for authorization to use an out of network doctor.	Claims against MCO completely preempted due to their administrative quality; negligence claims against doctors, not expressly preempted. Supports MCOs by allowing them time to refer insured to an outside provider without holding them accountable to state malpractice law which maintains the uniform regulatory scheme for MCOs intended in ERISA.
Horvath v. Keystone Health Plan E., Inc., 333 F.3d 450 (3d Cir. 2003)	Disclosure of incentive structures for providers.	MCOs do not have a fiduciary duty under ERISA to disclose the underlying incentives in the plan. Split with <i>Shea v. Esensten</i> (8th Cir. 1997)
DiFelice v. Aetna U.S. Health Care, 346 F.3d 442 (3d Cir. 2003)	MCO determination regarding medical necessity of tracheostomy tube.	Although a mixed quality/quantity decision, claim could have been brought under enforcement scheme of ERISA. Supportive of MCOs because it moves the quality/quantity line for preemption further away from pure quantity or eligibility decisions as was drawn in <i>Pappas II</i> . Without movement away from the pure eligibility decision required for preemption, any decision having a remote connection with the quality of medical care could not be preempted.

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Table 2—Continued

<u>Fourth Circuit</u>		
Custer v. Pan Am. Life Ins. Co., 12 F.3d 410 (4th Cir. 1993)	State law claims and claims under West Virginia Unfair Trade Practices Act.	State law claims against a nonfiduciary were preempted by ERISA. West Virginia Unfair Trade Practices Act claims not “saved” as regulations of insurance. Supports MCOs by not subjecting them to the varied regulatory schemes of the 50 states.
Sheppard & Enoch Pratt Hosp., Inc. v. Travelers Ins. Co., 32 F.3d 120 (4th Cir. 1994)	Recovery for benefits as a result of hospitalization.	MCO was not liable for payment. MCO’s determination that length of hospitalization was unnecessary did not abuse their discretion under an “abuse of discretion standard.” MCO has written provision for their interpretation of plan provisions. Strengthens MCOs by allowing them to interpret their plans with a deferential standard of review which gives them more power to control their costs via the distribution of care.
Tri-State Mach., Inc. v. Nationwide Life Ins. Co., 33 F.3d 309 (4th Cir. 1994)	State law claims and claims applying West Virginia Unfair Trade Practices Act.	State law complaints preempted by ERISA since they were about the processing of claims and therefore related to the plan. Unfair Trade Practices Act not “saved” since it did not regulate insurance. Decision supports MCOs requiring claims to be brought under ERISA, which is more favorable for MCOs because it imposes a uniform, nationwide, standard of regulation.

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Table 2—*Continued*

Booth v. Wal-Mart Stores, Inc. Assoc. Health and Welfare Plan, 201 F.3d 335 (4th Cir. 2000)	State action for denial of benefits for preexisting condition.	Standard of review for a denial of benefits claims is “abuse of discretion” which is a higher standard than the “arbitrary and capricious” standard of the plan. MCO did not abuse their discretion by denying benefits after a careful review of the patient’s history indicated a pre-existing condition. Supports MCOs because it allows them to demonstrate their reasons for denying benefits even under the higher “abuse of discretion” standard. MCOs retain some control over distribution of benefits, and therefore the costs they will incur.
Marks v. Watters, 322 F.3d 316 (4th Cir. 2003)	Claims against MCO for negligence and vicarious liability for premature release of mental patient.	State law claims against MCO were “completely preempted” under ERISA’s remedial scheme (§ 502) because decisions made were administrative in nature. Supports MCOs by removing insurer, who had no involvement in decision to discharge patient, from malpractice liability at the state level for medical decisions. MCOs only have to contend with one, nationwide scheme, as opposed to state-by-state regulations.

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Table 2—Continued

Singh v. Prudential Health Care Plan, Inc., 335 F.3d 278 (4th Cir. 2003)	Reimbursement for money paid under subrogation term which was illegal under MD HMO Act.	MD law “saved” from preemption because it regulated insurance but reimbursement of benefits unaffected by subrogation were “completely preempted” under § 502. Protects MCOs because validity, interpretation or applicability of plan terms fall under ERISA’s remedial scheme providing a uniform standard for MCOs to meet.
Fifth Circuit		
Perkins v. Time Ins. Co., 898 F.2d 470 (5th Cir. 1990)	Insured brought claim of breach of contract against MCO and insurance agent.	Claim against MCO was preempted because it did not regulate insurance and therefore was not “saved.” Supports MCOs by not subjecting them to the breach of contract laws of each state and instead requires meeting one regulatory scheme.
Gahn v. Allstate Life Ins. Co., 926 F.2d 1449 (5th Cir. 1991)	Louisiana “abuse of rights” statute regarding cancellation of insurance benefits and cancellation of insurance statute.	The “abuse of rights” statute would be preempted by ERISA (the case was remanded for other reasons) as a law that “related to” an ERISA plan. The decision supports MCOs by limiting the state regulations that the MCO must be responsible for by requiring uniform, nationwide, regulation.
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Table 2—Continued

Hermann Hosp. v. MEBA Med. & Benefits Plan, 959 F.2d 569 (5th Cir. 1992) [<i>Hermann II</i>] ⁴²⁰	Issue of preemption of a third-party provider's state law claims which were assigned to it by the deceased insured.	State law claims brought by third-party provider, standing in the shoes of the insured, were preempted by ERISA (note possible conflict with the holding of <i>Memorial</i>). Here the court noted that this was a claim for benefits. Supports MCOs by not allowing a hospital to stand in the shoes of the insured to receive benefits under state law.
Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992)	State law medical malpractice claim against MCO.	Preempted by ERISA since it "related to" the plan because the denial of care was made based on the benefits due under the contract. The MCO is supported because the state tort action is preempted, thus restricting the various and inconsistent state remedies that can be applied against the MCO for availability of benefit's decisions. ⁴²¹
Tingle v. Pac. Mut. Ins. Co., 996 F.2d 105 (5th Cir. 1993)	Louisiana statute regarding intent to deceive or to affect assumption of risk by insurer based on false statements on health insurance application.	State law was preempted by ERISA because it "related" to insurance and was not saved because it did not spread the insurance risk among policyholders thus failing one of the McCarran-Ferguson factors. Supports MCOs by removing a state form of regulation and restricting false representations that can be made on insurance applications.

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420. *Hermann II* is simply an affirmation of the courts decision in *Hermann Hosp. v. MEBA Med. & Benefits Plan*, 845 F.2d 1286 (5th Cir. 1988).

421. See also *Hubbard v. Blue Cross & Blue Shield Ass'n*, 42 F.3d 942 (5th Cir. 1995) (holding claim regarding benefits preempted); *Rodriguez v. Pacificare of Tex., Inc.*, 980 F.2d 1014 (5th Cir. 1993) (same).

Table 2—Continued

Cigna Healthplan of La., Inc. v. Louisiana <i>ex rel.</i> Ieyoub, 82 F.3d 642 (5th Cir. 1996)	State of Louisiana's Any Willing Provider statute.	Statute preempted by ERISA as a law that "relates to" an ERISA plan because it requires plans to purchase benefits of a specific structure when a PPO is purchased. Statute was not saved as a law that regulated insurance because it specifically referred to entities outside of the insurance industry. Supports MCOs by both freeing a MCO from the risk of being regulated by Louisiana, on top of federal regulation, and permits MCOs to freely contract with providers.
Tex. Pharmacy Ass'n v. Prudential Ins. Co., 105 F.3d 1035 (5th Cir. 1997)	State of Texas' Any Willing Provider statute.	TX "Any Willing Provider" statute preempted by ERISA because it related to ERISA plans via the inclusion of other organizations that provide health care, as opposed to just HMOs or PPOs. The state law was not "saved" because it applied to entities outside of the insurance industry. Supports MCOs by granting them freedom to selectively contract with providers.
Dowden v. Blue Cross & Blue Shield of Tex., Inc., 126 F.3d 641 (5th Cir. 1997)	State claim for breach of insurance policy obligation to provide benefits.	State law claim preempted by ERISA because it was an eligibility decision made under the plan and interpreted by the provider. Supports MCOs by allowing eligibility decisions to fall squarely under the provisions of ERISA and its singular regulatory scheme. ⁴²²

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422. See also *Gulf S. Med. & Surgical Inst. v. Aetna Life Ins. Co.*, 39 F.3d 520 (5th Cir. 1994) (holding administrator did not abuse discretion when denying benefits).

Table 2—Continued

Transitional Hosp. Corp. v. Blue Cross & Blue Shield of Tex., Inc., 164 F.3d 952 (5th Cir. 1999)	State law claims for misrepresentation and breach of contract.	State law claims for breach of contract were preempted by ERISA because they were based on benefits due to the insured patient who transferred her rights to the hospital. Supportive of MCOs by preempting benefit determinations and not exposing MCOs to multiple regulatory schemes.
Ehlmann v. Kaiser Found. Health Plan of Tex., 198 F.3d 552 (5th Cir. 2000)	Fiduciary duty to reveal to plan participants physician compensation plan.	ERISA does not impose a fiduciary duty on MCOs to reveal the compensation plan that the MCOs provide to their doctors. Supports MCOs by restricting information that must be provided to participants which they could then use as a basis for suits alleging a breach of duty based on the compensation scheme used by the MCO.
McNeil v. Time Ins. Co., 205 F.3d 179 (5th Cir. 2000)	State law claims for breach of contract and breach of duty of good faith, among others.	Claims were preempted under ERISA's § 514 conflict preemption section because they involved the right of the insured to receive medical benefits. Supports MCOs by permitting benefit determinations to be made by MCOs without regulatory intervention by the states.

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Table 2—Continued

Roark v. Humana, Inc., 307 F.3d 298 (5th Cir. 2002)	State law claims brought under Texas Health Care Liability Act and breach of con- tract.	Breach of contract claim was completely pre- empted under the civil enforcement scheme of § 502 of ERISA. Section 502 preemption allowed court to find medical malpractice claim com- pletely preempted. MCO's decision to re- strict home nursing was an eligibility decision made based on contract terms, and was pre- empted by ERISA. This portion of the decision supports MCOs by al- lowing for preemption for pure eligibility deci- sions and disputes over contract terms.
Haynes v. Prudential Health Care, 313 F.3d 330 (5th Cir. 2002)	Decision by MCO that insured's doctor was not his primary care physician.	Decision made by the MCO was an adminis- trative decision that is expressly preempted by ERISA. Supports MCO by allowing administra- tive decisions, such as decision regarding cov- erage and plan terms, to fall under one regula- tory scheme as opposed to a state-by-state regu- lation.
Arana v. Ochsner Health Plan, 352 F.3d 973 (5th Cir. 2003)	State action against in- surer on subrogation issue regarding com- pensation from auto ac- cident.	Action was completely preempted under ERISA's enforcement scheme because it was a claim for benefits. Sup- ports MCOs by regulat- ing claims for benefits under one federal scheme.

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Table 2—Continued

Mayeaux v. La. Health Serv. & Indem. Co., 376 F.3d 420 (5th Cir. 2004)	Various state law claims and a claim for denial of benefits brought by insured.	State law claims were conflict preempted. Denial of benefits claims was upheld as not an abuse of discretion by the plan administrator who ruled it was experimental or investigational. Supports MCOs by granting discretion for administrative decisions.
<u>Sixth Circuit</u>		
Miller v. Metro. Life Ins. Co., 925 F.2d 979 (6th Cir. 1991)	Termination of benefits by trustee.	Termination of benefits is permitted if trustee has discretion to terminate granted within the plan and he is not “arbitrary and capricious.” Supports MCOs by recognizing that determining benefits can be at the discretion of the plan if conferred by the plan contract. Gives MCOs control over the distribution of benefits, helping them control costs.
Baxter v. C.A. Muer Corp., 941 F.2d 451 (6th Cir. 1991)	Exhaustion of remedies before filing suit and liability as fiduciary.	Insured could be required to exhaust administrative remedies before bringing suit (see <i>Weiner</i> below). Administrator of plan was not a fiduciary under ERISA because they simply processed and paid claims (compare with <i>Libbey-Owens-Ford</i>). Supports MCOs by requiring alternate courses of action before filing suit, which may save MCOs on litigation costs. Limiting liability for administration of plan supports MCOs by reducing their exposure to lawsuits.
<i>(Continued on next page)</i>		

Table 2—Continued

Int'l Res., Inc. v. N.Y. Life Ins. Co., 950 F.2d 294 (6th Cir. 1992)	Employer brought state law claims against insurer for proposed cancellation of policy.	State law claims for the cancellation of a policy, bad faith and unfair and deceptive practices, was preempted by ERISA for relating to an ERISA plan. MCOs are supported by this decision because it limits the state causes of action that can be brought against them permitting them to work under a unified, nationwide, regulatory plan. ⁴²³
Tolton v. Am. Biodyne, Inc., 48 F.3d 937 (6th Cir. 1995)	Numerous state law claims including wrongful death and medical malpractice.	State claims preempted by ERISA because the denial of care was made because it was not due under the benefit contract. Support MCOs by limiting their exposure to the numerous remedies available under state law.
Zuniga v. Blue Cross & Blue Shield of Mich., 52 F.3d 1395 (6th Cir. 1995)	Breach of contract claim brought by psychiatrist against insurer.	State law breach of contract claim preempted by ERISA as a claim that "related to" an ERISA plan. Supports MCOs by limiting their exposure to the various state law remedies available to plaintiffs.
Schachner v. Blue Cross & Blue Shield of Ohio, 77 F.3d 889 (6th Cir. 1996)	State law claim under Ohio law for failure of insurer to pay a claim.	State law claim was preempted by ERISA based on the holding of <i>Pilot Life</i> . Supports MCOs by restricting the regulatory schemes they must comply with, to one uniform federal plan.

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423. See also *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272 (6th Cir. 1991) (holding state law claims of action for breach of contract, negligence, breach of good faith and promissory estoppel preempted by ERISA); *Ruble v. UNUM Life Ins. Co. of Am.*, 913 F.2d 295 (6th Cir. 1990) (holding breach of contract claim brought in state court preempted by ERISA).

NUMBER 1

MANAGED CARE POLICY 155

Table 2—*Continued*

Weiner, D.P.M. v. Klais & Co., Inc., 108 F.3d 86 (6th Cir. 1997)	Provider sued insurer, as assignee of insured, for services provided.	Provider's failure to exhaust administrative remedies under ERISA permitted rejection of the claim. Supports MCOs by requiring plaintiffs to utilize avenues of relief prior to filing a lawsuit which can save MCOs money by avoiding litigation.
Mass. Cas. Ins. Co. v. Reynolds, 113 F.3d 1450 (6th Cir. 1997)	Insured sued for specific performance and bad faith in state court.	Both state law claims were preempted by ERISA because they both "relate to" ERISA plans. Supports MCOs by not subjecting them to the regulatory schemes of every state's common law.
<u>Seventh Circuit</u>		
Pohl v. Nat'l Benefits Consultants, Inc., 956 F.2d 126 (7th Cir. 1992)	State law claim for damages from misrepresentation regarding plan coverage.	State law claim preempted by ERISA despite oral representations of coverage. Lack of remedy for oral representations is not a gap in coverage but an intentional requirement of spelling out plan terms in writing. Supports MCOs by eliminating a state remedy that might be used to disrupt ERISA's purpose of a uniform regulatory scheme.
<i>(Continued on next page)</i>		

Table 2—Continued

Smith v. Blue Cross & Blue Shield of Wis., 959 F.2d 655 (7th Cir. 1992)	State law causes of action for benefits.	State law causes of action, such as breach of contract, were conflict preempted by ERISA because they “relate[d] to” an ERISA plan. ⁴²⁴ ERISA claims were also subjected to exhaustion requirements. Supports MCOs by providing the uniform regulatory scheme envisioned in ERISA.
Shannon v. Shannon, 965 F.2d 542 (7th Cir. 1992)	Personal injury suit brought in state court.	State claim preempted by ERISA because plan at issue was not a governmental plan, and therefore could not be exempt from ERISA. Affirms preemption of state law claims, therefore supporting MCOs.
Anderson v. Humana, Inc., 24 F.3d 889 (7th Cir. 1994)	State law claim against HMO under Illinois Consumer Fraud Act.	State law claim was preempted by ERISA because it “relate[d] to” an ERISA plan and could not be “saved” as a regulation of insurance. MCOs are supported by this decision because it promotes a uniform, nationwide, regulatory scheme.
Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482 (7th Cir. 1996)	Negligence action brought under Illinois law against doctor, nurse and plan.	Vicarious liability claims against plan “relate[d] to” plan and were preempted by ERISA. Holding supports MCOs by preempting state cause of action that would have subjected MCOs to regulation by the states.

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424. See *Tomczyk v. Blue Cross & Blue Shield of Wis.*, 951 F.2d 771, 775 (7th Cir. 1991) (holding state law claims preempted by ERISA); *Maciosek v. Blue Cross & Blue Shield of Wis.*, 930 F.2d 536, 538–40 (7th Cir. 1991) (same).

Table 2—Continued

Morton v. Smith, 91 F.3d 867 (7th Cir. 1996)	Suit for benefits due from trustees of union health and welfare fund.	Insureds claim for benefits was denied under an abuse of discretion standard because trustee had discretion to make reasonable interpretations under the plan. Decision supports MCOs by allowing court deference to their decisions which will give them greater control over their costs. ⁴²⁵
Doe v. Blue Cross & Blue Shield United of Wis., 112 F.3d 869 (7th Cir. 1997)	Plan participant seeking benefits from employer and administrator of ERISA plan.	Among other holdings the court noted that participant was required to exhaust ERISA required internal remedies before filing suit. Supports MCOs by requiring exhaustion of internal appeals prior to being subjected to a lawsuit which helps them contain their litigation costs. ⁴²⁶
Kariotis v. Navistar Int'l Trans. Corp., 131 F.3d 672 (7th Cir. 1997)	Insured claim that defendant violated Illinois Health Insurance Claim Filing Act.	Illinois law expressly preempted by ERISA because it "relate[d] to" an ERISA plan. Supports MCOs by maintaining the uniform regulatory scheme for MCOs mandated by ERISA.
Leipzig v. AIG Life Ins. Co., 362 F.3d 406 (7th Cir. 2004)	Insured sued for benefits under long-term disability policy.	Denial of benefits by administrator/insurer was granted deferential review and the denial of benefits was not arbitrary and capricious. Supports MCOs by upholding their discretion to deny benefits.
<i>(Continued on next page)</i>		

425. See also *Kraut v. Wis. Laborers Health Fund*, 992 F.2d 113 (7th Cir. 1993) (upholding a denial of benefits under the arbitrary or capricious standard).

426. See also *Wilczynski v. Lumbermens Mut. Cas. Co.*, 93 F.3d 397, 401-02 (7th Cir. 1996); *Powell v. A.T.&T. Communications, Inc.*, 938 F.2d 823, 825-26 (7th Cir. 1991).

Table 2—Continued

<u>Eighth Circuit</u>		
Brewer v. Lincoln Nat'l Life Ins. Co., 921 F.2d 150 (8th Cir. 1990)	State law rule of construction for insurance contracts.	State law rule of requiring ambiguities to be decided in favor of the insured was preempted by ERISA and not saved from preemption. The law clearly affected plans and was not limited to insurance. Supports MCOs by supporting the uniform regulatory scheme envisioned by ERISA.
Ark. Blue Cross & Blue Shield v. St. Mary's Hosp., Inc., 947 F.2d 1341 (8th Cir. 1991)	Arkansas law permitting beneficiary to assign benefits to health care providers.	State law preempted as a law that "relate[d] to" ERISA plans because it took away control from administrators the ability to determine who would receive benefits. Supports MCOs by restricting the regulations that the several states can impose on MCOs.
Kuhl v. Lincoln Nat'l Health Plan of Kan. City, Inc., 999 F.2d 298 (8th Cir. 1993)	State law claims for medical malpractice, breach of contract, tortious interference and emotional distress.	Preempted by ERISA because the denial of care was made because it was not due under the benefit contract. Benefit determinations are preempted because they "relate[] to" ERISA plans. Support MCOs via a nationwide scheme of rules as opposed to a state by state approach. ⁴²⁷
Shea v. Esensten, 107 F.3d 625 (8th Cir. 1997)	Disclosure of incentive structures for providers and state law wrongful death claim.	State law wrongful death claim preempted by ERISA "relate[d] to" ERISA plan. Supports MCOs via a nationwide regulatory scheme.

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427. See also *Howard v. Coventry Health Care of Iowa, Inc.*, 293 F.3d 442 (8th Cir. 2002) (finding claims for breach of contract, violation of public policy and bad faith were preempted because they "relate[d] to" ERISA plan); *Thompson v. Gen-care Health Sys., Inc.*, 202 F.3d 1072 (8th Cir. 2000) (holding state law malpractice claim against administrator of plan preempted); *Hull v. Fallon*, 188 F.3d 939 (8th Cir. 1999) (holding state malpractice claim against administrator and plan was preempted by ERISA); *Robinson v. Linomaz*, 58 F.3d 365 (8th Cir. 1995) (holding state law claim preempted by ERISA).

Table 2—Continued

Farley v. Ark. Blue Cross & Blue Shield, 147 F.3d 774 (8th Cir. 1998)	State law claim for benefits due under plan.	Denial of benefits not an abuse of discretion based on preexisting condition. Supports MCOs by permitting denial of benefits under ERISA which allows for better cost controls (preemption decision at trial was not appealed) and maintaining a uniform regulatory scheme. ⁴²⁸
Prudential Ins. Co. of Am. v. Nat'l Park Med. Ctr., 154 F.3d 812 (8th Cir. 1998)	Arkansas' Patient Protection Act.	Arkansas law preempted in its entirety by ERISA and was not "saved" as a regulation of insurance because it was not sufficiently directed at insurance industry. Supports MCOs by providing the uniform regulatory scheme intended by ERISA.
Johnston v. Paul Revere Life Ins. Co., 241 F.3d 623 (8th Cir. 2001)	Nebraska state law regarding the alteration of policy without written consent.	State law was preempted by ERISA as a law that "relate[d] to" an ERISA plan. The law was not "saved" because it did not govern the actual content of insurance policies. Supports MCOs by maintaining the nationwide regulation scheme of ERISA.
Fink v. DakotaCare, 324 F.3d 685 (8th Cir. 2003)	State law claims for breach of contract and violation of South Dakota Unfair Trade Practices law.	All state law claims were completely preempted by § 502 of ERISA. Supportive of MCOs by establishing a uniform regulatory scheme for MCOs nationwide. ⁴²⁹

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428. See also *Stock v. SHARE*, 18 F.3d 1419 (8th Cir. 1994) (finding state law claims preempted and denial of benefits appropriate); *Farley v. Benefit Trust Life Ins. Co.*, 979 F.2d 653 (8th Cir. 1992) (holding denial of benefits that were not "medically necessary" appropriate); *Kirk v. Provident Life and Accident Ins. Co.*, 942 F.2d 504 (8th Cir. 1991) (finding denial of benefits appropriate under "preexisting condition" clause).

429. See also *Painter v. Golden Rule Ins. Co.*, 121 F.3d 436 (8th Cir. 1997).

Table 2—Continued

Shipley v. Ark. Blue Cross & Blue Shield, 333 F.3d 898 (8th Cir. 2003)	Rescission of coverage by insurer for omissions on application by insured.	Rescission of plan by plan administrator was reasonable under an abuse of discretion standard. Federal common law allowed such action. Decision supports MCOs by allowing administrators of MCO plans discretion to cancel policies which controls benefits paid, therefore controlling costs. ⁴³⁰
<u>Ninth Circuit</u>		
Spain v. Aetna Life Ins. Co., 11 F.3d 129 (9th Cir. 1993)	State law wrongful death action.	ERISA preempted wrongful death claim against administrator of plan as a claim that “relate[d] to” an ERISA plan. Supportive of MCOs by limiting exposure to the regulations of the several states.
Aloha Airlines, Inc. v. Ahue, 12 F.3d 1498 (9th Cir. 1993)	Airline sought declaratory relief that state law requiring physicals for pilots was preempted by ERISA.	State law, which required airlines to pay the costs of the physicals, was preempted as a “medical benefit” under ERISA. Supports MCOs by limiting the regulatory scheme that they must meet to a nationwide scheme.
<i>(Continued on next page)</i>		

430. See also *Clapp v. Citibank, N.A. Disability Plan*, 262 F.3d 820 (8th Cir. 2001).

Table 2—Continued

Babikian v. Paul Revere Life Ins. Co., 63 F.3d 837 (9th Cir. 1995)	Suit brought in federal court for continued benefits after dismissal.	ERISA preempted California rule for the vesting of health benefits upon termination. Law “relates to” ERISA plans and could not be saved because it was not specifically directed at insurance. Supports MCOs by not forcing the regulatory scheme of a state upon them when nationwide regulation is the goal of ERISA. ⁴³¹
Elliot v. Fortis Benefits Ins. Co., 337 F.3d 1138 (9th Cir. 2003)	State action under Montana’s Unfair Trade Practices Act.	Claim for compensatory and punitive damages was preempted under enforcement provision because they were claim processing causes of action. Supports MCOs by maintaining a uniform regulatory scheme nationwide. ⁴³²
Tenth Circuit		
Settles v. Golden Rule Ins. Co., 927 F.2d 505 (10th Cir. 1991)	State law wrongful death claim.	Preempted by ERISA because the denial of care was made because it was not due under the benefit contract. Supports MCOs by maintaining a nationwide regulatory scheme as opposed to state-by-state regulation.
<i>(Continued on next page)</i>		

431. See also *Serrato v. John Hancock Life Ins. Co.*, 31 F.3d 882, 887 (9th Cir. 1994); *Qualls v. Blue Cross of Cal., Inc.*, 22 F.3d 839, 843 (9th Cir. 1994).

432. See *Greany v. W. Farm Bureau Life Ins. Co.*, 973 F.2d 812, 819 (9th Cir. 1992) (using ERISA’s enforcement provision to preempt Montana’s UTPA); see also *Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1008 (9th Cir. 1998) (holding various state law claims preempted); *Parrino v. FHP, Inc.*, 146 F.3d 699, 705 (9th Cir. 1998) (same); *Crull v. GEM Ins. Co.*, 58 F.3d 1386, 1391 (9th Cir. 1995) (same); *Tingey v. Pixley-Richards W. Inc.*, 953 F.2d 1124, 1133 (9th Cir. 1992) (same); *Gibson v. Prudential Ins. Co. of Am.*, 915 F.2d 414, 418 (9th Cir. 1990) (same).

Table 2—*Continued*

Peckham v. Gem State Mut. of Utah, 964 F.2d 1043 (10th Cir. 1992)	State law claims for promissory estoppel, estoppel by conduct, and doctrine of substantial compliance.	State law estoppel claims were preempted by ERISA as claims that “relate[d] to” an ERISA plan. Support MCOs via a nationwide regulatory scheme as opposed to a state-by-state approach.
Jones v. The Kodak Med. Assistance Plan, 169 F.3d 1287 (10th Cir. 1999)	Payment for transfer to non-approved facility brought under ERISA.	MCO’s pre-certification criteria were acceptable, all plan details did not have to be published and independent review eliminated any possible conflict of interest. Decision to deny coverage was not arbitrary and capricious and was reviewed under that standard because the plan granted administrator discretion. Supports MCOs by allowing them to determine plan terms.
Hickman v. GEM Ins. Co., Inc. 299 F.3d 1208 (10th Cir. 2002)	Class action by insureds to recover unreimbursed charges.	Insurance policy terms were not ambiguous and the insurer was reasonable in its calculations. Supports MCOs by permitting discretion in determining the terms of policies.
Lefler v. United Healthcare of Utah, Inc., No. 01-4228, 2003 WL 21940936 (10th Cir. Aug. 14, 2003)	Class action regarding practice of calculating co-payments based on percentage of provider’s charges.	Although the practice of charging based on percentage of provider’s charges was a conflict of interest the practice was reasonable under ERISA. Supports MCOs by protecting their methods of allocating costs.

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Table 2—Continued

Kidneigh v. UNUM Life Ins. Co. of Am., 345 F.3d 1182 (10th Cir. 2003)	State law bad faith claim for benefits.	State law claim preempted under ERISA's remedial scheme. Alternatively, law of "bad faith" did not regulate insurance and was outside of "saving clause." Supportive of MCOs by maintaining nationwide regulations. ⁴³³
<u>Eleventh Circuit</u>		
Anderson v. Blue Cross/Blue Shield of Ala., 907 F.2d 1072 (11th Cir. 1990)	Participant sued insurer for denial of benefits under ERISA.	Denial of benefits was upheld based on the terms of the plan. Supports MCOs by upholding contract terms despite their negative effect on the insureds.
<i>(Continued on next page)</i>		

433. Conover v. Aetna U.S. Health Care, Inc. 320 F.3d 1076, 1080 (10th Cir. 2003) (holding Oklahoma's bad faith law "relate[d] to" an ERISA plan, was not "saved" from preemption and conflicted with ERISA's remedial scheme, thus mandating preemption); Moffett v. Halliburton Energy Servs., Inc., 291 F.3d 1227, 1237 (10th Cir. 2002) (holding Wyoming's bad faith statute preempted because it did not regulate insurance and conflicted with ERISA's remedial scheme); Gaylor v. John Hancock Mut. Life Ins. Co., 112 F.3d 460, 466, 468 (10th Cir. 1997) (holding Oklahoma's bad faith statute preempted but still finding that denial of benefits improper); Cannon v. Group Health Serv. of Okla., Inc., 77 F.3d 1270, 1273 (10th Cir. 1996) (holding state law claims for breach of contract and breach of fiduciary duty preempted); Pitman v. Blue Cross & Blue Shield of Okla., 24 F.3d 118, 122 (10th Cir. 1994) (finding state claim for breach of contract preempted); Kelso v. Gen. Am. Life Ins. Co., 967 F.2d 388, 390-91 (10th Cir. 1992) (finding breach of contract, misrepresentation and Oklahoma state law claims preempted).

Table 2—Continued

Swerhun v. Guardian Life Ins. Co. of Am., 979 F.2d 195 (11th Cir. 1992)	State law claims for breach of contract and bad faith denial of benefits.	Breach of contract claim was preempted as a claim that “relate[d] to” an ERISA plan. Bad faith claim was preempted because it was not a law that regulated insurance and was thus not “saved” from preemption. Supports MCOs by limiting the claims that can be brought in state court thereby keeping a nationwide regulatory scheme. ⁴³⁴
Variety Children’s Hosp., Inc. v. Century Med. Health Plan, 57 F.3d 1040 (11th Cir. 1995)	State law claims brought by hospital for payment of benefits for procedure.	First the plaintiff was required to exhaust administrative remedies prior to filing suit. Regardless, the state law claims, including fraud and misrepresentation, were preempted by ERISA because they “relate[d] to” an ERISA plan. The suit was against the plan itself and the claim for benefits had a nexus with the plan. Supports MCOs by maintaining a nationwide regulatory scheme under ERISA.
Garren v. John Hancock Mut. Life Ins. Co., 114 F.3d 186 (11th Cir. 1997)	State law claim for tortious interference with contract	State law claim preempted under “relate to” clause since claim involved proper administration of plan and obligations under the plan. Supports MCOs by providing the nationwide regulatory scheme envisioned by ERISA.

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434. First Nat’l Life Ins. Co. v. Sunshine-Jr. Food Stores, Inc., 960 F.2d 1546, 1550 (11th Cir. 1992) (holding state law claim for breach of contract bought by insurer against insured employer preempted); Mullenix v. Aetna Life & Cas. Ins. Co., 912 F.2d 1406, 1413 (11th Cir. 1990) (finding breach of contract and bad faith claims were preempted).

NUMBER 1

MANAGED CARE POLICY 165

Table 2—Continued

Hall v. Blue Cross/Blue Shield of Ala., 134 F.3d 1063 (11th Cir. 1998)	State law claim alleging fraudulent inducement.	Claim was preempted by ERISA as a claim that “relate[d] to” an ERISA plan. Supports MCOs by imposing the uniformity of ERISA as opposed to state-by-state actions against MCOs.
Gilbert v. Alta Health & Life Ins. Co., 276 F.3d 1292 (11th Cir. 2001)	Alabama statute governing bad-faith refusal to pay.	State law was preempted by ERISA as a law that did not regulate insurance and thus could not be “saved” from preemption. Supports MCOs by maintaining a nationwide regulatory plan for MCOs.
Land v. CIGNA Health-care of Fla., 381 F.3d 1274 (11th Cir. 2004)	Medical malpractice claim brought against HMO in state court.	State law claims for medical malpractice completely preempted by ERISA as claims to remedy the denial of benefits under an ERISA plan. 11th Circuit reversed its earlier decision not finding preemption in light of <i>Aetna Health Inc. v. Davila</i> . Supports MCOs by maintaining a uniform regulatory scheme under ERISA and not subjecting MCOs to potentially stricter state laws.

Table 3
ERISA and Managed Care Cases Supportive of MCOs Before State Courts (1990–Present)

CASE	ISSUE	HOLDING
Cramer v. Assoc. Life Ins. Co., 569 So. 2d 533 (La. 1990)	Plaintiff sought penalties and attorney's fees under La. Law for a denial of benefits due.	The civil enforcement provisions of ERISA preempted application of the La. law to any ERISA plan. Congress enacted an enforcement scheme that did not include penalties or mandatory attorney's fees, and this omission was intentional. Additionally, the La. law did not meet the McCarran-Ferguson factors.
Cathey v. Metro. Life Ins. Co., 805 S.W.2d 387 (Tex. 1991)	Claims against insurer for denial of benefits brought under Texas Insurance Code and Deceptive Trade Practices Act.	Both claims under Texas statute were preempted by ERISA because they "relate[d] to" ERISA plans. Even if the laws were "saved" as laws regulating insurance they conflicted with the civil enforcement provisions of ERISA. Supports MCOs by affirming a nationwide regulatory scheme. ⁴³⁵
Weems v. Jefferson-Pilot Life Ins. Co., Inc., 663 So. 2d 905 (Ala. 1995)	Requirement that insurer inform insured of possible termination of coverage due to lack of payments by employer.	Duty to inform insured of nonpayment of premiums was preempted by ERISA. The law did not regulate insurance and thus was not "saved" from preemption. Supports MCOs by maintaining a uniform regulatory scheme under ERISA.

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435. See *Pan Am. Life Ins. Co. v. Erbauer Const. Co.*, 805 S.W.2d 395, 395 (Tex. 1991) (preempting the same two Texas statutes); see also *Cramer v. Ass'n Life Ins. Co.*, 569 So. 2d 533, 538 (La. 1990) (finding state statute requiring penalties for late payment of benefits preempted).

Table 3—Continued

Kelly v. Fort Dearborn Life Ins. Co., 660 N.E.2d 1100 (Mass. 1996)	Suit alleging misrepresentation of coverage.	Claim preempted by ERISA because it “relate[d] to” an ERISA plan due. Claim involved scope of coverage of the ERISA plan, thus relating to the plan. Supports MCOs by maintaining a consistent regulatory scheme.
Garcia v. Kaiser Found. Hosp., 978 P.2d 863 (Haw. 1999)	State law claims for breach of contract and unfair trade practices, among others.	Claims were preempted under ERISA as claims that “relate[d] to” ERISA plans because the charges alleged that insurer failed to provide services entitled to within the plan. Support MCOs by restricting the various state law causes of action for which they can be exposed. ⁴³⁶
Midwest Sec. Life Ins. Co. v. Stroup, 730 N.E.2d 163 (Ind. 2000)	State law claims for breach of contract and bad faith.	Both breach of contract and bad faith claims were preempted by ERISA because they “relate[d] to” an ERISA plan. Support MCOs by continuing the practice of a uniform, nationwide regulatory scheme for MCOs. ⁴³⁷

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436. See also *Marshall v. Bankers Life and Cas. Co.*, 832 P.2d 573, 575 (Cal. 1992) (holding various state law claims, including breach of contract and fraud, preempted); *Southland Life Ins. Co. v. Estate of Small*, 806 S.W.2d 800, 800 (Tex. 1991) (finding claims for breach of contract, deceptive trade practices and several other claims preempted by ERISA).

437. See also *King v. John Hancock Mut. Life Ins. Co.*, 500 N.W.2d 619, 623 (S.D. 1993) (finding claim of bad faith preempted by ERISA); *Duncan v. Provident Mut. Life Ins. Co. of Phila.*, 427 S.E.2d 657, 659 (S.C. 1993) (same); *Lunn v. Time Ins. Co.*, 792 P.2d 405, 407 (N.M. 1990) (holding claims for breach of contract and bad faith preempted); *Baker Hosp. v. Isaac*, 391 S.E.2d 549, 551 (S.C. 1990) (finding breach of contract and other state law causes of action, preempted by ERISA).

Table 3—Continued

Hollaway v. UNUM Life Ins. Co. of Am., No. 98,120, 2003 WL 22439659 (Okla. Oct. 28, 2003)	Okla. law regarding bad faith breach of disability rights benefits.	OK's law of bad faith fails Miller test because it did not substantially affect the risk pooling arrangement and thus was not "saved" from ERISA preemption. Supports MCOs by preventing claims at the state level, confining them consistently to the nationwide scheme of ERISA. ⁴³⁸
EID v. Duke, 816 A.2d 844 (Md. 2003)	Medical malpractice action against administrator of health plan.	State law action "re-late[d] to" ERISA plan and was therefore preempted. Supports MCOs by maintaining the uniform regulatory scheme envisioned in ERISA.
Haw. Mgmt. Alliance Ass'n v. Ins. Comm., 100 P.3d 952 (Haw. 2004)	Hawaii Patient's Bill of Rights and its provision for external review and payment of costs of that review by insurer.	Held, under the doctrine of conflict preemption, that Hawaii Patient's Bill of Rights was preempted by ERISA. The provision for a external review was a adjudicative process which conflicted with ERISA. Supports MCOs by restricting external review by insureds.

438. Footnote 36 of the majority opinion provides a listing of numerous cases decided before *Miller*, 538 U.S. 329, that also found bad faith claims preempted by ERISA.

Table 4
ERISA and Managed Care Cases Restrictive of MCOs Before the Supreme Court (1990–Present).

CASE	ISSUE	HOLDING
N.Y. State Conference of Blue Cross & Blue Shield v. Traveler's Ins. Co., 514 U.S. 645 (1995)	Surcharges for hospital charges imposed on insurance companies.	Surcharges for hospital charges imposed on insurance companies.
De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806 (1997)	State tax on gross receipts of health care facilities.	State tax not preempted by ERISA as it is an area of law typically occupied by the states. Tax on facilities will impact MCOs by reducing available funds forcing a reduction in services or increase in premiums. Reaffirms <i>Travelers</i> .
UNUM Life Ins. Co. of Am. v. Ward, 526 U.S. 358 (1999)	State "claims notification" (notice-prejudice) common law and "agency" common law of California.	Notice-prejudice law "saved" from preemption by ERISA because it specifically regulated the business of insurance; agency rule not saved since it related to an employee benefit plan. Notice-prejudice rule of CA restricts MCOs by forcing them to prove they've been prejudiced if not timely notified by insured of claim, thus subjecting MCO to a law specific only to CA. Agency law does not effect MCO.

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Table 4—*Continued*

Rush Prudential HMO v. Moran, 536 U.S. 355 (2002)	State requirements for External Review of MCO's benefit decisions.	The law was saved from preemption because it regulated insurance and was not completely preempted because it did not expand the available claims under ERISA. MCOs are forced to abide by outside doctor's assessment. This restricts MCOs by not allowing them to make benefit decisions which limits their ability to control costs.
Ky. Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003)	Any Willing Provider (AWP) Laws.	ERISA does not preempt state AWP laws because they regulate insurance which is "saved" under ERISA. Restricts MCOs ability to selectively contract and therefore control their costs.

NUMBER 1

MANAGED CARE POLICY 171

Table 5
ERISA and Managed Care Cases Restrictive of MCOs Before Circuit Courts (1990–Present).

CASE	ISSUE	HOLDING
D.C. Circuit		
Eddy v. Colonial Life Ins. Co. of Am., 919 F.2d 747 (D.C. Cir. 1990)	Fiduciary duty of insurer under ERISA.	When insured is confronted with losing coverage and contacts the insurer, the insurer is obligated to provide complete and correct information regarding their options. Restricts MCOs by requiring them to inform the insured of their options with little prompting, thus placing the burden on MCO to assure that insured understands their coverage.
O'Connor v. UNUM Life Ins. Co. of Am., 146 F.3d 959 (D.C. Cir. 1998)	State of California's notice-prejudice rule.	Notice-prejudice rule not preempted by ERISA's "saved" as law that regulates insurance. Restricts MCOs by forcing them to comply with a state law and to prove they were prejudiced by an insured's late claim. Burden is upon MCO as opposed to plaintiff, thus possibly increasing MCO's litigation expenses. Note that this case, authored by Justice Ginsburg, is a precursor to the Supreme Court case <i>Ward</i> , also written by Justice Ginsburg.

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<u>Second Circuit</u>		
Masella v. Blue Cross & Blue Shield of Conn., 936 F.2d 98 (2d Cir. 1991)	Interpretation of policy terms to determine eligibility for treatment.	ERISA plan's terms was reviewed <i>de novo</i> and interpreted in favor of the insured because MCO had ability to include provision granting itself authority to interpret terms. Restricts MCOs by construing contract terms in insured's favor.
Travelers Ins. Co. v. Pataki, 63 F.3d 89 (2d Cir. 1995)	New York statute imposing surcharges on patients based on their insurance provider (on remand from Supreme Court case <i>New York State Conference of Blue Cross and Blue Shield v. Traveler's Insurance Company</i>)	New York law not preempted, even with respect to self-insured plans, based on Supreme Court's decision in <i>Travelers</i> . Restrictive of MCOs by affirming that they are subject to surcharges, even if insurance is self-funded.
NYS Health Maint. Org. Conference v. Curiale, 64 F.3d 794 (2d Cir. 1995)	New York law requiring health insurance pools to equalize risk of coverage of high-cost claims.	State law did not "relate to" an ERISA plan because it did not reference or have a connection to the plan. Additionally the cost impacts were limited. Thus MCOs are restricted by having to participate in a risk sharing arrangement not of their own creation.
New England Health Care Employees Union v. Mt. Sinai Hosp., 65 F.3d 1024 (2d Cir. 1995)	Connecticut law (Act I) that imposed surcharges on patients with health insurance.	Act I was not preempted because it did not "relate to" the plan due to the minimal cost impacts, despite 70% of revenue would come from ERISA plans. Restricts MCOs through the imposition of fees on their services, which reduces their ability to control costs and forces them to comply with possibly numerous state laws.

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Table 5—*Continued*

Conn. Hosp. Ass'n v. Weltman, 66 F.3d 413 (2d Cir. 1995)	Connecticut law (Act II) that imposed surcharges on patients with health insurance.	Act II was not preempted by ERISA because it was not shown that it would significantly effect cost to insurance providers or force them to change coverage. MCOs will be restricted by having a fee imposed on their services which reduces their ability to control costs and forces them to comply with possibly numerous state laws.
Marcella v. Capital Dist. Physicians' Health Plan, Inc., 293 F.3d 42 (2d Cir. 2002)	State claims brought against MCO via real estate brokerage firm and local chamber of commerce.	Claim brought via chamber not preempted because chamber was not an employer under ERISA. Claim by brokerage firm was also not preempted because firm did not maintain the plan. Restrictive on MCOs by limiting the types of businesses they can provide insurance to under ERISA, which means that in order to provide services to these businesses they must comply with regulations on a state-by-state basis.
Cicio v. Does, 321 F.3d 83 (2d Cir. 2003)	Utilization review (i.e. review of needed medical care by separate doctor).	Mixed eligibility and treatment decisions are not preempted by ERISA. Issue remanded back to state court to determine if a mixed medical and eligibility decision. Restricts MCOs by subjecting any decision that contains the slightest hint of medical component to state law.

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Table 5—Continued

<u>Third Circuit</u>		
Heasley v. Belden & Blake Corp., 2 F.3d 1249 (3d Cir. 1993)	Interpretation and application of health benefit plan.	Interpretive tool of <i>contra proferentem</i> (where ambiguous insurance contract terms are decided in favor of the insured) to be applied as part of ERISA common law. Restrictive of MCOs because all interpretations of ambiguous contract terms go in favor of the insured.
PAS v. Travelers Ins. Co., 7 F.3d 349 (3d Cir. 1993)	New Jersey statute prohibiting discrimination in terms and conditions of policy coverage.	State law was “saved” because it regulated insurance. Limits MCOs ability to control terms and conditions of policies. MCO restricted under state law to provide certain benefits which hinders MCO’s ability to control their product.
Dukes v. U.S. Healthcare, Inc., 57 F.3d 350 (3d Cir. 1995)	Vicarious Liability of MCOs for care provided by network providers	State law malpractice suits against MCOs are not preempted by ERISA. Issues regarding quality of care provided by MCOs can be brought to state court and are not preempted. Restricts MCOs by forcing them to comply with the malpractice laws of the several states.
<i>In re</i> U.S. Healthcare, Inc., 193 F.3d 151 (3d Cir. 1999)	Preemption of state law claims.	Claims not preempted because they challenged MCO’s adoption of specific policies such as discharging newborns within 24 hours and discouraging readmitting newborns with health problems. Restricts MCOs because their choice of policies can be directly contested under state laws.

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Table 5—*Continued*

Lazorko v Pa. Hosp., 237 F.3d 242 (3d Cir. 2000)	Financial disincentives placed on treating phy- sician by MCO	Complaints regarding incentive system of MCO not “completely preempted” by ERISA’s remedial scheme. In- centive plan of MCO can be challenged and plaintiffs can make that challenge in state court. Restricts MCOs by mak- ing their internal financ- ing arrangements sus- ceptible to lawsuit in state court, necessitat- ing compliance with regulation in many states.
Fourth Circuit		
Glocker v. W.R. Grace & Co., 974 F.2d 540 (4th Cir. 1992)	Denial of benefits under ERISA plan.	Plan did not provide for discretion to insurer to make decision, so the denial of benefits must be reviewed <i>de novo</i> by trial court. Ambiguities should be decided against the drafter. Re- stricts MCOs by decid- ing ambiguities in favor of the insured.
Stuart Circle Hosp. Corp. v. Aetna Health Mgmt., 995 F.2d 500 (4th Cir. 1993)	Virginia statute prohib- iting insurers from un- reasonably discriminat- ing in establishing PPOs.	State law was “saved” from preemption under ERISA because the law regulated insurance. Restricts MCOs by sub- jecting them to the regulatory regime of separate states, under- cutting the regulatory consistency sought by ERISA.
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Table 5—*Continued*

Doe v. Group Hospitalization & Med. Servs., 3 F.3d 80 (4th Cir. 1993)	Denial of coverage by insurer.	Insurer was afforded less deference when determining benefits due to dual role of being insurer and administrator of ERISA plan. Insurer abused its discretion in denying benefits based on court's interpretation of contract terms. Restricts MCOs by subjecting them to a higher standard of review when they have an administrative (i.e. a financial interest) function.
Jenkins v. Montgomery Indus., Inc., 77 F.3d 740 (4th Cir. 1996)	Denial of benefits by MCO for injuries sustained by insured while intoxicated.	Employee was entitled to coverage. Court created federal common law using state rule requiring insurer to establish causation between intoxication and injuries in order to deny coverage. The state law in question was not preempted by ERISA since it agreed with ERISA's purpose. Restricts MCOs by placing burden of denying coverage upon them and subjecting MCO to possible variation of laws nationwide.
Singh v. Prudential Health Care Plan, Inc., 335 F.3d 278 (4th Cir. 2003)	Reimbursement for money paid under subrogation term which was illegal under MD HMO Act.	MD law "saved" from preemption because it regulated insurance but reimbursement of benefits unaffected by subrogation were "completely preempted" under § 502. Restricts MCOs by allowing a state to control terms of the policy coverage which will increase administrative costs of MCO by having to comply with the regulations of several states.

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Table 5—Continued

Sonoco Prods. Co. v. Physicians Health Plan, Inc., 338 F.3d 366 (4th Cir. 2003)	Employers state action breach of contract claim against MCO.	Action by employer did not satisfy requirements of “complete preemption” under § 502 of ERISA because employer lacked standing under ERISA. Thus the state claim was remanded back to state court. Restricts MCOs by exposing them to state breach of contract claims which may vary from state-to-state as opposed to a nationwide regulatory scheme which would limit administrative costs.
<u>Fifth Circuit</u>		
Memorial Hosp. Sys. v. Northbrook Life Ins. Co., 904 F.2d 236 (5th Cir. 1990)	Violation of state insurance code for deceptive and unfair trade practices.	ERISA did not preempt a state law cause of action for negligent misrepresentation brought under the TX insurance laws. The claims of third-party providers were unique from claims by insureds for benefits due and thus could not be classified under traditional preemption analysis (compare with <i>Hermann I & II</i>). Restricts MCOs by allowing hospitals to sue under state law for benefits which an individual cannot do under state law. Also subjects MCOs to the various remedies of the states. ⁴³⁹

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439. See also *Cypress Fairbanks Med. Ctr. Inc. v. Pan-American Life Ins. Co.*, 110 F.3d 280 (5th Cir. 1997) (finding the facts of the case triggered use of the precedent set in *Memorial* which restricts MCOs). In *Cypress* the Fifth Circuit established the rule to distinguish *Hermann I* and *Memorial* by inquiring “whether the beneficiary under the ERISA plan was covered at all by the terms of the health care policy, because if the beneficiary was not, the provider of health services acts as an independent, third party subject to our holding in *Memorial*.” *Id.* at 284.

Table 5—*Continued*

Gahn v. Allstate Life Ins. Co., 926 F.2d 1449 (5th Cir. 1991)	Louisiana “abuse of rights” statute regarding cancellation of insurance benefits and cancellation of insurance statute.	Claim falling under the Louisiana statute dealing with cancellation of insurance policies was not preempted as a law that regulates insurance (saving clause). Restricts MCOs by subjecting them to the insurance regulations of the 50 states.
Pitts v. Am. Sec. Life Ins. Co., 931 F.2d 351 (5th Cir. 1991)	MCO’s refusal to pay for benefits.	MCO was obligated to pay for insured’s benefits despite allegations of misrepresentations by insured’s employer. MCO had knowledge of possible misrepresentations and could have cancelled policy. Restricts MCOs by forcing them to root out fraud prior to the submission of claims by insureds.
Hubbard v. Blue Cross & Blue Shield Ass’n, 42 F.3d 942 (5th Cir. 1995)	State law claim of fraudulent inducement regarding availability of benefits and advertising promoting insurer as honest and forthright.	Claim regarding advertising was not preempted by ERISA. Restricts MCOs by subjecting them to state regulation regarding their advertising and the promises therein.
Bellaire Gen. Hosp. v. Blue Cross & Blue Shield of Mich., 97 F.3d 822 (5th Cir. 1996)	Abuse of discretion by plan administrator under ERISA.	Plan administrator had abused his discretion and acted arbitrarily in denying benefits to insureds because their medical conditions met the plan’s criteria. Restricts MCOs by limiting their discretion when making benefit determinations.

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Table 5—*Continued*

Transitional Hosp. Corp. v. Blue Cross & Blue Shield of Tex., Inc., 164 F.3d 952 (5th Cir. 1999)	State law claims for misrepresentation and breach of contract.	State claim for misrepresentation regarding payment of bills was not preempted under ERISA because the claim did not depend on benefits due to insured. Restricts MCOs by possibly subjecting them to the regulatory scheme of every U.S. state for charges of misrepresentation.
Vega v. Nat'l Life Ins. Servs., Inc., 188 F.3d 287 (5th Cir. 1999)	Denial of benefits by self-interested administrator of plan.	Denial of benefits was not reasonable when administrator of MCO, which will also have to pay the claim, makes its decision based on unsupported suspicions. Restricts MCOs by limiting their discretion and increasing the scrutiny of their decision when they have a financial stake in the outcome.
Corp. Health Ins., Inc. v. Tex. Dep't of Ins., 215 F.3d 526 (5th Cir. 2000)	State cause of action against MCOs that did not meet ordinary standard of care.	Two parts: (a) liability for MCOs of physician's negligence was not preempted and (b) independent review of MCOs medical necessity determinations was preempted. Portion not preempted restricts MCOs by exposing them to liability for the actions of their providers which will increase their costs and exposure to regulations by multiple states.

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Table 5—*Continued*

Roark v. Humana, Inc., 307 F.3d 298 (5th Cir. 2002)	State law claims brought under Texas Health Care Liability Act and breach of contract.	The mixed eligibility/treatment decisions made by the MCO were not preempted by ERISA. Restrictive of MCOs because any decision that may have a treatment component will not be covered under ERISA and will subject the MCO to the regulatory regime of every state.
Sixth Circuit		
Int'l Res., Inc. v. N.Y. Life Ins. Co., 950 F.2d 294 (6th Cir. 1992)	Employer brought state law claims against insurer for proposed cancellation of policy.	Claim involving Kentucky insurance law was not preempted by ERISA and was "saved" as a law regulating insurance. Restricts MCOs by subjecting them to the insurance regulations of each state in which they do business.
Libbey-Owens-Ford Co. v. Blue Cross & Blue Shield Mut. of Ohio, 982 F.2d 1031 (6th Cir. 1993)	Claim for accounting and restitution from insurer who acted as administrator of health plan.	Insurer was a fiduciary under ERISA because they had the authority to deny or grant claims. Thus the insurer had to account for its conduct and report to the participants. Restricts MCOs by exposing them to liability for administering a benefits plan.
<i>(Continued on next page)</i>		

NUMBER 1

MANAGED CARE POLICY 181

Table 5—Continued

Davies v. Centennial Life Ins. Co., 128 F.3d 934 (6th Cir. 1997)	Claim for benefits under ERISA and counterclaim by insurer using state law.	State law permitting insurer to rescind policy “related to” ERISA plan and was preempted. Insureds claim for benefits was remanded to determine if insurer could rescind under federal law. Restricts MCOs by not permitting them to use a state law that worked in their favor to permit rescission of health insurance for fraud.
Chiera v. John Hancock Mut. Life Ins. Co., No. 99-3613, 99-3680, 2001 WL 111585 (6th Cir. Feb. 2, 2001)	Claim for benefits under ERISA.	Insureds claim for loss of eyesight was covered by insurance plan. Court was allowed to interpret plan language because the plan did not properly vest insurer with discretionary authority. Restricts MCOs by allowing court to interpret plan terms unless expressly spelled out by the insurer.
<u>Seventh Circuit</u>		
Safeco Life Ins. Co. v. Musser, 65 F.3d 647 (7th Cir. 1995)	Wisconsin law imposing fees on insurers.	State law was not preempted by ERISA since it did not “relate[] to” an ERISA plan. The court found the Supreme Court’s holding in <i>New York State Conference of Blue Cross & Blue Shield Plans</i> dispositive. The decision restricts MCOs by subjecting them to fees for doing business.
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Table 5—*Continued*

Rice v. Panchal, 65 F.3d 637 (7th Cir. 1995)	Vicarious liability of MCOs for care provided by network doctors.	State law malpractice suits against MCOs are not completely preempted by ERISA § 502. Insureds claim did not rest on the terms of the plan and the court did not need to review the plan, thus it did not fall under § 502. Restricts MCOs by subjecting them to liability for the acts of their providers under state law.
Cent. States, S.E. and S.W. Areas Health & Welfare Fund v. Pathology Labs. of Ark., P.A., 71 F.3d 1251 (7th Cir. 1995)	Plan brought suit under ERISA seeking repayment of funds to provider.	Plan could not receive a refund of the funds for treatments because they knew that the bills they were paying were not for “hands on” treatment, thus their claim of mistake of fact was denied. Restricts MCOs ability to recover costs once they have reimbursed a provider.

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Table 5—Continued

Pitcher v. Principal Mut. Life Ins. Co., 93 F.3d 407 (7th Cir. 1996)	Action for payment of health care costs.	The court interpreted the ERISA plan's language not to include diagnostic tests such as a mammogram, as evidence of a preexisting condition. Thus the insurer had to pay for treatment. Restricts MCOs by construing contract terms to their disadvantage. MCO unable to control their costs by having control over plan terms without court intervention. ⁴⁴⁰
Plumb v. Fluid Pump Serv., Inc., 124 F.3d 849 (7th Cir. 1997)	Illinois law limiting preexisting condition requirements and portability in health insurance plans for small businesses.	Illinois state law was not preempted by ERISA because it was "saved" as a law that regulated insurance. Limits MCOs by subjecting them to the regulatory scheme of the various states with respect to provisions controlling preexisting conditions and portability of coverage. ⁴⁴¹
Fritcher v. Health Care Serv. Corp., 301 F.3d 811 (7th Cir. 2002)	Administrator's decision to deny certain benefits.	Administrator's denial of in home care for insured was unreasonable. Terms of plan did not grant administrator discretion to make decision, thus it was subject to judicial review. Restricts MCOs by permitting judicial review when plan terms do not grant discretion to administrator which limits ability of MCO to control benefits and costs.

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440. See *McNeilly v. Bankers United Life Assurance Co.*, 999 F.2d 1199 (7th Cir. 1993) (requiring payment of benefits), *De novo* review of decision appropriate because plan did not give discretion to administrator. *Phillips v. Lincoln Nat'l Life Ins. Co.*, 978 F.2d 302 (7th Cir. 1992) (requiring payment of benefits after interpreting contract terms).

441. Note that of the several other holdings in the case the insurer was not a plan fiduciary in regards to notifying plan participants about the termination of coverage because such a duty was not spelled out in the agreement.

Table 5—Continued

<u>Eighth Circuit</u>		
Boyle v. Anderson, 68 F.3d 1093 (8th Cir. 1995)	Minnesota Health Right Act, which allowed health care providers to transfer 2% provider tax to third party health care purchasers.	State law was a law of general application and was not preempted by ERISA because of its indirect impact on ERISA plans. Restricts MCOs by subjecting them to the regulations of the several states.
United of Omaha v. Bus. Men's Assurance Co. of Am., 104 F.3d 1034 (8th Cir. 1997)	Missouri state law requiring continuation of coverage for the disabled upon termination.	State law was not preempted by ERISA because it regulated insurance under the "saving" clause. Restricts MCOs by subjecting them to some forms of state regulation.
Shea v. Esensten, 107 F.3d 625 (8th Cir. 1997)	Disclosure of incentive structures for providers and state law wrongful death claim.	MCOs do have a fiduciary duty under ERISA to disclose the underlying incentives in the plan. Split with <i>Horvath v. Keystone Health Plan East, Inc.</i> (3d Cir. 2003). Restricts MCOs by exposing financial incentives to judicial and individual scrutiny.
Milone v. Exclusive Healthcare, Inc., 244 F.3d 615 (8th Cir. 2001)	Denial of benefits claim brought under ERISA.	Denial of benefits was arbitrary and capricious under an abuse of discretion standard. Restricts MCOs by setting a boundary for the amount of discretion they can write into their plans.
Express Scripts, Inc. v. Wenzel, 262 F.3d 829 (8th Cir. 2001)	Missouri statute forbidding HMOs from providing incentives for insureds to order drugs in the mail.	The statute satisfied the "saving" clause of ERISA and was therefore not preempted. Restricts MCOs by eliminating a possible cost saving initiative and forcing state regulation upon them.

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Table 5—Continued

<u>Ninth Circuit</u>		
Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534 (9th Cir. 1990)	Denial of benefits for the treatment of autism, brought under ERISA.	Administrator acted arbitrarily and capriciously in denying benefits. The terms of the policy were ambiguous and should have been construed against the insurer. Restricts MCOs by limiting the discretion they have available to determine benefits.
The Meadows v. Employers Health Ins., 47 F.3d 1006 (9th Cir. 1995)	Third party health care provider brought state law suit against insurer.	Claim based on alleged misrepresentation by insurer about coverage of patient was not preempted by ERISA because it did not “relate[] to” an ERISA plan. Restricts MCOs by opening them up to third party suits under state law instead of a nationwide scheme.
Peterson v. Am. Life & Health Ins. Co., 48 F.3d 404 (9th Cir. 1995)	Insured brought claim seeking benefits under ERISA.	Insured was not due benefits but ERISA did not preempt a state statute that required specific benefits in insurance policies because such a law was “saved” from preemption. Decision restricts MCOs by allowing states to regulate MCOs via insurance laws, defeating the nationwide scheme envisioned in ERISA.
Gewke Ford v. St. Joseph’s Omni Preferred Care, Inc., 130 F.3d 1355 (9th Cir. 1997)	Employer, with a self-funded plan, sued third party administrator and excess liability insurer of its health plan for payments of expenses.	ERISA did not preempt the state law contract claims because they were laws of general application. Restricts MCOs by subjecting them to lawsuits under state law from employers using their health care plans.

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Table 5—*Continued*

Cisneros v. UNUM Life Ins. Co. of Am., 134 F.3d 939 (9th Cir. 1998)	Suit for disability benefits of policy governed by ERISA.	California notice-prejudice rule requiring insurer to show prejudice to avoid liability is not preempted by ERISA. Insurer obligated to show that prejudice. Restricts MCOs by subjecting them to a state regulatory scheme as opposed to a nationwide scheme.
Wash. Physicians Serv. Assoc. v. Gregoire, 147 F.3d 1039 (9th Cir. 1998)	Washington State's Alternative Provider Law.	Law did not 'relate to' an ERISA plan because it regulates a service MCOs provide; would have also satisfied the 'saving clause.' Restricts MCOs by permitting states to mandate their own regulatory scheme subjecting MCOs to various regulations.
LaVenture v. Prudential Ins. Co. of Am., 237 F.3d 1042 (9th Cir. 2001)	Insured brought state law claims against insurer for disability benefits.	Because the policy was purchased by the owners of the business for their sole benefit it was not an ERISA plan. Therefore the claims could not be preempted. As in <i>Waks</i> , this decision restricts MCOs by limiting the uniformity goal of ERISA and subjecting MCOs to various regulations.
Waks v. Empire Blue Cross/Blue Shield, 263 F.3d 872 (9th Cir. 2001)	State law claim brought by individual for their individual health insurance.	State law claims were not preempted because individual plans are not regulated by ERISA. Restricts MCOs by allowing them to be subjected to the law of every state when they cover individuals.

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Table 5—*Continued*

Providence Health Plan v. McDowell, Nos. 02-35263, 02-35841, 2004 WL 574982 (9th Cir. Mar. 24, 2004)	State law breach of contract claim brought by insurers against insureds under reimbursement clause.	State law cause of action was not removable to federal court because it did not “relate[] to” the ERISA plan because the action is merely for the enforcement of a contract term. The claim also did not fall within ERISA’s enforcement provisions because the insurer was seeking monetary damages. Restricts MCOs by forcing them to apply the laws of the several states when attempting to be reimbursed under contract terms.
<u>Tenth Circuit</u>		
Hospice of Metro Denver, Inc. v. Group Health Ins. of Okla., Inc., 944 F.2d 752 (10th Cir. 1991)	State law claim of promissory estoppel brought by provider against insurer.	Promissory estoppel claim was not preempted by ERISA because they simply asserted that they were promised that coverage for insured was available. Restricts MCOs by permitting state regulation of their practices.
McGee v. Equicor-Equitable HCA Corp., 953 F.2d 1192 (10th Cir. 1992)	Suit for denial of benefits brought by insured.	Denial of benefits by MCO was wrongful and insured should have received benefits. Denial was wrong because doctor had discretion to determine treatment and had indicated that insured required treatment. Restricts MCOs by limiting their ability to determine treatments.
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Table 5—*Continued*

Peckham v. Gem State Mut. of Utah, 964 F.2d 1043 (10th Cir. 1992)	State law claims for promissory estoppel, estoppel by conduct, and doctrine of substantial compliance.	State law claim under the doctrine of substantial compliance was not preempted by ERISA. The doctrine does not materially modify a plan and simply assists the court in deciding if conduct under the contract should be considered compliant. Limits MCOs by subjecting them to this rule in every state.
PacifiCare of Okla., Inc. v. Burrage, 59 F.3d 151 (10th Cir. 1995)	Vicarious liability of MCOs for care provided by network providers.	State law vicarious liability malpractice suit against MCO was not preempted by ERISA. Just as malpractice claims against individual doctors are not preempted, neither should those claims against the MCO that has held the doctor out as their agent. Restricts MCOs by imposing liability upon them on a state by state basis.
McGraw v. Prudential Ins. Co. of Am., 137 F.3d 1253 (10th Cir. 1998)	Benefits for treatment of MS.	Denial of treatment by MCO was arbitrary and capricious. Restricts MCOs by limiting their discretion in determining plan terms.
Haymond v. Eighth Dist. Elec. Benefit Fund, No. 01-4119, 2002 WL 1056976 (10th Cir. May 28, 2002)	Benefits for insureds wife.	Terms of the summary plan description regarding limitation periods was ambiguous. Thus the drafter of the plan (the insurance fund) was responsible for the inaccuracy. Restricts MCOs by creating a presumption against them if the terms of the plan are vague.

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Table 5—Continued

<u>Eleventh Circuit</u>		
Kane v. Aetna Life Ins., 893 F.2d 1283 (11th Cir. 1990)	Claim for equitable estoppel based on denial of coverage promised.	Equitable estoppel claim was not preempted by ERISA because insured did not want to modify plan terms but to hold insurer to their previous agreement. Restricts MCOs by subjecting them to the regulatory framework of every state.
Lee v. Blue Cross/Blue Shield of Ala., 10 F.3d 1547 (11th Cir. 1994)	State court action with respect to denial of coverage.	Because plan was ambiguous regarding coverage, the plan terms were interpreted against the drafter-insurer. Held that the denial of coverage was wrong and insureds interpretation that they were covered was reasonable. Limits MCOs by allowing courts to determine coverage of plan.
Lordmann Enters., Inc. v. Equicor, Inc., 32 F.3d 1529 (11th Cir. 1994)	State law negligent misrepresentation claim, among others, brought by third-party provider.	Georgia law of negligent misrepresentation is not preempted by ERISA because it did not "relate to" an ERISA plan. Court felt preemption would defeat, rather than promote the purpose of ERISA, and third party provider was beyond ERISA's scope. Court favorably cited <i>Memorial Hospital</i> (5th Cir.). Restricts MCOs permitting a state by state regulatory scheme if suit is brought by third party provider.

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Table 5—*Continued*

Morstein v. Nat'l Ins. Servs., Inc., 93 F.3d 715 (11th Cir. 1996)	State law claims brought by employer against insurer and agent for fraudulent inducement and negligence in processing the application.	The state law claims were not preempted because they did not have connections to sufficiently "relate to" the ERISA plan. The agent and agency were not ERISA entities therefore fell outside the scope of preemption. Restricts MCOs by allowing their agents to be sued in state court which will transfer the costs back to MCOs.
HCA Health Servs. of Ga., Inc. v. Employers Health Ins. Co., 240 F.3d 982 (11th Cir. 2001)	Provider brought claim for benefits on behalf of insured.	Denial of benefits by insurer was arbitrary and capricious and benefits should have been paid, despite contract terms granting insurer discretion. Restricts MCOs by limiting their ability to interpret their own contract terms and control benefits.

Table 6
ERISA and Managed Care Cases Restrictive of MCOs Before State Courts (1990–Present).

CASE	ISSUE	HOLDING
Blue Cross & Blue Shield v. St. Mary's Hosp., 426 S.E.2d 117 (Va. 1993)	Virginia statute regulating manner in which PPOs may be established and operated.	State law was not preempted by ERISA because it regulated insurance and was thus "saved" from preemption. Restricts MCOs by limiting their ability to create care organizations and subjecting them to the regulations of the several states.
Ingram v. Am. Chambers Life Ins. Co., 643 So.2d 575 (Ala. 1994)	Insureds sued insurer for fraud based on misrepresentation of coverage.	The claim was not preempted by ERISA because it had only a tenuous connection to an ERISA plan. The law made no reference to ERISA plans. Decision limits MCOs by permitting a state-by-state scheme of regulation.

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Table 6—Continued

Shaw v. PACC Health Plan, Inc., 908 P.2d 308 (Ore. 1995)	Employee brought charges, including negligence and breach of contract, against insurer for denying employer's application for health insurance.	Because insurer did not approve the application, an ERISA plan was never established, thus the claims fell outside of ERISA and could not be preempted. Restricts MCOs by permitting state-by-state regulation of their decisions not to provide coverage for employers.
Harper v. Healthsource N.H., Inc., 674 A.2d 962 (N.H. 1996)	Termination of contract between HMO and physician by HMO.	Contract term allowing termination without cause was violation of public policy and thus the doctors could bring their suit. Restricts MCOs by not allowing them to control the terms by which they can dismiss doctors within their plans.
Napoletano v. CIGNA Healthcare of Conn., Inc., 680 A.2d 127 (Conn. 1996)	Physicians and patients brought suit against MCO for violating several Conn. statutes by removing them from network.	The Conn. laws were not preempted by ERISA because they did not "relate to" ERISA plans. Instead of affecting the administration of plans, they simply required insurer to enforce plan terms. Limits MCOs by restricting their ability to control the providers they wish to include in their systems.
Nealy v. US Healthcare HMO, 711 N.E.2d 621 (N.Y. 1999)	Claims brought against doctor for malpractice, among others, for not following HMO referral process.	Claims were not preempted by ERISA because they did not "relate to" an ERISA plan. They were claims about medical care, not the administration of a plan. Restricts MCOs by permitting state-by-state suits of their providers.

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Table 6—*Continued*

Potvin v. Metro. Life Ins. Co., 997 P.2d 1153 (Cal. 2000)	Cal. common-law right to fair procedure regarding being on a provider list.	Provider lists effect the public interest and fall under the right to fair procedure. Doctors cannot be removed if the removal will impair their ability to practice medicine within a specified geographic area and will thus affect a substantial economic interest. Removal without case was also a violation of the right to fair procedure. Restricts MCOs by subjecting them to state law and limiting their control over their provider lists.
Pappas v. Asbel, 768 A.2d 1089 (Pa. 2001)	State law negligence claim brought by hospital and doctor against HMO for refusing to allow transfer of patient.	Mixed treatment/eligibility decision subject to state law and not preempted based on <i>Travelers</i> . Restrictive of MCOs because the line of preemption between quality/quantity decisions is drawn very close to pure quantity decisions (i.e. if not a pure quantity decision the law will not be preempted).
Conn. Gen. Life Ins. Co. v. Ins. Comm'n, 810 A.2d 425 (Md. 2002)	State statutes requiring insurers to establish internal grievance processes for insureds.	State laws were not preempted by ERISA, they were "saved" as laws that regulated insurance. The law satisfied both the common sense view and two of the McCarran-Ferguson factors. Restricts MCOs by imposing a state regulatory scheme.

(Continued on next page)

NUMBER 1

MANAGED CARE POLICY 193

Table 6—*Continued*

Villazon v. Prudential Health Care Plan, Inc., 843 So. 2d 842 (Fla. 2003)	Suit against HMO for vicarious liability for malpractice of physicians.	Claim of vicarious liability was not pre-empted by ERISA because it did not “relate to” an ERISA plan and was a suit for adequate medical treatment. Restricts MCOs by subjecting them to liability for the actions of their providers.
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