

# Report for Congress

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## **ERISA's Impact on Medical Malpractice and Negligence Claims Against Managed Care Plans**

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# ERISA's Impact on Medical Malpractice and Negligence Claims Against Managed Care Plans

## Summary

The Employee Retirement Income Security Act of 1974 (ERISA) provides a comprehensive federal scheme for the regulation of employee pension and welfare benefit plans offered by employers. To avoid the inconsistent regulation of employee benefit plans by state laws, ERISA preempts “any and all” state laws as they relate to any employee benefit plan. The effect of ERISA preemption on the ability to bring state medical malpractice and negligence claims against health insurers, namely health maintenance organizations (HMOs), has caused concern among participants who seek the generally larger remedies that are available under state tort law.

Litigation involving managed care plans and ERISA preemption has steadily increased. Various legislative proposals have been introduced to address managed care plans generally and the preemption issue specifically. The claims at issue fall basically into two categories. One type of claim brought against a managed care plan involves the plan's denial of a request for treatment or hospitalization. A second type of claim deals with the adverse consequences of treatment provided by a managed care plan through its employees or through a managed care affiliate. The use of cost containment practices by managed care plans and the treatment of cost containment decisions when determining liability remain constant issues.

This report will examine the preemption provisions of ERISA, the U.S. Supreme Court’s interpretation of these provisions, selected cases applying ERISA to state medical malpractice and negligence claims, and the congressional response to the issue.

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# ERISA's Impact on Medical Malpractice and Negligence Claims Against Managed Care Plans

The number of privately-insured Americans receiving healthcare coverage through some form of managed care has dramatically increased. In 1987, only 13 percent of privately-insured Americans received their health insurance from a managed care organization.<sup>1</sup> Today, 75 percent of privately-insured Americans participate in some form of managed care.<sup>2</sup> A significant number of managed care participants are workers who receive coverage through employer-sponsored group health plans. In most cases, these plans are subject to regulation under the Employee Retirement Income Security Act of 1974 (ERISA).<sup>3</sup>

ERISA has had a significant effect on litigation involving managed care plans. Until recently, its preemption provisions were interpreted broadly to preempt claims based on the liability of a managed care entity. Frustration with ERISA has prompted Congress to consider legislation that would amend ERISA to allow certain claims against managed care entities. This report will review ERISA's preemption provisions, selected cases involving ERISA and medical malpractice and negligence claims brought against managed care entities, federal proposals to reform managed care, and the enactment of patient protection legislation at the state level.

## ERISA and its Preemption Provisions

ERISA provides a comprehensive federal scheme for the regulation of employee pension and welfare benefit plans offered by employers.<sup>4</sup> While ERISA does not

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<sup>1</sup>See Center for Patient Advocacy, *Managed Care Reform - A Top Priority* (visited Sept. 15, 2000) [[http://www.patientadvocacy.org/section\\_fs.htm?section=hc\\_debate](http://www.patientadvocacy.org/section_fs.htm?section=hc_debate)].

<sup>2</sup>*Id.*

<sup>3</sup>29 U.S.C. § 1001 *et seq.* (ERISA does not apply to employee benefit plans offered by federal, state, or local governments; churches; or plans maintained to comply with workmen's compensation laws or unemployment compensation or disability insurance laws.).

<sup>4</sup>ERISA defines an "employee welfare benefit plan", in part, as "any plan, fund, or program . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . ." 29 U.S.C. § 1002. A "participant" in an employee benefit plan is defined as "any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an  
(continued...)

require an employer to offer pension and welfare benefits, it does mandate compliance with its provisions if such benefits are offered. Congress enacted ERISA to eliminate the conflicting and inconsistent regulation of pension and employee welfare benefit plans by state laws. The provisions at issue in the preemption debate are sections 502(a) and 514(a) of ERISA.<sup>5</sup> Section 514(a) expressly preempts “any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . .”<sup>6</sup> Section 502(a) creates a civil enforcement scheme that allows a participant or beneficiary of a plan to bring a civil action for the following reasons: “to recover benefits due to him 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.”<sup>7</sup> Under section 502(a), a participant or beneficiary is also entitled “to obtain other appropriate equitable relief.”<sup>8</sup>

ERISA regulates employee benefit plans that are offered by an employer to provide medical, surgical, disability, and health insurance benefits.<sup>9</sup> Many of these employee benefit plans have turned to managed care as a way to provide low-cost benefits. The term “managed care” refers to “a system of payment or delivery arrangement where the health plan attempts to control or coordinate use of health services by its enrolled members in order to control spending and promote improved health.”<sup>10</sup> Plans contain costs and monitor the delivery of health services through the use of case management and utilization review. Case management typically involves a third-party evaluation of information presented by the participant and his doctor.<sup>11</sup> This evaluation is used to determine the need for and type of medical care to be provided.

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<sup>4</sup>(...continued)

employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.” 29 U.S.C. § 1002(7). A “beneficiary” is defined as “a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.” 29 U.S.C. § 1002(8).

<sup>5</sup>29 U.S.C. §§ 1132(a), 1144(a).

<sup>6</sup>29 U.S.C. § 1144. See also 29 U.S.C. § 1132. There are exceptions to this rule and they include, among others, causes of action or any acts or omissions occurring prior to January 1, 1975; state laws regulating insurance; use by the Secretary of Labor of services or facilities of a state agency; banking or securities; generally applicable criminal laws; the Hawaii Prepaid Health Care Act; state insurance laws regulating multiple employer welfare arrangements; and qualified domestic relations orders issued by state courts.

<sup>7</sup>29 U.S.C. § 1132(a)(1)(B).

<sup>8</sup>29 U.S.C. § 1132(a)(3).

<sup>9</sup>See note 4 for plans excluded from coverage.

<sup>10</sup>See CRS Report 97-938, *Managed Health Care: Federal and State Regulation*, by Beth Fuchs. For general information on managed care, see CRS Report 97-913, *Managed Health Care: A Primer*, by Jason S. Lee.

<sup>11</sup>Blum, *An Analysis of Legal Liability in Health Care Utilization Review and Case Management*, 26 HOUS. L. REV. 191, 192-93 (1989).

Utilization review encompasses various techniques, including pre-certification and concurrent review. Pre-certification requires plan participants to seek approval from the managed care entity before obtaining certain medical procedures or utilizing certain benefits, such as non-emergency hospitalization.<sup>12</sup> Concurrent review occurs when a participant must seek continuing approval for utilizing certain benefits. While some form of utilization review is employed by most health plans, it is characteristically a function of health maintenance organizations (HMOs).

An HMO is a managed care entity that "accepts financial risk for a defined set of health care benefits in return for a fixed monthly per capita premium paid by or on behalf of each enrolled member."<sup>13</sup> Unlike fee-for-service plans or preferred provider organizations (PPO) that allow some flexibility for selecting a provider, HMOs require that healthcare be received through providers employed by or affiliated with the HMO. HMOs are favored by some because of their ability to provide healthcare in an efficient and cost-effective manner. However, there has been increasing concern over the HMOs' use of utilization review techniques and the quality of healthcare provided through HMOs. This concern has sometimes resulted in litigation.

Some federal courts have applied the preemption provisions of ERISA to preempt state tort claims of negligence or professional malpractice brought by patients against their doctors, health insurers, and/or companies that conduct cost containment measures on behalf of the health plan. The preemption of these claims has significantly impacted plaintiffs by denying them the opportunity to recover various types of damages under state law. In a state tort action, a plaintiff may recover compensatory, consequential, or punitive damages. However, under ERISA, a successful plaintiff may recover only the benefits he would have been entitled to under the terms of the plan, reasonable attorney's fees, and court costs.

## **U.S. Supreme Court Interpretation of ERISA Preemption**

The scope and application of ERISA's preemption provisions have been addressed by the U.S. Supreme Court. In general, the Court recognizes a presumption against preemption unless Congress has explicitly or implicitly shown an intent to preempt state laws.<sup>14</sup> ERISA contains an explicit preemption clause at section 514(a). The language of section 514(a) shows that Congress intended to preempt any state law that "relate[s] to any employee benefit plan."<sup>15</sup> The Court has interpreted this language as applying to any state law that "has a connection with or reference to such a plan."<sup>16</sup> The Court has stated that "[u]nder this 'broad common sense meaning,' a state law may 'relate to' a benefit plan, and thereby be pre-empted, even if the law is not specifically designed to affect such plans, or the effect is only

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<sup>12</sup> CRS Report 97-913, *Managed Health Care: A Primer.*, by Jason S. Lee.

<sup>13</sup>*Id.* at 4-5.

<sup>14</sup>*Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 95 (1982).

<sup>15</sup>29 U.S.C. § 1144.

<sup>16</sup>*Shaw* at 97.

indirect.”<sup>17</sup> While the Court’s early decisions suggested that the application of ERISA’s explicit preemption clause was limitless, its decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.* signals a change in the Court’s interpretation of section 514(a).

In *Travelers*, several commercial insurers challenged a state law that required them, but not Blue Cross and Blue Shield, to pay surcharges.<sup>18</sup> The commercial insurers argued that the law was preempted by ERISA because it “relate[d] to” employer-sponsored health insurance plans. In addressing the issue of ERISA’s preemption clause, the Court first noted that there is a “presumption that Congress does not intend to supplant state law.”<sup>19</sup> The Court then turned to whether Congress intended to preempt state law by looking to “the structure and purpose of the Act.”<sup>20</sup> The Court concluded 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 has been a matter of local concern.”<sup>21</sup> In other recent cases, the Court has similarly recognized the states’ ability to regulate matters of health and safety, and has concluded that state laws of general applicability are not necessarily preempted by ERISA.<sup>22</sup>

While section 514(a) provides a federal defense of ERISA preemption, section 502(a) implicates the jurisdictional doctrine of complete preemption. Section 502(a) identifies how a participant or beneficiary may recover benefits or enforce or clarify rights under the terms of a plan. The Court has reasoned that Congress may so completely preempt a particular area that “any civil complaint raising [a] select group of claims is necessarily federal in character.”<sup>23</sup> Under the doctrine of complete preemption, a state claim that conflicts with a federal statutory scheme may be removed to federal court. In the context of ERISA, complete preemption refers to state claims that duplicate causes of action provided under section 502(a).

In *Pilot Life Insurance Co. v. Dedeaux*, the Court found that ERISA preempted the respondent’s state common law causes of actions asserting improper processing

<sup>17</sup>*Ingersoll-Rand v. McClendon*, 498 U.S. 133, 139 (1990).

<sup>18</sup>*New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995).

<sup>19</sup>*Travelers* at 654.

<sup>20</sup>*Travelers* at 655.

<sup>21</sup>*Travelers* at 661. In analyzing whether the state surcharges violated ERISA’s preemption provision, the Court stated: “In *Shaw*, we explained that ‘a law “relates to” an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan.’ The latter alternative, at least, can be ruled out . . . [T]he surcharge statutes cannot be said to make ‘reference to’ ERISA plans in any manner.” *Travelers* at 656 (citations omitted).

<sup>22</sup>*De Buono v. NYSA-ILSA Medical and Clinical Services Fund*, 520 U.S. 806 (1997) (State tax on gross receipts of health care facilities not preempted by ERISA); *California Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316 (1997) (California’s prevailing wage law not preempted by ERISA).

<sup>23</sup>*Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58, 63-4 (1987).

of a claim for benefits under an employee benefit plan.<sup>24</sup> In *Metropolitan Life Insurance Co. v. Taylor*, a case decided on the same day as *Dedeaux*, the Court considered whether the respondent's state claims were not only preempted by ERISA, but also "displaced by ERISA's civil enforcement provision . . . to the extent that complaints filed in state courts purporting to plead such state common law causes of action are removable to federal court."<sup>25</sup>

After reviewing the language of ERISA and its legislative history,<sup>26</sup> the Court in *Taylor* held that state law claims concerning benefit plans governed by ERISA arise under the laws of the United States and are removable to federal court by the defendants.<sup>27</sup> Consequently, the respondent's remedies were limited to those provided under ERISA, rather than the more generous remedies available under state law.

The procedure for determining whether a case will be moved from state court to federal court is governed by Section 1441(a) of the Federal Rules of Civil Procedure (FRCP). Under FRCP §1441(a) any civil action brought in state court may be removed to federal district court if the defendants can show that the federal district court has original jurisdiction.<sup>28</sup> Courts follow the "well-pleaded complaint rule" which allows the plaintiff to determine whether an action is heard in state or federal court. The plaintiff is able to choose his forum because "[i]t is long settled law that a cause of action arises under federal law only when the plaintiff's well-pleaded complaint raises issues of federal law."<sup>29</sup> The fact that the defendant's defense arises under federal law is not enough to move the case to federal court. However, under the doctrine of complete preemption, a state claim may be removed to federal court if Congress has completely preempted a particular area.

The question of removal is important in liability cases against HMOs governed by ERISA. In a typical liability case against an HMO, the plaintiff files a tort claim, i.e., negligence, medical malpractice, wrongful death, personal injury, vicarious liability, etc., in state court. The defendant will usually remove the case to federal court and seek dismissal of the state law claims on the ground that such claims are preempted by ERISA, which provides the only cause of action for the plaintiff's claim. As a threshold issue, the federal district court must determine whether it has jurisdiction over the claim. If it does not have jurisdiction, it must remand the claim back to state court without considering the defendant's motion to dismiss. If the court

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<sup>24</sup>481 U.S. 41 (1987).

<sup>25</sup>*Taylor* at 60.

<sup>26</sup>The Court considered whether the civil enforcement provisions of ERISA are similar to the preemption provisions of § 301 of the Labor Management and Relations Act (LMRA) which the Court held fell within the exception to the well-pleaded complaint rule. The Court reached its conclusion after reviewing the legislative history and finding express language that ERISA's provisions should be interpreted in the same manner as § 301. *Taylor* at 65-6.

<sup>27</sup>*Taylor* at 58.

<sup>28</sup>28 U.S.C. § 1441(a).

<sup>29</sup>*Taylor* at 63.



does have jurisdiction over the claim, then it will consider the defendant's motion to dismiss the plaintiff's state liability claims. In determining whether the court has jurisdiction over an ERISA claim, the court will examine whether the plan in question is an ERISA plan and, if so, whether the state law claims are preempted by ERISA.

## ERISA Preemption and Managed Care Plans

**Medical Malpractice Claims Against Managed Care Plans Based on Utilization Review Decision.** In *Corcoran v. United Healthcare, Inc.*, one of the first cases to address the intersection between ERISA and state tort claims, a patient sued her employee disability plan for wrongful death and emotional distress after the death of her unborn child.<sup>30</sup> The patient belonged to a medical assistance plan which contracted with the defendant to conduct cost containment measures. United used several cost containment measures such as pre-certification, concurrent review, and case management.

The patient was pregnant and her doctor recommended complete bed rest and hospitalization so he could monitor the fetus. The patient's doctor sought pre-certification from United for the hospital stay. United denied the request and authorized only ten hours per day for the services of a home health nurse. Although the patient entered a hospital, she was forced to return home after United refused to cover her hospital stay. Subsequently, the fetus went into distress and died at a time when the home health nurse was not on duty.

The Corcorans brought suit in state court and the defendants removed the case to federal court, arguing that the Corcorans' claim was preempted by ERISA. The defendants also moved to dismiss the Corcorans' state tort claims by arguing that their claim concerned the administration of benefits under a benefit plan governed by ERISA. The federal district court agreed to dismiss concluding that “the ERISA plan was the source of the relationship between the Corcorans and the defendants, [and] the Corcorans' attempt to distinguish United's role in paying claims from its role as a source of professional medical advice was unconvincing.”<sup>31</sup>

Upon appeal, the U.S. Court of Appeals for the Fifth Circuit considered whether the state law giving parents a cause of action for the wrongful death of their child “permits a negligence suit against a third party provider of utilization review services . . .”<sup>32</sup> The court reasoned that such a suit is possible, but could still be preempted by ERISA. In determining whether a federal statute preempts state law, the court looked initially to the intent of Congress: “In performing this analysis we begin with any statutory language that expresses an intent to pre-empt, but we look also to the purpose and structure of the statute as a whole.”<sup>33</sup> The court found that the express

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<sup>30</sup>965 F.2d 1321 (5<sup>th</sup> Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992).

<sup>31</sup>*Corcoran* at 1325.

<sup>32</sup>*Corcoran* at 1327.

<sup>33</sup>*Corcoran* at 1328.

language in ERISA, as well as the legislative history, showed Congress' intent to preempt state laws relating to ERISA plans.

The next question the court addressed involved the extent of ERISA's preemption of state laws that "relate to" ERISA plans. The Corcorans argued that they were suing under generally applicable state negligence causes of action. United maintained that they had not made a medical decision, but rather a decision about what benefits were covered under the health plan. The court concluded that "United gives medical advice - but it does so in the context of making a determination about the availability of benefits under the plan."<sup>34</sup> As such, the court found that the Corcorans' claim was preempted by ERISA.<sup>35</sup> Further, the court reasoned that the lack of a remedy for medical malpractice under ERISA does not alter the conclusion that ERISA preempts state tort claims for administration of benefits under an ERISA plan.<sup>36</sup>

With respect to damages, the Corcorans argued that under section 502(a)(3) of ERISA, they were entitled to more than just benefits due under the plan. The Corcorans contended that they were entitled to extracontractual damages, particularly money for emotional injuries. Section 502(a)(3) allows a participant or beneficiary to obtain "other appropriate equitable relief."<sup>37</sup> The court rejected this argument by concluding that benefit plans are guided by principles of trust and contract law. Because there was no trust relationship or contract between United, a third party in the Corcoran's benefit plan, then no extracontractual damages were recoverable.

Since *Corcoran*, several similar lawsuits alleging malpractice have been filed against HMOs or other managed care plans and their physicians. Some federal circuit courts have found no ERISA preemption,<sup>38</sup> while others have found preemption.<sup>39</sup>

**Medical Malpractice Claims Against HMO and HMO Physician Based on Vicarious Liability of HMO.** In *Dukes v. U.S. Healthcare, Inc.*, the U.S. Court of Appeals for the Third Circuit held that ERISA does not completely

<sup>34</sup>*Corcoran* at 1331.

<sup>35</sup>See also *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7<sup>th</sup> Cir. 1995) (vicarious liability claims against HMO and negligence claim against doctor preempted by ERISA where HMO failed to approve and pay for physical therapy after knee surgery).

<sup>36</sup>*Corcoran* at 1321.

<sup>37</sup>29 U.S.C. § 1132(a)(3).

<sup>38</sup>*Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3<sup>rd</sup> Cir. 1995), *cert. denied*, 516 U.S. 1009 (1995).

<sup>39</sup>*Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6<sup>th</sup> Cir. 1995) (ERISA preempted malpractice claims brought against health insurer who refused to approve psychiatric care and patient later committed suicide); *Kuhl v. Lincoln National Health Plan of Kansas City*, 999 F.2d 298 (8<sup>th</sup> Cir. 1993), *cert. denied*, 510 U.S. 1045 (1994) (ERISA preempted malpractice claims for wrongful death after delay in certifying insured for heart surgery); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9<sup>th</sup> Cir. 1993), *cert. denied*, 511 U.S. 1052 (1994) (ERISA preempted wrongful death claim based on withdrawal of authorization for surgery).

preempt state tort claims for negligence.<sup>40</sup> The *Dukes* case presented two separate plaintiffs whose claims were consolidated on appeal. The first plaintiff, Cecilia Dukes, alleged that her husband's death resulted from the failure of the husband's HMO physicians to conduct a timely blood test that would have detected an extremely high blood sugar level.

The second plaintiffs, Ronald and Linda Visconti, alleged that their daughter was born stillborn because their HMO physician ignored Mrs. Visconti's symptoms which indicated a serious, but treatable, medical condition. Both plaintiffs sued for negligence and medical malpractice in state court against both the HMO and its doctors, all of whom were designated participating physicians under their HMO plan. Both plaintiffs alleged that the HMO should be held liable under theories of ostensible and actual agency. The ostensible and actual agency theory is based on the patient's reasonable belief that he or she is being treated by an employee of the HMO.<sup>41</sup> Both plaintiffs also sued under a direct negligence claim, asserting that the HMO was negligent in selecting, training, and monitoring the physicians in question.

The defendants removed both cases to federal court on the grounds that the federal court had jurisdiction over ERISA claims. The court stated initially that although ERISA's preemption provisions are extensive, they preempt only state laws that fall within the civil enforcement provisions of section 502(a)(1)(B), or claims "to recover benefits due . . . under the terms of [the] plan, to enforce . . . rights under the terms of the plan, or to clarify . . . rights to future benefits under the terms of the plan."<sup>42</sup> The plaintiffs argued that their claims fell outside of ERISA's civil enforcement provisions and thus were not preempted. They contended that the sole benefit they received was membership in the HMO, and they were not contesting their membership. U.S. Healthcare countered that the benefit is more than membership in the HMO; that the benefit also includes the medical care received by participants. The court agreed with U.S. Healthcare and found that the benefit to plan participants includes medical care, as well as membership in the HMO. Nonetheless, the court concluded that the plaintiffs' claims were not preempted by ERISA. The court stated:

Nothing in the complaints indicates that the plaintiffs are complaining about their ERISA welfare plans' failure to provide benefits due under the plan. . . . Instead of claiming that the welfare plans in any way withheld some quantum of plan benefits due, the plaintiffs in both cases complain about the low quality of the medical treatment that they actually received and argue that the U.S. Healthcare HMO should be held liable under agency and negligence principles. . . . We are confident that a claim about the quality of a benefit received is not a claim under § 502(a)(1)(B) to 'recover benefits due . . . under the terms of [the] plan.'<sup>43</sup>

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<sup>40</sup>57 F.3d 350 (3<sup>rd</sup> Cir. 1995), *cert. denied*, 516 U.S. 1009 (1995).

<sup>41</sup>*Dukes* at 352.

<sup>42</sup>*Dukes* at 356.

<sup>43</sup>*Dukes* at 356-7. See also *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151 (10<sup>th</sup> Cir. 1995) (vicarious liability claim against HMO not preempted by ERISA).

The *Dukes* court distinguished its decision from *Corcoran* by noting that the doctors in *Dukes* were not third party consultants, as in *Corcoran*, but doctors employed by the HMO to provide medical care to plan participants.<sup>44</sup> The court was careful to note that the defendant in *Corcoran* had not “provide[d], arrange[d] for, or supervise[d] the doctors who provided the actual medical treatment for plan participants,” but only provided the administrative function of utilization review.<sup>45</sup> The *Dukes* court went on to hold that claims based on administration of a benefits plan would be preempted by ERISA, whereas claims based on the quality of care or actual medical treatment provided would not be preempted under section 502(a)(1)(B).

The Third Circuit followed this line of reasoning in *Bauman v U.S. Healthcare*.<sup>46</sup> In *Bauman*, the plaintiffs brought their claim in state court against their doctor, hospital, and health plan after the death of their daughter. The Baumans were covered under a managed care plan provided by U.S. Healthcare. The plan pre-certified twenty-four hours in the hospital after birth and Mrs. Bauman was discharged after that time lapsed. The next day, the Baumans’ daughter fell ill. The Baumans contacted the doctor for advice and requested a home visit from the plan. The doctor did not instruct them to return to the hospital and the plan did not send a nurse. The Baumans' daughter died the same day from a bacterial infection that developed into meningitis.

Four of the six counts brought by the Baumans were against U.S. Healthcare. Count One alleged that the plan was directly liable because its policy directly or indirectly required the twenty-four hour discharge. The Baumans also alleged that the plan was vicariously liable for the negligence of its agents in carrying out the policy.<sup>47</sup> Count Two alleged that the plan “manifested reckless indifference” to the consequence of its policy.<sup>48</sup> In Count Five, the Baumans alleged that the plan negligently adopted the policy to discourage a physician from readmitting infants. Count Six alleged that medically appropriate care required an in-home visit, which

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<sup>44</sup>The court stated:

In these cases, the defendant HMOs play two roles, not just one. In addition to the utilization-review role played by United in *Corcoran*, the HMOs [in *Dukes*] also arrange for the actual medical treatment for plan participants. Only this second role is relevant for this appeal, however: on the faces of these complaints there is no allegation that the HMOs somehow should be held liable for any decisions they might have made while acting in their utilization-review roles. Stated another way, unlike *Corcoran*, there is no allegation here that the HMOs denied anyone any benefits that they were due under the plan. Instead, the plaintiffs here are attempting to hold the HMOs liable for their role as the arrangers of their decedents' medical treatment. *Dukes* at 361.

<sup>45</sup>*Dukes* at 360.

<sup>46</sup>1 F. Supp.2d 420 (D.N.J. 1998), aff’d in part, rev’d in part sub nom, *In re U.S. Healthcare Inc.*, 193 F. 3d 151 (3<sup>rd</sup> Cir. 1999).

<sup>47</sup>*Bauman* at 155-6.

<sup>48</sup>*Bauman* at 156-7.

the Baumans requested and which was available under their plan, but was not received.

The defendants removed the case to federal court asserting ERISA preemption. The district court remanded Counts One, Two, and Five to state court and retained jurisdiction over Count Six, as a claim properly heard under ERISA. On appeal, the Third Circuit held that the four counts dealt with the quality of care provided, not with quantity, and that they should all be remanded to state court. As in *Dukes*, the court found that section 502 provides only partial preemption to those state law claims that seek "to recover benefits due . . . under the terms of [the] plan, to enforce . . . rights under the terms of the plan, or to clarify . . . rights to future benefits under the terms of the plan."<sup>49</sup> The court maintained that the Baumans' claims were distinguishable because they dealt with the quality of care once it was provided. The court found "[i]t . . . significant that none of these three counts [Counts One, Two, and Five] as pled allege[d] a failure to provide or authorize benefits under the plan . . ." <sup>50</sup> With regard to Count Six, concerning the failure to provide an in-home visit, the court chose to view the claim as a "state cause of action for violating a tort duty 'to provide [the Bauman family] adequate medical care, rather than a violation of a [contractual] promise . . . made to them in their ERISA plan.'" <sup>51</sup>

Courts that have followed the *Dukes* line of reasoning include the Court of Appeals for the Tenth Circuit in *Pacificare of Oklahoma, Inc. v. Burrage*.<sup>52</sup> The Tenth Circuit considered "whether ERISA preempts a claim that an HMO is vicariously liable for alleged malpractice of one of its physicians. . . ." based on quality of care.<sup>53</sup> The court held that ERISA does not preempt such a claim because the claim does not involve the delivery of benefits under the plan, and adjudication of the claim does not require reference to the plan. In considering whether the claim "relate[d] to" the employee benefit plan, the court stated that:

As long as a state law does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the [law] has some economic impact on the plan does not require that the [law] be invalidated.<sup>54</sup>

Other federal courts have reached the opposite conclusion of the court in *Dukes* and *Bauman*, finding that state claims alleging direct or vicarious liability of HMOs

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<sup>49</sup>*Bauman* at 161. "We rejected U.S. Healthcare's complete preemption arguments in both cases. Analyzing the gravamen of the complaints, we observed that neither one pled state claims falling within the scope of ERISA's civil enforcement scheme because there was nothing raised regarding a failure 'to provide benefits due under the plan.' The plaintiffs did not allege that the failure to perform the tests arose in any way from a denial of benefits under the ERISA plan involved. . . . Rather, both complaints asserted claims regarding the quality of the care received."

<sup>50</sup>*Bauman* at 162.

<sup>51</sup>*Bauman* at 164.

<sup>52</sup>59 F.3d 151 (10<sup>th</sup> Cir. 1996).

<sup>53</sup>*Pacificare* at 153.

<sup>54</sup>*Pacificare* at 154.

are preempted by ERISA. The First Circuit recently held that ERISA preempts a state action for "negligent medical decisionmaking in the course of a precertification requirement . . . mandated by an [ERISA plan]."<sup>55</sup> In a Seventh Circuit case, *Jass v. Prudential Health Care Plan, Inc.*, the court concluded that the plaintiff's vicarious liability claims against the HMO based on the negligence of the plaintiff's doctor were preempted by ERISA.<sup>56</sup> The decision in *Jass* may be distinguished from *Burrage* because in *Burrage*, "the issue of the doctor's negligence can be resolved without reference to the benefit plan."<sup>57</sup> A different outcome was reached in *Jass* once the court determined that the doctor's "negligence is intertwined with the benefits determination because the alleged negligence concerned a failure to treat where the Plan denied payment for the treatment."<sup>58</sup>

**Liability Based on Financial Incentive Program.** Although the Supreme Court's recent decision on ERISA and financial incentives offered by an HMO does not address preemption directly, it has already been cited by the Fifth Circuit to support its decision on ERISA's preemptive effect on the Texas Health Care Liability Act.<sup>59</sup> In *Pegram v. Herdrich*, Cynthia Herdrich alleged that her HMO's provision of medical services under terms that rewarded physicians for limiting medical care entailed an inherent or anticipatory breach of fiduciary duty under ERISA.<sup>60</sup> Herdrich argued that the terms created an incentive to make decisions in the physicians' self-interest rather than the plan participants' exclusive interest.<sup>61</sup>

Herdrich was examined by Lori Pegram, her HMO physician, after experiencing pain in the midline area of her groin. Six days after the examination, Dr. Pegram discovered an inflamed mass in Herdrich's abdomen. Despite the noticeable inflammation, Dr. Pegram did not order an ultrasound diagnostic procedure at a local hospital. Instead, she decided that Herdrich would have to wait eight days for an ultrasound to be performed at a facility staffed by the HMO more than fifty miles away. During these eight days, Herdrich's appendix ruptured and she suffered peritonitis.

ERISA requires fiduciaries to discharge their duties with respect to a plan "solely in the interest of the participants and beneficiaries."<sup>62</sup> ERISA further provides that "[a]ny person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries . . . shall be personally liable to make good to such plan any losses to the plan resulting from

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<sup>55</sup>*Danca v. Private Health Care Systems, Inc.*, 185 F.3d 1 (1<sup>st</sup> Cir. 1999).

<sup>56</sup>88 F.3d 1482 (7<sup>th</sup> Cir. 1996).

<sup>57</sup>*Jass* at 1494.

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

<sup>59</sup>See *Corporate Health Insurance, Inc. v. Texas Department of Insurance*, 2000 WL 792345 (5<sup>th</sup> Cir. 2000).

<sup>60</sup>120 S.Ct. 2143 (2000).

<sup>61</sup>*Pegram* at 2146.

<sup>62</sup>29 U.S.C. § 1104(a)(1).

each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan . . .”<sup>63</sup>

The District Court dismissed Herdrich’s claim after finding that the HMO did not act as an ERISA fiduciary.<sup>64</sup> The Court of Appeals for the Seventh Circuit disagreed. It determined that the HMO did act as an ERISA fiduciary and reversed the decision. Further, the Seventh Circuit maintained that although an incentive program does not automatically give rise to a breach of fiduciary duty, such a program may constitute a breach when physicians delay providing necessary treatment or withhold administering proper care to a plan participant for the sole purpose of increasing their bonuses.<sup>65</sup>

The Supreme Court concluded that an HMO does not act as a fiduciary when its physicians make mixed eligibility and treatment decisions; that is, a treating physician determines that a procedure or condition is either covered or not covered based on a patient’s diagnosis. At common law, the Court reasoned, trustees and other fiduciaries make decisions about assets and property distribution in the sole interest of the beneficiary. While HMOs that act through their physicians make similar decisions for the provision of healthcare for their participants, the Court contended that because the physicians benefit from their decisions to refrain from ordering or providing care, they bear only a limited resemblance to traditional fiduciaries. Based on this distinction, the Court believed that it was unlikely that Congress intended for HMOs to be treated as fiduciaries to the extent that they make mixed eligibility and treatment decisions through their physicians.<sup>66</sup>

The Court supported its decision by considering the effect of recognizing mixed decisions as fiduciary in nature. A participant would likely prevail in an ERISA claim any time an HMO has a profit incentive to ration care because the HMO would not be acting solely in the interest of the participant. For-profit HMOs would probably be eliminated.<sup>67</sup> Further, a claim of fiduciary breach by an HMO physician making a mixed decision would likely resemble a malpractice claim. An HMO defending itself in a fiduciary breach case would probably argue that its physician was not acting out of financial interest, but for good medical reasons. Consequently, the Court believed that the fiduciary standard would be nothing but the malpractice standard applied in state actions against physicians.<sup>68</sup> The Court concluded that ERISA was not enacted to provide a federal fiduciary claim that applied the same standard available under state malpractice law.

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<sup>63</sup>29 U.S.C. § 1109(a).

<sup>64</sup>*Pegram* at 2148.

<sup>65</sup>*Id.*

<sup>66</sup>*Pegram* at 2155.

<sup>67</sup>*Pegram* at 2156.

<sup>68</sup>*Pegram* at 2157.

## Congressional Response

### 107<sup>th</sup> Congress.

Both the Senate and House have passed patient protection bills during the first session of the 107<sup>th</sup> Congress.<sup>69</sup>

The Senate passed the **Bipartisan Patient Protection Act, S. 1052**, on June 29, 2001.<sup>70</sup> S. 1052 would amend ERISA to allow a federal cause of action against a health plan for personal injury or wrongful death based upon the plan's failure to exercise ordinary care when considering a claim for benefits. Federal causes of action may not involve a "medically reviewable decision." The legislation would amend section 514 of ERISA to allow a state cause of action for personal injury or wrongful death, if the cause of action arises by reason of a medically reviewable decision.

Under the federal cause of action, the health plan may be assessed civil penalties of up to \$5,000,000 if the plaintiff establishes that the alleged conduct carried out by the defendant demonstrated bad faith and flagrant disregard for the rights of the participant or beneficiary and was a proximate cause of the personal injury or wrongful death. In a state cause of action, state law would be superceded insofar as it provides for punitive, exemplary, or similar damages, if the plan has met the utilization review, internal and external appeals provisions of the bill at the time of the personal injury or death. Punitive damages would be allowed in state causes of action for wrongful death, if the only damages available are punitive or exemplary in nature, and in cases where the plaintiff establishes by clear and convincing evidence that the defendant's alleged conduct was carried out with willful or wanton disregard for the rights or safety of others and was the proximate cause of the personal injury or wrongful death.

The legislation does not authorize a federal or state cause of action against employers or plan sponsors unless the employer or plan sponsor directly participated in the decision of the plan or the plan's failure to exercise ordinary care in making the decision. Additionally, employers and plan sponsors may shield themselves from liability by naming a designated decision maker. Group health plans that are self-insured and self-administered by an employer, as well as multiemployer plans that are self-insured and self-administered, cannot be held liable under the federal cause of action for the performance of, or the failure to perform, any nonmedically reviewable duty under the plan.

In general, all administrative remedies must be exhausted before a cause of action may be brought. However, there are exceptions for cases where the external review entity fails to make a determination within the time required, and the

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<sup>69</sup>For a detailed comparison of the Senate and House passed bills, see CRS Report RL30978, *Patient Protection During the 107<sup>th</sup> Congress: Side-by-Side Comparison of House and Senate Bills*.

<sup>70</sup>S. 1052, as introduced, closely mirrored S. 283 and S. 872, earlier bills introduced by Senator McCain and cosponsored by Senators Kennedy and Edwards.



participant or beneficiary may seek injunctive relief prior to the exhaustion of administrative remedies in cases where the exhaustion of such remedies would cause irreparable harm.

The House passed **H.R. 2563**, with a substantive amendment to the liability provisions, on August 2, 2001. The **Norwood Amendment** to H.R. 2563 replaced the bifurcated approach of the Senate-passed bill with a new federal cause of action, over which state courts would have concurrent jurisdiction. Under H.R. 2563, as passed, participants in group health plans would be able to bring a cause of action against a health plan's designated decision maker if the designated decision maker failed to exercise ordinary care (1) in making a determination denying the initial claim for benefits, (2) in making a determination denying the claim for benefits during the internal review process, or (3) in failing to authorize coverage in compliance with the determination of an independent external reviewer. If the designated decision maker's failure to exercise ordinary care contributed to a delay in receiving benefits, or a failure to receive benefits, and the delay or denial was the proximate cause of the participant's injury or death, the designated decision maker would be liable for economic and noneconomic damages.

The Norwood Amendment does not amend ERISA's preemption language to allow new causes of action to go forward under state law. However, state courts would have concurrent jurisdiction over the new federal causes of action. Thus, patients could either bring suit in federal court or in a state court located in the state in which he or she resides.

Under H.R. 2563, as passed, economic damages are not limited, but noneconomic damages may not exceed \$1.5 million. Punitive damages not to exceed \$1.5 million may be awarded only if the denial of the claim for benefits was reversed by an independent external reviewer and the designated decision maker failed to authorize coverage in compliance with the external review determination. States would be allowed to place additional limits on noneconomic or punitive damages.

In order to bring a cause of action, the participant would be required to exhaust internal and external review procedures. However, a participant or beneficiary may seek injunctive relief prior to the exhaustion of the internal and external review processes if it is demonstrated to the court, by a preponderance of the evidence, that the exhaustion requirement would cause irreparable harm to the health of the participant or beneficiary.

## **State Action**

Several states have enacted statutes that provide a cause of action to participants in managed care plans who have been harmed by the failure to adhere to a duty of care.<sup>71</sup> In general, managed care entities and other health insurance carriers in the

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<sup>71</sup>While the causes of action differ somewhat, and the extent to which liability is imposed varies, there are thirteen states that provide some form of a cause of action against managed care plans. Those states are Arizona, California, Georgia, Louisiana, Maine, Missouri, New (continued...)

eight states are bound by a specified duty of care. When this duty is breached, participants have a cause of action against the managed care entities and carriers. The cause of action appears to be a type of tort action alleging negligence and the breach of the specified duty. In any tort action, the plaintiff must prove his case by a preponderance of the evidence to be successful; that is, a plaintiff will prevail if the evidence shows that the fact sought to be proved is more likely than not.

***Corporate Health Insurance v. Texas Department of Insurance.*** The Texas Health Care Liability Act, which was enacted on May 22, 1997, seeks to regulate managed care in three ways.<sup>72</sup> First, it provides a statutory cause of action against managed care entities that fail to meet an ordinary care standard when making healthcare treatment decisions. Second, it establishes an independent review procedure to determine whether treatment is appropriate and medically necessary. Third, it protects physicians from HMO-imposed indemnity clauses and from retaliation by HMOs for advocating medically necessary care for their patients. Aetna challenged the Act on the grounds that it was preempted by section 514 of ERISA, but the U.S. Court of Appeals for the Fifth Circuit determined that various provisions of the Act are not preempted by ERISA.<sup>73</sup>

The Fifth Circuit concluded that the liability, anti-indemnification, and anti-retaliation provisions of the Act are not preempted by ERISA. However, the Court determined that the independent review provisions are preempted. The Fifth Circuit's opinion is discussed in detail below.

***Liability Provisions.*** The Fifth Circuit found that the liability provisions impose liability for only a "limited universe of events."<sup>74</sup> The provisions do not permit claims based on a managed care entity's denial of coverage. Claims involving coverage decisions in the administration of a plan would be preempted by ERISA. In this case, the provisions allow claims based on the negligent delivery of medical services and impose vicarious liability on managed care entities for that negligence. The Fifth Circuit maintained that vicarious liability does not "relate to" a provider's role as an ERISA plan administrator or affect the structure of the plans so as to require preemption.<sup>75</sup> Further, the Fifth Circuit stated that it was not persuaded that Congress intended for ERISA to supplant the state's regulation of the quality of medical practice.<sup>76</sup>

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<sup>71</sup>(...continued)

Jersey, New Mexico, Oklahoma, Oregon, Texas, Washington and West Virginia.

<sup>72</sup>The Texas Health Care Liability Act was codified at Tex. Civ. Prac. & Rem. Code Ann. § 88.002.

<sup>73</sup>*Corporate Health Insurance, Inc. v. Texas Department of Insurance*, 215 F.3d 526 (5<sup>th</sup> Cir. 2000).

<sup>74</sup>*Corporate Health Insurance* at 534.

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

<sup>76</sup>*Id.* at 535.

***Anti-Indemnification and Anti-Retaliation Provisions.*** The Act’s anti-indemnification provision prohibits a managed care entity from including an indemnification clause in its contracts with doctors and other healthcare providers that would hold it harmless for its own acts.<sup>77</sup> The anti-retaliation provision prohibits a managed care entity from refusing to renew a doctor or healthcare provider because he advocated medically necessary treatment.<sup>78</sup> Aetna argued that these provisions impermissibly mandate the structure and administration of ERISA plan benefits.

The Fifth Circuit concluded that the anti-indemnification and anti-retaliation provisions are not preempted by ERISA because they address the quality of care provided by the managed care entities and “do not compel the entities to provide any substantive level of coverage as health care insurers.”<sup>79</sup> Further, the Fifth Circuit contended that the provisions preserve a physician’s independent judgment in the face of a managed care entity’s incentives for cost containment. Citing *Pegram*, the Fifth Circuit reasoned that the effect of the provisions is consistent with the Court’s finding that “states are currently allowed to impose malpractice liability on HMOs for [providing incentives].”<sup>80</sup>

***Independent Review Provisions.*** The Fifth Circuit found that because the independent review provisions “attempt to impose a state administrative regime” on coverage determinations they are preempted by ERISA.<sup>81</sup> In responding to Texas’ argument that the independent review provisions may be saved by ERISA’s saving clause for laws that regulate insurance, the Fifth Circuit maintained that the clause does not operate if “the state law at issue creates an alternative remedy for obtaining benefits under an ERISA plan.”<sup>82</sup> In this case, the independent review provisions establish an alternate mechanism for obtaining benefits under the terms of a plan. Because a plan would be bound by the decision of the independent review organization, a participant could obtain a benefit even if he doesn’t follow ERISA’s civil enforcement procedures.

***Rush Prudential HMO v. Moran.*** In *Moran v. Rush Prudential HMO*, the Seventh Circuit concluded that an Illinois external review statute did not conflict with ERISA’s civil enforcement scheme and was saved from preemption by ERISA. Like the Fifth Circuit, the court determined that the statute “related to” an employee benefit plan. The court also found that the statute regulated insurance, and thus was protected by ERISA’s saving clause. Further, the court maintained that ERISA’s deemer clause was not applicable because the plan at issue was an insured plan, that

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<sup>77</sup>*Id.* at 536.

<sup>78</sup>*Id.*

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

<sup>80</sup>*Id.* at 536 n.34.

<sup>81</sup>*Id.* at 537. Despite its general finding of preemption, the Fifth Circuit concluded that additional independent review language accompanying the liability provisions and making review voluntary on the entity’s part is not preempted. See CRS Report RS20845, *Managed Care and State External Review Statutes*.

<sup>82</sup>*Id.* at 539.

is offered by an HMO and not self-funded by an employer.<sup>83</sup> The court relied on the Supreme Court’s interpretation of the deemer clause in *FMC Corp. v. Holliday*.<sup>84</sup> In that case, the Court found that the deemer clause “makes clear that if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer’s insurance contracts.”<sup>85</sup> In this case, the plan was offered by Rush Prudential HMO.

Unlike the Fifth Circuit, the Seventh Circuit found that the Illinois external review statute does not create an “alternative remedy scheme” that conflicts with section 502(a) of ERISA.<sup>86</sup> Although the statute requires an HMO to provide a covered service if an independent reviewing physician determines that the service is medically necessary, the court found that the procedure created by the statute is “not tantamount to the relief offered” under section 502(a).<sup>87</sup> The court explained that because the provisions of the statute were incorporated into the plaintiff’s insurance contract, they did not operate as an alternative remedy for recovering benefits. Rather, the provisions established an additional internal mechanism for making decisions about when a service is medically necessary. The court appears to have distinguished external review that becomes a part of a plan because of a state statute from external review that is simply mandated by state law.

On appeal, the Supreme Court affirmed the judgement of the Seventh Circuit.<sup>88</sup> The Court determined that section 4-10 of the Illinois statute was a regulation of the business of insurance, and thus saved from preemption pursuant to ERISA’s savings clause and the McCarran-Ferguson Act.<sup>89</sup> The Court reviewed section 4-10 against a multi-factor test used to determine whether a state law regulates the business of insurance.<sup>90</sup> Under the multi-factor test, the Court first asked whether, “with a common-sense view,” the law was specifically directed toward the insurance industry.<sup>91</sup>

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<sup>83</sup>*Moran*, 230 F.3d at 970.

<sup>84</sup>498 U.S. 52 (1990).

<sup>85</sup>*FMC Corp.*, 498 U.S. at 64.

<sup>86</sup>*Moran*, 230 F.3d at 971.

<sup>87</sup>*Id.*

<sup>88</sup>In its opinion, the Supreme Court acknowledged that it granted certiorari to resolve the conflict between the Fifth and Seventh Circuits. While this opinion does not directly address the Fifth Circuit’s opinion regarding preemption of the Texas statute, it is likely that the independent review provisions of the Texas statute will be recognized as permissible in light of this opinion.

<sup>89</sup>The McCarran-Ferguson Act requires that the business of insurance be subject to state regulation. The statute provides, with certain exceptions, that “[n]o Act of Congress shall be construed to invalidate . . . any law enacted by any State for the purpose of regulating the business of insurance . . . .” 15 U.S.C. 1012(b).

<sup>90</sup>See *Metropolitan Life Ins. v. Massachusetts*, 471 U.S. 724 (1985).

<sup>91</sup>536 U.S. \_\_\_, slip op. at 8 (2002).

With regard to the Illinois statute, the Court found that, despite Rush’s contrary assertions, the statute was directed at the insurance industry and did not apply to any other industry.<sup>92</sup> The Court then considered three factors established under McCarran-Ferguson to determine whether the Illinois statute should be saved from preemption. A state law would not be subject to preemption if it (1) has the effect of transferring or spreading risk; (2) if it is an integral part of the policy relationship between the insurer and the insured; or (3) if it is limited to entities within the insurance industry.<sup>93</sup> The Court noted that the factors were guideposts, and that a state law is not required to satisfy all three to survive preemption.<sup>94</sup> Applying the three factors to the Illinois statute, the Court determined that the second and third factors were clearly satisfied.

Recognizing that the statute could likely be saved from preemption under McCarran-Ferguson, Rush also argued that preemption was appropriate because Congressional intent should override ERISA’s savings clause. In making this argument, Rush compared the provisions in the Illinois statute to the claims for damages which the Court found to be preempted in *Pilot Life Ins. Co. v. Dedeaux*.<sup>95</sup> In *Pilot Life*, the Court found that ERISA preempted a participant’s claim for damages because the claim constituted an alternative remedy outside the limited scope of remedies Congress provided for in ERISA.<sup>96</sup> The Court distinguished the Illinois statute from the remedy sought in *Pilot Life* and other cases, finding that the Illinois statute merely prescribes “a state regulatory scheme that provides no new cause of action under state law and authorizes no new form of ultimate relief.”<sup>97</sup> The Court also rejected Rush’s argument that independent review was an “alternative scheme of arbitral adjudication,” and thus in conflict with Congress’ intent to confine dispute resolution under ERISA to the courts.<sup>98</sup> In dismissing Rush’s argument, the Court noted that the state scheme was significantly different from arbitration, and was actually closer to a “mandate for [a] second opinion” rather than arbitration.<sup>99</sup>

## Conclusion

Many hoped that *Corporate Health Insurance* and *Pegram v. Herdrich* would provide guidance for the resolution of managed care litigation under state law. The Fifth Circuit appears to have interpreted *Pegram* to allow the state regulation of managed care when such regulation targets the quality of care provided by a managed care entity. This interpretation is consistent with the prior conclusions of other Courts of Appeals. For example, in *Dukes*, the Third Circuit found that claims

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<sup>92</sup>Slip op. at 13.

<sup>93</sup>Slip op. at 16 (citing *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)).

<sup>94</sup>*Id.*

<sup>95</sup>See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

<sup>96</sup>*Id.* at 57.

<sup>97</sup>Slip op. at 23.

<sup>98</sup>Slip op. at 25.

<sup>99</sup>Slip op. at 27.

involving the quality of a benefit received by a participant are not preempted by ERISA.

However, the *Pegram* Court understood the decisions of HMO physicians to implicate both the quality (treatment decisions) and quantity (eligibility decisions) of healthcare.<sup>100</sup> The Court was unwilling to recognize these decisions as those made by a fiduciary for purposes of imposing liability under ERISA. This unwillingness has suggested to some that the Court believes that malpractice claims against an HMO should be the subject of state tort law.<sup>101</sup> However, this was not a central holding of *Pegram*.

The Court's acknowledgment that ERISA was not enacted to "federalize malpractice litigation in the name of fiduciary duty" does suggest that state malpractice claims will not be preempted.<sup>102</sup> However, a definite conclusion will probably be available only after additional case law is decided or upon enactment of any federal legislation.

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<sup>100</sup>See *Pegram* at 2154.

<sup>101</sup>See Susan L. Burke, *Suing HMOs: State Your Case*, LEGAL TIMES, July 31, 2000, at 60.

<sup>102</sup>*Pegram* at 2158.