

NOTE

RESTRICTING THE CORPORATE PRACTICE OF MEDICINE: SUBVERTING ERISA TO HOLD MANAGED CARE ORGANIZATIONS ACCOUNTABLE FOR HEALTH CARE TREATMENT DECISIONS—THE TEXAS INITIATIVE

*Dear Mrs. Black: On seven prior occasions this company has denied your claim in writing. We now deny it for the eighth and final time. You must be stupid, stupid, stupid!*¹

I. INTRODUCTION

Traditionally, physicians with absolute autonomy to make decisions concerning patient treatment provided medical care in the United States.² As the cost of medical treatment skyrocketed,³ however, it became a

¹JOHN GRISHAM, *THE RAINMAKER* 23 (1997). This quote, while admittedly fictitious, reflects the attitudes of some corporate entities responsible for the delivery of health care in the United States.

²See Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 394 (1994) (providing an historical survey of medical care in the United States, with the authors asserting that "[i]t is only a slight exaggeration to say that the hospital functioned as a patient hotel and physician laboratory, exercising little control over the manner in which individual physicians practiced medicine."). In this system, known as the fee-for-service model, "the patient chooses [his or her] own physician. . . . The health insurance carrier . . . does not employ the physician," and the insurance carrier is responsible for the payment of the physician's services on an indemnity or fee-for-service basis. Diana Joseph Bearden & Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 BAYLOR L. REV. 285, 288-90 (1995). See generally Brian P. Battaglia, *The Shift Towards Managed Care and Emerging Liability Claims Arising From Utilization Management and Financial Incentive Arrangements Between Health Care Providers and Payers*, 19 U. ARK. LITTLE ROCK L.J. 155, 157-68 (1997) (detailing historical development of traditional health care). Under the fee-for-service system, medical costs are exorbitant because there are no limitations on the amount of care physicians prescribe for their patients. For example, under the "pinball theory of reimbursement," the primary physician within an office practice refers the patient to other physicians within the practice in order to inflate the medical bill. Interview with Barry R. Furrow, Director, Health Law Institute, Widener University School of Law, in Wilmington, Delaware (Oct. 9, 1997).

³See BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS, AND PROBLEMS* 718 (3d ed. 1997) (stating that, in 1993, Americans spent \$761 billion dollars on medical care). Estimates in 1995 increased average spending to \$3,690 per man, woman, and child, and represented over 14% of the gross domestic product. *Id.* In addition, General Motors reported

national imperative to generate cost-containment initiatives.⁴ This led directly to an increase in managed care organizations (MCOs).⁵ The establishment of these corporations has led to the "transformation of health care from a purely professional undertaking to a business enterprise providing professional services."⁶

As with any corporate enterprise, most MCOs are profit-oriented.⁷ MCOs attain profits by obligating participating physicians to surrender their autonomy.⁸ Thus, MCOs require physicians to be "more sensitive to

in 1990 that it spent more on the health care of its employees than it spent on steel to make all of its cars and trucks. Christine Gorman, *Playing the HMO Game*, TIME, July 13, 1998, at 26.

⁴Battaglia, *supra* note 2, at 166-67.

⁵See Clifford A. Cantor, *Fiduciary Liability in Emerging Health Care*, 9 DEPAUL BUS. L.J. 189, 189 (1997). "Managed care" is a term used to describe organizations that provide "methods for controlling costs while attempting [to control the utilization of health care services using] closed panels of providers who agree to reduced charges, utilization [review], required use of primary care physicians, . . . and quality assurance." *Id.* at 205. There are several different types of managed care organizations. See Steven R. Buchholz, *Health Maintenance Organization's Gatekeeper: Opening the Gate to Liability Through the Ostensible Agency Theory*, 21 W. ST. U.L. REV. 241, 242 (1993) (describing a health maintenance organization (HMO) as "a legal entity through which . . . health care professionals agree to deliver comprehensive health care services to a defined, voluntarily enrolled membership" for a fixed prepaid amount (quoting Earlene P. Weiner, *Managed Health Care: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine*, 15 J. CORP. L. 535 (1990))). See also FURROW ET AL., *supra* note 3, at 802 (describing a preferred provider organization (PPO) as an "organized system of health care providers that agrees to provide services on a negotiated discounted basis to subscribers"). PPO's differ from HMO's in that they "are not limited to plan providers . . . but face financial disincentives . . . if they choose non-preferred providers." *Id.* The number of Americans enrolled in HMO's rose from 36.5 million in 1990 to 58.2 million in 1995. Jon Gabel, *Ten Ways HMOs Have Changed During the 1990s*, 16 HEALTH AFF. 134, 134 (1997) (citing Group Health Association of America, *Patterns in HMO Enrollment* (Washington: GHAA, June 1994); American Association of Health Plans, *Managed Health Care Overview* (Washington: AAHP, 1996)).

⁶Abraham & Weiler, *supra* note 2, at 396. See also Mark A. Hall & Justin G. Vaughn, *The Corporate Practice of Medicine*, in HEALTH CARE CORPORATE LAW 3-3, 3-4 (Mark A. Hall ed., 1993) (stating that "[c]orporate practice occurs when administrators hire doctors or when payment . . . flows from the patient to the corporation before it goes to the doctor rather than in a one-to-one payment relationship between doctor and patient"). In Texas alone, there are forty-four corporate entities licensed to provide full-range health care services, and eight more who have applied for such licenses. Mary Flood, *HMO Rules Haven't Led to Many Suits*, WALL ST. J., Oct. 1, 1997, at T1.

⁷Gabel, *supra* note 5, at 135. The author notes that in 1997, the majority of HMO plan participants (58%) were enrolled in for-profit organizations. *Id.* He attributes the growth in for-profits over nonprofits to three major factors: (1) aggressiveness in seeking growth, (2) greater access to capital, and (3) reliance on the Individual Practice Association (IPA) or network models of organization rather than staff or group models requiring greater capital expenditures. *Id.* at 135-36.

⁸Jason Mark, *HMO Liability: Medical Decisions Made in the Corporate Boardroom*, MASS. LAW. WKLY., June 30, 1997, at B25 (finding that "the HMO usurps the physician's clinical decision-making responsibilities, deciding when and to what extent treatment will be authorized,

cost-containment concerns . . . restrict[] physician discretion [and place] limits on the levels of reimbursement for certain treatment [services]."⁹ MCOs generally monitor cost containment through the use of utilization review.¹⁰ Utilization review is a case-by-case analysis that evaluates the necessity and propriety of prescribed medical treatment.¹¹ The main purpose of utilization review is "to promote the well recognized public interest in controlling health care costs by reducing unnecessary services while still intending to assure that appropriate medical and hospital services are provided to the patient in need."¹²

Through utilization review, the MCO retains full authority to make treatment decisions for plan beneficiaries.¹³ As a consequence of the Employee Retirement Income Security Act of 1974 (ERISA),¹⁴ however,

while the physician spends the majority of his or her time generating massive paperwork to try and obtain the needed approval"). MCOs contract directly with physicians and through that contract specify the amount and type of compensation that the physician will receive for medical services. Battaglia, *supra* note 2, at 176-77 (citing *Blue Cross & Blue Shield United v. Marshfield Clinic & Sec. Health Plan, Inc.*, 65 F.3d 1406, 1409 (7th Cir. 1995)). One of the most popular forms of physician reimbursement is capitation, which provides a specific physician prepayment for a stated time period. *Id.* at 177. The physician receives the same amount of payment regardless of the number of patient visits. *Id.* Capitation plans may also withhold some percentage of the total physician payment for later distribution, if performance goals (such as low number of referrals to specialists), are met. *Id.* These arrangements create an incentive for the physician to minimize patient services. See Andre Hampton, *Resurrection of the Prohibition on the Corporate Practice of Medicine: Teaching Old Dogma New Tricks*, 66 U. CIN. L. REV. 489, 509-10 (1998) (stating that in the financial incentive system, "the physician's fiduciary duty to the patient may be antagonistic to the physician's financial interests because referring the patient for specialized services has a financial consequence for the physician").

⁹See Abraham & Weiler, *supra* note 2, at 396. See also Barry R. Furrow, *Managed Care Organizations and Patient Injury: Rethinking Liability*, 31 GA. L. REV. 419, 465 (1997) (stating that MCOs have been criticized as creating incentives for physicians to lower costs through under treatment).

¹⁰FURROW ET AL., *supra* note 3, at 795.

¹¹*Id.* Utilization review is usually initiated by hospitals, doctors, or plan participants who want assurance that payment is secure. *Id.* at 796. There are two types of utilization review: (1) retrospective, whereby payment is denied for treatment that is already received by the plan participant, or (2) concurrent review, such as preadmission review, continued stay review, preprocedure review, or second opinion requirements. *Id.* at 795. This monitoring device has become universal; as of 1995, 96% of all plans were subject to utilization review. *Id.*

¹²Wickline v. State, 239 Cal. Rptr. 810, 811 (Cal. Ct. App. 1986).

¹³Cantor, *supra* note 5, at 208. Physicians adamantly oppose the use of utilization review, particularly concurrent review, because it interferes with their ability to make proper treatment decisions. Mary R. Kohler, *When the Whole Exceeds the Sum of Its Parts: Why Existing Utilization Management Practices Don't Measure Up*, 53 U. PITT. L. REV. 1061, 1077 (1992).

¹⁴29 U.S.C. §§ 1101-1461(a) (1994). Under this federal statute, state common law tort actions against health insurers who provide employee benefit plans are preempted. 29 U.S.C. § 1144(a) (1997).

MCOs engaged in this corporate practice of medicine have not been held accountable for poor treatment decisions.¹⁵

As a result, courts and some state legislatures are attempting to hold MCOs accountable for their substandard treatment decisions.¹⁶ For example, in May 1997, Texas became the first state¹⁷ to pass a law, the Texas Health Care Liability Act,¹⁸ that allows consumers to sue MCOs for negligence by its doctors, and for administrative decisions that affect the quality of the provided medical care. Nevertheless, ERISA will be an ever

¹⁵See *Kuhl v. Lincoln Nat'l Health Plan*, 999 F.2d 298, 303 (8th Cir. 1993) (holding that a wrongful death suit was preempted by ERISA); *Butler v. Wu*, 853 F. Supp. 125, 129-30 (D.N.J. 1994) (finding plaintiff's claims against HMO based on vicarious liability were preempted by ERISA); *Ricci v. Goberman*, 840 F. Supp. 316, 318 (D.N.J. 1993) (finding claim of vicarious liability preempted under ERISA).

There is currently considerable debate as to whether ERISA should be amended to allow plan participants to sue MCOs when treatment is deficient, denied, or delayed. Karen Tumulty, *Let's Play Doctor*, TIME, July 13, 1998, at 29. Several Democratic members of Congress have introduced a bill that supports this provision. See H.R. 3605, 105th Cong. (1998) (removing preemption of state law claims for personal injury or wrongful death attributed to decisions of plan providers and administrators). Senator Edward M. Kennedy (D. Mass.), who has signed on as a sponsor of the bill, stated that "[t]oo many managed care plans and other insurance companies have decided that the best route to higher profits is by denying patients the health care they need." Alissa J. Rubin, *Spurred by Public's Complaints, Congress Offers Managed-Care Cures Medicine*, L.A. TIMES, Oct. 22, 1997, at A6. While Democrats firmly assert that patients should be allowed to sue their health plans, the Republican Congress has proposed that plan participants seek an independent review process when treatment is denied rather than having an option to seek legal remedy against the MCO. Gorman, *supra* note 3, at 28-29.

¹⁶See *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182, 187 (E.D. Pa. 1994) (finding that ERISA does not preempt a vicarious liability claim); *Elsesser v. Hospital of the Phila. College of Osteopathic Med.*, 802 F. Supp. 1286, 1290 (E.D. Pa. 1992) (holding that under a theory of vicarious liability, ERISA does not preempt a claim against an HMO for its negligence in retaining, selecting, or evaluating the plaintiff's primary care physician); *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983, 988 (E.D. Pa. 1990) (holding that ERISA does not preempt claims against HMOs under the "ostensible agency" theory).

Several states have proposed legislation that would hold MCOs liable for patient injuries resulting from poor treatment decisions. See, e.g., S.B. 5314, 220th Leg., Annual Leg. Sess. sec. 2 (N.Y. 1997) (stating that organizations providing health care services may be liable for any injury resulting from delay or failure to approve, provide or pay for health care services that they are contractually obligated to provide in a timely manner). Similar statutes are being contemplated in Arizona, California, Connecticut, Florida, Maryland, Missouri, New Jersey, Rhode Island, Tennessee, and Virginia. David Schultz & Tracey Galinson, *Suits Against Managed Care Providers May Elude ERISA*, NAT'L L.J., July 6, 1998, at B19.

¹⁷Angela M. Easley, *A Call to Congress to Amend ERISA Preemption of HMO Medical Malpractice Claims: The Dissatisfactory Distinction Between Quality and Quantity of Care*, 20 CAMPBELL L. REV. 293, 317 (1998).

¹⁸S.B. 386, 75th Leg., Reg. Sess. (Tex. 1997).

present roadblock to these efforts unless legislatures carefully draft the statutes that attempt to hold MCOs accountable.¹⁹

This note scrutinizes the Texas law, arguing that its textual construction permits application under the common law exceptions to ERISA preemption, thereby allowing state tort claims against MCOs. Part II will discuss the various theories of liability that have been litigated against MCOs. Part III will examine ERISA as it relates to health insurance benefits, as well as the various exemptions that courts have carved out for medical malpractice claims against MCOs. Part IV will analyze the textual language of the Texas law, particularly in its capacity to qualify as an ERISA exemption, and will identify some of the potential shortcomings of the statute.

II. MANAGED CARE ORGANIZATIONS AND LIABILITY

Generally, ERISA does not preempt claims unless they flow from "employee benefit plans."²⁰ Plans that do not fall within this definition include insurance plans that are offered to the employees when:

- (1) [n]o contributions are made by an employer . . . ;
- (2) [p]articipation [in] the program is completely voluntary for the employees or members;
- (3) [t]he sole function[] of the employer . . . with respect to the program [is] . . . to permit the insurer to publicize the program to employees or members [and] to collect premiums through payroll deductions . . . ; and
- (4) [t]he employer . . . receives no consideration in the form of cash . . . in connection with the [plan, except for administrative fees].²¹

¹⁹*Aetna Sues to Block Texas HMO Malpractice Law*, BEST'S INS. NEWS, June 20, 1997 (available in 1997 WL 7078121). During debate on the proposed bill, lawmakers in Texas noted that even with specially crafted language, HMOs may still be successful in removing cases to federal court. *Id.*

²⁰See *infra* text Part III.A and accompanying notes 92-95 (describing employee benefit plans). Three types of "employee benefit plans" are covered by ERISA: welfare benefits, pension benefits, and plans that represent a combination of the two. *Garnatt v. Walker*, 121 F.3d 565, 569 (10th Cir. 1997). Employee welfare benefit plans include programs which promote an increase in the quality of life by providing "health and life insurance, disability and unemployment benefits, . . . prepaid legal services," etc. Frank J. Spanitz, *Inter-Modal Rail: Will ERISA's Newly Defined Welfare Benefit Noninterference Clause Curb Outsourcing?*, 23 DEL. J. CORP. L. 589, 592 (1998). "The hallmark of an ERISA benefit plan is that it requires an ongoing administrative program to meet the employer's obligation." *Id.* at 592 n.24 (quoting *Shahid v. Ford Motor Co.*, 76 F.3d 1404, 1409 (6th Cir. 1996)).

²¹29 C.F.R. § 2510.3-1(j)(1)-(4) (1997).

Certain government-sponsored plans, uninsured motorist policies, self-insured policies, and worker's compensation policies are also excluded from "employee benefit plans."²² Thus, plaintiffs who fall into this narrow category may succeed in their claims against MCOs because they are not subject to ERISA preemption.

Some theories of liability traditionally asserted against hospitals for the malpractice of its physicians may now be extended to cover MCOs despite ERISA.²³ Historically, hospitals were not targets in malpractice suits because "the relationship of [the] doctor to [the] hospital was one of [an] independent contractor rather than [an] employee."²⁴ As the relationship between doctors and hospitals evolved into that of an agency relationship,²⁵ however, patients and their attorneys, in search of deeper pockets, have asserted various theories of liability against hospitals.²⁶ These theories may also be applied to MCOs who fail to provide adequate care.

A. *Vicarious Liability: Ostensible Agency Theory*

HMOs have been held vicariously liable for their physicians' negligence under several traditional legal theories including: nondelegable duty by statute, nondelegable duty by contract, agency, joint venture, and ostensible agency.²⁷ Courts have recognized the theory of "ostensible

²²FURROW ET AL., *supra* note 3, at 813. Moreover, about 70% of all HMO plans are considered "employee benefit plans, and are thus preempted by ERISA, leaving only a small percentage of providers that do not present this enormous obstacle. See Michael Jonathan Grinfeld, *Tilting at HMOs*, 17 Cal. Law. 46, 48 (1997).

²³See Bearden & Maedgen, *supra* note 2, at 298 (discussing theories of liability that may be asserted against HMOs).

²⁴See FURROW ET AL., *supra* note 3, at 237 (discussing generally the liability of health care institutions).

²⁵See *infra* Part II.A.

²⁶See, e.g., *Schlotfeldt v. Charter Hosp.*, 910 P.2d 271, 274 (Nev. 1996) (bringing suit under a theory of vicarious liability); *Darling v. Charleston Community Mem'l Hosp.*, 211 N.E.2d 253, 256 (Ill. 1965) (suing under a theory of corporate negligence for the defendant's failure to properly review the physician's work).

²⁷Charles H. Baumberger, *Vicarious Liability Claims Against HMOs*, TRIAL, May 1998, at 30. Many state statutes prohibit employers from delegating their duties and therefore their liability to independent contractors. As such, the employers (e.g., hospitals) have nondelegable duties by statute. See, e.g., *Jackson v. Power*, 743 P.2d 1376, 1385 (Alaska 1987). This theory has rarely been invoked and, therefore, receives no further mention.

Another rarely used theory is that of nondelegable duty by contract. Under this theory, a hospital or HMO assumes a duty under contract (e.g., from HMO to hospital or from corporate client to HMO) which it then contracts with others (e.g., physicians) to supply. But one who formulates such a contract is vicariously liable for the negligence of its independent contractors who carry out those duties. This theory was argued successfully in *Jenkins v.*

agency" as arising under two separate legal theories.²⁸ The first theory is derived from the Restatement (Second) of Torts, section 429, which states: "[O]ne who employs an independent contractor to perform services for another which are accepted in the *reasonable belief* that the services are being rendered by the employer or by his servants, is subject to liability for physical harm caused by the negligence of the contractor in supplying such services."²⁹ The second theory is often referred to as agency by estoppel,³⁰ and is based on Restatement (Second) of Agency, section 267 which states:

One who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.³¹

While these two theories are distinct, they are often confused, misapplied, or treated as synonymous.³²

Both theories were used successfully in *Boyd v. Albert Einstein Medical Center*.³³ In *Boyd*, the plaintiff brought suit against his HMO after

Charleston Gen. Hosp. & Training Sch., 110 S.E. 560, 561 (W. Va. 1922) (stating that "[a] man cannot avoid his contract by devolving performance thereof upon a stranger").

Under a joint venture theory, the HMO provides the patients and the physicians provide the care. There is joint control over patient services, with a joint share in the profits and losses. If the patient is healthy, they share profits; if the patient becomes seriously ill, they may share losses. Baumberger, *supra*, at 31-32.

²⁸See *Sword v. NKC Hosps., Inc.*, 661 N.E.2d 10, 12 (Ind. Ct. App. 1996) (describing the two theories of ostensible agency).

²⁹RESTATEMENT (SECOND) OF TORTS § 429 (1986) (emphasis added).

³⁰*Sword*, 661 N.E.2d at 12.

³¹RESTATEMENT (SECOND) OF AGENCY § 267 (1984). The torts theory is seen as a somewhat "looser standard" than the agency theory because it only requires a reasonable belief rather than actual reliance. Baumberger, *supra* note 27, at 35 n.17.

³²*Sword*, 661 N.E.2d at 12. See also *Bearden & Maedgen*, *supra* note 2, at 310 (describing theories of managed care liability).

³³547 A.2d 1229 (Pa. Super. Ct. 1988). See also *Schleier v. Kaiser Found. Health Plan*, 876 F.2d 174, 177 (D.C. Cir. 1989) (holding that the HMO was vicariously liable for the negligence of a consulting physician even though that physician was not an HMO participant); *McClellan v. Health Maintenance Org.*, 604 A.2d 1053, 1058 (Pa. Super. Ct. 1992) (holding that the plaintiff stated a cause of action for liability based on ostensible agency where the physician was held out as an agent of the HMO). But see *Raglin v. HMO Ill., Inc.*, 595 N.E.2d 153, 157-58 (Ill. App. Ct. 1992) (stating that there was no reliance on the part of the plaintiff, nor did the HMO hold itself out as exerting control over its physicians; thus there was no ostensible agency relationship); *Chase v. Independent Practice Ass'n, Inc.*, 583 N.E.2d 251, 255 (Mass. App. Ct. 1991) (holding the ostensible agency theory inapplicable because there was no showing of

his wife died while under the care of her primary care physician.³⁴ The decedent went to her primary care physician in June of 1982, with a lump in her breast.³⁵ The physician performed a breast biopsy.³⁶ As a result of complications, however, the decedent saw her primary care physician again on August 19, 1982, in the emergency room of Albert Einstein Hospital.³⁷ The physician examined her, ordered tests to be performed in his office, and sent her home.³⁸ Later that afternoon, Mrs. Boyd died of a heart attack.³⁹ The plaintiff averred that the HMO was "negligent in failing to qualify or oversee its physicians and hospital who acted as its agents, servants, or employees in providing medical care to the decedent."⁴⁰ The plaintiff further asserted that the HMO "advertised that its physicians and medical care providers were competent, [and] that [the] decedent . . . relied on these representations in choosing their primary care physicians."⁴¹

In concluding that the HMO could be held liable under the ostensible agency theory, the Pennsylvania Superior Court applied two factors to determine whether an agency relationship exists between a hospital and an independent contracting physician:⁴² "(1) whether the patient looks to the institution, rather than the individual physician for care, and (2) whether the HMO 'holds out' the physician as its employee."⁴³ The court stated that "a holding out occurs 'when the hospital acts or omits to act in some way which leads the patient to a *reasonable* belief he is being treated by the hospital or one of its employees.'"⁴⁴ By analogy, the court noted that although the ostensible agency theory has generally been applied only to hospitals, the rationale applies equally to HMOs.⁴⁵ The court viewed the role of the primary care physician as the "gatekeeper into the health care delivery system,"⁴⁶ preventing the decedent from seeing a specialist

detrimental reliance by the plaintiff).

³⁴*Boyd*, 547 A.2d at 1230. The plaintiff's wife became eligible for participation through his employer. *Id.*

³⁵*Id.*

³⁶*Id.*

³⁷*Id.*

³⁸*Boyd*, 547 A.2d at 1230.

³⁹*Id.*

⁴⁰*Id.* at 1231.

⁴¹*Id.*

⁴²*Boyd*, 547 A.2d at 1234.

⁴³*Id.*

⁴⁴*Id.* at 1232 (quoting *Capan v. Divine Providence Hosp.*, 430 A.2d 647, 649 (Pa. Super. Ct. 1980)).

⁴⁵*Id.* at 1234.

⁴⁶*Boyd*, 547 A.2d at 1233.

directly.⁴⁷ The court found an agency relationship created by inference that "the decedent looked to the institution for care and not solely to the physicians."⁴⁸ The court sustained the existence of an issue of material fact as to the liability of the HMO.⁴⁹

Based on *Boyd*, it appears that to succeed on a carefully drafted claim of ostensible agency, the plaintiff must show: (1) that the HMO held itself out in such a way as to demonstrate control over the physician, and (2) that the plaintiff relied to her detriment on this representation.⁵⁰

B. Corporate Negligence

The doctrine of corporate negligence provides an alternative basis for holding HMOs accountable for failing to provide adequate care. This doctrine reflects the concept that the health care organization has a duty to its patients to ensure the "competency of its medical staff and the quality of medical care provided through the prudent selection, review, and continuing evaluation of the physicians granted staff privileges."⁵¹ This theory has been employed to hold hospitals accountable for the malpractice of practicing physicians within the hospital.⁵² Analogously, in order to succeed in a claim against a MCO under this theory, a plaintiff must show that the MCO breached an "independent, nondelegable duty . . . to exercise reasonable care" in the proper selection and retention of medical staff, and supervision of treatment plans.⁵³ This doctrine had its origin in the idea that hospitals have a responsibility to control the quality of care provided

⁴⁷*Id.* at 1235. The gatekeeper's role in this system is to "triage medical needs and to determine whether and how much treatment is necessary and by whom." Cantor, *supra* note 5, at 206; Gorman, *supra* note 3, at 26 (stating that it is the gatekeeper's responsibility to "question the necessity of nearly every medical procedure or referral"). See also Mark, *supra* note 8, at B25, stating:

In a managed care model, the treatment a patient receives may be influenced by the policies and procedures of the managed care plan. Here, the doctor-patient relationship invites physician "gatekeepers," administrators of provider networks, utilization review personnel, and health plan staff to all play the role of doctor in determining what is and what is not "medically necessary" for patients.

⁴⁸*Boyd*, 547 A.2d at 1235.

⁴⁹*Id.*

⁵⁰See Bearden & Maedgen, *supra* note 2, at 316 (stating that in order for HMOs to successfully evade ostensible agency claims, they "should scrutinize their promotional materials and advertising brochures to avoid such 'holding out' and representations from which one might reasonably conclude that the physicians within the system are HMO employees or agents").

⁵¹*Elam v. College Park Hosp.*, 183 Cal. Rptr. 156, 164 (Cal. Ct. App. 1982).

⁵²Bearden & Maedgen, *supra* note 2, at 321.

⁵³*Id.*

by their medical staffs.⁵⁴ Current jurisprudence permits plaintiffs to assert a claim under the doctrine of corporate negligence, including claims for improper utilization management, and inappropriate selection/supervision of medical staff.⁵⁵

1. Utilization Management⁵⁶

The seminal case that attempted to bind a third party payer to a malpractice claim was *Wickline v. State*.⁵⁷ Lois Wickline (Wickline), began to see Dr. Daniels, a family practitioner, for "problems associated with her back and legs."⁵⁸ Dr. Daniels referred Wickline to Dr. Polonsky, a peripheral vascular specialist, who determined that surgery was necessary to relieve an obstruction in her terminal aorta.⁵⁹ Dr. Polonsky successfully performed surgery in January 1977; Wickline's recovery, however, was problematic.⁶⁰ Nine days later, when Wickline was scheduled to be discharged from the hospital, Dr. Polonsky determined that it was "medically necessary that Wickline remain in the hospital for an additional eight days."⁶¹ Dr. Polonsky requested that the appropriate form, called a "Request for Extension of Stay in Hospital," be filed with Medi-Cal.⁶² The form was reviewed by a Medi-Cal consultant, Dr. Glassman, who did not at any time see Wickline or consult with a peripheral vascular specialist.⁶³

⁵⁴See Michael Kanute, *Evolving Theories of Malpractice Liability for HMOs*, 20 LOY. U. CHI. L.J. 841, 861 (1989).

⁵⁵See *Wickline v. State*, 239 Cal. Rptr. 810, 811 (Cal. Ct. App. 1986) (alleging that the defendant negligently discontinued her Medi-Cal eligibility); *Harrell v. Total Health Care, Inc.*, 781 S.W.2d 58, 59-60 (Mo. 1989) (asserting that defendant HMO was negligent in the selection of the specialist who performed plaintiff's surgery).

⁵⁶See *supra* note 11 (describing utilization management/review).

⁵⁷239 Cal. Rptr. 810, 810 (Cal. Ct. App. 1986).

⁵⁸*Id.* at 812. Wickline was eligible for California's medical assistance program (Medi-Cal). *Id.*

⁵⁹*Id.* When Dr. Daniels' prescribed physical therapy program failed to alleviate Wickline's symptoms, he referred her to a surgical specialist dealing with all vessels of the body excluding the heart. *Id.*

⁶⁰*Id.* In fact, she needed further surgery on that same day for a de-clotting, and again on January 12 for a lumbar sympathectomy. *Id.*

⁶¹*Wickline*, 239 Cal. Rptr. at 813.

⁶²*Id.* The treating physician provides the hospital's representative, who has the responsibility for filling out the Form 180, with the patient's diagnosis, history, clinical status, and planned course of treatment. *Id.* This information is then provided to the Medi-Cal "onsite nurse" or consultant, who may only approve such request if furnished timely, completely, and with indication of the medical necessity for the treatment. *Id.* This type of pre-approval constitutes a concurrent utilization review. See *supra* note 11.

⁶³*Wickline*, 239 Cal. Rptr. at 815.

Dr. Glassman approved only four of the eight days sought by Dr. Polonsky.⁶⁴ Subsequently, Wickline was discharged, but continued to suffer from difficulties, including excruciating pain and grayish discolorment.⁶⁵ Wickline was readmitted to the hospital nine days later, by which time she had developed clotting in her right leg, impaired circulation, and a complicating infection at the graft site.⁶⁶ It therefore became necessary to amputate Wickline's leg.⁶⁷ Dr. Polonsky concluded "to a reasonable medical certainty" that, had Wickline remained in the hospital for the additional eight days, her condition would have been detected and the amputation would *not* have been necessary.⁶⁸

Wickline brought suit against the State of California (Medi-Cal) claiming that the denial of the additional four days requested by her physician resulted in the amputation of her leg.⁶⁹ The California Court of Appeals stated that "[w]hile we recognize, realistically, that cost consciousness has become a permanent feature of the health care system, it is essential that cost limitation programs not be permitted to corrupt medical judgment."⁷⁰ The court held that "[t]hird party payers of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms as, for example, when appeals made on a patient's behalf for medical . . . care are arbitrarily ignored or unreasonably disregarded or overridden."⁷¹ Nevertheless, the court found no liability on the part of the defendant, because Wickline's care was Dr. Polonsky's ultimate responsibility.⁷²

While *Wickline* was the first case to specifically hold that third party payers may be held liable for their cost-containment decisions, subsequent

⁶⁴*Id.* at 814.

⁶⁵*Id.* at 816.

⁶⁶*Id.*

⁶⁷*Wickline*, 239 Cal. Rptr. at 816-17.

⁶⁸*Id.* at 817.

⁶⁹*Id.* at 811.

⁷⁰*Id.* at 820.

⁷¹*Wickline*, 239 Cal. Rptr. at 819.

⁷²*Id.* at 819-20. Under applicable case law and statutory construction, the court absolved Medi-Cal from liability as a matter of law. *Id.* at 818. In addition, while the court conceded that third party payers can be held legally accountable under some circumstances, the physician in this case must shoulder the responsibility. *Id.* at 819. As the court stated, "[T]he physician who complies without protest with the limitations imposed by a third party . . ., when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care." *Id.* The court was convinced that Dr. Polonsky should have taken more affirmative steps to extend Wickline's hospital stay. *Id.*

case law indicates that external utilization review bodies may be held liable for denial of care.⁷³

2. Negligent Selection/Supervision

A MCO's responsibility to its plan participants is analogous to that which a hospital owes to its patients in the proper selection of health care providers.⁷⁴ In fact, in the MCO setting this duty may be even greater because the patient has more control when choosing physicians in the traditional hospital setting.⁷⁵ In the managed care arena the control over physician selection belongs to the MCO.⁷⁶ Consequently, courts have reluctantly extended theories of corporate negligence against MCOs to include improper selection or supervision of its physicians.⁷⁷

In *Harrell v. Total Health Care*,⁷⁸ the plaintiff sought to impose liability on the HMO (Total), based on a claim of corporate negligence. Plaintiff alleged "that Total was negligent in the selection of the specialist who performed [her] surgery."⁷⁹ In March of 1983, Harrell was referred to specialist Dr. Witt because of complaints of urinary stress incontinence.⁸⁰ Dr. Witt, in a separate jury trial, was found to have negligently performed urological surgery on Harrell on March 23, 1983.⁸¹

⁷³See, e.g., *Wilson v. Blue Cross*, 271 Cal. Rptr. 876, 883 (Cal. Ct. App. 1990) (stating that there were sufficient material facts that the outside utilization reviewer's conduct, in directing that no further benefits be paid, was a substantial factor in decedent's death). The court distinguished this case from *Wickline* in that it involved claims directly against insurance companies and their agents, not against a physician. *Id.* at 884. A "substantial controversy" existed as to whether the insurance policy permitted utilization review and, as the court stated, "[N]o defendant has proven that such a reconsideration request would have been granted." *Id.* at 884-85.

⁷⁴Furrow, *supra* note 9, at 462.

⁷⁵*Id.*

⁷⁶*Id.* (arguing that the duty for an MCO is greater than the duty for the hospital because patients have no choice but to rely on the MCO for the selection of health care providers).

⁷⁷See *McClellan v. Health Maintenance Org.*, 604 A.2d 1053, 1059 (Pa. Super. Ct. 1992) (finding under a theory of "services rendered," pursuant to Restatement (Second) of Torts section 323, that it is appropriate to require an HMO to select and retain only competent physicians); *Elsesser v. Hospital of Phila. College of Osteopathic Med.*, 802 F. Supp. 1286, 1290 (E.D. Pa. 1992) (finding a valid cause of action based on the HMO's failure to exercise reasonable care in selecting and retaining the plaintiff's primary care physician).

⁷⁸781 S.W.2d 58 (Mo. 1989).

⁷⁹*Id.* at 59-60.

⁸⁰*Harrell v. Total Health Care, Inc.*, No. WD 39809, 1989 Mo. App. LEXIS 577, at *3 (Mo. Ct. App. Apr. 25, 1989), *aff'd*, 781 S.W.2d 58 (Mo. 1989).

⁸¹*Id.*

It was determined that Total Health Care provided a list of specialists for the use of its primary care physicians when making referrals.⁸² A three member committee conducted the review of new physicians by Total.⁸³ That committee's only mandate was to determine "if the applicant was licensed to practice medicine, that he had admitting privileges to hospitals and could dispense narcotics. No personal interview was conducted, no check was made of references listed, and no inquiry was made as to the applicant's standing in the medical community."⁸⁴ The Missouri Court of Appeals stated, "[U]nder the concept of corporate negligence, the duty owed is to refrain from any act which will cause foreseeable harm to others even though the nature of that harm and the identity of the harmed person is unknown at the time of the act."⁸⁵ It then concluded that the provider's failure to examine the credentials of professional applicants "gives rise to a foreseeable risk of unreasonable harm" thereby imposing a duty of care in the selection.⁸⁶

Ultimately, the appellate court found the HMO not liable under a state statute that shielded health service corporations from liability for its negligent acts or the negligent acts of its agents.⁸⁷ The Missouri Supreme Court, while recognizing the doctrine of corporate negligence, upheld the lower court's decision that the statute provided immunity from malpractice suits.⁸⁸ Nevertheless, despite the aforementioned cases finding MCOs liable on a number of different theories, plaintiffs who seek to hold MCOs accountable will frequently face a formidable obstacle in ERISA.

⁸²*Harrell*, 781 S.W.2d at 59. Total Health Care was under no obligation to pay for the services of any specialist that was not under contract with Total. *Id.*

⁸³*Harrell*, 1989 Mo. App. LEXIS 577, at *6.

⁸⁴*Id.* In fact, *Harrell* contended that, had an investigation been made, it would have revealed a number of medical malpractice claims against Dr. Witt. *Id.* at *7.

⁸⁵*Id.* at *10. The court noted that the doctrine of corporate negligence has a fairly wide range of recognition in other states. *Id.* It observed that though Missouri courts had not spoken on the issue, it predicted adoption in light of *Gridley v. Johnson*, 476 S.W.2d 475, 484 (Mo. 1972). *Harrell*, 1989 Mo. App. LEXIS 577, at *11.

⁸⁶*Harrell*, 1989 Mo. App. LEXIS 577, at *13.

⁸⁷*Id.* at *20.

⁸⁸*Harrell*, 781 S.W.2d at 60-61. In June 1997, the Missouri legislature passed a bill that repealed the legislation that provided immunity for improper care by HMOs. MO. REV. STAT. § 354.505(3) (Supp. 1997). The statute added HMOs to the definition of "health care provider," allowing tort actions against these corporate entities. *Id.* § 538.205(4). This type of action may allow for a different outcome in cases like *Harrell*. See also Edward S. Stevens, *He Who Laughs Last: Will Missouri's Attempt to Crack Down on Managed Care Entities Survive ERISA Preemption?*, 63 MO. L. REV. 411 (1998) (describing generally the Missouri law and its potential effect on HMOs).

III. ERISA

A. *The Meaning and Purpose of ERISA*

In 1974, Congress enacted the Employee Retirement Income Security Act (ERISA)⁸⁹ in response to the "inadequacy of current minimum standards for employee benefit plans."⁹⁰ An "employee welfare benefit plan" is defined as any fund "established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries . . . medical, surgical, or hospital care or benefits."⁹¹

The main purpose of ERISA is to "protect . . . the interests of participants in employee benefit plans and their beneficiaries."⁹² ERISA is designed to "establish[] standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, . . . by providing for appropriate remedies, sanctions, and ready access to the Federal courts."⁹³ As such, Congress intended for ERISA to establish employee benefit plan regulation entirely within the federal government's realm, thereby departing from the "exercise of state regulation power."⁹⁴ Federal regulation was necessary to assure uniform administration of employee welfare benefit plans by disassociating them from the various applicable state laws.⁹⁵ Thus, state regulation of claims that pertain to employee benefit plans are preempted broadly by ERISA.

ERISA enables plan participants to enforce the statute's provisions by bringing an action to recover benefits due under the terms of the plan, to enforce rights granted under the plan, or to clarify rights to future benefits.⁹⁶ In order to invoke ERISA, it must first be established that an "employee benefit plan" exists under the statutory language.⁹⁷ Generally, MCOs contract directly with an employer to provide health care benefits

⁸⁹29 U.S.C.A. §§ 1001-1461 (West 1985). Congress was concerned that: (1) many employees with long years of employment were losing retirement benefits, (2) there could be inadequate funds to pay promised benefits, and (3) beneficiaries have been deprived of anticipated benefits because of termination of plans before requisite funds have been accumulated. *Id.* § 1001.

⁹⁰*Id.* § 1001.

⁹¹29 U.S.C.A. § 1002(1) (West Supp. 1997).

⁹²U.S.C.A. § 1001(b) (West 1985).

⁹³*Id.*

⁹⁴*Malone v. White Motor Corp.*, 435 U.S. 497, 514 (1978). *See also* Furrow, *supra* note 9, at 494 (noting that ERISA has been highly successful with 75% of all MCOs ERISA-qualified; they are now the "leading source of payment for health services nationwide").

⁹⁵Furrow, *supra* note 9, at 494.

⁹⁶29 U.S.C.A. § 1132(a)(1)(B) (West 1985).

⁹⁷*Id.* § 1002(1)(A).

to employees; therefore these MCO plans usually fall within the purview of "employee benefit plans."⁹⁸ Once ERISA applies, the next question is whether the cause of action falls within the preemption clause of the statute. The preemption clause states that ERISA "supersede[s] any and all state laws insofar as they may now or hereafter *relate to* any employee benefit plan."⁹⁹ A savings clause, however, states in part that "except as provided in subparagraph (B), [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."¹⁰⁰ Finally, the deemer clause provides that a state law regulating insurance cannot "deem" an employee benefit plan to be an insurance plan if the plan is self-funded.¹⁰¹

ERISA preemption rests solely on the interpretation of the "relate to" language found in section 514. The United States Supreme Court addressed the meaning of the "relate to" language in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*¹⁰² In *Travelers*, the Court was faced with determining whether ERISA preempted "[a] New York statute that required hospitals to collect surcharges from patients covered by a commercial insurer, but not from patients insured by a Blue Cross/Blue Shield plan."¹⁰³ The Court stated that Congress intended for ERISA "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with

⁹⁸See Bearden & Maedgen, *supra* note 2, at 337 (discussing generally ERISA preemption).

⁹⁹29 U.S.C.A. § 1144(a) (West 1985)(emphasis added). See generally L. Frank Coan, Jr., *You Can't Get There From Here — Questioning the Erosion of ERISA Preemption in Medical Malpractice Actions Against HMOs*, 30 GA. L. REV. 1023, 1039 (1996) (stating that interpretation of this language is often difficult because "neither the statute nor the legislative history provides a definition of 'relate to,' [thus] creat[ing] an area of law fraught with uncertainty").

¹⁰⁰29 U.S.C. § 1144(b)(2)(A) (West 1985). But see *Psychiatric Inst. v. Connecticut Gen. Life Ins. Co.*, 780 F. Supp. 24, 28 (D.D.C. 1992) (finding "state law contract claims brought by plan participants and by health care providers that have rendered services to plan participants are preempted by ERISA because they 'relate to' employee benefit plans and are not based on state laws which regulate insurance" (citing *Thayer v. Group Hospitalization & Med. Servs., Inc.*, 674 F. Supp. 924, 925 (D.D.C. 1987))).

¹⁰¹29 U.S.C. § 1144(b)(2)(B) (West 1985). See *O'Reilly v. Ceuleers*, 912 F.2d 1383, 1389 (11th Cir. 1990) (finding that HMOs are not engaged in the "business of insurance" for the purposes of applying ERISA's preemption provision and therefore are governed by ERISA).

¹⁰²514 U.S. 645, 649 (1995). See also Coan, *supra* note 99, at 1039 (stressing the importance of the "relate to" clause).

¹⁰³*Travelers*, 514 U.S. at 649.

conflicting directives among States or between States and the Federal Government."¹⁰⁴

The Court further noted, "[N]othing 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."¹⁰⁵ The Court found that only those benefits that "relate to" the administration of a benefit plan fall within ERISA preemption, excluding those having an indirect economic influence on the plan.¹⁰⁶ The Court held that the provisions for the surcharge did not "relate to" employee benefit plans within the meaning of ERISA's preemption clause.¹⁰⁷ The decision in *Travelers* is seen as a shift from a broad interpretation of section 514 allowing preemption to a more narrow view that limits preemption.¹⁰⁸

While ERISA provides some valuable remedies to protect employee benefit plan participants, it also limits severely plan participants seeking to bring state tort claims against MCOs.¹⁰⁹

B. ERISA as a Defense to State Tort Actions

Corporate MCOs seeking to limit a plaintiff's ability to recover for malpractice claims against the MCO utilize ERISA as a shield to state tort claims. The ERISA defense, if successful, serves as a complete bar to all state claims, and provides a statutory right of removal to federal court.¹¹⁰ Once the claim has been removed to federal court, the amount of recovery is restricted substantially by ERISA.¹¹¹ In addition to the clause stating that plan participants can recover for benefits due under the plan,¹¹² ERISA has a catch-all clause providing recovery for "other appropriate equitable relief" as the court may deem necessary.¹¹³ This provision, however,

¹⁰⁴*Id.* at 656 (quoting *Ingersoll-Rand v. McClendon*, 498 U.S. 133 (1990)).

¹⁰⁵*Id.* at 661.

¹⁰⁶*Id.* at 662. See also Karen A. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Preemption*, 13 YALE J. ON REG. 255, 266-67 (1996) (stating that *Travelers* indicates that laws may "relate to" ERISA plans if they (1) expressly "reference" ERISA plans, (2) are a state common law cause of action within ERISA's civil enforcement provision, or (3) impermissibly affect employer or administrator decisions concerning ERISA plan benefit structure or administration).

¹⁰⁷*Travelers*, 514 U.S. at 649.

¹⁰⁸Coan, *supra* note 99, at 1039-40.

¹⁰⁹See Mark, *supra* note 8, at B25 (describing generally managed care malpractice and ERISA).

¹¹⁰29 U.S.C.A. § 1109 (West 1985).

¹¹¹*Id.* § 1132.

¹¹²*Id.* § 1132(a)(1)(B).

¹¹³*Id.* § 1132(a)(3)(B).

effectively precludes compensatory or punitive damages to compensate plan participants for personal injuries.¹¹⁴

This clause was upheld by the Supreme Court in *Massachusetts Mutual Life Insurance Co. v. Russell*.¹¹⁵ The Court held that an employee covered under her employer's welfare benefit plan could not recover compensatory or punitive damages for the mishandling of her disability benefits claim.¹¹⁶ These limitations on award damages make it imperative that plaintiffs who seek to hold MCOs accountable for their negligence fall within a common law exception to ERISA preemption.

Federal courts are split in their interpretation regarding preemption of malpractice claims against MCOs under ERISA.¹¹⁷ The issue plaguing the courts is "whether ERISA preempts a medical malpractice claim against an HMO employee benefits plan party or administrator by a beneficiary under an ostensible agency theory."¹¹⁸ To that end, some district courts have concluded that neither plan operators, administrators, nor HMOs are preempted from claims arising from vicarious liability for negligent treatment by a physician who is acting ostensibly as an agent of that HMO.¹¹⁹ Conversely, other jurisdictions have held that ERISA preempts vicarious liability suits where the liability claim is related to employee benefit plans.¹²⁰ Notwithstanding this disconnect, the prevailing trend among these district courts is the preemption of suits based on claims of

¹¹⁴Schultz & Galinson, *supra* note 16, at B9. This lack of adequate legal remedy is particularly problematic because a "managed care company has every financial incentive to deny or delay care — knowing full well that, even after years of litigation, the worst that can happen is that the plan will only have to pay for the services originally denied." *Texas Measure on Tort Liability for HMOs Faces ERISA Challenge*, DAILY REC., July 1, 1998, at 4B (quoting consumer advocate Ron Pollock's 1997 testimony before a Senate Subcommittee).

¹¹⁵473 U.S. 134, 138 (1985).

¹¹⁶*Id.*

¹¹⁷*See generally* Visconti v. U.S. Health Care, 857 F. Supp. 1097 (E.D. Pa. 1994) (holding that vicarious liability claim against HMO administering benefits plan for malpractice of participating physicians alleged to be ostensible agent is preempted); Nealy v. U.S. Healthcare HMO, 844 F. Supp. 966 (S.D.N.Y. 1994) (same); Ricci v. Goberman, 840 F. Supp. 316 (D.N.J. 1993) (same). *But see* Smith v. HMO Great Lakes, 852 F. Supp. 6669 (N.D. Ill. 1994) (holding that a vicarious liability claim against plan administrator for malpractice of participating physicians was not preempted).

¹¹⁸Kearney v. U.S. Healthcare, Inc., 859 F. Supp. 182, 185 (E.D. Pa. 1994).

¹¹⁹*See, e.g.,* Jackson v. Roseman, 878 F. Supp. 820, 826 (D. Md. 1995) (finding that vicarious liability claim not preempted); Elsesser v. Hospital of the Phila. College of Osteopathic Med., 802 F. Supp. 1286, 1290 (E.D. Pa. 1992) (finding that plaintiff's negligence claim against HMO to hold it vicariously liable for actions of a participating physician was not preempted by ERISA); Boyd v. Albert Einstein Med. Ctr., 547 A.2d 1229 (Pa. Super. Ct. 1988) (same).

¹²⁰*See, e.g.,* Pomeroy v. Johns Hopkins Med. Servs., Inc., 868 F. Supp. 110 (D. Md. 1994) (preempting claim based on vicarious liability); *accord* Butler v. Wu, 853 F. Supp. 125, 130 (D.N.J. 1994); Ricci v. Goberman, 840 F. Supp. 316, 318 (D.N.J. 1993).

direct corporate negligence, while permitting claims based on theories of vicarious liability and quality of care.¹²¹

1. Direct Corporate Negligence

In *Corcoran v. United Healthcare, Inc.*,¹²² the United States Court of Appeals for the Fifth Circuit held that ERISA preempted a tort action based on a theory of wrongful death against a third party utilization reviewer.¹²³ While employed at South Central Bell Telephone Company, Corcoran became pregnant.¹²⁴ In July 1989, her obstetrician recommended complete bed rest for the remainder of her pregnancy.¹²⁵ As Corcoran neared her delivery date, her obstetrician ordered her hospitalized so that the fetus could be monitored continuously.¹²⁶ At this time, all health plan participants were required to obtain "pre-certification" for overnight hospital admissions.¹²⁷ "Pre-certification" requests were reviewed by United Healthcare, a utilization review provider for health care plans.¹²⁸ Despite the obstetrician's recommendation, United determined that Corcoran's "hospitalization was not necessary, and instead authorized only

¹²¹See *Kearney*, 859 F. Supp at 185-86. Here the court held that a claim against an HMO for direct negligence was preempted, but when a plan operator or administrator rather than just arranging and paying for treatment elects directly to provide medical services or leads an enrollee reasonably to believe that it has, a vicarious liability claim for negligent treatment by a physician who is its agent or ostensible agency is not preempted.

Id. See also *Elsesser v. Hospital of Philadelphia College of Osteopathic Med.*, 802 F. Supp. 1286, 1290-91 (E.D. Pa. 1992) (holding that plaintiff's claims for direct negligence against an HMO for refusing to pay for use of a heart monitor were preempted because they clearly had a "connection with or reference to a benefit plan"; a claim based on a theory of vicarious liability or ostensible agency for failure to exercise reasonable care in selecting, retaining, and evaluating plaintiff's primary care physician, however, was not preempted). *But cf.* *Butler v. Wu*, 853 F. Supp. 125, 129 (D.N.J. 1994) (holding that a negligence claim against an HMO was preempted by ERISA because the claim related to a benefit plan whereby the HMO did not itself provide health services nor directly employ the physician).

¹²²965 F.2d 1321 (5th Cir. 1992).

¹²³*Id.* at 1339. See also *Kuhl v. Lincoln Nat'l Health Plan*, 999 F.2d 298, 303 (8th Cir. 1993) (holding that ERISA preempted a wrongful death action against an HMO that delayed pre-certification of heart surgery that led to the patient's death).

¹²⁴*Corcoran*, 965 F.2d at 1323.

¹²⁵*Id.* at 1322.

¹²⁶*Id.* at 1322-23.

¹²⁷*Id.* at 1323.

¹²⁸*Corcoran*, 965 F.2d at 1323.

ten hours per day of home nursing care."¹²⁹ Subsequently, the "fetus went into distress and died" during a time when no nurse was on duty.¹³⁰

The Corcorans filed a wrongful death suit in Louisiana state court alleging that the fetus died due to United's negligence in failing to approve the recommended hospital stay.¹³¹ The action was removed to federal court on the grounds that ERISA preempted it.¹³² The defendants then filed a motion for summary judgment, subsequently granted by the district court.¹³³ Though it stated that United made a medical decision, the Fifth Circuit found that these medical decisions were secondary to deciding what benefits were available under the plan.¹³⁴ Thus, the court stated that the decisions made by United "related to" the administration of the plan, and, therefore, were of the type Congress intended to be preempted under ERISA.¹³⁵

In contrast, the Pennsylvania Superior Court in *Pappas v. Asbel*¹³⁶ reversed a lower court decision, and held that ERISA did not preempt a claim of negligence against an HMO.¹³⁷ On May 20, 1990, Basile Pappas (Pappas), a United States Healthcare (USHC) subscriber, went to his primary care physician, Dr. Asbel, complaining of neck and shoulder pain.¹³⁸ Dr. Asbel gave Pappas an intramuscular injection of steroids and sent him home.¹³⁹ The next morning Pappas was "unable to walk, complaining of numbness in his arms, chest, abdomen, and legs," and was transported to Haverford Community Hospital in that condition at 11:00 a.m.¹⁴⁰ Pappas was subsequently diagnosed with an "epidural abscess which was compressing his spinal cord."¹⁴¹ This was deemed a "neurological emergency" by the attending doctor in the emergency room.¹⁴² The emergency room physician made arrangements within an

¹²⁹*Id.* at 1324.

¹³⁰*Id.*

¹³¹*Id.*

¹³²*Corcoran*, 965 F.2d at 1324-25.

¹³³*Id.* at 1325.

¹³⁴*Id.* at 1332.

¹³⁵*Id.* at 1332-33.

¹³⁶675 A.2d 711, 718 (Pa. Super. Ct.), *appeal granted*, 686 A.2d 1312 (Pa. 1996).

¹³⁷*Id.* at 716. The Pennsylvania Supreme Court heard arguments on this in April of 1997, and the outcome is expected to be precedent setting. *Aetna Sues to Block Texas HMO Malpractice Law*, *supra* note 19.

¹³⁸*Pappas*, 675 A.2d at 713.

¹³⁹*Id.*

¹⁴⁰*Id.*

¹⁴¹*Id.*

¹⁴²*Pappas*, 675 A.2d at 713.

hour to transfer Pappas to Thomas Jefferson University Hospital (TJUH) spinal cord trauma unit.¹⁴³ TJUH, however, was not an approved USHC facility, and authorization for Pappas' transfer was denied.¹⁴⁴ The USHC physician who made the decision to deny transfer refused to speak to the attending emergency room physician, despite being informed that Pappas' condition could worsen or become permanent.¹⁴⁵ Pappas was ultimately transferred to an approved facility at 3:30 p.m.¹⁴⁶ Because of the delay, Pappas suffered "permanent quadriplegia resulting from compression of his spine by the abscess."¹⁴⁷ Pappas brought suit against Asbel and Haverford "alleging negligence in causing an inordinate delay in transferring him to a[n appropriate] facility."¹⁴⁸ Haverford filed a third party complaint against USHC for its "refusal to authorize the transfer of . . . Pappas to the hospital selected by the Haverford physicians."¹⁴⁹

The superior court, in determining that ERISA did not preempt this case, interpreted broadly Congress' intent in adopting the Act.¹⁵⁰ The court stated that the purpose of ERISA was to "avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans."¹⁵¹ The court found that the negligence claim was not the type Congress intended to preempt,¹⁵² stating:

The type of recovery sought is based on negligence attributable to the delay occasioned by a cost containment protocol set by a for-profit organization, and which is aimed at conserving and increasing its profits, an intention diametrically opposed to ERISA's general purpose of protecting the rights of a plan's beneficiaries.¹⁵³

¹⁴³*Id.*

¹⁴⁴*Id.*

¹⁴⁵*Id.*

¹⁴⁶*Pappas*, 675 A.2d at 713.

¹⁴⁷*Id.*

¹⁴⁸*Id.*

¹⁴⁹*Id.* at 714.

¹⁵⁰*Pappas*, 675 A.2d at 718.

¹⁵¹*Id.* at 715 (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995)).

¹⁵²*Id.* at 716.

¹⁵³*Id.*

The court concluded that USHC's decision in refusing to transfer Pappas to TJUH was motivated by financial reasons, not the "protection of worker's rights," contrary to "the original focus of ERISA."¹⁵⁴

2. Vicarious Liability

While courts have traditionally been clear that ERISA preempts claims against HMOs based on direct corporate negligence, there has been much discord as to whether claims of vicarious liability should be permitted in state courts.¹⁵⁵ In *Schachter v. Pacificare*,¹⁵⁶ Barbara Davidson was admitted to St. John Medical Center in Tulsa, Oklahoma, with "an acute abdomen and a huge hematoma in her lower right abdominal wall."¹⁵⁷ Dr. Goen, Davidson's attending physician, informed her that she had internal bleeding.¹⁵⁸ Despite this alarming diagnosis, Dr. Goen discharged Davidson from the hospital.¹⁵⁹ That night, she bled to death.¹⁶⁰ The plaintiff, Davidson's daughter, alleged that Pacificare was "vicariously [liable] for the medical malpractice of its alleged ostensible agent, Dr. Goen."¹⁶¹ The district court declined to exercise supplemental jurisdiction over the vicarious liability claim, and sent the case back to state court holding that "the medical malpractice claim against the HMO does not sufficiently relate to the plan so as to warrant preemption."¹⁶²

The Tenth Circuit, reviewing the case on a writ of mandamus, concluded that "the district court correctly decided that ERISA does not preempt medical malpractice claim[s]" under the theory of vicarious liability.¹⁶³ The court noted that the claim did not involve the administration of benefits or the level or quality of benefits promised by the

¹⁵⁴*Pappas*, 675 A.2d at 716.

¹⁵⁵See *Jackson v. Roseman*, 878 F. Supp. 820, 826 (D. Md. 1995) (holding that ERISA does not preempt claims against an HMO based on a vicarious liability or ostensible agency theory); *accord* *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544, 548 (S.D. Ill. 1994); *Dearmas v. Av-Med, Inc.*, 865 F. Supp. 816, 818 (S.D. Fla. 1994); *Independence HMO Inc. v. Smith*, 733 F. Supp. 983, 988 (E.D. Pa. 1990). *But see* *Pomeroy v. Johns Hopkins Med. Servs., Inc.*, 868 F. Supp. 110, 113-14 (D. Md. 1994) (holding that ERISA preempts claims against HMOs that are based on vicarious liability); *accord* *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966, 972-73 (S.D.N.Y. 1994); *Ricci v. Goberman*, 840 F. Supp. 316, 318 (D.N.J. 1993).

¹⁵⁶923 F. Supp. 1448 (N.D. Okla. 1995).

¹⁵⁷*Id.* at 1450.

¹⁵⁸*Id.*

¹⁵⁹*Id.*

¹⁶⁰*Schachter*, 923 F. Supp. at 1450.

¹⁶¹*Id.*

¹⁶²*Pacificare v. Burrage*, 59 F.3d 151, 154 (10th Cir. 1995).

¹⁶³*Id.* at 153.

plan; rather the claim alleged negligence by the doctor and an agency relationship between the doctor and the HMO.¹⁶⁴ The court stated that "[j]ust as ERISA does not preempt the malpractice claim against the doctor, it should not preempt the vicarious liability claim against the HMO if the HMO has held out the doctor as its agent."¹⁶⁵

Therefore, the success of claims against MCOs will seemingly depend upon the specific type of claim made by the plaintiff, as well as interpretation of congressional intent by the federal courts. State legislative intent to hold MCOs accountable for malpractice, therefore, may also provide courts with much needed direction regarding these types of claims.

IV. THE TEXAS STATUTE¹⁶⁶

A. *The Plain Language*

In May 1997, the Texas legislature, responding to consumer anxiety over cost-containment mechanisms employed by corporate MCOs and the lack of legal remedy against MCOs for malpractice claims, passed a statute to allow consumers to sue MCOs for malpractice.¹⁶⁷ The statute provides

¹⁶⁴*Id.* at 155. See also *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 356 (3d Cir. 1995) (holding that a claim of vicarious liability is not a claim "to recover [plan] 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 as those phrases are used in section 502(a)(1)(B) of ERISA"). The court stated that the plaintiff's claim merely attacked the *quality* of benefits received, and did not allege that the plan erroneously withheld benefits; thus the claims fall outside of the scope of § 502(a)(1)(B) and the case must be remanded to state court. *Id.* at 357.

¹⁶⁵*Pacificare*, 59 F.3d at 155.

¹⁶⁶*Aetna, Inc.* has filed a lawsuit in federal court in an attempt to block the Texas statute from taking effect. The suit alleges that managed care plans are protected by ERISA since the federal law preempts all state laws in relation to employee benefit plans. *Aetna Sues to Block Texas HMO Malpractice Law*, *supra* note 19. In April 1998, a federal district judge heard argument on the *Aetna* suit. *Managed Care Monitor Texas: Judge Questions Aetna's HMO Liability Challenge*, AM. POL. NETWORK, Apr. 27, 1998, at 13. *Aetna* argued that MCOs do not practice medicine and, thus, should not be held accountable for treatment decisions that adversely affect patients. *Id.* In contrast, the lawyers arguing on behalf of the Texas statute stated that "HMOs practice medicine everyday," thus "making decisions based on the insurer's definition of medical necessity." *Id.* The judge hearing the case expressed "serious doubts" concerning *Aetna's* position, stating that in order for *Aetna* to prevail, it would have the burden of showing that there are no circumstances in which the statute could ever be applied. *Id.*

¹⁶⁷S.B. 386, 75th Leg., Reg. Sess. (Tex. 1997). State Senator David Shipley, R-Waco, a sponsor of the bill, stated that "[i]t's clear to me that some HMOs have been making medical decisions . . . without accountability." Darryl Van Duch, *HMO Liability Laws May Hit Roadblocks*, NAT'L L.J., at B1. Senator Shipley, a doctor-lawyer, further noted that "[HMOs] have been doing things to change the course of treatment, and if the outcome is bad, it's the doctor who gets sued. Meanwhile, the HMO says, 'tut-tut', and walks [away]." *Id.* Currently 4.2 million Texans rely on HMOs for their health care plans. See *Flood*, *supra* note 6, at T1.

in part: "A . . . health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making *health care treatment* decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care."¹⁶⁸ The statute goes on to state that the health maintenance organization is also liable for harm to an enrollee proximately caused by health care treatment decisions made by its: "1) employees, 2) agents, 3) ostensible agents, or 4) representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control which results in the failure to exercise ordinary care."¹⁶⁹

The language of the statute, as constructed, may allow common law tort claims to avoid ERISA preemption. Specifically, the statute attempts to hold MCOs accountable for health care treatment decisions falling below the standard of ordinary care.¹⁷⁰ Therefore, the key to a successful claim against an MCO under the statute lies within the definitions of "health care treatment decisions,"¹⁷¹ and "ordinary care."¹⁷²

The statute defines a "health care treatment decision" as a "determination made when medical services are *actually provided* by the health care plan and a decision which affects the *quality* of the diagnosis, care, or treatment provided to the plan's insureds or enrollees."¹⁷³ The United States Court of Appeals for the Third Circuit, in *Dukes v. U.S. Healthcare*,¹⁷⁴ addressed a claim based on the quality of benefits actually received by a plan participant.¹⁷⁵ Darryl Dukes visited his primary care physician for a variety of ailments.¹⁷⁶ The doctor determined that Dukes had a problem with his ear, and performed surgery on that ear a few days later.¹⁷⁷ The doctor also ordered blood tests.¹⁷⁸ When Dukes went to the

¹⁶⁸TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (West Supp. 1997) (emphasis added). The statute also mandates that plan participants exhaust administrative appeals procedures before bringing an action in state court. *Id.* § 88.003(a)(1).

¹⁶⁹*Id.* § 88.002(b). Texas previously shielded HMOs "from direct liability for physicians' medical negligence under the doctrine prohibiting the corporate practice of medicine." Bearden & Maedgen, *supra* note 2, at 307.

¹⁷⁰TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (West Supp. 1997).

¹⁷¹*Id.* § 88.001(5).

¹⁷²*Id.* § 88.001(10).

¹⁷³*Id.* § 88.001(5) (emphasis added).

¹⁷⁴57 F.3d 350 (3d Cir. 1995).

¹⁷⁵*Id.* at 351.

¹⁷⁶*Id.* at 352.

¹⁷⁷*Id.*

¹⁷⁸*Dukes*, 57 F.3d at 352.

Germantown Hospital and Medical Center to have the tests performed, however, the hospital refused to perform them.¹⁷⁹ The tests were eventually rendered by another hospital, although Dukes' condition deteriorated rapidly and he died.¹⁸⁰ It was later discovered that Dukes' blood sugar level was extraordinarily high, and that the tests, had they been performed in a timely manner, could have detected the condition.¹⁸¹

The decedent's wife brought suit in state court alleging that U.S. Healthcare was responsible for the physician's negligence as well as that of Germantown Hospital under an ostensible agency theory.¹⁸² The HMO removed the case to federal court.¹⁸³ The court held that removal to federal court under ERISA was improper¹⁸⁴ because, "[i]nstead of claiming that the welfare plans in any way withheld some quantum of plan benefits due, the plaintiffs . . . complain about the low *quality* of the medical treatment that they *actually* received."¹⁸⁵ The court further stated that:

[w]e find nothing in the legislative history suggesting that [section] 502 was intended as a part of a federal scheme to control the *quality* of benefits received by plan participants. Quality control of benefits . . . is a field traditionally occupied by state regulation and we interpret the silence of Congress as reflecting an intent that it remain such.¹⁸⁶

The language in the Texas statute bears a striking resemblance to the language of the Third Circuit in *Dukes*. Although the court's ruling in *Dukes* has no mandatory precedential authority in Texas, the similarity in language between the statute and the court's decision indicates a strong intent on the part of Texas legislators that claims arising from the "quality" of benefits received fall within an ERISA exception.

"Ordinary care," when relating to a MCO, is defined in the statute as "that degree of care that a [MCO] of ordinary prudence would use under the same or similar circumstances."¹⁸⁷ In addition, ordinary care pertaining to an employee, agent, ostensible agent, or representative of a MCO is

¹⁷⁹*Id.*

¹⁸⁰*Id.*

¹⁸¹*Id.*

¹⁸²*Dukes*, 57 F.3d at 352.

¹⁸³*Id.*

¹⁸⁴*Id.* at 356.

¹⁸⁵*Id.* at 357 (emphasis added).

¹⁸⁶*Id.* (emphasis added).

¹⁸⁷TEX. CIV. PRAC. & REM. CODE ANN. § 88.001(10) (West Supp. 1997).

defined as "that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as such person would use in the same or similar circumstances."¹⁸⁸ To that end, negligence litigation will focus on defining the national standard of care for MCOs.¹⁸⁹ In other words, what would a MCO, similarly situated, have done in this situation?¹⁹⁰ Nonetheless, establishing a national standard of care for MCOs is very difficult, and may alone provide courts with a formidable task.¹⁹¹

MCOs generally rely on the utilization review process when making treatment decisions for plan participants.¹⁹² Texas legislators, therefore, specifically installed a safeguard that provides plan participants with an immediate right to internal appeal of adverse determinations made by utilization reviewers.¹⁹³ In the case of emergency care or continued inpatient hospitalization denials, an expedited appeal process requires that plan participants have their case reviewed within twenty-four hours of the utilization reviewer's receipt of the information necessary to address the appeal.¹⁹⁴ In addition, patients whose condition qualifies as "life-threatening," have a right to immediate appeal with an independent review organization.¹⁹⁵ Furthermore, plan participants are also provided with the opportunity to have denied appeals reviewed by an independent reviewer.¹⁹⁶

Should this system of utilization review nevertheless fail to provide treatment or care falling within the "ordinary care" standard, the statute

¹⁸⁸*Id.*

¹⁸⁹Furrow, *supra* note 9, at 484. To succeed in a cause of action for negligence, the plaintiff must show that: (1) there was a duty or obligation requiring certain standards of conduct; (2) the defendant failed to comply with the standard, thus breaching his duty; (3) there was a causal connection between the conduct and the injury; and (4) the plaintiff suffered damages as a result of the defendant's conduct. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 30, at 164-75 (5th ed. 1984). To show that a health care provider has breached a duty owed, the plaintiff must show that the provider's conduct was below a nationally recognized standard. *Hall v. Hilbun*, 466 So.2d 856, 869-70 (Miss. 1985).

¹⁹⁰Furrow, *supra* note 9, at 484.

¹⁹¹*See infra* Part IV.B.

¹⁹²*See supra* notes 10-13 and accompanying text.

¹⁹³TEX. INS. CODE ANN. art. 21.58A, § 6(b)(1) (Supp. 1997). The Texas Health Maintenance Organization Act defines adverse determinations as a "determination by a health maintenance organization that the health care services furnished or proposed to be furnished to an enrollee are not medically necessary." *Id.* art. 20A.12A(c)(1). A physician must make this internal review. *Id.* art. 21.58A, § 6(b)(3).

¹⁹⁴*Id.* art. 21.58A, § 6(b)(4).

¹⁹⁵TEX. INS. CODE ANN. art. 21.58A, § 6(c) (Supp. 1997). Life threatening condition is defined as a "disease or other medical condition with respect to which death is probable unless the course of the disease or condition is interrupted." *Id.*

¹⁹⁶*Id.*

indicates clearly the legislative intent to hold MCOs accountable for the actions of its employees, agents, and ostensible agents. Specifically, the statute provides:

A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan is also liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by its: (1) employees; (2) agents; [or] (3) ostensible agents.¹⁹⁷

The Tenth Circuit in *Pacificare v. Burrage*,¹⁹⁸ and district courts in several jurisdictions, have held that claims against HMOs based on theories of ostensible agency are not preempted under ERISA.¹⁹⁹ Therefore, it is likely that the specific language in the statute provides the proper factors for finding MCO liability based on a theory of ostensible agency.²⁰⁰

In addition to the specific language making MCOs liable for the malpractice of their ostensible agents, the statute also indicates that MCOs can be held liable for the actions of "representatives . . . acting on its behalf and over whom it has the right to exercise influence or control . . . which result in the failure to exercise ordinary care."²⁰¹ Courts have generally found that ostensible agency relationships exist when the MCO "holds out" the physician as its employee.²⁰² The language of the Texas statute, however, indicates clearly an intent not to limit MCO accountability to those individuals whom the MCO "holds out" as its employees, but rather to extend such accountability to everyone over whom the MCO has the right to influence or control.²⁰³

This extension will undoubtedly include physicians under the current MCO system of capitation. Currently, MCOs control physician treatment decisions in a variety of ways, including: (1) salary-holdback provisions

¹⁹⁷TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(b)(1)-(3) (West Supp. 1997).

¹⁹⁸59 F.3d 151, 155 (10th Cir. 1995).

¹⁹⁹*Jackson v. Roseman*, 878 F. Supp. 820, 826 (D. Md. 1995); *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544, 548 (S.D. Ill. 1994); *Dearmas v. Av-Med, Inc.*, 865 F. Supp. 816, 818 (S.D. Fla. 1994); *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983, 988 (E.D. Pa. 1990).

²⁰⁰Note, there have not been any cases in Texas to date applying ostensible agency theories to HMOs. *Bearden & Maedgen*, *supra* note 2, at 320.

²⁰¹TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(b)(4) (West Supp. 1997).

²⁰²*See, e.g., Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229, 1234 (Pa. Super. Ct. 1988); *Thompson v. Nason Hosp.*, 535 A.2d 1177 (Pa. Super. Ct. 1988); *Capan v. Divine Providence Hosp.*, 430 A.2d 647, 649 (Pa. Super. Ct. 1980).

²⁰³TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(b)(4) (West Supp. 1997).

(where a certain percentage, usually twenty percent, of physician salaries are held in an MCO pool until the end of the year, and physicians who have too many referrals may "lose" this percentage of their salary);²⁰⁴ (2) restriction of referrals to a selected group of physicians or hospitals;²⁰⁵ (3) and denial of patient treatment that the physician deems necessary.²⁰⁶

Utilization review committees may also fall within the category of representatives over whom the MCO has influence or control. There are two types of utilization review committees:²⁰⁷ those that MCOs retain within its organization, and third party utilization reviewers who enter into a contractual relationship with the MCO to provide utilization review services.²⁰⁸ In the former situation, it seems apparent that the MCO is liable for the decisions of the utilization review committee because the committee actually serves a function within the MCO in making medical decisions.²⁰⁹ In the latter case, however, the relationship is more attenuated because the utilization review is actually performed by an independent agency.²¹⁰ Nevertheless, the MCO may still have substantial influence or control over the third party review committee. For example, if cost-containment is not kept within a limit that is acceptable to the MCO, the MCO may choose not to renew the contract with the third party reviewer. Merely knowing that the MCO expects such cost-containment measures may influence the utilization reviewer to make decisions based on

²⁰⁴See FURROW ET AL., *supra* note 3, at 296.

²⁰⁵See, e.g., *Pappas v. Asbel*, 675 A.2d 711, 713 (Pa. Super. Ct. 1996) (attending physician was not allowed to transfer plaintiff to a hospital that specialized in spinal trauma because it was not an HMO approved facility).

²⁰⁶See Furrow, *supra* note 9, at 474 (noting that these constraints often force doctors to advocate on behalf of the patient for necessary care, which includes being aware of reimbursement constraints and may mean assisting the patient in obtaining funding for the procedure).

²⁰⁷See Battaglia, *supra* note 2, at 169-70 (describing generally the history and types of utilization management).

²⁰⁸*Id.*

²⁰⁹Generally, in suits alleging that a third party reviewer has made a decision resulting in injury to the plaintiff, the third party reviewer is brought in as a separate defendant. Courts are split as to whether MCOs may be held liable for the decisions of these reviewers. See *Wickline v. State*, 239 Ca. Rptr. 810, 819 (Cal. Ct. App. 1986) (stating that third party payers can be held legally accountable for defects in cost-containment mechanisms). *But see Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1339 (5th Cir. 1992) (holding that decision by outside utilization reviewer pertained to the administration of the plan, and not to a medical decision, thus denying a state tort claim).

²¹⁰Nevertheless, at least one court has stated that a claim of corporate negligence existed against an HMO when the outside reviewer's conduct was a factor in the plan participant's death. *Wilson v. Blue Cross*, 271 Cal. Rptr. 876, 883 (Cal. Ct. App. 1990).

economic savings.²¹¹ If these decisions are not within the ordinary care standard, MCOs could be held liable.

B. Roadblocks to Reigning in the Legal Lasso²¹²

As with any ground breaking legislation, the Texas statute will be carefully scrutinized by lawmakers, courts, and private citizens to determine whether it actually accomplishes its intended purpose. A close examination of the statute, and its potential effects on the health care system in Texas, reveals several key problem areas that may hinder the effective implementation of the statute.

First, opponents of the statute have cautioned that this measure will open a floodgate of litigation, thereby causing health insurance premiums to soar out of control.²¹³ Despite his agreement that health care costs may increase, Texas Governor George W. Bush, who allowed the bill to take effect without his signature, stated: "Given the choice between doing nothing and doing something to address a problem that impacts on the health of thousands of Texans, I have concluded that the potential for good outweighs the potential for harm."²¹⁴ Thus, in order for the new statute to effectively and efficiently serve the citizens of Texas, health care costs must remain affordable, in the wake of increased legal remedies for substandard treatment decisions made by MCOs and their agents.

Thus far, the statute appears to be fulfilling this goal. Reports indicate that despite a new-found right to sue their MCO for malpractice, there has been no significant increase in litigation by plaintiffs in this area.²¹⁵ Despite newspaper ads seeking patients who have been wronged by MCOs, a Texas plaintiff lawyer stated that she has received

²¹¹The Texas statute addressed the problems associated with independent reviewers by establishing a set of standards governing the selection and retention of these independent agencies. For example, the name and biographical sketch of each director, or officer, of the independent organization must be made available, including any relationship which that individual has with any MCO, insurer, or utilization review agent. TEX. INS. CODE ANN. art. 21.58C, § 2(d)(4) (West Supp. 1997). The statute further requires that the independent review organization report the percentage of its revenue that is derived from performing such reviews. *Id.* § 2(d)(5).

²¹²Michael F. Conlan trumpeted the passage of the Texas law in an article for *Drug Topics* entitled "Legal Lasso." Michael F. Conlan, *Legal Lasso*, 141 DRUG TOPICS, July 7, 1997, at 79.

²¹³The Texas HMO Association predicted premium increases of up to 12% for enrollees. *Id.* Conversely, Families USA, a consumer advocacy group, predicts that premiums may increase only one to two percent. *Texas Measure on Tort Liability*, *supra* note 114, at 4B.

²¹⁴Conlan, *supra* note 212, at 79.

²¹⁵Flood, *supra* note 6, at T1.

approximately 500 calls, resulting in only ten litigable claims against MCOs.²¹⁶ Nevertheless, lawyers for managed care organizations believe that the greatest explosion of MCO cases has yet to come.²¹⁷ MCO lawyers predict that this "onslaught" of cases will occur after the plaintiff bar becomes better equipped to litigate in this technically difficult arena.²¹⁸ Nevertheless, even defense lawyers recognize that the Texas statute has caused MCOs to evaluate the level of services that they provide to plan participants.²¹⁹ Such a move heralds a positive attempt on the part of MCOs to make treatment decisions based on the patient's best interests, rather than on economic gain; a goal directly aligned with the ultimate purpose of the statute.

A second and very difficult obstacle faced by courts addressing the new statute is the establishment of an "ordinary care" standard for MCOs that provide services to plan participants. The statute states clearly that MCOs have a "duty to exercise ordinary care when making health care treatment decisions."²²⁰ This standard requires MCOs to use the degree of care that other MCOs of "ordinary prudence would use under the same or similar circumstances."²²¹ Determining "ordinary prudence," or professional standards, has been an arduous task for courts, however, where the entire industry is operating below an acceptable standard.²²² For example, the erudite Judge Learned Hand reasoned in *The T.J. Hooper*²²³ that:

in most cases reasonable prudence is in fact common prudence; but strictly it is never the measure; a whole calling may have unduly lagged in the adoption of new and available devices. It may never set its own tests, however persuasive be its usages. Courts must in the end say what is required; there

²¹⁶*Id.*

²¹⁷*Id.*

²¹⁸*Id.*

²¹⁹Flood, *supra* note 6, at T1. Austin lawyer Tom Bond, an HMO lawyer who provides continuing education workshops for attorneys on this subject, noted that "just the speculation about the law's effects has caused HMOs and doctors to become extremely cautious." *Id.*

²²⁰TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (West Supp. 1997).

²²¹*Id.* § 88.001(10).

²²²This may be the case regarding MCOs where reports of alleged negligence on the part of MCOs exists nationwide. Most MCOs operate to reduce costs and achieve financial profits, often gained at the expense of plan participants. See *supra* note 114 (discussing financial incentives that MCOs have to deny or delay care).

²²³60 F.2d 737 (2d Cir. 1932).

are precautions so imperative that even their universal disregard will not excuse their omission.²²⁴

This theory later resonated in the Washington Supreme Court's decision in *Helling v. Carey*.²²⁵ In that case, Barbara Helling visited her ophthalmologists, Doctors Thomas Carey and Robert Laughlin, eleven times over the course of five years, initially complaining of nearsightedness, and then subsequently complaining of eye irritation.²²⁶ Neither of Helling's treating ophthalmologists performed a glaucoma test on her until her final visit.²²⁷ When the test was performed, Helling was diagnosed with primary open angle glaucoma.²²⁸ Testimony of medical experts at trial indicated that the standards for the ophthalmology profession did not require the performance of a routine glaucoma test for patients under the age of forty.²²⁹ Because Helling had not yet reached forty years of age, this routine test was not performed.²³⁰

Helling filed a negligence claim against Dr. Carey and Dr. Thomas alleging that the delay in performing the glaucoma test caused her condition to worsen, resulting in her substantial loss of vision.²³¹ The defendants argued that the "standard of the profession . . . [was sufficient] to insulate [them] from liability" for failing to give the test in a timely manner.²³² The court held, as a matter of law, that "reasonable prudence" obligated performance of the glaucoma test and that it is the court's duty to determine the applicable standard required to protect patients under forty.²³³

²²⁴*Id.* at 740.

²²⁵519 P.2d 981, 983 (Wash. 1974).

²²⁶*Id.* at 981.

²²⁷*Id.* Glaucoma is a condition of the eye resulting from a diminished flow of fluids out of the eye. *Id.* This condition results in an increase in eye pressure causing damage to the optic nerve with resulting loss of vision. *Id.*

²²⁸*Id.* As a result, Helling lost her peripheral vision, and her central vision was significantly diminished as well. *Id.* at 982.

²²⁹*Helling*, 519 P.2d at 982. Routine glaucoma tests are not given to patients under 40 due to the rarity of occurrence in this age group. *Id.* Helling was 32 at the time diagnosis was made, and Dr. Carey testified that she had probably had the disease for 10 years or longer. *Id.* at 982-83.

²³⁰*Id.* at 982.

²³¹*Id.*

²³²*Id.*

²³³*Helling*, 519 P.2d at 983. Washington legislators later addressed this court decision by passing a statute stating that:

In any civil action for damages based on professional negligence . . . the plaintiff in order to prevail shall be required to prove by a preponderance of the evidence that the defendant or defendants failed to exercise that degree of skill, care, and learning possessed at that time by other persons

Thus, the court established the rule that "reasonable prudence may require a standard of practice which is higher than that exercised by the relevant professional community."²³⁴

Broad rules similar to those set forth by the courts in *The T.J. Hooper* and *Helling*, can be easily applied to MCOs when determining standards for "ordinary care." These standards will sink into ambiguity unless defined more specifically, thereby potentially preventing effective implementation of the Texas statute. Nevertheless, while successful application of the statute may necessitate a fixed standard for "ordinary care," this need not hinder a court's incentive to determine prudent professional standards, a primary imperative when established professional standards do not provide adequate care for individuals seeking services.

Lastly, although not stated explicitly, there seems to be an implied intent on the part of legislators to hold MCOs accountable when administrative decisions deny care to plan participants.²³⁵ Holding MCOs accountable when treatment is denied, however, may be an insurmountable task. Nationwide, courts have generally held that MCOs are not liable under theories of direct negligence for denying treatment, as these claims are preempted under ERISA.²³⁶ Courts have based these preemption decisions on the theory that they "relate to" the administration of the "employee benefit plan."²³⁷ Furthermore, the Fifth Circuit will, in all

in the same profession.

WASH. REV. CODE ANN. § 4.24.290 (West 1997). The Supreme Court of Washington, sitting en banc, held in *Gates v. Jensen*, 595 P.2d 919, 924 (Wash. 1979) (en banc), that the *Helling* rule was not abrogated by this statute. The court rejected the defendant's argument that the intent of the bill was to abolish the *Helling* rule, and found that the original bill was amended so as to broadly allow for application of the *Helling* rule. *Id.*

²³⁴*Gates*, 595 P.2d at 923.

²³⁵In this respect, the language of the statute is somewhat ambiguous. See TEX. CIV. PRAC. & REM. CODE ANN. § 88.001(5) (West Supp. 1997) (defining a health care treatment decision as "determination made when medical services are *actually provided* by the health care plan *and* a decision which affects the *quality* of the diagnosis, *care*, or treatment provided") (emphasis added). Lawyers in Texas are attempting to assert claims against MCOs when treatment is denied. See Flood, *supra* note 6, at T1 (discussing lawyer filing suit for denial of liver transplant).

²³⁶See *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182, 184-85 (E.D. Pa. 1994) (finding claim that HMO failed to provide specialized care preempted under ERISA); *Elsesser v. Hospital of the Phila. College of Osteopathic Med.*, 802 F. Supp. 1286, 1291-92 (E.D. Pa. 1992) (holding that claim against plan administrator for refusal to pay for heart monitor preempted); *Kohn v. Delaware Valley HMO, Inc.*, No. 91-2745, 1991 WL 275609, at *4 (E.D. Pa. Dec. 20, 1991) (finding that contractual disputes requiring interpretation of obligations preempted under ERISA).

²³⁷See *Kearney*, 859 F. Supp. at 184-85; *Elsesser*, 802 F. Supp. at 1291-92; *Kohn*, 1991 WL 275609, at *4.

likelihood, have jurisdiction and opportunity to review whether tort claims of this type are preempted under ERISA.²³⁸

The plain language of the statute states that "the standards [of the statute] create no obligation on the part of the health insurance carrier, health maintenance organization, or other managed care entity to provide to an insured or enrollee treatment which is not covered by the health care plan of the entity."²³⁹ This provision creates a loophole for MCOs to narrowly define what is covered under the plan, thereby excluding those treatments they deem "experimental" or marred by excessive cost. This MCO tactic may ultimately leave plan participants with no more legal remedy for denied treatment than they were afforded previously.

²³⁸Flood, *supra* note 6, at T1. Less than a month after passage of Texas Health Care Liability Act, Aetna Health Plans of Texas, and others, filed suit challenging the new legislation. Easley, *supra* note 17, at 318. In September 1998, the United States District Court for the Southern District of Texas (Gilmore, J.), upheld the statutory provision of the Texas Act that allows consumers to sue their MCOs for "health care treatment decisions." *Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, No. H-97-2072, 1998 WL 651003 (S.D. Tex. Sept. 18, 1998). The court strictly interpreted the plain language of this provision in finding that patients may only bring suit in cases where treatment was actually provided, rather than in instances where treatment was denied. *Id.* at *18. The court thereby distinguished potential suits arising under the Texas statute from the claim preempted by the court in *Corcoran*. *Id.* The court stated that "[i]n this case, a suit brought under the Act would relate to the *quality* of benefits received from a managed care entity when benefits are actually provided, not denied." *Id.* (emphasis added). The court found the rationale set forth by the court in *Dukes* particularly applicable to the Texas statute. *Id.* at *20-21 (citing *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995)). The distinction made by the court was one of denial of benefits as opposed to a claim concerning the quality of benefits received by the patient. *Id.* at *20. The court stated:

"[U]nlike *Corcoran*, [in *Dukes*] there . . . [was] no allegation . . . that the HMOs denied anyone any benefits that they were due under the plan. Instead, the plaintiffs [in *Dukes* were] . . . attempting to hold the HMOs liable for their role as the arrangers of their decedents' medical treatment." Likewise, a plaintiff bringing suit under the Act may seek to hold a HMO liable in its position as the arranger of poor quality medical treatment, thereby, avoiding any allegation that the HMO wrongfully denied benefits under the plan and therefore, any connection with ERISA.

Id. at *22 (quoting *Dukes*, 57 F.3d at 361) (footnotes and citations omitted).

This decision, while applauded by physicians and patient advocate groups, will likely be appealed to the Fifth Circuit. Laurie McGinley, *Texas Law Allowing Patients to Sue Health Plans for Damages is Upheld*, WALL ST. J., Sept. 21, 1998, at B10. That court has shown a propensity for finding ERISA preemption. See *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1331 (5th Cir. 1992). As one news commentator noted, however, "[The] court has never weighed the preemption against a state statute." Flood, *supra* note 6, at T1.

²³⁹TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(d) (West Supp. 1997).

V. CONCLUSION

A recent Time/CNN poll indicated that sixty-three percent of Americans want patients to have the right to sue their MCOs for medical care decisions, even if that right would raise costs and increase bureaucracy.²⁴⁰ The Texas statute is the first law in the nation to give credence to this right, long sought by health care consumers in this country. The statute strikes a perfect balance by providing an elaborate system of utilization review,²⁴¹ including independent review procedures, while simultaneously furnishing plan participants with an appropriate legal remedy for the MCO's failure to exercise "ordinary care when making health care treatment decisions."²⁴² The ultimate effect of the statute, while still largely unknown, has the potential to drastically change MCO accountability to plan participants, thus restricting the corporate practice of medicine. This statute may also provide other states with the impetus needed to enact similar legislation.²⁴³

²⁴⁰Gorman, *supra* note 3, at 32. The poll was conducted for Time/CNN on June 30 and July 1, 1998. *Id.* In addition, 70% of those polled wanted to be able to have a denial of benefits appealed to a neutral third party. *Id.* But of particular note is the survey result which found that only 32% of those polled trusted their HMO to provide the "best medical care available." *Id.*

²⁴¹See TEX. CIV. PRAC. & REM. CODE ANN. § 88.003(a)(1)-(2) (West Supp. 1997). This system also serves as a safeguard against frivolous law suits, because it requires plan participants to exhaust all administrative appeal procedures before instituting an action, give written notice of the claim, and agree to submit the claim to an independent review organization. *Id.*

The health insurance plans, challenging the Texas statute as preempted under ERISA, argue that by requiring an independent review process, the Act "improperly mandates the structure of plan benefits and their administration in violation of clear Supreme Court authority." *Corporate Health Ins.*, 1998 WL 651003, at *21. In holding that the independent review provision has a connection to ERISA plans and would, therefore, be subject to preemption, the court stated:

[Independent review procedures] would subject plans and plan sponsors to burdens not unlike those that Congress sought to foreclose through . . . [Section] 514(a). Particularly disruptive is the potential for conflict in state law. . . . Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement.

Id. at *27 (quoting *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 142 (1990)).

Nevertheless, the court found that the invalid independent review provision could be severed from other claims "without affecting the other provisions or conflicting with the legislative intent." *Id.* Ultimately, the court held that the "[p]laintiffs have not met their burden of proving that every claim brought under the Act would be preempted by ERISA. Even though some economic impact may result, a claim concerning the quality of a benefit actually received would remain invalid." *Id.* at *31.

²⁴²TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (West Supp. 1997).

²⁴³Thus far, several states have been unsuccessful in their attempts to pass such legislation. See, e.g., H.B. 1547, 1997 Reg. Sess. (Fla. 1997) (establishing liability for HMO's and authorizing civil suits against HMO's by "certain persons") (died in committee on May 1, 1998); H.B. 70, 1997 Reg. Sess. (Md. 1997) (attempting to hold HMOs liable for denying

Holding corporate MCOs accountable will force treatment decisions to be based on sound medical judgment, rather than on economic considerations. If, however, corporate MCOs fail to make proper medical decisions, and instead continue to base these decisions on financial incentives, this statute may provide plan participants with legal remedies not previously available under Texas law.²⁴⁴ Furthermore, if courts choose to enforce the plain language of the statute, plaintiffs will be able to subvert ERISA preemption and may bring certain state malpractice claims against MCOs. Thus, the MCO will ultimately be responsible for the health care treatment decisions it makes, as well as those made by its agents.

*Michelle R. King**

benefits recommended by physician providers); H.B. 78, 1998 Reg. Sess. (Md. 1998) (same).

²⁴⁴*See supra* note 168.

*The author wishes to dedicate this note to the loving memory of her grandmother, Isabelle King, whose life and own struggles with the health care system were an inspiration for this note.