Corporate Health Insurance Inc. v. The Texas Department of Insurance: Is the Texas Act Holding HMOs Liable for Substandard Medical Care Preempted by ERISA?

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Health care delivery in the United States has changed significantly over the past few decades. Specifically, public concern over soaring medical costs and financially-driven diagnostic and treatment decisions have led physicians to provide medical care as members of health maintenance organizations (HMOs) instead of as sole practitioners under the traditional fee-for-service method. In fact, HMOs have become

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2 See Michael Kanute, Comment, Evolving Theories of Malpractice Liability for HMOs, 20 Loy. U. Chi. L.J. 841, 841 (1989) (defining HMOs as “an alternative system of health care delivery, whereby health care providers . . . enter into contracts with or are employed by a health care entity to provide comprehensive health care to voluntarily enrolled patients”) (footnote omitted); id. at 841-42 (noting that the main trait of an HMO is that the “patient pays a prepaid, fixed fee for medical services . . . without regard to the actual amount of services provided”).

3 See MacDougall, supra note 1, at 860 (explaining that physicians receiving fees under the traditional method are compensated solely for the care they provide, creating an economic incentive to perform unnecessary medical procedures); Greg Otterson, Comment, Medical Malpractice for Texas HMOs: The End of a “Charmed Life?”, 39 S. Tex. L. Rev. 799, 800 (1998) (noting that subscribers to HMOs receive health care for lower prepaid fees than if they paid for the care at the time it was needed); Amy Stoeckl, Comment, Refusing to Follow Doctor’s Orders: Texas Takes the First Step in Holding HMOs Liable for Bad Medical Decisions, 18 N. Ill. U. L. Rev. 387, 389 (1998) (noting that, in order to reduce medical costs, employers and
the most common mode of health care delivery among both the
general public and employers providing health insurance
benefits to employees.\textsuperscript{4}

Prior to 1974, employee health plans were regulated by a
combination of common law and state and federal legislation.\textsuperscript{5}
In order to standardize the administration of these plans and to
protect employees, Congress enacted the Employment
Retirement Income Security Act of 1974 (ERISA).\textsuperscript{6} ERISA's
preemption clause, section 514(a),\textsuperscript{7} illustrates Congress’s intent
that employee health benefit plans function without state
interference.\textsuperscript{8} It is important to note, however, that in 1974,
managed health care did not exist as it does today. Congress
could not then foresee the use of ERISA by managed care
organizations as a defense to liability and a shield for HMOs.\textsuperscript{9}
Congress never intended to harm employees by preventing them
from bringing tort actions against HMOs associated with ERISA
health plans.\textsuperscript{10}

Litigation involving HMOs and their participating

\textsuperscript{4} See Jose L. Gonzalez, \textit{A Managed Care Organization's Medical Malpractice
(noting that there was a “veritable explosion” in the popularity of HMOs in the mid-
to late 1980s); Otterson, \textit{supra} note 3, at 800 (stating that the increase in medical
costs has made HMOs attractive to many employers interested in providing low-cost
health insurance benefits to employees); Stoeckl, \textit{supra} note 3, at 389 (noting that
approximately 150 million Americans participate in HMOs or managed care
entities).

\textsuperscript{5} See Otterson, \textit{supra} note 3, at 809 (noting that pre-ERISA employee benefit
plans “were governed primarily by state laws, common law, federal statutes, and
the Taft-Hartley Act”).


\textsuperscript{7} See \textit{id.} at § 1144(a).

\textsuperscript{8} See \textit{id.} (stating that ERISA “shall supersede any and all State laws insofar as
they may now or hereafter relate to any employee benefit plan”).

\textsuperscript{9} See Dawn Lauren Morris, Comment, \textit{ERISA Preemption, HMOs, and Denial
in the enactment of ERISA and the interplay between HMOs and employees regarding
liability under traditional tort theories versus preemption under ERISA).

\textsuperscript{10} See \textit{id.} at 999 (explaining issues surrounding ERISA preemption).
physicians has increased over the past few years.\textsuperscript{11} Physicians have been held personally liable for negligent acts leading to patient injuries.\textsuperscript{12} An issue remains, however, as to whether HMOs themselves can escape the liability imposed by state law. The HMOs argue that state laws holding them liable for the negligent acts of their member physicians "relate to" employee benefit plans and are therefore preempted by section 514(a) of ERISA.\textsuperscript{13}

In 1997, in response to the issue of preempted tort liability, the state of Texas passed the Texas Health Care Liability Act (the "Act"),\textsuperscript{14} making it the first state to impose liability on HMOs for substandard health care.\textsuperscript{15} In \textit{Corporate Health Insurance Inc. v. Texas Department of Insurance},\textsuperscript{16} the United States District Court for the Southern District of Texas held that ERISA does not preempt the sections of the Act that impose liability on HMOs for treatment decisions.\textsuperscript{17} The court also held, however, that provisions of the Act that establish an independent review process for adverse benefit determinations are preempted by ERISA.\textsuperscript{18}

In \textit{Corporate Health Insurance}, Corporate Health Insurance Inc., AEtna Health Plans of Texas, Inc., AEtna Health Plans of North Texas, Inc., and AEtna Life Insurance Co. ("Plaintiffs") sought injunctive and declaratory relief against the Commissioner of the Texas Department of Insurance, the Attorney General of the State of Texas, and the Texas Department of Insurance ("Defendants").\textsuperscript{19} Plaintiffs requested a declaration that specific sections of the Act\textsuperscript{20} were preempted

\textsuperscript{11} See MacDougall, \textit{supra} note 1, at 856 (stating that litigants seeking compensation for personal injuries from HMO physicians often include the HMO as a party).

\textsuperscript{12} See id. at 868 (noting that the controversy over an HMO's liability for a physician's negligence does not affect the physician's personal liability); Stoeckl, \textit{supra} note 3, at 390 (noting that when physicians provide substandard medical care, they are held liable under tort law for injuries caused by their treatment).

\textsuperscript{13} See MacDougall, \textit{supra} note 1, at 898 (stating that the question of whether a state law is preempted by ERISA is among the most litigated issues involving employee health benefit plans).


\textsuperscript{15} See Otterson, \textit{supra} note 3, at 821.


\textsuperscript{17} See id. at 620.

\textsuperscript{18} See id. at 625.

\textsuperscript{19} See id. at 602.

by ERISA, as well as an injunction preventing enforcement of
the Act against ERISA-protected employee benefit plans.\(^{21}\)
Plaintiffs challenged the portions of the Act that: (1) allowed
individuals to sue HMOs and managed care entities for their
"failure to exercise ordinary care" in medical decisions;\(^{22}\) (2) held
HMOs "liable for substandard . . . treatment decisions made by
their employees [or] agents";\(^{23}\) and (3) "establishe[d] an
independent review process [to examine] adverse
benefit determinations."\(^{24}\)

Defendants filed a motion to dismiss, which the court
converted into a motion for summary judgment.\(^{25}\) Illuminating
the difference between ERISA and the Act, Defendants reasoned
that ERISA controlled the type of regulation that may be
imposed on employee benefit plans, while the Act regulated the
quality of medical care provided by HMOs.\(^{26}\) Therefore, they
argued, ERISA's preemption clause did not apply to the Act,\(^{27}\)
and HMOs could not avoid liability for their substandard
medical decisions.\(^{28}\) Alternatively, Defendants requested
severance of any provisions of the Act that were determined to be
preempted in order to preserve the "quality of care
liability provisions."\(^{29}\)

Plaintiffs', in their motion for summary judgment, argued
that the Act interfered with the purpose of ERISA\(^{30}\) by "injecting
state law into an area exclusively reserved for Congress."\(^{31}\)
Plaintiffs asserted that "the Act . . . 'refer[ed] to' . . . and . . .
ha[d] a connection with ERISA plans"\(^{32}\) in that the Act
attempted to apply state law to the structure and administration
of employee health benefit plans.\(^{33}\)

\(^{21}\) See Corporate Health Ins., 12 F. Supp. 2d at 602.
\(^{22}\) Id. at 602.
\(^{23}\) Id.
\(^{24}\) Id. at 602–03.
\(^{25}\) See id. at 603.
\(^{26}\) See id. Defendants further argued that the Act does not govern how HMOs
determine benefits nor how benefit plans should be structured. See id.
\(^{27}\) See id.
\(^{28}\) See id. Defendants looked to the plain meaning of the statute to determine
the purpose of the Act, which was to deter HMOs from avoiding liability for
"medical decisions [that] they 'make,' 'control' or 'influence.'" Id.
\(^{29}\) Id.
\(^{30}\) See id.
\(^{31}\) Id. (internal quotations omitted).
\(^{32}\) Id.
\(^{33}\) See id.
The court granted in part 34 Defendants' motion for summary judgment on the issue of whether ERISA preempts the Act's provisions holding HMOs liable for negligent and substandard care. 35 The court, however, also granted in part 36 Plaintiffs' motion for summary judgment on the issue of whether ERISA preempts the Act's establishment of independent reviews for adverse benefit determinations. 37

District Judge Gilmore explained that in order to determine whether the Act was preempted by section 514(a) of ERISA, the court had to decide if the state law was "relate[d] to any employee benefit plan" covered by ERISA. 38 Relying on CIGNA Healthplan of Louisiana, Inc. v. State of Louisiana, 39 the court concluded that the Act "relates to" an ERISA plan if the Act or potential claims to be brought under the Act are "connect[ed] with" or "refer[ed] to" an ERISA plan. 40

The court first utilized the test applied by the Fifth Circuit in Meredith v. Time Insurance Co. 41 to determine whether the health plans involved in the suit were employee benefit plans covered by ERISA. The Meredith test asks "whether a plan: (1) exists; (2) falls within the safe-harbor provision established by the Department of Labor; and (3) satisfies the primary elements of an ERISA 'employee benefit plan'—establishment or maintenance by an employer intending to benefit employees." 42

Agreeing with Defendants, the court found that AEtna offered health care benefits to employees who were ERISA plan members. 43 The court determined, however, that AEtna's health plan did not qualify as an employee benefit plan under ERISA 44 because it functioned as a health plan, not as an employer-established ERISA plan. 45

34 See id. at 602.
35 See id. at 620.
36 See id. at 602.
37 See id. at 625.
38 Id. at 607 (quoting 29 U.S.C. § 1144(a) (1994)).
39 82 F.3d 642 (5th Cir. 1996).
40 Corporate Health Ins., 12 F. Supp. 2d at 607.
41 980 F.2d 352 (5th Cir. 1993).
42 Id. at 355.
43 See Corporate Health Ins., 12 F. Supp. 2d at 609.
44 See id.
45 See id. The plans provided by AEtna failed the third prong of the test because they were not created or maintained by an employer. See id. AEtna agreed that they were managed care entities and therefore did not involve "an employer
Nevertheless, relying on CIGNA, the court concluded that whether Aetna was not an ERISA health plan was immaterial to determining whether the Act was preempted by ERISA.\textsuperscript{46} The court therefore turned its attention to precedent\textsuperscript{47} and Congressional intent\textsuperscript{48} to determine whether the Texas Act “related to,” and was therefore preempted by, ERISA.\textsuperscript{49} ERISA was initially enacted in order to ensure uniformity in the administration of employee benefit plans,\textsuperscript{50} not to “ ‘supplant state law.’ ”\textsuperscript{51} The court therefore concluded that Plaintiffs had the “ ‘considerable burden’ ” of rebutting the presumption that Congress did not intend to bypass state law when enacting the ERISA statute.\textsuperscript{52}

Finally, the court analyzed the Act to determine whether it, in any way, “refer[red] to” an ERISA program.\textsuperscript{53} The court found that the Texas Act regulated the quality of care provided by HMOs and managed care entities without regard to whether those providers were associated with an ERISA plan. Therefore, the court concluded that the Act did not “make any reference to ERISA plans.”\textsuperscript{54} This conclusion was based on New York State Conference of Blue Cross & Blue Shield Plans v. Travelers

\textsuperscript{46} See id. at 610. The court in CIGNA decided whether a Louisiana statute was preempted by ERISA without determining whether CIGNA was an ERISA plan provider. See CIGNA Healthplan of Louisiana, Inc. v. Louisiana, 82 F.3d 642, 648 (5th Cir. 1996). As long as some provisions of the Act “relate to” ERISA employee benefit plans, it does not matter whether plaintiffs were ERISA employee benefit providers. See Corporate Health Ins., 12 F. Supp. 2d at 610.

\textsuperscript{47} See Corporate Health Ins., 12 F. Supp. 2d at 610–11. The court referred to CIGNA, stating that a state law is considered to relate to ERISA even if it only indirectly affects an employee benefit plan, and therefore will be preempted in cases where the law applies to an employee plan. See id. at 610.

\textsuperscript{48} See id. at 611. The court relied on the Supreme Court’s “pragmatic approach” in New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., 514 U.S. 645, 654–57 (1995), to determine whether a state law “relates to” an ERISA plan. See Corporate Health Ins., 12 F. Supp. 2d at 611. The Court in Travelers analyzed a state statute by looking to Congress’ intent when enacting ERISA rather than trying to define “relates to” by looking at the language in section 514(a) of ERISA. See Travelers, 514 U.S. at 656.

\textsuperscript{49} See Corporate Health Ins., 12 F. Supp. 2d at 610–11.

\textsuperscript{50} See id. at 611.

\textsuperscript{51} Id. (quoting DeBuono v. NYSA-ILA Medical & Clinical Services Fund, 520 U.S. 806, 814 (1997)).

\textsuperscript{52} Id. (quoting DeBuono, 520 U.S. at 814).

\textsuperscript{53} See id. at 611–14.

\textsuperscript{54} Id. at 612.
Insurance Co.\textsuperscript{55} and on language in the Act "exclud[ing] ERISA plans from the definition of a 'managed care entity.'"\textsuperscript{56}

Although the Act did not "refer to" an ERISA plan, "[a] law that does not refer to ERISA plans may yet be pre-empted if it has a 'connection with' ERISA plans."\textsuperscript{57} In determining whether the Act had a "connection with" an ERISA plan, the court focused its analysis on whether the Act inappropriately interjected state law liability into federally-regulated ERISA entities;\textsuperscript{58} improperly governed the administration and structure of the benefit plans;\textsuperscript{59} improperly bound "employers or plan administrators to particular choices;"\textsuperscript{60} or erroneously created a substitute enforcement mode.\textsuperscript{61}

In determining whether the Act imposed state liability on a federally-reserved area, the court, relying on \textit{Dukes v. United States Healthcare, Inc.},\textsuperscript{62} concluded that the Act regulated the quality of medical care provided by a health plan provider, but did not involve the determination of benefits and was therefore not connected with ERISA.\textsuperscript{63} Accordingly, the Act was not

\begin{itemize}
\item \textsuperscript{55} 514 U.S. 645 (1995).
\item \textsuperscript{56} \textit{Corporate Health Ins.}, 12 F. Supp. 2d at 612 (citing TEX. CIV. PRAC. \& REM. CODE § 88.001(8) (West Supp. 2000)). The district court in \textit{Corporate Health Insurance} noted that the Supreme Court in \textit{Travelers} held that a statute did not "refer[] to" an ERISA plan if surcharges mandated by the plan were imposed without regard to whether the health plan was associated with or regarded as an ERISA plan. \textit{Id.} (citing \textit{Travelers}, 514 U.S. at 656). The \textit{Corporate Health Insurance} court further held that, because the Act specifically omitted ERISA plans from the definition of "‘managed care entity,’" the Act could not "make any reference to" ERISA plans. \textit{Id.}
\item \textsuperscript{58} \textit{Corporate Health Ins.}, 12 F. Supp. 2d at 614–20.
\item \textsuperscript{59} \textit{Corporate Health Ins.}, 12 F. Supp. 2d at 621–26.
\item \textsuperscript{60} \textit{Corporate Health Ins.}, 12 F. Supp. 2d at 626–27.
\item \textsuperscript{61} \textit{Corporate Health Ins.}, 12 F. Supp. 2d at 628–29.
\item \textsuperscript{62} 57 F.3d 350 (3d Cir. 1995). The \textit{Corporate Health Insurance} court felt that the claims in \textit{Dukes} were "more akin to" those of the \textit{Corporate Health Insurance} plaintiffs than were the issues in \textit{Corcoran v. United HealthCare, Inc.}, 965 F.2d 1321 (5th Cir. 1992) and \textit{Rodriguez v. Pacificare of Texas, Inc.}, 980 F.2d 1014 (5th Cir. 1993). \textit{Corporate Health Ins.}, 12 F. Supp. 2d at 618. \textit{Rodriguez} was distinguishable because in that case the plaintiff was unable to "challenge the quality of [the] benefits actually received" from his HMO. \textit{Id.} \textit{Corcoran} differed from \textit{Corporate Health Insurance} in that \textit{Corcoran} involved the denial of benefits, not the quality of benefits actually provided. \textit{See id.} at 617.
\item \textsuperscript{63} \textit{Corporate Health Ins.}, 12 F. Supp. 2d at 620.
\end{itemize}
preempted by ERISA and did not improperly impose state liability.  

Lastly, the court analyzed the section of the Act mandating an independent review process for adverse benefit determinations to determine if that provision was preempted by ERISA. The court relied on the United States Supreme Court’s rationale in Travelers in determining that the imposition of independent reviews improperly interfered with the administration of employee benefit plans. There was thus a connection between the provisions for independent review and ERISA plans, triggering ERISA’s preemption clause. Under Texas law, however, this section could be severed from the Act, leaving the non-preempted sections of the statute intact and enforceable.

The Corporate Health Insurance court correctly ruled that the sections of the Act holding HMOs liable for negligent and substandard medical decisions were not preempted by ERISA. The court, however, misconstrued the section of the Act providing for independent reviews of adverse benefit determinations. The court should have acknowledged that, although these reviews are connected with the administration of ERISA plans, they are so closely tied to the provision of quality care by HMOs that preemption is improper. The denial of benefits can result in the denial of treatment, which can be detrimental and sometimes fatal. This Comment asserts that preemption decisions relating to this section of the Act should instead be made on a case-by-case basis.

Part I of this Comment explains that, although ERISA

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64 See id.
65 See id. at 624 (citing TEX. INS. CODE ANN. art. 21.58C (West Supp. 2000)).
66 See id. at 624–25.
69 See id. at 625.
70 See id. at 625–26. The court looked to the Texas Code Construction Act, which provides in pertinent part:
In a statute that does not contain a provision for severability or nonseverability, if any provision of the statute . . . is held invalid, the invalidity does not affect other provisions . . . of the statute that can be given effect without the invalid provision . . . and to this end the provisions of the statute are severable.
TEX. GOV’T CODE ANN. § 311.032(c) (West 1998).
preempts state laws that "relate to" employee benefit plans, courts are divided when deciding which state negligence causes of action "relate to" the plans and are therefore preempted by ERISA. Part II asserts that the Texas Act could have a profound impact in Texas, where the first case has already been brought under the Act, as well as in other jurisdictions where similar statutes are being contemplated to finally hold HMOs liable for negligent medical care. This Comment concludes that the Corporate Health Insurance court incorrectly held that independent reviews for adverse benefit determinations were preempted by ERISA. It stresses that future courts and legislatures should address the ambiguity of the "relates to" language in the ERISA statute. Further, courts and legislatures should recognize that, although denials of medical benefits in ERISA plans "relate to" the administration of ERISA plans, the denials themselves should be considered substandard health care. In order to ensure that HMOs deliver quality health care, it is imperative that state laws governing medical benefit denials are not preempted.

I. ERISA Preemption Analysis

A. Preempted State Tort Claims

Unfortunately, Congress did not specify how far it intended ERISA's preemption to extend into the area of negligent managed care.\(^71\) When ERISA's "relates to" language is

\(^71\) See Gonzalez, supra note 4, at 771 (suggesting that the purpose of federal preemption was to minimize the burden on employer benefit plans that would otherwise have to comply with a conflicting array of state regulations); Suzanne M. Grosso, Rethinking Malpractice Liability and ERISA Preemption in the Age of Managed Care, 9 STAN. L. & POLY REV. 433, 441 (1998) (explaining that although the statutory language of ERISA provides that ERISA "shall supersede any and all State laws . . . as they may . . . relate to any employee benefit plan," it does not clearly guide courts in determining how far Congress intended this language to extend) (quoting 29 U.S.C. § 1144(a) (1994)); MacDougall, supra note 1, at 901 (stating that Congress's intent is unclear as to whether ERISA was to preempt all state tort law claims and that "[there is no indication in the language of ERISA's preemption clause, or in ERISA's legislative history, that employers and benefit plans were to obtain some self-promoting protection from state law obligations" ) (quoting Larry J. Pittman, ERISA's Preemption Clause and the Health Care Industry: An Abdication of Judicial Law-Creating Authority, 46 FLA. L. REV. 355, 360 (1994)); Stoeckl, supra note 3, at 398–99 (stating that ERISA's complexity makes it very difficult to predict which claims will be preempted, and therefore a great deal of latitude is given when making this decision).
interpreted broadly, HMOs are relieved from tort liability.\textsuperscript{72} Courts preempt claims when resolution involves the interpretation of a health plan.\textsuperscript{73} Furthermore, courts tend to preempt all claims involving the quantity of care provided by HMOs, including claims attempting to impose liability on HMOs and managed care entities for negligent administration of employee benefits and for the negligent denial of benefits.\textsuperscript{74} An example of such a case is \textit{Corcoran v. United HealthCare, Inc.},\textsuperscript{75} in which the United States Court of Appeals for the Fifth Circuit held that ERISA preemption was appropriate for a tort claim brought by a woman against a utilization review company for denial of nursing care benefits leading to the unnecessary death of her unborn fetus.\textsuperscript{76} The Fifth Circuit's broad interpretation of the ERISA preemption clause suggests that state tort suits may be preempted if the lawsuits in any way disturb or regulate the administration of benefits, without regard to whether the administration of benefits leads to substandard health care decisions.\textsuperscript{77}

\textsuperscript{72} See MacDougall, supra note 1, at 902 (noting that federal district courts that interpret ERISA broadly have preempted causes of action against HMOs).

\textsuperscript{73} See Rice v. Panchal, 65 F.3d 637, 645 (7th Cir. 1995) (holding that a claim for an injury that neither arose from the administration of a health plan nor required a resolution based on the interpretation of the plan should not be preempted by ERISA); see also Angela M. Easley, Comment, \textit{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, 302-03 (1997) (stating that quantity of care decisions that involve referencing of plans "to determine what was promised" under the plan should be preempted).

\textsuperscript{74} See, e.g., Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482, 1485 (7th Cir. 1996) (holding that direct liability claims against HMOs are preempted by ERISA); Tolton v. American Biodyne, Inc., 48 F.3d 937, 942 (6th Cir. 1995) (holding that the improper denial of authorization of benefits "relate[s] to" ERISA and is therefore preempted); Spain v. Aetna Life Ins. Co., 11 F.3d 129, 132 (9th Cir. 1993) (holding that a wrongful death suit brought under state law and seeking damages for negligent handling of benefit claim was preempted by ERISA); Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc., 999 F.2d 298, 304 (8th Cir. 1993) (holding that claims for delays in allowing a surgical procedure by an insurer were preempted by ERISA); Corcoran v. United HealthCare, Inc., 965 F.2d 1321, 1339 (5th Cir. 1992) (holding that a tort claim for wrongful death of a child was preempted by ERISA); Danca v. Emerson Hosp., 9 F. Supp. 2d 27 (D. Mass. 1998) (holding that ERISA preempted a state law claim for improper denial of benefits that led to attempted suicide).

\textsuperscript{75} 965 F.2d 1321 (5th Cir. 1992).

\textsuperscript{76} See id. at 1330 (holding that decisions regarding the availability of benefits under an ERISA plan are preempted by the ERISA statute).

\textsuperscript{77} See Gonzalez, supra note 4, at 779 (noting that not only will tort claims be preempted if they interfere with benefits of health care plans, but also if they
When Congress enacted ERISA in 1974, managed care was not nearly as prevalent or structured as today. Therefore, many sections of the statute are outdated as applied to managed care. ERISA preemption is not an appropriate defense in negligence cases against HMOs. When it created ERISA, Congress intended to protect employees and guarantee that they receive the medical benefits they deserve. When HMOs are allowed to use ERISA as a defense, Congress's intent to provide employees with appropriate benefits is defeated. The legislature should therefore update ERISA and redefine the preemption defense so that it is used only in the appropriate circumstances.

B. Non-Preempted Tort Claims

Although some jurisdictions interpret ERISA broadly, there has been some movement by courts towards a narrower interpretation of ERISA preemption. Courts that narrowly interpret ERISA have recognized the importance of adhering to the traditionally-held presumption against preemption.

restrict options in the method of administration of these plans).

See Jane M. Mulcahy, Comment, The ERISA Preemption Question: Why Some HMO Members Are Dying for Congress to Amend ERISA, 82 MARQ. L. REV. 877, 899 (1999) ("Congress probably did not foresee that HMOs would run the whole show, including the doctors and the hospitals, which allows them to insulate the whole medical spectrum by invoking ERISA preemption."); Stoeckl, supra note 3, at 408 (noting that Congress could not have predicted how managed care would evolve when it enacted the ERISA statute).

See Stoeckl, supra note 3, at 408.

See id.

See id.

See Alexandra E. Trinkoff, Court Permits Malpractice Suit Against New York HMO, 6 No. 1 N.Y. Health L. Update 2 (Mar. 1999) (recognizing that the preemption defense is appropriate in circumstances where HMOs act as administrators, making determinations regarding treatment coverage under health plans); Julie K. Locke, Note, The ERISA Amendment: A Prescription to Sue MCOs for Wrongful Treatment Decisions, 83 MINN. L. REV. 1027, 1040 (1999) (noting that ERISA preemption is acceptable where state laws "impose[ ] unacceptable burdens on a plan, such as mandating benefit structures or their administration, or provid[e] alternate enforcement mechanisms") (citing New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 657–59, 661 (1995)).

See Gonzalez, supra note 4, at 780 (noting that some federal courts have looked to Congress's intent in enacting ERISA instead of the language of ERISA in evaluating claims against managed care entities).

See Travelers, 514 U.S. at 655; see also Northern Group Servs., Inc. v. Auto Owners Ins. Co., 833 F.2d 85, 91 (6th Cir. 1987) (noting that there is a strong presumption that Congress's intent was not to preempt state governance).
Specifically, the Third Circuit's decision reversing the lower court's preemption holding in both *Dukes v. United States Health Care*\(^8^5\) and *Visconti v. United States Health Care*\(^8^6\) demonstrates that ERISA preemption should not be applied to claims involving the quality of care provided by HMOs.\(^8^7\) Courts view quality of care claims as being unrelated or indirectly related to ERISA employee benefit plans.\(^8^8\)

**C. Independent Benefit Reviews: The Argument for Non-Preemption**

The court in *Corporate Health Insurance* should have determined that the Act's provision for independent reviews of adverse benefit decisions involved the quality of health care, not the quantity and administration of employee benefits. Furthermore, the court should have adopted the approach of *Kampmeier v. Sacred Heart Hospital*,\(^8^9\) in which the court refused to preempt a claim alleging a denial of timely approval for an ultrasound test.\(^9^0\) The *Kampmeier* court, citing *Dukes*, found that the untimeliness of the approval had a direct negative effect on the provision of quality medical services.\(^9^1\)

The *Corporate Health Insurance* court should also have found that preemption decisions relating to independent reviews be considered on a case-by-case basis. It appears that a broad preemption of this section of the Act was improper because not all adverse benefit determinations are purely administrative. Some determinations involve denials of benefits that lead to reduced medical treatment and substandard health care.

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\(^8^7\) See *Visconti v. United States Health Care*, 57 F.3d 350, 357 (3d Cir. 1995) (holding that Congress' silence concerning quality control of benefits should be regarded as allowing state regulation in this area); see also MacDougall, *supra* note 1, at 903 (asserting that the Third Circuit's reversal of the lower court's ruling in both *Dukes* and *Visconti* undermined the effect of these cases as support for preemption in tort claims against HMOs).

\(^8^8\) See *Easley*, *supra* note 73, at 302; see also *Dykema v. King*, 959 F. Supp. 736, 741 (D. S.C. 1997) (holding that allegations of failure to timely diagnose illnesses relate to the quality of medical care and are therefore not preempted by ERISA); *Prihoda v. Shpritz*, 914 F. Supp. 113, 118 (D. Md. 1996) (holding that claims of failure to diagnose patient illnesses relate to the quality of medical care and are therefore not preempted).


\(^9^0\) See *id.* at *3.*

\(^9^1\) See *id.* at *2–3; see also *Grosso*, *supra* note 71, at 443.
D. Remedies Under Preempted Versus Non-Preempted Claims

For HMOs and managed care entities faced with state tort claims, ERISA preemption is a convenient defense. The ERISA preemption defense has an enormous impact on the results of litigation because preemption provides HMOs with a total bar against all state claims. In addition, ERISA preemption prevents the injured plaintiff from recovering any punitive or compensatory damages. Remedies under ERISA include reinstatement in the health plan and recovery of the cost of the denied benefit. In Dukes, the Third Circuit distinguished between the quality and the quantity of benefits to determine preemption. The Dukes court noted, however, that ambiguity can be encountered when making this decision and acknowledged that this ambiguity tends to prevent the most severely injured plaintiffs from obtaining proper redress, leaving them without a remedy for their injuries. The quality of health care may thus decline as a result of HMOs relying on the preemption provision because the threat of tort liability as a deterrent is eliminated.

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92 See Otterson, supra note 3, at 808 (stating that HMOs and managed care entities depend on “ERISA as a defense against... claim[s] because of its significant impact on the outcome of the litigation”).

93 See id. (stating that, in addition to a comprehensive bar to state claims, ERISA permits HMOs to remove the action to federal court).

94 See Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 138 (1985) (reversing circuit court of appeals’ judgment, which held that ERISA did not bar award of compensatory and punitive damages); Otterson, supra note 3, at 808–09 (noting that ERISA does not allow awards of “punitive or extracontractual compensatory damages”).

95 See Otterson, supra note 3, at 809; Stoeckl, supra note 3, at 395 (stating that ERISA does not provide recovery for pain and suffering, lost wages, or medical expenses that may be incurred in the future).

96 See Dukes v. United States Health Care, Inc., 57 F.3d 350, 358 (3d Cir. 1995). The Dukes court stated:

There well may be cases in which the quality of a patient's medical care... will be so low that the treatment received... will not qualify as health care at all. In such a case, it well may be appropriate to conclude that the plan participant... has been denied benefits due under the plan.

Id.

97 See Natalie Zellner, Comment, Duking It Out: Beating the Complete Preemption of ERISA Under Dukes v. United States HealthCare, Inc., 14 GA. ST. U. L. REV. 925, 948 (1998) (explaining that the preemption doctrine has eliminated tort claims against employee HMO plans, resulting in a decline in the quality of health care because managed care entities are less concerned about their actions).
II. IMPACT OF THE TEXAS ACT

A. The First Texas Case Brought Under the Texas Act

The Texas legislature, concerned about the reduced accountability of HMOs for their negligent acts, passed the Act to allow malpractice claims to be made directly against HMOs. As a result of the court's holding in Corporate Health Insurance, the first case was brought under the Act alleging negligence by an HMO. In Plocica v. NYL Care of Texas, Inc., the plaintiff was a sixty-eight year old man with a history of depression. He was admitted to a hospital after an overdose and remained hospitalized until the defendant, NYL Care, demanded that the plaintiff be discharged—against the approval of his physician, who diagnosed him as medically unstable. On the evening after he was discharged, the plaintiff committed suicide by ingesting a half-gallon of antifreeze.

The plaintiff's family brought suit under section 88.001 of the Act, claiming that his HMO failed to provide the "degree of care that a ... health maintenance organization ... of ordinary prudence would use under the same or similar circumstances." In response, the defendants filed a notice of removal to the federal district court, claiming that the plaintiff's complaint alleged damages caused by the denial of benefits under the Medicare program. In turn, the plaintiffs filed a motion to remand, denying any claim for benefits under the Medicare Act. The plaintiff asserted that, since the claims sought damages for the substandard quality of health care provided by the HMO rather than "payment or reimbursement for any

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98 See Otterson, supra note 3, at 821 (noting that on May 22, 1997, Texas enacted a statute allowing negligence claims to be brought against HMOs, making it the first state to enact such a statute).
100 See id. at 662.
101 See id.
102 See id. at 662–63.
103 See id. at 663.
104 TEX. CIV. PRAC. & REM. CODE ANN. § 88.001(10) (West Supp. 1999).
106 See Plocica, 43 F. Supp. 2d at 662.
allegedly denied benefit,”\textsuperscript{107} the Medicare Act’s preemption provision was not applicable. Rather, the court, finding that a reimbursement remedy would be futile because Mr. Plocica was deceased,\textsuperscript{108} held that the plaintiff’s claims were “based in tort against defendants for their allegedly tortious conduct in the inadequate quality of care and treatment of [the decedent].”\textsuperscript{109} The implications of this case are substantial because it holds HMOs and managed care entities liable for substandard health care decisions that lead to the injury or the death of health plan holders.\textsuperscript{110}

\textbf{B. Jurisdictions Considering Statutes Similar to the Texas Act}

Many other jurisdictions have passed or are considering enacting statutes similar to the Act. For example, Missouri has passed a managed care law that permits suits against HMOs for medical malpractice.\textsuperscript{111} Under the Missouri statute, an HMO is a “health care provider”\textsuperscript{112} and therefore subject to liability for “making negligent medical decisions.”\textsuperscript{113} Statutes recently enacted in California\textsuperscript{114} and Georgia\textsuperscript{115} also allow for suits

\textsuperscript{107}Id. at 664.
\textsuperscript{108}See id. at 663–64.
\textsuperscript{109}Id. at 664.
\textsuperscript{110}Since Plocica, federal courts reviewing motions to remand state tort claims on the basis of ERISA preemption have come to differing conclusions. Compare In re United States HealthCare, Inc., 193 F.3d 151, 162–63 (3d Cir. 1999) (holding that ERISA did not preempt state negligence claim that an HMO’s policy of presumptively discharging newborns after 24 hours was implemented without due care for the health and safety of the newborn), and Giles v. NYLCare Health Plans, Inc., 172 F.3d 332, 339 (5th Cir. 1999) (affirming district court’s order to remand negligence claims against HMO for doctor’s failure to diagnose patient’s heart defect, resulting in death, upon a finding that plaintiff’s claims “relate to the regulation of health care—an area of traditional state regulation”), with Hull v. Fallon, 188 F.3d 939, 943 (8th Cir. 1999) (holding that ERISA preempts claim of negligence against HMO for physician’s decision to deny one kind of stress test in favor of another because such claim “rests on the denial of benefits,” not medical malpractice), and Danca v. Private Health Care Sys., Inc., 185 F.3d 1, 6 (1st Cir. 1999) (affirming dismissal of a complaint alleging negligence by HMO in denying patient’s request for placement in a psychiatric facility of her choice as a complaint of improper claims processing, which, although “quasi-medical in nature,” is preempted by ERISA).
\textsuperscript{112}Id. at § 538.205(4).
\textsuperscript{113}Locke, supra note 82, at 1044; see also Stoeckl, supra note 3, at 407 (stating that the Missouri law imposes HMO liability for “poor medical outcomes”).
\textsuperscript{114}See CAL. CIV. CODE § 3428(a) (Deering Supp. 1999) (imposing a duty of “ordinary care” on managed care entities providing services on or after
against HMOs. In addition, Georgia law allows an individual to appeal an HMO's adverse benefits decision to an independent body,116 as do Connecticut and Arizona law.117 The New York State legislature has passed a managed care law that allows for independent review of HMO decisions118 and is also considering a law that would allow medical malpractice suits to be brought against HMOs.119

Other states have simply chosen to regulate managed care entities more closely. Nevada’s managed care statute120 focuses on the costs of health care and the effect of those costs on the availability and quality of treatment.121 Colorado has passed a law setting standards for the quality of care provided by managed care entities.122

As HMOs continue to become more widespread, states are likely to continue enacting legislation that holds HMOs liable for providing substandard medical care. Despite such laws, however, HMOs may still be able to avoid liability by seeking preemption under the ERISA statute.123 As long as ERISA continues to be interpreted broadly without intervention by Congress, health care consumers may face maximized medical care costs with minimized health care quality.124

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115 See GA. CODE ANN. § 51-1-48(a) (Supp. 1999) (imposing a duty of “ordinary diligence” on managed care entities and providing for tort relief for breach of such duty without punitive damages).

116 See id. § 33-20A-32.

117 See CONN. GEN. STAT. ANN. § 38a-478n (West Supp. 1999) (providing an appeal to an “impartial health entit[y] to provide for medical review” of the HMO’s decision after the internal appeal process is exhausted); ARIZ. REV. STAT. ANN. §20-2537 (West Supp. 1999) (establishing specific “external independent review” procedures); see also Michael Higgins, Increased Exposure for HMOs, A.B.A. J., Sept. 1997, at 24 (surveying various state laws relating to stricter controls over HMOs).

118 See Locke, supra note 82, at 1044 (stating that the New York law “gives customers the right to ask for an independent review if they believe their claims for service were wrongly denied”).


121 See Stoeckl, supra note 3, at 407.

122 See COLO. REV. STAT. §§ 10-16-701 to 10-16-708 (1999); see also Stoeckl, supra note 3, at 407.

123 See Locke, supra note 82, at 1044 (noting that it is unclear whether HMOs will be held liable under these statutes while ERISA preemption exists); Stoeckl, supra note 3, at 408 (noting that ERISA would allow HMOs and managed care entities to “remain insulated from liability”).

124 See Grosso, supra note 71, at 433 (noting that health care consumers may
CONCLUSION

The Texas law has the potential to affect greatly the status of health care in the United States today. Congress, however, must address issues surrounding ERISA preemption because most health care consumers are members of health plans that are offered through their employers as employee benefit plans. As a result, HMOs and managed care entities seek shelter under the ERISA preemption provision. They do not strive to improve the quality of care they provide because they are free from the fear of potential litigation. It is imperative that Congress enact legislation to narrow the interpretation of the preemption provision and recognize that a denial of benefits might be equivalent to substandard health care. It is only by this course of action that health care consumers and their families will avoid the potentially devastating effects and unnecessary anguish caused by the denial of benefits that limits medical intervention—intervention that could ease a person's suffering or even cure the disease that causes it.