
Managed Care Liability

2000

An Update



by George Parker Young*

I. Introduction: The Most Important Recent Decisions

During a two week span in June of 2000, four highly significant decisions were issued in the Employee Retirement Income Security Act (ERISA) and federal preemption area involving litigation against health maintenance organizations (HMOs).¹ First and foremost was the Supreme Court's unanimous opinion in *Pegram v. Herdrich*.² The second case was *Corporate Health Ins., Inc. v. Texas Department of Insurance*,³ written by Judge Higginbotham for the Fifth Circuit Court of Appeals. The third in this series of cases involved the Supreme Court's action in *U.S. Healthcare Systems, Pa. v. Pa. Hosp. Ins. Co.*,⁴ vacating a Pennsylvania Supreme Court opinion which found no ERISA preemption of state law tort claims. Finally, was the Supreme Court's denial of certiorari in *U.S. Healthcare, Inc. v. Bauman*,⁵ in which the Third Circuit expanded the quality of care definition applied to "HMO entities."

Five Broad Conclusions:

Five broad conclusions can be drawn from these four cases:

- ERISA's predominance and federal preemption of patients' state law claims against HMOs is now much narrower, continuing a trend that was started by the Supreme Court in 1995. The viability of federal preemption and removal to the federal courts by HMOs is even more circumscribed. Moreover, the federal remedies available to patients under ERISA have become more clearly defined and are now extremely limited.
- State law claims against HMOs tied to financial incentives are clearly viable; they will not be preempted by ERISA.
- Courts continue to sidestep the difficult issues challenging HMOs delegation of medical

treatment decisions to themselves (these include "coverage" definitions giving HMOs the exclusive right to determine what is "medically necessary"), leaving much confusion in the area, to be, no doubt, a primary subject of most HMO litigation over the next several years.

- Vicarious liability and ostensible agency claims against HMOs have continued to gain ground. They are clearly the easiest to bring, especially under HMO liability statutes in place in Texas and other states. It is now highly unlikely that a court would find such state laws preempted by ERISA.
- The final *disturbing* conclusion flows from the Supreme Court's willingness to derive congressional intent and legislative purpose from briefs submitted by the insurance industry and *amicus curiae*. The Court has embraced the industry's factual assumptions even though they are not reflected in the record of the cases before the Court and are nowhere to be found in published legislative history.

II. Discussion of The Four Recent Decisions

A. Pegram v. Herdrich.

1. The Herdrich Holding.

Stated simply, the holding of *Herdrich* is that mixed treatment and eligibility decisions by an HMO, acting through its physicians, are not fiduciary acts under ERISA.⁶ The basis for the Court's holding is that Congress did not intend for an HMO to be treated as a fiduciary when it makes "mixed decisions on eligibility" through its physicians. Accordingly, there is no cause of action under ERISA for the simple payment of financial incentives by an HMO to its physicians. An HMO does not breach its fiduciary duty by providing such incentives to physicians. Although *Herdrich* does not raise any preemption issues directly,⁷ much in the decision refines the Court's continuing redevelopment



of preemption analysis, which began with Justice Souter's unanimous opinion in *Travelers*, and was followed by the Court's decisions in *DeBuono* and *Dillingham* ("the Trilogy").⁸

2. *The Herdrich Facts.*

Cynthia Herdrich (Herdrich) was examined by her physician, Lori Pegram (Pegram), after experiencing abdominal pain.⁹ Although Herdrich required certain diagnostic testing Pegram did not order it at the local hospital.¹⁰ Instead, she decided that Herdrich would have to wait eight days for the testing and ordered it at the HMO staffed hospital located 50 miles away.¹¹ Because of the delay, and before the testing was performed Herdrich's "appendix ruptured, causing peritonitis."¹² The HMO involved was physician-owned, so that Pegram stood to gain financially every time she withheld care and treatment from a patient.¹³

3. *Herdrich's Procedural History.*

Herdrich sued Pegram and the HMO (defendants) in state court for medical malpractice. The defendants removed the case to federal court, and Herdrich amended her petition to allege breach of fiduciary duty under ERISA.¹⁴ The district court dismissed the breach of fiduciary duty claim, and Herdrich appealed. The Seventh Circuit reversed the district court's dismissal of the claim holding that the HMO was acting as an ERISA fiduciary when Pegram made the challenged medical treatment decision.¹⁵ In a wide-ranging broadside against managed care the court allowed the ERISA claim for breach of fiduciary duty to go forward.¹⁶ The Supreme Court reversed. The opinion, authored by Justice Souter, turned on the issue of whether the HMO acted as an ERISA fiduciary when its physician owners acted in the provider treatment role.

4. *Supreme Court's Opinion: Managed Care Background.*

To establish a foundation for its opinion, the Court first set forth "some background of fact and law about HMO organizations, medical benefit plans, fiduciary obligations, and the meaning of Herdrich's allegations."¹⁷

The Court's discussion begins in Section II.A with Justice Souter's overview of the history of the health care delivery system and the development of HMOs against the background of the prior fee-for-service system. The Court recognized that HMOs are risk-bearing organizations, functioning much like traditional insurance companies, when making coverage decisions. However, unlike traditional insurance companies, HMOs also determine "standards of medical necessity or the reasonableness of the proposed treatment" *after* premiums have been collected but before the payment risk accrues.¹⁸

Interestingly, Justice Souter recognized that in a fee-for-service system, the physicians' financial incentives are generally in line with the patients' interests, in providing (and receiving) more care, not less.¹⁹ In contrast, the financial incentives implemented by HMOs in many contexts reward physicians for decreasing utilization of health care services and penalize doctors for providing more care.²⁰

Through the first part of Section II.A of the opinion Justice Souter's analysis is more sophisticated than most opinions reviewing this area, and recognizes that in addition to acting as insurers, HMOs implement various cost containment measures, including "utilization review (in which specific treatment decisions are reviewed by a decision-maker other than the treating physician)."²¹ In addition, Justice Souter notes:

These cost-controlling measures are commonly

complemented by specific financial incentives to physicians, rewarding them for decreasing utilization of health-care services, and penalizing them for what may be found to be excessive treatment....*Hence, in an HMO system, a physician's financial interest lies in providing less care, not more.*²²

Justice Souter goes on to state that the check (and probably the only check) on strong financial influences placed by HMOs on physicians is professional ethics. He cites the American Medical Association's *amicus curiae* brief for this proposition.²³

In Section II.B of the opinion Justice Souter reaches the first of a number of serious factual conclusions without any foundational basis. He concludes that "[n]o HMO organization could survive without some incentive connecting physician reward with *treatment rationing*. The essence of an HMO is that salaries and profits are limited by the HMOs' fixed membership fees."²⁴ This conclusion misses the point and is in fact wrong. As will be seen, Justice Souter *ignores* congressional purposes in adopting the HMO Act.

Of course, in any insurance arrangement where premiums are collected based on underwriting principles, an insurer determines the acceptable level of risk it is willing to undertake in return for a reasonable profit. The primary difference between an HMO and a traditional insurance company (which Justice Souter glosses over) is that in an HMO context, because of its role as provider, and its involvement in physician medical decision-making, the HMO actually exercises a strong guiding hand in minimizing the payment risk after the premium has been calculated and collected. Put simply, under the euphemism of "managing its risks," after the premium has been taken in, the HMO has the opportunity to minimize its risk and ensure that medical bills are within its budget by denying care, even necessary care. This distortion of the typical insurance relationship is much like playing craps in a casino where the house can turn one of the dice after the roll, but before payout, to ensure minimum risk to the casino. Justice Souter also overlooks the existence of other ways some HMOs control their expenses, including but not limited to the less onerous device of straight capitation.

More disturbing than Justice Souter's unsupported factual conclusion about the necessity of financial incentives is his conclusion that Congress intended to create a system of treatment rationing:

"But whatever the HMO, there must be rationing and inducement to ration. . . . inducement to ration care goes to the very point of any HMO scheme..."²⁵

The Court offers no support for this conclusion. It does not cite the record, the legislative history of the HMO Act, any law review article, or any other source. The conclusion does not follow from the statements that precede it; it is sitting on an island without logical support. Moreover, the Court's conclusion is startling, and one that the authors of the 1973 HMO Act never intended (the Act's legislative history mentions nothing about encouraging onerous financial incentives on doctors directly tied to treatment).²⁶

Strangely, Justice Souter goes on to recognize that the determination of the appropriate HMO structure, and whether or not some HMOs engage in unacceptably-risky financial incentives endangering patient health, is "complicated fact finding" and "debatable social judgment" not wisely required of courts.²⁷ But to preclude or avoid liability is a "debatable social judgment," even when done under the guise of interpreting legislative intent. In other words, not to decide *is* to decide: to sanction and encourage the onerous incentives, in the absence of any evidence Congress intended to do so.

5. Herdrich *ERISA Analysis: Section II.C.*

The Court begins its analysis of ERISA in Section II.C of the opinion. In this section, Justice Souter makes an important distinction between an ERISA plan instituted by an employer for the benefit of employees, and an HMO health plan.²⁸ The failure to distinguish the two has led to confusion in a number of ERISA cases.

Justice Souter adopts the *Webster's Dictionary* definition of the term "plan" and then goes on to state:

Here the *scheme* comprises a set of rules that define the rights of a beneficiary and provide for their enforcement. Rules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a plan....Thus, when employers contract with an HMO to provide benefits to employees subject to ERISA, the provisions of documents that set up the HMO *are not*, as such, an *ERISA plan*, but the agreement between an HMO and an employer who pays the premiums may, as here, provide elements of a plan by setting out rules under which beneficiaries will be entitled to care.²⁹

The key in this quote is probably not so much the focus on the agreement between the ERISA plan and the HMO as it is the recognition that the documents and arrangements constituting the HMO's structure, i.e., its contracts and arrangements between the HMO and its physicians, are *not* part of the ERISA scheme or plan. This distinction becomes incredibly important to ERISA preemption analysis, as demonstrated in Judge Higginbotham's opinion in *Corporate Health*, discussed at page 248.

6. *Is the HMO Acting as an ERISA Fiduciary?*

Section II.D of the opinion examines the central issue of the case: whether the HMO acted as an ERISA fiduciary.³⁰ The Court recognizes that "although [the HMO] is not an ERISA fiduciary merely because it administers or exercises discretionary authority *over its own HMO business*, it may still be a fiduciary if it administers the plan."³¹ The Court then discusses fiduciary duty under ERISA, which requires "fiduciaries to discharge their duties with respect to a plan 'solely in the interest of the participants and beneficiaries.'"³² The Court notes that fiduciary responsibilities under ERISA originate in the common law, but goes on to state that because the ERISA trustee wears several hats its position is not analogous to that of a common law trustee.³³ "ERISA does require, however, that the fiduciary with two hats wear only one at a time, and wear the fiduciary hat when making fiduciary decisions."³⁴

The Court then states:

In every case charging breach of ERISA fiduciary duty...then, the threshold question is not whether the actions of some person employed to provide services under a plan adversely affected a plan beneficiary's interest, but whether that person was acting as a fiduciary (that is, was performing a fiduciary function) when taking the action subject to complaint.³⁵

The court notes that Herdrich does not allege that her physician acted negligently, rather Herdrich alleges that the HMO breached its fiduciary duty by providing financial incentives that ultimately compromise the medical services rendered to patients.³⁶ The Court then concludes that the HMO was not acting in an ERISA fiduciary capacity by

compensating its physicians; there was no violation of ERISA when the HMO provided for the payment of incentives to its physicians.³⁷ "The HMO is not the ERISA plan, and the incorporation of the HMO preceded its contract with the State Farm plan."³⁸

7. *The Mixed Eligibility Decision.*

In a section extremely important to federal preemption analysis, the Court discusses two types of administrative acts and their relationship to ERISA fiduciary duty.

It will help to keep two sorts of arguably administrative acts in mind. *Cf. Dukes v. U.S. Healthcare, Inc.*... (discussing dual medical/administrative roles of HMOs).³⁹ What we will call pure 'eligibility decisions' turn on the plan's coverage of a particular condition or medical procedure for its treatment. 'Treatment decisions,' by contrast, are choices about how to go about diagnosing and treating a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response?⁴⁰

The Court finds that these two decisions are often inextricably intertwined as a practical matter, citing as authority for this factual determination the briefs of *amici curiae* filed in the case on both sides.⁴¹ The Court then wrestles with the HMO's combined insurance risk assumption role, administrative role, and provider role involving the exercise of medical judgment:

This [inextricable intertwining] is so not merely because, under a scheme [involving financial incentives to physicians], treatment and eligibility decisions are made by the same person, the treating physician. It is so because a great many and possibly most coverage questions are not simple yes-or-no questions, like whether appendicitis is a covered condition (when there is no dispute that a patient has appendicitis), or whether acupuncture is a covered procedure for pain relief (when the claim of pain is unchallenged). The more common coverage question is a when-and-how question. Although coverage for many conditions will be clear and various treatment options will be indisputably compensable, *physicians* still must decide what to do in particular cases. The issue may be, say, whether one treatment option is so superior to another under the circumstances, and needed so promptly, that a decision to proceed with it would meet the **medical necessity** requirement that conditions the HMO's obligation to provide or pay for that particular procedure at that time in that case. . . . In practical terms, these eligibility decisions cannot be untangled from physicians' judgments about reasonable medical treatment. . . .⁴²

Dr. Pegram's decision was classified as mixed: "The eligibility decision and the treatment decision were inextricably mixed, as they are in countless medical and administrative decisions every day."⁴³

Justice Souter then lists several examples of mixed eligibility and treatment decisions:

[P]hysicians' conclusions about when to use diagnostic tests; about seeking consultations and making referrals to physicians and facilities other than [the HMO's]; about proper standards of care, the experimental character of a proposed course of treatment, the reasonableness of a certain treatment, and the emergency character of a medical condition.⁴⁴

8. *The End of Federal ERISA Preemption of “Medical Necessity” Decisions.*

Thereafter, the opinion signals the end of ERISA preemption of medical necessity decisions.⁴⁵ The Court finds that Herdrich’s ERISA claim *does not* involve the type of administrative decision that consists of pure eligibility decisions. Relying on Herdrich’s brief which “targets *medical necessity* determinations” the Court States:

[C]ongress did not intend...any...HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians. *We begin with doubt that Congress would ever have thought of a mixed eligibility decision as fiduciary in nature.*⁴⁶

Then, in a passage sure to receive much attention in the next several years, the Court finds:

Mixed eligibility decisions by an HMO acting through its physicians *have, however, only a limited resemblance to the usual business of traditional trustees...* Traditional trustees administer a medical trust by *paying out* money to buy medical care, whereas physicians making mixed eligibility decisions consume the money as well. Private trustees do not make treatment judgments, *whereas treatment judgments are what physicians reaching mixed decisions do make, by definition. Indeed, the physicians through whom HMOs act make just the sorts of decisions made by licensed medical practitioners millions of times every day, in every possible medical setting:* HMOs, fee-for-service proprietorships, public and private hospitals, military field hospitals, and so on . . . Thus, it is at least questionable whether Congress would have had *mixed eligibility decisions* in mind when it provided that *decisions administering a plan were fiduciary in nature.*⁴⁷

Thus, “mixed” eligibility decisions are not fiduciary decisions under ERISA for purposes of ERISA preemption because they are not “decisions administering a plan.” This conclusion bodes the end of ERISA preemption of state court claims based on an HMO’s medical necessity decisions. They are by definition “mixed eligibility” decisions.

The Court justifies its conclusion by finding that the federal ERISA claim argued by Herdrich would mandate preemption of state law regulation of the health and safety area, which the Court finds was *not* intended by Congress. Thus, the Court continues the clarification of the scope of ERISA preemption which started with *Travelers*.

Justice Souter further concludes that holding an HMO liable under ERISA for breach of fiduciary duty for the improper payment of financial incentives “in effect would be nothing less than elimination of the for-profit HMO.”⁴⁸ This conclusion is alarmist; it is not supported by the record or the legislative history of the HMO Act.⁴⁹ However, the Court makes much of congressional approval of HMOs:

The fact is that for over 27 years the Congress of the United States has promoted the formation of HMO practices. The Health Maintenance Organization Act of 1973...allowed the formation of HMOs that assume financial risks for the provision of health care services.⁵⁰

However, Congress’ provision for the establishment and organization of HMOs under federal law does not lead to the conclusion that Congress intended to encourage or permit financial incentives of any kind that cause physicians (or even an HMO in its risk-taking mode) to restrict medically-necessary care. Yet, by characterizing Herdrich’s claim not as

one focused on financial incentives, but as a “wholesale attack” on existing HMOs solely because of their structure, the Court reaches its desired result.⁵¹

9. *State Law Should Apply to These Claims.*

Admitting that there may be common law standards to which HMOs and physicians should adhere, the Court expresses its reluctance to recast those standards as fiduciary in nature.

[F]or all practical purposes, every claim of fiduciary breach by an HMO physician making a mixed decision would boil down to a malpractice claim, and the fiduciary standard would be nothing but the malpractice standard traditionally applied in actions against physicians.⁵²

The Court then reasons that a cause of action under ERISA for breach of fiduciary duty is not necessary because of the existence of remedies that are “already available” in state courts:

It is true that *in States that do not allow malpractice actions against HMOs* the fiduciary claim would offer a plaintiff a further defendant to be sued for direct liability, and in some cases the HMO might have a deeper pocket than the physician.⁵³

Accordingly, Justice Souter views existing state law claims against HMOs based on financial incentives, that are available in many states, as yet another reason not to recognize a federal ERISA claim.

Finally, coming full circle to the narrowing of ERISA preemption begun in *Travelers*, the Court justifies its refusal to recognize a breach of fiduciary claim as a way to avoid preempting state malpractice law claims against HMOs:

On its face, federal fiduciary law applying a malpractice standard would seem to be a prescription for preemption of state malpractice law, since the new ERISA cause of action would cover the subject of a state-law malpractice claim. To be sure...*Travelers*...throws some cold water on the preemption theory; there, we held that, in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose. But in that case the convergence of state and federal law was not so clear as in the situation we are *positing* [the rejected federal fiduciary law standard through ERISA, while there is already coexisting HMO malpractice liability at the state level]; the state-law standard had not been subsumed by the standard to be applied under ERISA. We could struggle with this problem, but first it is well to ask, again, what would be gained by opening the federal courthouse doors for a fiduciary malpractice claim....⁵⁴

10. *Herdrich’s Impact.*

The Court makes it clear that “mixed decisions” are nothing more than medical treatment decisions made millions of times each day in other contexts, and that the decisions in those contexts are subject to state law. Thus, *Herdrich* stands for the proposition that even when the HMO assigns to itself the “medical necessity” second-guessing function by the way that it writes its coverage agreement, the “medical necessity” analysis by the HMO’s medical director would not trigger preemption. Indeed, state law continues its vital role of regulating the HMO’s health care treatment decisions. This conclusion is reinforced by the Court’s

citations to such cases as *Dukes* and *Travelers*.

11. *The Actual Legislative History of the Federal HMO Act.*

The factual foundation for parts of Justice Souter's opinion in *Herdrich* is derived solely from broad assertions contained within briefs submitted by members of the insurance industry. Much of the juridical "foundation" for this opinion is nowhere to be found in the legislative history of ERISA, which was passed in 1974, or the HMO Act which was passed in 1973, and the amendments thereto. The most glaring misconception within *Herdrich* is the unfounded assumption that Congress *intended* to implement widespread health care rationing in 1973 and 1974!

This does not mean that Justice Souter has reached the wrong result. There are other valid foundations supporting his opinion. For example, regulation of financial incentives between HMOs and doctors falls within the traditional health care regulation field occupied by the states. Moreover, a breach of fiduciary duty claim could be predicated not simply on the existence of a conflict of interest, but also the failure to disclose such a conflict. This avenue for pursuing an ERISA breach of fiduciary duty claim is recognized in footnote 8 of the opinion, but the Court leaves for a later day the viability of pursuing such a cause of action.⁵⁵

In *Herdrich*, the Supreme Court, for the first time, indicates that courts should examine the interaction between ERISA and the HMO Act when it states, "[t]he fact is that for over 27 years the Congress of the United States has promoted the formation of HMO practices," and the federal judiciary "would be acting contrary to the congressional policy of allowing HMO organizations if it were to entertain an ERISA fiduciary claim portending wholesale attacks on existing HMOs solely because of their structure, untethered to claims of concrete harm."⁵⁶ The Court's analysis, applying the

congressional intent behind the HMO Act to resolve the congressional intent behind ERISA, yields surprising results.

Analysis of the Federal HMO Act including its 1973, 1976, 1978, and 1988 amendments and legislative history shows there is no support for the proposition that Congress meant to encourage the adoption of physician-oriented financial incentives by HMOs, especially those tied to treatment decisions by the physician. Indeed, the opposite appears to be the case. The legislative history of the Act makes it clear that Congress intended the *states* to regulate HMO quality, and "medical necessity" determinations. It never contemplated that HMOs would be able to delegate to themselves the practice of medicine through a statute (ERISA) requiring almost unquestioned deference to a plan administrator's "benefit" decision. Stated another way: there is no Congressional intent, or even cognizance, of the process whereby *health plans* take from treating doctors, and the states, the authority to determine what care is appropriate or medically necessary.

a. The legislative history of the HMO Act contained within the Senate Labor and Public Welfare Committee Report indicates that the HMO Act was designed, from the Senate's point of view, to *reduce* "financial risks" on physicians:

[T]he organization of health resources in an HMO provides substantial economic and professional advantages to participating physicians as well, in the form of significant reductions in the cost of medical practice . . . and *reduced financial risks* in entering medical practice.⁵⁷

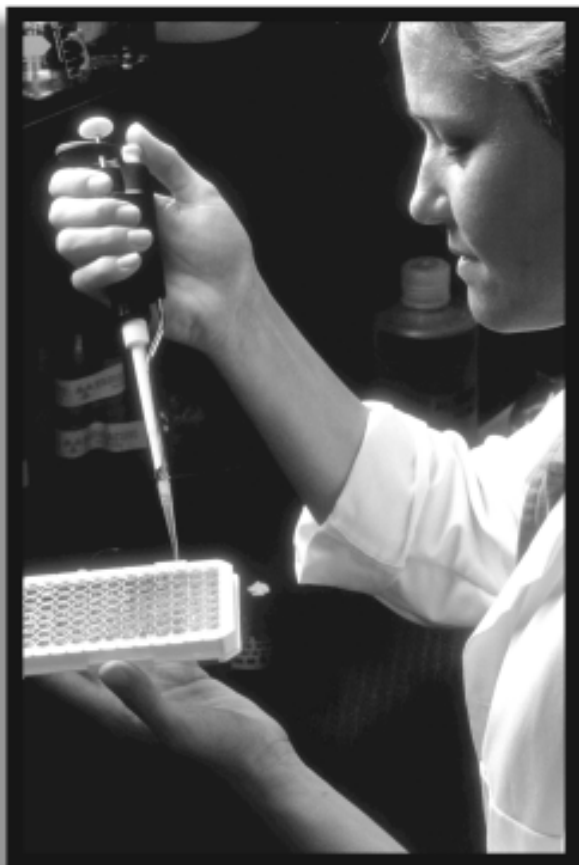
b. While Congress toyed with the idea of a comprehensive federal regulation of quality, ultimately, it decided to leave quality of care regulation to the states⁵⁸ and adopted express provisions designed to *encourage* state regulation of quality of care provided by HMOs. Indeed, the only preemption provisions of the Act address states' barriers to the formation of HMOs, such as those prohibiting prepaid plans.⁵⁹

c. The Senate Report also makes it clear that the Senate considered HMOs *at that time* to **remove** any financial incentives from the practice of medicine at the physician level:

The medical group approach also provides opportunity for a restructuring of financial incentives. A health professional's income is not related directly to the number of services he provides, thereby removing a major incentive for over-utilization of services. In addition, it allows the *health professionals* to make judgments based on *medical necessity alone*.⁶⁰

This language in the Senate report has never received substantial attention, especially when analyzing the interplay between the HMO Act and ERISA. Justice Souter, in *Herdrich*, recognizes the importance of the two Acts passed one year apart, yet (perhaps understandably) adopts the insurance industry's spin on that interplay without giving any attention to the actual legislative history of the Acts. It is inconceivable that Congress would have intended to facilitate the removal of any financial incentives ("towards over- or under-utilization") impacting physicians' diagnosis, testing, treatment and referral decisions, encouraging "health professionals" and not HMOs to "make judgments based upon medical necessity alone,"⁶¹ under the HMO Act, but under ERISA, the very next year, somehow intended to bestow on employee benefit plans, or HMO providers contracting with ERISA plans, the ability to circumvent congressional intent that "*health professionals* would make judgments based on *medical necessity alone*."⁶²

In a separate section of the Senate Report entitled "State Standards" the Committee discusses the proposed Commission



on Quality Health Care Assurance, concluding that “states, through a designated state agency, should be given the opportunity to develop health care standards...”⁶³ In the following paragraph the Senate Committee states:

An added factor in this Committee’s decision to encourage states to develop their own standards is the fact that experience in the medical care field has indicated that the closer the responsibility for standard development of health care regulation is to the actual provider of the care, the more likely the provider is to become involved in the development and setting of standards. The result is that these providers are more responsive to these standards when they have assisted in the development of the standards.⁶⁴

Accordingly, the Committee determined that the states should be given the opportunity to promulgate and enforce their own standards. Nothing in the subsequent House Conference Report or floor debate negates this clear congressional intent that:

- (1) medical professionals, not HMOs, would determine “medical necessity”; and
- (2) the states would be responsible for administering quality standards for health care, including “medical necessity.”

d. Moreover, the Senate Report reveals that the version of the Act passed in the Senate allowed a “state agency or court to assert its jurisdiction under State law over any health issue that is not affected by a standard criterion or norm promulgated under section 1302” of the Act.⁶⁵ Section 1302 set forth the functions of the proposed Commission on Quality Health Care Assurance.⁶⁶ As ultimately passed, the Commission did not have the broad powers contemplated by the Senate. The absence of any manifested intent to preempt state law quality of care standards, and the Senate’s adoption of state law enforcement of health care standards, negates any argument that the HMO Act began an attempt by Congress to allow federal preemption of state law medical necessity regulation under the guise of either the HMO Act or ERISA.

e. With regard to congressional intent and financial incentives, the 1976 House Conference Report, adopted the Senate amendment which allowed medical groups to “pool their income from practice as members of the group and distribute it among themselves according to a prearranged salary or drawing account or other similar plan “unrelated to the provision of specific health services.”⁶⁷ In other words, Congress clearly intended to prohibit financial incentives tied to health care in a way that created disincentives to treat. Further, just two years after ERISA was passed Congress considered but rejected a federal court remedy for enrollees of an HMO who were given assurances, directly or indirectly, respecting basic and supplemental health services.⁶⁸ The House Conference Substitute noted that a resolution of these issues in this manner “does not change any existing right of individuals to bring suit in State courts.”⁶⁹ Thus, even state law fraud claims against HMOs were not intended to be preempted by Congress, as indicated just two years after ERISA was passed.

f. In 1978, the HMO Act was amended again without any indication that either its scheme of preemption, or its prohibition of financial incentives tied to treatment, was modified. The 1978 House Conference Report used the term “medically necessary,” but only with respect to requiring HMOs to reimburse members who had to seek medically necessary treatment which was immediately required because of unforeseen ailments, injury, or condition.⁷⁰ At no point was the determination of what is “medically necessary” made the sole province of HMO decision making. Such an interpretation

would frustrate the very purpose of the Conference substitute.⁷¹

g. Finally, in 1988, the last significant amendments to the HMO Act were passed. The Senate Committee on Labor and Human Resources allowed an HMO, preferred provider organization (PPO), and indemnity plan or self-insurance administrative arrangement, to operate through one entity.⁷² By not distinguishing between, and apparently blurring the lines between what had previously been required to exist in separate legal entities, the indication is that Congress did not intend to treat self-insured plans, and purchase money insurance plans any differently when it came to HMO regulation.

h. While financial incentives were discussed briefly in the Senate Report, this discussion had to do with deductibles that could be charged for out-of-plan services.⁷³ Nothing indicates that Congress intended to supplant state law regulation or meant to encourage a scheme of financial incentives tied to treatment.⁷⁴

It is inconceivable that just one year later Congress, through ERISA, intended to supplant the states’ quality and medical regulation of HMOs by the adoption of ERISA. This is especially true when one considers the legislative history of ERISA: it was originally designed to address retirement plans. Employee health plans were added at the last minute in the legislative process, late in the conference. Nothing in the subsequent development of ERISA or its amendments indicates any intent by Congress, at any time, to supplant the clear intent contained in the prior year’s Senate Report on the HMO Act: the states would be the ones to adopt and enforce “medical care standards” and “health care regulation.”

B. *Pappas v. Asbel.*

In *Pappas*, the Supreme Court of Pennsylvania found that ERISA does not preempt state law tort claims. On appeal, the Supreme Court vacated the state supreme court’s opinion and remanded the case “for further consideration in light of *Pegram v. Herdrich*...”⁷⁵

1. *Pappas’ Basic Facts.*

Basile Pappas was admitted to Haverford Community Hospital complaining of paralysis and numbness in his extremities.⁷⁶ The emergency room physician concluded that he was suffering from an abscess pressing on his spinal column, and after consulting with a neurologist and neurosurgeon, decided that Pappas’ condition was a neurological emergency.⁷⁷ The best medical care was to transfer Pappas to Jefferson University Hospital.⁷⁸ However, U. S. Healthcare, Pappas’ HMO, denied the authorization for the transfer, resulting in a three hour delay in treatment.⁷⁹ Pappas now suffers from permanent quadriplegia, a result of the compression of his spine caused by the abscess.⁸⁰

2. *Pappas’s Procedural History.*

Pappas sued his primary care physician and Haverford Hospital in state court. Haverford Hospital filed a third party complaint and joined the HMO as a party defendant, alleging that it negligently refused to authorize the transfer.⁸¹ The HMO filed a motion for summary judgment arguing that the claims against it were preempted by ERISA.⁸² The trial court granted the motion. On appeal, the superior court reversed the trial court, finding no preemption of the state law claims.⁸³ The HMO appealed. The Supreme Court of Pennsylvania (which is situated in the Third Circuit), noted that the United States Supreme Court has yet to speak directly to the issue of whether negligence claims against HMOs “relate to” an ERISA

plan.⁸⁴ The court then identified the “noticeable change in tack” wrought by *Travelers*, *DeBuono*, and *Dillingham*, and recognized a new position on ERISA preemption demonstrated in the Trilogy: “*Travelers* and its progeny have thrown the expansive holdings of those earlier cases into question.”⁸⁵ Thus “find[ing] the recent turn of the Supreme Court to be so compelling,” the *Pappas* court concluded:

We believe that it would be highly questionable for us to find that these claims were preempted when the United States Supreme Court has stated that there was no intent on the part of Congress to preempt state laws concerning the regulation of the provision of safe medical care.⁸⁶

The court also held that negligence laws have:

[O]nly a tenuous, remote peripheral connection with [ERISA] covered plans, as in the cases with many laws of general applicability, and therefore are not preempted....We acknowledge that by allowing negligence claims, there will be a financial impact on HMOs. Yet, that is not enough to countermand the conclusion that these claims are not preempted.⁸⁷

The HMO appealed, and the Supreme Court vacated the opinion and remanded the case.⁸⁸

3. *The Supreme Court's Action.*

There are two possible conclusions that can be drawn from the Supreme Court's action in *Pappas*. First, the Court may view the *Pappas* outcome as incorrect. However, *Herdrich* does not contain anything that would cause the Supreme Court of Pennsylvania to change its ultimate decision. The second and better conclusion is that *Herdrich* provides a different type of reasoning for the result reached by the state supreme court in *Pappas*. Indeed, the analysis of “mixed decisions” and the determination by the Supreme Court that mixed decisions are no different than medical decisions made in a variety of other contexts, coupled with the admonition to apply congressional intent analysis, which looks at the congressional intent behind both ERISA and the HMO Act, should lead the state supreme court to the same result. Lending credibility to this conclusion is the fact that the Supreme Court denied certiorari in *Bauman v. U.S. Healthcare, Inc.*,⁸⁹ the same day of its action in *Pappas*.

C. *Bauman v. U.S. Healthcare, Inc.*

The *Bauman* opinion issued by the Third Circuit is another case involving U. S. Healthcare. The plaintiffs sued U.S. Healthcare, their HMO, in state court for medical malpractice related to the death of their newborn daughter.⁹⁰ The HMO removed the case to federal district court, but a month later the court granted the Baumans' motion to remand the case.⁹¹ The HMO appealed and filed a petition for a writ of mandamus.⁹² The Third Circuit held that because all of the Baumans' counts were not completely preempted by ERISA, the district court lacked jurisdiction to determine if any of the counts were either in conflict with ERISA or expressly preempted.⁹³ The court noted that under the theory of complete preemption all claims are preempted where Congress has expressed intent to completely preempt a particular area of law.⁹⁴

The court stated that it last considered the issue of complete preemption in the ERISA/HMO context in *Dukes v. U.S. Healthcare, Inc.*⁹⁵ In *Dukes* the court held that the complete preemption doctrine did not apply to the plaintiffs' state law claims.⁹⁶ Keeping in mind that *Bauman* is a complete preemption jurisdictional decision, the Third Circuit's

analysis is very important to the continuation of the *Dukes* line of reasoning.

The basis of the complaint in *Bauman* was that newborn, Michelina Bauman, pursuant to the HMO's precertification procedure, was discharged from the hospital after only twenty-four (24) hours.⁹⁷ The day after discharge, and two days after she was born, she became ill.⁹⁸ Despite numerous telephone calls to the treating HMO physician, the Baumans were not advised to bring Michelina back to the hospital.⁹⁹ The HMO also declined a request for an in-home pediatric nurse visit.¹⁰⁰ Michelina contracted a group B strep infection that went undiagnosed and untreated, and eventually developed into meningitis, causing her death.¹⁰¹

It is significant that the Supreme Court denied certiorari, leaving the *Bauman* decision untouched, considering that the case involved an HMO's failure to provide additional precertified days and an in-home pediatric nurse. These claims smack of “benefit denials” under the *Dukes* analysis, unlike the redirection of care to different hospitals by the HMO in the *Pappas* decision. Yet, the Supreme Court vacated the opinion in *Pappas* and remanded the case for further deliberation, while it denied certiorari and left standing the Third Circuit's analysis in *Bauman*, which arguably had more to do with benefits “denied.” The Third Circuit's key holding is that:

[I]t is the HMO's essentially *medical determination* of the appropriate level of care that the Baumans claim contributed to the death of their daughter. This is not a claim that a certain benefit was requested and denied....As the Secretary (of Labor in an *amicus brief*) points out under the facts as pleaded in the complaint, U. S. Healthcare's policy and incentive structure was such that ‘the Baumans never had the option of making an informed decision as to whether to pay for the hospitalization themselves’ as would occur in a situation in which coverage is sought and denied. Accordingly, this claim fits squarely within a class of claims that we identified in *Dukes* as involving the quality of care. Here, as in *Dukes*, ‘the plaintiffs are attempting to hold the HMO liable for its role as the arranger of their [decedent's] medical treatment.’¹⁰²

The Supreme Court's action in *Bauman* indicates that the Court meant it in *Herdrich*, when it held that claims against HMOs involving mixed decisions belong in state court.

D. *Corporate Health Ins., Inc. v. Texas Department of Insurance.*

The day after the Supreme Court's action in *Pappas* and *Bauman*, a panel of the Fifth Circuit issued a long-awaited decision in Aetna's declaratory judgment suit, *Corporate Health* (sometimes referred to as “Aetna” because of the common affiliation of all of the plaintiffs in the case with Aetna). Judge Higginbotham, for a panel consisting of two other judges, affirmed in large part and reversed in limited part, the district court's decision upholding the liability provisions of the 1997 Texas HMO Liability Statute.¹⁰³ The court found that the statute's non-liability and independent review provisions were preempted by ERISA.¹⁰⁴ It also reversed the district court's ruling that the statute's anti-indemnity and anti-retaliation provisions were preempted, finding that those provisions constituted regulation of the “quality” of care by the state in a valid exercise of its traditional police powers.¹⁰⁵

1. An Effort At Regulating the Quality of Care.

The introduction to Judge Higginbotham's well-written opinion begins with the recognition that the health care delivery system has undergone radical change.¹⁰⁶ It now involves billions of dollars flowing through HMOs and other structures, creating "equally large difficulties of governance and daily tensions between quality and quantity."¹⁰⁷ Judge Higginbotham then frames the issue as follows:

Today we decide questions regarding the ability of the State of Texas to regulate the quality of health services when such efforts impose a duty of care upon service providers to ERISA plans.¹⁰⁸

One can discern that Judge Higginbotham understands the same distinction made by Justice Souter in *Herdrich* the week before, regarding the difference between an ERISA plan and an HMO or health plan. Also, he appears to ratify the "quality" versus "quantity" of care dichotomy adopted by the Third Circuit in *Dukes* on the heels of *Travelers*.¹⁰⁹

2. No ERISA Preemption of States' HMO Regulation under the Trilogy or Herdrich.

Section I of the opinion recognizes that Texas has exercised its police power to protect its citizens by regulating the new field of managed health care by passing a statute that: (1) creates a cause of action against managed care entities that fail to meet an ordinary standard of care for "health care treatment decisions;" (2) establishes an independent review process tied to review of "medical necessity decisions;" and (3) protects doctors from indemnity clauses imposed by HMOs and from retaliation by HMOs for advocating medically necessary care for their patients.¹¹⁰ Judge Higginbotham also recognizes the distinction between an HMO health plan and an ERISA plan, noting specifically that the Aetna managed care entities "are not ERISA plans."¹¹¹

After finding standing for Aetna's attack on the statute, in Section III of the opinion Judge Higginbotham states, "[w]e have repeatedly struggled with the open-ended character of the preemption provisions of ERISA...."¹¹² He further notes that the Fifth Circuit has followed the Supreme Court's broad reading of ERISA, which requires preemption of state laws that "relate to" any employee benefit plan.¹¹³ However, the trilogy of Supreme Court cases:

[C]onfronted the reality that if 'relate to' is taken to the furthest stretch of its indeterminacy, preemption will never run its course, for 'really, universally, relations stop nowhere.' Justice Souter, speaking for a unanimous court in *Travelers*, acknowledged that 'our prior attempt to construe the phrase 'relate to' does not give us much help drawing the line here.' Rather, the Court determined that it must go beyond the unhelpful text . . . and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.¹¹⁴

3. States' Police Powers to Regulate Quality of Care.

Judge Higginbotham goes on to discuss the trilogy recognizing that in *Dillingham*, the "Court began with the 'assumption that the historic police powers of the States were not to be superseded by the Federal [HMO] Act unless that was the clear and manifest purpose of Congress."¹¹⁵

Judge Higginbotham characterizes *Dillingham* as a finding that state regulation of the "underlying industry" is not preempted.¹¹⁶ Then, referring to all three cases that make up the trilogy, Judge Higginbotham states:

In each of these three cases, the Court was returning to a traditional analysis of preemption, asking if a state regulation frustrated the federal interest in uniformity. . . . [T]he Court has insisted on a significant conflict with an 'identifiable federal policy or interest.' And significantly for our case, this *return* has included the observation that a broader reading of 'relates to' would sweep away common state action with indirect economic effects on the costs of health care plans, such as quality standards which may vary from state to state.¹¹⁷

At this stage, Judge Higginbotham could have appropriately included additional citations to *Travelers* and *DeBuono*, but did not do so. As *Travelers* states:

Quality standards, for example, set by the State in one subject area of hospital services but not another would *affect* the relative cost of providing those services over others and, so, of providing different packages of health insurance benefits. Even basic regulation of employment conditions will invariably affect the costs and price of services.¹¹⁸

4. Narrowly Interpreted, the Liability Provisions Are Not Preempted.

Section IV of the opinion identifies the liability provisions of the Texas statute (also known as Senate Bill 356) noting that the State "avoided the difficult genre of cases complaining of medical care" *not* being provided "by excluding a duty to provide treatment not covered by a plan."¹¹⁹ In a provision which no doubt will be quoted frequently by HMOs, he continues:

We agree with Texas' interpretation of the Act. When the liability provisions are read together, they impose liability for a limited universe of events. The provisions do not encompass claims based on a managed care entity's denial of coverage for a medical service recommended by the treating physician: that dispute is one over coverage, specifically excluded by the Act.¹²⁰

In fact, Texas' position was not so strongly limited. Rather, its position was that *at a minimum*, coverage decisions did not *necessarily* trigger the Act's liability provisions, and that the liability provisions properly regulate *other* HMO conduct.¹²¹ As seen above, in light of *Herdrich*, the "mixed decision" is properly regulated by the liability provisions. Judge Higginbotham sidesteps this issue by immediately focusing on vicarious liability claims as not triggering federal "relates to" preemption.

5. The Dual Roles of HMOs.

Judge Higginbotham's analysis of the dual roles of HMOs represents the most sophisticated by any Fifth Circuit Judge to date:

Courts have observed that HMOs and MCOs [managed care organizations] typically perform two independent functions—health care insurer and medical care provider. A managed care entity can provide administrative support for an insurance plan, which may entail determining eligibility or

Judge Higginbotham characterizes *Dillingham* as a finding that state regulation of the "underlying industry" is not preempted.

coverage. At the same time, a managed care entity can act as an arranger and provider of medical treatment.¹²²

Judge Higginbotham concludes that the state's efforts to regulate an entity in its capacity as "plan administrator" are preempted by ERISA.¹²³ He notes, however:

[M]anaged care providers operate in a traditional sphere of state regulation when they wear their hats as medical care providers. *ERISA preempts malpractice suits against doctors making coverage decisions in the administration of a plan*, but it does not insulate physicians from accountability to their state licensing agency or association charged to enforce professional standards regarding medical decisions.¹²⁴

The italicized portion of the court's statement above stands in stark contrast to the Supreme Court's statement in *Herdrich* that:

Mixed eligibility decisions by an HMO acting through its physicians have, however, only a limited resemblance to the usual business of traditional trustees. . . . Traditional trustees administer a medical trust by paying out money to buy medical care, whereas physicians making mixed eligibility decisions consume the money as well. Private trustees do not make treatment judgments, whereas treatment judgments are what physicians reaching mixed decisions do make, by definition. Indeed, the physicians through whom HMOs act make just the sorts of decisions made by licensed medical practitioners millions of times every day, in every possible medical setting: HMOs, fee-for-service proprietorships, public and private hospitals, military field hospitals, and so on Thus, it is at least questionable whether Congress would have had mixed eligibility decisions in mind when it provided that decisions administering a plan were fiduciary in nature.¹²⁵

Thus, "mixed" eligibility decisions are not "administrative decisions" under ERISA, for purposes of ERISA preemption, because they are not "decisions administering a plan."

6. Reliance on *Corcoran* Conflicts with *Herdrich*'s "Mixed Decisions" Ruling.

The problem with the aforementioned passage written by Judge Higginbotham is that it fails to recognize and apply the Supreme Court's holding in *Herdrich*, which specifically states that HMO physicians making medical necessity decisions are not making either fiduciary or administrative decisions. Instead, they are engaging in "mixed decisions" identical to those made by doctors in millions of other contexts. Further, it does not follow that a state licensing agency can enforce sanctions against a physician who acts on behalf of an HMO, for example, as medical director, making medical necessity decisions, but the state cannot regulate that very same decision-making in any other context.

What is more, Judge Higginbotham's reliance on and continued affirmation of the Fifth Circuit's holding in *Corcoran v. United Healthcare, Inc.* is misplaced.¹²⁶ *Corcoran*'s holding that mixed decisions are preempted is no longer valid in light of *Herdrich*. In *Herdrich* the Court specifically found that no ERISA claim or cause of action exists for mixed medical decisions because it did not want to trigger ERISA preemption of state law regulation of medical necessity decisions. Regardless, Judge Higginbotham reaches the proper conclusion, in line with the Second, Third, and Seventh Circuits,¹²⁷ when he states:

[A]ccountability is necessary to ensure that plans operate within the broad compass of sound

medicine. We are not persuaded that Congress intended for ERISA to supplant this state regulation of the quality of medical practice. While it may impose some indirect costs on ERISA plans, the [Supreme] Court has considered such effects too tenuous to require [ERISA] preemption.¹²⁸

The court goes on to note that the liability provisions of the Texas statute do not refer to ERISA plans: "The provisions are indifferent to whether the health care plan operates under ERISA and do not rely on the existence of ERISA plans for their operation."¹²⁹ Judge Higginbotham concludes his preemption analysis of the statute's liability provisions by stating:

We see nothing to take the liability provisions from the regulatory reach of states exercising their traditional police powers and regulating the quality of health care. . . . Likewise, the vicarious liability of the entities for whom the doctor acted as an agent is rooted in general principles of state agency law. Seen in this light, the Act simply codifies Texas's already-existing standards regarding medical care. These standards of care are at the heart of Texas's regulatory power.¹³⁰

7. Proper Finding of No Preemption of Non-Liability Provisions.

Before reaching the independent review provisions, Judge Higginbotham finds the anti-retaliation and anti-indemnification provisions of the statute to be valid. The court notes that HMOs and MCOs perform *two* types of functions (as "health care insurers" and as medical care providers), distinguishing the any willing provider cases which have been so problematic out of the Fifth Circuit (and which conflict with decisions from other circuits), and then finds:

[T]he anti-retaliation and anti-indemnity provisions complement the Act's liability provisions by realigning the interests of the managed care entities and their doctors. The liability and indemnity provisions force the managed care entity to share in its doctors' risks of tort liability; the anti-retaliation provision avoids the situation in which a doctor must choose between satisfying his professional responsibilities and facing retaliatory action by the managed care entity [for advocating medically necessary treatment]. . . . [T]he provisions thus preserve the physician's independent judgment in the face of the managed care entity's incentives for cost containment. Such a scheme is again the kind of quality of care regulation that has been left to the states.¹³¹

Included in the court's reasoning is the implicit recognition that advocating for "medically necessary" care is part of a physician's professional responsibility, and therefore within the ambit of state regulation. Judge Higginbotham, however, fails to conclude that the statute's independent review provisions also fall within the scope of state regulation and outside of ERISA's preemptive reach.

Unfortunately, Judge Higginbotham did not follow through on his insightful analysis when it came to analyzing the statute's independent review provisions. Those provisions regulate "medical decision-making" under the auspices of the state's regulatory and police powers.

8. HMOs Cannot Manufacture ERISA Preemption Where None Exists.

One significant problem with Judge Higginbotham's decision is that he ignores the briefing of the State of Texas and

Fifth Circuit precedent set forth in *Hook v. Morrison Milling*.¹³² In *Hook* the court held that an employer could not create ERISA preemption where Congress intended that there be none.¹³³ In that case an employer attempted to evade certain requirements of Texas' workers' compensation insurance laws by including provisions in an ERISA plan that relieved it of its obligations under state law.¹³⁴ The court held that the employer could not create ERISA preemption by including terms in its ERISA plan that conflicted with state law:

ERISA was not enacted to allow employers to control which laws or claims are preempted and those which are not....[W]e find no authority for the proposition that a law or claim is preempted merely because the employer crafts its ERISA plan in such a way that the plan is inconsistent with that law or claim.¹³⁵

Hook is consistent with Congress' principal objective in enacting ERISA, namely, the protection of employees.¹³⁶ At its very inception, ERISA sought to protect employees from employer abuse and mismanagement; as the Supreme Court stated in *Dillingham*:

Congress's primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employee benefits from...accumulated funds. To that end, it established extensive reporting, disclosure, and fiduciary duty requirements to insure against the possibility that the employees expectation of the benefit would be defeated through poor management by the plan administrator.¹³⁷

Section after section ERISA either explicitly or implicitly provides protections for employees.¹³⁸ As the United States argued in its *amicus curiae* brief in *DeBouno*:

[I]t would be extraordinary if a Congress that was intent on protecting the rights of plan participants and beneficiaries, see 29 U.S.C.A. § 1001, in fact deprived those parties of the protection of traditional state regulation merely because the services ordinarily subject to that regulation were provided by ERISA plans.¹³⁹

ERISA was enacted to protect employees, not to deprive them of the protection of traditional state health care regulation. Fifth Circuit precedent prohibits employers from creating ERISA preemption by crafting plan terms that are inconsistent with state law. Surely this principle extends to *managed care entities*.

However, Judge Higginbotham finds that the independent review provisions of the Texas statute are preempted. Those provisions allow patients to seek independent review of determinations made by managed care entities.¹⁴⁰ Moreover, the provisions allow patients to appeal adverse determinations to an independent review organization (IRO). The HMO or its utilization review agent must comply with the IRO's medical necessity determinations.¹⁴¹ Utilization review only includes concurrent and prospective requests for treatment.¹⁴²

Utilization review means a system for prospective or concurrent review of the medical necessity and appropriateness of health care services being provided or proposed to be provided to an individual within this state. Utilization review shall not include elective requests for clarification of coverage.¹⁴³

Interestingly, "[t]hirty-eight states . . . have laws authorizing independent, or external, review of health plan decisions."¹⁴⁴

It is because of the way that HMOs write the definition of what they will and will not "cover," and assign to themselves the role of medical necessity decision-making, that HMOs

engage in the practice of medicine, which is historically regulated by the states. While this position is repeatedly urged in both the initial briefing and replies of the State of Texas, Judge Higginbotham ignores this point. Indeed, without very much analysis at all, he simply concludes that the IRO regime "is squarely within the ambit of ERISA's preemptive reach."¹⁴⁵

9. *Savings Clause Rendered Meaningless if Pilot Life Dicta Controlling.*

The court goes on to analyze the statute's independent review provisions from the standpoint of ERISA's "savings clause," which saves state laws that regulate the business of insurance from preemption. To determine whether the savings clause saves the Texas statute from preemption, the court considers whether the statute regulates insurance as a "common sense" matter.¹⁴⁶ The court notes that the Fifth Circuit has always recognized and applied the "common sense" test, as described by the Supreme Court in *UNUM Life Ins. Co. v. Ward*, as part of its preemption analysis.¹⁴⁷ However, prior to *UNUM* the Fifth Circuit required satisfaction of the common sense requirement *and all three* McCarran-Ferguson factors, rather than using them as "guideposts," as is now clearly directed in *UNUM*.¹⁴⁸ The McCarran-Ferguson Act provides that a state law regulates the business of insurance, and is therefore exempt from preemption if (1) it has the effect of transferring or spreading the policyholder's risk; (2) it is an integral part of the policy relationship between the insured and the insurer; and (3) [it] is limited to entities within the insurance industry.¹⁴⁹ Without comment on the error in prior cases, Judge Higginbotham recognizes this clarified application of the McCarran-Ferguson factors and finds that the statute's independent review provisions fall within ERISA's savings clause.¹⁵⁰

Judge Higginbotham easily finds satisfaction of the "common sense" test noting that the provisions "create a regulatory scheme governing health benefit determinations. They do not rely on general legal rights used in other areas of law."¹⁵¹ The court then addresses a common argument made by HMOs that the insurance exception does not apply to them because they are not "traditional insurers."¹⁵²

That the provisions apply to managed care entities as well as to traditional insurers does not exclude them from the saving clause. In determining whether a statute regulates the insurance industry, courts have examined whether a statute governs only entities acting as insurers. A statute may regulate insurance if it applies to insurers, health care service contractors, and HMOs. If the law sweeps more broadly, however, covering employers and others not engaged in insurance practices, it cannot be said to be regulating insurance. Our own cases are consistent with this distinction. Here, the preempted provisions apply to HMOs and to utilization review agents for insurers, administrators, and non-ERISA health benefit plans. In making benefit determinations, these entities are functioning as insurers.¹⁵³

No longer requiring satisfaction of each McCarran-Ferguson factor, Judge Higginbotham summarily concludes that the second and third factors are met in that the statutory provisions "are integral to the policy relationship and regulate the insurance industry."¹⁵⁴ However, although the independent review provisions appear to be saved under the savings clause, the court finds they are still subject to preemption if they conflict with a substantive provision of ERISA.¹⁵⁵

Unfortunately, Judge Higginbotham is then side-tracked by the language in *Pilot Life v. Dedeaux*, in which the Supreme

Court concluded that ERISA's enforcement scheme "preempts not only directly conflicting remedial schemes, but also supplemental state law remedies."¹⁵⁶ Although the *Pilot Life* Court based its conclusion as to the exclusivity of ERISA's remedies on the comprehensiveness of § 502 of the Act, such a statement cannot withstand scrutiny when analyzed in the context of the entire ERISA statute and, in particular, ERISA's insurance savings clause.¹⁵⁷

The savings clause (or insurance exception), in § 514(a) of ERISA, provides in pertinent part, ". . . nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance..." Although at its peak when *Pilot Life* was issued, the landscape of ERISA preemption jurisprudence clearly presents a different view in light of the Supreme Court's renewed federalism emphasizing the starting presumption against preemption "which counsels against federal abrogation of states' police powers, particularly in matters of health and safety."¹⁵⁸ It is undisputed that insurance regulation falls within the historic police powers of the States which Congress clearly intended to protect by inclusion of the insurance exception in ERISA.

Further, although the *Pilot Life* ruling relied upon the Solicitor General's position—at that time—that § 502 of ERISA provided an exclusive remedial scheme preempting any conflicting state remedies, the Solicitor General specifically recanted that view in *UNUM Life Ins. Co. v. Ward*, and urged reconsideration of the language in *Pilot Life*.¹⁵⁹ The *UNUM* Court declined to revisit the issue as it was unnecessary for the *UNUM* decision, reserving it for another case—a case such as *Corporate Health*.¹⁶⁰

10. Rehearing Sought on IRO Preemption Ruling.

The State of Texas moved for rehearing *en banc* on July 5, 2000. Relevant excerpts from the State's Motion follow:

In *Corcoran*, 965 F.2d at 1332, this Court recognized that the effect of a utilization review agent's reversal of a treating physician's medical necessity decision was effectively the denial of treatment. The Court further recognized the consequences of its decision, but nevertheless felt compelled to hold such mixed eligibility decisions preempted under §514(a). *Id.* at 1338. The *Corcoran* Court's mixed eligibility analysis, however, is directly at odds with the Supreme Court's analysis of mixed eligibility decisions in *Pegram*.

If the Panel's ERISA analysis is correct, and a medical necessity decision is an ERISA administrative decision, then, by definition, it is an ERISA fiduciary decision.¹⁶¹ The Supreme Court held precisely the opposite in *Pegram*.¹⁶²

* * *

If an HMO making a medical necessity decision is not "a fiduciary with respect to a plan," the HMO cannot be exercising "discretionary authority or responsibility in the administration of such a plan." 29 U.S.C. §1002(21)(A). A state law regulating medical necessity decisions cannot therefore interfere with the administration of an ERISA plan.

* * *

Part of the basis for the Court's conclusion was that a federal ERISA breach of fiduciary duty cause of action would duplicate existing state malpractice actions. *Pegram* at *11. That reasoning could only be valid if existing state malpractice actions based on "mixed eligibility decisions" were not preempted by ERISA. If a state malpractice action based on "mixed eligibility decisions" is not preempted, neither is a

state regulatory action reviewing such decisions. The Panel held precisely the opposite, in direct conflict with *Pegram*.

That the medical necessity decision is made by a medical director of an HMO in the context of utilization review—as opposed to a treating physician—does not change the medical nature of the decision. HMOs:

commonly require utilization review (in which specific **treatment decisions** are reviewed by a decisionmaker other than the treating physician) and approval in advance (precertification) for many types of care, keyed to standards of **medical necessity** or the reasonableness of the proposed treatment.

These "eligibility decisions cannot be untangled from physicians judgments about reasonable medical treatment." *Pegram*, at *9. "The eligibility decision and the treatment decisions [are] inextricably mixed, as they are in countless **medical administrative decisions** every day." *Id.* (emphasis added).

* * *

Managed care entities make administrative medical decisions daily, determining what care will or will not be provided. *Pegram* makes clear that when these decisions involve determinations of medical necessity, "mixed eligibility decisions," they are medical decisions.

The Supreme Court's analysis, however, offers a simple solution to preserve both the financial health of HMOs and the physical health of patients. What treatments or conditions are covered is an ERISA-regulated administrative **coverage** decision. What treatments are medically necessary is a state-regulated administrative **medical** decision. "[I]n the field of health care, there is **no** ERISA preemption without clear manifestation of congressional purpose." *Pegram*, at *13 (emphasis added). In order to reconcile the congressional purposes of allowing managed care to exist (*Pegram*: no ERISA fiduciary duty as to medical decisions) and state regulation of health care to continue (*Travelers*: no ERISA preemption of health care), the Court need only extend *Pegram* to hold that the Texas IRO is not preempted, thus letting HMOs manage the costs of health care without jeopardizing the health of members.

* * *

Rather, the Panel relied on the fact that medical necessity determinations had been included in an ERISA plan to hold "that an attempt to impose a state administrative regime governing coverage determinations is squarely within the ambit of ERISA's preemptive reach." *Corporate Health*, slip op. at 18. This holding conflicts with this Court's decision in *Hook v. Morrison Milling* that "ERISA was not enacted to allow employers to control which laws or claims are preempted." *Id.* at 783. The Supreme Court reasons similarly: an insurer cannot "displace any state regulation simply by inserting a contrary term in plan documents." *UNUM Life Ins. Co. of Am. v. Ward*, 119 S.Ct. 1380, 1390 (1999).

The Panel decision ignores these holdings and allows employers and HMOs to create their own standards for medical necessity based on whatever the HMO thinks is medically necessary at any given time.¹⁶³

The principal reason for the *Corcoran* decision was that “[t]he principal of *Pilot Life* that ERISA preempts state law claims alleging improper handling of benefit claims is broad enough to cover the causes of action asserted here.” *Id.* If *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) foreclosed malpractice actions based on “mixed eligibility questions” as the *Corcoran* Court found, then there could be no “duplicative” state cause of action as discussed in *Pegram*.

The secondary reason for the *Corcoran* decision was that allowing a malpractice action “to go forward would contravene Congress’s goals of ensur[ing] that plans and plan-sponsors would be subject to a uniform body of benefit law.” *Corcoran*, at 1332. As discussed, *infra*, after *Pegram*, a “mixed eligibility decision” cannot be considered an ERISA administrative decision because it is not an ERISA fiduciary decision. Thus, there can be no interference with plan uniformity.

11. Fifth Circuit’s Denial of Rehearing.

On July 27, 2000, the Fifth Circuit panel denied the Texas Department of Insurance’s motions for rehearing and rehearing en banc.¹⁶⁴ Focusing on the State’s arguments that *Herdrich* dictated different results in the ERISA preemption analysis of the IRO provisions, Judge Higginbotham began by insisting that the Supreme Court’s decision in *Herdrich*:

[C]omports with our holding that certain liability provisions were not preempted, specifically direct liability for physicians’ malpractice when making ‘health care treatment decisions’ and the ensuing vicarious liability for the HMOs. However, we do not read [*Herdrich*] to entail that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment, and *Corcoran* held otherwise.¹⁶⁵

Reiterating the panel’s holding that the IRO provisions addressed coverage decisions, not merely negligent physician decisions, such that the IRO process created an alternative mechanism to seek plan benefits, Judge Higginbotham stood firm on the court’s interpretation of the record, declining to accept the State’s attempt to clarify that the IRO provision was merely implementing “a procedural right to obtain medical care...by imposing a mandatory insurance contract term that goes to the heart of the insured-insurer relationship” as opposed to an alternate enforcement mechanism.¹⁶⁶

[The State’s] distinction is a fine one: the IRO provisions reflect Texas’s effort to mandate and regulate the quality of medical care for a covered condition, but do not detail or provide a mechanism for determining or receiving benefits.

This ambitious spin on the IRO provisions is accented in Texas’s petition for panel rehearing. While it is not without some persuasive force, it does not comport with our view of the record, which reflects that the IRO process binds HMOs to pay for treatment the IRO mandates and in so doing substitutes the medical judgment of a third party physician for the HMO’s, or treating physician’s, judgment as to medical necessity.¹⁶⁷

The Panel’s opinion interprets the IRO process as merely establishing a binding second opinion on medical necessity, thereby creating an impermissible supplementary claims process.¹⁶⁸

Obviously, this portion of the Fifth Circuit’s opinion does not address the IRO provisions as modified in senate bill 1884

(SB 1884), which amends the IRO provisions to make the process voluntary. Thus, SB 1884 specifies that if an HMO does use the IRO process, it must adhere to the procedures and requirements set forth in state law, such as agreeing that the decision of the IRO is binding. Presumably this revision to make the process voluntary removes the amended IRO provisions from the reach of the Fifth Circuit’s finding of ERISA preemption.¹⁶⁹

Judge Higginbotham also addressed the “powerful argument . . . that Texas can demand [a minimum standard of care] as a mandated term of insurance” with IRO provisions designed to review whether a proposed treatment meets the standard of care demanded of Texas physicians:

The argument is that Texas can demand this level of care as a mandated term of insurance for covered conditions regardless of whether an HMO chooses to define the scope of its coverage in terms of its own definition of medical necessity.

Under this view, what Texas can regulate through malpractice suits, Texas could also administratively regulate as a mandated term of insurance. The independent review would not be a second opinion about which reasonable physicians might disagree. Rather the inquiry would be confined to whether providing the medical services found to be necessary would constitute medical malpractice.¹⁷⁰

However, Judge Higginbotham adhered to the panel’s prior opinion finding ERISA preemption based on the interpretation that “the IRO provisions here are plainly a state regime for reviewing benefit decisions and not a system for implementing a mandated term of insurance regulating a minimal standard of care...”¹⁷¹

In footnote 6 of the opinion, Judge Higginbotham left *Corcoran*’s continuing validity in question:

It may be that state causes of action persist only for actions based in some part on malpractice committed by treating physicians. *If so*, state causes of actions against HMOs for the decisions of their utilization review agents would still be preempted, as *Corcoran* held. Because [*Herdrich*] did not exhaustively discuss the specific kinds of state causes of action that it implied were not preempted, we make no additional inferences.¹⁷²

12. The Impact of Corporate Health.

Corporate Health clearly reaches the proper determination that the recently refined and more limited scope of ERISA preemption does not extend to the HMO liability provisions. The ruling on the IRO provisions, however, presents an issue of exceptional importance in light of the fact that thirty-eight states now have independent review statutes in place. Moreover, Judge Higginbotham’s ruling directly conflicts with *Herdrich* and Fifth Circuit precedent. The panel’s ruling finding ERISA preemption of the IRO provisions under *Pilot Life* begs for review by the United States Supreme Court.

Corporate Health clearly reaches the proper determination that the recently refined and more limited scope of ERISA preemption does not extend to the HMO liability provisions.

III. Additional Recent Developments

A. Ostensible Agency and Apparent Authority.

1. *Kirkwood v. PrimaCare Inc.*

In *Kirkwood v. PrimaCare Inc.*,¹⁷³ a Texas court of appeals found that PrimaCare, like a hospital, could be held vicariously liable for the medical malpractice of its physicians. The court reasoned that under a theory of ostensible or apparent agency an employer is responsible for the actions of its agents even though it “has not personally committed a wrong.”¹⁷⁴ Although PrimaCare argued that it was not “the type of entity amenable to a medical malpractice claim” under the state’s Medical Liability and Insurance Improvement Act the court disagreed.¹⁷⁵ The court held that the Act does not bar a suit against an entity that employs physicians to treat patients. Likewise, the Act does not bar a “suit against an entity which has a physician as its apparent agent.”¹⁷⁶

2. *Petrovich v. Share Health Plan of Illinois, Inc.*

Similarly, in *Petrovich v. Share Health Plan of Ill., Inc.*,¹⁷⁷ noting the applicability of agency principles to hospitals, the Illinois Supreme Court held that an HMO may be held vicariously liable for the negligence of its physicians. The court concluded that a plaintiff may recover under a theory of apparent agency by showing (1) that the HMO held itself out as a health care provider without informing the patient that the care given was performed by an independent contractor; and (2) that the patient justifiably relied on the actions of the HMO “by looking to the HMO to provide health care services, rather than to a specific physician.”¹⁷⁸ The court also found that where a plaintiff can establish “that an HMO exerted such sufficient control over a participating physician so as to negate that physician’s status as an independent contractor” the HMO may be held liable under a theory of implied agency.¹⁷⁹ The court reasoned:

Physicians, of course, should not allow the exercise of their medical judgment to be corrupted or controlled. Physicians have professional ethical, moral and legal obligations to provide appropriate medical care to their patients. These obligations on physicians, however, will not act to relieve an HMO of its own legal responsibilities. Where an HMO effectively controls a physician’s exercise of medical judgment, and that judgment is exercised negligently, the HMO cannot be allowed to claim that the physician is solely responsible for the harm that results. In such a circumstance, both the physician and the HMO are liable for the harm that results.¹⁸⁰

The court also recognized the various methods by which HMOs control physician’s medical judgment.¹⁸¹ Further, the court noted that in other jurisdictions HMOs have been held liable for medical malpractice under theories of vicarious liability, direct corporate negligence, breach of contract, and breach of warranty.¹⁸²

3. *Jones v. Chicago HMO Ltd. of Illinois.*

Shortly after *Petrovich*, in *Jones v. Chicago HMO Ltd. of Ill.*,¹⁸³ the Illinois Supreme Court ruled that HMOs, like hospitals, may be held liable for direct corporate negligence (also known as institutional negligence). The court reasoned that “because HMOs undertake an expansive role in arranging for and providing health care services to their members, they have corresponding corporate responsibilities....”¹⁸⁴ Accordingly, “an HMO must act as would a ‘reasonably

careful’ HMO under the circumstances.”¹⁸⁵

B. Prohibition of the Corporate Practice of Medicine.

1. *Center For Sight of Central Illinois I, S.C. v. Deranian.*

In *Center For Sight of Central Illinois I, S.C. v. Deranian*,¹⁸⁶ a management services organization (MSO) arranged for a physician to create a medical corporation to run an ophthalmology clinic. The MSO performed the clinic’s management and administrative duties, including the negotiation of employment contracts, leaving the physicians free to focus on patient care.¹⁸⁷ The corporation sought an injunction to prevent Deranian from violating the covenant-not-to-compete clause in his employment contract. The trial court denied the corporation’s motion for an injunction. An Illinois appellate court affirmed the trial court’s ruling holding that an MSO engages in the corporate practice of medicine, in substance, when it negotiates a physician employment contract for a medical practice.¹⁸⁸ The court reasoned that under the circumstances of the case “the medical corporation was a ‘dummy’ corporation whose president was controlled by nonphysicians,” in violation of state law.¹⁸⁹

2. *TLC The Laser Center, Inc. et al. v. Midwest Eye Institute II, LTD.*

In an MSO fee splitting case, another Illinois appellate court held that while an asset purchase of a medical corporation with a resulting administrative services arrangement does not result in the corporate practice of medicine, a fee arrangement for administrative services that relate directly to the medical corporation’s revenue does.¹⁹⁰ In *TLC The Laser Center, Inc. et al. v. Midwest Eye Institute II, LTD.*, the court reasoned that the long standing policy reasons behind the prohibitions of fee splitting include “the danger that such an arrangement might motivate a non-professional to recommend a particular professional out of self-interest, rather than a professional’s competence.”¹⁹¹ Further, the court noted that “the professional might be compromised, because the awareness that he would have to split fees might make him reluctant to provide proper (but unprofitable) services to a patient, or conversely, to provide unneeded (but profitable) treatment.”¹⁹²

3. *Health Horizons, Inc. v. State Farm Mutual Automobile Ins. Co.*

In *Health Horizons, Inc. v. State Farm Mutual Auto. Ins. Co.*,¹⁹³ a Georgia court of appeals held that the assignment of accounts by a physician to a for-profit corporation that provides health care services does not result in the corporate practice of medicine. The court reasoned that:

[T]here is nothing either by statute or case law that prohibits a duly licensed physician in good standing or other health care professional who has a professional physician-patient relationship and has earned fees and incurred expenses for professional services rendered to his patient from assigning such choses in action to a for-profit corporation for purposes of administration, billing, and collection of such fees, because such corporation does not create, define, direct, limit, or interfere with the physician-patient relationship or the attendant obligations, duties, rights, or liabilities arising from such professional relationship.¹⁹⁴

4. *California Medical Association v. UCLA.*

In *California Medical Association v. Regents of the University of California*, plaintiffs sued the university (UCLA) for violations of the state's statutory ban on the corporate practice of medicine.¹⁹⁵ In 1995, UCLA purchased Santa Monica Hospital Center. Prior to the purchase, a group of independent physicians provided anesthesiology services at the hospital. However, in 1998, UCLA determined that in order to operate the hospital in conformity with its educational goals the physicians providing anesthesiology services would have to be employed as faculty members. Accordingly, UCLA offered full-time faculty positions to the group of independent anesthesiologists. Each of the physicians declined UCLA's offer of employment. Thereafter, several of the anesthesiologists joined the California Medical Association (CMA) in filing suit against UCLA. They alleged that:

[U]CLA...has gone far beyond its praiseworthy teaching and research activities...and has commenced an aggressive business plan designed to enable the unlicensed practice of medicine by UCLA, to force community based physicians into an unlawful fee-splitting and referral scheme which jeopardizes the quality of patient care, disrupts the continuity of patient care in the community, and forces private physicians out of practice, under the guise of teaching and research activities.¹⁹⁶

The plaintiffs then sought a preliminary injunction to prevent UCLA from operating its faculty staffed anesthesia service. The plaintiffs argued that UCLA was accepting "compensation for services rendered to non-indigent and non-teaching patients," in violation of state law.¹⁹⁷ The trial court granted the plaintiffs' motion for an injunction. UCLA appealed, and the appellate court reversed the trial court's decision. The court found that because UCLA operates a teaching hospital and every patient is a potential teaching case, it is not subject to the state's statutory ban on the corporate practice of medicine.¹⁹⁸

C. *RICO Claims.*

1. *Maio v. Aetna, Inc.*

In *Maio v. Aetna, Inc.*¹⁹⁹, a Pennsylvania district court dismissed the plaintiffs' class action suit alleging violations of the Racketeer Influenced and Corrupt Organizations Act (RICO). The plaintiff argued that Aetna represented that it was primarily concerned with quality of care through its nationwide advertising campaign when the HMO was actually more interested in profits and cost containment.²⁰⁰ The district court found that plaintiffs had no standing under RICO, in that their petition failed to allege a concrete "injury in fact."²⁰¹ Further, the court found that the Aetna's advertisements committing its HMOs to "quality of care" were puffery, and did not constitute fraudulent inducement.²⁰²

The plaintiffs appealed. In August of 2000, the Third Circuit affirmed the district court's dismissal on the grounds that the plaintiffs had "not alleged an injury to business or property cognizable under RICO."²⁰³

The court began its analysis by noting that plaintiffs seeking to recover under RICO must satisfy certain standing requirements.²⁰⁴ Among other things, plaintiffs must show injury to business or property and that such injury was proximately caused by the defendant's violation of RICO.²⁰⁵ The court then analyzed whether the plaintiffs' injury, namely, the "financial loss occasioned as a result of their purchase of an 'inferior healthcare product'" constituted a "tangible

economic harm compensable under RICO."²⁰⁶

The court found "no factual basis" for the plaintiffs' "conclusory allegation that they have been injured in their 'property' because the health insurance they actually received was inferior and therefore 'worth less' than what they paid for it."²⁰⁷ The court reasoned that the plaintiffs' injury theory suffered "a fundamental problem . . . which is fatal to their RICO claims."²⁰⁸ The court stated that Aetna's HMO is not a tangible property interest "like a plot of land or a diamond necklace"; instead, it is a contract for health insurance.²⁰⁹ As a result, the plaintiffs' economic harm cannot be characterized in terms of "diminution in product value."²¹⁰

Rather, to recover under RICO the court found that the plaintiffs would have to show that they:

[S]uffered medical injuries, a denial or delay of medically necessary care, or the receipt of inferior or inadequate care. . . . Absent such assertions of diminished benefits or care under Aetna's HMO plan, [plaintiffs] simply cannot establish as a factual matter that they received anything less than what they bargained for and Aetna promised to provide, i.e., a quality health care product, and consequently cannot claim that they paid too much for the health insurance they received.²¹¹

2. *Wineinger v. United Healthcare.*

In *Wineinger v. United Healthcare*,²¹² a Nebraska district court held that the plaintiffs' RICO allegations were barred by the McCarran-Ferguson Act. The court noted that under the McCarran-Ferguson Act a federal statute may not "invalidate, impair or supersede" a state law that regulates the business of insurance, "unless the federal law 'specifically relates to the business of insurance.'"²¹³ Wineinger alleged that the HMO unlawfully charged its subscribers a co-payment ten percent higher than the rate contracted for with various health care providers.²¹⁴ The court held that "permitting the plaintiff to pursue a RICO claim against the defendant would 'frustrate' or 'supplant' Nebraska's insurance regulatory scheme."²¹⁵

D. *REPAIR Team and Other Class Actions.*²¹⁶

1. *REPAIR Team Class Actions Lawsuits Against Foundation Health Systems, Cigna, Aetna, Prudential, PacifiCare, and Humana.*

a. Mississippi Class Actions Transferred to Florida

In the Southern District of Mississippi, the RICO and ERISA Prosecutors Advocating for Insurance Industry Reform (REPAIR) team of attorneys filed a series of class action lawsuits against Foundation Health Systems, Cigna, Aetna, Prudential, PacifiCare, and Humana.²¹⁷ Each of these lawsuits alleged that the defendant managed care organizations failed to disclose material facts regarding their internal systemic policies and practices, including:

- (1) Financial arrangements with physicians that contain incentives and disincentives to limit treatment to the enrollees;
- (2) "Gag clause" provisions in their physician contracts which penalize or prohibit physicians from communicating to enrollees certain sensitive information such as medical treatments which are not covered;
- (3) Controlled "medical necessity" decisions differing from those decisions made by the member's primary care physician;

(4) Controlled access to prescription drugs listed on the defendant's formularies, which are subject to change at the defendant's discretion; and

(5) Economic profiling of physicians in order to exploit fears of economic loss.

These internal policies, it is alleged, served to reduce the quality of healthcare services provided to the class members, rather than maintaining and improving the quality of their health care, contrary to the defendant's advertising, marketing, and member materials. These materials allegedly served to induce the class members into subscribing to and enrolling in the defendant's plans, all in order to maximize profits.

Since the date of filing the lawsuits have been consolidated, transferred, and merged into *In Re Humana Inc. Managed Care Litigation*,²¹⁸ which is currently pending in a Florida district court.

b. California Class Actions

The REPAIR Team has filed several other class action lawsuits in California state court.²¹⁹ Like the Mississippi lawsuits, the California class actions charge that the HMOs have failed to disclose their reimbursement methods for primary care physicians and, thus, concealed the conflict of interest that physicians faced when working under a capitation payment system. Instead of relying on federal racketeering and employee benefits law, however, these lawsuits claim that the HMOs have violated state laws prohibiting false advertising and unfair competition.

The REPAIR Team's lawsuit against Aetna in California has been removed to federal court, where Aetna has filed its pending Motion to Dismiss. The REPAIR Team's Motion to Remand is currently pending.

2. *Conte v. Aetna U.S. Healthcare, Inc.*

In Pennsylvania, a class action was filed against Aetna U.S. Healthcare alleging that the HMO breached its fiduciary duty under ERISA by failing to disclose material facts related to insurance benefits.²²⁰ The complaint alleges Aetna's contractual relationships with its primary care physicians:

[I]mpose an array of restrictions which are intended to, may in fact, and in certain instances do in fact, discourage the physicians from referring their patients for, and from prescribing for their patients, the optimal form of medical care which would be dictated by the physician's independent medical judgment. In particular, certain kinds of care and/or medication are discouraged altogether, while in other instances, [Aetna] gives the physicians financial incentives to deviate from his or her own independent medical judgment.²²¹

3. *Price v. Humana.*

Price v. Humana, filed in a Florida federal court, is another class action alleging the HMO engaged in "systematic and intentional concealment from members in its health plans of accurate information about when health care will be provided, when claims will be approved or disapproved, and what criteria and procedures are actually used to determine the extent and type of their coverage."²²² The petition also addresses the undisclosed financial incentives imposed upon physicians and other non-physicians making medical necessity and claim determinations.

On April 13, 2000, *Price* and three other lawsuits (including the REPAIR Team's Mississippi class action, *Messina v. Humana* from the Southern District of Florida, and

Johnson v. Humana from the Northern District of Illinois) were consolidated in response to Humana's motion to centralize the actions in the Southern District of Florida, pursuant to 28 U.S.C.S. § 1407.²²³ The panel found that the actions in the litigation involved "common questions of fact relating to allegations that Humana's utilization review process and physician financial incentives violate various federal statutes."²²⁴ The panel transferred the cases to the Southern District of Florida, noting that the actions in the Florida court are proceeding expeditiously and two of the four actions are pending there.²²⁵

Humana, Inc. filed a motion to dismiss in July 2000, saying the claims were without merit and could not be maintained in the face of federal and state laws that expressly authorize the same practices Humana was accused of concealing. In response, Price said her claims do not challenge under ERISA the underlying practices that Humana failed to disclose, and therefore are not like those rejected in *Herdrich*. Instead, her claims are based on the law governing the duty of an ERISA fiduciary to disclose material facts, relying on footnote 8 of *Herdrich* and a recent Eleventh Circuit case, *Hamilton v. Allen Bradley*, which rejected the argument that failure to disclose information to an ERISA plan participant does not rise to the level of a fiduciary duty.²²⁶

4. *Harrison v. United Health Group.*

Harrison v. United Health Group, another nationwide RICO class-action lawsuit filed in Alabama, alleges that United Healthcare has been engaged in a systematic attempt to reduce the quality of healthcare provided to its subscribers by undermining the ability of its physicians to use their medical judgment.²²⁷ The petition also alleges that undisclosed policies of United discouraged its physicians from delivering medically necessary services, and otherwise interfered with the medical judgment of the physicians by substituting their claims reviewers' judgments for those of the physicians.

5. *California Med. Ass'n v. Blue Cross of California.*

In *California Med. Ass'n v. Blue Cross of California*, the California Medical Association filed its own RICO class-action against Blue Cross of California, PacificCare Health Systems, Inc. and Foundation Health Systems, Inc.²²⁸ This class action alleges improper influence and control of the traditional physician-patient relationship, charging that the plans negotiated unfair contracts, denied and delayed needed health services and set reimbursement levels too low. According to the petition, physicians who protest the plans' policies are punished through "non-payment, inadequate payment, delayed payment, denial of access to patients, loss of business and other coercive tactics."²²⁹

6. *Beer v. United HealthCare.*

As the first nationwide "hybrid" class action, *Beer v. United HealthCare*²³⁰ seeks to recover damages for doctors who allege a breach of contract and fraudulent inducement to enter into provider contracts with United, as well as the patients who were not told about United's billing/claim payment practices, as well as United's interference with patient care. The lawsuit, which was filed in Florida state court, alleges that United "consistently told subscribers to United plans that coverage and treatment decisions will be made on the basis of 'medical necessity.'" Instead, the Plaintiffs alleged that United interfered with the ability of doctors to provide necessary and independent professional

services and failed to make timely and complete payments to the physicians.

7. *Green v. Aetna U.S. Healthcare, Inc.*

In *Green v. Aetna U.S. Healthcare, Inc.*,²³¹ plaintiffs filed a class action in California state court alleging that the defendant HMOs wrongfully terminated the coverage of approximately 40,000 Medicare HMO enrollees. The complaint charges that the HMOs, knowing that they may shortly leave the market, induced class members to leave their health care programs to enroll their Medicare HMO plans. The complaint also alleges that the HMOs conspired to restrain trade.

8. *American Medical Assn. v. Metropolitan Life Ins. Co.*

This class action lawsuit was filed by the American Medical Association and the Medical Society for the State of New York.²³² The plaintiffs allege that the defendants used inappropriate data to understate the usual and customary charges paid to physicians, and concealed the data from subscribers and providers, resulting in lower payments by the defendants to out-of-network providers, forcing patients to pay more for treatment rendered by out-of-network providers. The plaintiffs seek damages for breach of contract, deceptive trade practices, and trade libel.

9. *Harrison v. Coventry Healthcare of Georgia.*

Several class actions were filed by the Medical Association of Georgia and a group of physicians against Coventry Health Care of Georgia, Inc., Prudential Healthcare Inc., and United Healthcare of Georgia, Inc.²³³ The class actions are based on allegations that the defendants delayed payment of claims in violation of state law requiring insurance companies to pay claims within 15 working days or send notice of the reasons for the failure to do so. The plaintiffs seek compensation for all claims not paid in a timely manner, plus interest.

E. ERISA.

1. *Tompkins v. United Healthcare of New England, Inc.*

In *Tompkins v. United Healthcare of New England, Inc.*, the First Circuit found ERISA preemption of state anti-discrimination laws.²³⁴ The Tompkins argued that the state laws at issue were exempt from preemption because they “contribute to the overall federal enforcement regime” of the ADA.²³⁵ However, the court found the Tompkins’ position problematic. Although the HMO originally denied coverage of the Tompkins’ claims relating to their daughter’s chromosome disease, it reversed its benefits denial decision before the Tompkins ever filed suit.²³⁶ The court rejected the Tompkins’ argument that state anti-discriminatory statutes target conduct that is unlawful under the ADA, noting that “the ADA’s enforcement regime does not depend on the availability of the state statutory claims.”²³⁷

2. *Garofalo v. Empire Blue Cross and Blue Shield.*

Also, in *Garofalo v. Empire Blue Cross and Blue Shield*,²³⁸ the court followed the Supreme Court’s guidance in *UNUM* finding that the provisions of the state law at issue were saved from ERISA preemption. The *Garofalo* court intuitively reasoned in its “common-sense” analysis that:

While the provisions on their face also cover entities beyond those traditionally considered to be ‘insurance companies,’ such as HMOs and payors under the Workers’ Compensation laws and similar laws...this is of no moment because, unlike laws of general applicability...the provisions here in issue only regulate such payors to the extent they are parties to coinsurance contracts and thus, in effect, are acting as insurers under classic insurance arrangements. See *Washington Physician Serv.*, 147 F.3d at 1045-46 (holding that HMOs and other health contractors, even if not “traditional” insurance companies, operate in the “business of insurance” and function as insurance companies).²³⁹

3. *McNeil v. Time Insurance Company.*

In *McNeil v. Time Ins. Co.*, a Texas federal district court held that the plaintiff’s state law claims were preempted by ERISA because they pertained to an area of exclusive federal concern, i.e., the right to receive benefits under the terms of an ERISA plan.²⁴⁰ McNeil alleged that the insurer’s failure to provide the maximum lifetime benefit set forth in his insurance policy violated state law.

Affirming the district court’s ruling, the Fifth Circuit found there was an ERISA plan, and that the plaintiff’s state law claims (“breach of contract, breach of the duty of good faith and fair dealing, negligent misrepresentation, common law discrimination, waiver, estoppel and ratification”) were ERISA preempted.²⁴¹ The court stated that the plaintiff’s claims addressed the

[R]ight to receive benefits under the terms of an ERISA plan. Moreover, these claims directly affect the relationship between Dr. McNeil’s estate and [the insurer]. A finding for either party will affect the obligations owed to the other under the provisions of the plan. For these reasons, we hold that the district court’s determination of ERISA preemption over the state claims was correct.²⁴²

4. *Kondos Employee Health Care Plan v. First Integrated Health, Inc.*

In *Kondos Employee Health Care Plan v. First Integrated Health, Inc.*, the HMO sought removal of the case to federal court.²⁴³ Because the plaintiff’s claim involved breach of contract, allegations of deceptive trade practices, and violations of the state’s insurance code the court wisely followed the Supreme Court’s guidance in *Travelers* and found no ERISA preemption:

This case is nothing more than a contract for administrative services. Plaintiffs contend that the Defendants did not honor their contract. No allegation is made that benefits were not paid, that a fiduciary obligation was breached, or that the claims more than indirectly touch on the underlying plan.²⁴⁴

Finding the plaintiff’s claims had no more than a tenuous and remote connection with ERISA, the court granted the plaintiff’s motion to remand the case to state court.²⁴⁵

5. *Hinterlong v. Baldwin.*

In *Hinterlong v. Baldwin*,²⁴⁶ an Illinois court of appeals found that the Hinterlongs’ medical malpractice claim against an independent practice association type HMO did not “relate to” an ERISA plan, and therefore was not preempted. The court started its discussion by noting the “strong presumption

that Congress did not intend to supercede state law,” and stated that the HMO had the “considerable burden” of overcoming the presumption against preemption of the plaintiff’s claims that “sound in medical malpractice, which undisputably falls within the traditional ambit of state law.”²⁴⁷ After its detailed discussion of the evolution of the Supreme Court’s ERISA preemption analysis,²⁴⁸ the court reasoned that “ERISA did not create ‘a fully insulated legal world that renders all state law preempted whenever there is [an ERISA] plan in the picture.’”²⁴⁹ Accordingly, the court concluded that “[p]oor medical decisions are not sufficiently analogous to the denial of plan benefits or sufficiently intertwined with benefit determinations to implicate ERISA preemption.”²⁵⁰

6. *Danca v. Private Health Care Systems, Inc.*

In *Danca v. Private Health Care Systems, Inc.*,²⁵¹ the First Circuit found that the plaintiff’s allegations of negligent medical decision making were based on a denial of benefits, and therefore preempted by ERISA. Although the plaintiff’s complaint alleged negligence, the court found her inclusion of allegations regarding the HMO’s precertification procedures problematic. Under the HMO’s procedures the plaintiff, who suffered from mental illness, was denied precertification for treatment at the desired facility.²⁵² Instead, the HMO precertified treatment at an inadequate facility, where the plaintiff attempted suicide, which resulted in permanent disfigurement.²⁵³ The court reasoned:

What matters, in our view, is that the conduct was indisputably part of the process used to assess a participant’s claim for a benefit payment under the plan. As such, any state-law-based attack on this conduct would amount to an ‘alternative enforcement mechanism’ to ERISA’s civil enforcement provisions contained in ERISA § 502(a).²⁵⁴

7. *Blue Cross of California v. Anesthesia Care Associates Medical Group, Inc.*

Not only do HMOs ask courts to recharacterize injured plaintiffs’ claims as denial of benefits claims under ERISA, but HMOs also attempt to use ERISA as a shield against suits by medical providers. In *Blue Cross of California v. Anesthesia Care Associates Med. Group, Inc.*,²⁵⁵ the court examined whether a group of medical providers’ breach of contract claims were preempted by ERISA. The medical providers participated in a Blue Cross health care plan whereby Blue Cross furnished plan subscribers with the names of physicians employed by the medical providers.²⁵⁶ In return, the medical providers agreed to accept payment from Blue Cross, in accordance with its fee schedule, for services rendered to the subscribers. Following a dispute over the fee schedule, the medical providers sued Blue Cross in state court. Although Blue Cross successfully removed to federal court, the case was later remanded.²⁵⁷ Blue Cross appealed, and the Ninth Circuit held “the [p]roviders’ claims, which arise from the terms of their provider agreements and could not be asserted by their patient-assignors, are not claims for benefits under the terms of ERISA plans, and hence do not fall within § 502(a)(1)(B).”²⁵⁸ Under § 502(a)(1)(B) a participant of an ERISA plan may bring a civil action to “recover benefits due to him under the terms of his plan....”²⁵⁹ Contrary to Blue Cross’ argument that the medical providers’ claims would “implicate relationships regulated by ERISA,” the court found the medical providers’ claims did not “relate to” an ERISA plan, and therefore were not preempted.²⁶⁰

8. *Bonestroo v. Continental Life and Accident Co.*

In *Bonestroo v. Continental Life and Accident Co.*,²⁶¹ the court found ERISA preemption of provisions of an Iowa statute regulating continuation of coverage, policy conversion rights, and notice of termination of membership/modification of coverage, relating to group health insurance. The court began its analysis by determining that Bonestroo’s group insurance plan was an employee benefit plan within the meaning of ERISA.²⁶² However, the court noted that Bonestroo could escape ERISA preemption by showing that the plan fell within the Department of Labor’s “safe harbor” regulation.²⁶³ Under the “safe harbor” regulation an employee benefit plan that is not “established or maintained” by an employer is exempt from ERISA preemption.²⁶⁴ The regulation requires that:

(1) the employer makes no contribution to the policy; (2) employee participation in the policy is completely voluntary; (3) the employer’s sole functions are, without endorsing the policy, to permit the insurer to publicize the policy to employees, collect premiums through payroll deductions and remit them to the insurer; and (4) the employer receives no consideration in connection with the policy other than reasonable compensation for administrative services actually rendered in connection with payroll deduction.²⁶⁵

The court found that Bonestroo failed to present evidence or raise a material fact issue with respect to *all four* factors. Accordingly, it determined that the plan was, indeed, an employee benefit plan governed by ERISA.²⁶⁶

The court then examined Bonestroo’s state law claims, concluding that the provisions of the statute regulating continuation of coverage and policy conversion implicitly referred to an ERISA plan.²⁶⁷ Accordingly, the court found ERISA preemption of those provisions, while noting that the conversion rights provision “directly encroaches upon an area that Congress intended to be governed exclusively by ERISA.”²⁶⁸ The court went on to analyze the notice of termination of membership/modification of coverage provisions, finding that they were not saved from preemption because they were neither directed specifically toward the insurance industry, nor regulated the business of insurance.²⁶⁹

9. *Harlan v. Occidental Oil & Gas Co.*

In *Harlan v. Occidental Oil & Gas Co.*, beneficiaries of a term life insurance policy sued the decedent’s employer for failure to give adequate notice of the policy’s cancellation in violation of state insurance laws.²⁷⁰ Citing *UNUM*, the Louisiana district court found that although the decedent’s life insurance policy was provided through his employee benefit plan, and therefore governed by ERISA, the state insurance laws were nevertheless exempt from preemption.²⁷¹ The court reasoned that the state statute at issue clearly regulated insurance, “the policy relationship between insurer and insured, and is directed at life insurers and the way insurers conduct the business of insurance.”²⁷²

Like the Louisiana insurance statute in

The provisions of the statute regulating continuation of coverage and policy conversion implicitly referred to an ERISA plan.

Harlan, article 21.21 of the Texas Insurance Code “by definition regulates the...relationship between the insurer and the insured, and is directed at...insurers and the way insurers conduct the business of insurance,”²⁷³ and therefore would be exempt from ERISA preemption in a similar case.

10. *New England Mutual Life Ins. Co., Inc. v. Baig*.

In *New England Mutual Life Ins. Co., Inc. v. Baig*²⁷⁴ the insurer sued its insured in federal court for violations of ERISA. The insurer sought reimbursement on the ground that Baig made misrepresentations in his application for insurance.²⁷⁵ The insurer also argued that because the insurance policy was an ERISA plan Baig’s state law counterclaims were preempted.²⁷⁶ The First Circuit affirmed the district court’s finding that there was no ERISA plan where Baig made the initial policy purchase directly from the insurer; Baig paid the premiums directly to the insurer; and the policy was an individual policy covering only Baig.²⁷⁷ Moreover, under the “circumstances, the reimbursement by his employer of premiums paid directly by Baig did not create a plan under ERISA.”²⁷⁸ Accordingly, the district court properly dismissed the insurer’s case for lack of subject matter jurisdiction.

11. *Demars v. Cigna Corp.*

In *Demars v. Cigna Corp.*,²⁷⁹ the First Circuit provided a thorough and insightful discussion of the less common issue of:

[W]hether ERISA preempts all state law claims related to an individual insurance policy obtained by an employee after termination of employment through the exercise of conversion rights granted by the employee benefit plan.²⁸⁰

Demars sued Cigna in state court after it demanded that she return more than \$70,000 in overpayments, based on its review of her conversion policy application, submitted seven years earlier.²⁸¹ The First Circuit rejected Cigna’s attempts use the shield of ERISA preemption to avoid liability. The court addressed the issue of “whether ERISA preemption applies to claims arising from a conversion policy” by focusing its analysis on whether a conversion policy is an ERISA plan.²⁸² The court noted the important distinction between conversion policies, which are not subject to ERISA, and conversion rights, which are.²⁸³

[W]e use the label ‘conversion policy’ to refer only to a private (non-employer-financed) insurance policy obtained by a former employee, after termination, through the exercise of conversion rights. We do not use the term “conversion policy” to refer to the guaranteed option to convert from employer-sponsored coverage to a private insurance policy (this is a ‘conversion right’), nor do we use the term ‘conversion policy’ to refer to an employer plan that contains conversion rights.²⁸⁴

Because Demars owned a conversion policy, it was not subject to ERISA. Accordingly, her state law claims against Cigna were not preempted.

In some cases, a plaintiff may be receiving health care or disability benefits through an individual conversion policy, which is governed by state law, at the time of death or injury. In such a situation an HMO or insurer will likely attempt to escape liability for state law claims by arguing ERISA preemption. However, the HMO continues to bear the burden to establish that the non-group, private conversion policy purchased by the plaintiff is an ERISA plan subject to ERISA regulation.²⁸⁵

12. *Kennedy v. Columbia*.

In *Kennedy v. Columbia Medical Ctr. of McKinney*, Jessica Kennedy filed suit against several of her treating physicians, Columbia Medical Center, and multiple Aetna defendants after her streptococcal meningitis went undiagnosed, resulting in permanent brain damage and paralysis.²⁸⁶ Kennedy alleged that the quality of medical care delivered to her was substandard and argued that Aetna was responsible for the negligence its agents, servants, nurses, physicians, physician assistants, representatives, employees and/or other health care providers under theories of respondeat superior, apparent/ostensible agency, single business enterprise, partnership and joint enterprise, as those concepts are understood under Texas law.²⁸⁷

Kennedy also brought a claim under the Texas Health Care Liability Act, alleging that Aetna, as a healthcare provider, negligently directed, controlled and/or influenced the actions and medical judgments of the defendants.

Aetna removed the case to federal court, pleading ERISA preemption. Kennedy filed a Motion to Remand, arguing that Aetna failed:

to plead and prove the existence of an ERISA plan, fail[ed] to demonstrate that Plaintiffs’ state causes of action “relate to” or have a ‘connection with’ decisions made in the administration of benefits or a cost containment determination under an ERISA plan, and fail[ed] to demonstrate that Plaintiffs’ Original Petition seeks “to recover benefits” due to her under the terms of the alleged plan, “to enforce [her] rights” under the terms of the alleged plan, or “to clarify [her] rights to future benefits” under the terms of the alleged plan.

Kennedy also relied on *Gonzales v. NYLCare Health Plans of the Southwest, Inc.*, Civil Action No. 3:98-CV-0065-X, another case remanded to state court by Judge Kendall on August 23, 1999.

On August 10, 2000, Judge Joe Kendall granted Kennedy’s Motion to Remand, finding no subject matter jurisdiction over the cause of action. The case is currently pending in the 160th District Court in Dallas County.

F. *ERISA & Subrogation*.

In *Paris v. Iron Workers Trust Fund*,²⁸⁸ the Fourth Circuit affirmed the district court’s finding that Maryland’s make whole doctrine is preempted by the subrogation provisions of an ERISA plan.²⁸⁹ Under the make whole doctrine “the insured must be made whole before the insurer can exercise [its] right of subrogation.”²⁹⁰

After Paris was injured in an auto accident his parents submitted a claim for benefits to their ERISA plan.²⁹¹ The plan advanced \$200,000 in benefits and entered into a subrogation agreement with the Parises.²⁹² The Parises then sued the driver of the other car involved in the accident; the parties settled the case for \$100,000, although Paris’ damages exceeded that amount.²⁹³ Thereafter, the fund administering the ERISA plan sought reimbursement for benefits paid under the subrogation provisions of the plan.²⁹⁴ The Parises argued that the make whole doctrine prevented subrogation by the fund. Affirming the district court’s ruling, the Fourth Circuit held (1) “ERISA preempts state law regarding subrogation rights,”²⁹⁵ and (2) the unambiguous provision of the ERISA plan providing for subrogation may not be overridden “by grafting onto it the make-whole doctrine.”²⁹⁶

The court cited the Fifth Circuit’s opinion in *Sunbeam-Oster Co. v. Whitehurst*, which states:

When [the Plan’s] language is read in context and viewed in light of all the circumstances, it can only mean that the Plan is entitled to be paid back by

the beneficiary all amounts that the Plan has paid to the beneficiary, or on his behalf, to the full extent . . . that the beneficiary recovers from another source”²⁹⁷

G. ERISA’s Savings Clause.

1. Selby v. Principal Mutual Life Ins. Co.

In *Selby v. Principal Mut. Life Ins. Co.*, a New York district court recently addressed the issue of whether § 502(a) of ERISA, which “provides the exclusive remedies for claims asserted by ERISA plan participants,” preempts a state law that “regulates insurance whin the meaning of ERISA’s saving clause.”²⁹⁸ The court noted that the Supreme Court has not spoken to this issue and then followed Second Circuit precedent by holding that ERISA does not preempt “state law enforcement of...a statute which regulates insurance within the meaning of ERISA’s saving clause.”²⁹⁹ Moreover, the court stated that preemption of enforcement of provisions of state law “would be plausible only if the state law itself were also preempted.”³⁰⁰

Arguably, there is a split in the circuits where the Second Circuit has not extended the Supreme Court’s dicta in *Pilot Life* to support a finding of ERISA preemption of a state statutory regulation which falls squarely within the savings clause, and conversely, where the Fifth Circuit in *Corporate Health* relies on *Pilot Life* to find ERISA preemption of Texas’ IRO provisions even though they fall within ERISA’s savings clause.

2. Dang v. UNUM Life Ins. Co. of America.

In *Dang v. UNUM Life Ins. Co. of Am.*, the court cited the Supreme Court’s opinion in *UNUM*, concluding that:

“Oklahoma’s notice-prejudice rule falls under ERISA’s savings clause as a rule that regulates insurance, and is not preempted.”³⁰¹

H. ERISA’s Deemer Clause.

ERISA’s deemer clause was recently analyzed in *Citizens Ins. Co. of Am. v. Am. Med. Sec. Inc.*³⁰² After Fifelski was injured in an auto accident her auto insurer and health insurer disputed coverage obligations.³⁰³ Both policies contained a coordination of benefits (COB) clause stating that the insurer would not pay for injuries if the insured had other insurance.³⁰⁴ Thus, each policy assigned primary responsibility for coverage to the other insurer. Citizens, the auto insurer, filed a suit for declaratory judgment asking the court to determine that it was not the primary insurer.³⁰⁵ Although Michigan state law would normally mandate that the health insurer be treated as primary under these facts, because ERISA governed the health care policy the court considered the interaction between the state law and ERISA.³⁰⁶ The court stated:

If a state law ‘relate[s] to’ an ERISA benefit plan it is preempted; but if the state law ‘regulates insurance’ it is not preempted. But an ERISA covered employee benefit plan that provides insurance coverage is ‘deemed’ not to be an insurance company for purposes of state laws regulating insurance, and ERISA, therefore, preempts such state laws.³⁰⁷

The court found that the state law assigning primary responsibility to the health insurer was saved from preemption as a law that regulates the business of insurance.³⁰⁸ The court went on to analyze ERISA’s deemer

clause which prevents states from regulating ERISA plans by prohibiting states “from deeming an ERISA plan to be an insurance company.”³⁰⁹ The court noted that, generally speaking, there are two types of ERISA plans: “self-funded” plans and “insured” plans.³¹⁰ “Under a self-funded plan, the employer who promises the benefit incurs the liability defined by the plan’s terms.”³¹¹ The deemer clause prevents states from deeming self-funded plans insurers for the purpose of regulating the plans. In contrast, under an insured plan the plan purchases insurance for its employees.³¹² When the plan is insured “a State may regulate it indirectly through the regulation of...insurer[s] and...insurance contracts...”³¹³ Accordingly, the deemer clause “has no application when the plan is...insured.”³¹⁴

Because Fifelski’s ERISA plan was fully insured, the court concluded that it was subject to indirect state regulation though the Michigan statute assigning primary liability to health insurers.³¹⁵ Thus, the court held that the health insurer was primarily liable for Fifelski’s injuries.

I. Medicare Preemption.

In *Statum v. NYLCare Health Plans of the Gulf Coast, Inc.*,³¹⁵ the court initially denied the plaintiff’s motion to remand with a five line order due, at least in part, to the parties’ failure to submit relevant authorities on the issue of Medicare preemption as discussed in *Ardary*. Subsequently, on April 30, 1999, Judge Hittner granted a motion to reconsider the order denying remand and, upon consideration of relevant case law, and following the guidance of *Ardary*, the court granted and order remand to state district court. The *Statum* court found that the plaintiffs’ case did “not address the administration of health care benefits but instead allege[d] state law tort claims,” challenging the quality of care rather than a denial of benefits.

J. Statutory Managed Care Liability - Cases Asserting State Law Patient Protections.

1. Plocica v. NYLCare, et al.

Plocica v. NYLCare was the first lawsuit ever brought under the Texas Health Care Liability Act.³¹⁶ Although the case ultimately settled, the plaintiff successfully moved for partial summary judgment on the HMO defendants’ purported “failure to appeal” defense. Under that defense the defendants argued that the plaintiffs were responsible for the decedent’s discharge and death because they had not pursued an administrative appeal of the decision to discharge the decedent from the hospital. In their motion, the plaintiffs primarily relied on repeated admissions by the HMO defendants’ representatives that there was “nothing to appeal.” The plaintiffs also argued that no legal duty existed on the part of the plaintiffs to appeal the treatment decisions, given that the claims did not “arise under” the Medicare Act. Further, the plaintiffs argued that there was no duty to mitigate their damages under Texas law. The HMO defendants’ attempts to raise an issue of fact with respect to the plaintiffs’ arguments were rebuffed by the trial court, and the plaintiffs prevailed on the motion.

2. Moran v. Rush Prudential HMO, Inc.

In *Moran v. Rush Prudential HMO, Inc.*, the plaintiff sued her HMO after it refused to approve and pay for a surgical procedure on the ground that it was not medically necessary.³¹⁷ Pursuant to the state’s HMO statute, the court ordered the HMO to appoint and independent physician to

review the denial of benefits decision.³¹⁸ The independent physician concluded that the surgery was medically necessary.³¹⁹ Thereafter, Moran sought reimbursement from the HMO in the amount of \$94,841.³²⁰ The HMO removed the case to federal district court where the court held Moran's reimbursement claim was preempted by ERISA.³²¹ The court then granted summary judgment in favor of the HMO reasoning that the HMO did not abuse its discretion or act arbitrarily when it denied Moran's claim for benefits.³²² Moran appealed.

The Seventh Circuit began its analysis by noting that state laws are preempted to the extent that they "relate to an employee benefit plan."³²³ A state law relates to an employee benefit plan if it has a "connection with" or "reference to such a plan."³²⁴ The court concluded that while the state's HMO statute did not expressly refer to an ERISA plan it did have a connection with an ERISA plan.³²⁵ Because the statute requires all HMOs, including those that service ERISA plans, to provide an independent review mechanism it "has an effect on how benefit determinations are made and, thus, squarely falls within ERISA's preemption clause."³²⁶ The court concluded, however, that the statute was saved from preemption because it regulates the business of insurance.³²⁷ The court reasoned that the statute regulates insurance "under a common sense understanding...is aimed exclusively at members of the insurance industry," and "goes to the core of the relationship between the insurer and the insured."³²⁸ The court further found that the statute did not conflict with any substantive part of ERISA.³²⁹ Accordingly, the Seventh Circuit reversed the district court's ruling and found that Moran was entitled to summary judgment.³³⁰

K. Bad Faith Claims, HMOs and Possible Federal Preemption.

1. McEvoy v. Group Health Cooperative of Eau Claire.

Few states have considered whether HMO's are subject to the same bad faith cause of action recognized against other insurers. The Wisconsin Supreme Court addressed the issue of whether HMOs can be sued by subscribers under the common law tort of bad faith traditionally applied to insurance companies in *McEvoy v. Group Health Cooperative of Eau Claire*.³³¹ The court concluded that for purposes of the application of the common law doctrine of bad faith, HMOs making out-of-network decisions are insurers. The court recognized that in the course of the contractual relationship between the HMO and subscriber, a "power imbalance" exists that is similar to that of a classical insurer and policyholder relationship where there are "prepackaged" policy terms and bureaucratic hurdles.³³² Furthermore, statutory regulations in Wisconsin support the general characterization of HMOs as insurers for bad faith purposes and many HMOs are subject to the same regulations as insurance companies.³³³

The court concluded that its decision to equate HMOs and insurers for purposes of applying the bad faith tort was supported by public policy.³³⁴ The court recognized the significant influence that HMOs have over the costs and types of treatment available to patients based on their contractual arrangements with both providers and patients.³³⁵ The court also noted that the tort of bad faith was specifically designed to protect insureds from the harm caused by such control, and in the HMO context the tort would ensure that HMOs do not disregard the legitimate medical needs of subscribers.³³⁶

The court then distinguished between bad faith and malpractice, finding that bad faith does not apply to a health care providers' mistakes or negligence in diagnosis or treatment.³³⁷ Nor is the bad faith action limited to decisions

made by the HMO medical director, rather, it can also be applied to all decisions made by all employees.³³⁸ The court held that "the more closely a particular decision made by an HMO or HMO employee resembles coverage decisions made by traditional insurers, the more appropriate the tort of bad faith becomes."³³⁹ The court, however, specifically recognized the ERISA preemption that applies to state law claims against HMOs providing services under ERISA plans. Thus, the only HMOs that are subject to the tort of bad faith are those with subscribers that receive benefits under an ERISA exempt plan or those with subscribers that purchase the plans individually.³⁴⁰

2. Morris v. Health Net of California, Inc.

In *Morris v. Health Net of Cal. Inc.*,³⁴¹ the Supreme Court of Utah, applying California law, made no distinction between an HMO and any other insurer when it recognized the viability of a claim for breach of the covenant of good faith and fair dealing against an HMO.

L. Qui Tam and the False Claims Act.

Allowing for fines ranging from not less than "\$5,000 and not more than \$10,000" *per* false claim, plus treble damages, the feds eagerly pursue investigations under the False Claims Act.³⁴² In *Vt. Agency of Natural Res. v. United States ex rel. Stevens* the Supreme Court recently upheld the Act's qui tam provisions, which allow a "private person" to bring a civil action "for the person and for the United States Government against the alleged false claimant, in the name of the Government."³⁴³ The qui tam provisions also allow individuals aiding in the prosecution of an action to receive an award of up to 25 percent of the government's ultimate recovery.³⁴⁴ Accordingly, the Act "provide[s] the government with powerful ammunition for fighting fraud and abuse in federal health care programs."³⁴⁵ Moreover, the Supreme Court's validation of the Act's qui tam provisions may result in increased whistleblower referrals in the HMO context.

M. Financial Incentives - Allegations Supporting State Law Claims.

1. Stewart v. Berry Family Health Center.

Consistent with the Supreme Court's holding in *Herdrich*, district courts most often find that a plaintiff's allegations of HMO negligence, including assertions that the HMO's financial incentive arrangements affected medical decisions and the quality of care rendered, are purely state law issues not preempted by ERISA. For example, in *Stewart v. Berry Family Health Center*,³⁴⁶ the court found no ERISA complete preemption jurisdiction over the plaintiffs' allegation that the HMO committed negligence by utilizing financial incentives that induced medical malpractice by her health care providers.

"Plaintiffs allege that [the HMO's] financial incentive program impacted the quality of care that she received from her physicians while at [Miami Valley Hospital]. Thus, Plaintiffs' Complaint is more properly characterized as challenging a medical decision to deny proper treatment to a patient rather than an administrative decision to deny benefits."³⁴⁷

2. *Neade v. Portes*.

In *Neade v. Portes*, the Supreme Court of Illinois declined to recognize a cause of action against a physician for breach of fiduciary duty.³⁴⁸ Neade alleged that his physician, Dr. Portes, breached his fiduciary duty by failing to disclose that his contract with an HMO created a financial incentive to withhold care, thereby putting Neade's medical well being in direct conflict with Dr. Portes' financial interests.³⁴⁹ The court recognized the existence of a fiduciary *relationship* between physician and patient, but went on to state that it had never "addressed the issue of whether a plaintiff can state a cause of action for breach of fiduciary duty"³⁵⁰ based on that relationship. After reviewing the treatment by other jurisdictions of claims for breach of physician fiduciary duty the court concluded that such claims "boil down" to claims for "medical malpractice".³⁵¹ Accordingly, the court refused to recognize a state cause of action for physician breach of fiduciary duty."

3. *Moore v. Regents of the University of California*.

In another case involving the physician-patient relationship the Supreme Court of California recognized the existence of a cause of action for a physician's breach of fiduciary duty. In *Moore v. Regents of the Univ. of Cal.*³⁵², the plaintiff alleged that his physician breached his fiduciary duty by failing to disclose "the extent of his research and economic interest in Moore's cells before obtaining consent to the medical procedure" at issue.³⁵³ The court concluded that "a physician must disclose personal interests unrelated to the patient's health, whether research or economic, that may affect the physician's professional judgment."³⁵⁴ The court recognized that the legislature's intent to protect patients from possible physician conflicts of interest was reflected in the state's laws prohibiting patient referrals to physician owned organizations without first disclosing a physician's financial interest.³⁵⁵

N. *Financial Incentives – Class Actions*.

In *Ehlmann v. Kaiser Foundation Health Plan*, the plaintiffs alleged that the HMOs breached their fiduciary duty by failing to disclose the existence of financial incentive arrangements with their physicians.³⁵⁶ However, the Fifth Circuit held "that the district court correctly dismissed Ehlmann's claim for the breach of such a duty to disclose because ERISA imposes no such duty."³⁵⁷ The court did not mention or recognize the Supreme Court's holding in *Herdrich*, which directly supported the plaintiffs' breach of ERISA fiduciary duty claims based on the conflict of interest arising out of the HMOs occupying the dual roles of ERISA fiduciary and profit-seeking health plan. Like the district court, the Fifth Circuit found that "ERISA nowhere contains any specific reference to a duty to disclose physician compensation plans." The court then relied on "the canon of statutory construction that the specific language in a statute rules the general," in making its determination that the plaintiffs' claims should be dismissed.³⁵⁸ Without any actual support in legislative history or Supreme Court opinions, the Fifth Circuit's rationale results in the implicit ruling that all of an ERISA fiduciary's duties of disclosure are fully enumerated in the reporting and disclosure requirements which Congress delineated for administrators of ERISA plans in the statute.

O. *Attorney General's Assurance of Voluntary Compliance With Aetna*

In 1998, Texas Attorney General Dan Morales sued Aetna U.S. Healthcare for providing improper financial incentives to physicians to limit patient care in violation of various state laws. In April of 2000, Morales' successor, Attorney General John Cornyn reached a settlement with Aetna, termed an "Assurance of Voluntary Compliance" (AVC).³⁵⁹

In the AVC, Aetna has pledged to discontinue the use of withholds, which serve to punish physicians who provide more health care services not less. Aetna has also agreed to leave to physicians the decision to determine what is medically necessary. Aetna has further agreed to create a consumer advocate role to act on behalf of patients with respect to appeals and complaints.

In 1998, Texas Attorney General Dan Morales sued Aetna U.S. Healthcare for providing improper financial incentives to physicians to limit patient care in violation of various state laws.

The settlement has not gone without criticism. Physician groups have noted that the agreement includes no fines, penalties, or admissions of wrongdoing by Aetna, and complained that it does little to change the company's control of determining whether treatments are "medically necessary."

Notably, a class action was filed in New Jersey the same day Aetna entered into the Texas settlement. In *McCarron v. Prudential Ins. Co. of America, et al.*, the plaintiffs challenged Aetna to expand the Texas agreement to limit medical necessity determinations to qualified medical professionals to its plans nationwide.³⁶⁰ The lawsuit was later transferred to a Florida federal court and merged with several other cases into *In Re Humana Inc. Managed Care Litigation*.³⁶¹

* George Parker Young is a partner with the law firm of Friedman, Young, Suder & Cooke, P.C., 500 Throckmorton Street, Suite 2000, Fort Worth, Texas 76102.

1. This article covers decisions through September, 2000.
2. *Pegram v. Herdrich*, 120 S. Ct. 2143 (2000).
3. *Corporate Health Ins., Inc. v. Tex. Dept. of Ins.*, 215 F.3d 526 (5th Cir. 2000), *reh'g denied*, 220 F.3d 641 (5th Cir. 2000).
4. *U.S. Healthcare Sys. of Pa., Inc. v. Pa. Hosp. Ins. Co.*, 120 S. Ct. 2686 (2000).
5. *U.S. Healthcare, Inc. v. Bauman*, 193 F.3d 151 (3rd Cir. 2000), *cert. denied*, 120 S. Ct. 2687 (2000).
6. *Herdrich*, 120 S. Ct. at 2147.
7. *Id.* at 2147 n.2 (In footnote 2 the Court states: "Herdrich does not contest the propriety of removal before us, and we take no position on whether or not the case was properly removed"). The Court makes it clear that it had jurisdiction because Herdrich's amended complaint alleged ERISA violations.
8. *See N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995); *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316 (1997); *DeBuono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997).
9. *Herdrich*, 120 S. Ct. at 2147.
10. *Id.*
11. *Id.*
12. *Id.*
13. *Id.* at 2147-48.
14. *Id.* at 2148.

15. *Id.*
16. *Id.*
17. *Id.*
18. *Id.* at 2149 (emphasis added). This is an important recognition as the “insurance exception” to ERISA preemption revitalized in UNUM Life Ins. Co. of Am. v. Ward, 119 S. Ct. 1380 (1999), continues to be developed.
19. *Herdrich*, 120 S. Ct. at 2149.
20. *Id.*
21. *Id.*
22. *Id.* (emphasis added) (citations omitted). Unfortunately this broad statement ignores the wide variation in compensation models adopted by various HMOs.
23. *Id.*
24. *Id.* at 2150 (citations omitted).
25. *Id.*
26. The HMO Act’s legislative history is devoid of support for this conclusion. Indeed, Congress separately has taken a stand against financial incentives that act as inducements to limit medically necessary care, both directly and indirectly, by authorizing Health Care Financing Administration (HCFA) to enact regulations involving Medicare HMOs that specifically prohibit such inducements. *See* 42 C.F.R. § 411.357(i) (2000) (delineating exceptions to permissible physician incentive plans, such plans may not include payments to physicians “as an inducement to reduce or limit medically necessary services”); 42 C.F.R. § 417.479(a)(1) (2000) (requirements for physician incentive plans include prohibition of payment to a physician “as an inducement to reduce or limit medically necessary services”); 42 C.F.R. § 422.208 (2000) (M+C requirements prohibit payments to physicians “as an inducement to reduce or limit medically necessary services”). Recognizing this Congressional stand *against* onerous financial incentives in the HMO area and in the Medicare context perhaps would have moderated Justice Souter’s unsupported conclusion that Congress *intended* such onerous incentives in the HMO Act and amendments.
27. *Herdrich*, 120 S. Ct. at 2150.
28. *Id.* at 2151.
29. *Id.* (emphasis added) (citations omitted).
30. *Id.* at 2152.
31. *Id.* (emphasis added).
32. *Id.*
33. *Id.*
34. *Id.* at 2152.
35. *Id.* at 2152-53.
36. *Id.* at 2153.
37. *Id.*
38. *Id.* at 2153 (citation omitted).
39. The significance of the citation to *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 361 (1995), cannot be overstated. *Dukes* was the first major case after *Travelers*, wherein the Third Circuit developed the quality of care/quantity of care distinction that has been so important in defining limitations on the scope of ERISA preemption.
40. *Herdrich*, 120 S. Ct. at 2154.
41. *Id.* at 2154.
42. *Id.* (emphasis added).
43. *Id.*
44. *Id.* at 2155.
45. *Id.*
46. *Id.* (emphasis added).
47. *Id.* at 2155-56 (emphasis added).
48. *Id.* at 2156.
49. 42 U.S.C. §§ 300e-300e-17 (1994 & Supp. III 1997).
50. *Herdrich*, 120 S. Ct. at 2156-57.
51. *Id.* at 2157.
52. *Id.*
53. *Id.* at 2158.
54. *Id.* If this isn’t making public policy, what is?
55. *Id.* at 2154 n.8.
56. *Id.* at 2157 (citing The Health Maintenance Organization Act, 42 U.S.C. §§ 300e-300e-17 (1994 & Supp. III 1997)).
57. S. REP. NO. 93-129, at 2 (1973), *reprinted in* 1973 U.S.C.C.A.N. 3033, 3034 (emphasis added).
58. S. REP. NO. 93-129, at 3035, 3077-78.
59. *Id.* at 3034-35.
60. *Id.* at 3047 (emphasis added).
61. *Id.*
62. *Id.*
63. *Id.* at 3077.
64. *Id.* (emphasis added).
65. *Id.* at 3113.
66. *Id.* at 3108-10.
67. H.R. CONF. REP. NO. 94-1513, at 22 (1976), *reprinted in* 1976 U.S.C.C.A.N. 4355, 4358.
68. H.R. CONF. REP. NO. 94-1513, at 4366.
69. *Id.*
70. H.R. CONF. REP. NO. 95-559, at 21 (1978), *reprinted in* 1978 U.S.C.C.A.N. 4958, 4966.
71. H.R. CONF. REP. NO. 95-559, at 4966.
72. S. REP. NO. 100-304, at 6 (1988), *reprinted in* 1988 U.S.C.C.A.N. 3231, 3233.
73. S. REP. NO. 100-304, at 3234.
74. Interestingly, there were additional views of Senator Dan Quayle published in the Senate Report that made it clear that he thought it was time to get the federal government out of the business of encouraging, fostering, or otherwise subsidizing HMO industry growth. *See id.* at 3240-41. Perhaps Senator Quayle was smarter than he has been given credit for being.
75. *U.S. Healthcare Sys. of Pa., Inc. v. Pa. Hosp. Ins. Co.*, 120 S. Ct. 2686 (2000).
76. *Pappas v. Asbel*, 724 A.2d 889, 890, *vacated sub nom.* *U.S. Healthcare Sys. of Pa., Inc. v. Pa. Hosp. Ins. Co.*, 120 S. Ct. 2686 (2000).
77. *Pappas*, 724 A.2d at 890.
78. *Id.*
79. *Id.*
80. *Id.*
81. *Id.*
82. *Id.*
83. *Id.* at 891.
84. *Id.*
85. *Id.* at 893.
86. *Id.*
87. *Id.* (citing *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995)).
88. *U.S. Healthcare Sys. of Pa., Inc. v. Pa. Hosp. Ins. Co.*, 120 S. Ct. 2686 (2000).
89. *See U.S. Healthcare, Inc. v. Bauman*, 193 F.3d 151 (3rd Cir. 2000), *cert. denied*, 120 S. Ct. 2687 (2000).
90. *Bauman*, 193 F.3d at 155.
91. *Id.* at 157.
92. *Id.*
93. *Id.* at 164.
94. *Id.* at 160.
95. *Id.* at 161.
96. *Dukes v. U.S. Healthcare, Inc.* 57 F.3d 350, 351-52 (3rd Cir. 1995).
97. *U.S. Healthcare, Inc. v. Bauman*, 193 F.3d 151, 156 (3rd Cir. 2000), *cert. denied*, 120 S. Ct. 2687 (2000).
98. *Bauman*, 193 F.3d at 156.
99. *Id.*
100. *Id.*
101. *Id.* at 156.
102. *Id.* at 163 (emphasis added) (citing *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 361 (3rd Cir. 1995)).
103. *Corporate Health Ins., Inc. v. Tex. Dept. of Ins.*, 215 F.3d 526 (5th Cir. 2000), *reh’g denied*, 220 F.3d 647 (5th Cir. 2000).
104. *Corporate Health*, 215 F.3d at 526. The Second Circuit entered a contrary ruling in *Franklin H. Williams Trust v. Travelers Ins. Co.*, 50 F.3d 144, 151 (2d Cir. 1995), finding that “[i]t would be quixotic to rule that a claim under a state statute that is saved from ERISA preemption...may nonetheless be enforced only via ERISA provisions and remedies.”
105. *Corporate Health*, 215 F.3d at 536.
106. *Id.* at 531.
107. *Id.*
108. *Id.*
109. This is notable because at the February 2000 oral argument, the panel uniformly expressed frustration with this dichotomy as not really helpful in determining when the states can regulate HMO conduct.
110. *Corporate Health*, 215 F.3d at 531. The recognition that the anti-retaliation clause was tied to “medical necessity” advocacy by physicians, and the Court’s finding that such anti-indemnity is a “quality of care” regulation, should be kept in mind when one considers that the Court also found the medical necessity regulation in the IRO preempted! This is but one of several inconsistencies in the opinion, probably due to the fact that Judge Higginbotham feels compelled to follow *Corcoran*, because one Fifth Circuit panel “may not overrule another, even when the later panel disagrees with the earlier one’s holding. . . . [O]ne panel cannot overturn another panel, regardless of how wrong the earlier panel decision may seem to be.” *United States v. McPhail*, 119 F.3d 326, 327 (5th Cir. 1997) (Smith, J., dissenting) (citations omitted) (internal quotations omitted). As will be pointed out, this probably means that it will take a rehearing *en banc* or the Supreme Court to actually overrule

the *Corcoran* opinion and its continuing mischief.

111. *Corporate Health*, 215 F.3d at 531.
112. *Id.* at 532.
113. *Id.* at 531-32.
114. *Id.* at 532-33 (quoting N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 677 (1995)).
115. *Corporate Health*, 215 F.3d at 533 (quoting Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc., 519 U.S. 316 (1997)).
116. *Corporate Health*, 215 F.3d at 533.
117. *Id.* at 533 (citing Boyle v. United Tech Corp., 487 U.S. 500, 507 (1988)).
118. *Travelers*, 514 U.S. at 660 (emphasis added).
119. *Corporate Health*, 215 F.3d at 534.
120. *Id.* at 534.
121. Brief of Texas Dept. of Ins. in Response to Brief of Aetna, filed with Fifth Circuit Court of Appeals (TDI noted that the district court properly recognized the distinction between (1) medical benefits actually provided—no coverage decisions at issue—and (2) a coverage determination by an HMO denying benefits. “If the question concerns what is or should be the diagnosis, care, or covered treatment of the employee or enrollee, a medical determination will need to be made. If the MCE affects this determination and medical decisions are negligently made, then—and only then—will liability attach.”).
122. *Corporate Health*, 215 F.3d at 534.
123. *Id.*
124. *Id.* at 534-35 (emphasis added). In footnote 24 Judge Higginbotham notes that “this distinction is consistent with *Corcoran*’s holding that medical decisions involving coverage determinations are preempted.”
125. *Herdrich*, 120 S. Ct. 2155-56 (emphasis added).
126. *Corcoran v. United Healthcare Inc.*, 965 F.2d 1231 (5th Cir. 1992).
127. *Corporate Health*, 215 F.3d at 535 n.24 (stating that the Second, Third, and Seventh Circuits have held medical negligence claims against HMOs are not preempted).
128. *Id.* at 535 (citations omitted).
129. *Id.* (While the same is true of the independent review provisions—as regulating non-ERISA plan decisions, but regulating their providers to ERISA plans—this distinction is absent from Judge Higginbotham’s reasoning.)
130. *Id.*
131. *Id.* at 536 (citing Pegram v. Herdrich, 120 S. Ct. 2143 (2000)).
132. *Hook v. Morrison Milling*, 38 F.3d 776, 783 (5th Cir. 1994).
133. *Id.*
134. *Id.*
135. *Id.* at 785.
136. H.R. REP. NO. 95-533, (1974), reprinted in 1974 U.S.C.C.A.N. 4639, at 4639.
137. Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc., 519 U.S. 316, 326-27 (1997) (citing Massachusetts v. Morash, 490 U.S. 107, 115 (1989)).
138. See 29 U.S.C.A. § 1001(a)-(c) (West 1994).
139. Brief of Amici Curiae United States at 20, De Buono v. NYSA-ILA Medical and Clinical Services Fund at 20 (November 1996).
140. *Corporate Health*, 215 F.3d at 536.
141. *Id.* at 537
142. The Legislature expressly intended not to include retrospective review of reimbursement claims, but intended to study the issue. See TEX. INS. CODE ANN. § 21.58A historical note (Vernon Supp. 2000) [Act approved June 6, 1991, 72nd Leg., R.S., ch. 242 § 11.03(b), 1991 Tex. Gen. Laws 939, 1054]. The Act has never been amended to include such review.
143. TEX. INS. CODE ANN. Art. 21.58 § 2(20) (Vernon Supp. 2000) (emphasis added).
144. Robert Pear, *In a Test Case on H.M.O.’s, Patients Both Win and Lose*, N.Y. TIMES, June 23, 2000, at A12.
145. *Corporate Health*, 215 F.3d at 537.
146. *Id.* at 537.
147. *Id.* (citing UNUM Life Ins. Co. of Am. v. Ward, 119 S. Ct. 1380, 1386 (1999)).
148. *Corporate Health*, 215 F.3d at 537 (citing UNUM, 119 S. Ct. at 1386-89 (1999)) (emphasis added). See Cigna Healthplan of Louisiana, Inc. v. Louisiana, 82 F.3d 642, 650 (5th Cir. 1996) (“If the statute fitted the common sense definition of insurance regulation and the court answered “yes” to each of the questions in the three part test, then the statute fell within the savings clause exempting it from ERISA preemption.” And citing other Fifth Circuit cases misapplying the McCarran-Ferguson factors: Tingle v. Pac. Mut. Ins. Co., 996 F.2d 105, 108 (5th Cir. 1993); see also NGS Am., Inc. v. Barnes, 998 F.2d 296, 299 (5th Cir. 1993)).
149. *Corporate Health*, 215 F.3d at 537.
150. *Id.* at 537-38.
151. *Id.* at 538.
152. *Id.* at 538-39 (internal citations omitted).
153. *Id.* at 539.
154. *Id.* at 538.
155. *Id.*
156. *Id.* at 538-39 (citing Pilot Life v. Dedeaux, 481 U.S. 41, 52 (1987)).
157. *Pilot Life*, 481 U.S. at 52.
158. See Seema R. Shah, *Loosening ERISA’s Preemptive Grip on HMO Medical Malpractice Claims: A Response to PacifiCare of Oklahoma v. Burrage*, 80 MINN. L. REV. 1545, 1557 n.64 (1996) (citing Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230 (1947)). See also Pegram v. Herdrich, 120 S. Ct. 2143 (2000) (finding no ERISA cause of action where mixed treatment decisions involved, in part because the area is regulated by the states under their traditional police powers); N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 655 (1995) (starting the ERISA preemption analysis with the “assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of congress.”); DeBuono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806, 814 (1997) (“the historic police powers of the State include the regulation of matters of health and safety.”).
159. *Pilot Life*, 481 U.S. at 52; UNUM Life Ins. Co. v. Ward, 119 S. Ct. 1380, 1391 n.7 (1999). See also Brief of Amici Curiae Secretary of Labor, <http://www.dol.gov/dol/pwba/public/pubs/ab/corphlth.txt> (emphasizing that the IRO provisions were merely procedural prerequisites to filing suit under ERISA: “[t]he HMO Act does not, therefore, create an alternative, state law cause of action for recovering benefits and does not conflict with Congressional intent that ERISA’s civil enforcement scheme be exclusive.”)
160. UNUM, 119 S. Ct. at 1390 n. 7.
161. See 29 U.S.C § 1002(21)(A) (West 1999) (“[A] person is a fiduciary with respect to a plan to the extent . . . (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.”).
162. The Panel did not address *Herdrich* in discussing the IRO but properly concluded that *Herdrich* supported its holding that the statute’s liability provisions were not preempted.
163. Aetna’s own definition of “medically necessary” is “the *diagnosis, care or treatment* of the Member’s physical or mental condition as determined by [Aetna].” (Affidavit of Joseph T. Blanford III) R. 20:78 (emphasis added).
164. *Corporate Health Ins., Inc. v. Tex. Dept. of Ins.*, 220 F.3d 641 (5th Cir. 2000).
165. *Id.* at 643-44 (citations omitted).
166. *Id.* at 644.
167. *Id.*
168. *Id.* at 645.
169. S. REP. NO. 14407-01, reprinted in 1999 WL 1015452 (Cong.Rec.)
170. *Id.*
171. *Id.*
172. *Id.* at 644 n.6.
173. Kirkwood v. PrimaCare, Inc., No. 05-97-01934-CV, 2000 WL 124675, at *1 (Tex. App.—Dallas Feb. 23, 2000, no pet.) (NOTICE: Pursuant to the Texas Rules of Appellate Procedure, unpublished opinions shall not be cited as authority by counsel or by a court.)
174. *Id.* at *6.
175. *Id.*
176. *Id.*
177. Petrovich v. Share Health Plan of Ill., 719 N.E.2d 756, 765-66, 772 (Ill. 1999) (citations omitted).
178. *Id.* at 766.
179. *Id.* at 772.
180. *Id.* at 772.
181. *Id.* at 771.
182. *Id.* at 764.
183. Jones v. Chicago HMO Ltd. of Ill., 730 N.E.2d 1119 (Ill. 2000).
184. *Id.* at 1128.
185. *Id.* at 1129.
186. Center for Sight of Central Ill. I, S.C. v. Deranian, 712 N.E.2d 417 (Ill. App. Ct. 1999).
187. *Id.* at 418.
188. *Id.* at 422.
189. *Id.* at 421-22.
190. TLC The Laser Center, Inc. v. Midwest Eye Institute II, Ltd., 714 N.E.2d 45, 54, 56 (Ill. App. Ct. 1999).
191. *Id.* at 56.
192. *Id.*
193. Health Horizons Inc. v. State Farm Mut. Auto. Ins. Co., 521 S.E.2d 383 (Ga. Ct. App. 1999)

194. *Id.* at 389.
195. *Cal. Med. Ass'n v. Regents of the Univ. of Cal.*, 94 Cal. Rptr.2d 194 (Cal. Ct. App. 2000).
196. *Id.* at 196-97.
197. *Id.* at 197.
198. *Id.* at 198-200.
199. *Maio v. Aetna, Inc.*, 221 F.3d 472, 474 (3rd Cir. 2000).
200. *Id.*
201. *Id.*
202. *Id.*
203. *Id.*
204. *Id.* at 483.
205. *Id.*
206. *Id.* 487-88.
207. *Id.* at 488.
208. *Id.*
209. *Id.* at 488-89.
210. *Id.* at 489.
211. *Id.* at 492, 494.
212. *Wineinger v. United Healthcare Ins. Co.*, No. 8:99CV141, 2000 WL 1277629, at *1 (D. Neb. Feb. 16, 2000).
213. *Id.* at *6.
214. *Id.* at *1.
215. *Id.* at *8.
216. The REPAIR team is the same group of lawyers who took on the tobacco companies.
217. <http://www.aishealth.com/HMOLawsuitWatch/ONeill.html> (website address is case sensitive).
218. <http://www.aishealth.com/HMOLawsuitWatch/InReHumana.html> (website address is case sensitive).
219. *See, e.g., Curtright v. Aetna*, Cause No. n/a, Sup. Ct. Cal., Contra Costa County (filed October 1999), *removed* Dec. 12, 1999 (N.D. Cal. 1999); *Cruz v. PacificCare*, Cause No. n/a, Cal. Sup. Ct. (filed Nov. 2, 1999).
220. *Conte v. Aetna U.S. Healthcare, Inc.*, No. 99-CV-4929 (E.D. Pa. filed Oct. 4, 1999).
221. *See* Plaintiffs' Complaint, http://www.aetna.com/legal_issues/pdf_documents/Conte-class-action-complaint.pdf.
222. *Price v. Humana, Inc.*, No. n/a, S.D. Fla., Miami Division (October 4, 1999).
223. *In re Humana, Inc. Managed Care Litigation*, No. 1334, 2000 U.S. Dist. LEXIS 5099 (April 13, 2000)(Judicial panel on multidistrict litigation).
224. *Id.* at *2.
225. *Id.* at *3.
226. *See Hamilton v. Allen-Bradley Co.*, No. 99-11766, 2000 U.S. App. LEXIS 15844 (11th Cir. July 10, 2000).
227. *Harrison v. United Health Group*, No. n/a, N.D. Ala, Western Division (November 17, 1999).
228. California Med. Ass'n v. Blue Cross of Cal., No. CV1894 (N.D. Cal. filed May 25, 2000), <http://www.aishealth.com/HMOLawsuitWatch/CaliforniaBlueCross.html> (website address is case sensitive).
229. *See* Plaintiff's Complaint, <http://www.cmanet.org/upload/RICOsuit.pdf>.
230. *Kenneth Beer, M.D. and W.S. Cohen, et al. v. United HealthCare, Inc, et al.*, No. CL 00-2023, Fla. Cir., Palm Beach Co.
231. *Green v. Aetna U.S. Healthcare, Inc.*, No. 412180 (Cal. Super. Ct. filed Mar. 6, 2000), <http://www.aishealth.com/HMOLawsuitWatch/GreenAetna.html> (website address is case sensitive).
232. American Med. Ass'n v. Metro. Life Ins. Co., No. 00105266 (N.Y. Sup. Ct. filed Mar. 15, 2000); [see http://www.aishealth.com/HMOLawsuitWatch/AmMedical.html](http://www.aishealth.com/HMOLawsuitWatch/AmMedical.html) (website address is case sensitive).
233. *Harrison v. Covnetry Healthcare of Georgia, Inc.*, et al., Nos. 2000-CV-22194, 2000-CV-22196, 2000-CV-22204 (Ga. Super. Ct. filed Apr. 18, 2000), <http://www.aishealth.com/HMOLawsuitWatch/HarrisonCoventry.html> (website address is case sensitive).
234. *Tompkins v. United Healthcare of New England, Inc.*, 203 F.3d 90 (1st Cir. 2000).
235. *Id.* at 96.
236. *Id.* at 92.
237. *Id.* at 96.
238. *Garofalo v. Empire Blue Cross & Blue Shield*, 67 F. Supp. 2d 343, 352 (S.D. N.Y. 1999).
239. *Id.* at 352 (citations omitted). *See also* Citizens Ins. Co. of America, 92 F.Supp 2d 663, 669 (W.D. Mich. 2000) (noting that "[t]here is no requirement that, in order to be saved, the subject law must affect only traditional insurance.") (emphasis added).
240. *McNeil v. Time Ins. Co.* 205 F.3d 179 (5th Cir. 2000).
241. *Id.* at 182.
242. *Id.* at 191.
243. *Kondos Employee Health Care Plan v. First Integrated Health, Inc.*, No. 3:99-CV-2190-X, 2000 WL 12732, at *1 (N.D. Tex. Jan. 7, 2000).
244. *Id.* at *2.
245. *Id.*
246. *Hinterlong v. Baldwin*, 720 N.E. 2d 315, 318 (Ill. App. Ct. 1999).
247. *Id.* at 319.
248. *Id.* at 320-322.
249. *Id.* at 322 (citing *Scholten v. Schneider*, 173 Ill.2d 375, 392 (1996)).
250. *Id.* at 325.
251. *Danca v. Private Health Care Sys., Inc.*, 185 F.3d 1 (1st Cir. 1999).
252. *Id.* at 4.
253. *Id.* at 3.
254. *Id.* at 6.
255. *Blue Cross of Cal. v. Anesthesia Care Assocs. Med. Group, Inc.*, 187 F.3d 1045, 1047 (9th Cir. 1999).
256. *Id.* at 1048.
257. *Id.* at 1049.
258. *Id.* at 1050.
259. *Id.* (citing 29 U.S.C. § 1132(a)(1)(B)).
260. *Id.* at 1052, 1054.
261. *Bonestroo v. Cont'l Life & Accident* 79 F. Supp 2d 1041 (N.D. Iowa 1999).
262. *Id.* at 1049.
263. *Id.* at 1047.
264. *Id.*
265. *Id.*
266. *Id.* at 1047-48.
267. *Id.* at 1051.
268. *Id.* at 1054.
269. *Id.*
270. *Harlan v. Occidental Oil & Gas Co.*, No. CIV.A.98-3320, 1999 WL 649637, at *1 (E.D.La. Aug. 25, 1999).
271. *Id.* at *1.
272. *Id.* (citing *UNUM Life Ins. Co. of Am. v. Ward*, 119 S. Ct. 1380, 1386 (1999)).
273. *Harlan*, 1999 WL 649637, at *1.
274. *New England Mut. Life Ins. Co., Inc. v. Baig*, 166 F.3d 1 (1st Cir. 1999).
275. *Id.* at 2.
276. *Id.*
277. *Id.* at 4.
278. *Id.*
279. *Demars v. Cigna, Corp.*, 73 F.3d 443 (1st Cir. 1999).
280. *Id.* at 444.
281. *Id.*
282. *Id.* at 445.
283. *Id.* at 448-50 (citing *Gabner v. Metro. Life Ins. Co.*, 938 F. Supp. 1295, 1302 (E.D. Tex. 1996); *Mimbs v. Commercial Life Ins. Co.*, 818 F. Supp. 1556 (S.D. Ga. 1993); *Barringer-Willis v. Healthsource North Carolina Inc.*, 14 F. Supp. 2d 780, 783-85 (E.D. N.C. 1998); *Mizrabi v. Provident Life and Accident Ins. Co.*, 994 F. Supp. 1452, 1453-54 (S.D. Fla. 1998); *Loudermilch v. New England Mut. Life Ins. Co.*, 942 F. Supp. 1434, 1437 (S.D. Ala. 1996); *McCale v. Union Labor Life Ins. Co.*, 881 F. Supp. 233, 235-36 (S.D. W. Va. 1995); *Vaughn v. Owen Steel Co.*, 871 F. Supp. 247, 249 (D. S.C. 1994) (all of which discuss the distinction between conversion rights and conversion policies)).
284. *Demars*, 73 F.3d at 445 n.1.
285. In some cases, a conversion policy is not available to an individual where (1) the employer has fewer than 20 employees and is thus excepted from the requirement; and (2) the individual was not entitled to continuation coverage under ERISA, which is a prerequisite to the conversion option under an ERISA plan. *See* 29 U.S.C. §§ 1161-1169 (1994); *Powers v. United Health Plans of New England, Inc.*, 979 F. Supp. 64, 66 (D. Mass. 1997) ("Under ERISA, to obtain conversion coverage, an employee must first be eligible for (and must select) COBRA continuation coverage.").
286. *Kennedy v. Columbia Med. Ctr. McKinney*, No. 3-00CV0830-X (N.D. Tex. filed Mar. 13, 2000).
287. Brief of Amici Curiae United States, <http://www.dol.gov/dol/pwba/public/pubs/ab/kennedy1.txt>.
288. *Paris v. Iron Workers Trust Fund*, No. 99-1558, 2000 WL 384036, at *1 (4th Cir. Apr. 17, 2000) (per curiam) (this is an unpublished opinion).
289. *Id.*
290. *Id.* at *1 n.1 (citing *Harris v. Harvard Pilgrim Health Care, Inc.*, 20 F.Supp. 2d 143, 150 (D.Mass. 1998)).
291. *Paris*, 2000 WL 38406, at *1.
292. *Id.*
293. *Id.*
294. *Id.*

295. *Id.* at *2 (citing *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990)).
296. *Paris*, 2000 WL 38406, at *2.
297. *Id.* at *3 (citing *Sunbeam-Oster Co., Inc. v. Whitehurst*, 102 F.3d 1368, 1375-76 (5th Cir. 1996)); *but cf.* *Barnes v. Indep. Auto. Dealers Ass'n of Cal. Health & Welfare Benefit Plan*, 64 F.3d 1389, 1395 (9th Cir. 1995) (adopting "as federal common law this generally accepted rule that, an insured must be made whole before an insurer can enforce its right to subrogation.").
298. *Selby v. Principal Mut. Life Ins. Co.*, No. 98 CIV.5283(RLC), 2000 WL 178191, at *2, *3 (S.D.N.Y. Feb. 16, 2000).
299. *Id.* at *3 (citing *Franklin H. Williams Ins. Trust v. Travelers Ins. Co.*, 50 F.3d 144, 147 (2nd Cir. 1995)).
300. *Selby*, 2000 WL 178191, at *3 (quoting *Franklin H. Williams Ins. Trust Co.*, 50 F.3d at 151.).
301. *Dang v. UNUM Life Ins. Co.*, 175 F.3d 1186, 1192 (10th Cir. 1999).
302. *Citizens Ins. Co. of Am. v. Am. Med. Sec., Inc.*, 92 F.Supp 2d 663 (W.D. Mich. 2000).
303. *Id.* at 665.
304. *Id.*
305. *Id.*
306. *Id.* at 666.
307. *Id.* (quoting *Liberty Mut. Ins. Group v. Iron Workers Health fund of E. Mich.*, 879 F.2d 1384, 1386 (6th Cir. 1989)).
308. *Id.* at 670.
309. *Id.* (citing *UNUM v. Life Ins. v. Ward*, 526 U.S. 358, 376 n.2 (1999)).
310. *Id.* at 667-68.
311. *Id.* at 668 (quoting *Am. Med. Sec. Inc. v. Bartlett*, 111 F.3d 358 (4th Cir. 1997)).
312. *Citizens*, 92 F. Supp. 2d at 670.
313. *Id.* (quoting *FMC Corp. v. Holliday*, 498 U.S. 52, 64 (1990)).
314. *Citizens*, 92 F. Supp. 2d at 670.
315. Civil Action No. 98-3547 (S.D. Tex., Jan. 15, 1999).
316. *Plocica v. NYLCare*, 43 F.Supp. 2d 658 (N.D.Tex 1999) (settled); *See* TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-88.003 (Vernon Supp. 2000).
317. *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959, 6364 (7th Cir. 2000).
318. *Id.* at 964.
319. *Id.* at 965.
320. *Id.*
321. *Id.*
322. *Id.* at 966.
323. *Id.* at 968 (quoting *UNUM Life Ins. Co. of Am. v. Ward* 119 S. Ct. 1380, 143 (1999)).
324. *Id.* at 967 (citing *Cal. Div. of Labor Standards & Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 324 (1997)).
325. *Id.* at 968-69.
326. *Id.* at 969.
327. *Id.*
328. *Id.*
329. *Id.*
330. *Id.* at 973.
331. *McEvoy v. Group Health Cooperative of Eau Claire*, 570 N.W.2d 397, 401 (Wis. 1997).
332. *Id.* at 402.
333. *Id.* at 402-403.
334. *Id.* at 403.
335. *Id.*
336. *Id.*
337. *Id.* at 407.
338. *Id.* at 404.
339. *Id.*
340. *Id.* at 406 n.6. *But see* *Waddell v. Kaiser Found. Health Plan of Tex.*, 877 S.W.2d 341, 345 (Tex. App.–Dallas 1994, writ denied) (finding "any cause of action which arises out of wrongful denial of benefits 'relates to' employee welfare benefit plan" and is therefore preempted by ERISA).
341. *Morris v. Health Net of Cal. Inc.*, 988 P.2d 940 (Utah 1999).
342. 31 U.S.C. § 3729(a) (1994); *The False Claims & Monetary Penalty Acts*, HEALTH CARE FRAUD & ABUSE NEWSLETTER (Am. Lawyer Media, New York, N.Y.), June 2000, at 3 [hereinafter *False Claims*].
343. *Agency of Natural Res. v. United States ex rel. Stevens*, 120 S. Ct. 1858, 1870-71 (2000); *False Claims*, *supra* note 276.
344. 31 U.S.C. § 3730(d) (1994).
345. *False Claims*, *supra* note 342.
346. *Stewart v. Berry Family Health Ctr.*, 105 F. Supp. 2d 807 (S.D. Ohio 2000).
347. *Id.* at 815.
348. *Neade v. Portes*, 739 N.E.2d 496 (Ill. 2000).
349. *Id.* at 498.
350. *Id.* at 500.
351. *Id.* at 502 (citing *Herdrich*, 120 S. Ct. at 2157).
352. *Moore v. Regents of Univ. of Cal.*, 793 P.2d 479 (Cal. 1990).
353. *Id.* at 483.
354. *Id.*
355. *Id.* at 483-84.
356. *Ehlmann v. Kaiser Found. Health Plan of Tex.*, 198 F.3d 552 (5th Cir. 2000).
357. *Id.* at 555.
358. *Id.*
359. *See* *Aetna Settlement Agreement*, http://www.oag.state.tx.us/notice/avc_fin1.pdf.
360. *McCarron v. Prudential Ins. Co. of America, et al.*, Cause No. 00-CV-1693 (D.N.J. April 11, 2000).
361. *See* <http://www.aishhealth.com/HMOLawsuitWatch/McCarron.html>; <http://www.aishhealth.com/HMOLawsuitWatch/InReHumana.html>. (website address is case sensitive).