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# Patients' Bill of Rights: Legislative Cure-All or Prescription for Disaster

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### INTRODUCTION

American society is built upon a foundation of freedoms and rights.<sup>1</sup> Inherent in a freedom-loving society is the notion of choice. American citizens have a multitude of choices—among others, the freedom to decide where to work, where to live, and where to send their children to school.<sup>2</sup> Representative democracy itself is built upon the free exercise of choice for all citizens in determining the course of public policy.<sup>3</sup>

What may seem to pervert the theory of choice to many Americans is the system used to finance the health care services they consume. Under the modern managed care system in place in the United States,<sup>4</sup> a patient enrolled in a health plan has limited choices

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1. See THE DECLARATION OF INDEPENDENCE para. 2 (U.S. 1776) (declaring that all men are created with certain "inalienable" rights).

2. See, e.g., *Zelman v. Simmons-Harris*, 122 S. Ct. 2460, 2463 (2002) (holding that the government can enact a school voucher program without violating the Establishment Clause of the United States Constitution, thereby supporting parents' rights to choose where they send their children to school).

3. The Constitution of the United States provides this essential freedom of representative choice throughout its articles and amendments. U.S. CONST. art. I, § 2, cl. 1 (providing direct election of Members of the United States House of Representatives); *id.* amend. XVII, § 1 (providing direct election of Members of the United States Senate).

4. See DAVID DRANOVE, *THE ECONOMIC EVOLUTION OF AMERICAN HEALTH CARE: FROM MARCUS WELBY TO MANAGED CARE* 65–90 (2000) (describing the

of health service providers,<sup>5</sup> treatment decisions are made in consultation with the health plan paying for the treatment,<sup>6</sup> and health care providers contract with the health plan and are rewarded financially for controlling costs.<sup>7</sup> The basic model for managed care is simple: managed care insurance plans collect premiums from consumers—or, in most cases, consumers' employers—and arrange for medical services to be supplied by providers with whom the plan has pre-arranged fee agreements.<sup>8</sup> Managed care organizations review payment claims and base coverage decisions on such vague ideas as "medical necessity" and "most cost-effective alternative."<sup>9</sup> Medical service providers are paid a flat fee, regardless of the number of services they provide to enrolled patients, forcing providers to share the financial risk of enrollee illness and providing incentives to ration care.<sup>10</sup> Not only does the managed care structure reduce a patient's control over his health care consumption and expenditures, federal law limits the ability of individuals to sue certain decision-makers in their health plans for coverage decisions that deny payment for needed health care, even in cases where the coverage denial proximately resulted in harm to the patient.<sup>11</sup> Thus, choice, access, and even redress of grievances are limited for managed care customers.

Despite this apparent lack of choice and individual control in the modern health insurance environment for the vast majority of working Americans, managed care enrollment continues to increase.<sup>12</sup> Growing resentment by many managed care enrollees has led

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evolution of health care financing and the rise of managed care in the latter half of the twentieth century); WALTER A. ZELMAN & ROBERT A. BERENSON, *THE MANAGED CARE BLUES AND HOW TO CURE THEM* 10–11 (1998) (stating that over eighty percent of individuals with employer-provided insurance in 1997 were enrolled in a managed care plan).

5. See ROBERT D. MILLER & REBECCA C. HUTTON, *PROBLEMS IN HEALTH CARE LAW* 159 (8th ed. 2000) (describing the cost savings managed care achieves by limiting enrollees to a finite list of medical providers).

6. See SHERRY TATAR DACSO & CLIFFORD C. DACSO, *MANAGED CARE ANSWER BOOK* §§ 12:37–12:39 (3d ed. 1999) (discussing managed care organizations' involvement in medical necessity determinations and utilization review).

7. LOIS WRIGHT MORTON, *HEALTH CARE RESTRUCTURING: MARKET THEORY VS. CIVIL SOCIETY* 40 (2001) (discussing health care provider incentive programs and the rationing that they create).

8. *Id.*

9. E. HAAVI MORREIM, *HOLDING HEALTH CARE ACCOUNTABLE: LAW AND THE NEW MEDICAL MARKETPLACE* 47 (2001).

10. LISA YOUNT, *PATIENTS' RIGHTS IN THE AGE OF MANAGED CARE* 82–84 (2001).

11. *Id.* at 65.

12. ZELMAN & BERENSON, *supra* note 4, at 11.

legislators in many states and in Congress to introduce an array of measures aimed at changing the way managed care operates to make it more amenable to consumers. Many of the legislative initiatives<sup>13</sup> aimed at improving the quality of and access to healthcare for the millions of Americans covered by managed care tend to thwart the fundamental underpinnings of managed care—cost containment and efficient distribution of medical services—by requiring health plans to cover an array of medical services, thereby increasing costs.<sup>14</sup> Under a pure managed care system—a theoretical system not beholden to state and federal government interference—patients would receive coverage for only the care that the health plan deemed medically necessary to treat or prevent a medical condition, leaving the insured with little control over decisions regarding more expensive treatments, experimental treatments, or other courses of medical care not deemed “medically necessary” by the plan.<sup>15</sup> To offset health plan control over medical care and afford consumers broader options in deciding on a course of medical treatment, state legislatures and Congress have spent the past several years mandating that managed care plans provide costly coverage for an array of medical services

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13. See, e.g., Bipartisan Patient Protection Act, S. 1052, 107th Cong. (2001) (proposing criteria for utilization review programs); Act of Apr. 20, 1999, § 3, 1999 Ga. Laws 350, 352–62 (codified at Ga. Code Ann. §§ 33-20A-30 to 33-20A-41 (2000)) (amending previous statute to provide enrollees of managed care plans with an independent review of plan determinations); Act of Oct. 18, 2001, ch. \_\_, 2001 N.C. Sess. Laws \_\_ (2001) (establishing a Managed Care Patient Assistance Program to provide information to individuals enrolled in managed care plans); TEX. CIV. PRAC. & REM. CODE ANN. § 88 (Vernon Supp. 2003) (creating in health insurance carriers, HMOs, and other managed care entities a duty to exercise ordinary care when making health care treatment decisions); see also Gail A. Jensen & Michael A. Morrissey, *Employer-Sponsored Health Insurance and Mandated Benefit Laws*, 77 MILBANK Q. 425, 427–33 (1999) (summarizing the more than one thousand enacted state and federal health care access and benefit mandates and their impact on the cost of health insurance), available at <http://www.milbank.org/quarterly/7704feat.html> (last visited Nov. 13, 2002) (on file with the North Carolina Law Review); PricewaterhouseCoopers, *The Factors Fueling Rising Healthcare Costs*, prepared for the American Association of Health Plans, at 3–4, 6 (Apr. 2002) [hereinafter PWC Report] (discussing many factors contributing to the dramatic inflation of health care expenses, including government mandates and regulation and increased litigation costs), at <http://www.aaahp.org/InternalLinks/PwCFinalReport.pdf> (on file with the North Carolina Law Review). The PWC Report indicates that, while the two largest health care cost-drivers continue to be general inflation and drugs, devices and medical advances, expenses associated with litigation, risk management, and government mandates and regulation have increasingly fueled rising health costs. *Id.* at 5–9.

14. See Jensen & Morrissey, *supra* note 13; PWC Report, *supra* note 13.

15. See DACSO & DACSO, *supra* note 6, §§ 12:32–12:40 (providing an overview of how plans define and determine “medical necessity”).

and treatment.<sup>16</sup> Recent proposals aimed at requiring external review, allowing health plans to be sued under a wide array of causes of action, capping premium rates, and guaranteeing health insurance access regardless of the patient's health have the potential to undo the benefits realized by the health insurance market reforms of the 1970s and 1980s.<sup>17</sup> While there are conflicting viewpoints regarding the effect that state mandates and market reforms have had on quality of care and cost,<sup>18</sup> over-regulation of the fragile managed care market could give rise to a health care crisis similar to the one that led to the explosion of managed care popularity.<sup>19</sup> While the health care system in America may not have reached crisis point yet,<sup>20</sup> continued over-regulation, increased mandated benefit adoptions, and enactment of health insurer liability, "patients bill of rights" legislation threaten to destabilize the managed care system. As the states and Congress implement or look to adopt patients' rights measures that include health insurer tort liability for coverage decisions,<sup>21</sup> policymakers must thoroughly examine the costs imposed by the systems they employ. Given the origins of managed care and the pressures that caused it to come about, departures from the traditional managed care formula threaten to bring about dramatic premium increases and an expansion of the uninsured population, as individuals and employers cease to have the ability to pay for health insurance.<sup>22</sup>

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16. Jensen & Morrissey, *supra* note 13 (citing Massachusetts as the first state to adopt mandatory benefits as early as 1956); PWC Report, *supra* note 13, at 6 (noting a twenty-five-fold increase in mandated benefits from 1970–1996).

17. See, e.g., YOUNT, *supra* note 10, at 56 (arguing that the health care system and its survival will critically depend on control over cost escalation).

18. Patricia Butler, *Key Characteristics of State Managed Care Organization Liability Laws: Current Status and Experience* 6 (Aug. 2001) ("It is premature to assess the impacts of state [managed care organization] liability laws on overall health care spending . . ."), at <http://www.kff.org/content/2001/3155/MCOReport.pdf> (on file with the North Carolina Law Review); *Patient Protection in Managed Care, Hearing Before the Subcommittee on Health of the Committee on Ways and Means of the House of Representatives*, No. 107-14, at 22–32 (Apr. 24, 2001) (statement of Dr. Richard Corlin, President-Elect, American Medical Association).

19. See *infra* notes 36–37 and accompanying text.

20. See ZELMAN & BERENSON, *supra* note 4, at 102–18 (evaluating the credibility of managed care horror stories and suggesting that they are overstated).

21. See, e.g., BiPartisan Patient Protection Act, S.1052, 107th Cong. (2001).

22. *Smarter Health Care Partnership for American Families: Making Federal and State Roles in Managed Care Regulation and Liability Work for Accountable and Affordable Health Care Coverage, Hearing Before the Subcommittee on Health of the Committee on Energy and Commerce of the House of Representatives*, 107th Cong. 59–62 (2001) (Sup. Doc. No. Y4.C73/8:107-9) (statement of Stephen deMontMollin, Vice President and General Counsel, AvMed Health Plan) (citing a study by the Barents Group at KPMG

Further cause for concern with today's managed care system spurs from states potentially overreaching their own authority in implementing liability and increased coverage mandates upon health insurers. As discussed *infra*, managed care arose from an expansion of health care costs and a lack of medical resources to meet increasing demand. Federal laws to authorize the creation of managed care organizations and to restrict state interference in employer-sponsored benefit plans, including health plans, took from the states some authority to regulate certain aspects of the health care financing system. With well over one thousand mandated benefits<sup>23</sup> and scores of managed care regulations already on the books,<sup>24</sup> states seeking to impose liability and increased coverage mandates upon health insurers must examine both the feasibility of their proposals and the legality of their legislation vis-à-vis federal law.

Because state authority to impose liability on employee-sponsored health insurance plans is tenuous and likely preempted by federal law, states that have not enacted liability statutes are wise to take a wait-and-see approach with Congress. Congress, given skyrocketing health care costs and the likelihood of even higher costs with widespread health plan liability, should take a moderate approach and adopt patient-friendly compromises, such as external review and arbitration, to deal with health care financing disputes.

Section I of this Comment discusses the historical development of managed care and the theories behind its implementation. Section II discusses the Employee Retirement and Income Security Act of 1974 and its preemption of state law claims against managed care organizations. Section III tracks the evolution of managed care following the adoption of the Health Maintenance Organization Act of 1973 and ERISA in 1974. Section IV outlines two major United States Supreme Court cases regarding ERISA preemption of state law claims against managed care companies and the confusion that these two decisions, and others, have caused on the issue of ERISA preemption. Section V discusses state legislative efforts to impose liability on managed care organizations for coverage decisions and other state strategies to reform managed care. Section VI outlines two major Congressional proposals to reform managed care and the differences between the two that have stymied passage. Finally, this Comment concludes that Congressional action is necessary to

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indicating that health plan liability could raise health insurance premiums by as much as 8.6%, possibly forcing employers to drop coverage for their employees).

23. See PWC Report, *supra* note 13, at 6.

24. See *id.*

alleviate the confusion caused by overlapping state and federal judicial action on the issue of ERISA preemption and managed care liability, but that Congress should take a moderate approach toward resolving this issue to preserve the fundamental benefits of managed care that were recognized in the HMO Act of 1973.

### I. THE ORIGINS OF MANAGED CARE IN AMERICA

The early models of managed care can be traced back to the late nineteenth century.<sup>25</sup> Membership groups such as lodges and fraternal orders began contracting with healthcare providers to provide services to their members at reduced costs in a manner similar to that which is used by health plans today, although many of the features of modern managed care did not exist in these early health care contracting arrangements.<sup>26</sup> In the early part of the twentieth century, wealthy construction contractor Henry Kaiser established the first employer-sponsored health plan.<sup>27</sup> Kaiser contracted with local physicians to provide health services to his employees on a pre-paid basis, in what served as a preliminary model for many of today's employer-sponsored managed care plans.<sup>28</sup>

Prior to the Great Depression, health insurance in the modern sense was a rarity in America.<sup>29</sup> Low wages and lack of employment made healthcare a luxury for many Americans.<sup>30</sup> In response to the Great Depression and the relative shortage of access to affordable medical care, health care providers launched Blue Cross and Blue Shield—providing insurance coverage for hospitalization and medical services, respectively—in the 1930s to pool contributions and thus spread financial risk of illness among many enrollees.<sup>31</sup> Providers in the Blues networks were paid on a fee-for-service basis, which served as a model for the vast majority of health insurance plans following the Depression and beyond World War II.<sup>32</sup> Health insurance

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25. See DRANOVE, *supra* note 4, at 36–40 (tracing the evolution of managed care from prepaid medical agreements in the 1890s to modern day HMOs).

26. *Id.*

27. YOUNT, *supra* note 10, at 6.

28. *Id.*

29. DRANOVE, *supra* note 4, at 37 (“[T]he Great Depression put the cost of health care out of the reach of millions of Americans.”).

30. *Id.* at 36–38.

31. *Id.* at 37–38 (describing the creation of fee-for-service health insurance pools such as Blue Cross and Blue Shield). These fee-for-service plans, referred to collectively as “the Blues,” were initially more popular with the medical provider community because they guaranteed payment for services instead of providing “unlimited services for limited pay,” a feature of prepaid plans such as the lodge plans and the Kaiser plan. *Id.*

32. *Id.*

enrollment continued to grow through the 1950s and 1960s, as employers followed the example of Kaiser and provided health insurance to their workers.<sup>33</sup> The federal and state governments followed suit in the 1960s with the establishment of the Medicare and Medicaid programs, providing health insurance to the nation's elderly and, with assistance and involvement from the states, poor, respectively.<sup>34</sup> Medicare and Medicaid both offer managed care options to their enrollees.<sup>35</sup>

Expanding access to health services via employer-sponsored health insurance and government-funded public insurance caused a dramatic spike in the utilization of healthcare services and the quality of services demanded by consumers.<sup>36</sup> The rise in health care utilization led to an increase in health insurance costs, causing health care inflation to rise above the level of overall inflation.<sup>37</sup>

Despite the creation of the Kaiser and other prepaid insurance plans, traditional fee-for-service remained the dominant health care financing model for nearly three-fourths of the twentieth century. Beginning in 1970, however, Paul M. Ellwood, a Minnesota physician and advisor to President Richard M. Nixon, decried the traditional fee-for-service structure of health care financing and urged legislators to adopt a "Health Maintenance Strategy" premised on intense competition, self-regulation, and fixed costs.<sup>38</sup> Ellwood argued that medical inflation was caused by increases in demand spurred by the advent of private and public health insurance programs (including Medicare and Medicaid), and that continued over-utilization of limited health care resources threatened collapse of the health care

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33. RICHARD DEAN SMITH, *MANAGED CARE: ANATOMY OF A MASS MOVEMENT* 2-8 (2000).

34. *Id.* at 5-8.

35. See ZELMAN & BERENSON, *supra* note 4, at 61-62 (discussing the rising numbers of Medicare and Medicaid beneficiaries enrolling in managed care systems).

36. J.D. KLEINKE, *OXYMORONS: THE MYTH OF A U.S. HEALTH CARE SYSTEM* 13-18 (2001). This trend in increased utilization is termed "Moral Hazard," wherein consumers will utilize more health care services when their insurance pays the bill in much the same manner as consumers are more likely to drive faster or avoid wearing their seatbelts when their automobile is equipped with air bags. DRANOVE, *supra* note 4, at 28-31 (discussing the notion of moral hazard); see also Paul M. Ellwood et al., *Health Maintenance Strategy*, 9 MED. CARE 291, 291-95 (1971) (discussing the need for a new approach to health care financing).

37. SMITH, *supra* note 33, at 3; see also DRANOVE, *supra* note 4, at 29 (noting the difference between utilization rates of insured persons who were required to pay a co-payment to receive medical services and persons whose insurance covered the entire cost of the services received); PWC Report, *supra* note 13, at 7-8 (discussing the increase in consumer demand for health care services).

38. Ellwood et al., *supra* note 36, at 295.

system in the United States.<sup>39</sup> He observed that a system of nationalized health insurance, also being considered at the time,<sup>40</sup> promised not to curb but to actually stimulate demand for limited health resources.<sup>41</sup> The ability of the health care industry to restrain itself was undermined by a lack of market controls, such as informed consumer choice of health services and competition, and neither continuing the current structure nor imposing federal price controls appeared to be the solution.<sup>42</sup> The price inflation trend and demand-induced supply shortage of medical services caused U.S. health indicators to fall behind those of other industrialized nations despite a higher physician-to-patient ratio in the United States as compared to those industrialized nations.<sup>43</sup>

Ellwood's "Health Maintenance Strategy" envisioned a health care financing system governed by contracts, wherein fees would be fixed and pre-paid, and providers and consumers would be encouraged to conserve medical resources.<sup>44</sup> In addition, emphasis in the health care financing and delivery system would be proactive, focusing on health promotion and disease prevention, rather than treatment for diseases contracted, the traditional reactive approach of the health community, under the assumption that preventive care is cheaper than medical treatment after an ailment has been contracted.<sup>45</sup> Thus, under Ellwood's vision, cost savings would be achieved through a combination of encouraging less expensive preventive health care and reducing health care inflation via pre-paid and fixed-fee agreements with providers. Ellwood and his collaborators, Alain Enthoven of Stanford University and the American Rehabilitative Institute for which Ellwood served as executive director, called on the federal government to encourage the implementation of health maintenance organizations ("HMOs")

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39. *Id.* at 291.

40. See DRANOVE, *supra* note 4, at 30 (describing the Kennedy-Mills national insurance proposal in the early 1970s).

41. See Ellwood et al., *supra* note 36, at 291. Ellwood essentially believed that, while the health of the population gradually increases as the population receives more health care services, there comes a point when increased health care services do not increase the health of the population. See DRANOVE, *supra* note 4, at 36. Ellwood and others theorized that as long as American society continued to be dominated by the fee-for-service insurance system, the country would stay in the "flat of the curve," consuming more health care resources than are needed to increase the overall health of society. *Id.*

42. Ellwood et al., *supra* note 36, at 292, 293.

43. *Id.* at 294.

44. *Id.* at 295.

45. See David A. Bennahum, *The Crisis Called Managed Care*, in *MANAGED CARE: FINANCIAL, LEGAL AND ETHICAL ISSUES* 1, 3 (David A. Bennahum ed., 1999).

throughout the country by passing enabling legislation adopting Ellwood's health maintenance strategy.<sup>46</sup> At the urging of Ellwood and other professionals in the field, the Nixon Administration pushed for the adoption of the Health Maintenance Organization Act of 1973 ("HMO Act").<sup>47</sup>

While no federal law expressly prohibited the creation of a managed care organization, managed care systems were not in wide use in the United States. Several members of Congress, the Nixon Administration, and the public saw legislation as a means to encourage the expansion of managed care coverage throughout the country.<sup>48</sup> As enacted, the HMO Act defines an HMO as an organization that provides listed health services to its enrollees in return for a fixed payment.<sup>49</sup> The Act requires that all HMOs provide "basic health services"<sup>50</sup> to each enrollee, and allows for the provision of "supplemental health services"<sup>51</sup> in the event that such services are

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46. Ellwood et al., *supra* note 36 at 291-92. Ellwood proposed enabling legislation that would have: (1) eliminated legal barriers to and provided incentives for the creation of managed care systems; (2) achieved cost savings in the Medicare and Medicaid programs by purchasing health care services through managed care agreements; (3) ensured that health care service providers would receive adequate return on investments in research and development, manpower, and facilities; and (4) mandated the review of government activities in the health field to determine which they contribute to and which detract from the health maintenance strategy. *Id.*

47. Mike Mitka, *A Quarter Century of Health Maintenance*, 280 JAMA 2059, 2059 (Dec. 23/30 1998). The Senate version of the HMO Act, entitled the Health Maintenance Organization and Resources Development Act of 1973, listed the following findings: (1) medical care is too expensive; (2) the medical care system is oriented toward the provision of acute care; (3) medical resources are maldistributed; (4) HMOs will assist in alleviating the above-mentioned problems; (5) technical and resource assistance is needed to establish and operate HMOs; and (6) the quality of medical care varies excessively. S. REP. NO. 93-621, at 27-28 (1973), *reprinted in* 1973 U.S.C.C.A.N. 3121, 3122. While these findings did not appear in the final version of the legislation, they are strong indications of the impetus behind creation of the HMO Act.

48. See ZELMAN & BERENSON, *supra* note 4, at 51-52 ("The centerpiece of the Nixon program was the HMO Act of 1973 . . .").

49. 42 U.S.C. §§ 300e, 300e-1 (2000).

50. *Id.* § 300e(a)(1). Basic health services include: (1) physician services including consultation and referral; (2) inpatient and outpatient hospital services; (3) emergency health services; (4) mental health services; (5) medical treatment and referral services for the abuse of or addiction to alcohol and drugs; (6) diagnostic laboratory and diagnostic and therapeutic radiological services; (7) home health services; and (8) preventive health services (including voluntary family planning services and infertility services). *Id.* § 300e-1(1). Despite what appears to be a broad list of required services, the legislation strictly limited the definition of these required basic health services.

51. The term "supplemental health services" means any health service not defined by the statute as a basic health service, specifically those services that may be legally provided under state law by a non-physician medical care provider (dentist, podiatrist, etc.). *Id.* § 300e-1(2).

available within the coverage area of the HMO and the patient contracted for such services.<sup>52</sup> The HMO Act also provides for grievance procedures for enrollees who are denied medical services, requires annual open enrollment periods, and mandates HMO solvency procedures within guidelines specified by regulations.<sup>53</sup> The law also contains provisions to encourage the development of HMOs, including the provision of loans and loan guarantees by the federal government to entities establishing HMOs.<sup>54</sup> The legislation preempts any state laws restricting the creation of an HMO.<sup>55</sup> To further encourage the development and use of HMOs, the law requires all employers of twenty-five or more employees who offer health benefits to include in their health benefit packages an option for employees to choose an HMO.<sup>56</sup>

The objective of the HMO model is simple—to coordinate health care by focusing on cost efficiencies, preventive medicine, and oversight of medical services providers.<sup>57</sup> While lately many critics of managed care have denounced the use of primary care physicians as “gatekeepers” restricting access to specialists and requiring pre-approval of services, the gatekeeper function was designed both to control the cost of unnecessary medical expenses and to ensure the quality of care through coordination of care by the primary care

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52. *Id.*

53. *Id.* § 300e(c)(4)–(5), (7) (providing that “health maintenance organizations must be organized in such a manner that provides meaningful procedures for hearing and resolving grievances between the health maintenance organization . . . and the members of the organization” and that health organizations adopt procedures to avoid insolvency).

54. 42 U.S.C. § 300e-3 (1982) (providing loan guarantees to fledgling HMOs), *repealed by* Health Maintenance Organization Amendments of 1986, Pub. L. No. 99-660, Title VIII, § 803(a), 100 Stat. 3799, 3799 (1986).

55. *Id.* § 300e-10 (preempting certain state laws that limit or forbid the creation of HMOs).

56. *Id.* § 300e-9 (“If a health benefits plan offered by an employer or a State or political subdivision includes contributions for services offered under the plan, the employer or State or political subdivision shall make a contribution under the plan for services offered by a qualified health maintenance organization.”).

57. See ZELMAN & BERENSON, *supra* note 4, at 9. To help realize these objectives, the HMO model uses, among other devices, gatekeepers and utilization review. Gatekeepers are generally health-plan-contracted physicians who serve as primary care physicians for an insured. The primary care physician’s role is to manage the overall health care of the enrollee, promote health through preventive medicine, and approve only those medical services that are necessary given the patient’s condition and the provisions of the health policy. See DACSO & DACSO, *supra* note 6, § 1:40. Utilization review is an additional cost containment check whereby HMO employees review proposed medical treatments to ensure they conform to the provisions of the managed care contract. If the treatments are outside the scope of the contract, the HMO will deny coverage. See *id.* §§ 7:1–7:7, 7:23–7:28 (describing the model for a typical utilization review procedure).

physician.<sup>58</sup> Contrary to traditional fee-for-service plans that reward physicians and other providers for each service they provide, managed care plan flat-fee arrangements actually provide incentives to contract providers to prescribe and conduct fewer medical services.<sup>59</sup> While rewarding doctors to refuse services may appear to undermine the very notion of increased access sought by Ellwood and his peers, the physician's oath,<sup>60</sup> the HMO Act, and HMO contracting regulations sought to ensure that, regardless of cost control measures, patients would still have access to necessary medical services.<sup>61</sup> The core of the health maintenance strategy was to focus physicians on less costly preventive medicine in the present in lieu of expensive and invasive surgery in the future, a concept that, while not opposed by the medical community, was not uniformly being followed throughout the medical establishment.<sup>62</sup>

Rising health care costs in the 1970s led to Ellwood's health maintenance strategy and eventually the passage of the Health Maintenance Act of 1973.<sup>63</sup> The rise of HMOs following passage of the Act helped to stave off spiraling health care inflation during the late 1980s and early 1990s.<sup>64</sup> As policymakers look to improve patient satisfaction in managed health care through patients' bills of rights, it would be perverse for Congress and the states to ignore the benefits of Ellwood's model for cost containment through health maintenance. Federal and state policymakers should consider methods to stave the trend of rising inflation,<sup>65</sup> instead of adopting

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58. See generally Delilah Brummet Flaum et al., *An Overview of Managed Care Organizations: Sorting Out the Alphabet Soup*, in *MANAGED CARE LIABILITY: EXAMINING RISKS AND RESPONSIBILITIES IN A CHANGING HEALTH CARE SYSTEM* 1, 1–14 (David L. Leitner ed., 1996) (describing the general structure and function of most managed care plans).

59. ZELMAN & BERENSON, *supra* note 4, at 9.

60. While it varies from state to state, the Hippocratic Oath at a minimum requires that physicians "do no harm." The American Medical Association lists several states' oaths. See Oath Registry, at <http://www.ama-assn.org/ama/pub/category/5573.html> (last visited Oct. 1, 2002) (on file with the North Carolina Law Review).

61. See 42 U.S.C. § 300e(b) (2000) (requiring HMOs to provide basic and supplemental health services); 42 C.F.R. § 3417.104 (2001) (same).

62. ZELMAN & BERENSON, *supra* note 4, at 10.

63. See SMITH, *supra* note 33, at 3.

64. See ZELMAN & BERENSON, *supra* note 4, at 53–55 (discussing the rise in enrollment in managed care in the 1980s and early 1990s and the corresponding effects on health care cost containment); see also YOUNT, *supra* note 10, at 12 ("To a large extent, the HMO prescription worked: The rate of increase in health care costs slowed substantially in the mid 1990s."); cf. DRANOVE, *supra* note 4, at 84 (indicating that U.S. healthcare spending as a percentage of gross domestic product ("GDP") peaked in 1993 and remained constant or declined for several years thereafter).

65. See *infra* note 288 and accompanying text.

knee-jerk responses to consumer complaints such as health plan liability and increased mandated benefits, measures that could exacerbate, not remediate, health care inflation.

## II. ERISA AND THE LIABILITY SHIELD

Following the adoption of the HMO Act, Congress once again became involved in the managed care movement in 1974, by passing the Employee Retirement Income Security Act of 1974 ("ERISA").<sup>66</sup> In enacting ERISA, Congress stated the following:

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, . . . ; it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans . . . .

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.<sup>67</sup>

ERISA sought to govern the establishment and management of employer-sponsored benefit plans and protect them from the soaring costs of inflation felt in the 1970s.<sup>68</sup> Furthermore, the increased complexity of multi-state regulation threatened to bankrupt or at

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66. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. §§ 1001-1461 (2000)).

67. *Id.* § 2(a) & (b), 88 Stat. at 832-33.

68. 29 U.S.C. § 1001 (declaring Congressional findings).

least severely handicap them in their capacity to serve their members.<sup>69</sup> Since many such benefit plans were administered on an interstate basis,<sup>70</sup> Congress established federal guidelines for such plans and preempted state laws "relating to" such plans.<sup>71</sup> ERISA preemption of all state laws "relating to" employee benefit plans was interpreted broadly by the United States Supreme Court in *Pilot Life Insurance Co. v. Dedeaux*.<sup>72</sup>

This preemption of state law claims against employee benefit plans has been interpreted to apply to employee retirement, health care, and other employee benefit programs. Many state tort and contract law claims for malpractice, wrongful death, breach of contract, fraud, intentional or negligent infliction of emotional distress, and other related claims have also been interpreted to be preempted.<sup>73</sup> While employee benefit plans were not completely immune from all state causes of action, ERISA strictly prohibits certain types of state claims that may be brought against a benefit plan.<sup>74</sup> Furthermore, ERISA expressly states the available causes of action that an aggrieved enrollee in an employee benefit plan may

69. See YOUNT, *supra* note 10, at 65. For instance, increased costs to comply with multiple complex state regulations could reduce a benefit plan's assets, as could multiple state provisions that conflict with one another. See *id.*

70. See 29 U.S.C. § 1001(a).

71. The ERISA preemption clause states:

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

29 U.S.C. § 1144(a).

72. 481 U.S. 41 (1987). Justice Sandra Day O'Connor, writing for the majority, indicated that *Dedeaux's* complaint was preempted by ERISA because the claims asserted "relate[d] to" the employee benefit health plan. *Id.* at 47-48. The Supreme Court, in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985), and *Shaw v. Delta Airlines*, 463 U.S. 85 (1981), had held that the ERISA "relate to" clause is given a "broad, common-sense meaning." *Id.* Such an expansive reading of the clause "is not limited to 'state laws specifically designed to affect employee benefit plans.'" *Dedeaux*, 481 U.S. at 47-48 (quoting *Delta Airlines*, 463 U.S. at 98).

73. See MORREIM, *supra* note 9, at 161 (describing the original ERISA environment and the erosion of ERISA protections for managed care health plans over time).

74. 29 U.S.C. § 1144(a)-(c) (2000); see *Dedeaux*, 481 U.S. at 47-48; see also DACSO & DACSO, *supra* note 6, § 9.33 (discussing several types of state law claims preempted by ERISA). See generally Barry R. Furrow, *Litigation Over Quality in Managed Care: Individual Malpractice/Negligence Claims in Arbitration and Litigation*, in MANAGED CARE LIABILITY: EXAMINING RISKS AND RESPONSIBILITIES IN A CHANGING HEALTH CARE SYSTEM, *supra* note 58, at 15-38 (outlining several state causes of action permissible despite ERISA preemption).

pursue,<sup>75</sup> and provides that those in control of the plan have an express fiduciary duty to all plan enrollees.<sup>76</sup> Commentators, however, have criticized the ERISA remedies as lacking the strength of state court remedies.<sup>77</sup>

The enactment of ERISA was not specifically intended to signal further Congressional preference for HMOs and managed care.<sup>78</sup> ERISA efforts to streamline regulation of employee benefit plans, however, further promote the cost-saving focus of managed care, in theory, by enabling employer-sponsored managed care health benefit plans to avoid the cost of multiple, overlapping state regulations. When ERISA was adopted, most individuals covered by employer health insurance were enrolled in traditional fee-for-service, third party insurance plans, which did not fall under the rubric of ERISA's employee benefit plan.<sup>79</sup> Part of this confusion rests in the hybrid notion of managed care entities as part health service provider—because the plan “delivers” medical services through its contracted physicians—and part health insurer—because of its payment system. Regardless of ERISA's original narrow application to the health insurance coverage of the majority of the insured population, the expansion and evolution of managed care coverage from the 1970s through today<sup>80</sup> have led to sizeable increases in the number of health plan enrollees whose state law grievances against their managed care organizations are preempted.<sup>81</sup> Meanwhile, as patient dissatisfaction<sup>82</sup> with managed care's limitations increases, state legislatures have attempted to expand regulation of health benefit plans while courts have made some attempts to erode some of the traditional ERISA protections for HMOs and other managed care entities.<sup>83</sup> Despite efforts at the state and federal level to chip away at the cost-containment structure of managed care, ERISA's federal preemption of state law has served the health maintenance strategy well by

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75. 29 U.S.C. § 1132.

76. *Id.* § 1002(14). The fiduciary duty is interpreted broadly to include plan managers and employees and even physicians in some situations, depending on their relationship with the benefit plan.

77. See MORREIM, *supra* note 9, at 178–79; YOUNT, *supra* note 10, at 65.

78. § 1001(a) (discussing benefit plans in general).

79. See YOUNT, *supra* note 10, at 65.

80. See *supra* note 4 and accompanying text.

81. See *supra* note 71 and accompanying text.

82. See ZELMAN & BERENSON, *supra* note 4, at 103 (listing some of the factors indicating decreased satisfaction among health plan enrollees).

83. See MORREIM, *supra* note 9, at 37.

limiting duplicative and costly regulation and restricting causes of action and recovery to more strict federal limits.

### III. THE EVOLUTION OF MANAGED CARE, FROM ELLWOOD TO CLINTON-CARE AND BEYOND

Following the adoption of the HMO Act and ERISA, HMOs and managed care plans did not immediately enjoy vast increases in enrollment. In fact, it was not until the late 1980s and early 1990s that dramatic enrollment in managed care plans began to occur.<sup>84</sup> The high medical inflation that prompted passage of the HMO Act in the early 1970s began to level with overall inflation in the early 1980s, slowing the impetus for managed care.<sup>85</sup> Public skepticism and physician resistance to ceding control over health treatment decisions prompted a gradual migration from traditional health insurance to managed care.<sup>86</sup> Despite early evidence that HMOs provide equal or even better health care treatment at significantly reduced costs,<sup>87</sup> the public was hesitant to embrace the restrictions of managed care and has remained skeptical and at times hostile to the notion of managed care.<sup>88</sup> The health care environment remained placid until the mid-1980s, when health care inflation again began to climb higher than the level of overall inflation.<sup>89</sup> Employers, prompted by high costs compared to their overseas competitors, and employees seeking to reduce their own costs, began to flock to cost-effective managed care alternatives.<sup>90</sup>

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84. ZELMAN & BERENSON, *supra* note 4, at 11 (depicting an increase from twenty-five to eighty percent in enrollment by employees with employer-sponsored health insurance in managed care plans).

85. See MORTON, *supra* note 7, at 22 (describing health care inflation as a percentage of gross domestic product and demonstrating an increase from 7.1 percent of GDP in 1970 to 13.5 percent in 1997).

86. See KLEINKE, *supra* note 36, at 56.

87. See ZELMAN & BERENSON, *supra* note 4, at 119–36 (demonstrating that managed care has performed better and provided higher health care quality than critics acknowledge).

88. See *id.* at 102–05 (discussing anti-managed care public sentiment); David S. Hilzenrath, *Backlash Builds Over Managed Care; Frustrated Consumers Push for Tougher Laws*, WASH. POST, June 30, 1997, at A1 (summarizing polling data regarding consumer satisfaction with their HMOs).

89. See MORTON, *supra* note 7, at 22 fig. 2.2 (depicting medical inflation spiking to twelve percent in the mid-1970s and early 1980s and then trending downward below three percent by 1995).

90. SMITH, *supra* note 33, at 66.

Prompted by a growing uninsured population,<sup>91</sup> continued skepticism toward managed care, and double-digit medical inflation, the Clinton Administration in 1993 introduced the Health Security Act to provide a mandated package of health service benefits at a fixed cost covered by a federal medical budget.<sup>92</sup> The Health Security Act failed to gain Congressional approval in the wake of one of the most aggressive media and lobbying campaigns ever waged on a Congressional health initiative.<sup>93</sup> Unlikely allies, physicians groups and insurers convinced a wary public that its skepticism of a government-run health care program was well-founded.<sup>94</sup>

Following the demise of President Clinton's Health Security Act proposal, employers and employees seeking lower-cost health care continued to turn to managed care programs. However, continued public dissatisfaction with the limited choices offered by managed care, the emergence of several high profile managed care "horror stories," and increased backlash from disgruntled employees fueled the social unpopularity of managed care in general and HMOs in particular.<sup>95</sup> Despite health plan efforts to address public concern and innovation in managed care offerings, the public has continued to be wary of the managed care system in general.

Today's managed care system is much different than that envisioned by Ellwood thirty years ago. The traditional notion of

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91. The uninsured population has grown steadily since the late 1980s from 33.6 million to over 44 million today. CATHERINE HOFFMAN & ALAN SCHLOBOHM, *UNINSURED IN AMERICA: A CHART BOOK OF THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED* 2-4 (2d ed., May 2000) (citing statistics showing the growth of the uninsured population), at <http://www.kff.org/content/archive/1407/Uninsured%20in%20America.pdf> (on file with the North Carolina Law Review).

92. CLARK C. HAVIGHURST, *HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM* 45 (1995). The Health Security Act originally included, among other provisions, an express right for patients to sue participating health plans for the negligent acts of their employees or contract providers. *Id.* at 59. This "enterprise liability" concept was struck from the final proposal presented to Congress amid intense pressure from provider groups and the health insurance and managed care industries. *Id.*

93. *Id.*; see also Ruth Marcus & Charles R. Babcock, *System Cracks Under Weight of Cash*, WASH. POST, Feb. 9, 1997, at A1 ("The 'Harry and Louise' ads—sponsored by the Health Insurance Association of America and featuring two homespun characters questioning Clinton's proposal—were the \$15 million centerpiece of a much larger advertising assault that the president blamed for scuttling his reform ambitions.").

94. See Bennahum, *supra* note 45, at 1.

95. See generally ZELMAN & BERENSON, *supra* note 4, at 102-18 (detailing the growing unpopularity of health plans with the public and provider community). Zelman and Berenson argue that managed care has been unfairly demonized by the press, public, and provider community, which has led to growing demand for fundamental reform of the health care financing and delivery system. *Id.*

health maintenance organizations has evolved into a number of different types of managed care plans offering enrollees several choices in determining the scope of control of patients, providers, and payors.<sup>96</sup> Ellwood and his peers, however, have observed that, while the health maintenance movement has at least partially fulfilled its promise by checking costs, the industry has lost sight of the other hallmarks of the health maintenance strategy, including competition and quality.<sup>97</sup> In a 1998 interview, Ellwood posited that a second evolution of health maintenance, driven by disgruntled consumers, will demand quality and choice in managed care.<sup>98</sup> The "profound disappointment" felt by Ellwood and his peers is characterized by one commentator's definition of HMOs as patient-doctor relationship regulators who do not engage in health maintenance.<sup>99</sup>

Despite the public failure of the 1993 Clinton Administration health care reform proposal, many Americans have remained wary of the private, market-based managed care system.<sup>100</sup> This skepticism has fueled the reform debate in Congress and at the state level and has led to an increased call for medical coverage mandates and health plan liability.<sup>101</sup> Despite the problems with managed care, its evolution away from Ellwood's vision, and the public's dissatisfaction both in terms of private insurance and government-led universal coverage, Congress and the states need to respond with a moderate approach that will address consumer concerns without crippling the health care financing system in America.

#### IV. JUDICIAL EFFORTS TO DEFINE LIABILITY

While Congress, the states, and recent presidents have grappled with health care financing and the challenges of managed care, the courts have also had their say in the debate. Health maintenance organization coverage decisions have been challenged on many state and federal fronts. One of the most recent and prominent cases to reach the United States Supreme Court on the issue of ERISA

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96. See Mitka, *supra* note 47, at 2059.

97. *Id.* at 2060.

98. *Id.*

99. *Id.* (discussing disappointment by many in the medical profession regarding the manner in which managed care has evolved).

100. See ZELMAN & BERENSON, *supra* note 4, at 103 (citing polls conducted in the late 1990s where a majority of consumers "believed the trend in managed care is harmful for them" and that the "government needs to 'protect consumers from being treated unfairly' in managed care plans").

101. *Id.* at 103-04 (discussing how growing public concern for the dominance of managed care has sparked increased activity in Congress and state legislatures).

preemption of state causes of action is *Pegram v. Herdrich*.<sup>102</sup> Plaintiff Cynthia Herdrich belonged to Carle Clinic Association, a health maintenance organization, through her husband's employer.<sup>103</sup> Herdrich sought treatment for pain she was experiencing in her abdomen from Carle physician Lori Pegram.<sup>104</sup> Pegram examined Herdrich on two occasions and on the second occasion observed an inflammation in the abdominal area.<sup>105</sup> Rather than referring Herdrich immediately to the closest emergency room for ultrasound diagnosis, Pegram required Herdrich to wait eight days until an ultrasound could be performed at a Carle-owned clinic, thereby reducing the costs associated with the test.<sup>106</sup> During the period she was required to wait, Herdrich suffered a ruptured appendix that could have been fatal.<sup>107</sup>

Herdrich sought to distinguish her case from most challenges to managed care physician incentives by arguing that the particular incentive in this case of profits paid directly to an owner-physician at the end of the year violated the plan's fiduciary duty under ERISA.<sup>108</sup> The Seventh Circuit adopted this logic,<sup>109</sup> but the Supreme Court rejected it.<sup>110</sup> Writing for the Court, Justice Souter concluded that "courts are not in a position to derive a sound legal principle to

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102. 530 U.S. 211 (2000). The brief analysis of *Pegram* that follows is offered as background to the evolution of managed care liability and the state and federal legislative environments. For a comprehensive review of *Pegram*, see generally *HEALTH CARE LITIGATION: WHAT YOU NEED TO KNOW AFTER PEGRAM* (Karen S. Boxer & Manuel del Valle eds., 2000) (compiling numerous expert commentaries for the Practising Law Institute).

103. *Pegram v. Herdrich*, 530 U.S. 211, 215 (2000).

104. *Id.*

105. *Id.*

106. *Id.*

107. *Id.* Herdrich sued Pegram and Carle in state court for medical malpractice and fraud, and the defendants had the case removed to federal court, arguing that ERISA governed the case, thus providing federal court jurisdiction. *Id.* The district court dismissed one fraud count, but allowed Herdrich to amend her complaint on the other fraud count. *Id.* at 216. The medical malpractice claims against Pegram were ultimately settled in state court in favor of Herdrich. *Id.* Herdrich's amended complaint alleged an inherent or anticipatory breach of fiduciary duty by Carle in placing physician and company financial interests ahead of patient care. *Id.* The district court dismissed Herdrich's ERISA claim, but the Seventh Circuit reversed and found in favor of Herdrich. *Id.* at 217. Carle and Pegram appealed. *Id.*

108. *Id.* at 220.

109. *Herdrich v. Pegram*, 154 F.3d 362, 369 (7th Cir. 1998).

110. *Pegram*, 530 U.S. at 218. "Since inducement to ration care goes to the very point of any HMO scheme, and rationing necessarily raises some risks while reducing others . . . any legal principle purporting to draw a line between good and bad HMOs would embody, in effect, a judgment about socially acceptable medical risk." *Id.* at 221.

differentiate an HMO like [the one in this case] from other HMOs.”<sup>111</sup>

The Court considered the difference between treatment decisions and eligibility decisions and observed that, at least in the managed care context, the two are intertwined.<sup>112</sup> When deciding whether to provide treatment to an HMO enrollee, the HMO, generally through its employee or contract physician, must determine whether the service is covered by the contract and whether it is medically necessary to treat the patient's condition.<sup>113</sup> Dr. Pegram, in assessing Herdrich's condition, found that her symptoms did not warrant immediate action, which the Court indicated is not a determination of eligibility for treatment but a judgment about course of treatment.<sup>114</sup> Such a decision, despite being unfortunate, does not rise to the level of fiduciary duty violation because the decision respected treatment course and not resource allocation.<sup>115</sup>

This case and similar cases regarding HMO coverage denials incorporate an element of physician professional judgment that distinguishes them from the traditional breach of fiduciary duty cases.<sup>116</sup> Justice Souter pointed out that even in cases where the physician herself has a direct financial interest in making treatment determinations, the fact that the decision presents a mix of treatment and eligibility conclusions presents a unique situation that was not contemplated in the fiduciary duty of ERISA.<sup>117</sup> The opinion states that it would not be possible to “translate fiduciary duty into a standard that would allow recovery from an HMO whenever a mixed decision influenced by the HMO's financial incentive resulted in a bad outcome for the patient.”<sup>118</sup> According to Justice Souter, “It would be so easy to allege, and to find, an economic influence when sparing care did not lead to a well patient, that any such standard in practice would allow a factfinder to convert an HMO into a guarantor of recovery.”<sup>119</sup>

In the end, the Court held that ERISA's fiduciary duty is not the appropriate vehicle for challenging HMO decisions to deny care that

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111. *Id.* at 222.

112. *Id.* at 228.

113. *Id.* at 229.

114. *Id.* at 229–30.

115. *Id.* at 231 (“At common law, fiduciary duties characteristically attach to decisions about managing assets and distributing property to beneficiaries.”).

116. *Id.* at 232.

117. *Id.*

118. *Id.* at 234.

119. *Id.* at 234–35.

lead to injury.<sup>120</sup> To the extent that managed care plans make coverage determinations based upon medical necessity and the provisions of the plan contract, the *Pegram* Court is correct in finding no violation of a fiduciary duty. As these determinations are not purely financial in nature, they are beyond the intended scope of the ERISA protection against breach of fiduciary duty.<sup>121</sup>

*Pegram v. Herdrich* is not a complete victory for the managed care industry because, even though mixed decisions cannot be challenged as breaches of ERISA fiduciary duty, the holding does not foreclose the right of individuals to sue their physicians and their HMOs in state court for malpractice.<sup>122</sup> In fact, some experts have read *Pegram* to suggest that state court malpractice suits are more preferable in mixed-decision cases than ERISA fiduciary duty cases pressed in federal court.<sup>123</sup> *Pegram* further clouded the already confusing framework of federal and state laws governing managed care liability, suggesting that a Congressional remedy may be necessary or at the very least preferred by the Court.<sup>124</sup>

The United States Supreme Court announced a second landmark decision in June 2002. In *Rush Prudential HMO, Inc. v. Moran*,<sup>125</sup> the Court resolved a split between the Fifth and Seventh Circuits involving the ERISA preemption of binding state external review programs. The Fifth Circuit, in *Corporate Health Insurance Inc. v. Texas Department of Insurance*,<sup>126</sup> had ruled that a state cannot require a health plan to submit to a binding external review of its coverage decision without running afoul of ERISA. The circuit court reasoned that because such external review laws "relate to" employee benefit plans, they were preempted by ERISA.<sup>127</sup> Conversely, the Seventh Circuit, in *Moran v. Rush Prudential HMO, Inc.*,<sup>128</sup> held that

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120. *Id.* at 237.

121. *Id.* at 232 ("Indeed, when Congress took up the subject of fiduciary responsibility under ERISA, it concentrated on fiduciaries' financial decisions, focusing on pension plans, the difficulty many retirees faced in getting the payments they expected, and the financial mismanagement that had too often deprived employees of their benefits.").

122. *Id.* at 235-36 (indicating that states already provide a remedy for cases involving HMO malpractice).

123. Judy Greenwald, *Court May Revisit Pegram: Interpretations Muddy Waters on HMO Ruling*, BUS. INS., Oct. 8, 2001, at 1.

124. *Id.*

125. 122 S. Ct. 2151 (2002).

126. 215 F.3d 526 (5th Cir. 2000), *reh'g denied*, 220 F.3d 641 (5th Cir. 2000), *cert. granted and vacated sub nom.* Montemayor v. Corporate Health Ins., Inc., 122 S. Ct. 2617 (U.S. 2002). See *infra* notes 162-74 and accompanying text for an extensive discussion of its precedential value on other grounds.

127. *Id.* at 538-39.

128. 230 F.3d 959 (7th Cir. 2000).

a "saving clause" contained within section 1144(b) of ERISA that exempts state insurance regulations removed the external review law from ERISA's preemptive reach.<sup>129</sup>

Rush Prudential argued that the saving clause did not apply because HMOs are not merely insurers, but health care providers as well.<sup>130</sup> Justice Souter, writing for the majority, rejected this rigid interpretation of the saving clause:

In sum, prior to ERISA's passage, Congress demonstrated an awareness of HMOs as risk-bearing organizations subject to state insurance regulation, the state Act defines HMOs by reference to risk bearing, HMOs have taken over much business formerly performed by traditional indemnity insurers, and they are almost universally regulated as insurers under state law. That HMOs are not traditional "indemnity" insurers is no matter; . . . . [T]he Illinois HMO Act is a law "directed toward" the insurance industry, and an "insurance regulation" under a "commonsense" view.<sup>131</sup>

The Court equally rejected Rush Prudential's other arguments.<sup>132</sup> The Court did not discuss other aspects of ERISA preemption of state managed care reforms, but settled the ERISA preemption debate in favor of state-imposed binding external review programs.<sup>133</sup>

#### V. LEGISLATIVE EFFORTS TO PROMOTE PATIENTS' RIGHTS: THE STATES

Health plan liability for coverage determinations that deny medical care appears to be the cornerstone of the patients' rights movement.<sup>134</sup> Health plan liability, however, has met with mixed success in the states, where less onerous managed care reforms were sought and enacted throughout the latter half of the 1990s. Legislative proposals aimed at governing the review and denial processes of HMO claims, dictating the expertise level of the HMO employees making such determinations, mandating internal and

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129. *Id.* at 969.

130. *Rush Prudential*, 122 S. Ct. at 2160.

131. *Id.* at 2163.

132. *Id.* at 2163–72. The majority consisted of five justices: Justices Souter, Stevens, O'Connor, Ginsburg, and Breyer. In his dissent, Justice Thomas argued that the ERISA saving clause does not apply where the state law remedy seeks to supplement the remedies provided by ERISA. *Id.* at 2172 (Thomas, J., dissenting) (citing *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984)). This argument had previously been adopted by the Fifth Circuit in *Corporate Health*, 215 F.3d 526, 538–39 (5th Cir. 2000).

133. *Rush Prudential*, 122 S. Ct. at 2165–67.

134. See *infra* notes 144–47, 200, & 261 and accompanying text.

external appeals processes for patients denied services, and providing for increased disclosure to patients by both the health plan and the provider have been enacted in several states and sought at the federal level.<sup>135</sup>

Legislative proposals aimed at external review of health plan coverage decisions, offer valid solutions to the complaints of managed care enrollees without compromising the financial security of the managed care industry by subjecting insurers to costly litigation and potentially high jury verdicts. Congress would be wise to consider seriously this “middle ground” approach when examining various “patients’ rights” proposals.

Managed care is built on the notion that treatment options will be evaluated to determine their efficacy and cost-effectiveness.<sup>136</sup> When an enrollee submits a claim or request for coverage, the contract physician and employees of the managed care company evaluate the available treatment options. Managed care plans frequently require approval for certain medical procedures before the procedure is undertaken, and thus plan employees review coverage requests “prospectively, concurrently, or retrospectively.”<sup>137</sup> This process is termed “utilization review,” and while its practice is essential to the existence of managed care, its use, and at times abuse, can thwart the fundamental goal of health maintenance.<sup>138</sup> Utilization review pits the necessity of a medical procedure against its cost and determines what is covered under the contract governing the relationship among the managed care entity, provider, and patient.<sup>139</sup> Courts have held that ERISA preemption includes utilization review as it fundamentally “relates to” the management of employee benefit plans. Some states have proposed reforming utilization review procedures by, among other things, imposing strict licensure

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135. See, e.g., Bipartisan Patient Protection Act, S. 1052, 107th Congress (2001) (comprising legislation currently stalled in Congress that would adopt many of these reforms on a national level).

136. Ellwood et al., *supra* note 36, at 295.

137. Flaum et al., *supra* note 58, at 6–7; see also Judith Feinberg, *Utilization Review as the Practice of Medicine: Scaling the Wall of ERISA*, 9 B.U. PUB. INT. L.J. 89, 93 (1999) (explaining that these attempts to control costs “ha[ve] significant impact on what care the patient actually receives.”).

138. Feinberg, *supra* note 137, at 95. For example, if a preventive medical procedure is deemed not “medically necessary” by a utilization review agent, coverage for the procedure could be denied. *Id.* at 93.

139. *Id.* at 96–97.

requirements on utilization review agents, limits on compensation paid to reviewers, and other reforms.<sup>140</sup>

In addition to utilization review regulation, another area of managed care reform relates to the benefits provided by a managed care contract. ERISA specifically states that it does not require an employer to provide a specific level or amount of benefit coverage to its employees, and the benefits provided by health plans are generally governed by the contract between the plan and the employer or enrollees.<sup>141</sup> Managed care plans, absent state regulation, would thus be free to cover or restrict coverage for any medical services they so chose.<sup>142</sup> Public outcry and legislator concern have prompted the adoption of mandated benefit bills across the fifty states and in Congress in areas ranging from coverage for emergency services, direct access to pediatricians and obstetricians, pregnancy coverage and minimum maternity length of stay, mastectomy coverage, prostate screening, and many others.<sup>143</sup>

Legislative efforts to control utilization review, provide safety mechanisms when utilization review denies coverage, enact some method of health plan liability, and increase coverage by way of mandated benefits, have all fallen under the rubric of "patients' rights" and "patient protections" in the state legislatures and Congress. Despite the consumer-friendly nature of these measures, health plan liability, mandated benefits, and other costly reforms are ripe with pitfalls. As more states adopt such "patients' rights," the potential for dire consequences rises. While a handful of states have adopted health plan liability legislatively without yet bringing a collapse to the health care financing system, too few states have acted and no law has been on the books long enough for the effects to be known completely.

#### A. Texas

Texas was the first state in the nation to enact what is commonly known as the "patients' bill of rights" with its passage of the 1997

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140. See Lauren Fielder Redman, Comment, *Softening the ERISA Blow: Minimizing Physician Liability for Patient Injuries Caused by Managed Care Organization Cost Containment Measures*, 35 TULSA L. J. 679, 683 (2000).

141. 29 U.S.C. § 1191(c) (2000).

142. But see ASPEN HEALTH LAW CENTER, *MANAGED CARE: STATE REGULATION* 13-21 (1998) (outlining common legislatively-mandated benefits).

143. *Id.*

Texas Health Care Liability Act ("THCLA").<sup>144</sup> These rights include a right to sue in state court for coverage denials, requirements for the use of utilization review, and increased regulation of grievance procedures to address enrollee complaints.<sup>145</sup> The law defines "ordinary care" as "that degree of care that a health insurance carrier, health maintenance organization, or managed care entity [or employee of such] of ordinary prudence would use under the same or similar circumstances."<sup>146</sup> The legislation imposes a duty of care upon health insurance carriers, health maintenance organizations and managed care entities and their employees, agents, ostensible agents, and representatives.<sup>147</sup> The Act requires the enrolled individual to exhaust all internal appeals procedures within his insurance carrier or managed care plan before proceeding to court,<sup>148</sup> but the company is not entitled to summary judgment in a lawsuit if the insured fails to do so.<sup>149</sup> In addition, if the insured has already suffered harm from a company's decision or if the review process described in the Act would not be beneficial to the treatment of the individual, the obligation to follow the internal appeals process is alleviated.<sup>150</sup> Finally, the Act expressly allows other judicial remedies including injunctive or declaratory relief if the delay caused by the internal or independent review processes would severely threaten the individual's health.<sup>151</sup>

In addition to creating an express cause of action against health insurers and managed care organizations for failure to exercise ordinary care, the Texas law creates a procedure for independent, external review of a coverage decision after it has been denied by the carrier and appealed by the individual.<sup>152</sup> The legislation defines the scope of the external review procedure and requires that all health

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144. Act of May 22, 1997, ch. 163, 1997 Tex. Gen. Laws 317 (codified at TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001–88.003 (Vernon Supp. 2003) & scattered sections of TEX. INS. CODE ANN. (Vernon Supp. 2003)).

145. TEX. CIV. PRAC. & REM. CODE ANN. § 88 (Vernon Supp. 2003).

146. *Id.* § 88.001.

147. *Id.* § 88.002(a). This duty of care requires the insurer "to exercise ordinary care when making health care treatment decisions" and holds an insurer liable for harm proximately caused by the entity's failure to exercise such care. *Id.* Employers purchasing health insurance for their employees are not subject to the liability provisions. *Id.*

148. *Id.* § 88.003(a)(1).

149. *Id.* § 88.003(e). The law grants discretion to the court to determine the appropriate settlement of the dispute when the individual does not comply with the Act. *Id.*

150. *Id.* § 88.003(f).

151. *Id.* § 88.003(h).

152. TEX. INS. CODE ANN. art. 21.58A, § 6A (Vernon Supp. 2003).

plans that employ utilization review submit to binding independent external review.<sup>153</sup> The plan is required to disclose the availability of external review to patients upon denial of a submitted claim and must pay for the costs associated with the external review, regardless of the outcome.<sup>154</sup> An individual can immediately seek external review, circumventing the internal appeal process, when the individual is suffering from a life-threatening condition.<sup>155</sup> Additionally, the legislation prohibits gag clauses, restrictions in managed care provider contracts that limit what a provider can disclose to a patient regarding treatment alternatives, and indemnity clauses, contract clauses requiring the care provider to indemnify the health plan for patient injury suffered following a denial of coverage for a requested treatment.<sup>156</sup>

It has been argued that the Texas health plan liability law should serve as a model to other states and to Congress when considering patient protections and the individual's right to challenge his health plan.<sup>157</sup> When the measure was still under consideration, opponents argued that the probability of skyrocketing health premiums resulting from massive jury awards, legal costs associated with defending utilization review decisions in court, and the impetus to managed care plans to practice defensive medicine via utilization review would cripple the health industry.<sup>158</sup> In the five years since the Act became effective, the predicted cost crisis has not materialized. In fact, statistics from the Texas Department of Insurance indicate that HMO premiums actually fell slightly in 1998, and then rose only five percent in 1999 and nine percent in 2000, as compared to nationwide premium increases of just over one percent in 1998, nearly five and one-half percent in 1999, and nine and one-half percent in 2000.<sup>159</sup> Furthermore, proponents argue, there have been less than fifty lawsuits filed under the new law since it came into effect in 1997,

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153. *Id.* § 6A(3). The requirement binding health plans to follow the decision of the independent review panel was later repealed in favor of a voluntary approach, following a decision in the U.S. District Court that such requirement violated ERISA. *See infra* notes 162–74 and accompanying text (discussing *Corporate Health Insurance v. Texas*).

154. TEX. INS. CODE ANN. § 6A(4).

155. *Id.* § 6A. A life threatening condition is “a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.” *Id.* § 2.

156. TEX. CIV. PRAC. & REM. CODE ANN. § 88.002 (Vernon Supp. 2003).

157. *See* Geri Aston, *Texas Trial: HMO Liability Law*, AM. MED. NEWS, May 28, 2001, at [http://www.ama-assn.org/sci-pubs/amnews/pick\\_01/gvsa0528.htm](http://www.ama-assn.org/sci-pubs/amnews/pick_01/gvsa0528.htm) (on file with the North Carolina Law Review).

158. *Id.*

159. *Id.*

further evidence that the prediction of a flood of litigation by the managed care and insurance industries was wrong.<sup>160</sup> The health insurance industry has argued that five years is too short of a time period in which to assess the impact of the legislation.<sup>161</sup> Regardless of which argument prevails in Texas, on a national level, interstate health plans could suffer some of the severe financial consequences that Congress intended to avoid by enacting ERISA, if other states adopt their own approaches. Unilateral action by many states only threatens to cause more confusion over managed care liability than that which already exists.

Two prominent recent cases, *Corporate Health Insurance, Inc. v. Texas Department of Insurance*<sup>162</sup> and *Roark v. Humana, Inc.*,<sup>163</sup> illustrate that Texas's enactment of a patient right-to-sue law did little to reduce confusion in the legal community regarding the extent of health plan liability. Following the 1997 enactment of Senate Bill 386, Corporate Health Insurance, Inc., a subsidiary of Aetna Health Plans of Texas, filed suit in the U.S. District Court for the Southern District of Texas, challenging the law as preempted under ERISA.<sup>164</sup> Corporate Health argued that the Act's liability, anti-indemnification, anti-retaliation, and independent review provisions "related to" an "employee benefit plan" prohibited under ERISA.<sup>165</sup>

The Fifth Circuit Court of Appeals upheld the district court decision that state liability laws are not preempted because they address issues of quality of care that are not contemplated under ERISA.<sup>166</sup> In addressing the question of preemption for liability, Circuit Judge Higginbotham stated:

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.<sup>167</sup>

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160. *Id.* ("Supporters [of broader adoption of health plan liability] say Congress need only look to Texas to see how the worst fears about plan liability . . . are unfounded.").

161. *Id.*

162. 215 F.3d 526 (5th Cir. 2000), *reh'g denied*, 220 F.3d 641 (5th Cir. 2000), *cert. granted and vacated sub nom.* Montemayor v. Corporate Health Ins., Inc., 122 S. Ct. 2617 (2002).

163. No. 3:00-CV-2368-D, 2001 U.S. Dist. LEXIS 14115 (N.D. Tex. Sept. 12, 2001).

164. *Corporate Health Ins.*, 215 F.3d at 527, 531-32.

165. *Id.* at 531-32.

166. *Id.* at 540.

167. *Id.* at 534.

Because the liability provision of the Texas law imposes a duty of care and thus addresses quality of care issues, it is not preempted by ERISA.<sup>168</sup> The court also noted that the recent Supreme Court decision in *Pegram*<sup>169</sup> verified a state's right to impose malpractice liability on HMOs.<sup>170</sup>

The Fifth Circuit overturned the district court's findings on the anti-indemnity and anti-retaliation provisions of the Texas law. Judge Higginbotham held that these provisions relate directly to quality of care and not to plan administration.<sup>171</sup> The court rejected Aetna's argument that such provisions improperly mandate the structure and administration of ERISA plan benefits "because ERISA plans are forced to contract with doctors only on those terms."<sup>172</sup> The restrictions on indemnification and retaliation govern the terms on which plans contract with their independent providers and "do not compel the entities to provide any substantive level of coverage as health care insurers" that would violate ERISA.<sup>173</sup>

The court of appeals thus structured its decision to concur with the separation of administrative and medical functions of managed care entities articulated in *Pegram*.<sup>174</sup> The court's analysis breeds confusion regarding which functions of utilization review officers are medical and which are strictly administrative, and one is left to wonder to what extent coverage determinations can play into medical decisions.

While *Corporate Health* may appear to be a victory for consumers over health plans, the subsequent decision in *Roark v. Humana, Inc.*<sup>175</sup> casts doubt on the completeness of their victory. In *Roark*, the plaintiff suffered an injury from an insect bite that became infected and gradually deteriorated to the point that the plaintiff's leg had to be amputated.<sup>176</sup> Throughout the course of her treatment, plaintiff and her physician repeatedly attempted to gain access to medical services to stave the infection and reverse the deterioration

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168. *Id.* at 535. "We are not persuaded that Congress intended for ERISA to supplant this state regulation of the quality of medical practice." *Id.*

169. *Pegram v. Herdrich*, 530 U.S. 211 (2000).

170. *Corp. Health Ins.*, 215 F.3d at 536 n.34.

171. *Id.* "Together, the[se] provisions thus better 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." *Id.*

172. *Id.*

173. *Id.*

174. *Id.*

175. No. 3:00-CV-2368-D, 2001 U.S. Dist. LEXIS 14115 (N.D. Tex. Sept. 12, 2001).

176. *Roark v. Humana, Inc.*, No. 3:00-CV-2368-D, 2001 U.S. Dist. LEXIS 7554, at \*2 (N.D. Tex. May 25, 2001).

of the injury, but Humana repeatedly denied coverage.<sup>177</sup> Plaintiff brought an action in state court alleging, among other things, that the denials of coverage for needed treatment violated THCLA.<sup>178</sup> The court determined that “the controlling question [was] whether [plaintiff’s] THCLA claim, fairly construed, challenges the administration of benefits or the quality of medical treatment performed.”<sup>179</sup> In rendering its verdict, the court relied on *Pryzbowski v. U.S. Healthcare, Inc.*,<sup>180</sup> an ERISA preemption case, adopting the *Pryzbowski* holding that distinguished between administration of benefits and quality of medical treatment decisions.<sup>181</sup>

The court also cited *Corcoran v. United Healthcare, Inc.*,<sup>182</sup> an early 1990s case wherein the Fifth Circuit Court of Appeals found that a “state-law medical malpractice claim against [a] company that provided utilization review services was preempted where plaintiffs complained of medical decisions that were incidental to benefit determinations.”<sup>183</sup> The *Roark* court determined that plaintiffs’ claim fit the category of benefit determination and not medical decision,

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177. *Id.* at \*2–3. Mrs. Roark’s care for the insect bite had been covered by Prudential Insurance, but during the ongoing course of her treatment, her insurance coverage was switched to Humana. *Id.* at \*8. Humana denied coverage for the course of treatment. *Id.* Roark’s physician appealed the decision several times and was generally denied. *Id.* At this point, Humana agreed to cover the treatment Roark’s physician sought, but only covered it for ninety days before denying a requested extension. *Id.*

178. *Id.* Procedurally, the case was first brought under several Texas statutes including the Texas Deceptive Trade Practices-Consumer Protection Act, TEX. BUS. & COM. CODE ANN. §§ 17.41–17.63 (Vernon 1987 & Pamp. Supp. 2001), the Texas Insurance Code, TEX. INS. CODE ANN. art. 21.21 § 2(a) (Vernon 1981 & Supp. 2001), the Texas Health Care Liability Act, TEX. CIV. PRAC. & REM. § 88.001–88.003 (Vernon 1997), and under common law breach of duty of good faith and fair dealing and breach of contract. *Roark*, 2001 U.S. Dist. LEXIS 7554, at \*2–3. Humana removed the case to federal district court, where the court ruled that claims under the Deceptive Trade Practices and Insurance Codes were preempted by ERISA. *Id.* at \*3. Roark amended her complaint to challenge Humana’s decision only under the Health Care Liability Act and moved to remand the case to state court. *Id.* The remand motion was denied. *Id.*

179. *Id.* at \*6.

180. 245 F.3d 266 (3d Cir. 2001). In *Pryzbowski*, the Third Circuit held that ERISA preempted claims that the HMO negligently and carelessly delayed approval of the medical service requested, that it acted in an arbitrary and capricious manner in doing so, that it acted in willful and wanton disregard for the beneficiary’s health insurance contract, that it acted in bad faith, and that it breached the beneficiary’s health insurance contract. *Roark*, 2001 U.S. Dist. LEXIS 7554, at \*11.

181. *Roark*, 2001 U.S. Dist. LEXIS 7554, at \*11 (citing *Pryzbowski*, 245 F.3d at 273 (holding that state law claims challenging administration of benefits or eligibility for benefits are preempted by ERISA, while claims challenging the quality of care are the subject of state actions)).

182. 965 F.2d 1321 (5th Cir. 1992).

183. *Roark*, 2001 U.S. Dist. LEXIS 7554, at \*11.

and thus was foreclosed by ERISA preemption.<sup>184</sup> In his Memorandum Opinion and Order, Judge Sidney Fitzwater stated that, “[w]ith one exception, each reference to a medical professional is positive—offered to show that the individual supported the Roarks’ efforts to persuade Humana that the device, treatment, or facility in question was medically necessary . . . .”<sup>185</sup>

Judge Fitzwater reconciled his decision with the holding in *Corporate Health*,<sup>186</sup> and distinguished it from *Pegram*, by observing that *Roark* involved neither a mixed coverage decision—the basis of the controversy in *Pegram*—nor a claim of breach of ERISA fiduciary duty, and that the claim involves not a medical malpractice decision—as was discussed in dicta in *Pegram*—but an administration claim.<sup>187</sup>

The Fifth Circuit Court of Appeals rendered its decision on ERISA preemption of Roark’s claim and those of four other claimants arising under THCLA on September 17, 2002.<sup>188</sup> All four appellants filed their original claims in state court, had their cases removed to federal district court by their insurance company, and then had their claims dismissed as preempted under ERISA.<sup>189</sup> In his opinion, Circuit Judge Smith drew a distinction among the appellants based upon whether their claims arose under THCLA’s definition of “ordinary care,”<sup>190</sup> or whether their claims were based on an interpretation of “medically necessary” under their health plan contract.<sup>191</sup> Claims involving contract interpretation, such as the claim filed by appellant Roark, are preempted under the *Corcoran* precedent.<sup>192</sup> Judge Smith distinguished Roark’s situation from other appellants’, whose claims arose exclusively under the “ordinary care” standard of the Texas Act.<sup>193</sup> However, Judge Smith also advocated for an en banc reversal of *Corcoran*, citing Supreme Court precedent

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184. *Id.* at \*14.

185. *Id.* at \*10.

186. *Id.* at \*12. “The [liability provisions of the THCLA] 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.” *Id.* (quoting *Corporate Health Ins. v. Texas Dep’t of Ins.*, 215 F.3d 526, 534 (5th Cir. 2000)) (alteration in original).

187. *Id.*

188. *Roark v. Humana, Inc.*, 307 F.3d 298 (5th Cir. 2002).

189. *Id.* at 302–04.

190. *Id.* at 308–11.

191. *Id.*

192. *Id.* at 313 (citing *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1332 (5th Cir. 1992) (“[T]he Corcorans are attempting to recover for a tort allegedly committed in the course of handling a benefit determination.”)).

193. *Id.* at 308–11.

chipping away at ERISA preemption.<sup>194</sup> While the courts have become more skeptical over claims of ERISA preemption for state laws affecting health plans, conflicting messages from several courts suggest that the ERISA shield enjoyed by HMOs since 1974 has yet to be completely eliminated.

While THCLA, heralded by consumer advocates and physicians as a major advance in patient protection, articulates a state cause of action for patients to bring against their managed care plans, one must question the practical effect of the Act given possible ERISA preemption. Under the cases interpreting THCLA, it appears that the liability extends only to malpractice claims against the treating physician directly.<sup>195</sup> Health plans have often been subject to vicarious liability for the medical mistakes of their employee-physicians.<sup>196</sup> The fact that the Texas legislature chose to include a liability provision in a bill that addressed issues such as utilization review, appeals, and physician contracting suggests that the legislative intent was to enact a measure that would offer patients an avenue of relief when their health plan denied coverage for a medical procedure recommended by their treating physician. Despite the express holding in *Corporate Health* that the liability portion of the Texas Act is not preempted by ERISA, the subsequent holding in *Roark* and the cases on which it relies dilutes this protection sought by the legislature, and seems to render the law a simple affirmation of a right that many have argued was already vested in the health care consumer.

Enactment of the THCLA and the confusing jurisprudence that followed suggest that states may lack the legal authority to develop their own patients' rights bills extending managed care liability without Congressional clarification of ERISA preemption. Other states have followed the Texas lead and have adopted varying forms

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194. *Id.* at 313–15; *see also* *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997) (holding that state gross receipts tax on patient services did not violate ERISA even though it had a direct effect on ERISA plans); *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316 (1997) (holding that ordinary state police powers were not meant to be superceded by the federal Act with respect to non-ERISA programs that operate like ERISA programs); *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) (holding that state economic incentives asserting “indirect economic influence” over ERISA plans do not violate ERISA).

195. *See Furstonsberg v. Mintz*, 170 F. Supp. 2d 695, 699 (N.D. Tex. 2001).

196. *Pegram v. Herdrich*, 530 U.S. 211, 220 (2000).

of health plan liability,<sup>197</sup> each of which is likely to meet the same muddled fate as Texas's law

### B. Georgia

While Texas was the first state to enact a law granting patients the right to sue their HMOs, ten other states have adopted similar measures to date.<sup>198</sup> The Georgia General Assembly enacted its own version of a patient protection act in 1999.<sup>199</sup> The Georgia law, while similar to the Texas Act, differs in several key aspects. The Georgia Act imposes a standard of ordinary diligence upon employees of a health plan to act "in a timely and appropriate manner in accordance with the practices and standards of the profession of the health care provider generally," and creates a tort action for injuries or death resulting from abdication of this duty.<sup>200</sup> The language expressly excludes punitive damages from the liability equation.<sup>201</sup> Before being allowed to sue, a patient must exhaust her insurer's internal plan grievance procedures, or she must allege either that harm has already occurred or that review of the treatment decision would be futile before proceeding in court.<sup>202</sup> Once an action is initiated, the health plan may request a stay to submit the disputed claim to external review and be bound by the reviewer's decision.<sup>203</sup>

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197. To date, the other states that have enacted health plan liability include Arizona, Act of Mar. 22, 2000, ch. 37, 2000 Ariz. Sess. Laws 147; California, Managed Health Care Insurance Accountability Act of 1999, 1999 Cal. Legis. Serv. Ch. 536 (West); Georgia, Act of Apr. 20, 1999, §§ 1, 3, 1999 Ga. Laws 350, 350-52, 352-60 (codified at GA. CODE ANN. § 33-20A-30 to 33-20A-41 (2000) & § 51-1-148 (2000)); Maine, An Act to Establish a Patient's Bill of Rights, ch. 742, § 19, 2000 Me. Laws 1759, 1766 (codified at ME. REV. STAT. ANN. tit. 24-A § 4313 (West 2002)); New Jersey, Health Care Carrier Accountability Act, 2001 N.J. Sess. Law Serv. Ch. 187 (West); North Carolina, Act of Oct. 18, 2001, ch. \_\_, 2001 N.C. Sess. Laws \_\_; Oklahoma, Managed Health Care Reform Accountability Act, ch. 163, 2000 Okla. Sess. Laws 568 (codified at OKLA. STAT. ANN. tit. 36, §§ 6591-6596 (West Supp. 2000) & OKLA. STAT. ANN. tit. 63, § 2528.5 (West Supp. 2003)); Oregon, Act of May 30, 2001, 2001 Or. Laws Ch. 266 (West); Washington, Health Care Patient Bill of Rights Act, ch. 5, 2000 Wash. Laws 22; and West Virginia, Act of Apr. 14, 2001, ch. 166, 2001 W. Va. Acts 1716 (codified at W. VA. CODE ANN. § 33-25C-7 (Michie Supp. 2002)).

198. See *supra* note 197. Most of the current state laws incorporate aspects of the Texas, Georgia, and North Carolina acts, thus allowing those three acts to serve as models for the universe of state legislation in this arena.

199. Act of Apr. 20, 1999, §§ 1, 3 1999 Ga. Laws 350, 350-52, 352-60 (codified at GA. CODE ANN. §§ 33-20A-30 to 33-20A-41 & § 57-1-48 (2000)).

200. GA. CODE ANN. § 51-1-48 (2000).

201. *Id.* This provision somewhat mitigates the financial impact of health plan liability upon HMOs by limiting damage awards.

202. *Id.* § 51-1-49.

203. *Id.*

Unlike the Texas law, the Georgia Patient Protection Act includes a rebuttable presumption in favor of the managed care plan when external review has upheld the plan decision to deny coverage.<sup>204</sup> This provision offers the managed care entity some cover in court to mitigate the effect of juror emotion in favor of a sympathetic plaintiff.<sup>205</sup> Where both the health plan and the external review agent have determined that a service is not covered or is not “medically necessary” as defined by state law or the health plan contract, a high burden is placed upon the plaintiff to prove otherwise.

The Georgia language provides that the cost of services shall meet a minimum threshold of five hundred dollars to proceed to binding external review.<sup>206</sup> Unlike THCLA, the language of the Georgia Act appears to apply narrowly to managed care plans, although this distinction is probably moot as most traditional (indemnity) “health insurers” would not fall under the auspices of the Texas liability provision because they do not conduct utilization review in the manner prescribed in the law.

With respect to the punitive damage caps and external review rebuttable presumption, the Georgia law softens the impact of a Texas-like approach. Given time, however, the confusion that exists among state and federal courts with respect to ERISA preemption could cast doubt upon the effectiveness of the Georgia law. Like the Texas law, it appears that Congressional amendment of ERISA preemption may be necessary to clarify what rights were actually granted to patients under the Georgia law.

### C. North Carolina

On October 18, 2001, North Carolina became the eleventh state to enact a state cause of action for health coverage denials by managed care organizations. The legislation, Senate Bill 199,<sup>207</sup> is one of the broadest state “patient protection” acts enacted at one time. The legislation contains several measures advanced by patient

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204. *Id.* § 33-20A-37.

205. *Id.*; see, e.g., Rose & Somerville, *supra* note 74 (discussing the possibility of sympathetic juries and judges particularly in the context of terminal illnesses and experimental treatments).

206. GA. CODE ANN. § 33-20A-35 (2000).

207. Act of Oct. 18, 2001, ch. \_\_, 2001 N.C. Sess. Laws \_\_ (to be codified at N.C. GEN. STAT. § 90-21.51).

advocates including direct access to pediatricians for minor patients;<sup>208</sup> a “continuity of care” provision requiring a health plan to continue to pay for specific patients’ ongoing treatment for a special condition performed by a provider despite the termination of the contract by the provider, the plan, or the provisions of the contract;<sup>209</sup> an express requirement allowing patients to select a specialist as their primary care provider;<sup>210</sup> mandatory health insurance coverage for newborn hearing screenings;<sup>211</sup> standing referrals to specialists;<sup>212</sup> and mandated coverage for patient participation in clinical trials approved by centers that are funded by the National Institutes of Health, Food and Drug Administration, Centers for Disease Control, Agency for Health Care Research and Quality, Department of Defense, or Department of Veterans Affairs.<sup>213</sup> The law also prohibits health plans from discriminating against or refusing to contract with duly licensed providers<sup>214</sup> and prohibits incentives to deny care.<sup>215</sup> In addition to the aforementioned measures, the Act establishes a North Carolina Office of Managed Care Patient Assistance Program to provide educational services to the public regarding managed care plans offering coverage in the state, provide assistance with internal

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208. N.C. GEN. STAT. § 58-3-240 (2001) (providing that “health care providers shall allow an insured to choose a contracting pediatrician in the network as the primary care provider”).

209. *Id.* § 58-67-88(b).

210. *Id.* § 58-3-235. This provision applies specifically to patients with chronic illnesses requiring constant specialist care, in which the specialist agrees to act as the gatekeeper and coordinator of the patient’s overall health care, much in the same manner as a primary care physician. *Id.*

211. *Id.* § 58-3-260(b). The North Carolina mandate is subject to the same restrictions and copayment requirements to which other covered treatments are subject. *Id.*

212. *Id.* § 58-3-223(a). When managed care plans require patients to obtain referrals from a gatekeeper, such “standing” referrals shall continue to be effective so long as the care is provided by the same specialist and regards the same course of treatment but are not to exceed twelve months. *Id.*

213. *Id.* § 58-3-255.

214. *Id.* § 58-50-30(g).

215. *Id.* § 58-3-265. This section states that a health plan may not provide any financial incentives that prompt the provider to “deny, reduce, withhold, limit, or delay specific medically necessary and appropriate health care services covered under the health benefit plan to a specific insured.” *Id.* (emphasis added). It allows health plans to pay providers on a capitated (pre-paid, flat fee) basis and to offer incentives for the overall cost of care supplied by the provider to all patients in the plan. *Id.* This provision seems to address situations in which an individual patient’s care has become too expensive and the physician may be enticed to limit or deny care in order to reduce costs. At first glance, limits on physician incentives to cut costs may appear to be contrary to Ellwood’s vision of “health maintenance,” but this provision does not violate Ellwood’s strategy because it continues to allow incentives based on aggregate cost savings, preserving the very foundation of managed care.

grievance and external review processes, and compile data on the managed care market and the work of the program.<sup>216</sup> The North Carolina law also includes amendments to the internal grievance processes of managed care plans, establishes external review of denied decisions, and imposes a duty of due care on managed care and health insurance plans.

One important feature of the North Carolina approach is its external review structure. Like the external review structures in other states, North Carolina's requires patients to pursue appeals through an internal appeals process before requesting independent review.<sup>217</sup> Exhaustion of the internal appeals process is waived when waived by the insurer<sup>218</sup> or when delay in treatment could jeopardize the patient's life or cause death.<sup>219</sup> Plans are required to notify claimants of their eligibility for review and the review process upon each coverage denial, including those situations in which the patient's condition renders his claim immediately reviewable.<sup>220</sup> The North Carolina external review procedure is established in much the same manner as its predecessors in other states, and the legislation stipulates that determinations from the external review entity are binding.<sup>221</sup> Unlike Texas and Georgia, however, North Carolina external review decisions are binding on both the health plan and the enrollee,<sup>222</sup> and patients are forbidden from submitting the same

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216. *Id.* § 143-730. Such programs have become increasingly popular since the late 1990s, and have ranged in design from being strictly educational bodies to being aggressive advocacy and quasi-regulatory bodies. The North Carolina program falls somewhere between the extremes, providing some advocacy services on behalf of patients in the appeals process but serving mainly educational and public disclosure functions. In the next several months the Governor will establish this program and appoint its first director, and patient advocates and the managed care industry will be keenly watching the program's structural and personnel development.

217. *Id.* § 58-50-79; *see, e.g.*, TEX. CIV. PRAC. & REM. CODE ANN. § 88.003 (Vernon Supp. 2003) (providing that person may not maintain a cause of action unless the person has "exhausted the appeals and review under the utilization review requirements" or gives written notice and "agrees to submit the claim to a review by an independent review organization").

218. N.C. GEN. STAT. § 58-50-79(d) (2001) (describing the external review procedure and stating that "[a] request for an external review of a noncertification may be made before the covered person has exhausted the insurer's internal grievance and appeal procedure under G.S. 58-50-61 and G.S. 58-50-62 whenever the insurer agrees to waive the exhaustion requirement").

219. *Id.*

220. *Id.*

221. *Id.*

222. *Id.*

denied claim for review once the external review board has ruled.<sup>223</sup> This key difference between North Carolina and other state approaches is a victory of sorts for health insurers because the decisions of external reviewers are given greater finality and are applied equally whether the insurer or the insured wins the appeal.

North Carolina's patients' bill of rights imposes a duty on all health benefit plans to exercise ordinary care when making "health care decisions" and imposes liability for harm proximately caused by failure to exercise such care.<sup>224</sup> The law expressly states that such claims are not considered medical malpractice claims and exempts employers and other health care purchasers from liability for decisions made by health plans, removing even the possibility of a party arguing that an employer or health insurance purchaser is vicariously liable for the torts committed by the health plan or its contract providers.<sup>225</sup> The repudiation of liability claims as "malpractice claims" presents a unique issue regarding the "corporate practice of medicine" doctrine.<sup>226</sup> The doctrine, established by courts and legislatures in many states before the adoption of the HMO Act of 1973,<sup>227</sup> prohibits corporations from engaging in the practice of medicine by restricting their ability to hire certain medical professionals.<sup>228</sup> This doctrine was established to protect patients from the ever-growing influence of corporate entities during the middle of the twentieth century,<sup>229</sup> but was basically turned on its head with the advent of Ellwood's health maintenance strategy in the 1970s.<sup>230</sup> The doctrine, which still technically exists in many states,<sup>231</sup> is based upon the belief that, "[b]ecause corporations are compelled by their nature to a uniformity of approach that is viewed as anathema by the medical profession, corporations are by definition

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223. *Id.* The binding effect on the individual is mitigated by language excepting "other remedies available" to the enrollee under state or federal law.

224. *Id.* § 90-21.51(a).

225. *Id.* § 90-21.51(e) & (f).

226. *Id.* A lengthy discussion of the evolution of the corporate practice of medicine doctrine is beyond the scope of this Comment. For more information on the status of the doctrine in the states, see generally D. Cameron Dobbins, *Survey of State Laws Relating to the Corporate Practice of Medicine*, 9 THE HEALTH LAW. 18 (1997) (describing the status of the corporate practice of medicine doctrine in every state).

227. Dobbins, *supra* note 226, at 18-23.

228. See MORREIM, *supra* note 9, at 39-40.

229. Dobbins, *supra* note 226, at 18-23.

230. See *id.*

231. *Id.*

incapable of practicing medicine.”<sup>232</sup> Because the practice of medicine in some capacity underlies the notion of a malpractice claim, it appears that HMOs and managed care entities can defend malpractice suits by asserting the corporate practice of medicine doctrine.<sup>233</sup>

The doctrine can allow HMOs to escape liability for medical malpractice if they argue that they were not making treatment decisions.<sup>234</sup> The irony here is that HMOs do, in fact, make treatment decisions.<sup>235</sup> HMOs prevent doctors from exercising their individual judgment in a given case, but have somehow succeeded in persuading at least some courts that their control over the physicians in their employ does not constitute the practice of medicine.<sup>236</sup>

The drafters of S.B. 199 astutely observed the possibility of managed care plans asserting their innocence under the corporate practice of medicine doctrine and thus created a new cause of action, distinct from medical malpractice, that patients can assert against their insurers without fear of the insurer using the corporate practice of medicine doctrine as a shield against liability.<sup>237</sup> While this is a unique approach to eliminating a potential loophole through which health plans can defend against legal claims by insureds, it remains unsettled whether this distinct cause of action will survive ERISA preemption, given the uncertainty surrounding health plan liability in other states.<sup>238</sup>

Some other interesting features about the health plan liability language of the North Carolina law are the admissibility in evidence of external review decisions and the mandatory separation of claims.<sup>239</sup> The law demands that courts “shall order separate discovery and a separate trial of any claim, cross-claim, counterclaim, or third-party claim against any physician or other health care

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232. Ellen Wertheimer, *Symposium: Pursuing Health In An Era of Change: Emerging Legal Issues In Managed Care: Article: Ockham's Scalpel: A Return to a Reasonableness Standard*, 43 VILL. L. REV. 321, 332 (1998).

233. *See id.* at 335–36.

234. *Id.*

235. *Id.*

236. *Id.* at 335–37. The author cites *Propst v. Health Maintenance Plan, Inc.*, 582 N.E.2d 1142, 1143 (Ohio Ct. App. 1990), wherein the Ohio Court of Appeals found that the corporate defendants “may not be held liable under a complaint which sounds in medical malpractice.” *Id.* at 335 n.40.

237. *See id.* at 335–37 (discussing how the corporate practice of medicine doctrine has been used as a defense in medical malpractice cases).

238. *See supra* notes 162–96 and accompanying text (describing the uncertainty of the Texas liability law following the decisions in *Corporate Health* and *Roark*).

239. N.C. GEN. STAT. § 90-21.55 (2001).

provider.”<sup>240</sup> Presumably, this section is designed to prevent prejudice against health care provider defendants when a health plan has denied a coverage request and the patient has sued both the treating provider and the insurer. External review decisions are admissible at trial and may be introduced by either party, so long as they are subject to proper cross-examination.<sup>241</sup> While this language does not provide a rebuttable presumption like the Georgia law,<sup>242</sup> it does allow a health plan to introduce independent medical expert opinions that validate its decision to deny coverage.<sup>243</sup>

Like the patient protections in Georgia and Texas, North Carolina’s patients’ bill of rights faces the same judicial uncertainty that led to the decisions in *Corporate Health, Roark*, and other cases.<sup>244</sup> While advocates of expanding health plan liability, external review, and other patient protections in other states may consider these and the eight other states’ laws as models for reform, state legislators considering such patient protections would be wise to view not only the language of the patients’ bills of rights, but also the reactions of the courts, to gauge whether their actions will be upheld under or preempted by ERISA. Regardless of whether other states adopt patient protection laws similar to those in North Carolina, Georgia, Texas, and elsewhere, action in the federal courts and in Congress within the next few years could drastically change the landscape, positively or negatively, for the state patient protection acts currently on the books and under consideration in the states.

## VI. THE CONGRESSIONAL PERSPECTIVE

Noting its important role in the patients’ rights debate and spotting a ripe political issue, Congress has attempted unsuccessfully over the past several years to enact a federal patients’ bill of rights.<sup>245</sup> As insurance regulation has long been a state concern,<sup>246</sup> much of the

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240. *Id.* § 90-21.53.

241. *Id.* at § 90-21.55(a).

242. See *supra* notes 204–05 and accompanying text; see also GA. CODE ANN. § 33-20A-37(b) (2000) (“A determination by the independent review organization in favor of a managed care entity shall create a rebuttable presumption in any subsequent action that the managed care entity’s prior determination was appropriate . . .”).

243. Admissibility of external review outcomes varies from state to state.

244. See *supra* notes 162–96 and accompanying text.

245. Charles Ornstein, *Little Hope Is Seen in Reviving Bills on Patients’ Rights*, L.A. TIMES, Jan. 10, 2002, at A17 (tracing the movement of patients’ rights bills in Congress in the preceding four years).

246. Robert L. Schwartz, *How Law and Regulation Shape Managed Care*, in MANAGED CARE: FINANCIAL, LEGAL AND ETHICAL ISSUES, *supra* note 45, at 21, 28–30.

law regarding mandated benefits and HMO plan design have been the subject of state law.<sup>247</sup> Congress has considered, but failed to enact, so-called patient protection acts in each of the last several sessions.<sup>248</sup>

The year 2001 brought the most positive Congressional environment for managed care reform to date. The upheaval caused by the departure of Senator James Jeffords from the Republican Party caused party control of the Senate to change hands and left the new leadership needing to address some long-tabled pieces of legislation to assert power.<sup>249</sup> The newly amenable Senate, coupled with a President who had pledged enactment of a patients' bill of rights similar to that enacted in Texas during his tenure as governor,<sup>250</sup> made 2001 an excellent time for proponents of a federal patients' rights bill to strike.

In a Presidential Communication to Congress at the start of the 107th Congress, President George Bush outlined his vision of a comprehensive patients' rights bill.<sup>251</sup> The President called for binding external review of all health plan coverage decisions, the right to a federal judicial remedy to address patient grievances once the appeals process has been exhausted, and caps on damage awards to avoid subjecting health plans to crippling jury verdicts.<sup>252</sup> The President also advocated mandated coverage including: emergency room and specialty care; direct access to obstetricians, gynecologists, and pediatricians; access to needed prescription drugs and clinical treatment trials; continuity of care protection; increased health insurance disclosure and consumer education; and a prohibition on gag clauses and other provider contracting provisions.<sup>253</sup> President Bush also sought a specific exemption from liability for employers who purchase coverage for their employees, so long as the employer does not participate in any way in treatment decisions.<sup>254</sup>

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247. *Id.*

248. See Ornstein, *supra* note 245.

249. John Lancaster & Helen Dewar, *Jeffords Tips Control of Senate*, WASH. POST, May 27, 2001, at A3 ("Daschle and other Democrats said one of their first orders of business will be a patients' bill of rights, which has not ranked high on Bush's list of legislative goals.").

250. H.R. DOC. NO. 107-42, at 1 (2001) (Sup. Doc. No. Y1.1/7:107.42), available at [http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=107\\_cong\\_documents&docid=f:hd042.107.pdf](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=107_cong_documents&docid=f:hd042.107.pdf). (on file with the North Carolina Law Review).

251. *Id.*

252. *Id.*

253. *Id.* at 3.

254. *Id.* at 4.

On June 29, 2001, the Senate approved the Bipartisan Patient Protection Act.<sup>255</sup> An identically titled bill passed the U.S. House of Representatives on August 2, 2001, by a vote of 226–203.<sup>256</sup> Despite the identical names of the bills, significant differences will force the two versions into conference before they are submitted to the President for approval.<sup>257</sup> President Bush appeared equally prepared to sign the House version upon presentment or to veto the Senate version if passed.<sup>258</sup> Action on a comprehensive, national patients' bill of rights appeared imminent. And then the terrorist attacks of September 11 occurred, pushing patients' rights and all other measures irrelevant to national security to the back burner.<sup>259</sup>

Both the House and Senate bills contain many of the traditional patient protection provisions currently in force in many states.<sup>260</sup> But while the House and Senate bills are substantially similar in many respects, the differences between the two versions are significant enough to thwart efforts at compromise. Both measures adopt liability for health plans, but do so in drastically different ways. The House bill provides for a federal cause of action for failure to exercise ordinary care and allows joint federal and state court jurisdiction for medical decisions.<sup>261</sup> The Senate version of the bill creates similar federal/state joint jurisdiction over medical decision disputes, but is far broader in that it basically removes the ERISA preemption for

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255. 147 CONG. REC. S7338-61 (daily ed. July 9, 2001); Bipartisan Patient Protection Act, S. 1052, 107th Cong. (2001).

256. 147 CONG. REC. H5315 (daily ed. Aug. 2, 2001); Bipartisan Patient Protection Act, H.R. 2563, 107th Cong. (2001).

257. The significant differences are discussed *infra* at notes 261–74 and accompanying text.

258. See Ornstein, *supra* note 245; see also H.R. DOC. NO. 107-42, at 1 (2001) (Sup. Doc. No. Y1.1/7:107-42) available at [http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=107\\_cong\\_documents&docid=f:hd042.107.pdf](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=107_cong_documents&docid=f:hd042.107.pdf). (expressing President Bush's interest in enacting a federal patients' rights law).

259. See Ornstein, *supra* note 245.

260. Such patient protections include: access to emergency services when deemed necessary by a "prudent layperson;" timely access to specialty care when appropriate; direct access to obstetrician, gynecologist, or pediatric care as a primary care provider; protections for continuity of care despite changes to the provider network; coverage for treatment in accordance with approved clinical trials; mandatory minimum hospital stays following mastectomy and lymph node dissection in connection with breast cancer treatment and mandatory coverage for costs associated with obtaining second opinions in such cases; a mandatory point-of-service option; and express prohibitions on provider gag clauses, discrimination against providers on the basis of patient advocacy, retaliation against providers, and improper use of financial incentives to limit care. S. 1052, 107th Cong. §§ 113–35 (2001). See also H.R. 2563, 107th Cong. (2001) (enacting many of the same mandated benefits as S. 1052).

261. H.R. 2563, § 402.

coverage decisions.<sup>262</sup> The House Bipartisan Patient Protection Act caps damage awards for punitive and non-economic damages at \$1.5 million each,<sup>263</sup> while the Senate version contains no such cap.<sup>264</sup> The Senate bill allows employees to pursue lawsuits against their employers when the employer is substantially involved with the coverage decision.<sup>265</sup> Pursuit of judicial remedy is available under the Senate bill either after exhaustion of all internal and external appeals processes or upon a certification that the delay would cause irreparable harm, while the House version bars the filing of a lawsuit until a written determination has been issued by an external review entity.<sup>266</sup> Arbitration is expressly provided for in the House bill but not in the Senate bill.<sup>267</sup>

There are also significant differences between the external review structures established under the House and Senate bills. The House version creates a federal external review procedure under ERISA that preempts all existing state external review procedures.<sup>268</sup> The Senate bill sets minimum standards for external review and allows states to apply for certification of their external review procedures that are at least as protective as the federal provisions.<sup>269</sup> Both measures bind the health plan but not the enrollee to the decisions of external reviewers.<sup>270</sup>

The House measure also contains tax incentives for the purchase of health insurance that are absent in the Senate bill.<sup>271</sup> The House version provides deductions for individual purchases of health insurance for self-employed individuals,<sup>272</sup> expanded income tax benefits for medical savings accounts,<sup>273</sup> and credits for the purchase of employee health insurance for small businesses.<sup>274</sup> With its tax incentive provisions, approach to reforming ERISA, national

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262. S. 1052, 107th Cong. § 402(b) (2001). The House bill expressly maintains the status quo distinction between treatment decisions and coverage decisions discussed in *Pegram v. Herdrich*, 530 U.S. 211, 228 (2000) and *Corporate Health Ins., Inc. v. Tex. Dept. of Ins.*, 215 F.3d 526, 534 (2000).

263. H.R. 2563, § 402(a)(4)(A).

264. S. 1052, § 402.

265. Compare S. 1052, § 402(b), with H.R. 2563, § 402.

266. Compare S. 1052, § 402, with H.R. 2563, § 402.

267. H.R. 2563, § 402.

268. *Id.* § 104(a).

269. S. 1052, § 104.

270. *Id.* § 104(f)(1)(A); H.R. 2563 § 104(f)(1)(A).

271. H.R. 2563, §§ 501-515.

272. *Id.* § 512. The bill provides a 100 percent deduction for health premiums. *Id.*

273. *Id.* § 511.

274. *Id.* § 513. The credit varies from twenty to thirty percent, depending on the type of health coverage purchased. *Id.*

standardization of external review, and caps on damages and limits on liability, House Resolution 2563 is a good first step towards a national patients' rights scheme that balances the needs of consumers against the fiscal viability of the nation's employers and health insurers.

With these significant discrepancies between the House and Senate versions of these patient protection acts, however, enactment of a comprehensive measure remains for a future Congress. The first year of the Bush Administration presented the most favorable climate yet for comprehensive managed care reform at the federal level, but the events of September 11, 2001, coupled with the swing of political control in the Senate may have withered any chance of passage during the 107th Congress.<sup>275</sup> With other matters such as the flagging economy, the ongoing "homeland security" and terrorism debates, and midterm Congressional elections,<sup>276</sup> the federal landscape for patients' rights in the near term may be bleak.

### CONCLUSION

Unless Congress repeals ERISA preemption for state managed care oversight, states will need to consider how ERISA impacts the effectiveness of the patients' bills of rights that they enact. The decisions in cases such as *Roark*, *Corporate Health*, and *Pegram*, suggest that, despite judicial attempts to reconcile the cases with each other, the landscape for such state proposals as health plan liability and binding external review appears cloudy at best. *Pegram* removes a significant ERISA protection, that of the fiduciary duty, from the managed care claim denial arena.

Americans rely heavily on the solvency and ability of their health plans to pay for their day-to-day and year-to-year health needs. Removal of ERISA preemption and adoption of more state liability laws could lead to an environment where HMOs and managed care plans are defending a number of lawsuits against a number of different plaintiffs in a number of different states arising under a number of different types of causes of action. This is exactly the

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275. See Bob Gatty, *Patients Rights Bill: A New Political Football?*, DERMATOLOGY TIMES, Mar. 1, 2002, at 6 (stating that many business lobbyists believed that the House version of the patients' bill of rights would definitely be signed by President Bush before September 11, 2001).

276. See, e.g., David S. Broder, *The Gridlock Dilemma*, Editorial, WASH. POST, Sept. 8, 2002, at B7 (suggesting that the patients' bill of rights will probably not be enacted); Helen Dewar, *Congress Gets Back to Unfinished Business*, WASH. POST, Sept. 1, 2002, at A4 (citing lawmakers as saying that the patients' bill of rights is likely to die).

environment from which Congress was trying to protect employee benefit plans generally when it enacted ERISA in 1974.<sup>277</sup>

Proponents of broader patient protections dismiss this argument as overstating the danger of managed care failure.<sup>278</sup> They cite statistics in Texas and elsewhere suggesting that only a small number of lawsuits have been filed under the 1997 Act, and that juries have yet to run rampant over health plans and their funds.<sup>279</sup> This analysis of the landscape is short sighted for two reasons. First, and most obvious, is that the law simply has not been in effect long enough to determine whether the flood of lawsuits that the naysayers predict will eventually arise.<sup>280</sup> In order for a case to come to final verdict under the Texas law a person must become ill, the treating physician must diagnose the illness and request treatment, coverage for the treatment must be denied, an appeal process must commence, an external review must find in favor of the patient, and only then can the patient enter the sluggish state court system.<sup>281</sup> It is quite possible, given the lengthy nature of this process, that not enough cases have made their way to verdict yet, thus preventing observers from getting a full picture of the law's financial impact on health plans.

Second, confusion in the current legal environment has prevented the experience of Texas (and other states) from painting a full picture of the potential danger of managed care liability. States have enacted various causes of action and conflicting opinions have come down from an array of federal and state judges regarding the preemption or validity of such causes of action.<sup>282</sup> Considering ERISA and its cloudy interpretation by the state and federal benches,<sup>283</sup> some form of Congressional action is necessary to determine the validity of state-imposed health plan liability.

Given the confusion regarding health plan liability, effectiveness at the state level, and the potential for disaster if ERISA preemption is removed, a more moderate approach is warranted. Certainly,

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277. 29 U.S.C. § 1001(a) (2001).

278. See Aston, *supra* note 157.

279. *Id.*

280. *Id.*

281. See *supra* notes 145–56 and accompanying text. Most cases would have to proceed through internal and external review prior to commencing legal action. See TEX. CIV. PRAC. & REM. CODE ANN. § 88.003(a) (Vernon Supp. 2003). The exception to the general rule under which a patient cannot avail himself immediately to the courts, is where harm has already occurred or where review would not be beneficial to the enrollee. *Id.* § 88.003(f).

282. See *supra* notes 162–90 and accompanying text.

283. See *supra* notes 161–90 and accompanying text.

Americans will no longer tolerate a system in which health plans are completely free from reproach regarding their coverage decisions. External review fills this void. External review allows for health plan decisions to be questioned and mistakes to be rectified, but does not put insurance company holdings and assets into the jeopardy of indiscriminate jury verdicts. External review also serves as an additional level of due process for a patient, giving the patient an independent, expert avenue through which to hold his health plan accountable for claim denials.

External review has proven no more burdensome to the managed care industry or to the patient. The Texas experience indicates that external review panels have ruled in favor of health plans slightly less than half the time.<sup>284</sup> Evidence from Ohio, where external review was enacted without health plan liability in 1999, shows an even better track record for health plan decisions than in Texas.<sup>285</sup> Few patients in Ohio have opted to undergo external review and fewer still have won at the external review panel.<sup>286</sup> This suggests that the horror stories that are batted about the press that patients are dying due to negligent HMO claims decisions may be overstated.<sup>287</sup> While it remains true in theory that a person can exercise his absolute

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284. See Aston, *supra* note 157.

285. Cheryl Powell, *Few Ohio Patients Use Health Insurance Coverage Review*, AKRON BEACON J., Nov. 23, 2001, at A1. "In the first year, only 100 Ohioans took advantage of the right to appeal, according to the Ohio Department of Insurance." *Id.* "Of the appealed cases in Ohio, the review firm upheld the insurance company's decision in [fifty] cases. Another [thirty-four] were reversed in the patients' favor and [eleven] were partially reversed." *Id.* Other states have shown similar success for insurance companies in external review processes. For example, the Maine Bureau of Insurance website indicates that, in 2001, only twenty external review requests were filed against major health plans in the state and of those twenty cases, only two were decided in favor of the complaining enrollee. See Maine Department of Professional and Financial Regulation, *2001 Maine Consumer Guide to Health Insurers, Bureau of Insurance*, at [http://www.state.me.us/pfr/ins/HealthGuide\\_External\\_Review.htm](http://www.state.me.us/pfr/ins/HealthGuide_External_Review.htm) (last visited Nov. 14, 2002) (on file with the North Carolina Law Review). A similar experience was noted in Illinois in 2000, where out of forty-three external review requests filed, only thirteen were decided in favor of the enrollee. Office of Consumer Health Insurance, Illinois Department of Insurance 2001 Annual Report, *available at* [http://www.ins.state.il.us/Reports/OCHI/OCHI\\_2001\\_annual\\_report.pdf](http://www.ins.state.il.us/Reports/OCHI/OCHI_2001_annual_report.pdf) (last visited Nov. 14, 2002) (on file with the North Carolina Law Review). While it would be unwise to extrapolate the one-year experience of a few states to predict the effect of a national program of external review on the health care system, at least these early numbers suggest that managed care organizations are correct in many of the coverage decisions that are examined by independent reviewers.

286. Powell, *supra* note 285, at A1.

287. For more on the "horror story" environment surrounding the patients' rights debate, see ZELMAN & BERENSON, *supra* note 4, at 102-18. The authors devote an entire chapter to debunking the myth of HMO horror stories and the mass harm caused by managed care.

right of health care choice simply by choosing fee-for-service or other similarly flexible health insurance options, reality suggests that the pervasiveness of managed care and the public's mass reliance on employer-sponsored health insurance assures a future for managed care in our health care financing system. Given the bevy of proposals at the state and federal level, policymakers need to sort out and reject ideas that either fail to address consumer needs or fail to consider cost impacts to HMOs. Health care inflation continues to trend higher than inflation overall,<sup>288</sup> and legislation that has the potential to hasten the inflationary spiral should be rejected outright, even at the expense of political capital or public perception. States would be wise to let Congress take the lead on a national approach, and Congress would be wise to moderate its approach by foregoing full-blown health plan liability in favor of a national external review process.

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288. United States Dept. of Labor, Bureau of Labor Statistics, *Consumer Price Index: November 2002* (Dec. 17, 2002) (revealing a 5.0% rise in the cost of medical care compared to a 2.2% inflation rate overall), available at <http://www.bls.gov/news.release/pdf/cpi.pdf> (on file with the North Carolina Law Review).