

THE MODEL HEALTH CARE ACCOUNTABILITY AND INFORMATION ACT: MANAGED CARE AND MEDICAL MALPRACTICE LIABILITY UNDER AN AMENDED ERISA

INTRODUCTION

Managed care is “[a] health care program designed to make sure that [plan beneficiaries] receive the highest quality medical care for the lowest cost, in the most appropriate setting.”¹ This flattering portrait of managed care—furnished by a managed care organization—runs counter to what many health care providers and consumers in general have concluded about this method of health care delivery.² While representatives of managed care organizations

1. CIGNA HEALTHCARE HANDBOOK 21 (1997).

2. Dr. Harvey F. Wachsman wrote, “[Managed care executives] and their companies institute policies that deny patients care and place lives at risk.” Harvey F. Wachsman, M.D., Letter, *Reforms Must Target HMOs and Their CEOs*, WALL ST. J., Nov. 7, 1997, at A19. For further discussion of the tension between containing health care costs and providing high-quality care, see George F. Indest III & Barbara A. Egolf, *Is Medicine Headed for an Assembly Line? Exploring the Doctrine of the Unauthorized Corporate Practice of Medicine*, 6 BUS. L. TODAY 32, 33-34 (1997); John V. Jacobi, *Patients at a Loss: Protecting Health Care Consumers Through Data Driven Quality Assurance*, 45 U. KAN. L. REV. 705, 705-09 (1997); Jack K. Kilcullen, *Groping for the Reins: ERISA, HMO Malpractice, and Enterprise Liability*, 22 AM. J. L. & MED. 7, 8-10 (1996); Arti Kaur Rai, *Rationing Through Choice: A New Approach to Cost-Effectiveness Analysis in Health Care*, 72 IND. L. J. 1015, 1016-18 (1997); John P. Little, D.M.D., Note, *Managed Care Contracts of Adhesion: Terminating the Doctor-Patient Relationship and Endangering Patient Health*, 49 RUTGERS L. REV. 1397, 1397-1401 (1997); Jonathan Gardner & Eric Weissenstein, *Washington Report: Election-Year Alert: Consumer Pressure May Drive Reforms in Health Care Fraud, Managed Care*, MODERN

maintain that they offer medical care that is both cost-effective and of high quality, critics contend that cost control has predominated at the expense of quality—with dangerous and unjust consequences for the persons enrolled in these plans.³ This struggle between providing high-quality health care and containing the cost of medical treatment serves as the back-drop for the issue of managed care tort liability.

While physicians and other health care providers⁴ have long faced liability for the consequences of their own malpractice, managed care

HEALTHCARE, Jan. 19, 1998, available in 1998 WL 7268904; Linda A. Johnson, *Field hearing addresses complaints about managed health care*, ASSOCIATED PRESS POL. SERV., Jan. 22, 1998, available in 1998 WL 7378604 (“Sen. Robert Torricelli and Rep. Frank Pallone heard testimony about problems with managed care and suggestions on how Congress can protect the public from abuses.”); Barbara Marsh, *HMO Drug Lists New Focus of Backlash: Health care critics charge that managed care firms limit the medications doctors can prescribe in a bid to save money*, L.A. TIMES, Jan. 18, 1998, at D1; Troy May, *Doctors Back Managed Care Liability Bill*, CINCINNATI BUS. COURIER, Jan. 23, 1998, at 21; *All Things Considered* (National Public Radio broadcast, Jan. 28, 1998) (transcript on file with the author) (interview with Kaiser Permanente nurses striking to protest unsatisfactory pay and falling standards of patient care in this HMO). *But see* Rhonda L. Rundle & Laurie McGinley, *Medicine: California Voters Are Cool to “Hot” HMO Issue*, WALL ST. J., Oct. 31, 1996, at B1 (“[P]eople are more worried about the security of their medical coverage than about its quality.”).

3. The American Medical Association has expressed concern that HMOs will mandate that physicians in their employ base their treatment decisions on the interests of the HMOs in lieu of their patients’ welfare. *See* Vemellia R. Randall, *Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1, 11, 31 (1993), cited in Jim M. Perdue & Stephen R. Baxley, *Cutting Costs—Cutting Care: Can Texas Managed Health Care Systems and HMOs Be Liable for the Medical Malpractice of Physicians?*, 27 ST. MARY’S L. J. 23, 67 n.12 (1995). Managed care directors (and their employer-customers) are sensitive to this criticism, as illustrated by the following assertion in an employee handbook: “Managed care is not cost control.” NATIONSBANK ASSOCIATE HANDBOOK § 5.5. Additionally, while they defend their industry against charges of sacrificing patient care in order to reduce costs, managed care executives continue to insist that the high price of health care poses a greater threat to American consumers than do issues of quality. *See* Julius A. Karash, *Managed-care firms in area not enthusiastic about bill*, KAN. CITY STAR, Jan. 29, 1998, at A10 (statement of Jan Stallmeyer, executive director of Principal Health Care of Kansas City) (“True consumer protection begins with consumers having access to care they can afford, and whose quality is assured. And managed care has worked hard to do that.”)

4. In this note, the term “provider” refers to any medical personnel who administers treatment or care to patients. To wit, CIGNA HealthCare uses “provider” to refer to a “doctor, hospital, laboratory, nurse, or anyone who delivers medical or health related care.” *See* CIGNA HEALTHCARE HANDBOOK, *supra* note 1, at 20. While beyond the scope of this Note, many physicians bristle at the term “provider,” which to some signifies the end of physician autonomy and prestige and the advent of the doctor’s role as a mere managed care employee. *See* Brigid McMenamin, *Crusader*, FORBES, Mar. 9, 1998, 102 (Statement of Jane Orient, M.D., executive director of the Association of American Physicians & Surgeons) (“I’m a doctor, not a ‘provider.’”).

organizations thus far have enjoyed immunity from malpractice suits due to language in the Employee Retirement Insurance Security Act (ERISA) that exempts employee benefit plans from state law provisions.⁵ Certain bills currently under consideration in Congress would remove this immunity so that patients injured due to the denial of coverage for treatments could recover damages from their health insurance organizations under state tort law or federal law.⁶

This Note proposes the adoption of legislation that would remove ERISA's exemption of employee health plans from state tort law liability. Pursuing this course of action would not come free of certain undesirable results; however, it presents the least federally intrusive way to ensure that managed care organizations are held fully accountable for the medical decisions their own directors and case reviewers make. Among possible maleffects of this proposal is the potential for higher health care premiums as health plans try to avoid litigation by authorizing more and costlier procedures and to defend and insure against lawsuits formerly prohibited by ERISA. These higher costs could make it prohibitively expensive for employers to provide health benefits for their employees and thereby could further reduce the ranks of Americans with access to health insurance. Imposing direct accountability on these organizations, however, is the solution most likely to spur those who determine treatment coverage to make decisions with a sharper focus on patient well-being. Moreover, allowing enrollees to sue their health care plans when policy decisions result in patient injury merely removes the special protection that does not shield any other health care decision-maker. Finally, this proposal would not impose any intrusive

5. 29 U.S.C. § 1144 (1994). See 61 AM. JUR. 2d *Physicians, Surgeons, and Other Healers*, § 200 (1981):

The welfare of the citizens of a state . . . demands that those persons practicing medicine and surgery shall be duly able and careful. This rule[']s . . . purpose is to protect the health and lives of the public . . . from careless, unskillful, or negligent medical practitioners by making such practitioners answerable in damages to their patients for failure to employ the requisite care, skill, or knowledge in the performance of their professional duties.

6. This note will examine various congressional proposals aimed at making managed care organizations answerable in court for the unwarranted withholding of health care coverage. See *infra* notes 70-92 and accompanying text.

government-mandated operating requirements on managed care organizations and would keep malpractice suits in the state realm.

Part I of this Note examines the history of employee health care plans, ERISA, the problems that have resulted under the current system, and the current legislative proposals for correcting the flaws that relate to ERISA and benefit plans. Part II analyzes these proposals for reform and notes their effects on the plan beneficiaries, employers, and managed care organizations likely to be affected by any change of health care coverage policy or of ERISA. Part III includes the author's proposal for a law that balances the sometimes competing interests of beneficiaries, employers, insurers, and sound public policy. This proposal incorporates elements of the various congressional plans.

I. HISTORY EMPLOYER-PROVIDED HEALTH CARE PLANS

Over seventy-five percent of U.S. physicians now participate in some form of managed care.⁷ There are now approximately 160 million Americans enrolled in managed care plans.⁸ This marks a drastic change from traditional health care insurance known as "fee-for-service" or "indemnity" coverage.⁹ Under these traditional plans, insurance companies pay physicians for each procedure or office visit on behalf of the insured. As health care costs increased dramatically in the 1980s, employers looked to managed care as a way to control

7. Barry R. Furrow et al., *HEALTH LAW* 97 (Supp. 1995), cited in Barbara A. Noah, *The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?*, 48 *MERCER L. REV.* 1219, 1219 (1997). This figure includes a variety of arrangements, from working as an employee of a health maintenance organization, to treating some patients enrolled in a managed care plan while owning one's own practice. *Id.* at 1219-20. "In essence, managed care is a system combining insurance (i.e., financing) with health care delivery." Phyllis C. Borzi, *Managed Care and ERISA Health Plans*, *FIDUCIARY RESPONSIBILITY ISSUES UNDER ERISA—1996 Q245 ALI-ABA COURSE OF STUDY* 133, 135 (1996).

8. *President Clinton's State of the Union Address* (NPR radio broadcast, Jan. 27, 1998). Approximately two-thirds of those persons are beneficiaries of HMO plans, while the other one-third receive health care through other types of managed care organizations. Noah, *supra* note 7, at 1219-20.

9. Borzi, *supra* note 7, at 135. In 1987, over half of the physicians in the United States were self-employed, solo practitioners, or were partners in small physician groups and received payment from fee-for-service insurance plans; by 1993, however, only 37 percent of physicians practiced in this manner. Furrow, *supra* note 7, at 97.

the cost of the health benefits they purchase on behalf of their employees.¹⁰

Managed care organizations (MCOs) include several different types of organizations designed to provide health care to plan enrollees while using various methods to contain the costs of the care. Health Maintenance Organizations (HMOs) function simultaneously as health care insurer and provider.¹¹ These organizations contract with physicians to provide all of the care required by the person enrolled for a set periodic rate.¹² This per-patient basis for payment is known as "capitation." Under this system, the insurer pays a set fee to the enrollee's physician regardless of the cost of the care actually provided to the enrollee during the period.¹³ There are three basic types of HMOs: the "staff" model,¹⁴ the "group" model,¹⁵ and the "independent practice association" model.¹⁶

Preferred provider organizations (PPOs) constitute another kind of managed care delivery system. PPOs contract with physicians, physician groups, and hospitals to provide care for enrollees on a

10. Borzi, *supra* note 7, at 135. Health care costs in the United States now amount to approximately 14 % of U.S. GDP and have increased at an average rate of 4.8% per year between 1960 and 1993. CENSUS BUREAU STATISTICAL ABSTRACT 1996, at 111, *cited in* Noah, *supra* note 7, at 1221.

11. Ila S. Rothschild, et al. *Recent Developments in Managed Care*, 32 TORT & INS. L.J. 463, 464 (1997).

12. *Id.*

13. Noah, *supra* note 7, at 1223. For an analysis of the cost-saving benefits and the care-compromising risks of capitation, see Frances H. Miller, *Foreword: The Promise and Problems of Capitation*, 22 AM. J. L. & MED. 167, 167-70 (1996); *Capitation & Physician Autonomy: Master of the Universe or Just Another Prisoner's Dilemma?*, 6 HEALTH MATRIX 89, 89-93 (1996); Andrew Ruskin, *Capitation: The Legal Implications of Using Capitation to Affect Physician Decision-Making Processes*, 13 J. CONTEMP. HEALTH L. & POL'Y 391, 391-92 (1997); Michelle M. Kwon, Comment, *Move Over Marcus Welby, M.D., and Make Way for Managed Care: The Implications of Capitation, Gag Clauses, and Economic Credentialing*, 28 TEX. TECH L. REV. 829, 829-31 (1997).

14. Under the staff model, physicians work as salaried employees of the HMO at a central location and earn fixed per-patient fees. Noah, *supra* note 7, at 1223.

15. In the group model HMOs, physicians, through partnerships or corporations, form contracts with the HMO to provide care for the HMO enrollees. These physicians treat enrollees at the group facility for a set fee per enrollee. *Id.* at 1223-24.

16. Independent physician associations (IPAs) operate through contracts between physicians (usually in partnerships or corporations) and the HMO. Under this arrangement, the physicians see patients in their own facilities and often do not work exclusively with the HMO. The IPAs receive capitation fees from the HMO and in turn pay their member physicians based on independent contracts between the IPAs and the physicians. *Id.* at 1224.

reduced fee-for-service basis, as contrasted with the capitation agreements under the HMO form.¹⁷ Under this plan, enrollees may receive care from unaffiliated physicians; however, the PPO provides disincentives (such as larger copayments¹⁸ and deductibles¹⁹ for the enrollee) for visiting "nonpreferred providers."²⁰

Other forms of managed care include the exclusive provider organization (EPO) and the point of service (POS) plan.²¹ Under the EPO, certain physicians and health care facilities provide to subscribers only the authorized medical services within the plan.²² A POS plan resembles aspects of both the HMO and the PPO. When enrollees select physicians within the plan, the organization pays the physicians as they would under an HMO. Under the POS scheme, though, enrollees may choose physicians outside the plan. When beneficiaries choose providers outside the plan, they must pay higher deductibles and co-payments.²³

Managed care organizations control costs through a variety of means. One such strategy is utilization review.²⁴ Utilization review saves costs by allowing the managed care organization to determine the procedures for which it will pay based on what it deems medically necessary and effective.²⁵ Managed care organizations hail

17. Noah, *supra* note 7, at 1225. The fee is "reduced" because the PPO contracts to pay the physician much less than the amount the physician charges for a given procedure or office visit. See Kevin Grumbach, *Mechanisms for Controlling Costs*, J. AM. MED. ASS'N, April 19, 1995, at 15; Thomas Bodenheimer, *Reimbursing Physicians and Hospitals*, J. AM. MED. ASS'N, Sept. 28, 1994, at 12.

18. Copayment refers to the "dollar amount [the enrollee] must pay directly to the provider for office-based physician care." NATIONS BANK ASSOCIATE HANDBOOK, *supra* note 3, at § 5.3.

19. A deductible is "the portion of covered medical expenses [the enrollee] pay[s] before the plan starts to pay any benefit." *Id.*

20. Noah, *supra* note 7, at 1225.

21. Rothschild, *supra* note 11, at 465.

22. Bryan A. Liang, *An Overview and Analysis of Challenges to Medical Exclusive Contracts*, 18 J. LEGAL MED. 1, 1-3 (1997). These exclusive provider contracts, however, can pose antitrust problems for the HMOs and physicians. See Mark L. Glassman, *Can HMOs Wield Market Power? Assessing Antitrust Liability in the Imperfect Market for Health Care Financing*, 46 AM. U. L. REV. 91, 135-37 (1996).

23. Smeeta S. Rishi, *Getting a Jump on the Jargon: Beware the Gag Clauses on Ids*, 6 BUS. LAW TODAY, 9, 9 (1997).

24. Rothschild, *supra* note 11, at 463-64.

25. Utilization reviews can operate prospectively or retrospectively. When performed prospectively, utilization reviews allow plans to monitor and control the care provided by

utilization review as a way to assure that physicians under the plan do not provide medically unnecessary treatment.²⁶

Another important cost-containing method under managed care is the requirement that patients use primary care physicians who carry the responsibility for ordering services, lab tests, and procedures for patients, and who alone can refer patients to more expensive specialists.²⁷ Using such "gatekeeper" primary care physicians has the effect of reducing visits to specialists with a corresponding

requiring the physician or patient to obtain approval before dispensing or receiving treatment. *See id.* at 464. Examples of prospective utilization review include precertification of hospital stays, reviews of requests for extended hospital stays, and permission for procedures like surgery and radiation. Managed care organizations use retrospective utilization review to assess the quality and necessity of services already performed. Under the traditional system, insurers employed utilization review retrospectively to gauge the kind of treatment doctors provided insured patients for statistical purposes as well as to determine future insurance rates. A traditional indemnity plan also could refuse to pay the doctor's bill if the treatment in issue were clearly something not covered under the policy. *See* Vernellia R. Randall, *Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1, 1-3 (1994). Managed care plans employ these techniques retrospectively largely to review providers for providing what the plan deems excessive treatment. This review policy allows plans to track physicians' performance and to terminate providers who prescribe procedures that plan administrators think excessive or inappropriate. Health plans also perform utilization review to manage ongoing treatment when a patient suffers a serious or chronic illness or injury. *See* Alycia C. Regan, Note, *Regulating the Business of Medicine: Models for Integrating Ethics and Managed Care*, 30 COLUM. J. L. & SOC. PROBS. 635, 684 n.14 (1997). Under capitation-based plans, administrators use utilization review to ascertain that physicians, who receive one lump sum per patient, are not withholding treatment. Rothschild, *supra* note 11, at 464.

26. Rothschild, *supra* note 11, at 464. Critics of managed care—both patient/consumer advocates and physicians—cite utilization review as a particularly objectionable aspect of managed care. Physicians resent the interference with their medical judgment and autonomy to prescribe the treatments they think most likely to result in favorable outcomes for their patients. *See* Robert M. Goldberg, *What's Happened to the Healing Process?*, WALL ST. J., June 18, 1997, at A22. Patient advocates worry that utilization review results in the denial of necessary treatment by plan employees under pressure to reduce costs as much as possible. *See* Jamie Court, *HMOs Continue to Evade Accountability*, ALBANY TIMES UNION, Jan. 27, 1998, at A7. One author noted the story of a boy whose health plan denied his parents' request for an MRI to detect the source of the boy's lingering pain after a serious head injury. Although the persons conducting the utilization review knew that the boy's pain could stem from an injury-induced abscess, they persisted in suggesting the flu or meningitis as the cause, and refused to allow the \$800 MRI. As his parents feared, the child's head injury had led to a brain abscess, which had caused his continuing pain. The abscess thus went untreated during a critical period and resulted in blindness and cerebral palsy for the child. *See* Goldberg, *supra* at A22.

27. Stephen R. Latham, *Regulation of Managed Care: Incentive Payments to Physicians*, 22 AM. J. L. & MED. 399, 401 (1996).

decrease in the costs incurred by such visits.²⁸

Managed care organizations also restrict hospitalization by directing doctors to perform more procedures on an outpatient basis²⁹ and by limiting the amount of time they permit patients to remain in the hospital.³⁰ Managed care organizations also have included "gag clauses" in their contracts with physicians.³¹ These restrictions on provider-patient communication reduce costs if the patient's consumption of expensive care declines as a result of his lack of information about "noncovered" care.³² Other cost-containment

28. *Id.* One managed care organization explains the benefits of requiring enrollees always to consult their primary care physician first for any medical problem: "Less need for specialists. By seeing your primary care physician first, you may not even need to see a specialist. This means faster recovery and lower costs." NATIONSBANK ASSOCIATE HANDBOOK, *supra* note 3, at § 5.8 (emphasis added). According to one author, these plans also reward primary care gatekeepers for reducing the number of referrals to specialists and the consequent cost of specialty services. See Latham, *supra* note 27, at 399.

29. Between 1980 and 1993, outpatient hospital procedures increased by more than 34 percent, due to both new technologies and managed care cost-reducing pressures. See Sarah Q. Duffy, Dean E. Farley, Patterns of Decline Among Inpatient Procedures, U. S. Dep't HHS, Public Health Rep. 1995; 110: 674-681 Nov. 1995-Dec. 1995, available in LEXIS, Health Library, Alljnl File.

30. "If there is a difference of opinion between your physician and the medical consultant regarding the length of your hospital stay, coverage of room and board charges associated with the disputed hospital days will be denied." NATIONSBANK ASSOCIATE HANDBOOK, *supra* note 3, at § 5.4 (emphasis in the original). Examples of managed care restrictions include the policy of some organizations to limit maternity hospital stays to twenty-four hours, a practice managed care critics have termed "drive-through deliveries." These limitations incited a public outcry and prompted many state legislatures, as well as Congress, to enact bills requiring insurers to cover longer hospital stays for maternity patients. See Suzanne Seaman, Comment, *Putting the Brakes on Drive-Through Deliveries*, 13 J. CONTEMP. H. L. & POL'Y 497, 497-500, 502-04 (1997), David S. Hilzenrath, *Backlash Builds over Managed Care: Frustrated Consumers Push for Tougher Laws*, WASH. POST, June 30, 1997, at A1. Similar practices of requiring surgeons to perform mastectomies in an outpatient setting have angered patient advocates and inspired legislation prohibiting this policy. See *Minimum Mastectomy Debate Heats Up*, MED. OUTCOMES AND GUIDELINES ALERT, Nov. 20, 1997, available in LEXIS, Legnew Library, Allnws File (thirteen states have passed laws requiring health plans to allow mastectomy patients to remain in the hospital as long as their physicians deem appropriate).

31. The term "gag clause" refers to a provision in a physician's contract with a managed care organization that forbids the physician to discuss "noncovered" available treatment with a patient. See Eleanor D. Kinney, *Procedural Protections for Patients in Capitated Health Plans*, 22 AM. J. L. & MED. 301, 319 (1996).

32. Critics have condemned the explicit and implicit "gag" rules imposed on physicians. See Julia A. Martin & Lisa K. Bjercknes, *The Legal and Ethical Implications of Gag Clauses in Physician Contracts*, 22 AM. J. L. & MED. 433, 443 (1996). Martin and Bjercknes cite four areas of restricted physician-patient speech under these gag rules. These include restraints on physicians discussing the full range of available treatment options with their patients, bans on

methods include refusals to cover therapy deemed by the organization to be "experimental"; upper limits or maximum quotas on primary care gatekeepers' referral of patients to outside services; and withholding some of each physician's payment to create a fund to cover specialists' costs when the plan determines that enrollees have overused these specialists' services.³³ Additionally, some types of payment systems used by managed care organizations furnish incentives for physicians to keep costs as low as possible.³⁴ Finally, the plans structure some explicit incentives for physicians to reduce costs. By paying the physicians year-end bonuses out of pools set up for specialist treatment and other ancillary services, some plans create

physicians revealing the plan's payment and incentive structure, prohibitions against physicians discussing other health care providers with their patients, and prohibitions against physicians participating in political debate relating to health care. *See id.* *See also* Jennifer L. D'Isidori, *Stop Gagging Physicians!*, 7 HEALTH MATRIX 187, 194-99 (1997). While critics of managed care have denounced gag rules, managed care organizations dispute the prevalence and purpose of such clauses. *See The News Hour with Jim Lehrer: A Bill of Health* (PBS television broadcast, Feb. 5, 1998) (transcript on file with the author); Frank Bass, *Insurer Alters "Gag Rule" after Outcry*, WALL ST. J., May 29, 1996 at T1. Bill Gradison, president of the Health Insurance Association of America, an organization composed of managed care companies, admitted that gag clauses did exist in physician—managed care organization contracts at one time, but insisted that the industry had changed with respect to this practice, "without the necessity of passing laws to [bring about the change]." *See NewsHour, supra*. Public pressure in Texas forced the HMO Humana, Inc. to abandon its policy of requiring physicians to contact its hospital preadmission review department "before conveying the possibility of admission to [a] plan member." *See Bass, supra*, at T1. A spokesman for Humana defended the policy as simply a means of ensuring that physicians do not confuse patients by leading them to believe that a noncovered treatment is actually covered. *See id.*

Several states have passed laws banning gag rules. *See id.* Missouri, for example, enacted such a measure as part of its managed care reform bill in 1997. *See* H.B. 335, 89th Leg., 1st Reg. Sess. (Mo. 1997). Section 354.441 of the bill provides:

No health maintenance organization plan, medical group/staff model, independent practice association or other entity shall prohibit or restrict any provider from disclosing to any subscriber, enrollee or member any information that such provider deems appropriate regarding the nature of treatment, risks or alternatives thereto, the availability of other therapy, consultation or test, the decision of any plan to authorize or deny services, or the process that the plan or any person contracting with the plan uses or proposes to use, to authorize or deny health care services or benefits.

33. Noah, *supra* note 7, at 1226.

34. By paying physicians either on a salary or a capitation basis, some of these organizations ensure that physicians, who are paid one fee regardless of the amount of care they provide, will have a financial interest in providing the least amount of care possible. *See* Latham, *supra* note 27, at 404-05.

a disincentive for physicians to refer patients to specialists.³⁵ Other plans pay physicians the amount of their fees withheld by the plan throughout the year minus any amount spent on specialists' services.³⁶

A. ERISA

Congress established ERISA in 1974 to protect employees' retirement accounts and general benefit plans.³⁷ The drafters of the legislation intended it to deter mismanagement and abuse of employee benefit funds and to establish a mechanism for the uniform regulation of pensions.³⁸

In order to facilitate this uniformity in benefit administration, the authors of ERISA included in it an express preemption clause, which

35. *Id.* Under some state laws, managed care companies have had to strike or restructure mechanisms like this, which encourage physicians to limit referrals to specialists. See *Letter to Provider, Amendment to HealthLink HMO Agreement*, Jan. 15, 1998 (on file with the author). In this letter, HealthLink, an HMO, informs its providers about the amendments to the HealthLink provider-HMO contract under Missouri's revised health insurance laws. *Id.* The letter states in relevant part, "House Bill 335 requires that contracts and arrangements do not 'induce a provider to limit, restrict or deny access to, or delivery of, medical or other services prior to the delivery of such services.' Accordingly, we are eliminating the primary care physician incentive program." *Id.* HealthLink states that "[t]he purpose of the [incentive] program was to provide incentives for effective management of utilization." *Id.*

36. Latham, *supra* note 27, at 404-05. Latham asserts that insurers increasingly use these kinds of incentives for physicians to provide less care and cheaper care. He cites a survey showing that approximately half of American physicians have at least some patients whose plans use capitation, or payment withholding mechanisms in fee-for-service schemes. See *id.* at 405 (citing Physician Payment Review Committee, *Physician Practices Report*, at 46,846).

37. Perdue & Baxley, *supra* note 3, at 59. The bill's sponsor, Sen. Javits, described ERISA's purpose as "maintain[ing] the voluntary growth of private [pension and employee benefit] plans while at the same time making needed structural reforms in such areas as vesting, funding, termination, etc. so as to safeguard workers against loss of their earned or anticipated benefits" See Michael S. Gordon, *Overview: Why Was ERISA Enacted*, in U.S. Senate Special Comm. On Aging, 98th Cong., 2d Sess., *The Employee Retirement Security Act of 1974: The First Decade* 25 (Comm. Print 1984), cited in Catherine L. Fisk, *Lochner Redux: The Renaissance of Laissez-Faire Contract in the Federal Common Law of Employee Benefits*, 56 OHIO ST. L. J. 153, 169 n.57 (1995), cited in Margaret G. Farrell, *ERISA Preemption and Regulation of Managed Health Care: The Case for Managed Federalism*, 23 AM. J. L. & MED. 251, 251 (1997).

38. Farrell, *supra* note 37, at 260. Under ERISA, employee plans are of two types: pension, which provides income deferral or retirement income; and welfare, under which plans administer "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, or death." See 29 U.S.C. § 1002 (1).

makes nugatory all state law that “relates to” employee benefit plans.³⁹ The Supreme Court has interpreted the preemption clause as preempting any state law with “a connection with or reference to such a plan.”⁴⁰ Although it would seem from the language of the preemption clause that ERISA would preempt any state law action that a plaintiff would bring against a plan, this is not the case.⁴¹ Under ERISA’s “savings clause,” ERISA reserves to the states their traditional right to regulate insurance.⁴² Thus, the Supreme Court has held that the savings clause allows a state to require its insurers to provide a particular benefit under its power to regulate the business of insurance.⁴³ Under the savings clause, however, state law causes of action for improper processing of benefit claims do not constitute the regulation of the business of insurance and so fall subject to ERISA preemption.⁴⁴ The “deemer” clause prevents self-insured employee benefit plans from regulation by state insurance laws by deeming them not insurance companies for the purposes of the savings

39. 29 U.S.C. § 1144 (a) (1988). Section 514 of ERISA states that “except as provided in sub-section (b) of this section, the provisions of this subchapter . . . shall supercede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan.” *Id.*

40. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983).

41. ERISA contains a “savings” clause, which preserves states’ rights to regulate insurance, banking, and securities. 29 U.S.C. § 1144(b)(2)(A). The savings clause expressed Congress’ desire not to supplant all state laws regulating other areas of insurance long overseen by states. The Supreme Court has applied a three-pronged test to determine whether a state law regulates the business of insurance for savings clause purposes. The first step entails determining “whether the practice has the effect of transferring or spreading a policyholder’s risk.” Second, a practice concerns the business of regulating insurance if it “is an integral part of the policy relationship between the insurer and the insured.” Finally, the practice regulates the business of insurance if it also “is limited to entities within the insurance industry.” See *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982), cited in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743 (1985) (holding a state law requiring health insurance plans to cover treatment of mental illness satisfied the provisions of the savings clause as a practice regulating the business of insurance). ERISA’s “deemer” clause sets forth that employee benefit plans shall not be considered “insurance compan[ies] or other insurer[s] . . . or to be engaged in the business of insurance . . . for the purpose of any law.” See 29 U.S.C. § 1144 (b)(2)(B). Thus, the deemer clause prevents self-insured employee benefits plans from falling under state insurance regulations. See Farrell, *supra* note 37, at 263.

42. 29 U.S.C. § 1144(b)(2)(A). See *supra* note 41 for an explanation of the operation of the savings clause.

43. *Union Labor Life Ins. Co.*, 458 U.S. at 129.

44. *Pilot Life Ins. v. Dedeaux*, 481 U.S. 41, 48-49 (1987). For the test to determine whether a law concerns the regulation of the business of insurance, see *supra* note 41.

clause.⁴⁵

The Supreme Court held in *Shaw v. Delta Air Lines* that “[s]ome state actions may affect employee benefit plans in too tenuous, remote or peripheral a manner to warrant a finding that the law “relates to” the plan.”⁴⁶ Some courts thus have allowed plaintiffs to bring actions against such plans on vicarious liability theories, where the plan was at fault for hiring and retaining physicians who themselves were liable for malpractice.⁴⁷ A California case suggested the possibility of liability for managed care organizations if their cost-containment policies result in a violation of a standard of care.⁴⁸

45. 29 U.S.C. § 1144(b)(2)(B). The term “self-insured” refers to the practice of some employers of insuring their employee benefits plans themselves, instead of through a third party insurer or an HMO. See Farrell, *supra* note 37, at 263.

46. *Shaw v. Delta Air Lines*, 463 U.S. at 100 n.21 (citing *AT&T v. Merry*, 592 F.2d 118, 121 (2d Cir. 1979)). See *supra* note 41 for a discussion of the deemer clause.

47. See Noah, *supra* note 7, at n.119 (citing *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Prihoda v. Shpritz*, 914 F. Supp. 113, 117-18 (D. Md. 1996); *Jackson v. Roseman*, 878 F. Supp. 820, 825 (D. Md. 1995); *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544, 548 (S.D. Ill. 1994)). In *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 356 (3d Cir. 1995), *cert. denied* 116 S. Ct. 564 (1995), the Third Circuit held that when a plaintiff sues a plan for negligence due to the poor quality of the services rendered, this does not fall within the purview of ERISA’s civil enforcement provision, § 502 (a)(1)(B), and thus state courts can apply state tort law to the matter. *Dukes* involved two cases in which the plaintiffs brought claims for wrongful death based on theories of indirect and direct negligence. The plaintiffs based their indirect negligence claims on an ostensible agency theory and claimed that the managed care organization had held out the allegedly negligent physicians as agents and thus should incur liability when the physicians negligently failed to administer proper care. *Dukes*, 57 F.3d at 352-53. The plaintiffs sued for direct negligence based on theories of negligent hiring, retention, and supervision of the physicians. *Id.* The court acknowledged that plaintiffs find their only remedies for denial of benefits, enforcement of their rights under their health plans, and requests for future benefits under ERISA’s civil enforcement provision. *Id.* at 356. The claims at issue in *Dukes*, however, addressed the quality of the plaintiffs’ benefits, for which ERISA’s civil enforcement clause does not provide a remedy. *Id.* Thus, the court concluded that it should remand these negligence issues to the state court. *Id.*

48. See *Wickline v. California*, 239 Cal. Rptr. 810 (Cal. Ct. App. 1986). In this case a patient sued her insurer for its decision to require her discharge from the hospital four days earlier than the time initially recommended by her surgeon. The patient developed complications after her release, which resulted in the amputation of her leg. *Id.* at 668. The treating physician asserted that the patient’s leg would not have required amputation had she been allowed to remain in the hospital, because her post-operative problems would have been diagnosed and treated in a timely manner. *Id.* at 662. The court did not hold the insurer liable, based on its finding that the company’s utilization review consultant had not breached relevant medical standards of care in prescribing the earlier discharge. *Id.* at 670-71. The court further held, though, that had the organization’s utilization review process violated the standard of care in its decision to withhold payment for further hospitalization, it could have been held liable. *Id.* at 671. While the organization did recommend this earlier release, the patient’s physician still

The holding of this case, however, seems limited to plan decisions that amount to a mistaken or medically insufficient recommendation under the plan utilization review process.⁴⁹

To mark the boundaries of ERISA preemption more clearly, the Supreme Court expanded on its *Shaw* definition of "relate to" in *New York Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*⁵⁰ In this case, the Court upheld a New York state law which imposed surcharges on certain health insurers.⁵¹ ERISA did not preempt the rate-setting scheme because it did not require plans to provide any particular benefits, and its effect on the health plans was too indirect to "relate to" the plans for the purposes of ERISA.⁵²

By contrast, courts have dismissed state actions brought by plaintiffs for a plan's denial of certain benefits. Courts have held that these coverage denials "relate to" the plan and thus fall under the preemption clause of ERISA.⁵³ Furthermore, when an action "relates

carried potential liability, for he had the burden of appealing any decisions made by the organizations that he believed would deprive the patient of adequate care. *Id.* at 671.

49. The case of *Wilson v. Blue Cross*, 271 Cal. Rptr. 876 (Cal. Ct. App. 1990), illustrates the potential for organizational liability when a plan mistakenly denies benefits authorized under its terms. In *Wilson*, the court found it possible that an insured person's suicide stemmed from the plan's refusal to pay for the length of hospitalization deemed necessary by the insured's psychiatrist. *Id.* at 883. The organization had told the treating physician that it disagreed with the doctor's assessment of the patient's need for hospitalization and would pay for only eleven days' hospitalization, not the three to four weeks recommended by the doctor. *Id.* at 882. The patient lacked the resources to pay for the remainder of the time and thus had to leave the hospital. *Id.*

Twenty days after his release, the patient committed suicide. *Wilson*, 271 Cal. Rptr. at 878. The court refused to exempt the company from tort liability and relied on common law tort causation principles to arrive at its decision. *Id.* at 883.

50. 115 S. Ct. 1671 (1995).

51. *Id.* at 1682.

52. *Id.* at 1679. The Court found this rate surcharge system was intended to aid plans that insure higher risk patients by making these companies more competitive with commercial insurers. *Travelers*, 115 S. Ct. at 1678. According to the Court, the surcharges system had only an "indirect economic influence . . . [and] does not bind plan administrators to any particular choice of benefits . . ." *Id.* at 1679.

53. Noah, *supra* note 7, at 1243. See *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 57 (1987). In this case, the Court held that ERISA preempted a bad faith breach of contract claim against the insurer of the plaintiff's disability benefits. *Id.* The Court reasoned that Congress had intended that ERISA would furnish the exclusive remedy for improper administration of benefits. *Id.* at 52-54.

With respect to denials of coverage, health plans typically include clauses in their beneficiary handbooks listing procedures for which the plans will not pay. Additional clauses disclaim liability for the costs of treatment designated as "experimental" or "investigatory."

to” an ERISA-covered plan, an enrollee’s exclusive remedy is provided under ERISA sections 502 and 409.⁵⁴ These ERISA remedies can prove insufficient, however, in which case an injured enrollee can find himself with no remedy available under either state or federal law. *Corcoran v. United Health Care, Inc.* illustrates such a situation.⁵⁵

In *Corcoran*, Florence Corcoran, an employee of South Central Bell Telephone Company, had obtained insurance through Bell’s Medical Assistance Plan, an ERISA-qualified plan.⁵⁶ Mrs. Corcoran became pregnant, and her obstetrician diagnosed her condition as high-risk. The obstetrician recommended bed rest during the final

Borzi, *supra* note 7, at 136-37. Plaintiffs then bring claims to protest a plan’s denial of coverage for treatment such as bone marrow transplants with high doses of chemotherapy. Ordinarily the plans grant their medical directors the ultimate authority to determine what constitutes “experimental” and “investigatory.” Borzi, *supra* note 8, at 136-37. Many courts have upheld the rights of the plan to determine which categories of care it will not cover and have allowed the plans significant leeway in determining what constitutes “experimental therapy.” *See Peruzzi v. Summa Medical Plan*, 137 F.3d 431, 433 (6th Cir. 1998) (holding high dose chemotherapy and bone marrow transplant for breast cancer reasonably could have been considered experimental and so excluded from coverage); *Turner v. Fallon Community Health Plan, Inc.*, 127 F.3d 196, 200 (1st Cir. 1997) (holding ERISA preempted state law wrongful death claim, based on improper denial of bone marrow transplant with high dose chemotherapy for metastatic breast cancer); *Painter v. Golden Rule Ins. Co.*, 121 F.3d 436, 439 (8th Cir. 1997) (holding state law contract claim for bad faith denial of cancer treatment was preempted by ERISA); *Cannon v. Group Health Serv. Of Oklahoma*, 77 F.3d 1270, 1275 (10th Cir. 1996) (holding denial of coverage for a bone marrow transplant for leukemia was preempted by ERISA); *Variety Children’s Hospital v. Century Medical Health Plan*, 57 F.3d 1040, 1042 (11th Cir. 1995) (holding a hospital’s suit to compel payment by HMO for high dose chemotherapy and bone marrow transplant preempted by ERISA); *Hubbard v. Blue Cross & F.* 3d 942, 945 (5th Cir. 1995) (holding that plaintiff’s state law fraudulent inducement claim that unclear plan language led her to believe her ovarian cancer treatment would be covered was preempted by ERISA); *Bechtold v. Physicians Health Plan of Northern Indiana, Inc.*, 19 F.3d 322, 327 (7th Cir. 1994) (holding that the plain language of the plan allowed administrators to deny coverage of bone marrow transplant and high dose chemotherapy for a young patient even though physicians deemed this not experimental for young patients); *Hermann Hosp. v. MEBA Medical and Benefits Plan*, 959 F.2d 569, 578 (5th Cir. 1992) (holding state law fraudulent inducement and breach of contract claims were preempted by ERISA when the health plan refused to pay for certain cancer treatment).

54. ERISA allows beneficiaries to sue in federal court to “recover benefits due under the terms of [their] plans, to enforce [their] rights under the terms of the plan, or to clarify [their] rights to future benefits under the terms of the plan.” *See* 29 U.S.C. § 1132(a)(1)(B) (1994). ERISA § 503(a)(1) also requires that a plan’s denial of care for particular treatment “set forth specific reasons for the denial.”

55. 965 F.2d 1321 (5th Cir. 1992).

56. *Id.* at 1323.

months of Mrs. Corcoran's pregnancy; however, the plan administrators denied her request for temporary disability benefits for the last months of her pregnancy.⁵⁷ Due to this denial, the obstetrician wrote to Bell's medical consultant to advise him that Mrs. Corcoran was carrying a high-risk pregnancy. The plan's medical consultant inquired about Mrs. Corcoran's condition, and his consulting specialist, an obstetrician, explained that the company was pursuing a risky course in ignoring Mrs. Corcoran's obstetrician's recommendation.⁵⁸ As Mrs. Corcoran approached her due date, her doctor ordered hospitalization to allow for full-time fetal monitoring.⁵⁹ Mrs. Corcoran's obstetrician requested pre-certification for her hospitalization, as required under the terms of the health plan.⁶⁰ The organization, United HealthCare, however, refused this request, reasoning that hospitalization was not medically necessary.⁶¹ In lieu of hospitalization, United provided for home monitoring by a nurse.⁶² Following this denial of coverage, Mrs. Corcoran returned home from the hospital, where she had stayed pending a decision by the health plan. Thirteen days after Mrs. Corcoran had left the hospital, the fetus became distressed and died during a period when the nurse was off-duty.⁶³

The Corcorans brought a wrongful death suit in Louisiana state court against Blue Cross and United, as well as actions for loss of consortium and aggravation of Mrs. Corcoran's depression.⁶⁴ Defendants Blue Cross and United removed the case to federal district court after convincing the court that the case "related to" an ERISA-governed plan.⁶⁵ Blue Cross and United prevailed in district court on ERISA preemption grounds as well, and the court granted

57. *Id.* at 1322.

58. *Id.*

59. *Id.* at 1322-23.

60. *Corcoran*, 965 F.2d at 1324.

61. The plan determined this through its utilization review procedure. *Id.* at 1322-24.

62. *Id.*

63. *Id.*

64. Blue Cross and Blue Shield of Alabama served as the administrator of the plan, while United administered the plan's "Quality Care Program," which provided for pre-certification of procedures and utilization review. *Corcoran*, 965 F. 2d at 1323.

65. *Id.* at 1324.

their motion for summary judgment.⁶⁶

On appeal to the Fifth Circuit Court of Appeals, the Corcorans argued that the district court incorrectly held that ERISA pre-empted their state tort action against United.⁶⁷ The Fifth Circuit, however, upheld the district court's decision, explaining that, although the health plan did make determinations about medical matters, this did not alter its status as shielded from state tort actions under ERISA.⁶⁸ While the court viewed this result as "compelled" by ERISA, it noted that the consequence of this decision was that "the Corcorans have no remedy, state or federal, for what may have been a serious mistake."⁶⁹

B. Congressional Proposals for Managed Care Reform: Patient Access to Responsible Care Act

To address the managed care organizations' perceived lack of commitment to patients' health interests, as demonstrated by cases like *Corcoran*, members of Congress have proposed various pieces of managed care reform legislation.⁷⁰ The bill proposed by Rep. Charles Norwood and Sen. Alfonse D'Amato, the Patient Access to Responsible Care Act (PARCA), includes a range of provisions designed to further the interests of consumers and providers of managed care.⁷¹ Provisions of the bill include those that guarantee

66. *Id.* at 1325.

67. *Id.* at 1326.

68. *Corcoran*, 965 F.2d at 1331. "United makes medical decisions, . . . it does so in the context of making a determination about the availability of benefits under the plan[,] . . . [and] the Louisiana tort action asserted by the Corcorans . . . is pre-empted by ERISA." *Id.*

69. *Id.* at 1338. ERISA provided no remedy for the Corcorans either, for the court determined that § 502(a)(3) of ERISA, which allows for "other equitable relief," did not include damages for emotional distress. Because the plan had paid the actual medical expenses of Mrs. Corcoran, § 502(a)(1)(B) was not an appropriate channel for relief. *Id.* at 1334-35.

70. Rep. Charles Norwood expressed his concern for the problems faced by patients and providers operating under managed care: "We have seen an alarming number of horror stories from around the country of patients denied access to necessary care, of providers being told what they can tell their patients about treatment options, of denied reimbursement of catastrophic-level medical expenses because of fine-print technical clauses in insurance plans." See HEALTH NEWS DAILY, April 23, 1997, at 1, available in 1997 WL, HND.

71. H.R. 1415, 105th Cong. (1997). In the bill's opening statement, the sponsors have set forth the purpose of the bill: "To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to establish standards for relationships between group

enrollees access to care by specialists, require plan coverage of emergency treatment without prior certification by health plan administrators, ban "gag rules," require health plans to furnish consumers with certain services such as fair and prompt utilization reviews and payment of claims, and mandate that health plans follow certain procedures for terminating physicians.⁷² While these provisions address issues important to patients and providers alike, the bill's proposed amendment of ERISA to allow plan enrollees to sue their health plans for medical malpractice has attracted considerable attention from insurance companies and managed care organizations.⁷³

Under ERISA as it currently exists, health plan beneficiaries cannot bring suit against the plan for medical malpractice because ERISA exempts such plans from state tort law under its preemption clause.⁷⁴ The PARCA amends ERISA to remove its clause preempting state tort law in matters relating to employee benefit plans.⁷⁵

C. Managed Care Plan Accountability Act

While the Norwood-D'Amato bill would permit plaintiffs to bring causes of action against ERISA under state tort law, a proposal introduced by Reps. Pete Stark, Nita Lowey, George Miller, and Dale Kildee would allow plaintiffs to sue in federal court for compensatory and punitive damages currently denied under ERISA remedies.⁷⁶

health plans and health insurance issuers with enrollees, health professionals, and providers." *Id.*

72. HEALTH NEWS DAILY, *supra* note 70, at 1-2. See *supra* note 32 and accompanying text for a discussion of gag rules.

73. See *New Bill Opens Malpractice Door to Health Plans*, MEDICAL INDUSTRY TODAY, April 24, 1997, at 29, available in LEXIS, Genmed Library, Alljrn File (describing the ERISA amendment as "one of the most controversial provisions [of the PARCA]").

74. See *supra* note 41 and accompanying text for an explanation of ERISA's preemption clause.

75. The PARCA amends § 514(b) of ERISA through the addition of the following paragraph: "(9) Subsection (a) of this section shall not be construed to preclude any State cause of action to recover damages for personal injury or wrongful death against any person that provides insurance or administrative services to or for an employee welfare benefit plan maintained to provide health care benefits." See H.R. 1415, 105th Cong. § 4 (1997).

76. See H.R. 1749, 105th Cong. (1997) ("Managed Care Plan Accountability Act"). See also Health News Daily, May 23, 1997, available in WL, HND (summarizing the Managed

Under the Stark-Kildee proposal, HMOs would face liability for patient injuries that stem from their negligent actions—even if the action at issue entailed merely administering the plan as designed.⁷⁷ Furthermore, the Stark-Kildee bill would require plans to indemnify providers for any malpractice liability they incur that results from a plan's restrictions on provider-patient communications.⁷⁸

Care Plan Accountability Act). Currently ERISA's civil enforcement provision allows civil suits in certain circumstances. A plan participant or beneficiary may sue for damages when a plan's administrators fail to provide certain information requested by the participant or beneficiary or in order to recover benefits due him under the plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan. *See* ERISA § 502(a)(1)(A) & (B). Additionally, a plan secretary, beneficiary, participant, or fiduciary may sue for breaches of fiduciary duty imposed on plan fiduciaries by § 409(a) ERISA. *See* ERISA § 502(a)(2). Designated persons also may sue for a plan's failure to abide by the tax registration procedures of ERISA. *See* ERISA § 502(a)(4). Finally, a participant, beneficiary, or fiduciary may bring suit to enjoin any act or practice which violates any provision of ERISA or the terms of the plan, or to obtain other appropriate equitable relief to redress such violations or to enforce any provisions of this subchapter or the terms of the plan. *See* § 502(a)(3)(A)-(B)(i)-(ii). The Supreme Court has held that § 502 (a) does not imply a private right to extracontractual damages not provided in the sections of ERISA. *See* *Varity v. Howe*, 515 U.S. 489, 495 (1995); *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 148 (1985). Thus, "other equitable relief" excludes extracontractual remedies such as punitive and pain and suffering damages for a private plaintiff. *See* *Corcoran*, 935 F.2d at 1338. Rather, plaintiffs recover their exclusive remedies in the cost of the procedure that the plan wrongfully denied to the plaintiff. *See* *Corcoran*, 935 F.2d at 1334-35. This civil enforcement mechanism provides the remedy for the aggrieved beneficiary who seeks benefits due but withheld from him under the plan. *See* ERISA § 502 (a)(1)(B). The Managed Care Plan Accountability Act would amend ERISA § 502 (c) to provide:

In any case in which a group health plan, or a health insurance issuer offering health insurance coverage in connection with such plan, provides benefits under such plan under managed care, and such plan or issuer fails to provide any such benefit in accordance with the terms of the plan or such coverage, insofar as such failure occurs pursuant to a clinically or medically inappropriate decision or determination resulting from—(i) the application of any cost containment technique, (ii) any utilization review directed at cost containment, or (iii) any other medical care delivery policy decision which restricts the ability of providers of medical care from utilizing their full discretion for treatment of patients, each specified defendant shall be jointly and severally liable to any participant or beneficiary aggrieved by such failure for actual damages (including compensatory and consequential damages) proximately caused by such failure, and may, in the court's discretion, be liable to such participant or beneficiary for punitive damages.

77. *See* HEALTH NEWS DAILY, *supra* note 70, at 1. Denying benefits available under the plan would result in liability for the organization because the organizations control which benefits they will cover, and their refusal to pay for procedures often determines the treatment the patient will or will not receive. *Id.*

78. H.R. 1749, 105th Cong. § 2(b) (1997). The bill's sponsors thus have attempted to curb the managed care organizations' temptations to impose gag rules on the providers with whom

D. Patients' Bill of Rights

In March, 1998, Rep. John Dingell introduced a Patients' Bill of Rights in the House, and Senator Tom Daschle introduced a parallel measure in the Senate. Both Patients' Bill of Rights proposals would amend ERISA's preemption provision to allow for lawsuits in state court against health plans and employers who sponsor them.⁷⁹ In addition to the ERISA amendment, these bills would impose numerous requirements on health plans. Examples of such requirements include: mandating that health plans allow beneficiaries to use emergency services without obtaining prior authorization,⁸⁰ requiring health plans to offer a point-of-service option to beneficiaries,⁸¹ and mandating that plan enrollees be allowed to participate in clinical trials and that plans cover the costs associated with such participation.⁸²

E. Other Managed Care Reform Proposals with Amendments to ERISA

Also concerned about consumers' difficulties with managed care plans, Rep. Marge Roukema introduced the Quality Health Care and Consumer Protection Act.⁸³ This bill would require all managed care health plans to allow patients more choice of physicians; to pay for more drugs, health devices, and experimental treatment; to eliminate all gag rules; and to require plans to provide enrollees with information about the plans' grievance procedures and financial

they contract.

79. See H.R. 3605, 105th Cong. (1998), S. 1890, 105th Cong. (1998). The bills would permit suits against employers or other plan sponsors "only if [the lawsuit] is based on the employer's or sponsor's exercise of discretionary authority to decide a claim for covered benefits, and such exercise resulted in personal injury or wrongful death." H.R. 3605, § 302; S. 1890, § 302.

80. See H.R. 3605, § 101; S. 1890, § 101.

81. See H.R. 3605, § 102; S. 1890, § 102.

82. See H.R. 3605, § 106; S. 1890, § 106.

83. H.R. 1222, 105th Cong. (1997). Rep. Roukema noted the "disturbing trend of the health insurance industry putting bottom-line medicine ahead of quality medical care" and urged her colleagues in the House not to "allow green-eyeshaded bean counters in insurance company accounting departments" to rob Americans of their world renowned medical care. See CONG. REC. E563 (daily ed. Mar. 21, 1997) (statement of Rep. Roukema).

arrangements with plan medical directors.⁸⁴ The bill adds the above consumer protection provisions to ERISA as well, thus ensuring that plans regulated under ERISA also will provide these services.⁸⁵ Other members of Congress also have proposed similar measures designed to correct the perceived shortcomings of managed care plans.⁸⁶

While some bills have proposed sweeping legislation that would mandate that managed care organizations provide certain benefits and administrative procedures for their enrollees, other bills, like the Norwood and Stark measures, remove the ERISA preemption shield from managed care organizations. Rep. Pallone, for example, introduced a bill that would amend § 514(b) of ERISA to allow beneficiaries to sue health insurance companies in state court for damages for personal injury or wrongful death.⁸⁷ Similarly, Rep. Valezquez's "Managed Care Bill of Rights for Consumers Act" requires all managed care organizations to establish certain quality, access, and procedural safeguards, and allows for state laws to supercede the new ERISA provisions if they offer stricter standards for patient care and service.⁸⁸

In contrast to the measures that would remove ERISA protection for managed care organizations, however, Rep. Fawell has introduced a bill that would extend ERISA preemption to health insurance purchasing cooperatives organized through trade, business, and

84. H.R. 1222, 105th Cong. § 3(a) (1997).

85. *Id.* Rep. Roukema's bill would include all these provisions under ERISA at 29 U.S.C. 1185 et seq. by adding a new § 713. *See* H.R. 1222, 105th Cong. § 3 (1997).

86. Rep. Nadler's bill to reform managed care lists certain benefits and appeals procedures managed care plans must provide their enrollees. This "Comprehensive Managed Health Care Reform Act", like Rep. Roukema's bill, amends ERISA to guarantee that ERISA plans will provide the enumerated benefits and services to their enrollees. *See* H.R. 2905, 105th Cong. (1997). *See also* Sen. Kennedy's "Health Insurance Bill of Rights Act," which would amend ERISA to guarantee ERISA plan beneficiaries improved access to emergency care, specialists, the physicians of their choice, and prescription drugs; the right to participate in clinical trials; and more efficient complaint and appeals procedures, among other provisions. S. 353, 105th Cong. (1997). Rep. Lowey's managed care bill also would amend ERISA, albeit for the narrower purpose of providing managed care plan enrollees with access to a wider range of prescription drugs. *See* H.R. 1525, 105th Cong. § 2(d) (1997).

87. H.R. 3009, 105th Cong. § 204 (1997). This "Health Care Consumer Protection Act" also contains requirements for quality of care, access to care, information disclosure, and appeals processes for providers. *Id.* at (I)-(III).

88. H.R. 2606, 105th Cong. § 3 (1997).

professional associations.⁸⁹ Rep. Fawell portrayed his bill as a means of making health care accessible and affordable for those who work in small businesses.⁹⁰ The sponsors of this bill intended that these newly formed Association Health Plans would help small businesses by allowing them the efficiencies and effectiveness of collective bargaining with providers and insurers and by allowing cost savings through the ERISA preemption of state health care laws.⁹¹ Rep. Fawell has criticized competing bills that would impose coverage and operating requirements on health care insurers, thereby increasing costs and making health insurance prohibitively expensive for employers and employees.⁹²

II. THE EFFECT OF THE PROPOSED ERISA AMENDMENTS ON MANAGED CARE

The proposed ERISA changes would affect health care consumers, health care providers, managed care organizations, and employers in different ways and to varying extents. Most of the proposed reforms create the risk of increased costs for the managed care organizations and the employers who provide benefits to their employees.⁹³ With respect to patients' interests, the proposals would

89. H.R. 1515, 105th Cong. (1997). Rep. Fawell has designated his measure the "Expanded Portability and Health Insurance Coverage Act."

90. CONG. REC. E830 (daily ed. May 1, 1997) (statement of Rep. Fawell). In his speech on the floor of the House, Rep. Fawell described the "problem of the uninsured, both children and adults, [as] a problem of small businesses lacking access to affordable health coverage." *Id.*

91. *Id.* Rep. Fawell estimates that the employers affected by the bill "could save as much as 30 percent in overhead costs and that up to one-half of the 40 million uninsured would find accessible and affordable health care in the private market . . . without new taxes or costly mandates." *Id.*

92. CONG. REC. *supra* note 83, at E830.

93. The amount by which health care costs would rise as a result of such reforms is a source of debate. One study released by the Health Benefits Coalition, a pro-managed care group, predicted that the PARCA could add costs to U.S. health care delivery of nearly \$1 billion per year. See *Study Calls PARCA the Billion-Dollar Bill*, MEALEY'S LITIGATION REP.; MANAGED CARE, Mar. 24, 1998, available in 1998 WL 6MLRMC13. Similarly, a study commissioned by the American Association of Health Plans concluded that the passage of the PARCA or a similar bill would result in a 10 percent increase in health costs in the U.S. See Mary Sit-DuVall, *Adding Up the Bills*, HOUSTON CHRON., June 16, 1998, at 1 (Business section), available in LEXIS, News Library, Cumws File. The Kaiser Family Foundation, however, released a study conducted by the accounting firm Coopers & Lybrand which predicts only a modest increase in health costs due to bills like the PARCA or the Patients' Bill of

expand beneficiaries' rights to a variety of health care services and procedural protections. These rights may come at a cost to enrollees, however, in the form of higher premiums passed on by employers and managed care organizations.⁹⁴

With the exception of Rep. Fawell's bill, each of the comprehensive proposals would impose specific provider availability requirements on managed care organizations.⁹⁵ These provisions restrict the freedom of managed care organizations to contract with the kinds and numbers of providers they choose. This kind of provision could make the plans more expensive for managed care companies to administer if it resulted in the organizations hiring more physicians or paying more claims on behalf of patients. For patients, this would allow improved access to physicians, and could increase their consumption of physicians' services.

Additionally, the provisions in many of these plans, which give consumers certain rights to specialty care, have the potential to affect both the health plan payors and beneficiaries.⁹⁶ Insofar as these

Rights. See *Consumer Health Mandates May Raise Premiums a Little or a Lot—Depending*, MED. UTILIZATION MGMT, May 14, 1998, available in LEXIS, Legnew Library, Allnws File.

94. While the Kaiser Family Foundation study estimates that the PARCA could result in an increase in premiums of \$40 per year for the typical family HMO policy, see Sit-DuVall, *supra* note 93, at 1, the AAHP study predicted possible increases in premiums of 2.2 to 8.6 percent, see *Consumer Health Mandates*, *supra* note 93, a significant amount, considering the fact that a typical family HMO policy costs \$5160 per year. See Sit-DuVall, *supra* note 93, at 1. The AAHP has criticized the Kaiser study for its exclusion of the costs of expanded tort liability for managed care organizations under the PARCA from its study. See *Consumer Health Mandates*, *supra* note 93.

95. See PARCA, H.R. 1415, at § 2771(a)(1): "[A] health insurer shall establish and maintain adequate arrangements, as defined by the applicable State authority, with a sufficient number, mix, and distribution of health professionals and providers to assure that covered items and services are available and accessible to each enrollee under health insurance coverage." Rep. Stark's bill contains a similar provision governing access to health care. See H.R. 1749, at § 100 (A). The Patients' Bill of Rights measures, in addition to their requirement of POS options, further contain provisions mandating that patients be allowed to choose any participating providers under their plans. See H.R. 3605, § 103; S. 1890, § 103. Rep. Nadler's Comprehensive Managed Health Care Reform Act also describes its provider availability and access requirements in language almost identical to that of the PARCA. See H.R. 2905, at § 4(a). See also H.R. 1222, at § 713(a); S. 353, at § 713, subpart 1; H.R. 3009, at §§ 2770, 102; H.R. 2606, at §§ 2773, 2774.

96. See H.R. 1415, *supra* note 71, at § 2(c) ("A health insurance offering network coverage shall demonstrate that enrollees have access to specialized treatment when such treatment is medically or clinically indicated in the professional judgment of the treating health professional . . ."); H.R. 3605, § 104; S. 1890 § 104 ("If the individual has a condition or

access-to-specialists requirements would increase the use of specialists by enrollees, costs would rise for managed care organizations and the employers who purchase the group policies. It is unclear, though, whether these provisions actually would result in increased treatment by specialists on a broad scale.⁹⁷

Furthermore, provisions in the bills that prohibit financial incentive plans designed to encourage doctors to limit care could increase the costs of the plans if patients consume more care, or more expensive care, as a result.⁹⁸ No one can predict for certain, though, the effects of removing these incentives on the amount of care patients receive.⁹⁹

The impact of the proposals' mandatory procedural safeguards would depend on the ease with which enrollees could avail themselves of these provisions and the extent to which patients understand their rights under them. Most of the proposals would establish procedural guidelines under which all managed care organizations would structure their complaint and appeals

disease of sufficient seriousness and complexity to require treatment by a specialist, . . . the plan or issuer shall make or provide for a referral to a specialist . . ."; H.R. 2905, at § 4(b)(1); H.R. 1222, at § 713(a)(1)(B)(4) (imbuing patients with the right to "[t]he availability of specialty medical services, including physical therapy, occupational therapy, and rehabilitation services"); S. 353, at § 713, subpart 1, § 2772; H.R. 2606, at § (c) (2776).

97. The HealthLink HMO agreement noted that "[u]nfortunately," its primary care incentive program for "effective management of utilization" did not result in decreased use of specialists by patients. *See supra* note 35. Thus, if primary care physicians refer patients to specialists as often as is needed, and no more, this specialist access provision would be unlikely to change rates of specialist care consumption. *But see* *Shea v. Eesensten*, 107 F.3d 625, 625 (8th Cir. 1997) ("Despite all the warning signs [of a heart attack], Mr. Shea's doctor said a referral to a cardiologist was unnecessary. . . . Unknown to Mr. Shea, [the health plan's] contracts with its [] doctors created financial incentives that were designed to minimize referrals.").

98. *See, e.g.*, H.R. 1415, at § 2(d)(1)(A) ("No specific payment [may be] made directly or indirectly under the plan to a professional or provider or group of professionals or providers as an inducement to reduce or limit medically necessary services provided with respect to a specific enrollee."). *See also* H.R. 2606, at § c(2781) (imposing a strict prohibition on all such incentives to limit care). Rep. Roukema's bill would require only that a health plan inform beneficiaries of the financial arrangements between the plan and the participating providers. *See* CONG. REC., *supra* note 83, at E564.

99. One study detected no difference in treatment received by colorectal cancer patients in traditional fee-for-service plans, which give providers a natural incentive to provide more care, and HMOs, many of which use financial incentives to discourage their providers from "overtreating" patients. *See* KAREN DAVIS ET AL., HEALTH CARE COST CONTAINMENT 213-16 (1990), cited in Jack K. Kilcullen, *supra* note 2, at 28 n.192.

processes.¹⁰⁰ In order to ensure that patients know their rights to appeal denials and limitations of coverage under their plans, Rep. Roukema's bill would mandate that plans notify enrollees in writing of their right to file grievances.¹⁰¹ The PARCA would direct plan administrators to review complaints and appeals within a certain amount of time after the enrollees file their grievances.¹⁰² Such protections would help consumers take advantage of their right to appeal denials of treatment; however, this could come at the cost of extra administrative expense. If plans overturned many of their earlier coverage limitations on appeal, this would raise costs well above that added by the administrative expense of the more rigorous review procedures.

Although these and similar measures interfere with the autonomy of managed care organizations to decide how much and what kind of health care to provide, the PARCA's and Patients' Bill of Rights' provisions eliminating ERISA preemption for state law causes of action against managed care organizations has generated the most vocal opposition among managed care organizations and employers.¹⁰³ Lobbying groups representing these interests have warned that, if enacted, bills like the PARCA and the Patients' Bill of Rights could pave the way for a flood of litigation while not improving health care for plan beneficiaries.¹⁰⁴ Additionally, these groups contend that removing ERISA preemption of malpractice suits would raise the costs of providing health insurance, thus putting health care out of the reach of many employees.¹⁰⁵ Finally, these

100. See H.R. 1415, at § 2 (2775); CONG. REC., *supra* note 83, at E564; H.R. 3605, at §§ 131-133; S. 1890, at §§ 131-133; H.R. 2905, at § 9; S. 353, at § 713 (2784-2785); H.R. 3009, at § 5 (501) & (2781); H.R. 2606, at § 3 (2783).

101. See CONG. REC., at E564.

102. See H.R. 1415, at § c(2776)(b).

103. Gwen Moulton, *Insurance Regulation: Managed Care Reform Debate Hinges on Republican Leaders, Rank-and-File Support*, Jan. 19, 1998, available in LEXIS, Health Library, BNAHCP File. See also, William B. Schwartz, *Make HMOs Accountable Too*, WASH. POST, Sept. 15, 1998, at A21.

104. "Lawyers like this bill because without ERISA's preemption of state laws, they would be free to sue employers for medical malpractice. . . . This bill does nothing for patients and everything for lawyers," asserted a representative for the National Association of Manufacturers. See *Managed Care Regulation: NAM Study Blasts PARCA*, HEALTH LINE, Dec. 18, 1997, available in LEXIS, Legis Library, APN File.

105. In an interview with the author, a staff member of the House Subcommittee on

industry groups maintain that such reform measures represents unnecessary government interference in health care and that the market will correct for any deficiencies in the system if left alone.¹⁰⁶

Employee and Employer Relations noted that managed care plans and employers alike have voiced their disapproval of the PARCA. According to this staff member, employers fear lawsuits from employee-beneficiaries in the absence of ERISA preemption. Employers contend that the risk of employee suits against health insurers and against the employers who purchase the benefit plans would raise employers' costs and would result in employers offering cheaper, less generous benefit plans, or even no health benefits at all. These PARCA opponents assert that the bill thus would lead to restricted access to health care for employees. Telephone interview with Marjorie Watson, Assistant to the Subcommittee on Employer and Employee Relations (Feb. 20, 1998). See also Moulton, *supra* note 103 (discussing the liability risk for employers who administer their employees' benefits programs). It was for these reasons that Governor Lawton Chiles vetoed a measure passed in 1996 by the Florida legislature that would have created a cause of action for health plan malpractice. Gov. Chiles noted the concerns of the health insurance industry as well as those of employers: "[H]ealth costs could soar if plans became embroiled in litigation. . . . [S]uch legislation would destroy the benefits of managed care by gutting the concept of cost control." See *HMO Liability: Battle at State Level Heats Up*, HEALTH LINE, Jan. 12, 1998, available in LEXIS, Legis Library, APN File.

106. The president and CEO of the American Association of Health Plans questioned "whether (PARCA) represents the appropriate role of government in health care." See *PARCA: Debates Begin on Norwood's Bill Today*, HEALTH LINE, Oct. 23, 1997, available in LEXIS, Legis Library, APN File. The vice president for government affairs at the same organization insisted that many of the provisions in PARCA and other congressional bills simply duplicate policy changes already under way in state legislatures and in the managed care industry to address consumers' complaints. See *New Bill Opens Malpractice Door to Health Plans*, MEDICAL INDUSTRY TODAY, Apr. 24, 1997, available in LEXIS, Genmed Library. See also Robert Novak, *A Health Care Bill That's DOA*, WASH. POST, Feb. 2, 1998, at A22 ("[The PARCA] fits [President Clinton's] covert plans for big government."). Additionally, to warn against the dangers of some of the proposed legislation, the Health Benefits Coalition, a group that includes the National Federation of Independent Business, the U.S. Chamber of Commerce, the National Association of Manufacturers, the American Association of Health Plans, and the Health Insurance Association of America, placed an ad in a Capitol Hill newspaper declaring that the congressional bills "would mandate a monstrous bureaucracy." See David S. Hilzenrath, *Art Imitates Life when it Comes to Frustration with HMOs*, WASH. POST, Feb. 10, 1998, at C1. The CEO and chairman of the insurance company, Aetna, Inc., also wrote that "[a]lthough politicians seem not to notice, [quality assurance measures are] occurring without a federal mandate, a presidential task-force, or a new set of regulations from Congress. Yet somehow the belief persists in Washington that yet another dose of federal 'quality control' will make patients healthier." Richard L. Huber, *Let the Market Remedy What Ails Health Care*, WALL ST. J., July 13, 1998, at A14.

Patients' rights groups and members of Congress have pressured the health insurance industry to address health care consumer protection issues. See Moulton *supra* note 85. Among those advising the managed care industry to improve its consumer protection standards was Rep. Kasich, who had written to the AAHP in December, 1997 to warn the managed care industry that the pressing needs of health care consumers and the abuses under the current system would force Congress to enact regulations to reign in managed care organizations absent voluntary reforms on the part of the industry. See Moulton, *supra* note 103. In response to consumers' and policy maker's concerns, the American Association of Health Plans (AAHP)

Advocates for health care consumers counter that the right to sue plans for medical malpractice would provide an essential remedy to patients, which they now lack.¹⁰⁷ Furthermore, the bills' sponsors dispute the contentions that the bill would raise health care costs and make insurance unaffordable for those currently covered.¹⁰⁸ Finally, in response to criticism that proposals such as the PARCA mean federal intrusion into the health care market, Rep. Norwood describes the current ERISA preemption provision as government-mandated protection of the managed care industry.¹⁰⁹

Rep. Stark's Managed Care Plan Accountability Act would have less drastic effects on managed care organization liability than would the PARCA. While Rep. Stark's bill would allow plaintiffs to recover

developed *Putting Patients First*, a patient protection initiative that all of its more than one thousand member managed care organizations must adopt. See *Health Plans Vote to Require Patient-Centered Policies for Membership in AAHP* (1997) <<http://www.aahp.org>>. Managed care industry executives have argued that their organizations hardly need this nudging from government leaders, let alone the blunt force of federal regulations. Bill Gradison, president of the Health Insurance Association of America, explained why extensive government regulation is unnecessary for improving the delivery of health care: "[F]rankly, today in health care the consumers are king." *The News Hour with Jim Lehrer: A Bill of Health* (PBS television broadcast, Feb. 5, 1998).

107. The executive director of the Center for Patient Advocacy insisted that "unless patients have the right to sue, managed care companies will be free to deny services without fear of being held accountable." See *PARCA: Debate Begins on Norwood's Bill*, *supra* note 72. Rep. Norwood summed up the reason for the proposed bill: "[W]e're saying to the managed care companies, 'If you make decisions about utilization of care, the patient and provider should have some appeal to a higher authority other than your accountants.'" See Ronald M. Schwartz, *PARCA bill would rein in managed care*, AM. DRUGGIST, July, 1997, at 31, available in LEXIS, Genmed Library, Alljnl File. According to a study by Harvard University and the Kaiser Family Foundation, more than three out of five people surveyed said beneficiaries should have the right to sue their health care plans for malpractice. See Hilzenrath, *supra* note 106, at C1.

108. Rep. Norwood denied that his proposal would drive up costs for managed care organizations currently providing sufficient and fair benefits. He acknowledged, however, that for health plans that "do everything they can to add to the profit [rather] than to the care of the patient, there will be some cost." See Schwartz, *supra* note 78, at 31. While the opponents of PARCA emphasize the bill's potential to raise costs for the employer and beneficiaries, Rep. Norwood focused on the possible cuts in managed care organizations profits. He admonished, "[R]emember, these managed care companies take 30 cents out of the health care dollar. What we say is, 'You may not be able to have but 29 cents after this bill passes.'" See *id.*

109. Charlie Norwood, *Protection for Patients*, WASH. POST, Feb. 18, 1998, at A21. Rep. Norwood pointed out that "[h]ealth insurance is the only industry in this country that enjoys a federally mandated shield against liability for its actions . . ." *Id.* He further noted the irony that "those who oppose reform because of their dislike of government involvement don't have a bit of a problem supporting this kind of deadly involvement in the health care market." *Id.*

compensatory and punitive damages for a plan's improper denial of benefits, the bill includes this right as part of ERISA rather than allowing a state law cause of action.¹¹⁰ Thus, this bill introduces the risk that a managed care organization would have to pay punitive damages to a wronged beneficiary, yet does not expose the organizations to litigation under varying state laws.

By contrast, Rep. Fawell's bill proposes to add small business insurance purchasing groups to those health insurers sheltered from state and federal tort liability under ERISA's preemption provision.¹¹¹ While this bill would make insurance more affordable for small businesses and their employees, it would do this in part by shielding managed care organizations and employers from liability for medical cost containment policies and from state coverage mandates.¹¹² Thus, while more consumers would have access to health care, this bill would limit the patient protections available to them to the terms of the plan.¹¹³

III. PROPOSAL: THE MODEL HEALTH CARE ACCOUNTABILITY AND INFORMATION ACT

For American health care consumers to receive affordable, high-quality health care, they must have the ability to bargain on a more equal level with both the insurers and the providers of their care. While providers have long labored under the threat of malpractice suits for their medical errors, health care insurers have yet to contend with the consequences of their own medical decisions. The Model Act thus would remove the ERISA preemption of state tort law as applied to health care plans.¹¹⁴ Eliminating the ERISA tort liability shield might drive up health insurance costs as insurers paid to defend lawsuits and practiced more "defensive" medicine.¹¹⁵ In part,

110. See *supra* note 76 and accompanying text for a discussion of the Managed Care Plan Accountability Act.

111. See *supra* notes 95-99 and accompanying text for discussion of Rep. Fawell's bill.

112. See CONG. REC., *supra* note 83, at E830.

113. *Id.*

114. This echoes identical provisions in H.R. 1415, at § 4; H.R. 3605, at 302; S. 1890, at 302; H.R. 2606, at § 4; and in H.R. 3009, at § 204.

115. "Defensive" medicine refers to the practice of physicians, out of fear of lawsuits, providing excessive care, which furnishes little added benefit to the patients. For a discussion of

though, this "defensive" medicine would correct for some of the unrealistic and harmful cost-cutting practices of the managed care organizations.¹¹⁶ To prevent large jury awards from bankrupting health plans, the plan directors would have to carry malpractice insurance, which currently is carried by hospitals and physicians.¹¹⁷ Although exposing managed care organizations to tort liability might raise costs, no other health care decision-maker in America enjoys this far-reaching immunity from tort actions; removing this special protection recognizes the principle that those who cause harm in the course of their business should be held accountable to those harmed.¹¹⁸

Plan beneficiaries need adequate information as well as the right to sue their health plans. The market for health care can function properly only if consumers know exactly what their plans cover and do not cover.¹¹⁹ The Model Act would impose uniform reporting measures on all U.S. health care plans, which would require plans to inform beneficiaries fully of the plans' policies. Failure to do so would be actionable under any applicable state contract laws.

the costs of defensive medicine and malpractice suits, see Kenneth Pedroza, Note: *Cutting Fat or Cutting Corners, Health Care Delivery and Its Respondent Effect on Liability*, 38 ARIZ. L. REV. 399, 399, 402 (1996).

116. Had United feared a lawsuit in *Corcoran*, the company administrators probably would have heeded, or at least considered more carefully, the advice of Mrs. Corcoran's obstetrician. One author summarized the health plan lawsuit immunity trade-off thusly: "Concealing the true price [of health plans' improper care decisions] to patients by barring lawsuits may keep premiums low, but it simply shifts the burden to the patients and eliminates a highly desirable signal that can deter improper refusals of HMOs to pay for care." Schwartz, *supra* note 103, at A 21.

117. The executive director of the AAHP expressed concern that "members of Congress think a vote against managed care is a free vote with no consequences. But the larger consequence is to take us back to fee-for-service medicine" with resultant soaring health care costs. See Laurie McGinley, *All Sides get Ready for Push to Regulate HMOs*, WALL ST. J., Nov. 17, 1997, at A28.

118. See Jack K. Kilcullen, *supra* note 2, at 10 (discussing the theory behind enterprise liability that "the party benefited by the behavior" should bear the cost of the conduct "which put the victim at risk"). A health care consultant insisted that managed care companies "can't have it both ways. They can't . . . save money through effective utilization review, and then, when something goes wrong, say 'It has nothing to do with us.'" See Laurie McGinley, *Broad Battle to End HMOs' Limited Liability for Treatment-Coverage Denials Gains Steam*, WALL ST. J., Jan. 12, 1998, at A22.

119. Rep. Fawell has voiced his support for disclosure measures and due process proceedings for enrollees' grievances. See *Insurance Regulation*, HEALTH CARE POLICY REPORT, Feb. 2, 1998, available in LEXIS, Health Library, BNA File, at 211.

Additionally, the Act would require plans to notify beneficiaries of the plans' appeals processes and their rights thereunder as well.¹²⁰

The Model Act distinguishes itself from the congressional proposals currently under consideration in that it would not mandate that health care plans provide any particular substantive benefits. With ERISA preemption of state health insurance laws removed, however, the states would enjoy free reign to enact any reforms they deem necessary to protect their health care consumers or their managed care businesses.¹²¹ States also would be free to impose damages caps on jury awards for health plan malpractice. In this way, the different entities in the health care market (consumers, providers, insurers, and employers) could negotiate openly for compromises with one another and could compete for state legislation, which benefits their respective interests.

IV. CONCLUSION

Over the last two decades, health care has changed from a fee-for-service based system, with its spiraling costs, to a managed care-dominated industry with its success in cost containment. This industry-wide shift has resulted in a lowered rate of growth for health care costs; however, this change has not come without costs of its own. The drive to lower costs has caused managed care organizations to sacrifice the quality of the care they provide by denying treatments deemed too costly and by bypassing the recommendations of the physicians with whom they contract. ERISA's preemption of state tort law claims has left injured consumers without an effective remedy for what amounts to medical malpractice. A Health Care Accountability and Information Act would remove this liability shield, allowing consumers to seek redress for wrongs committed against them and giving a powerful disincentive to insurers to skimp

120. See *supra* notes 101-13 and accompanying text for discussion of notification provisions in current congressional proposals.

121. One HMO industry representative noted that a federal scheme of rights could benefit insurers who are "getting nicked and dined to death by the Disease of the Month Club," a reference to the many different anti-managed care state bills currently under consideration. See McGinley, *Push to Regulate HMOs*, *supra* note 117, at A28 (statement of David Abernathy, senior vice president of Health Insurance Plans, a New York HMO).

on the quality of the care they deliver. The Act's information requirement would ensure that consumers know their rights under their plans and are well-equipped to assert their rights. This Act, though, balances the rights of insurers with those of consumers by not imposing legislatively required benefits on health plans, leaving the market to determine the benefits that consumers find cost-justified.¹²²

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122. For a discussion of the need for consumer information to allow the market for health care to function efficiently, see J. Patrick Green, *Speculations on Managed Care*, 31 CREIGHTON L. REV. 679, 687 (1998).

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