January 1998

A Call to Congress to Amend ERISA Preemption of HMO Medical Malpractice Claims: The Dissatisfactory Distinction between Quality and Quantity of Care

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Recommended Citation

Angela M. Easley, A Call to Congress to Amend ERISA Preemption of HMO Medical Malpractice Claims: The Dissatisfactory Distinction between Quality and Quantity of Care, 20 Campbell L. Rev. 293 (1998).

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A CALL TO CONGRESS TO AMEND ERISA PREEMPTION OF HMO MEDICAL MALPRACTICE CLAIMS: THE DISSATISFACTORY DISTINCTION BETWEEN QUALITY AND QUANTITY OF CARE

“In effect, the ERISA provisions which overrule state law mean that the majority of Americans have been stripped of their historical legal protections against injury or death resulting from the actions of health insurance companies.”

I. INTRODUCTION

On September 3, 1991, eleven-year-old Paige Lancaster went to her Health Maintenance Organization (HMO) clinic, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser), where she saw pediatric physician Dr. Corder Campbell for nausea and severe daily headaches. Dr. Campbell only treated Paige as a pediatric patient and did not administer any diagnostic tests. Although Paige visited Kaiser’s clinic for the next five years to be treated by Dr. Campbell and Dr. L. Pauls for recurring headaches, the physicians continued to treat her with adult strength narcotic pain medication. They never sought the advice of a neurological specialist, nor did they recommend any diagnostic test to determine the cause of the child’s symptoms. On May 13, 1996, approximately five years after Paige’s initial visit to Kai-

3. Id. at 1139-40.
4. Id. at 1140.
5. Id.
ser clinic, physicians suggested that Paige undergo both an EEG and MRI.\(^6\) The tests were recommended only because Paige's school psychologist wrote the Kaiser physicians about Paige's deteriorating academic performance, vomiting, blood-shot eyes, and severe headaches.\(^7\) The tests revealed that Paige had a frontal tumor and cystic mass that covered over forty percent of her brain.\(^8\) As a result, she has undergone several brain surgeries as well as radiation therapy.\(^9\)

Paige's parents sued Kaiser physicians Dr. Corder Campbell and Dr. L. Pauls, as well as the HMO, Kaiser, in state court.\(^10\) Dr. Campbell and Dr. Pauls were under contract with Kaiser to provide medical services to Kaiser participants at clinics owned by Kaiser.\(^11\) Paige's membership in Kaiser was paid for by an Employee Retirement Income Security Act (ERISA) plan through her father's employment.\(^12\) The law suit alleged vicarious liability claims against Kaiser for the negligence of Dr. Campbell and Dr. Pauls.\(^13\) In addition, the law suit alleged direct liability claims for both: (1) Kaiser's failure to establish guidelines for the appropriate treatment of Paige's headaches; and (2) Kaiser's establishment of an Incentive Program which prevented the adequate and timely treatment of Paige's brain tumor.\(^14\) Under the Incentive Program, Kaiser physicians received bonuses for avoiding costly treatment and tests.\(^15\)

Defendants removed the action to federal court under an exception to the well-pleaded complaint rule, the doctrine of complete preemption, which allows removal of state claims to federal court when the claims conflict with federal law.\(^16\) The United

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6. Id.
7. Id.
9. Id.
10. Id. at 1139.
11. Id.
12. Id.
13. Id. at 1141.
15. Id. at 1140.
16. Id. at 1138-39, 1141 ("In the ERISA context, the Supreme Court determined that the complete preemption doctrine supports removal of state causes of action that fit within the scope of ERISA's civil enforcement provision . . . ." Id. at 1143.). Here, the plaintiff's claims fall within the scope of ERISA's civil enforcement provision, § 502(a)(1)(B), and therefore qualify for removal to federal court. *See also* Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 66 (1987) (holding that because of the clear intent of Congress to make causes of
States District Court for the Eastern District of Virginia dismissed the plaintiff's direct liability claims, stating that they were preempted by ERISA, and remanded the vicarious liability claims to the Circuit Court of Prince William County, Virginia. The vicarious liability claims, however, are subject to Virginia's medical malpractice law, which does not allow recovery for damages beyond one million dollars.

The different treatment accorded to patients who belong to employee group health plans that are governed by ERISA and those who are not enrolled in ERISA plans is apparent when contrasting Lancaster with Fox v. Healthnet. In Fox, Mrs. Fox and her husband brought suit against their HMO, Healthnet, claiming direct liability for denying her bone marrow transplant. Instead of dismissing the direct liability claim as the United States District Court for the Eastern District of Virginia did in Paige Lancaster's suit, the jury awarded the plaintiffs 89 million dollars. In cases where an ERISA plan is involved, specifically those like Lancaster, in which a managed care organization is directly negligent or those in which the managed care organization's actions amount to a denial of benefits, a plaintiff will not recover at all.

action under ERISA civil enforcement provisions removable to federal court, a preemption defense provides a basis for removal to federal court notwithstanding the well-pleaded complaint rule. See also infra notes 56-60 and accompanying text (discussing the complete preemption doctrine).

18. Id. at 1150-51, 1151 n.48.
21. Id. at 199 (recognizing that "[t]his difference in outcomes, based solely on whether benefits were provided through a privately sponsored ERISA plan or a publicly sponsored non-ERISA plan, begs for legislative resolution"). See also Laura H. Harshbarger, ERISA Preemption Meets the Age of Managed Care: Toward a Comprehensive Social Policy, 47 SYRACUSE L. REV. 191, 198 (1996) (noting that the 89 million dollar award is the largest medical malpractice award against an HMO).
22. See, e.g., Dukes v. U.S. HealthCare, Inc., 57 F.3d 350 (3d Cir. 1995) (holding that the direct liability claim, not the vicarious liability claim, related to the plaintiff's employee benefit plan and was preempted by ERISA); Tolton v. American Biodyne, Inc., 48 F.3d 937 (6th Cir. 1995) (holding that American Biodyne's benefit determinations in refusing to authorize psychiatric benefits prior to utilization review related to an employee benefit plan and were preempted by ERISA); Spain v. Aetna Life Ins. Co., 11 F.3d 129 (9th Cir. 1993) (holding that ERISA preempted a state law claim for wrongful death because it was a claim that Aetna was negligent in administering benefits); Kuhl v. Lincoln
Recovery is denied in these cases regardless of whether ERISA preempts a plaintiff's state law claim and regardless of whether plaintiffs, such as Fox, who are not enrolled in ERISA plans can bring suit under state law. 23 The Fox and Lancaster rulings also differ in the amounts recoverable by an injured plaintiff. In Fox, the plaintiffs were awarded 89 million dollars, 77 million dollars of which was for punitive damages alone. 24 Since the plaintiffs' health plan was not governed by ERISA, the managed care organization was subject to suit for all types of compensation available under state law. However, as in Lancaster, where an ERISA plan is involved, the plaintiff may only recover for the amount of benefits that were denied under the ERISA plan. 25 ERISA does not permit other types of compensatory or punitive damages, such as damages for unreasonable delay or pain and suffering. 26

Nat'l Health Plan of Kansas City, Inc., 999 F.2d 298 (8th Cir. 1993) (holding that the actions of Lincoln National Health Plan of Kansas City in refusing to preapprove heart surgery amounted to a denial of benefits, and, thus, the plaintiff's claims were preempted by ERISA); Kearney v. U.S. Healthcare, Inc., 859 F. Supp. 182 (E.D. Pa. 1994) (holding that ERISA preempts plaintiff's direct negligence claim, but not its vicarious liability claim).

23. See Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1333 (5th Cir. 1992) (The "absence of a remedy under ERISA's civil enforcement scheme for medical malpractice committed in connection with a plan benefit determination does not alter our conclusion. While we are not unmindful of the fact that our interpretation of the preemption clause leaves a gap in remedies within a statute intended to protect participants in employee benefit plans [citations omitted], the lack of an ERISA remedy does not affect a preemption analysis."). See also Memorial Hosp. Sys. v. Northbrook Life Ins. Co., 904 F.2d 236, 248 (5th Cir. 1990) ("We have held under different circumstances that ERISA preemption may occur even though ERISA itself could not offer an aggrieved employee a remedy for alleged misrepresentations.").

24. Conrad & Seiter, supra note 20, at 193 (citing Fox, No. 219692).

25. See infra note 41 and text (discussing ERISA's enforcement section, § 502(a)(1)(B), which limits a beneficiary's remedies to "recover[ing] benefits due to him under the terms of the plan, to enforc[ing] his rights under the terms of the plan, or to clarify[ing] his rights to future benefits under the terms of the plan"). See also Michael Higgins, Increased Exposure For HMOs: Texas Law Allows Patients to Sue; Health Plans Will Wage Preemption Battle, A.B.A. J., September 1997 at 24 (noting that plaintiffs in ERISA plans can only receive damages for the cost of the treatment that they were denied by their HMO).

26. Mertens v. Hewitt Assocs., 508 U.S. 248, 255-262 (1993) (holding that compensatory and punitive damages are not available under ERISA § 502(a)(1)(B)). See also Metropolitan Life Ins. Co., 481 U.S. 58 (explaining that the federal scheme of ERISA would be undermined if ERISA-plan participants were able to obtain remedies under state law that Congress rejected in ERISA);
This Comment begins with an overview of the Employee Retirement Income Security Act (ERISA) and the preemption clause found therein. Section III explains the distinction between quality and quantity of care, the test many courts have relied on to determine whether ERISA preempts a medical malpractice claim. Section IV examines state common law theories of liability which are asserted against managed care organizations, specifically claims of direct and vicarious liability. Section V addresses the HMO's role in medical decision making, and Section VI describes recent legislation regarding ERISA and HMO liability. This Comment contends that the more active role an HMO has regarding the quality of care they offer, the more they should be subject to vicarious and direct liability for negligent provision of care under state law. It further argues that the distinction between quantity of care or benefit determinations and decisions about the quality of care is unclear among the courts, and Congress must step in to amend ERISA and resolve the confusion.

II. ERISA

A. Overview of ERISA

In 1974, Congress enacted the Employee Retirement Income Security Act (ERISA) in response to: (1) a growing number of participants affected by employee welfare benefit and pension benefit plans; (2) mismanagement of employee welfare benefit and pension benefit plans; and (3) ineffective legislation to prevent mismanagement of these plans. Beginning in the 1940s, there was an increasing number of employee benefit plans, and by
1970, employee benefit plans covered over 30 million employees.\textsuperscript{30} Frequently, employees who were the beneficiaries of these pension and welfare benefit plans worked for many years only to discover at retirement that their benefits had been mismanaged and sometimes had not vested.\textsuperscript{31} Because ERISA had not yet been enacted, however, these employees relying on state common law to obtain their benefits, particularly state contract and trust law,\textsuperscript{32} encountered judicial difficulties which prevented them from recovering funds.\textsuperscript{33} Thus, the motivation behind ERISA was to eliminate many of the barriers facing a plaintiff in trying to recover benefits.\textsuperscript{34} Specifically, ERISA's purpose was to protect "the well-being and security of millions of employees and their dependents" by "requiring the disclosure and reporting to participants and beneficiaries of financial and other information," and "providing for appropriate remedies, sanctions, and ready access to the Federal Courts."\textsuperscript{35} Indeed, the United States Supreme Court has observed


\textsuperscript{33} Stephens, supra note 31, at 151 (citing Miller v. Davis, 507 F.2d 308, 310 (6th Cir. 1974); Menke v. Thompson, 140 F.2d 786, 790 (8th Cir. 1944)). See also Conison, supra note 32, at 645 (noting that contract law "was limited and weak, affording very few protections to participants," and that trust law "was not specially adapted to plans and gave little protection to participants"); Flint, supra note 32, at 611 n.6 (citing Lewis v. Jackson & Squire, Inc., 86 F. Supp. 354, 359-60 (W.D. Ark. 1949); Fickling v. Pollard, 179 S.E. 582, 583 (Ga. Ct. App. 1935); Wallace v. Northern Ohio Traction & Light Co., 13 N.E.2d 139, 143 (Ohio Ct. App. 1937); David v. Veitscher Magnesitwerke Actien Gesellschaft, 35 A.2d 346, 349 (Pa. 1944)).

\textsuperscript{34} Stephens, supra note 31, at 151.

\textsuperscript{35} 29 U.S.C. § 1001(a) & (b) (1994).
that ERISA was enacted as a "comprehensive statute designed to promote the interest of employees and their beneficiaries in employee benefit plans."36

ERISA is composed of five subchapters containing both regulatory and enforcement provisions.37 The regulatory provisions require reporting and disclosure,38 and establish standards for minimum vesting, fiscal responsibility,39 and fiduciary duties.40 ERISA's enforcement sections provide judicial remedies to recover benefits due, enforce rights, or clarify rights to future benefits under the terms of the plan.41 The enforcement sections also enable a plaintiff to seek state law remedies in either state or federal court.42 Finally, the enforcement sections include a preemption provision which states that the Act shall "supersede any and all state laws insofar as they may now or thereafter relate to any employee benefit plan . . . ."43

B. ERISA Preemption

ERISA's broad preemption clause, found in § 514(a), provides that the Act "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 1003(b) of this title."44 The preemption clause expresses Congress' view that employee benefit plans should be regulated by the federal government without state involvement.45 Congress, then, can simplify the administration of employee benefit plans by administering them under a single body of federal law. Specifically, the

44. § 1144(a).
purpose of ERISA's preemption clause is "to ensure that plans and plan sponsors [are] subject to a uniform body of law; the goal [is] to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government."46

Because Congress used such broad language in defining ERISA's preemption clause,47 particularly in defining the terms "state law"48 and "relate to,"49 ERISA's scope has caused much debate. This debate is most widely seen in the field of vicarious and direct liability medical malpractice claims. HMOs, one of the most common types of managed care organizations,50 frequently use ERISA preemption to limit or sometimes escape medical malpractice liability altogether. Although all courts have allowed ERISA preemption of direct liability medical malpractice claims,51 courts are undecided on whether ERISA preempts state law claims that hold a health plan, generally an HMO, vicariously liable for medical malpractice of physicians.52 This issue is crucial,

48. See 29 U.S.C. § 1144(c)(1), which describes ERISA's definition of state law as "all laws, decisions, rules, regulations, or other State action having the effect of law of any State." See also F. Christopher Wethly, New York Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.: Vicarious Liability Malpractice Claims Against Managed Care Organizations Escaping ERISA's Grasp, 37 B.C.L. REV. 813, 827 (1996) (noting that the term, "state law," found in ERISA's preemption clause includes common law causes of action, such as direct and vicarious liability claims, and state statutes).
49. See infra notes 61-64 and accompanying text (explaining the meaning and relevance of the phrase "relate to").
51. See infra note 83.

http://scholarship.law.campbell.edu/clr/vol20/iss2/3
considering that there are approximately 120 million Americans whose medical care is paid for through ERISA-covered plans sponsored by their employers. Preemption serves as a complete bar to all state claims and allows an HMO to remove an action to federal court. Since ERISA does not entitle one to a jury trial or enable one to recover compensatory or punitive damages for injury, preemption essentially denies a malpractice cause of action.

There is a distinction between the jurisdictional doctrine of complete preemption under section 502(a) and federal preemption under section 514(a). Complete preemption is required when a state law claim cannot be decided without an interpretation of an ERISA health plan. Only those claims which are subject to complete preemption under ERISA's civil enforcement provision, section 502(a)(1)(B), are a basis for removal to federal court. When a claim is not completely removable, the district court cannot decide the issue of ERISA preemption. The case then falls to the state court on remand to determine whether the claim is preempted under section 514(a).


54. Coan, supra note 45, at 1035 (citing Mark A. Rothstein & Lance Liebman, Employment Law: Cases and Materials 468 (3d ed. 1994)).

55. Id. See supra notes 25-26 and accompanying text (discussing the remedy an injured plaintiff has under an ERISA plan, which is essentially the amount of benefits that were denied to him).

56. Dukes, 57 F.3d at 355 (noting that when a claim is completely preempted under § 502(a), it is necessarily preempted under § 514(a); however, the opposite is not true).

57. Rice, 65 F.3d at 646 (holding the plaintiff's claim not completely preempted because the claim "does not rest upon the terms of an ERISA plan, and it can be resolved without interpreting an ERISA plan").


59. Dukes, 57 F.3d at 355.

60. Id.
III. THE DISTINCTION BETWEEN QUALITY AND QUANTITY OF CARE

Courts determining whether an HMO may be directly or vicariously liable for negligence in the treatment of patients enrolled in ERISA plans have focused on the distinction between a claim that a patient received poor quality of care from a physician and a claim that involves quantity of care or a denial of plan benefits. The general rule is that ERISA does not preempt:

'laws of general application - not specifically targeting ERISA plans - that involve traditional areas of state regulation and do not affect relations among the principal ERISA entities.'61 'As long as a state law does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the law has some economic impact on the plan does not require that the law be invalidated.'62

In other words, state laws of general application with a limited or indirect economic effect on ERISA plans do not “relate to” ERISA plans.63 A state law “relates to” an employee benefit plan only if it has a connection with or reference to such a plan.64 Thus, claims which are not related or are indirectly related to employee benefit plans, essentially claims concerning the quality of care, are not preempted by ERISA.

However, when a plan beneficiary claims that he or she was injured because a managed care organization was negligent in administering the benefits provided under an employee benefit plan or denied a promised benefit altogether, the claim is preempted.65 ERISA preemption exists for these claims regarding


62. Pacificare, 59 F.3d at 154 (quoting Airparts, 28 F.3d at 1065).

63. See supra note 43 (defining ERISA’s preemption language as “superseding any and all State laws insofar as they may now or hereafter relate to any employee benefit plan”). See also Mackey v. Lanier Collections Agency & Serv., 486 U.S. 825, 833 (1988) (holding that “run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan are relatively commonplace,” and are not preempted by ERISA); Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 100 n.21 (1983) (holding that some state law causes of action “affect employee benefit plans in too tenuous, remote or peripheral a manner to warrant a finding that the law ‘relates to’ the plan”).

64. Shaw, 463 U.S. at 97.

65. See, e.g., Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc., 999 F.2d 298 (8th Cir. 1993) (holding that the actions of Lincoln National Health Plan of
quantity of care, because they involve referencing the plan to determine what was promised. Indeed, ERISA, in section 502(a)(1)(B), specifically states that claims "to recover benefits due . . . under the terms of [the] plan, to enforce rights under the terms of the plan, or to clarify . . . rights to future benefits under the terms of the plan" are preempted.

Although this distinction between quality and quantity of benefits seems clear, its scope is confusing, and it has been unevenly applied by the courts. For example, in Dukes v. U.S. HealthCare, Inc., the United States Court of Appeals for the Third Circuit noted the confusion between constructions of quantity of benefits due under a welfare benefit plan and the quality of those benefits by stating:

the distinction between the quantity of benefits due under a welfare plan and the quality of those benefits will not always be clear in situations . . . where the benefit contracted for is health care services rather than money to pay for such services. There well may be cases in which the quality of a patient's medical care or the skills of the personnel provided to administer that care will be so low that the treatment received simply will not qualify as health care at all. In such a case, it well may be appropriate to conclude that the plan participant or beneficiary has been denied benefits due under the plan.

In other words, if a patient's care is so poor that it qualifies as a denial of benefits, then ERISA will preempt a medical malpractice claim. This seems to leave the most injured plaintiffs with no remedy at all.

IV. STATE COMMON LAW THEORIES OF LIABILITY OF MANAGED CARE ORGANIZATIONS

Individuals or entities failing to exercise reasonable care in the medical treatment of patients can be held liable for patient

Kansas City in refusing to pre-approve heart surgery amounted to a denial of benefits, and, thus, the plaintiff's claims were preempted by ERISA).

68. See, e.g., California Div. of Labor Standards Enforcement v. Dillingham Constr., 117 S. Ct. 832, 843 (1997) (noting that "applying the 'relate to' provision according to its terms was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else").
69. 57 F.3d 350.
70. Id. at 358.
injuries caused by their negligent actions. Thus, when a health maintenance organization commits malpractice through its own negligence or through the negligence of one of its physicians, state common law theories of liability permit recovery to those injured. Claims asserting HMO liability for medical malpractice injuries fall into two main categories: vicarious liability and direct liability.

Health maintenance organizations are vicariously liable for the negligence of their employees either under the theory of respondeat superior or that of ostensible agency. The doctrine of respondeat superior is an ancient phrase literally meaning, "let the master answer" for the torts of his servants. In the HMO context, a plaintiff under a respondeat superior theory must prove that the physician health care provider acted negligently in treating the patient, that a master-servant relationship existed between the HMO and the physician, and that the physician's tortious behavior fell within the scope of his employment. Similarly, under the doctrine of agency or ostensible agency, HMOs may be held liable for the negligence of their agents or of those who are held out to be their agents. Under this theory, HMOs will be liable when a patient looks to the HMO for treatment instead of the health care provider, and when the managed care organization "holds out" the health care provider as its

71. See Restatement (Second) of Torts § 283 (1965) (stating that "the standard of conduct to which [one] must conform to avoid being negligent is that of a reasonable man under like circumstances"). See also Brown v. Kendall, 60 Mass. (6 Cush.) 292 (1850) (holding an actor liable for negligence if he fails to exercise ordinary care).


74. Wethly, supra note 48, at 821.


76. Chittenden, supra note 73, at 453-54 (referring to W. Page Keeton et al., Prosser & Keeton on the Law of Torts § 69 (5th ed. 1984); Restatement (Second) of Agency § 219 (1958)).

77. Restatement (Second) of Torts § 140 (1965).
employee. These two doctrines impose vicarious liability on an HMO, because the organization controls the physician providers who actually commit the legal wrong.

Organizations can also be directly liable for their own negligent acts and omissions under one of two main theories: the corporate negligence doctrine and liability arising from cost-containment systems or utilization review. The doctrine of corporate negligence is used to insure that hospitals exercise reasonable care in retaining and selecting competent physicians. Liability arising from cost-containment systems, on the other hand, is imposed when managed care organizations, in order to receive certain incentives, refrain from ordering tests or treatments within the accepted standards of medical care. In a cost-containment system, medical services are reviewed before being administered to patients to ascertain whether less costly treatment and tests are available.

A. Direct Liability Claims

All courts that have addressed this issue have held that ERISA preempts direct liability claims against HMOs for corporate negligence in the selection and retention of physicians as well as for negligence arising from cost-containment systems or utilization review. Thus, HMOs have successfully raised ERISA preemption as a defense in medical malpractice cases based on direct negligence. Because these suits are seen as an attack on the administration of benefits, the courts have decided that these claims "relate to" the plan and thus fall within the scope of ERISA

78. Chittenden, supra note 73, at 453-54. See also Wethly, supra note 48, at 821.
79. Zamora, supra note 73, at 1053.
82. Zamora, supra note 73, at 1055 (citing Robert C. Macaulay, Health Care Cost Containment and Medical Malpractice: On a Collision Course, 21 Suffolk U.L. Rev. 91 (1987)).
83. Five circuit courts of appeals have found ERISA preemption for direct liability claims. See Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482 (7th Cir. 1996); Tolton v. American Biodyne, Inc., 48 F.3d 937 (6th Cir. 1995); Spain v. Aetna Life Ins. Co., 11 F.3d 129 (9th Cir. 1993); Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc., 999 F.2d 298 (8th Cir. 1993); Corcoran v. United HealthCare, Inc., 965 F.2d 1321 (5th Cir. 1992).
preemption. In other words, such suits relate to the "quantity of care" provided under a welfare benefit plan.

One of several important federal cases in this area is *Kuhl v. Lincoln National Health Plan of Kansas City, Inc.* 84 In this case, Buddy Kuhl suffered a heart attack on April 29, 1989. 85 Mr. Kuhl was an employee of Belger Cartage Services, Inc. and received medical benefits under an employee welfare benefit plan administered by Lincoln National Health Plan of Kansas City, Inc. 86 Physicians examining Mr. Kuhl determined that he needed immediate heart surgery. 87 This heart surgery could only be performed at Barnes Hospital in St. Louis, Missouri since Mr. Kuhl's employee group health plan in Kansas City did not have the necessary facilities or as much success and experience with heart surgery as did Barnes Hospital. 88 The Lincoln Health Plan, however, refused to precertify Mr. Kuhl for the required procedures, because Barnes Hospital in St. Louis was not in its service area. 89 Accordingly, Barnes Hospital canceled Mr. Kuhl's July 6, 1989 surgery. 90 The surgical team at Barnes Hospital was not available for another surgery until September 1989. 91 However, by September 1989 after Lincoln National had finally approved surgery at Barnes Hospital, Mr. Kuhl's heart had deteriorated to the point where he could no longer withstand surgery; thus, a heart transplant at Barnes Hospital was recommended by physicians. 92 In addition to refusing Mr. Kuhl's precertification for necessary heart procedures earlier that year, Lincoln Health Plan refused to precertify payment for the recommended heart transplant. 93 Mr. Kuhl, sadly, died waiting for a heart transplant. 94

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84. 999 F.2d 298.
85. Id. at 300.
86. Id. at 299-300. Lincoln National Health Plan is an independent HMO which pays for medical services to Belger employees under Belger's Group Health Plan. Id. The Belger Group Health Plan is an employee welfare benefit plan governed by ERISA. Id.
87. Id. at 300.
88. Id.
89. Id. at 299-300. Lincoln National Health Plan's service area is Kansas City, and it is not obligated under its contract with Belger Cartage Services, Inc. to pay for medical services administered outside of this area. Id.
90. *Kuhl*, 999 F.2d at 300.
91. Id.
92. Id.
93. Id.
94. Id.
Mr. Kuhl's family sued the health plan for medical malpractice, emotional distress, tortious interference with Mr. Kuhl's right to contract for medical care, and a breach of contract through Mr. Kuhl as a third party beneficiary. The United States Court of Appeals for the Eighth Circuit found that their claims were all based on Lincoln's misconduct in delaying Mr. Kuhl's heart surgery in St. Louis. However, the court ruled that the claims were a denial of benefits or improper processing of benefits under the Belger Plan, which is exactly the type of claim that ERISA preempts. In other words, the court found that Lincoln did not administer medical advice, but instead made a benefit determination - refusal to pre-approve heart surgery. The court in its decision recognized that preventing HMOs from preempting state law remedies would actually deter poor precertification decisions and questionable insurance practices, such as those exhibited by Lincoln Health Plan in this case. However, without any intervention by Congress to modify ERISA preemption, the court ultimately left the Kuhl family without a remedy.

Another example of ERISA preemption of direct liability claims can be seen in *Corcoran v. United HealthCare, Inc.* Florence Corcoran had a high-risk pregnancy in early 1989, and close to her delivery date, her physician, Dr. Collins, ordered her hospitalized so that he could continuously monitor the fetus. Mrs. Corcoran's health plan, South Central Bell Telephone Company Medical Assistance Plan, required all hospitalizations to be approved in advance. Thus, Dr. Collins sought precertification from United HealthCare (United), a utilization review company, for Mrs. Corcoran's hospitalization. United denied Dr. Collin's

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95. *Id.*
96. *Kuhl*, 999 F.2d at 302.
97. *Id.*
98. *Id.* at 304 (observing “the obvious salutary effect that imposing state law liability on Lincoln National might have on deterring poor pre-certification decisions”).
99. *Id.*
100. 965 F.2d 1321.
101. *Id.* at 1322-23.
102. *Id.* at 1323. Mrs. Corcoran is a member of the Medical Assistance Plan through her employer South Central Bell Telephone Company. *Id.* The Medical Assistance Plan is a welfare benefit plan governed by ERISA and administered by Blue Cross and Blue Shield of Alabama pursuant to a contract between Blue Cross and South Central Bell. *Id.*
103. *Id.* at 1323-24.
request stating that hospitalization was not necessary. Instead, United authorized 10 hours per day of home nursing care. During a time when there was no nurse on duty, the fetus went into distress and died.

Mrs. Corcoran and her husband sued United under state medical malpractice law for causing the wrongful death of their baby by negligently determining that only home nursing care rather than hospital care was necessary. The United States Court of Appeals for the Fifth Circuit found that United had made medical decisions, but determined that those medical decisions were made in the context of making a decision about the availability of benefits. Thus, the court ruled that the Corcoran's wrongful death claim "related to" the employee benefit plan because it involved a benefit determination and was preempted by ERISA. The court, though, seemed dissatisfied with its ruling, concluding that, "the result ERISA compels us to reach means that the Corcorans have no remedy state or federal, for what may have been a serious mistake. This is troubling . . . ."

The court in Tolton v. American Biodyne, Inc. issued the same result as in both the Kuhl and Corcoran cases. There, Henry Tolton committed suicide after his employee benefit plan administrator denied him psychiatric benefits prior to utilization review. As an employee of United Way, Mr. Tolton received mental health benefits under the Exclusive Provider Plan, an employee benefit plan, provided by American Biodyne, Inc. The court found that the Tolton family's claims of wrongful death, improper refusal to authorize benefits, medical malpractice, and insurance bad faith were the result of American Biodyne's denial of certain psychiatric benefits under the Exclusive Provider Plan.

104. *Id.* at 1324.
105. *Id.*
106. *Corcoran*, 965 F.2d at 1324.
107. *Id.*
108. *Id.* at 1331.
109. *Id.*
110. *Id.* at 1338.
111. 48 F.3d 937.
112. *Id.* at 940.
113. *Id.* at 939-40. The Exclusive Provider Plan is governed by ERISA. *Id.* The benefits under the plan are provided to plan participants like Mr. Tolton pursuant to a contract between Cigna Health Plan of Ohio, Inc. and American Biodyne. *Id.*
Yet, the court ruled that American Biodyne’s benefit determinations related to the employee benefit plan and were preempted by ERISA. The fact that Mr. Tolton was refused benefits prior to utilization review did not change the court’s analysis, since the court found that American Biodyne was only determining what benefits were available to Mr. Tolton under the plan.

The results in these cases and other similar cases asserting direct liability claims for HMO negligence is troubling. It appears that the courts could have just as easily concluded that the actions by the defendant organizations were medical decisions not preempted by ERISA, instead of ruling that the actions involved benefit determinations. A court could make such a conclusion, seemingly, because a decision that a service is medically necessary for purposes of quantity of care or determining benefits is also a decision that the service is medically sufficient for purposes of quality patient care.

B. Vicarious Liability Claims

Five out of twelve circuit courts of appeals and several lower courts have found that HMOs may be vicariously liable for the malpractice of their employees and agents, even if the injured plaintiff was enrolled in an ERISA plan. The federal and state courts reviewing this issue have held that patients who have been injured by negligent treatment decisions controlled, arranged for, or provided by health plans, should be permitted to pursue state remedies for negligence against those managed care organizations. These courts have held that ERISA was not intended to bar injured patients from seeking traditional state law remedies against managed care organizations that have negligently controlled or arranged for their medical treatment.

In Pacificare of Oklahoma, Inc. v. Burrage, the Federal Court of Appeals for the Tenth Circuit found that ERISA did not

114. Id. at 942. For instance, Mr. Tolton’s psychologists prescribed outpatient treatment and a challenge policy in which Mr. Tolton was to return for treatment only if he met the “challenge” of remaining off drugs for five days. Id. at 940. Physicians following Biodyne’s policies recommended this treatment even after Mr. Tolton expressed serious suicidal thoughts, requested inpatient care, and expressed a dislike for Biodyne’s challenge policy. Id.

115. Id. at 942.

116. Id.

117. Julie Johnsson, Supreme Court, Texas Law Strike Blows at ERISA, AM. MED. NEWS, June 23, 1997, at 8. See supra note 52 for a listing of these cases.

118. 59 F.3d 151 (10th Cir. 1995).
preempt a claim of vicarious liability for malpractice against a managed care organization, therefore becoming the first circuit court to rule on this issue.\textsuperscript{119} In Pacificare, the plaintiffs brought suit against HMO, Pacificare of Oklahoma, Inc., claiming both vicarious liability for the malpractice of physician Dr. Goen in the wrongful death of their mother, and direct liability for Pacificare's negligent and fraudulent administration of an employee benefit plan.\textsuperscript{120} The court ruled that the plaintiffs' vicarious liability medical malpractice claim was not preempted by ERISA, because it did not sufficiently relate to an ERISA plan.\textsuperscript{121} The vicarious liability claim, therefore, was remanded to state court for resolution.\textsuperscript{122} The court noted that in regards to vicarious liability claims against HMOs for the malpractice of their physicians, it is not necessary to reference a benefit plan to determine the issue of a physician's negligence in treating a patient.\textsuperscript{123} The court continued to observe that any reference to a benefit plan in deciding whether an agency relationship exists between an HMO and the physician is too tenuous a relationship to the plan to warrant preemption.\textsuperscript{124} Neither is the effect of liability on the benefit plan enough to warrant preemption.\textsuperscript{125} In another case, Kampmeier v. Sacred Heart Hospital,\textsuperscript{126} the United States Federal Court for the Eastern District of Pennsylvania held that a beneficiary's claims of vicarious liability against a managed care organization were not completely preempted by ERISA, because the claims were based upon when an ultrasound test was supposed to have been performed, not on whether it would have been authorized by the managed care organization.\textsuperscript{127} The plaintiffs alleged that, due to the managed

\begin{itemize}
\item \textsuperscript{119} Id. at 153.
\item \textsuperscript{120} Id. at 154.
\item \textsuperscript{121} Id. Instead, the claim only alleged that physician Dr. Goen was negligent in treating the plaintiffs' mother and that HMO Pacificare held out Dr. Goen as its agent. Id.
\item \textsuperscript{122} Id. at 155.
\item \textsuperscript{123} Id. at 154. Rather, that determination "requires evidence of what transpired between the patient and physician and an assessment of whether in providing admittedly covered treatment or giving professional advice the physician possessed and utilized the knowledge, skill and care usually had and exercised by physicians in his community or medical specialty." Id.
\item \textsuperscript{124} Pacificare, 59 F.3d at 154.
\item \textsuperscript{125} Id.
\item \textsuperscript{126} No. CIV.A.95-7816, 1996 WL 220979 (E.D. Pa. May 2, 1996).
\item \textsuperscript{127} Id. at *3.
\end{itemize}
care organization protocols, an ultrasound, ordered by the plaintiff's obstetrician to diagnose whether the fetus was at risk due to its large size, was delayed for three days. During the delay, the plaintiff mother went into labor. The baby suffered brachial plexus injury due to shoulder dystocia, which allegedly could have been avoided had the baby's size been appreciated via ultrasound prior to delivery. The court observed the plaintiff's allegation, that the test was untimely due to the delay occasioned by the managed care policies, related to USHC's role in "arranging for medical treatment" and not to its "role in determining whether to approve or disapprove the benefit." Therefore, the claims were not preempted.

In Dukes v. U.S. HealthCare, Inc., the United States Court of Appeals for the Third Circuit also found that ERISA did not preempt Darryl Dukes' vicarious liability malpractice claim against U.S. HealthCare. Mr. Dukes' primary care physician, Dr. William Banks, identified an ear problem, performed surgery, and ordered blood studies to be performed, but Germantown Hospital refused to perform the tests. Mr. Dukes sought treatment the next day from another physician, Dr. Edward Hosten, who also ordered blood tests. Although the tests this time were administered, Mr. Dukes condition worsened, and he died soon thereafter with an extremely high blood sugar level that could have been diagnosed by a timely blood test.

Mr. Dukes' wife sued the physicians, Germantown Hospital, and U.S. HealthCare in state court for medical malpractice. Mr. Dukes' membership in his HMO, United States Health Care Systems of Pennsylvania, was paid for by an ERISA plan through his employer. Mrs. Dukes alleged vicarious liability against

128. Id. at *1.
129. Id.
130. Id.
131. Id. at *3.
132. Id. at *3.
134. Id.
135. Id. at 361.
136. Id.
137. Id.
138. Id.
139. Dukes, 57 F.3d at 352. HMO United States Health Care Systems of Pennsylvania is organized under U.S. HealthCare. Id.
U.S. HealthCare under an ostensible agency theory. Mrs. Dukes also claimed direct liability against the HMO for failing "to exercise reasonable care in selecting, monitoring, and evaluating" the physician providers.

The district court dismissed both vicarious and direct liability claims stating that they were "related to" the employee benefit plan and were therefore preempted by ERISA. Mrs. Dukes appealed and the Third Circuit reversed the ruling regarding the vicarious liability claim. The court found that Mrs. Dukes was not asserting that the HMO withheld benefits due under the plan. Instead, Mrs. Dukes was complaining of the low quality of the benefit that was actually received. The court observed that the ERISA statute says nothing about the quality of benefit received, but only provides a remedy for benefits not received. Therefore, the court did not preempt Mrs. Dukes' state law remedy for U.S. HealthCare's negligence in its provision of quality of care.

Although the rulings in the aforementioned cases seem promising, these courts have only opened the door to preserving state health care regulation. The rulings are not without loopholes. Even Dukes could not completely rule on preemption. For instance, the court commented that HMOs may impliedly promise that their physicians or services will be of acceptable quality. The court continued to observe that if the promise was found to be a contractual benefit, any claim that the services provided were not of acceptable quality might be considered a claim that benefits were denied, which could be preempted by ERISA.

In fact, several rulings have allowed preemption of vicarious liability claims. Take the case of Ricci v. Gooberman, for instance. In this case, Christine Ricci brought suit against the

140. Id.
141. Id.
142. Id. at 353.
143. Id. at 361. The vicarious liability claim, then, was remanded to state court for resolution of whether it is preempted under ERISA § 514(a). Id.
144. Id. at 356.
145. Dukes, 57 F.3d at 357.
146. Id.
147. Id. at 356.
148. Id. at 359.
149. Id.
150. See supra note 52 for a listing of these cases.
HMO, U.S. Healthcare, for the negligence of physicians in failing to advise her of certain abnormalities on a mammogram, and for performing and evaluating her mammogram in a careless, reckless and negligent manner.\textsuperscript{152} Christine Ricci received medical care benefits from U.S. Healthcare which furnished employee health care benefits for her employer under ERISA.\textsuperscript{153} The United States District Court in this matter held that the vicarious liability claims were preempted by ERISA.\textsuperscript{154} The court gave several reasons for its conclusion. Notably, the court decided that to deny preemption in vicarious liability claims while allowing preemption in direct negligence claims would lead to conflicting results by allowing “decreasing HMO liability in correlation with the extent of its involvement in providing care.”\textsuperscript{155} Therefore, the court decided the best solution would be to preempt all medical malpractice claims. The court also ruled that “denying preemption in vicarious liability cases against HMOs . . . requires that both the provider and the HMO carry liability insurance for the acts of the provider, resulting in higher costs that certainly trickle down to plan beneficiaries.”\textsuperscript{156} Finally, the court felt that it was ultimately up to Congress to clarify the scope of ERISA preemption, not the courts.\textsuperscript{157}

The \textit{Ricci} holding is inaccurate on two grounds. First, conflicting results will actually be caused by preempting both direct and vicarious liability claims for medical malpractice. Managed care organizations actively make medical decisions; thus, it logically follows, they should be held liable for their control and influence. To hold otherwise would allow managed care organizations to take no responsibility for their medical decisions and to escape liability for their negligent actions. This is clearly unacceptable.

Secondly, the court and managed care organizations argue that by subjecting managed care organizations to liability, these organizations will be forced to increase their expenditures, in turn causing them to drastically raise premiums and reduce benefits for patients. However, liability for such wrongs comes with the territory in all professions. It is an ordinary cost of doing business. Furthermore, the managed care organization is in a better

\begin{itemize}
  \item \textsuperscript{152} \textit{Id.} at 316.
  \item \textsuperscript{153} \textit{Id.}
  \item \textsuperscript{154} \textit{Id.} at 318.
  \item \textsuperscript{155} \textit{Id.} at 317-18.
  \item \textsuperscript{156} \textit{Id.} at 318.
  \item \textsuperscript{157} \textit{Ricci}, 840 F. Supp. at 318.
\end{itemize}
position than the patient to ward against the loss. Patients do not choose their insurance plans; instead their employers do.\textsuperscript{158} Thus, "it cannot be said that they are freely entering into a contract by which they should be bound," and it cannot be argued that patients are assuming the risk.\textsuperscript{159}

Although \textit{Dukes} ruled that Mrs. Dukes' vicarious liability claim were not preempted under ERISA, the court cautioned that preemption may apply in cases where the quality of care is extremely low and in contractual cases where HMOs promise certain benefits in treating patients. Furthermore, some cases have ruled that all vicarious liability claims are preempted. As one judge aptly noted, "the split among courts exemplifies the difficulty this preemption issue presents."\textsuperscript{160} Courts, however, should continue to look at decisions such as \textit{Pacificare} and \textit{Kampmeier} as models, for the \textit{Ricci} holding and others like it fail.

\section*{V. HMOs' Role in Decision Making}

Today, HMOs no longer just pay the bills for covered services. Many actively manage patient care and control or influence medical treatment decisions.\textsuperscript{161} Because these health plans now actively control, arrange for, and manage the quality of medical treatment made available to patients, it has become difficult, if not impossible, to separate vicarious from direct liability for patient care.\textsuperscript{162} Mistakenly, courts have often ruled that managed care medical decisions involve quantity of care or administration of benefits rather than quality patient care. The more responsibility managed care organizations take in providing quality care to patients, the more they should be held accountable under the doctrines of direct and vicarious liability for their negligence in providing these services.

HMOs are also involved in medical decision making through their establishment of financing incentive programs. By giving incentives to physicians for avoiding costly treatments and surgeries, HMOs are in effect influencing the decisions made by phy-
sicians concerning the medical treatment of patients. For example, in Lancaster, discussed in the introduction, bonuses and profit incentives were given to physicians for not rendering diagnostic tests or a neurology consult for eleven-year-old Paige Lancaster.163 Dr. Campbell and Dr. Pauls argued that the Incentive Program caused them to refrain from administering the full and adequate care the minor child needed.164

Pappas v. Asbel165 provides another example of the involvement of managed care organizations in medical decision making through the establishment of financing incentive programs. In this case, Mr. Basile Pappas became a permanent quadriplegic while his doctors and insurer, U.S. Healthcare, spent more than four hours arguing over HMO benefit plan policies.166 Mr. Pappas was initially admitted to the emergency department at Haverford Community Hospital in Pennsylvania where after examination doctors diagnosed him as suffering from a neurological emergency, specifically a cervical epidural abscess which was compressing his spinal cord.167 Haverford Hospital's physicians were certain of the treatment required to remedy Mr. Pappas' condition. They wanted Mr. Pappas immediately transferred to the Spinal Cord Trauma Center at Thomas Jefferson University Hospital which had both available beds and surgical specialists skilled in the procedure Mr. Pappas needed.168

However, Thomas Jefferson did not contract with Mr. Pappas's insurer, U.S. Healthcare.169 The HMO refused to authorize his transfer and instead required the physicians to move Mr. Pappas to a hospital in the U.S. Healthcare provider network.170 For more than four hours, doctors negotiated with the HMO and two of its approved hospitals concerning Mr. Pappas' transfer and care.171 When the doctors and the HMO finally obtained authorization to transfer him to the Medical College of Pennsylvania, Mr. Pappas' condition had already deteriorated to quadriplegia.172

164. Id.
166. Id. at 713.
167. Id.
168. Id.
169. Id.
170. Id.
171. Pappas, 675 A.2d at 713.
172. Id.
Cost-containment in this case was the motivation behind USHC’s medical decision to refuse transfer of Mr. Pappas to Jefferson Hospital. USHC is a for-profit managed care organization and many of its medical decisions are often aimed at increasing its own profits. Here, USHC negligently eliminated the most effective and readily available source of care for Mr. Pappas and in effect tied the hands of his physicians who had already planned the best and quickest course of treatment for his neurological emergency. The court even noted that, “[d]ecisions such as that made by USHC concerning where Mr. Pappas might receive treatment are propelled by dollar savings, not the protection of worker’s rights, in this case the right to the most effective medical care, which was the original focus of ERISA.” The managed care organization’s profit-oriented decisions and cost containment protocols in Lancaster, Pappas, and many other cases interfere with the quality of health care which treating physicians are able to provide to patients.

VI. RECENT LEGISLATION REGARDING HMO LIABILITY

Federal lawmakers are currently debating new legislation that would clarify much of the confusion surrounding ERISA pension law. The bill entitled the “Patient Access to Responsible Care Act of 1997” essentially “offer[s] patients access to due process and avenues of appeal, ensure[s] that patients have access to providers to receive benefits covered by the health plan in a timely manner and guarantee[s] open communication between patients and providers.” Several groups supporting the ERISA reforms include the American Medical Association and the Center for Patient Advocacy.

The relevant sections of the bill are found in § 3, entitled “Patient Protection Standards Under the Employee Retirement Income Security Act of 1974,” and in § 4, entitled “Non-Preemption of State Law Respecting Liability of Group Health Plans.”

173. Id. at 716.
174. Id.
175. Id.
176. Overman, supra note 1, at 34. See also S. 644, 105th Cong. (1997); H.R. 1415, 105th Cong. (1997).
178. S. 644, § 3-4; H.R. 1415, § 3-4.
Section 3(b) in particular concerns modification of the preemption standard. It states that the provisions of section 713, Patient Protection Standards, found in subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 "shall not be construed to preempt any state law, or the enactment or implementation of such a state law, that provides protections for individuals that are equivalent to or stricter than the protections provided under such provisions." Section 4(a) states:

In general - section 514(b) of the Employee Retirement Income Security Act of 1974 (20 U.S.C. § 1144(b)) is amended by redesignating paragraph (9) as paragraph (10) and inserting the following new 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.'

Federal legislators are not the only ones recognizing the need for ERISA reform. On May 22, 1997, the Texas state Senate enacted the Managed Care Responsibility Act, making Texas the first state in history to subject HMOs to liability when they act negligently in treating patients. Under the new law, HMOs may be liable if they “fail[ed] to use ‘ordinary care’ when deciding whether to pay for a medical procedure.” Senator David Sibley, who introduced the Texas bill, defined the core of the bill as this: "If the HMOs choose to make medical decisions - stand in the shoes of the doctor, as it were - they ought to stand in the shoes of the doctor in court, too." Many say the legislation will likely be effective because of the fact that it is similar to the vicarious liability doctrine already approved by many courts.

Texas' new law has started a trend in other states. For example, Missouri’s House Bill 335, enacted June 25, 1997, adds HMOs to the definition of health care provider, holding HMOs

179. S. 644, § 3; H.R. 1415, § 3.
180. Id.
185. Guglielmo, supra note 183, at 90.
accountable for making negligent medical decisions.\textsuperscript{188} In addition, similar bills have been proposed in Arizona, California, Colorado, Connecticut, Georgia, Massachusetts, New Jersey, New York, Ohio, and Rhode Island.\textsuperscript{189}

Yet less than one month after the enactment of Texas' Managed Care Responsibility Act, Aetna Health Plans of Texas and related companies filed suit in the United States District Court of the Southern District of Texas challenging the new legislation.\textsuperscript{190} The HMOs are arguing that ERISA's language invalidates the Texas law.\textsuperscript{191} Other states will be looking carefully to see whether the Texas law withstands the ERISA challenge. Even if the challenge is successful, however, states may still be able to use the Texas case as a tool for developing different state liability laws that will be able to withstand attack.

VII. CONCLUSION

HMOs must be held accountable for their negligent actions. The more responsibility they take in providing medical care and making medical decisions, the more they should be held accountable for these duties. Many of these responsibilities, such as utilization or precertification review and cost-containment considerations, were not even in existence when Congress contemplated ERISA. Thus, Congress certainly could not have intended ERISA to serve as a means for HMOs to escape corporate and vicarious liability for such actions.

Because of HMOs' greater role in providing medical care, courts have had difficulty in applying a uniform standard with regard to ERISA preemption. Judge Birch in his dissenting opinion of \textit{Sanson v. General Motors Corp.},\textsuperscript{192} in which the plaintiff's claim was preempted by ERISA, points to the effect of this problem. He states, "I do not subscribe to the view that for every wrong there must necessarily be a remedy. However, where there is a remedy (here a state fraud action), I find it is difficult to comprehend, in a common sense way, how a law enacted to protect the

\begin{thebibliography}{99}
\bibitem{188} Roselyn Bonati, \textit{Texas and Missouri Lead the Way in Protecting HMO Members}, ATLA ADVOCATE PERIODICALS, March 1998 at 3.
\bibitem{189} Bonati, \textit{supra} note 187, at 8; Guglielmo, \textit{supra} note 183, at 97; Higgins, \textit{supra} note 25, at 24; Johnsson, \textit{supra} note 117, at 8.
\bibitem{190} Guglielmo, \textit{supra} note 183, at 98.
\bibitem{191} \textit{Id.}
\bibitem{192} 966 F.2d 618 (11th Cir. 1992).
\end{thebibliography}
very class of individuals into which the appellant squarely fits can be construed to deny him such a preexisting remedy.”

Congress must take Judge Birch’s position and provide a remedy for injured plaintiffs. In addition, other states should follow Texas’ lead in an attempt to resolve the issue of ERISA preemption. Without this change, HMOs have little incentive to protect patients from injuries; HMOs can simply shift the risk of such injuries to physicians and patients that they serve, which leaves patients like Paige Lancaster with no recourse at all.

Angela M. Easley

193. Id. at 623 n.2.