

Nova Law Review

Volume 19, Issue 3

1995

Article 7

Medical Malpractice and Health Maintenance Organizations: Evolving Theories and ERISA's Impact

O. Mark Zamora*

*

Copyright ©1995 by the authors. *Nova Law Review* is produced by The Berkeley Electronic Press (bepress). <https://nsuworks.nova.edu/nlr>

Medical Malpractice and Health Maintenance Organizations: Evolving Theories and ERISA's Impact

O. Mark Zamora

Abstract

Employers are now turning in increasing numbers to Health Maintenance Organizations ("HMO") and Preferred Provider Organizations ("PPO") to deliver health insurance benefits to their employees.

KEYWORDS: ERISA, malpractice, health

Medical Malpractice and Health Maintenance Organizations: Evolving Theories and ERISA's Impact

O. Mark Zamora*

TABLE OF CONTENTS

I.	INTRODUCTION	1047
II.	THE STRUCTURE OF HMOS	1048
III.	THE THEORIES OF LIABILITY	1048
A.	<i>Vicarious Liability</i>	1049
1.	Respondeat Superior	1049
2.	Ostensible/Apparent Agency	1050
3.	Nondelegable Duty	1052
B.	<i>Direct Liability</i>	1053
1.	Corporate Negligence	1053
2.	Cost-Containment Systems	1055
IV.	A DEFENSE BASED UPON ERISA	1056
V.	CONCLUSION	1061

I. INTRODUCTION

Employers are now turning in increasing numbers to Health Maintenance Organizations ("HMO") and Preferred Provider Organizations ("PPO") to deliver health insurance benefits to their employees. The organizations provide savings to both the worker and the business owner. As with the traditional role of physicians, however, concerns have been raised regarding liability arising from the administration, implementation, and operation of HMOs throughout the United States. Courts have seen cases where parties have sought to impose liability against HMOs for malpractice based upon an HMO's member physicians with respect to services provided to members, quality assurance programs related to the HMOs, and the cost-containment mechanisms common to HMOs.

Courts (as well as legislatures) are now faced with issues presented in heretofore uncharted waters of HMO liability in the context of medical malpractice actions. The Plaintiffs' Bar has sought to graft theories of

* Senior Litigation Associate with Gobelman & Love in Jacksonville, Florida. B.A., University of Florida, 1984; J.D., Cumberland School of Law, Samford University, 1988.

liability asserted in traditional malpractice cases in the context of an HMO liability action. The Defense Bar has, in turn, developed several defenses, the most significant of which is the application of the Employment Retirement Income Security Act. This article will briefly explain the structure of the HMO, outline the theories of liability used most commonly by plaintiff lawyers, and explore in detail the ERISA defense which is currently being asserted with varying degrees of success in the federal and state courts of the United States.

II. THE STRUCTURE OF HMOs

In the context of health care, the HMO systems are generally categorized into several basic structures: the staff model HMO; the Indorsement Practice Association (“IPA”); and the group model. The staff model HMO employs its own physicians who receive their salaries directly from the HMO. The IPA model usually is made up of an association of physicians which contracts separately with the HMO to provide medical services to the organization’s members. The IPA, in turn, contracts with physicians who agree to provide health care to HMO members. The IPA physicians also treat patients who are not enrolled under an HMO plan. The group model HMO provides prepaid services to members who usually enroll either at work (through their employers) or through individual medical provider groups.

In addition to the three HMO models, there also exists what is known as the PPO. A PPO brings together physicians, hospitals, and other medical service providers to give discounted services to a specific patient group. A PPO subscriber will usually pay a premium to the organization. This organization then pays the providers for the services which were rendered. The benefits of belonging to a PPO include deductibles which may be lower than those found in traditional HMOs, additional levels of benefits, and other protections.

III. THE THEORIES OF LIABILITY

Claims seeking to establish HMO liability for injuries arising from medical malpractice are usually classified into two main theories: vicarious liability and direct liability.

A. *Vicarious Liability*

Vicarious liability is a theory of liability which is made up of several sub-theories: respondeat superior, ostensible/apparent agency, and nondelegable duty.

1. Respondeat Superior

Respondeat superior is the type of theory commonly alleged in cases against doctors in a malpractice setting. In certain instances, an HMO was held liable based upon this doctrine; in fact, this theory is considered the substantive bedrock for an HMO-based malpractice action. Courts have ruled in favor of HMO liability for physician negligence based on a respondeat superior theory.¹ In the cases where it was found that an HMO could be held liable for the malpractice of provider physicians, the courts focused on the degree of control exercised over the negligent physician and the identity of the person directly responsible for supervising the physician.

An HMO is more likely to be held liable where the supervising individual is a medical professional rather than a lay person. For example, in *Sloan v. Metropolitan Health Council, Inc.*,² the court found liability against an HMO based upon respondeat superior. The court reasoned that the HMO's staff physicians were under the control of the HMO medical director (a physician), who supervised medical services and established policy.³ Relevant to the *Sloan* decision was a state statute entitled the Professional Corporation Act of 1983 which detailed the elements of vicarious liability of a corporation. The court stated that it saw "no reason why [the HMO] should be exempt from the doctrine of respondeat superior while professional corporations are not."⁴ The court held that "where the usual requisites of agency or an employer-employee relationship exists, a corporation may be held vicariously liable for malpractice for the acts of its employee-physicians."⁵

1. *Lighterman v. Porter*, 548 So. 2d 891, 892 (Fla. 3d Dist. Ct. App. 1989); *Variety Children's Hosp., Inc. v. Perkins*, 382 So. 2d 331, 335 (Fla. 3d Dist. Ct. App. 1980).

2. 516 N.E.2d 1104 (Ind. Ct. App. 1987).

3. *Id.* at 1105. In *Sloan*, the members of the HMO paid a monthly charge in return for certain enumerated medical services. The member would choose one physician, who essentially served the role of the personal physician, directing care and referring the member to other health providers. *Id.*

4. *Id.* at 1109.

5. *Id.*

The federal courts have likewise applied respondeat superior in the context of a malpractice action. In *Schleier v. Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.*,⁶ the court found liability based upon respondeat superior where the physician “acted neither on his own initiative nor independently of the [HMO] physician” but merely made recommendations to the HMO’s physicians.⁷

Neither the *Sloan* court nor the *Schleier* court specified the degree or manner of control necessary to find vicarious liability. The *Schleier* court, however, noted that the power to control a servant’s conduct was the only controlling factor in its test for determining whether the requisite “master-servant” relationship existed.⁸ Both the *Schleier* and *Sloan* courts found that a degree of evidence of control may be enough to find vicarious liability.

Other state courts have held likewise. In Florida, an appellate court held that “it is the *right* of control, and not *actual* control, which determines the relationship between the parties.”⁹ Therefore, evidence of actual control over the physician is not necessary to establish that an employer/employee relationship exists. Rather, it must be shown that the HMO is in a position to control the physician to establish the requisite relationship for respondeat superior.

2. Ostensible/Apparent Agency

In the absence of an actual employment relationship, apparent/ostensible agency (or agency by estoppel) may be used as a theory of liability. While the two theories have distinct and separate elements, the courts have not necessarily drawn a clear distinction between the two.¹⁰ Apparent agency is divided into three elements: a representation by the principal; reliance on the representation by a third person; and a change of position by the third person in reliance upon such representation to his detriment.¹¹

6. 876 F.2d 174 (D.C. Cir. 1989) (per curiam).

7. *Id.* at 178

8. *Id.* at 177.

9. *Nazworth v. Swire Fla., Inc.*, 486 So. 2d 637, 638 (Fla. 1st Dist. Ct. App. 1986) (citations omitted).

10. *See, e.g., Tampa Sand & Material Co. v. Davis*, 125 So. 2d 126, 127 (Fla. 2d Dist. Ct. App. 1960) (referring to actual authority and ostensible authority as two theories of liability, but not discussing estoppel).

11. *See Orlando Executive Park, Inc. v. Robbins*, 433 So. 2d 491, 494 (Fla. 1983) (approving *Orlando Executive Park, Inc. v. P.D.R.*, 402 So. 2d 442 (Fla. 5th Dist. Ct. App.

The elements of ostensible agency are found in section 429 of the *Restatement (Second) of Torts*, "Negligence in Doing Work Which Is Accepted in Reliance on the Employer's Doing the Work Himself:"

One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or by his servants, is subject to liability for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as though the employer were supplying them himself or by his servants.¹²

The elements of ostensible agency in the physician/HMO relationship are: whether the patient looks to the institution, rather than the individual physician for medical care; and whether the hospital or HMO holds out the physician as its employee. Numerous cases have been decided under this theory. In Florida, one court held that a hospital would be liable for a physician's negligence where the hospital "holds out" the physician as its employee and the patient accepts treatment from the physician "in the reasonable belief that it is being rendered in behalf of the hospital."¹³

The leading case on ostensible agency in the HMO context is *Boyd v. Albert Einstein Medical Center*.¹⁴ In *Boyd*, the decedent and her husband were HMO participants. Upon enrolling, the decedent was given a directory listing the participating physicians. Restricted to this list, the decedent chose two primary care physicians. She contacted one of the doctors for treatment; he referred her to a surgeon who was also a participating HMO physician. The treatment provided by the surgeon ultimately led to her death. In the complaint it was alleged that the HMO physicians were represented to be competent, and that the decedent relied upon these representations.

In *Boyd*, the court set out the factors of ostensible agency as: "(1) whether the patient looks to the institution, rather than the individual physician for care, and (2) whether the HMO 'holds out' the physician as

1981), and setting forth the three elements in the context of a tort action, not a medical malpractice action).

12. RESTATEMENT (SECOND) OF TORTS § 429 (1965).

13. *Irving v. Doctors Hosp. Inc.*, 415 So. 2d 55, 59 (Fla. 4th Dist. Ct. App. 1982). The court referred to the theory of liability as "apparent authority," but not as ostensible agency, calling it "an admixture of the agency doctrine of apparent authority and the doctrine of estoppel." *Id.* at 57.

14. 547 A.2d 1229 (Pa. Super. Ct. 1988).

its employee.”¹⁵ The court then looked to the *Restatement (Second) of Agency*, rather than to the *Restatement (Second) of Torts* for further elucidation on ostensible agency.¹⁶ The *Boyd* court expanded the ostensible agency theory in the hospital/physician setting to the HMO/physician relationship on the rationale that the changing role of health care providers in recent years justified the extension.¹⁷

Several facts are central to an understanding of *Boyd* and its holding: the HMO covenanted to provide health care to protect and promote the health of its members; the HMO operated on a direct service rather than on an indemnity basis; doctor’s fees were paid to the HMO, not to the physician; the HMO provided a list from which patients had to choose their primary care physician; primary care physicians were screened and regulated by the HMO; a primary physician’s referral was required in order to see a specialist; and patients had no choice as to the specialist.¹⁸ The court held that these factors created the inference that the patient looked to the HMO for care, and not solely to the physicians.¹⁹

3. Nondelegable Duty

The nondelegable duty theory of liability has been utilized in actions against the HMO. Generally, courts follow the rule of law that a principal is not liable for the negligence of an independent contractor. An exception arises, however, where it is determined that the principal owes a non-delegable duty to another party regardless of who else undertakes such duty.

The law of the nondelegable duty was recognized in Florida in *Mills v. Krauss*.²⁰ The *Mills* court stated that “[i]n some circumstances duties may devolve upon an employer which he cannot delegate to another, and in such cases the employer is liable for breach or non-performance of such duties even though he employs an independent contractor to do the work.”²¹ Once the duty is established, the employer will be held liable for an employee’s negligence as a matter of law.

15. *Id.* at 1234.

16. *Id.*

17. *Id.*

18. *Id.* at 1235.

19. *Boyd*, 547 A.2d at 1235. Agency by estoppel is more difficult to prove than ostensible agency because one must show detriment or reliance upon the representation made by the principal. Under an ostensible agency theory, there is no need to show detrimental reliance on the principal’s conduct in “holding out” the agent as its employee.

20. 114 So. 2d 817 (Fla. 2d Dist. Ct. App. 1959).

21. *Id.* at 819.

In *Irving v. Doctors Hospital of Lake Worth, Inc.*,²² the plaintiffs filed a negligence claim against an emergency room physician. The court held that it was error not to instruct the jury that a party may not escape its contractual liability by delegating performance under the contract to an independent contractor.²³ The court, noting that *Mills* involved an express contract, stated that the same nondelegable duty rests with a hospital in the implied contractual relationship between a hospital and an emergency room patient.²⁴ Therefore, a hospital does not absolve itself of the duty to provide nonnegligent care to emergency room patients by contracting with a physician to provide medical treatment. The *Irving* case is instructive because the hospital/emergency room physician-patient relationship is analogous to that of the HMO physician-patient.²⁵

B. Direct Liability

Plaintiffs seek to hold the HMO directly liable for negligent behavior through application of direct liability. The main theories of direct liability are the corporate negligence doctrine and liability arising from cost-containment systems. Corporate negligence is then further divided into negligent selection/retention and negligent supervision or control.

1. Corporate Negligence

The doctrine of corporate negligence in the context of hospitals was first introduced in *Darling v. Charleston Community Memorial Hospital*.²⁶ In *Darling*, the court found liability when the defendant hospital failed to properly review the patient's treatment and require proper consultation.²⁷ The court established that a hospital had an independent responsibility to patients to supervise the medical treatment provided by medical staff.²⁸ Liability was found as to the hospital's *own* negligence, not that of the physician.

22. 415 So. 2d 55 (Fla. 4th Dist. Ct. App. 1982).

23. *Id.* at 59.

24. *Id.* at 60.

25. See William A. Chittenden III, *Malpractice Liability and Managed Health Care: History and Prognosis*, 26 TORT & INS. L.J. 451, 461 (1991).

26. 211 N.E.2d 253 (Ill. 1965).

27. *Id.*

28. *Id.* at 260-61.

In *Pedroza v. Bryant*,³⁰ the Washington Supreme Court traced the history of the corporate negligence doctrine concisely, and explained its operation and effect in plain terms. The *Pedroza* court noted that the doctrine has been used to require a hospital to exercise reasonable care to insure that those physicians selected as part of the hospital's medical staff are competent.³¹ The court viewed the corporate negligence doctrine as a theory separate and apart from others because of the "increased public reliance upon hospitals."³² Faced with the duty that a hospital independently owes to a patient, the court then defined the standard of care as the degree of care of an average, competent hospital acting in the same or similar circumstances.³³

The seminal case on corporate negligence in Florida is *Insinga v. LaBella*.³⁴ *Insinga* involved a hospital which had admitted a man impersonating a doctor (under the name of Dr. LaBella) to its medical staff with full privileges. While on the staff, LaBella admitted plaintiff's wife to the hospital where she died nearly three weeks later.³⁵ The Supreme Court of Florida adopted the corporate negligence doctrine and held that hospitals "have an independent duty to select and retain competent independent physicians seeking staff privileges."³⁶ The court, citing *Pedroza*, reasoned that hospitals are in the best position to protect their patients.³⁷ The public policy supporting the decision was phrased by the *Insinga* court as "the present day view that a hospital is a multifaceted health care facility that should be responsible for proper medical treatment on its premises."³⁸ Elaborating further, the court opined that the "hospital is in a superior position to supervise and monitor physician performance and is, consequently, the only entity that can realistically provide quality control."³⁹

Insinga encompassed both negligent supervision/control and negligent selection/retention. Negligent selection or retention requires proof of two concurrent negligent acts, the negligent selection or retention of the

30. 677 P.2d 166 (Wash. 1984).

31. *Id.* at 168; see also *Elam v. College Park Hosp.*, 183 Cal. Rptr. 156 (Ct. App. 1982); *Mitchell County Hosp. Auth. v. Joiner*, 189 S.E.2d 412 (Ga. 1972).

32. *Pedroza*, 677 P.2d at 169. The *Pedroza* court noted that the role of the hospital is changing rapidly and is becoming that of a community health center.

33. *Id.* at 170.

34. 543 So. 2d 209 (Fla. 1989).

35. *Id.* at 210.

36. *Id.* at 214.

37. *Id.*

38. *Id.*

39. *Insinga*, 543 So. 2d at 214.

physician *and* the physician's malpractice.⁴⁰ The plaintiff must also show that the negligent selection or retention proximately caused the injury.⁴¹ Negligent supervision or control arises "when the hospital fails to detect physician incompetence or to take steps to correct the problems upon learning of information raising concerns of patient risk."⁴² Once again, by analogizing the relationship between the hospital and the emergency room to the relationship between the physician and patient, a plaintiff may be able to apply the doctrine to an HMO.⁴³

2. Cost-Containment Systems

Courts have also recognized the potential for liability stemming from the negligent implementation of a cost-containment system used by the HMO to pay for medical services provided to its members. In a cost-containment system medical services are reviewed prior to being provided in order to determine whether a less expensive treatment is available which would accomplish the same purpose.⁴⁴ In order to contain costs, employers turn to a PPO or HMO to furnish health care. Because of the emphasis on prospective cost containment, the HMO's involvement in a potential malpractice situation arises. An adverse determination of whether to pay for a service may result in a claim that a patient did not receive the needed medical help.

A cost-containment system was first implicated in *Pulvers v. Kaiser Foundation Health Plan*.⁴⁵ In *Pulvers*, the doctors were part of a health care plan which provided incentives to refrain from unnecessary tests and treatments. The plaintiff brought suit alleging that a death was caused by a physician's malpractice resulting from the doctor's failure to conduct proper treatment. The court noted that incentive plans were required by

40. Chittenden, *supra* note 25, at 472.

41. *Id.*

42. *Id.*

43. Other states have also followed the corporate negligence doctrine. *See, e.g., Tucson Medical Ctr., Inc. v. Misevch*, 545 P.2d 958, 960 (Ariz. 1976); *Elam*, 183 Cal. Rptr. at 160; *Ferguson v. Gonyaw*, 236 N.W.2d 543, 550 (Mich. Ct. App. 1975); *Raschel v. Rish*, 488 N.Y.S.2d 923, 924 (App. Div. 1985); *Johnson v. Misericordia Community Hosp.*, 301 N.W.2d 156, 164 (Wis. 1981).

44. *See* Robert C. Macaulay, *Health Care Cost Containment and Medical Malpractice: On a Collision Course*, 21 SUFFOLK U. L. REV. 91 (1987) (detailing the various control costs).

45. 160 Cal. Rptr. 392 (Ct. App. 1979).

federal statutes and supported by public policy.⁴⁶ The court also intimated that in order for liability to attach, the treating physicians would have to refrain from ordering tests or treatments which the accepted standards of the medical profession would require in order to receive certain incentives.⁴⁷

The litmus test for liability resulting from cost-containment programs was explained in *Wickline v. State*.⁴⁸ In *Wickline*, no liability was attached because the third party payor did not override the treating physician's medical judgment.⁴⁹ The court addressed the responsibility of a third party payor (the State of California) for harm suffered by a patient under a cost-containment program. The court stated that "[t]hird party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms."⁵⁰ The *Wickline* court went on to say that a doctor "cannot avoid [the] ultimate responsibility for his patient's care" when he "complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise."⁵¹

IV. A DEFENSE BASED UPON ERISA

As plaintiffs throughout the United States have expanded the medical malpractice horizon to include actions against HMOs, so too have new defenses been asserted. Of particular interest and significance is a defense based upon the Employment Retirement Income Security Act of 1974 ("ERISA").⁵² The successful application of ERISA effectively serves to eviscerate a malpractice action, because it eliminates any chance for a jury to consider the alleged wrongdoing and substantially narrows the recoverable damages, excluding pain and suffering as well as other consequential damages.

46. *Id.* at 394. The court did, however, rule that no malpractice was committed.

47. *Id.*

48. 228 Cal. Rptr. 661 (Ct. App. 1986).

49. *Id.* at 671. The same court, however, in *Wilson v. Blue Cross*, 271 Cal. Rptr. 876, 882-83 (Ct. App. 1990), dismissed a motion for summary judgment on a similar fact pattern based on the treating physician's testimony that the patient was dismissed because of a lack of funds to pay for a longer hospital stay. *See also DeGenova v. Ansel*, 555 A.2d 147 (Pa. Super. Ct. 1988) (remanding the trial court's dismissal of a suit based on the negligence of a reviewing physician when the plaintiff sought a mandatory second opinion prior to accepting health services).

50. *Wickline*, 228 Cal. Rptr. at 670.

51. *Id.* at 671.

52. 29 U.S.C. § 1001 (1988).

ERISA⁵³ was promulgated subsequent to the rapid rise of employee benefit plans used to provide health, medical, and pension-related services to employees throughout the United States.⁵⁴ The purpose of the ERISA statute is to protect the interests of participants in the plan by requiring disclosure of plan specifics and by establishing standards of responsibility and conduct, as well as providing access to the federal court system.⁵⁵ As a result, “ERISA comprehensively regulates . . . employee welfare benefit plans that, ‘through the purchase of insurance’ provide medical, surgical, or hospital care, or benefits in the event of sickness, disability, or death.”⁵⁶ ERISA’s application to a dispute is significant because of its myriad of procedural requirements, the federal law’s incorporation of trust law principles, and its elimination of the right to proceed with a jury trial.

The statute is implicated when a dispute arises which involves an employee benefit plan. As a result, most state laws and state law related claims are preempted by the terms of the statute. The preemptive effects are found in three statutory provisions.⁵⁷ ERISA provides for preemption if a state law relates to an employee benefit plan;⁵⁸ the saving clause excepts from the preemption clause laws that regulate insurance;⁵⁹ and the deemer clause makes clear that a state law that purports to regulate insurance cannot deem an employee benefit plan to be an insurance company.⁶⁰

How then does ERISA impact a malpractice action brought against an HMO? A Louisiana case provides an explanation. In *Rollo v. Maxicare, Inc.*,⁶¹ the plaintiff was injured in an accident and his dispute centered upon the subsequent medical treatment he received.⁶²

The court began by explaining that a threshold issue in a case which may implicate ERISA is whether the case involves a plan of the type

53. The statute sets out the congressional declaration of policy, *id.* § 1001(a)-(c), and sets forth regulatory provisions, *id.* §§ 1021-1030, among other things. ERISA has been called a “symbol of unnecessarily complex government regulation.” *Id.* § 1001 (quoting President Jimmy Carter in a message to Congress).

54. *Id.* § 1001(a).

55. 29 U.S.C. § 1001(a), (b) (1988).

56. *Pilot Life Ins. Co. v. Dedeux*, 481 U.S. 41, 44 (1987) (citing 29 U.S.C. § 1002(1) (1982)).

57. 29 U.S.C. §§ 1144(a), (b)(2)(A), (b)(2)(B) (1988).

58. *Id.* § 1144.

59. *Id.* § 1144(b)(1)(A).

60. *Id.*

61. 695 F. Supp. 245 (E.D. La. 1988).

62. *Id.* at 246.

contemplated by ERISA.⁶³ As noted, ERISA makes reference to a welfare benefit plan, which is “any employer program . . . which provides medical, surgical or other hospital benefits in the event of sickness, accident or disability.”⁶⁴ Notably, as in *Rollo*, a welfare benefit plan is typically involved in a medical malpractice case brought against an HMO. Thus, a cause of action involving such a plan should immediately raise a red flag as to ERISA’s application. Once it is determined that the relevant plan is of the type contemplated by ERISA, one must look to ERISA’s statutory language to determine whether the damages claim is preempted. The import of the application of ERISA is that damages are very limited. Therefore, the usual damages associated with a medical malpractice action are *not* generally recoverable.

In a traditional medical malpractice action an aggrieved plaintiff may seek, and a jury may award, economic damages such as past and future wage loss, and compensatory damages such as past and future medical expenses, including costs associated with life care plans. Further, non-economic damages based upon pain and suffering or emotional distress visited upon the plaintiff may be sought. A derivative claim sounding in consortium may also be made by the spouse of the injured plaintiff.

ERISA, however, limits or eliminates extra-contractual damages. A number of circuit courts of appeal have held that no extra-contractual money damages may be awarded.⁶⁵ Notably, courts adhere to the statutory language that requires preemption of state-promulgated extra-contractual damages that may seek to circumvent ERISA’s dictates.⁶⁶

A decision of the Fifth Circuit Court of Appeals also explains the effect of ERISA on a medical malpractice action. In *Corcoran v. United Healthcare, Inc.*,⁶⁷ the plaintiffs filed a wrongful death action against United Healthcare, Inc. and Blue Cross and Blue Shield of Alabama (“Blue Cross”), alleging that their unborn child died as a result of various acts of negligence in the administration of an employee plan from which the plaintiffs sought medical treatment for their unborn child.⁶⁸ The issue before the court was “whether ERISA pre-empts [sic] a state-law malprac-

63. *Id.* at 247.

64. *Id.* (citing 29 U.S.C. § 1002(1) (1982)).

65. *Drinkwater v. Metropolitan Life Ins. Co.*, 846 F.2d 821 (1st Cir.), *cert. denied*, 488 U.S. 909 (1988); *Sokol v. Bernstein*, 803 F.2d 532 (9th Cir. 1986).

66. *See Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992).

67. *Id.*

68. *Id.* at 1324.

tice action brought by the beneficiary of an ERISA plan against a company that provides 'utilization review' services to the plan."⁶⁹

In analyzing the nature of the claims, the Fifth Circuit noted that the plaintiffs alleged that Blue Cross wrongfully denied appropriate medical care and failed to oversee the medical decisions adequately.⁷⁰ Notwithstanding the state law basis of the claims, the court held that ERISA governs.

ERISA contains three provisions addressing preemption: the preemptive clause, the saving clause, and the deemer clause.⁷¹ Quoting the Supreme Court, the *Rollo* court summarized the effects of the three clauses as follows: "'If a state law 'relate[s] to . . . employee benefit plan[s],' it is pre-empted [sic]. . . . The saving clause excepts from the preemption clause laws that 'regulat[e] insurance.' . . . The deemer clause makes clear that a state law that 'purport[s] to regulate insurance' cannot deem an employee benefit plan to be an insurance company."⁷² Congress intended the preemptive clause, and thus the language "relate to," to be broadly interpreted.⁷³ In determining whether the claim relates to the plan, one must examine the nature of the claim. Claims for personal injury, whether physical or nonphysical, resulting from design or implementation of cost-containment or claims handling systems are typically preempted by ERISA because they are based on the HMO's administration of the plan.⁷⁴ Claims for personal injuries resulting from provider malpractice, however, may withstand preemption because the connection between claims such as medical malpractice and employee benefits plans do not relate to administration. Such claims may be deemed too tenuous, remote, or peripheral to warrant preemption. The saving clause relates to the regulation of insurance.⁷⁵ Under the clause, "the state law at issue must be said to directly regulate insurance."⁷⁶ The scope of the saving clause is accordingly very narrow. It is not enough that the relevant state law have some application in an insurance context or generally impact on the business of insurance.

69. *Id.* at 1322.

70. *Id.* at 1326.

71. *Rollo*, 695 F. Supp. at 247 (citing 29 U.S.C. §§ 1144(a), (b)(2)(A), (b)(2)(B) (1982)).

72. *Id.* at 247-48 (quoting *Pilot Life*, 481 U.S. at 44-45 (quoting 29 U.S.C. § 1144 (1974))).

73. *Pilot Life*, 481 U.S. at 47.

74. Chittenden, *supra* note 25, at 487-88.

75. 29 U.S.C. § 1144(b)(2)(A) (1988).

76. *Rollo*, 695 F. Supp. at 248.

Section 1132(a) of ERISA provides for civil remedies. Outside of these listed remedies, legislative policy dictates that no other actions shall be maintained against an ERISA plan.⁷⁷ Therefore, the analysis that a plaintiff is entitled to a remedy because preemption would leave him or her without a remedy is improper.⁷⁸ The claim simply must be one included under section 1132(a) of ERISA.

Essentially, the determination of preemption of a claim depends upon the claim's relation to the plan at issue. In *Independence HMO, Inc. v. Smith*,⁷⁹ the court held that Smith's state court medical malpractice claim was not preempted by ERISA because of the claim's relation to the welfare benefit plan.⁸⁰ Smith sued Independence HMO on a theory of ostensible agency. The court reasoned that the state law based tort action did not impact upon the employee benefit plan or affect the congressional scheme in the ERISA statute, and therefore was not preempted.⁸¹ Additionally, the court held that the plan's grievance procedure could not, by virtue of its design, adequately redress state tort claims against Independence HMO.⁸² The court also held that Smith had no obligation to exhaust the available remedies under the plan before filing suit.⁸³ The court reasoned that Smith's state tort action sought a remedy that did not arise under ERISA and the action did "not depend upon her contractual entitlement to health plan benefits."⁸⁴ The court cited *Mackey v. Lanier Collection Agency & Service, Inc.*,⁸⁵ for support of its position that the claim was not preempted.⁸⁶ The *Mackey* court stated that ERISA plans may be sued for run-of-the-mill state law claims such as torts committed by an ERISA plan.⁸⁷ Thus, under the *Independence HMO* rationale, not all claims involving ERISA plans would be preempted.

77. *Pilot Life*, 481 U.S. at 54.

78. See *Corcoran*, 965 F.2d at 1338-39; see also *DeGenova*, 555 A.2d at 150 (holding that the action was only remotely related to ERISA and thus not preempted).

79. 733 F. Supp. 983 (E.D. Pa. 1990).

80. *Id.* at 989; see also *Elsesser v. Hospital of the Philadelphia College of Osteopathic Medicine, Parkview Div.*, 802 F. Supp. 1286, 1290 (E.D. Pa. 1992) (holding that claims of state medical malpractice actions are not preempted by ERISA).

81. *Independence HMO*, 733 F. Supp. at 988.

82. *Id.*

83. *Id.*

84. *Id.*

85. 486 U.S. 825 (1988).

86. *Independence HMO*, 733 F. Supp. at 989.

87. *Mackey*, 486 U.S. at 833.

In contrast to *Smith*, the Fifth Circuit held that certain state law causes of action *are preempted* by ERISA.⁸⁸ In *Corcoran*, the court held that a tort claim based upon a wrongful death cause of action was preempted.⁸⁹ The court concluded that even though the provider made medical decisions and gave medical advice, it did so for the purpose of making a determination about the availability of benefits under the plan.⁹⁰ The court found that the claim was preempted by the *Pilot Life* principle found that ERISA preempts state law claims which allege that benefit claims were improperly handled.⁹¹ The *Corcoran* court also stated that allowing such a suit to proceed could contravene Congress's policy of providing a uniform body of law relating to benefit plans.⁹²

The *Corcoran* court distinguished its case from *Independence HMO, Inc. v. Smith*.⁹³ The court stated that *Independence HMO* involved the medical decisions of a doctor made in the course of treatment, whereas *Corcoran* involved a medical decision made in connection with a cost-containment feature of a plan.⁹⁴ Although the court found it "troubling" to hold that the plaintiffs had no available remedy, it stressed that the statutory scheme of ERISA demanded such a holding.⁹⁵ Any hope for a remedy in similar cases must be created by a congressional amendment to the ERISA legislation.⁹⁶

V. CONCLUSION

The states whose courts have developed the greatest amount of case law on HMO liability are California, Pennsylvania, and Louisiana. California has opened the door to HMO liability for the negligent design or negligent implementation of cost-containment systems. The California courts have implied a willingness to hold HMOs liable when cost limitation programs corrupt medical judgment. For example, a plaintiff would stand

88. *Corcoran*, 965 F.2d at 1339.

89. *Id.* at 1331; see *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 66 (1987) (holding that in ERISA cases, preemption defense provides sufficient basis for removal to federal court, notwithstanding the "well-pleaded" complaint doctrine).

90. *Corcoran*, 965 F.2d at 1331.

91. *Id.* at 1332; see also *Elsesser*, 802 F. Supp. at 1291 (holding that claims of negligent refusal to pay benefits are preempted by ERISA).

92. *Corcoran*, 965 F.2d at 1332.

93. *Id.* at 1333 n.16.

94. *Id.*

95. *Id.* at 1338.

96. *Id.* at 1339.

a good chance of recovering from an HMO if the plan suggested the provider physician refrain from ordering medical tests or treatment required by the accepted standards of the profession. Furthermore, California courts have also recognized the potential for liability where the HMO overrides the judgment of a plaintiff's treating physician to deny funding for diagnostic tests or for an extended hospital stay. The Pennsylvania courts are also developing HMO law which is decidedly pro-plaintiff. The Superior Court of Pennsylvania has held that a physician may be the ostensible agent of an HMO. Pennsylvania has also been hesitant to preempt claims under ERISA.

While it is generally agreed among courts that claims involving the administration of a plan are preempted, courts in different states differ as to the reach of the ERISA preemption. For example, Pennsylvania courts have held that ERISA does not preempt medical malpractice claims. Pennsylvania has also expressed a willingness to allow a claim for personal injuries when a remedy for the injury is not provided by ERISA. Allowing such claims is a liberal interpretation of Supreme Court cases addressing ERISA preemption.

Louisiana courts, on the other hand, have been more restrictive than the Pennsylvania courts in allowing claims where an ERISA plan is at issue. Louisiana courts have held ERISA preempts state medical malpractice and other state law tort claims. The Louisiana courts have noted that where Congress has explicitly exempted an area of state law, e.g., insurance, there is no reason to imply exemptions in areas which Congress did not specifically address. Had Congress intended to create further exemptions it could have drafted such exceptions into the legislation. Therefore, the Louisiana courts have stated that if a claim would interfere with ERISA's "carefully constructed scheme of legislation" then it should be preempted. It does not matter that preemption would leave the plaintiff without a remedy. The Louisiana courts have stated their preference for disallowing state law claims relating to ERISA plans, true to Congress's intent, thereby deferring to Congress in the fashioning of remedies under ERISA. Accordingly, it is relatively difficult to recover for a claim in which a welfare benefit plan is at issue in Louisiana.