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BAD MEDICINE: ERISA'S EQUITABLE REMEDIES AND THE PREEMPTION OF FUNDAMENTAL LEGAL RIGHTS

MARILYN LABLAIKS*

*I conceive that the great part of the miseries of mankind are brought upon them by false estimates they have made of the value of things.*¹

Benjamin Franklin

INTRODUCTION

The title of the Employee Retirement Income Security Act (ERISA)² could lead one to think that the sole purpose of this legislation is to protect employees by safeguarding or retirement income and otherwise improving their security.³ Further, the preamble of the Act seems to describe the protection of interstate commerce or the federal taxing power.⁴ However, the case law reveals that ERISA's fundamental purpose is to protect the employer's benefit plan from employee claims even when an employee dies or suffers a disability as a result of the plan.⁵

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1. DONALD O. BOLANDER, INSTANT QUOTATION DICTIONARY 263 (1962).

2. 29 U.S.C. § 1001 (1994).

3. *See id.* § 1001(a) (describing the need for safeguards to protect employee interests from loss of anticipated benefits).

4. *See id.* § 1001(b)(c) (respecting the government's interest in the soundness of such plans).

5. *See generally* *Hull v. Fallon*, 188 F.3d 939, 941-42 (8th Cir. 1999), *reh'g denied*, (Oct. 7, 1999), and *cert. denied*, 68 U.S.L.W. 3433 (U.S. Feb. 28, 2000) (No. 99-1083) (dismissing a claim for negligence where approval for a thallium stress test was denied and the employee subsequently suffered a myocardial infarction and permanent heart damage); *Shea v. Esenstein*, 107 F.3d 625, 627-29 (8th Cir. 1997), *cert. denied*, 66 U.S.L.W. 3137 (U.S. Oct. 14, 1997) (No. 97-225) (holding no cause of action was available to plaintiff for wrongful death where beneficiary died of massive myocardial infarction after repeated refusals to grant a referral to a specialist in cardiology); *Jass v. Prudential Healthcare Plan, Inc.*, 88 F.3d 1482, 1493-94 (7th Cir. 1996) (holding Congressional intent to exclude actions based on negligence and vicarious liability where approval for limited physical therapy following knee surgery resulted in permanent disability); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1324-34 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992) (finding medical decision to deny hospitalization for high risk pregnancy that ended in

Patrick Shea was forty years old with a family history of heart disease.⁶ His employment provided health insurance managed by a Health Maintenance Organization (HMO). Shea visited his HMO doctor complaining of chest pain, dizziness, and shortness of breath.⁷ Although Shea offered to pay for a cardiac consultation, his HMO doctor insisted that a referral to a cardiologist was unnecessary.⁸ A few months later, Shea died of heart disease.⁹ Afterwards, his family learned that the HMO doctor received a year-end bonus based on restricting referrals to specialists.¹⁰

Likewise, in another case, Betty Jass' surgeon recommended that she receive two weeks of rehabilitation following knee surgery.¹¹ However, her managed care utilization reviewer approved only four days of physical therapy.¹² Consequently, she suffered permanent disability because she was unable to pay for additional physical therapy out-of-pocket.¹³

Under ERISA, a court can transfer a well-pleaded complaint for personal injury due to negligence¹⁴ into an "artfully pleaded complaint" which can be construed as a claim for benefits.¹⁵

stillbirth was incidental to a benefit decision); *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 52-56 (D. Mass. 1997) (decrying the lack of recovery under ERISA, while dismissing a claim for wrongful death, loss of consortium and infliction of emotional distress when an insurer refused to authorize a thirty-day alcoholic treatment program for a beneficiary under court order for treatment). This resulted in an involuntary commitment to a state facility where instead of therapy or treatment, the "beneficiary" was raped and sodomized by another inmate, culminating in a successful suicide attempt. *Id.* at 51.

6. *Shea*, 107 F.3d at 626.

7. *Id.*

8. *Id.*

9. *Id.*

10. *Id.* at 627.

11. *Jass*, 88 F.3d at 1485.

12. *Id.*

13. *Id.*

14. 28 U.S.C. § 1331 (1994); 28 U.S.C. § 1441(b) (1994). See *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 353-54 (3rd Cir. 1995), *cert. denied*, 516 U.S. 1009 (1995) (analyzing the well-pleaded complaint rule as applying to some actions brought where ERISA is a defense to a state claim but preemption does not remove the claim to federal court); *accord Crum v. Health Alliance-Midwest, Inc.*, 47 F. Supp. 2d 1013, 1019-20 (C.D. Ill. 1999) (holding that liability for substandard care relates to the quality of care, and is not a claim for benefits).

15. *Jass*, 88 F.3d at 1488. See also *Hull v. Fallon*, 188 F.3d 939, 943 (8th Cir. 1999), *reh'g denied*, (Oct. 7, 1999) *cert. denied*, 68 U.S.L.W. 3433 (U.S. Feb 28, 2000) (No. 99-1083) (holding that Dr. Fallon was acting as a plan administrator rather than a treating physician, and therefore claim was for benefits, not negligence); *accord Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1332 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992) (characterizing medical decisions made by utilization review as "part and parcel of mandate to

ERISA only entitles individuals to recover benefits under the plan, even though authorization for a cardiology consult after death or ten days of physical therapy after suffering an irreversible physical disability are woefully inadequate remedies.¹⁶ Welcome to ERISA-land,¹⁷ where employers and insurers contract,¹⁸ while employees pay and assume the risks.¹⁹ ERISA-land is a place where anonymous functionaries make "benefit decisions" and deny essential medical treatment based solely on cost.²⁰ It is a place where employees are forced to bear the benefit of the bargain in the form of death,²¹ disability,²² and suffering.²³

Part I of this Comment describes the historical context of healthcare systems, individual rights for recovery of bodily harm, and the purpose and policy underlying ERISA. Part II discusses the judicial interpretation of ERISA's preemptive effect on bodily tort injuries and the current split regarding the preemption application. Part III contends that ERISA unjustly preempts constitutionally guaranteed fundamental rights. Finally, Part IV proposes that ERISA's preemption must be narrowly construed to avoid constitutional conflicts related to Federalism and individual common law rights guaranteed by the Seventh Amendment.

I. HEALTHCARE, INDIVIDUAL RIGHTS AND ERISA

*There is hardly anything in the world that some man cannot make a little worse and sell a little cheaper.*²⁴

-John Ruskin

decide benefits under [a] plan").

16. 29 U.S.C. §1132(a)(1)(B) (1994). "A civil action may be brought by a participant or beneficiary to recover benefits due him under the plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." *Id.*

17. See *Health Cost Controls of Ill., Inc. v. Washington*, 187 F.3d 703, 712 (7th Cir. 1999) *cert. denied*, 120 S. Ct. 979 (2000) (referring to the confusion in "ERISA land" regarding what document among several agreements is really "the plan" in an insurance subrogation claim).

18. See *Herdrich v. Pegram*, 154 F.3d 362, 365-72 (7th Cir. 1998), *rev'd*, *Pegram v. Herdrich*, 530 U.S. 211 (2000) (describing the relationship between Carle Clinic, a direct provider; Health Alliance Medical Plans, a service provider; Carle Health Ins. Management Co., a plan administrator; and State Farm Insurance, the employer who sponsored the plan).

19. See, e.g., *id.* at 374 (delaying ultrasound results in ruptured appendix and peritonitis).

20. See *Corcoran*, 965 F.2d at 1324 (overruling physician's recommendation for hospitalization). Utilization review authorized limited home nursing instead. *Id.*

21. See, e.g., *Shea v. Esensten*, 107 F.3d 625, 626 (8th Cir. 1997).

22. See, e.g., *Jass*, 88 F.3d at 1485.

23. See, e.g., *Hull v. Fallon*, 188 F.3d 939, 941 (8th Cir. 1999), *cert. denied* 68 U.S.L.W. 3433 (U.S. Feb. 28, 2000) (No. 99-1083).

24. BOLANDER, *supra* note 1, at 217.

A. *The Evolution of Healthcare from Social Paradigm to Business Model*

1. *The Traditional Model of Social Service*

In the traditional model of healthcare, medical care is a basic necessity.²⁵ Prevention and treatment of disease, like education and welfare, benefits both the individual and society.²⁶ Historically, healing was seen as a divine gift or an inherent talent.²⁷ Hospitals were charitable institutions run by religious orders.²⁸ Further, treatments such as bloodletting, although crude, ineffective, and dangerous, were accepted practice.²⁹ Fortunately, in the last 150 years, technical advances and expenditures for public health have led to an increase in life expectancy and the overall quality of life.³⁰

However, as a result of dependence on employer sponsored insurance improved medical treatment translated into higher treatment costs.³¹ Medical insurance, modeled on other types of indemnity insurance, began as a non-profit venture under Blue Cross Blue Shield to provide coverage for major medical expenses.³² Employers offered group medical insurance as an

25. See LEIYU SHI & DOUGLAS A SINGH, DELIVERING HEALTHCARE IN AMERICA 51 (1998) (contrasting market justice and social justice as concepts; describing how healthcare differs from other goods and services because it is driven by need rather than cost).

26. See *id.* (describing the collective burden to society that an unhealthy individual creates). See also VICTOR R. FUCHS, THE FUTURE OF HEALTH POLICY 55-57 (1993) (correlating health status, schooling and poverty, to suggest poverty is often a result of poor health rather than its cause); ANNE FREEMANTLE, AGE OF FAITH 12 (1965) (tracing the roots of social welfare to the Church theocracy of the middle ages which acted as the sole provider of hospitalization and education for the poor).

27. See FIELDING H. GARRISON M.D., AN INTRODUCTION TO THE HISTORY OF MEDICINE 91-98 (1913) (explaining how Hippocrates associated healing with art).

28. See FREEMANTLE, *supra* note 26, at 150 (discussing the development of licensing the practice of medicine, and the establishment of the first chartered hospitals by monks in the thirteenth century).

29. See THOMAS SZASZ, THE THEOLOGY OF MEDICINE 25 (1977) (comparing bloodletting or venesection with modern electroshock as medical interventions justified by practice custom but therapeutically ineffective and detrimental to health).

30. See WILLIAM C COCKERHAM, MEDICAL SOCIOLOGY 3-7 (3rd ed. 1986) (tracing the effects of discovery of the germ theory, antibiotics, anesthetics, x-rays, epidemiology and scientific methods of research on medical treatment).

31. See *id.* at 231 (indexing consumer prices for medical care from 1947-1982 according to statistics provided by the U.S. Dept. of Labor).

32. See, e.g., SHI & SINGH, *supra* note 25, at 89-90 (describing the need to spread financial risk for future needs that are unpredictable); CHARLES ANDREWS, PROFIT FEVER: THE DRIVE TO CORPORATIZE HEALTHCARE AND HOW TO STOP IT 5-6 (1995) (explaining traditional indemnity insurance which limited benefits, covered only hospitals and surgical procedures, and left

employee benefit when wartime regulations froze wages.³³ Group plans became increasingly popular because they benefited both employees and employers.³⁴

However, the unemployed, indigent, and elderly lacked medical coverage.³⁵ Thus, in the 1960's, Medicare and Medicaid initiated partial reimbursement to medical providers through government programs.³⁶ Providers of medical services financed this plan by inflating costs to private insurers.³⁷ Employers passed on rising premiums to employees,³⁸ causing a vicious cycle of decreasing affordability.³⁹

All other industrialized nations have universal coverage through government sponsored national healthcare.⁴⁰ Countries with universal healthcare have lower healthcare costs,⁴¹ lower infant mortality rates, and longer life expectancy than the United

policy-holders with large deductibles and routine care to be paid out of pocket).

33. See SHI & SINGH, *supra* note 25, at 90 (describing the Supreme Court ruling that allowed health insurance benefits to be subject to collective bargaining, leading to the expansion of employer provided coverage); ANDREWS, *supra* note 32, at 6, 16 (tracing the historical addition of health insurance to attract labor during the World War II labor shortage and wage freeze). Stagnating wages adjusted by inflation since the 1960's have been offset by tax exempt medical benefits. *Id.*

34. See SHI & SINGH, *supra* note 25, at 90 (correlating postwar affluence with the expansion of health benefits).

35. See ANDREWS, *supra* note 32, at 18 (comparing auto insurance to health insurance; how competition for low risk beneficiaries excludes, limits, or places severe restrictions on high risk groups more likely to need services).

36. See, e.g., GEORGE ANDERS, HEALTH AGAINST WEALTH 174-75, 192-93 (1996) (contrasting government programs for the elderly and poor); ANDREWS, *supra* note 32, at 17 (showing how spending increases in these programs between 1966-1990 correlate with inflation in the cost of medical services).

37. See SHI & SINGH, *supra* note 25, at 90-93 (describing the policy of shifting costs previously borne by charity to society at large).

38. See *id.* at 203 (noting the erosion of margins for cost shifting as private plans implement cost-containment measures).

39. See D.W. Roslokken, Esq., *Countdown to Patient Protection*, BUSINESS & HEALTH, Apr. 1999, at 36, 40 (citing Healthcare Financing Administration figures from 1996 that show employee contributions to premiums increasing, with most employees limited to a single "take it or leave it" plan).

40. See ANDREWS, *supra* note 32, at 37-38 (comparing the United States system with that of Canada). See also COCKERHAM, *supra* note 30, at 247-62 (comparing financing and delivery of healthcare systems in Sweden, Great Britain, Canada, West Germany, Japan, Soviet Union, People's Republic of China and ranking statistics of infant mortality and life expectancy).

41. See SHI & SINGH, *supra* note 25, at 449 (comparing the average per capita spending of fourteen industrialized nations in 1994). Healthcare spending in Europe averaged \$1609 per capita, compared to the United States at \$3465; the proportion of GNP, respectively 8.3 to 13.6 in 1995. *Id.* Canada's insurance overhead per person is \$34 compared to \$212 in the United States. ANDREWS, *supra* note 32, at 37-38. Yet rates of transplant surgery in Canada are higher in all categories except kidney transplants, which are the only transplants covered by Medicare in the United States. *Id.*

States.⁴² Thus, a medical system based on social humanitarianism ultimately delivers superior health outcomes.

2. *The New Business Model*

The United States has rejected the universal healthcare model, continuing to rely on private payers to provide coverage for the young, healthy, and employed.⁴³ Private payers, forced to supplement government programs directly through taxation and indirectly through cost-shifting by medical providers, looked to a new business model of medical care emphasizing cost containment that emerged in the 1980's.⁴⁴ Prepaid Health Maintenance Organizations (HMOs) focused care on prevention and intervention designed to promote health rather than to treat illness.⁴⁵ The early non-profit HMOs evolved into for-profit Managed Care Organizations (MCOs).⁴⁶ MCOs contract with employers and other groups to provide medical services to their members.⁴⁷ Group contracts limit the use and availability of facilities, equipment, drugs, and specialists.⁴⁸ The strategy is to

42. See SHI & SINGH *supra* note 25, at 522 (listing World Health Organization life expectancy and infant mortality rates for twenty-seven countries in 1996, with the United States ranking ahead of third world and communist countries, but behind almost all industrialized western nations). See also COCKERHAM, *supra* note 30, at 248-49 (listing similar statistics from the United Nations Demographic Yearbook for the years 1975 and 1980).

43. See SHI & SINGH, *supra* note 25, at 90 (describing the expansion of healthcare benefits provided by employers as public policy).

44. See REGINA HERZLINGER, MARKET DRIVEN HEALTHCARE 111 (1997) (applying systems analysis from the military to healthcare in an attempt to set rational protocols to reduce the need for individual judgment); *but see id.* at 126-27 (pointing out the problem of standardizing care because medical treatment involves uncertainty).

45. See SHI & SINGH, *supra* note 25, at 524 (opining that preventive care is cheaper than treating problems after they occur); *but see* MICHAEL E. MAKOVER, M.D., MISMANAGED CARE 264-66 (1998) (pointing out a consumer incentive to maximize benefits through the indiscriminate use of services not directly paid for).

46. See *Herdrich v. Pegram*, 154 F.3d 362, 375 (7th Cir. 1998), *rev'd*, *Pegram v. Herdrich*, 530 U.S. 211 (2000) (commenting on the transformation of healing from covenant to business contract; siphoning healthcare dollars into marketing, administration and profits). See also ANDERS, *supra* note 36, at 26-27 (comparing original non-profit pre-paid group plans devised in the 1930's that forced providers to work within a fixed budget with capitation and case rate payment schemes of MCOs that make sick people unprofitable).

47. See ANDERS, *supra* note 36, at 31 (describing how savings from MCOs enticed large corporate employers such as Allied Signal, Southwestern Bell and Sears to switch plans); ANDREWS, *supra* note 32, at 31-32 (pointing out that MCO's customers are the employers, not the consumers).

48. See, e.g., MAKOVER, *supra* note 45, at 176 (explaining how one MCO blamed medical specialists for high fees, and advocating the increased use of lesser-trained physician assistants and nurse practitioners with emphasis on primary care); ANDERS, *supra* note 36, at 77 (describing the practice of

contain costs through policies that discourage treatment.⁴⁹ This policy assumes that most illnesses are self-limiting.⁵⁰ It further assumes that most treatment is ineffective⁵¹ and rarely justifies the received benefit.⁵²

MCOs delivered healthcare by contracting with hospitals and physicians to manage medical services.⁵³ To make a profit, reimbursement is structured to shift the cost of care to providers through capitation and bonus carve-outs.⁵⁴ Moreover, MCOs can set prices because they control large segments of the market.⁵⁵

steering heart surgery patients to hospitals that offer discounts to the MCO, even when survival rates compare unfavorably to more conveniently located facilities, requiring permission for emergency room visits, and refusing to pay even when the emergency is clearly life threatening); JEFFREY M. THURSTON M.D., DEATH OF COMPASSION 143-53 (1996) (describing cases of arbitrary MCO decisions that harmed patients). One MCO refused a blood screening test for early detection of ovarian cancer in a high risk patient who went on to develop the disease and die. *Id.* at 143-48. Another MCO denied use of a drug shown to be safe in pregnant women, because it was not on the MCO's list of preferred drugs, and substituted a cheaper drug, known to cause birth defects to a pregnant woman. *Id.* at 148-49.

49. See HERZLINGER, *supra* note 44, at 120 (identifying MCO policy to attract healthy enrollees and discourage enrollment of the sick through rationed care); ANDERS, *supra* note 36, at 235-36 (reviewing clinical charts for quality assurance). One MCO was reluctant to order a spinal tap in a patient later diagnosed with meningitis. *Id.* at 235. Another MCO failed to refer a woman with severe weight loss to a specialist. *Id.* Two years later she needed small bowel transplantation. *Id.*

50. *But see* MAKOVER, *supra* note 45, at 176-77 (noting that symptoms of a common cold could be differentiated into fifteen different conditions or illnesses, from serious to life threatening).

51. See SZASZ, *supra* note 29, at 25-27 (opining that medical intervention is often based on the capricious preferences of patient and provider rather than medical effectiveness).

52. See ANDERS, *supra* note 36, at 18-25 (finding the use of high tech medical tools did not correlate with increased life expectancy). Regional variations on treatments and procedures suggested overuse and inappropriate use of services where reimbursement was automatic. *Id.*

53. See SHI & SINGH, *supra* note 25, at 304-13 (describing payment models of MCOs). These include capitation per person; fee schedules for discounted rates on procedures; case management and gatekeeping by primary providers; delegating patient care to assistants and nurses; awarding bonuses when no other service is used; and utilization review requiring providers to obtain authorization for all services. *Id.* Physician's contracts are renewed on the basis of frugal practice. *Id.*

54. See *Herdrich v. Pegram*, 154 F.3d 362, 372 (7th Cir. 1998), *rev'd*, *Pegram v. Herdrich*, 530 U.S. 211 (2000) (limiting referrals leads to year-end bonuses for physician-administrators); *Shea v. Esenstein*, 107 F.3d 625, 627 (8th Cir. 1997) (reducing reimbursement to primary care doctors if too many referrals are made to specialists). See also FUCHS, *supra* note 26, at 161-62 (citing drug company profits and physician salaries as examples of excess to be controlled through eliminating incentives to treat).

55. See ANDERS, *supra* note 36, at 200-01 (noting that a consulting firm found a Medicaid MCO controlled the market and set prices in Tennessee at

Therefore, it is not surprising that standard MCO contracts contain gag clauses to prevent providers from discussing payment incentives and unauthorized treatment options with patients. MCO contracts afford for provider termination without cause clauses and hold harmless clauses to prevent actions for indemnification against MCOs.⁵⁶

B. Traditional Rights of Patients, Consumers, and Common Law Tort for Personal Injury

1. Patient's Rights

Traditional patient's rights, based on common law, center on the right of autonomy in treatment decisions,⁵⁷ including informed consent⁵⁸ and confidentiality.⁵⁹ In fact, the Supreme Court has held that patients have the right to accept or reject a recommended treatment.⁶⁰ In addition, personal autonomy is a fundamental privacy right.⁶¹

Medical treatment is not an arms length transaction between equal parties,⁶² but a relationship of professional reliance.⁶³ Reliance by one party on the special skill or knowledge of the other creates a relationship of trust and gives rise to a legally recognized

45% of actual cost, resulting in hospital cutbacks, and physicians starting salaries too low to pay back student loans).

56. *See id.* at 80 (describing how participating doctors who break the code of silence are expelled from the plan). *See also* Stephen Franklin & Bruce Japsen, *Union Idea May Be Just What Doctors Ordered*, CHI. TRIB., Feb. 7, 1999, § 5, at 1 (describing the lack of mutual bargaining power in MCO contracts).

57. *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

58. *See* BARRY R. FURROW ET AL., *HEALTH LAW CASES MATERIALS AND PROBLEMS* 397 (3d ed. 1997) (identifying the purpose of consent in setting boundaries for the doctor-patient relationship and regulating medical experimentation).

59. *See id.* at 380 (distinguishing between the physician's testimonial privilege of confidentiality and access to medical records by various parties, including insurers, employers, credit investigators and law enforcement agencies for non-medical purposes). *See, e.g.*, ANDERS, *supra* note 36, at 30-31, 76 (noting that competition among MCOs results in provider turnover and repeated duplication and transfer of medical records).

60. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 270 (1990).

61. *Id.*

62. *See* FURROW, *supra* note 58, at 360 (distinguishing the physician-patient relationship from traditional contract because of inequality in negotiation and the vaguely defined service to be provided). Standard intentions and reasonable expectations of quasi-contract apply to the physician-patient agreement. *Id.*

63. *See* JOHN W. WADE ET AL., *PROSSER, WADE AND SCHWARTZ'S CASES AND MATERIALS ON TORTS* 130 (9th ed. 1994) (assuming an obligation of service based on public confidence includes surgeons).

duty of loyalty.⁶⁴ This duty of loyalty is an obligation to act in the other's best interest that is similar to a fiduciary duty.⁶⁵ Arguably, providers breach the duty when their loyalty is divided between financial gain and patient care.⁶⁶ Therefore, full disclosure of a provider's interest when recommending a treatment or procedure is necessary to insure the patient's informed consent.⁶⁷ However, this disclosure is expressly prohibited in contractual agreement with the MCO.⁶⁸ A provider's duty to a patient may also be breached through a negligent act or failure to act that results in physical injury.⁶⁹ The provider's standard for negligence is that of a reasonably prudent professional as determined by a finder of fact.⁷⁰ Professional competence is regulated through national standards,⁷¹ testing, and state licensing requirements to assure the minimum knowledge required for the practice of medicine.⁷² Nevertheless, approval for provider recommended treatment is often subject to the judgment of unlicensed laymen employed by the MCO.⁷³

2. Consumer Rights

Unlike patient's rights, consumer rights are protected by state statute under the authority of the Tenth Amendment police power.⁷⁴ State police power extends to those areas of daily life that affect the health, safety, welfare, and education of its citizens.⁷⁵ This extended power includes statutes governing the regulation of insurance carriers⁷⁶ and healthcare providers doing business in a state.⁷⁷ When insurance carriers and healthcare providers violate

64. RESTATEMENT (SECOND) OF TORTS § 874 (1977).

65. *Id.*

66. *Moore v. Regents of U. of Cal.*, 793 P.2d 479, 483-85 (Cal. 1990).

67. *Id.*

68. ANDERS, *supra* note 36, at 80.

69. RESTATEMENT (SECOND) OF TORTS § 284 (a), (b) (1965).

70. *See Hall v. Hilbun*, 466 So. 2d 856, 879 (Miss. 1985) (holding that a jury had the right to hear the expert testimony of a physician from outside the community because professional standards are national).

71. *Id.* at 868.

72. *See, e.g.*, 225 ILL. COMP. STAT. 60/1-63 (West 1998) (licensing physicians in Illinois).

73 *See SHI & SINGH, supra* note 25. Authorization for services can only be approved through the MCO utilization review process. *Id.*

74. U.S. CONST. amend. X. *See, e.g.*, 815 ILL. COMP. STAT. § 5-505 (West 1998) (governing actions for consumer fraud).

75. *Lochner v. New York*, 198 U.S. 45, 65-67 (1905) (5-4 decision) (Harlan, dissenting).

76. *See, e.g.*, 15 U.S.C. § 1012(b) (1994) (stating "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . ."). *See also* 215 ILL. COMP. STAT. 5-165 (West 1998) (regulating the business of insurance in Illinois).

77. 210 ILL. COMP. STAT. 3-145 (West 1998) (regulating healthcare facilities

these statutes, long arm statutes allow states to claim jurisdiction over actions that arise from commercial or tortious activities in each respective state.⁷⁸ Federal law requires that all common law actions be determined through interpretation of state decisions.⁷⁹ However, state law may be expressly or impliedly preempted by federal law under the power of the Supremacy Clause of the United States Constitution.⁸⁰

3. Common Law Tort of Personal Injury

Common law actions for bodily harm have a history that can be traced from antiquity.⁸¹ Ancient doctrines speak of the concept of "an eye for an eye"⁸² and "blood money"⁸³ for retribution and compensation of harm done.⁸⁴ Early law was less concerned with the actor's intention and more concerned with the results of the conduct. Early law allowed suits for bodily injury without distinction between intentional and negligent harm.⁸⁵ The Magna Carta expanded this by establishing the right to petition for redress of private wrongs, and the right to a trial by jury.⁸⁶ By the fifteenth century, negligence developed as a separate cause of action in the English courts.⁸⁷ The negligence action included the

in Illinois); 225 ILL. COMP. STAT. 5-110 (West 1998) (regulating medical professionals in Illinois).

78. 735 ILL. COMP. STAT. 5/2-209 (West 1998).

79. 28 U.S.C. § 1652 (1994); *Erie R.R. v. Tompkins*, 304 U.S. 64, 78 (1938).

80. U.S. CONST. art. VI.

81. See SAMUEL NOAH KRAMER, *CRADLE OF CIVILIZATION* 125-26 (1967) (discussing the discovery of written legal codes, cases, and precedents in Mesopotamia 1750 B.C.). The code of Hammurabi proscribed that an eye surgeon should forfeit his or her hand if the surgeon's treatment of a patient results in the patient's blindness. *Id.* This is one of the first malpractice cases! *Id.*

82. *Exodus* 21:24.

83. Belinda Wells & Michael Burnett, *When Cultures Collide: An Australian Citizen's Power to Demand the Death Penalty Under Islamic Law*, 22 SYDNEY L. REV. 5, 13 (2000).

84. See generally *Exodus* 21:1-32 (describing a series of personal injuries and their legal remedies, including the payment of damages by coin). See also WADE, *supra* note 63, at 4 (characterizing the development of the law of torts from moral standards of culpability to our present fault system).

85. See *Weaver v. Ward*, 80 Eng. Rep. 284 (K.B. 1616) as cited in WADE, *supra* note 63, at 5 (finding that justifies a criminal act does not excuse the civil injury; motive does not diminish liability for harm).

86. See FREEMANTLE, *supra* note 26, at 145-46 (citing the guarantee of rights enumerated in sixty-three provisions of the Magna Carta as signed by King John in June of 1215). Twelve provisions in the Magna Carta continue to this day. *Id.* Incorporated into our own Bill of Rights are the right to a trial by jury in article thirty-nine, and the equal, universal application of the law promised in article sixty. *Id.*

87. See LARRY L. TEPLY & RALPH U. WHITTEN, *CASES & PROBLEMS ON CIVIL PROCEDURE: BASIC & ADVANCED* 8 (1997) (describing how recovery for injury under the writ of trespass on the case led to modern negligence law).

right to a jury and compensation for physical loss through money damages.⁸⁸

Our current system determines fault by analyzing foreseeable harm to a foreseeable person⁸⁹ and the utility of an act balanced against its risk.⁹⁰ Furthermore, the original common law immunities have eroded and a negligent party is more likely to be liable for the resulting harm.⁹¹ Therefore, the idea that an innocent party should not bear the cost of harm caused by the deliberate act of another is a central tenet of our system of tort law.⁹²

Consequently, an alternative no-fault system of compensation has evolved to protect both business and consumer interests from increasing liability.⁹³ Examples of no fault compensation are product liability,⁹⁴ worker's compensation,⁹⁵ and no-fault auto statutes.⁹⁶ However, a no-fault scheme that simply shifts the cost

88. See *id.* at 12-13 (distinguishing actions at law and actions in equity at early common law by identifying the remedy requested). Courts of law awarded judgment of money damages and afforded a right to trial by jury, while equitable courts could only act if the remedy at law was inadequate. *Id.*

89. See *Palsgraf v. Long Island R.R.*, 162 N.E. 99, 102-05 (N.Y. 1928) (establishing duty and breach of duty, analyzing causation through foreseeability, and laying the foundation for three of the four elements of negligence, the fourth being actual damages).

90. See *United States v. Carroll Towing Co.*, 159 F.2d 169, 173 (2nd Cir. 1947) (balancing factors to determine when a risk is so unreasonable as to rise to the level of negligence); RESTATEMENT (SECOND) OF TORTS §§ 291-293 (1965).

91. See *Abernathy v. Sisters of St. Mary's*, 446 S.W.2d 599, 601-06 (Mo. 1969) (superseded by statute as stated in *Harrell v. Total Health Care*, 781 S.W.2d 58 (Mo. 1989) (removing traditional common law immunity from a charitable hospital)). The court rejected the theory of implied waiver from one who accepts a benefit against recourse for harm done, because modern charity has become a "corporate big business." *Id.*

92. See RICHARD A. POSNER, *ECONOMIC ANALYSIS OF LAW* 272-73 (5th ed. 1998) (describing negligence as "socially wasteful conduct" and the need for liability to deter such behavior by allocating resources to safety).

93. See WADE, *supra* note 63, at 1209 (describing how fault litigation results in substantial administrative and transactional costs).

94. See *id.* at 694 (explaining how strict liability was extended to goods sold that resulted in physical harm). Principles of implied warranty replaced tort elements of duty and breach, thereby shifting the risk to the party with the ability to pay, and encouraging the development of safer goods. *Id.*

95. See *id.* at 1190-94 (describing the development of worker's compensation). No remedy existed at common law. *Id.* Worker's compensation changed this to allow partial recovery without proof of negligence by creating an equitable recovery system. *Id.* This reflects public policy that "[t]he cost of the product should bear the blood of the workman." *Id.*

96. See *id.* at 1206-08 (reciting the benefits of a no-fault system). These benefits include (1) reducing the overall costs of compensation by avoiding litigation through fixed amounts matched to actual economic loss, (2) speeding up compensation to injured parties, and (3) allowing greater predictability of

of risk from the tortfeasor to the injured party violates public policy and may be unconstitutional.⁹⁷

C. ERISA: Purpose, Means and Remedies

1. Purpose of ERISA

Prior to 1974, the United States Congress held lengthy congressional hearings on the inadequacy, instability, and often illusory issue of employee benefits that are provided through employer pension plans.⁹⁸ The product of those hearings is the statute known as the Employment Retirement Income Security Act, or ERISA.⁹⁹ The purpose and backbone of ERISA is to safeguard employee benefits.¹⁰⁰ Congressional authority with respect to ERISA stems from the notion that the solvency of benefit plans ultimately affect interstate commerce.¹⁰¹

2. Legislative Scope and Means

ERISA regulations are applicable where an employer provides an employee benefit or pension plan through a separately established fund.¹⁰² Some plans, including those covering government and church employees, may qualify for exempt status.¹⁰³ ERISA does not require employer contribution or minimum benefits.¹⁰⁴ ERISA seeks only to promote minimum standards by requiring plan fiduciaries¹⁰⁵ to regularly disclose and report a plan's status.¹⁰⁶ ERISA also requires adequate funding¹⁰⁷ and the setting of standards for the vesting of benefits.¹⁰⁸ Fiduciaries have a duty¹⁰⁹ of loyalty to plan participants and beneficiaries.¹¹⁰ ERISA also preempts all state laws that "relate

costs for insurers and businesses. *Id.*

97. *Kluger v. White*, 281 So. 2d 1, 3-5 (Fla. 1973).

98. 29 U.S.C. § 1001(a) (1994).

99. *Id.* § 1001.

100. *Id.* § 1001b (a)(2)-(4), (c)(3)-(5).

101. U.S. CONST. art. I, § 8, cl. 3; 29 U.S.C. § 1001b (a)(1), (c)(1).

102. 29 U.S.C. § 1002.

103. *Id.* § 1003(b)(1)(2).

104. *Shaw v. Delta Air Lines*, 463 U.S. 85, 93 (1983).

105. *See* 29 U.S.C. § 1002 (21)(A)(i) (1994) (defining a fiduciary as one who exercises authority or discretion in the management, administration, or disposition of a plan's assets).

106. *See id.* § 1021 (enumerating to whom, when, and what must be reported).

107. *See id.* § 1021(d)(1) (proscribing that failure to meet the minimum funding standard in a timely fashion requires notice to participants of the failure).

108. *See id.* § 1002 (including methods of calculating cost, accruals, and liabilities).

109. *See id.* § 1104(a) (describing fiduciary standard as "prudent man").

110. *See* 29 U.S.C. § 1106(b)(1) (1994) (prohibiting a fiduciary from using the

to¹¹¹ employee benefit plans under the power of the Supremacy Clause¹¹² of the Constitution.¹¹³ Lastly, ERISA establishes federal jurisdiction for all benefit claims,¹¹⁴ providing specific remedies to beneficiaries against injuries.¹¹⁵

3. *Equitable Remedies Only*

The only remedies¹¹⁶ available under ERISA are enforcement,¹¹⁷ declaratory judgments regarding beneficiary rights,¹¹⁸ and removal of a fiduciary that acts in bad faith.¹¹⁹ Any injury that occurs accrues to the plan rather than the individual beneficiary.¹²⁰ When a patient seeks an equitable remedy for the denial of benefits, the court reviews the decision under an abuse of discretion standard¹²¹ with deference given to the plan administrator.¹²²

II. ERISA SHIELDS MCO'S FROM LEGAL ACCOUNTABILITY

*He mocks the people who propose that the government shall protect the rich that they in turn may care for the laboring poor.*¹²³

-Grover Cleveland

plan's assets for self-interest). *But see* § 1108(c)(2) (allowing a fiduciary reasonable compensation for services rendered to the plan).

111. *See id.* § 1144(a) (superceding all state laws); *id.* § 1144(c)(1) (defining state law to include "laws, decisions, rules, regulations, or other State action having the effect of Law, of any State").

112. U.S. CONST. art. VI, cl. 2.

113. *Id.*, art. I, § 8, cl. 3.

114. 29 U.S.C. § 1132(e) (1994).

115. *See id.* § 1132(c)(2) (stating that failure to report as required shall result in civil penalties); *id.* § 1132(a)(1)(B) (detailing recovery of benefits due under plan; enforcement of rights under plan; and clarification of future benefits); *id.* § 1132(a)(3)(B) (providing equitable relief to correct violations or enforce provisions).

116. 29 U.S.C. § 1132(a)(1)(B) (1994).

117. *See id.* (providing for civil actions to be brought by a participant or beneficiary to enforce his rights under the terms of the plan).

118. *See Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1010 (9th Cir. 1998), *cert. denied*, 528 U.S. 870 (1999) (holding that recovery for the cost of a procedure never done calls for compensatory damages at law, and is not available under the equitable remedy of ERISA).

119. *See Varsity Corp. v. Howe*, 516 U.S. 489, 513 (1996) (noting that ERISA immunizes breaches of fiduciary duty by denying beneficiaries a remedy, and this does not further the general objective of requiring fiduciaries to act in the interest of beneficiaries).

120. *See Murphy v. Wal-Mart Assoc. Group Health Plan*, 928 F. Supp. 700, 710 (E.D. Tex. 1996) (holding that any recovery by an individual for fiduciary breach is payable to the plan, not the individual).

121. *Groft v. Healthcare Corp. of Mid-Atlantic*, 792 F. Supp. 441, 442 (D. Md. 1992), *aff'd*, 991 F.2d 789 (4th Cir. 1993).

122. *Id.* at 443.

123. BOLANDER, *supra* note 1, at 129.

A. *Judicial Interpretation of ERISA's "Relates To," "Savings," and "Deemer" Clauses*

1. *"Relates To" Sweeps Broadly to Preempt All State Actions*

A series of decisions in the 1980s, originating with *Shaw v. Delta Airlines*, suggested that ERISA preemption shielded employer benefit plans from all state and common law protection of individual rights.¹²⁴

In fact, the Supreme Court found that denying benefits to a pregnant employee was permissible under ERISA, in spite of two state laws to the contrary.¹²⁵ In the 1987 case *Pilot Life v. Dedeaux*, the Supreme Court expanded the "relates to" clause to preempt any state law that has "a connection with or reference to" an employee benefit plan.¹²⁶ Specifically, the Court held that state common law tort and contract actions were preempted because they "related to" the processing of a claim for long-term disability under an ERISA employee benefit plan.¹²⁷

Using *Pilot Life* as a guide, in 1992, the Fifth Circuit applied the preemption doctrine to a health plan utilization review decision.¹²⁸ This decision involved a pregnant woman whose doctor requested hospitalization for continuous monitoring when she developed complications.¹²⁹ However, the utilization review "Quality Care Program" denied the doctor's recommendation for hospitalization approving instead limited home nursing.¹³⁰ The cost containment action was a complete *financial* success.¹³¹ Tragically, however, the fetus died and the mother had no remedy because ERISA preempts all applicable state law and only offers

124. See 463 U.S. 85, 96-99 (1983) (holding that the N.Y. Human Rights Law was preempted by ERISA because it offered protection beyond what was required under Title VII). Combining disability benefits in a benefits package rather than a separate policy removed those benefits from regulation under the N.Y. Disability Benefit Law. *Id.*

125. See *id.* at 88 (preempting state laws that forbid discrimination on the basis of pregnancy in employee benefit plans that require payment of sick-leave benefits to pregnant employees).

126. 481 U.S. 41, 47 (1987).

127. See *id.* at 56-57 (holding that the processing of ERISA claims should be treated as a federal question, and restricted to the remedies offered under ERISA in accordance with Congressional intention; comparing suits involving claims for benefits under ERISA with those brought under LMRA § 301).

128. *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1331 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992).

129. See *id.* at 1322-24 (mandating utilization review authorization and the loss of benefits when authorized treatment is not adhered to).

130. *Id.* at 1324.

131. See *id.* at 1338 (acknowledging that "bad medical judgments will end up being cost free to plans that rely on [utilization review] to contain medical costs").

equitable relief.¹³² While the court confessed that the lack of remedies permitted under ERISA was “troubling,”¹³³ it found that United Healthcare “was merely performing claim handling functions.”¹³⁴ Enforcement of a state law duty of care would undermine congressional intent to retain federal control through specific remedies.¹³⁵

2. State Insurance Regulations Are “Saved” From Preemption

Some state laws are “saved” from preemption by ERISA.¹³⁶ In 1985, the United States Supreme Court acknowledged that ERISA did not preempt state laws that regulate the insurance industry.¹³⁷ Metropolitan Life Insurance Company challenged a Massachusetts law mandating mental health coverage for all policies issued in the state.¹³⁸ The Court reasoned that while the state law affected the substantive terms of ERISA plans,¹³⁹ it did so indirectly through regulation of the business of insurance generally.¹⁴⁰

Similarly, in 1995, the State of New York imposed a series of surcharges on commercial insurers and HMO hospital charges.¹⁴¹ The Supreme Court upheld the surcharges although they created an economic burden on ERISA plans.¹⁴² The Court held that Congress could not have intended to entirely supplant the historic police power of the states.¹⁴³ Additionally, it stated that the broad reading of “relates to” originally adopted by the court could conceivably stretch on forever and never run its course.¹⁴⁴ The Court then limited the preemption of ERISA by holding that a

132. *Id.* at 1324 (finding that no remedy, state or federal, was applicable to the Corcorans).

133. *Corcoran*, 965 F.2d at 1333.

134. *Id.* at 1330.

135. *Id.* at 1333-34.

136. *See* 29 U.S.C. § 1144(b)(2)(A) (1994) (stating that “[n]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.”). *See also* 15 U.S.C. § 1012(a) (1994) (stating that “[t]he business of insurance, . . . shall be subject to the laws of the several States which relate to the regulation or taxation of such business.”). *See id.* § 1012(b) (stating that “[n]o act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . .”).

137. *Metro. Life Ins. Co. v. Mass.*, 471 U.S. 724, 735-41 (1985).

138. *Id.* at 743.

139. *Id.* at 729.

140. *See id.* at 742-44 (applying a three part test to the determination of whether a practice falls within the definition of business of insurance under the McCarran-Ferguson Act 15 U.S.C. § 1012(a) (1948)).

141. *N.Y. State Conf. State of Blue Cross & Blue Shield v. Travelers Ins. Co.*, 514 U.S. 645, 650 (1995).

142. *Id.* at 654.

143. *Id.* at 654-56.

144. *Id.* at 655.

state's indirect economic influence, through quality control, hospital workplace regulation, or surcharges,¹⁴⁵ have "only a tenuous, remote, or peripheral connection with" ERISA plans.¹⁴⁶ However, state insurance laws based in contract law governing breach of contract, bad faith and fraud are not laws that govern the insurance business and are preempted by ERISA.¹⁴⁷

3. Only Self-Insured Employer Plans are "Deemed" Preempted from State Insurance Laws

In *Metropolitan Life v. Massachusetts*, the United States Supreme Court interpreted the "deemer" clause of ERISA to allow a distinction between plans insured directly by employers and those who purchase insurance to cover their employees.¹⁴⁸ Only employers who choose to purchase insurance are open to indirect regulation by state insurance laws because the risk is spread to all purchasers of insurance rather than being borne solely by the employer through a self-funded plan.¹⁴⁹

B. Quality of Service and Quantity of Benefits are Distinguished by the Courts

1. Harm Occurring Through Malpractice Involves the Quality of Service and Is Not a Benefit Issue

On the same day in 1987, the Supreme Court rendered two decisions interpreting ERISA.¹⁵⁰ One was the decision in *Pilot Life* and the other involved a breach of contract disability claim against Metropolitan Life Insurance Company by a General Motors employee named Taylor.¹⁵¹ In *Metropolitan Life*, the Court held that any claim for benefits under ERISA is an exception to the

145. *Id.* at 660-61.

146. *Travelers*, 514 U.S. at 661.

147. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50-51 (1987) (using a common-sense definition of "regulates" in determining that a law must be directed specifically to the insurance industry to fall under the savings clause of ERISA, whereas the roots of bad faith lie in general principles of tort and contract law). *See also Herdrich v. Pegram*, 154 F.3d 362 (7th Cir. 1998), *rev'd*, *Pegram v. Herdrich*, 120 S. Ct. 2143 (2000) (holding that state law fraud counts were preempted by ERISA, with summary judgment granted for MCO defendant based on a lack of remedy under ERISA).

148. *See Metro. Life*, 471 U.S. at 732 (citing 29 U.S.C. § 1002(1) (1994)) (allowing ERISA plans the option of purchasing insurance, subject to state regulation; or bearing the risk of providing welfare-benefits directly through a separate corporate fund with self-funded plans preempted from state insurance regulations).

149. *Id.* at 747.

150. *Pilot Life*, 481 U.S. at 41; *Metro Life Ins. Co. v. Taylor*, 481 U.S. at 58.

151. *See Taylor*, 481 U.S. at 61-62 (upholding the termination of an employee who refused to return to work after a physician claimed he was no longer disabled).

well-pleaded complaint rule and is subject to complete preemption and removal to federal court.¹⁵² The Court reasoned that civil enforcement of ERISA was solely a federal cause of action.¹⁵³ The Court likened the preemptive force of ERISA to that of preemption under section 301 of the Labor Management Relations Act (LMRA) of 1947, which displaced state authority over employment contract claims involving unions.¹⁵⁴ However, the LMRA was enacted as a reaction to the inadequacy of a remedy at common law by establishing the National Labor Relations Board (NLRB) to expeditiously mediate disputes.¹⁵⁵ In contrast, ERISA usurps adequate state law remedies and replaces them with "equitable" remedies that are largely illusory and disallow compensation for damages.¹⁵⁶

Initially, based on the reasoning of *Metropolitan Life*, district courts removed all state tort claims involving ERISA plans to federal court, including those based on physician malpractice.¹⁵⁷ The courts reasoned that vicarious liability claims were "related to" employee benefit plans because they indirectly resulted in higher costs for those plans, violating the public policy objectives of ERISA.¹⁵⁸ However, this viewpoint soon came under scrutiny. The problems with automatic removal through complete preemption was first considered in *Dukes v. U.S. Healthcare, Inc.*¹⁵⁹ The Third Circuit held that physician malpractice claims that implicate MCOs under vicarious liability theories do not involve "rights under the terms of the plan," or "benefits due under the plan."¹⁶⁰ The court reasoned that these claims properly fell into the category of conflict preemption rather than complete preemption, and as such, were subject to the well-pleaded complaint rule

152. *Id.* at 65.

153. *Id.* at 65-67.

154. *Id.*

155. See MICHAEL C. HARPER & SAMUEL ESTREICHER, LABOR LAW, CASES MATERIALS AND PROBLEMS 59-62 (4th ed. 1996) (describing the need for federal legislation to protect worker's rights following the decision in *Lochner v. New York*, 198 U.S. 45 (1905)). *Lochner* invalidated state labor reform by states on the basis of impairment of contract under the U.S. CONST. art. I, § 10. *Id.*

156. *Pilot Life*, 481 U.S. at 50-54; *Shaw v. Delta Air Lines Inc.*, 463 U.S. 85, 96-99 (1983).

157. *Ricci v. Goberman*, 840 F. Supp. 316, 317 (D.N.J. 1993).

158. *Id.* at 317-18. *Accord*, *Nealy v. U.S. Healthcare HMO*, 703 N.E.2d 269 (N.Y. Sup. Ct. 1998), *but see id. rev'd*, 711 N.E.2d 621 (N.Y. 1999), *reh'g denied*, 716 N.E.2d 700 (N.Y. 1999).

159. See *Dukes*, 57 F.3d at 355-56, *cert. denied*, 516 U.S. 1009 (1995) (allowing removal only for claims that fall within 29 U.S.C. § 1131(a)(1)(B)). These are remedies to recover, enforce, or clarify benefits under the plan that are based on claim processing procedures. *Id.* See also *Nealy*, 711 N.E.2d at 625, *reh'g denied*, 716 N.E.2d 700 (N.Y. 1999) (holding that negligent medical care does not "relate to" administration of a benefit plan).

160. *Dukes*, 57 F.3d at 358.

precluding removal.¹⁶¹ As a result of this reasoning, claims involving misdiagnosis,¹⁶² delay,¹⁶³ failure to treat,¹⁶⁴ test,¹⁶⁵ referral to a specialist,¹⁶⁶ or injury resulting from negligent treatment by a

161. *Id.* at 355.

162. *See Prudential Healthcare Plan Inc. v. Lewis*, 77 F.3d 493 (10th Cir. 1996) (failing to detect a malignant lesion of the rectum); *Harris v. Deaconess Health Serv. Corp.*, 61 F. Supp. 2d 889, 891 (E.D. Mo. 1999) (failing to diagnose and treat appendicitis, resulting in rupture and permanent injury); *McDonald v. Damian*, 56 F. Supp. 2d 574, 575 (E.D. Pa. 1999) (misdiagnosing malignant melanoma as benign, and discovering mistake only after disease had metastasized); *Blum v. Harris Methodist Health Plan, Inc.*, No. Civ.A. 3:97-CV-0374P, 1997 WL 452750, at *1 (N.D. Tex. July 31, 1997) (misdiagnosing osteogenic sarcoma in a twenty-nine year old man as a calcium deposit contributed to metastasis to the lungs and liver); *Prihoda v. Shpritz*, 914 F. Supp. 113, 115 (D. Md. 1996) (failing to detect a kidney tumor until after it had metastasized to the lung).

163. *See Nealy*, 711 N.E.2d at 625, *reh'g denied*, 716 N.E.2d 700 (N.Y. 1999) (delaying referral to a cardiologist by the primary care physician contributed to death from myocardial infarction); *Pappas v. Asbel*, 724 A.2d 889, 890 (Pa. 1998), *vacated by U.S. Healthcare Sys. of Penn, Inc. v. Penn Hosp. Ins. Co.*, 120 S. Ct. 2686 (2000) (delaying authorization for transfer from community hospital emergency room to university hospital resulted in permanent quadriplegia).

164. *See Dukes*, 57 F.3d at 352-53 (ruling on two cases consolidated on appeal and reversed, holding no preemption by ERISA). The failure to perform a blood sugar test led to Duke's death from hyperglycemia. *Id.* Ignoring symptoms of preeclampsia in Mrs. Visconti led to the still birth of her full-term infant. *Id.* *See Whelan v. Keystone Health Plan East*, No. CIV. A. 94-5733, 1995 WL 394153, at *1-4 (E.D. Pa. June 29, 1995) (failing to regulate blood sugar levels in a pregnant diabetic resulted in an automobile crash that killed both her and her unborn child); *Tufino v. Coyne*, 223 A.D.2d 245, 246 (N.Y. App. Div. 1996) (failing to monitor anticoagulant therapy following mitral valve surgery led to death from a subdural hematoma).

165. *See Eaccarino v. Canlas*, No. CIV.A. 97-CV-5497, 1998 U.S. Dist. Lexis 4904, at 1-4 (E.D. Pa. April 1, 1998) (failing to diagnose, order testing, or refer patient to a specialist led to the death of a patient suffering from Hodgkins lymphoma); *Lancaster v. Kaiser Found. Health Plan of Mid-Atlantic St., Inc.*, 958 F. Supp. 1137, 1139-44 (E.D. Va. 1997) (failing to diagnose, test for, or refer an eleven-year old girl to a neurologist for symptoms of a brain tumor that progressed over a five year period). The treating physicians received year-end bonuses for avoiding tests. *Id.*

166. *See Crum v. Health Alliance-Midwest, Inc.* 47 F. Supp. 2d 1013, 1015-19 (C.D. Ill. 1999) (advising treatment for heartburn over the telephone when the patient was actually suffering a fatal myocardial infarction); *Yanez v. Humana Med. Plan, Inc.*, 969 F. Supp. 1314, 1315 (S.D. Fla. 1997) (treating a high risk pregnancy without a specialist resulted in the premature birth of twins, the death of one, and the permanent disability of the other); *Dykema v. King*, 959 F. Supp. 736, 738-39 (D.S.C. 1997) (failing to diagnose a pulmonary emboli by a medical student and a medical resident led to the patients death a day later); *Smith v. HMO Great Lakes*, 852 F. Supp. 669, 670 (N.D. Ill. 1994) (failing to obtain consultants for high risk birth led to the birth of a severely disabled infant); *Blaine v. Community Health Plan*, 179 Misc. 2d 331, 333 (N.Y. Sup. Ct. 1998) (using a physician's assistant rather than a physician to treat a back problem led to back deterioration requiring repeated back surgeries).

MCO physician¹⁶⁷ are no longer preempted by ERISA. These claims are no longer subject to removal and dismissal in federal court but are remanded back to state court.¹⁶⁸

2. Harm Occurring Through MCO Policies Involve the Quantity of Benefits

Courts generally continue to apply the doctrine of complete Federal preemption to injuries,¹⁶⁹ losses,¹⁷⁰ and deaths¹⁷¹

167. See *In re U.S. Healthcare, Inc. v. Bauman*, 193 F.3d 151, 157 (3rd Cir. 1999), *cert. denied*, *U.S. Healthcare, Inc. v. Bauman*, 120 S. Ct. 2687 (2000) (discharging a newborn within twenty-four hours without home follow-up or authorization for hospital readmission contributed to the infant's death the day after her hospital discharge); *Rice v. Panchal*, 65 F.3d 637, 638-39 (7th Cir. 1995) (deciding negligent care led to a patient's handicap); *Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151, 152-55 (10th Cir. 1995) *mandamus denied*, (finding wrongful death and loss of consortium due to negligent malpractice); *Delucia v. St. Luke's Hosp.*, No. Civ.A. 98-6446, 1999 WL 387211, at *1 (E.D. Pa. May 25, 1999) (discharging a premature infant who suffered daily "blue" spells without an apnea monitor led to Sudden Infant Death Syndrome); *Herrera v. Lovelace Health Sys., Inc.*, 35 F. Supp. 2d 1327 (D.N.M. 1999) (finding injuries resulted from a negligently performed vasectomy).

168. *Dukes*, 57 F.3d at 355, *cert. denied*, 516 U.S. 1009 (1995). See also *Moreno v. Health Partners Health Plan*, 4 F. Supp. 2d 888, 889-90 (falling below the applicable standard of care with resulting damages is not preempted). "[P]laintiff is the master of her complaint, not the defendant." *Id.*

169. See *Hull v. Fallon*, 188 F.3d 939, 943 (8th Cir. 1999), *cert. denied*, 68 U.S.L.W. 3433 (U.S. Feb. 28, 2000) (No. 99-1083) (substituting a treadmill test for a thallium stress test led to myocardial infarction and subsequent heart disease). However, the M.D. named in the suit acted as utilization reviewer and did not commit malpractice, but instead made a benefit decision. *Id.* *Danca v. Private Healthcare Sys., Inc.*, 185 F.3d 1, 2-4 (1st Cir. 1999) (refusing to pre-certify a mentally ill patient to a recommended hospital, and substituting a different hospital was a benefit decision). Patient eventually set herself on fire during a suicide attempt, resulting in permanent disfigurement from burns. *Id.* See also *Jass*, 88 F.3d at 1489-92 (allowing a shorter course of physical therapy than that recommended by surgeon leading to permanent knee injury was a benefit decision); *Garrison v. Northeast Ga. Med. Cent. Inc.*, 66 F. Supp. 2d 1336, 1343 (N.D. Ga. 1999), *aff'd*, 211 F.3d 130 (11th Cir. Ga. 2000) (refusing to authorize a repeat cesarean section, even though it was included in the plan as a covered benefit, was determined not to be the unauthorized practice of medicine, but a benefit decision); *Schmid v. Kaiser Found. Health Plan of the Northwest*, 963 F. Supp. 942, 943 (D. Or. 1997) (refusing to authorize testing and treatment for TMJ was a benefit decision); *Ouellette v. Christ Hospital*, 942 F. Supp. 1160, 1162 (S.D. Ohio 1996) (discharging a patient two days after removal of ovaries in spite of symptoms of fever and pain were based on MCO policy described as an ERISA benefit).

170. See *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1322-31 (5th Cir. 1992) *cert. denied*, 506 U.S. 1033 (1992) (authorizing limited home nursing, rather than hospitalization was a benefit decision); *Brandon v. Aetna Serv., Inc.* 46 F. Supp. 2d 110, 111-13 (D. Conn. 1999) (refusing to authorize treatment for substance abuse and anxiety disorder despite recommendation and plan coverage of such treatment was a benefit decision, and therefore

attributable to delay,¹⁷² substitution,¹⁷³ and denial¹⁷⁴ of care caused by MCO policies. Although they acknowledge that utilization review and provider incentives shape medical decisions, the courts find these decisions to be “part and parcel” of benefit decisions and allow preemption of ERISA to deprive patients of state law remedies.¹⁷⁵

Because Congressional intent in enacting ERISA was to create a “uniform body of benefit law,” free of conflicting state regulations,¹⁷⁶ some federal courts look “beyond the face of the complaint” to detect “artful pleading” and to reveal when a claim is “really based on ERISA.”¹⁷⁷ Tragically, Courts will re-characterize a state law damage claim as an ERISA suit for benefits,¹⁷⁸ and then dismiss it for lack of remedy.¹⁷⁹ The result is that an MCO can escape liability for the foreseeable harm caused by its denial of care by bundling medical and benefit decisions together through financial incentives or utilization review.¹⁸⁰ Some courts have noted that shielding MCO misconduct through a statute designed

reimbursement was not an available remedy).

171. See *Bast v. Prudential Ins. Co. of Amer.*, 150 F.3d 1003, 1005-06 (9th Cir. 1998), *cert. denied*, 528 U.S. 870 (1999) (delaying authorization of bone marrow transplant led to patient's death); *Kuhl v. Lincoln Nat'l. Health Plan of Kansas City, Inc.*, 999 F.2d 298, 300-01 (8th Cir. 1993) *cert. denied*, 510 U.S. 1045 (1994) (delaying pre-certification of heart surgery led to the patient's deterioration and death); *Silva v. Kaiser Permanente*, 59 F. Supp. 2d 597, 598 (N.D. Tex. 1999) (using inadequate diagnostic procedures caused patient to be misdiagnosed with hepatitis C, delaying treatment of lymphoma that led to death); *Huss v. Green Spring Health Serv.*, No. 98-6055 1999 WL 455666 at *1 (E.D. Pa. Jul. 16, 1999) (refusing benefits for in-patient mental health services because of erroneous information showing no enrollment in plan). This caused a delay in the hospitalization of a depressed sixteen-year-old who killed himself the same day a referral was finally granted. *Id.* See also *Person v. Physicians Health Plan, Inc.*, 20 F. Supp. 2d 918, 919-21 (E.D. Va. 1998) (delaying implantation of a cardiac defibrillator because the MCO erroneously believed the request was for a liver transplant). This delay resulted in the patient's deterioration causing the patient's death while waiting for a heart transplant. *Id.* See also *Andrews-Clarke v. Travelers Ins. Co.* 984 F. Supp. 49, 50-53 (D. Mass. 1997) (authorizing only five in-patient days for alcohol abuse, when the plan allowed for thirty, ultimately led to suicide).

172. *Bast*, 150 F.3d at 1005-06; *Kuhl*, 999 F.2d at 300; *Huss*, No.98-6055 1999 WL 455666 at *1; *Person*, 20 F. Supp. 2d at 920.

173. *Hull*, 188 F.3d at 941; *Danca*, 185 F.3d at 2; *Jass*, 88 F.3d at 1485; *Corcoran*, 965 F.2d at 1324; *Andrews-Clarke*, 984 F. Supp. at 50-51. See also *Lancaster v. Chandra*, No. 93 C 2717 1994 WL 33962 at *1 (N.D. Ill. Feb. 4, 1994) (transferring a patient from Loyola University Medical Center to Copley Memorial Hospital in an unstable condition led to the patient's death).

174. *Garrison*, 66 F. Supp. 2d at 1343; *Brandon*, 46 F. Supp. 2d at 112.

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

176. *Id.*

177. *Jass*, 88 F.3d at 1488-89.

178. *Id.* at 1487.

179. *Id.* at 1490.

180. *Id.* at 1488.

to protect the people it injures is disconcerting.¹⁸¹ Yet, most courts continue to interpret congressional silence as intent to shield MCOs.¹⁸² However, this interpretation conflicts with the public policy that shaped the creation of ERISA.¹⁸³

The primary purposes of ERISA are to protect employee benefits, encourage employers to offer benefit coverage, and keep benefits affordable. However, the underlying purpose of ERISA is to benefit and protect the employees' interests.¹⁸⁴ Therefore, MCO decisions that affect the quality of care should conform to the medical standard of care.¹⁸⁵ Even at the lowest level of rationality, exposing a beneficiary to the threat of physical harm and denying that beneficiary the right to seek legal compensation when the harm occurs does not protect this interest.¹⁸⁶

3. *Quality v. Quantity: a Distinction Without a Difference*

Confusion abounds when courts struggle to distinguish between service and benefit or between quality and quantity. When a primary physician refuses to order tests or refer the patient to a specialist, it is not clear whether he is acting as utilization reviewer or care provider.¹⁸⁷ The following three cases illustrate the most common areas of confusion.

The first case is *Hull v. Fallon*.¹⁸⁸ There, the Eighth Circuit held that a physician who worked in utilization review could not be held liable for malpractice¹⁸⁹ because he was not acting as a treating physician, but merely determining whether benefits would be rendered.¹⁹⁰ Following this argument, a physician could

181. *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 56, 60 (D. Mass. 1997).

182. *Id.* at 60.

183. *Id.*

184. 29 U.S.C. 1001(a) (1994).

185. See *Murphy v. Wal-Mart Assoc. Group Health Plan*, 928 F. Supp. 700, 706 (E.D. Tex. 1996) (using outside consultants and medical literature to support the finding that the patient was a poor risk). The decision to deny bone marrow transplant met the standard of care); *Groft v. Healthcare Corp. of Mid-Atlantic*, 792 F. Supp. 441, 442-43 (D. Md. 1992), *aff'd*, 991 F.2d 789 (4th Cir. 1993) (finding that not providing lung transplant at a facility that does not perform lung transplants still met standards because decision was supported by expert opinion).

186. See notes 162-64 *supra*. Individuals forced to bear the burden of harm inflicted by the "benefit" of ERISA protected MCOs. *Id.*

187. See *Shea v. Esensten*, 107 F.3d 625, 629 (8th Cir. 1997), *cert. denied*, 208 F.3d 712 (8th Cir. 2000) (failing to refer the patient to a cardiologist based on MCO financial incentives was preempted as a claim for fiduciary breach). *But see Nealy*, 711 N.E.2d at 621, *reh'g denied*, 716 N.E.2d 700 (1999) (failing to refer the patient to a cardiologist was a negligent violation of the physician's standard of care and not preempted).

188. *Hull v. Fallon*, 188 F.3d 939 (8th Cir. 1999).

189. *Id.* at 943.

190. *Id.*

violate the minimal standard of professional care he has sworn to uphold so long as he has no direct contact with the patient.

In *Silvo v. Kaiser Permanente*,¹⁹¹ a federal district court in Texas held that a misdiagnosis by a primary physician, typically a malpractice act, is preempted if the petition claims that the MCO's practice of physician incentives is responsible for the injury.¹⁹² The court held that the physician's incentive scheme triggered immunity by raising a question of how the plan is administered to its recipients.¹⁹³

Finally, in *Pegram v. Herdrich*,¹⁹⁴ the United States Supreme Court addressed the issue of incentive schemes. The Court held that such schemes do not violate the fiduciary duty to beneficiaries imposed under ERISA.¹⁹⁵ The Court noted the differences between traditional trustees and administrators of medical plans and decided that mixed decisions involving financial and medical decisions are not fiduciary in nature.¹⁹⁶ Further, the Court pointed out that such incentive schemes are part of the contract between the MCO and the provider, not the employee benefit plan.¹⁹⁷ The value in admitting evidence of an incentive scheme lies in establishing an alternative theory of liability against the MCO, a liability that the Supreme Court did not rule out.¹⁹⁸ Regardless of the fiduciary duty demanded by ERISA, incentive schemes that encourage under-treatment create a foreseeable risk of harm to a foreseeable group of patients treated by that provider.¹⁹⁹ This scheme violates an ordinary duty of care.²⁰⁰

C. Beneficiary Rights and Theories of Recovery Outside of ERISA

Many state courts, including Illinois, have increasingly recognized MCO liability.²⁰¹ These state courts have based MCO

191. *Silva v. Kaiser Permanente*, 59 F. Supp. 2d 597 (N.D. Tex. 1999).

192. *Id.* at 600.

193. *Id.*

194. 120 S. Ct. 2143 (2000).

195. *Id.* at 2157-59.

196. *Id.* at 2155-56.

197. *Id.* at 2153.

198. *See id.* at 2157-58 (suggesting that mixed decisions fall under malpractice standards rather than fiduciary standards, and that allowing a federal cause of action under ERISA would duplicate the remedies available in state courts). The Court implies that it falls to the discretion of state law whether malpractice actions can be brought against MCOs. *Id.* at 2158.

199. *See infra* note 209.

200. *See Stewart v. Berry Family Health Ctr.*, 105 F. Supp. 2d 807, 812-13 (S.D. Ohio 2000) (remanding a claim based on financial incentives that allegedly induced providers to commit malpractice). The court stated that "the proper characterization, . . . of Plaintiff's Complaint is highly important . . ." *Id.* The court held that the claim was not based on denial of benefits, but the relationship between the MCO and provider. *Id.*

201. *See infra* note 202.

liability on the theories of apparent authority for the malpractice of its physicians,²⁰² as well as institutional liability,²⁰³ with the intent to counteract attempts by MCOs to extend the ERISA doctrine of preemption to non-ERISA beneficiaries.²⁰⁴

1. Medicare Beneficiaries

Emboldened by ERISA, MCOs have attempted to remove state tort claims brought by Medicare enrollees by alleging preemption on the basis that such claims are federal questions because they "arise under" the Medicare Act.²⁰⁵ However, unlike cases involving ERISA beneficiaries, courts uniformly refuse to characterize the denial of Medicare benefits as a federal question. In fact, courts do allow a cause of action for medical negligence based on the quality of care where utilization review decisions result in harm to Medicare beneficiaries.²⁰⁶

2. Medicaid Beneficiaries

An Illinois Medicaid recipient's three-month-old daughter suffered permanent brain damage when an untreated ear infection developed into bacterial meningitis.²⁰⁷ The appellate court applied an apparent agency theory because the MCO's policy requires prior authorization from the primary physician before permitting any care to patients.²⁰⁸ On appeal, the Illinois Supreme Court found an additional theory of institutional negligence applied

202. See *Raglin v. HMO Ill. Inc.*, 595 N.E.2d 153, 158 (Ill. App. Ct. 1992) (holding that physicians were independent contractors, and not agents of the MCO), *overruled by*, *Petrovich v. Share Health Plan of Ill. Inc.*, 719 N.E.2d 756, 765-68 (Ill. 1999) (holding vicarious liability can be established by apparent or inherent authority where a provider is "held out" as an agent and relied on by a third party, or control is established through facts and circumstances).

203. See *Jones v. Chicago HMO LTD of Ill.*, 730 N.E.2d 1119, 1128 (Ill. 2000) (comparing services delivered by MCOs to those delivered by hospitals, and applying the doctrine of institutional negligence to both). "Institutional negligence is also known as direct corporate negligence." *Id.* "Liability is predicated on the hospital's own negligence, not the negligence of the physician." *Id.*

204. See *supra* note 196.

205. See *Ardary v. Aetna Health Plans of Cal., Inc.*, 98 F.3d 496, 498 (9th Cir. 1996), *cert. denied*, *Aetna v. Ardary*, 520 U.S. 1251 (1997) (removing a claim for wrongful death to federal court as a claim for Medicare benefits when a patient died after the MCO refused to authorize transfer from a small community hospital to one with cardiac intensive care facilities). The case was remanded by the court. *Id.* See also *Plocica v. Nylcare of Tex., Inc.*, 43 F. Supp. 2d 658, 660-62 (N.D. Tex. 1999) (remanding after removal to federal court where the patient was discharged from a mental hospital against the treating physician's advice, and later committed suicide).

206. *Ardary*, 98 F.3d at 499; *Nylcare*, 43 F. Supp. 2d at 663.

207. *Jones*, 730 N.E.2d at 1123.

208. *Id.* at 1127.

because the HMO assigned 4,527 patients to a single doctor, in violation of its own policy limit of 3,500 patients per doctor.²⁰⁹

3. Government Employees

The thirteen-year-old anorexic daughter of a government worker was denied in-patient treatment for her disease despite the recommendation of her treating physician.²¹⁰ The Wisconsin Supreme Court upheld a state tort verdict for bad faith and an award of punitive damages. The court held that such actions are necessary to redress the power imbalance between insurer and insured.²¹¹ The court reasoned that if the MCO had unilateral authority to decide what services it would pay for, it would result in the "unbridled discretion" of an illusory contract.²¹² An Oregon court upheld a similar claim based on bad faith coupled with physical harm and emotional distress.²¹³

III. CONSTITUTIONAL GUARANTEES OF FUNDAMENTAL RIGHTS: JUSTICE AND THE DIFFUSION OF POWER

*Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficent.*²¹⁴

-Louis D. Brandeis

A. Law, Equity, and Seventh Amendment Right to a Jury

Certain natural rights are so essential that their protection is demanded in writing.²¹⁵ The Bill of Rights was essentially a codification of fundamental common law rights added to the Constitution in 1791.²¹⁶ Federalist factions protested the need for

209. See *id.* at 1134 (describing public policy to hold HMO's accountable for their actions and decisions, so they may not simply "wash their hands" after patients are placed in jeopardy).

210. *McEvoy by Finn v. Group Health Co-op of Eau Claire*, 570 N.W.2d 397, 400 (Wis. 1997).

211. *Id.* at 402.

212. *Id.* at 404.

213. *McKenzie v. Pacific Health & Life Ins. Co.*, 847 P.2d 879, 881-82 (Or. App. Ct. 1993).

214. BOLANDER, *supra* note 1, at 267.

215. ROBERT ALLEN RUTLAND, *THE BIRTH OF THE BILL OF RIGHTS 1776-1791* 145, 163, 170 (revised ed. 1983) (describing the insistence on a Bill of Rights by "Agrippa" James Winthrop, "Cassius" James Sullivan, Samuel Adams, Patrick Henry and Thomas Jefferson).

216. See *id.*, at 4 (describing the Bill of Rights as "the palladium of our liberty," grounded in common law and the Magna Carta); *id.* at 119 (citing the lack of a Bill of Rights as a fatal objection to ratification of the Constitution by George Mason); *id.* at 129 (proclaiming entitlement to a Bill of Rights against every government, expressed and not inferred, by Thomas Jefferson); *id.* at 137 ("Idiots who trust their future security to the whim of the present hour" an "Old Whig" writes in the Philadelphia Independent Gazette).

a written Bill of Rights, claiming "nothing was surrendered, but everything [was] retained by the people outside of the few enumerated powers specifically granted."²¹⁷ Nevertheless, Thomas Jefferson wrote to James Madison urging the creation of a Bill of Rights to grant authority to the judiciary to check "the tyranny of the legislature."²¹⁸

The diffusion and division of power as a check on governmental tyranny is the bedrock of our constitutional system.²¹⁹ Nowhere is this more evident than in the diffusion of power in the hands of twelve jurors rather than a single judge.²²⁰ The right to a jury trial in civil cases was universally cherished and stirred less controversy than any other amendment.²²¹ Colonists trusted twelve ordinary jurors to favor the common citizen in a civil suit, while fearing that a judge might favor the wealthy and powerful.²²²

However, the right to a trial by jury is not absolute and can be vested in an alternative tribunal when Congress creates an equitable cause of action unknown at common law.²²³ Yet, personal injury and physical harm resulting from the act of another are actions deeply embedded in the common law.²²⁴ Even in mixed questions of law and equity, the right to a jury trial cannot be denied.²²⁵ Likewise, in a Labor Management Relations Act

217. See THE FEDERALIST No. 45 (James Madison) (describing powers of the federal government as "few and defined" and the powers of the states as "numerous and infinite"); THE FEDERALIST No. 84 (Alexander Hamilton) (declaring that "the people surrender nothing, retain everything" because the Constitution was not meant to regulate private concerns).

218. See RUTLAND, *supra* note 215, at 237 (quoting from the PAPERS OF JAMES MADISON XII).

219. THE FEDERALIST No. 51 (James Madison). See also MORTON WHITE, PHILOSOPHY, THE FEDERALIST, AND THE CONSTITUTION 97, 163, 177 (1987) (describing the theory that concentrations of power feed into the natural human tendency to force one's will on others). The division of power, particularly between federal and state, will cause both governments to check each other, allowing men to "fall short of angels without becoming a beast." *Id.* at 97.

220. See RUTLAND, *supra* note 215, at 4-5, 19-20, 39, 100-02, 115-18 (acclaiming universal belief in the right to a jury trial in "lawsuits between man and man," to assure judicial fairness, and guard against corrupt judges who might favor creditors in suits for debts); JOHN PHILIP REID, CONSTITUTIONAL HISTORY OF THE AMERICAN REVOLUTION 49 (1986) (explaining that the jury function precluded secrecy and corruption through community participation in open court). A juror has a similar "community interest in the security of his property" as his neighbor. *Id.*

221. RUTLAND, *supra* note 215.

222. *Id.* at 115-18.

223. *Connors v. Ryan's Coal Co., Inc.*, 923 F.2d 1461, 1465 (11th Cir. 1991); *Rowell v. Cigna*, 962 F. Supp. 1093, 1094 (N.D. Ill. 1997).

224. TEPLY, *supra* note 87, at 82.

225. See generally *Dairy Queen, Inc. v. Wood*, 369 U.S. 469 (1962); *Beacon Theaters v. Westover*, 359 U.S. 500 (1959) (upholding the right to a jury trial

(LMRA) action brought by a labor union, the Supreme Court upheld the right to a jury trial where legal rights and money damages were intertwined with equitable issues.²²⁶

When a court denies a party their right to a jury trial by re-characterizing a cause of action from personal injury to benefit administration,²²⁷ it confirms the fear that powerful parties can control the judicial system. Similarly, it is so even more troublesome when a wronged party is denied their day in court and forced into binding arbitration. MCO contracts typically contain provisions mandating binding arbitration for malpractice claims against them.²²⁸ In fact, the California Supreme Court found that one MCO's self-administered arbitration plan was so biased as to constitute fraud.²²⁹ The court noted that the contract bound the employee, but was actually between the MCO and the plaintiff's employer. These two were powerful parties whose interests were served by cost containment rather than quality of service.²³⁰ Both the efficiency and cost savings that result from the denial of a jury trial cannot outweigh the substantial injustice done to individual rights.²³¹

B. Federalism: the Commerce Clause and the Tenth Amendment

The division of state and federal power in domestic matters acts as a check on the arbitrary use of power by either,²³² and promotes the efficient resolution of local issues. The Commerce Clause²³³ allows federal regulation of economic concerns between the states,²³⁴ while issues involving life and property, civil and criminal matters are left to the Tenth Amendment police power of

in mixed questions of law and equity).

226. *Chauffeurs, Teamsters and Helpers v. Terry*, 494 U.S. 558, 564 (1990). ERISA is based on the LMRA. *Id.*

227. *Jass*, 88 F.3d at 1488. *See also* *Hull v. Fallon*, 188 F.3d 939, 941 (8th Cir. 1999), *reh'g denied*, (Oct. 7, 1999), *cert. denied*, 66 U.S.L.W. 3137 (U.S. Oct. 14, 1997) (No. 97-225) (holding that Dr. Fallon was acting as a plan administrator rather than a treating physician, and therefore claim was for benefits, not negligence); *accord* *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1332 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992) (characterizing medical decisions made by utilization review as "part and parcel of mandate to decide benefits under a plan").

228. *Engalla v. Permanente Med. Group, Inc.*, 938 P.2d 903, 914 (Cal. 1997).

229. *See id.* at 925 (finding Kaiser had "an unfair advantage as a repeat player in [the] arbitration" system when it reserved a veto right as to the naming of an arbitrator).

230. *Id.* at 908.

231. *Id.* at 925.

232. *See* WHITE, *supra* note 219 (discussing the theory behind the division of political power).

233. U.S. CONST. art. I, § 8, cl. 3.

234. THE FEDERALIST No. 42 (James Madison).

the states.²³⁵ Increasingly, however, Congress has invoked the Commerce Clause, one of its “few enumerated powers specifically granted,” to pass legislation that effectively limits state control of health, safety and welfare.²³⁶ Rather than using the federal spending power to encourage states to develop policies fitting the local needs of its citizens, the plenary power of the Commerce Clause²³⁷ is used to bludgeon states into conformity, dangerously eroding the balance of power under federalism.²³⁸ This ultimately leads to a usurpation of the state’s power to protect its citizens.

The misuse of ERISA preemption clearly usurps the state’s power to protect its citizens.²³⁹ For example, when Texas passed a law mandating independent review of MCO utilization review decisions,²⁴⁰ a consortium of health plans and insurers immediately sought, and received, a declaratory judgment eviscerating this law on the basis of a conflict with ERISA.²⁴¹ The Court granted a declaratory judgment despite the clear language in *Travelers* upholding a state’s right to regulate the quality of healthcare.²⁴² The states have long had a legitimate role in regulating the delivery of healthcare.²⁴³ Federal action that usurps the legitimate power of the states reduces the Tenth Amendment to a mere “truism,”²⁴⁴ and “meaningless rhetoric.”²⁴⁵

235. THE FEDERALIST No. 28 (Alexander Hamilton).

236. See *United States v. Lopez*, 514 U.S. 549, 564 (1995) (reasoning that almost all activities could be regulated through a sufficiently broad reading of the commerce clause, including marriage, family, crime, and education, leading to unlimited federal power).

237. *United States v. Darby*, 312 U.S. 100, 115 (1941).

238. See *Lopez*, 514 U.S. at 581-83 (holding that the Gun-Free Schools Act precluded states from experimenting in finding solutions to local problems involving crime and education, areas beyond the realm of commerce).

239. See *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 n.19, 100 n.20 (1983) (holding that it was the intent of Congress to give sole authority to the federal government for the regulation of employee plans).

240. TEX. INS. CODE ANN. §§ 20A.09, 20A.12, 20A.12A, 21.58A, 21.58C (West Supp. 1999-2000); TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-88.003 (West Supp. 1999-2000).

241. See *Corporate Health Ins. Inc. v. Texas Dept. of Ins.*, 220 F.3d 641 (5th Cir. 2000), cert. filed, 69 U.S.L.W. 3317 (Oct. 24, 2000) (holding that ERISA does not preempt liability, independent review, anti-indemnity, and anti-retaliation provisions of the statute, and holding that severing articles 20A.09(e) and 21.58A and 6(b) from the remainder of the Act, are preempted).

242. *New York State Conf. of Blue Cross & Blue Shield v. Travelers Ins. Co.*, 514 U.S. 645, 660-61 (1995).

243. U.S. CONST. amend. X. See, e.g., 815 ILL. COMP. STAT. 5-720 (West 1998); 210 ILL. COMP. STAT. 3-145 (West 1998); 225 ILL. COMP. STAT. 5-110 (West 1998); THE FEDERALIST No. 45 (James Madison); THE FEDERALIST No. 84 (Alexander Hamilton).

244. *Darby*, 312 U.S. at 124.

245. *Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 560 (1985) (5-4 decision) (Powell, J. dissenting) *reh'g denied*, 471 U.S. 1049 (1985).

IV. PROPOSAL

*It is the duty of the government to make it difficult for people to do wrong, easy to do right*²⁴⁶

- William E. Gladstone

A. *Judicial Action and Interpretation*

ERISA must be narrowly construed to allow state actions for bodily injury that result when MCOs make medical decisions. First, because ERISA itself is utterly silent regarding compensation for bodily injury,²⁴⁷ the United States Supreme Court must interpret the meaning of that silence while retaining the legitimate separation of powers under federalism.²⁴⁸ If the Supreme Court were to determine that Congress meant to deny all compensation for bodily harm, the fundamental right to legal redress through a jury trial would likely be violated.²⁴⁹ Whenever two interpretations of a statute are possible, and one interpretation could raise a constitutional challenge, the Supreme Court must choose to interpret the statute in a way that does not raise the constitutional issue.²⁵⁰

When medical decisions and benefit decisions are intertwined, MCO policies direct medical treatment.²⁵¹ Whoever assumes the duty of determining a medical treatment should be held legally accountable for the foreseeable injury that may occur from the treatment.²⁵² MCOs that hurt people should be accountable for their actions. The line separating contract and tort is crossed the moment a physical injury occurs.²⁵³ A tort involving physical injury caused by an MCO affecting medical treatment is not a

246. BOLANDER, *supra* note 1, at 93.

247. *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 55 (D. Mass. 1997).

248. *See Travelers*, 514 U.S. at 655 (assuming that Congress did not intend to usurp the state's police powers in the absence of a clear manifestation of that intent); *accord* *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr. Inc.*, 519 U.S. 316, 329 (1997) (holding that ERISA "relates to" clause could not be stretched to include state actions concerning quality standards or regulations affecting medical care).

249. RUTLAND, *supra* note 215.

250. *See NLRB v. Catholic Bishop of Chicago* 440 U.S. 490, 504 (1979) (reasoning that exercise of jurisdiction over a church-operated school could raise a first amendment question, the court denied jurisdiction based on a lack of expressed intent by Congress).

251. *See Herdrich v. Pegram*, 154 F.3d 362, 376 (7th Cir. 1998), *reh'g denied*, 170 F.3d 683 (7th Cir. 1999), *cert. granted*, 527 U.S. 1068 (1999) *rev'd*, 120 S. Ct. 2143, 2158 (2000) (holding that mixed eligibility decisions by HMO physicians are not fiduciary decisions under ERISA) and (describing restrictions by "medically ignorant administrators" seeking to limit patient care).

252. *Id.*

253. RESTATEMENT (SECOND) OF TORTS § 323(a)(b) (1965).

legitimate concern of interstate commerce, but within the police power of the state.²⁵⁴ Therefore, a victim should be given the appropriate state law remedy for tort damages.

B. Legislation: The Commerce Clause and the Business of Medicine

The public policy underlying the Commerce Clause is the promotion of economic efficiency through free market principles.²⁵⁵ Yet, liability for bodily injury occurring in the course of business is part of the cost of doing business in a free market.²⁵⁶ Therefore, the MCOs cannot expect to shield themselves from liability. Unfortunately, ERISA preemption distorts and creates an illusion of MCO efficiency by exempting utilization review from legal accountability for personal injury.²⁵⁷ When MCOs are not held accountable, the cost benefit analysis shifts, and unfortunately the creation of increased harm through the under-utilization of services becomes efficient.²⁵⁸ Further, the MCOs' broad discretion to interpret the terms of their own contracts of adhesion renders MCO contracts and the benefits under them largely illusory.²⁵⁹ Kessler warned that standard contracts in the hands of powerful business interests could be used "to impose a new feudal order . . . [creating] a vast host of vassals."²⁶⁰

An employee's dependence on the discretion of the employer and the MCO for healthcare decisions limits the employee's opportunity for economic choice.²⁶¹ Just as a diffusion of political power prevents governmental tyranny, a diffusion of economic power prevents economic tyranny, and promotes market competition.²⁶² In order for the free market to really work,

254. 735 ILL. COMP. STAT. 5/2-209 (West 1998); 820 ILL. COMP. STAT. 305/1 (West 1998).

255. THE FEDERALIST No. 11 (Alexander Hamilton); THE FEDERALIST No. 42, 44 (James Madison).

256. See POSNER, *supra* note 92, at 272-73 (describing the economic function of negligence liability as the efficient allocation of resources to safety where individuals have the right to be free of injury).

257. See Stevenson Swanson, *Patient's Rights Movement Targets HMO Liability*, CHI. TRIB., Mar. 14, 1999 § 1, at 9 (calling for accountability for medical decisions through litigation).

258. *Herdich*, 154 F.3d at 374, *reh'g denied*, 170 F.3d 683 (7th Cir. 1999), *rev'd*, 120 S. Ct. 2143 (2000).

259. *Finn ex rel. McEvoy v. Group Health Coop. of Eau Claire*, 570 N.W.2d 397, 404 (Wis. 1997).

260. Friedrich Kessler, *Contracts of Adhesion-Some Thoughts About Freedom of Contract*, 43 COLUM. L. REV. 629, 640 (1943).

261. MAKOVER, *supra* note 45, at 264-69.

262. See A. MITCHELL POLINSKY, AN INTRODUCTION TO LAW AND ECONOMICS 85-86 (1989) (describing the ideal competitive market as one where there are many producers and many consumers).

consumers must regain the power to choose their own plan.²⁶³ First, this requires providing alternatives to reliance on employee benefits by transforming beneficiaries into purchasing customers. Second, legislation that allows employees to choose between the employer's plan and an equivalent value would promote consumer choice and encourage quality service.²⁶⁴ Lastly, individual tax deductions for health insurance premiums and medical savings accounts would allow consumers to regain control and responsibility for their healthcare decisions.²⁶⁵ Consequently, consumers would retain the protection of state law regulations in contract and insurance disputes as well as tort actions for personal injury.²⁶⁶

However, the free market solution would lead to the ironic result that a federal law passed to encourage and protect employee benefits would ultimately be responsible for the destruction or phase out of one of the most valued benefits. The free market solution would also revive the basic problem of those too sick or too poor to pay for their own health insurance. Perhaps the answer lies in charity, social humanitarianism and government programs rather than medicine as big business.

CONCLUSION

The problem of insurability and access to healthcare is a problem far beyond the scope of ERISA. The shield of immunity conferred on MCO policies that results in bodily injury has not resulted in greater access or affordability but has encouraged harm to the beneficiaries that ERISA was intended to protect.²⁶⁷ Accordingly, the Supreme Court must decide that medical decisions resulting in physical harm demand constitutional separation from the benefit decisions preempted under ERISA. If MCOs are truly efficient, let them compete on a level playing field and hold them legally accountable for the outcome of their decisions.²⁶⁸

263. MAKOVER, *supra* note 45, at 264-69.

264. *Id.*

265. *Id.*

266. 215 ILL. COMP. STAT. 5-165 (West 1998); 735 ILL. COMP. STAT. 5/2-209 (West 1998); 815 ILL. COMP. STAT. 5-720 (West 1998).

267. 29 U.S.C. § 1001(a) (1994).

268. MAKOVER, *supra* note 45, at 264-69.