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ERISA PREEMPTION: WILL THE ELIMINATION OF THE ERISA PREEMPTION CLAUSE HELP OR HARM AMERICA’S ABILITY TO DEAL WITH ITS PENDING HEALTH CARE CRISIS?¹

A SELECTIVE ANALYSIS OF PAST GOVERNMENTAL REGULATION OF THE HEALTH CARE SYSTEM AND ITS RELATIONSHIP TO CURRENT EFFORTS TO RENDER MOOT THE ERISA PREEMPTION CLAUSE

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¹See William P. Danielczyk, president and CEO for Ambulatory Healthcare Corp. of America, Remarks at the Ambulatory Healthcare Corp. of America Briefing at the National Press Club, Wash., D.C. (Aug. 12, 1998), (*available in* LEXIS, Nexis Library, IN THE NEWS File. “The health care industry represents 13.7[%] of our gross domestic product—only second to the defense industry. But yet, we are faced with escalating costs, a decrease in competition, an alarming increase of fraud and abuse scandals across our industry, the lowest possible confidence by the consumer and most importantly, a lack of leadership from within our own industry.” *Id.*

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I. INTRODUCTION

Many health experts argue that “the American health system is a work in progress; it can and . . . will get better.”² Unfortunately, for individuals like Barbara Garvey, the health care system had not progressed fast enough to save her life.³ In 1994, Barbara Garvey was vacationing with her husband in Hawaii when large bruises began to appear on her body.⁴ She immediately went to a local clinic and was admitted into the oncology department at the Queen’s Medical Center in Hawaii.⁵ After trying remedial procedures, her doctors diagnosed her with aplastic

²See Paul M. Ellwood Jr. & George D. Lundberg, *Managed Care: A Work in Progress*, 276 JAMA 1083-86 (1996).

³See *Transcripts of Clinton Remarks in Patients’ Bill of Rights Roundtable*, U.S. NEWswire, July 20, 1998.

⁴See *Id.*

⁵See *Id.*

anemia and recommended that she undergo a bone-marrow transplant.⁶ Several days into Mrs. Garvey's treatment, her Health Maintenance Organization (HMO), a third-party payor (like self-insured employers),⁷ conducted a prospective utilization review process—in which the third-party payor determines whether or not it will reimburse the patient for a medical procedure.⁸ Upon completing the procedure, her HMO refused to pay for her treatment in Hawaii and furthermore, ordered that she return to Chicago where she could be treated by one of the HMO-designated providers (doctors).

Following a last-ditch plea by Mrs. Garvey's husband, their HMO reiterated its refusal to pay for her bone-marrow transplant in Hawaii and she was forced to fly back to Chicago on a commercial airline.⁹ Mrs. Garvey's condition left her without a functional immune system. As Mr. Garvey testified at a roundtable sponsored by President Clinton on Patient's Bill of Rights legislation: "We had to take her from isolation, put her on a commercial flight and expose her to all the impurities of recirculated air [and] the pressure changes, which most people here it wouldn't affect at all, but [to] somebody in her condition could, and may have, proved fatal."¹⁰

Due to her weakened state, Mrs. Garvey suffered a stroke in mid-flight. Nine days later she died, never becoming stable enough to receive the bone-marrow transplant in Chicago.¹¹

⁶*See Id.*

⁷*See* Kathleen J. McKee, *Liability of Third-Party Health-Care Payor for Injury Arising from Failure to Authorize Required Treatment*, 56 A.L.R. 5th 737, n.4 (1998). Third-party payor is a term used to describe entities responsible for paying health care services made on behalf of plan participants. *Id.* Examples of third-party payors are: insurance companies, managed care entities (HMOs, PPOs, IPAs), Medicare and Medicaid, and self-insured employers. *Id.*

⁸*See Id.* at § 2(a) Although the HMO demanded Mrs. Garvey's return, her doctor in Hawaii said she was not stable enough to be moved that far of a distance. *Transcript of Clinton Remarks in Patients' Bill of Rights Roundtable*, *supra* note 3. Mr. Garvey phoned Chicago and spoke to a doctor working for the HMO. *Id.* The doctor agreed with Mr. Garvey that his wife was in no condition to be moved. *Id.* The same day that this conversation took place, the doctor working for the HMO, who agreed that Mrs. Garvey should not be removed, was taken off the Garvey case. DEMOCRATIC LEADERSHIP COMMITTEES, SPECIAL REPORTS: PATIENTS BEFORE PROFITS: 18 REASONS FOR HMO REFORM, (visited Mar. 29, 1999) <http://www.senate.gov/~dpc.patients_rights/> [hereinafter SPECIAL REPORTS: PATIENTS BEFORE PROFITS]. A new doctor assumed control and demanded Mrs. Garvey must return to Chicago at the Garvey's expense. *Id.* Mr. Garvey requested a medivac to ensure and safe and sterile travel. *Id.* Their HMO refused, citing expense and awaited Mrs. Garvey's return in Chicago. *Id.* *see also* Larry Pittman, *ERISA's Preemption Clause and the Health Care Industry: An Abdication of Judicial Law-Creating Authority*, 46 FLA. L. REV. 355, 356 (1994). Prospective utilization review is a process where a third-party payor (self-insured employer or HMO, among others) deems whether or not treatment is medically necessary. *Id.* Upon its decision as to whether or not the treatment is medically necessary, the third-party payor informs the patient and/or the provider on whether or not the third-party payor will grant or deny payment. *Id.*

⁹*See Transcripts of Clinton Remarks in Patient's Bill of Rights Roundtable*, *supra* note 3.

¹⁰*See Id.*

¹¹*See Id.*

While Mrs. Garvey's HMO's acts were reprehensible, even more disturbing is the fact that Mrs. Garvey's surviving family was denied any and all state law claims because of a preemption clause in the 1974 Employment Retirement Income Securities Act (ERISA). The preemption clause denied Mrs. Garvey's family all state remedies and affords her family only those remedies set forth in ERISA. The clause states, in part, that ERISA itself "supersede[s] any and all State laws" as they relate to health-benefit plans.¹² In *Pilot Life Insurance Co. v. W. Dedeaux*, the U.S. Supreme Court held that a state law cause of action is preempted by [the 1974 Employment Retirement Income Securities Act] if [the action] relates to an employee-benefit plan.¹³ The Court held that because ERISA already includes a civil enforcement mechanism—which affords patients the ability to bring a civil action to obtain compensation for plan benefits refused, injunctions against refusals by plans to pay benefits, and attorney's fees—Congress did not intend to permit other remedies such as punitive damages in state courts for tortious claims by plan participants.¹⁴

Compounding this disturbing situation, the lower federal courts maintain that while they are troubled by apparent injustices being committed against patients like Mrs. Garvey, it is not their responsibility to remedy the situation. They suggest, rather, it is Congress' responsibility to revisit ERISA and to reevaluate the preemption clause and its adverse effect on patients.¹⁵

Although unjust and highly controversial, the Garvey incident is not unique within the American health care system experience.¹⁶ Incidents like this have prompted serious debate in Congress as to whether immunity for third-party payors from state law actions is a form of immunity with which a country with arguably the best health care and legal systems in the world can live. In response to the Garvey ordeal and incidents like it, many entities—doctors, lawyers, patients, and politicians (Republican and Democrat)—argue that a patient's bill of rights law must be passed that includes a measure eliminating the preemption clause so as to protect patients from third-party payors who are sacrificing medical ethics to business profits.¹⁷ Proponents of the bill state that approximately 125 million people currently enrolled in health care plans have no opportunity for substantive legal remedy, because their third-party payors are exempt from being sued for punitive damages for injuries

¹²29 U.S.C. § 1144(a) (1998).

¹³*Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

¹⁴*Id.* at 52. The ERISA civil enforcement mechanism is located at 29 U.S.C. § 1132 (1999). In addition to the civil enforcement mechanism, ERISA provides two other remedies: (1) 29 U.S.C. § 1131 (1999): Criminal penalties for violations of the disclosure and reporting provisions of ERISA; and (2) 29 U.S.C. § 1133 (1999): notice and a reasonable review must be afforded to plan participants for any claims denied. *Id.* at 53.

¹⁵See AMERICAN PSYCHOLOGICAL ASSOCIATION, *Congress: Give Injured Patients Legal Recourse By Closing the ERISA Loophole* (visited Mar. 3, 1999) <<http://www.apa.org/practice/erisalooophole.html>>.

¹⁶See generally SPECIAL REPORTS: PATIENTS BEFORE PROFITS, *supra* note 8.

¹⁷The term—patient's bill of rights legislation—does not encompass one bill per se, but is generally used as a generic term for all proposed legislation that surrounds Congress's current deliberation on the state of health care.

caused by their decisions to, among others, delay treatment or deny procedures recommended by the patients' doctors.¹⁸ Both consumer advocates and medical-doctor associations urge Congress to eliminate, or significantly alter, the federal-preemption clause so as to empower people like Mrs. Garvey's surviving family to use the legal system as a means to obtain legal redress in state courts for tortious acts committed by third-party payors.¹⁹

Consumer advocates, nor their opponents among HMOs and other third-party payors, like to admit that these issues are not cut-and-dried. They cannot be easily resolved by simple alterations to ERISA. For example, while it appears that Mrs. Garvey's HMO committed an act that should be subject to legal liability, third-party payors and their lobbyists maintain that they should not be subject to inconsistent, emotional, and outrageously high judgments in state courts, because logical and health-related reasons could have accounted for her HMO's refusal to cover the prescribed treatment in Hawaii.²⁰ Furthermore, they argue that while doctors are seriously concerned for the health and welfare of patients, doctors make mistakes, and their concern with earning a sizable income can affect their ability to provide quality care.²¹ Therefore, third-party payor advocates maintain certain health care

¹⁸See POLICY.COM: THE POLICY NEWS & INFORMATION SERVICE, *Can Managed Care Be Managed: Erisa Reform*, (visited Jan. 31, 1999) <<http://www.policy.com/issue/wk/98/0608/060898d.html>>. Consumer advocates argue that health care providers (doctors) and their managed care companies need to assume more responsibility for their actions. *Id.* Managed Care Companies argue if the ERISA exemption is lifted, the costs of premiums (amount employers pay for their employees health care coverage) will undoubtedly go up. *Id.* Furthermore, in addition to the increased premiums, managed care companies argue this will naturally lead to an alarming increase in the number of uninsured people in the country. *Id.*

¹⁹Throughout this Article, when referring to state law, the author is encompassing state medical malpractice laws. See BLACK'S LAW DICTIONARY 400 (Pocket ed. 1996). These references do include state law or common law which place a general duty of reasonable care on an individual who performs on behalf of another for which a breach of that duty will subject the breaching part to liability for damages caused by the breach. See BLACK'S LAW DICTIONARY 400 (Pocket ed. 1996).

²⁰Interview with M. Ruth Coleman, president and CEO of Health Design Plus, in Hudson, Ohio (Feb. 2, 1999) [hereinafter Interview with Coleman]. The HMO could have made their decision to deny her the treatment in Hawaii because the bone marrow transplant was too much for Mrs. Garvey's body to handle. *Id.* Furthermore, there is a real possibility of medical malpractice by the doctor and the HMO may have wanted to protect itself from liability for allowing an unapproved provider to administer health care to their patient. *Id.* M. Ruth Coleman stated that she recently had a client, whose employee's doctor prescribed that the employer's employee needed a bone marrow transplant. *Id.* The employer was concerned with such an extreme measure and wanted to obtain a separate opinion on the matter. *Id.* M. Ruth Coleman's company, Health Design Plus, obtained three reputable doctors from the Northeast Ohio region. *Id.* They were informed of the matter and told that the original doctor prescribed a bone marrow transplant. Interview with Coleman, *supra* note 21. Following the review of this matter, all three doctors stated if this employee-patient goes through with the bone marrow transplant, she will die on the operating table. *Id.* See also MICHAEL L. MILLENSON, DEMANDING MEDICAL EXCELLENCE: DOCTORS AND ACCOUNTABILITY IN THE INFORMATION AGE 156-60 (1997).

²¹See MILLENSON, *supra* note 20, at 298. In a *Forbes* magazine article, in 1986, Dr. James Silverman, chief of staff at Stanford University Medical Center, stated, "[Back then] There

claim decisions, while seemingly callous, are in fact calculated to provide cost-efficient solutions that are in the best interest of the patient and that seek to avoid possible mistakes by doctors.²² Lastly, this free-market contingent of third-party payors argue that over the past twenty years, America's insured patients have been afforded health care at virtually no cost to themselves.²³ The insured American patient has come to expect quality affordable health care at no financial risk, even though the costs of such care could produce "an irrational health care system" in which health costs will never stop increasing.²⁴ Therefore, this free-market contingent concludes that if America's insured patients' unrealistic assumptions motivate significant alteration to, or elimination of, the preemption clause, they will be forced to increase premiums to offset any increased liability costs. If that does not work, they threaten that they will exit the health care benefits business altogether and leave patients to fend for themselves in securing affordable health insurance.²⁵

was no shortage of work, and everyone was happy. At the beginning of the year, doctors would target their income and reach it in a number of ways. You could always charge for lab tests you didn't do." *Id.* In the magazine, *Mother Jones*, Alan Stone, professor of law and medicine at Harvard, stated, "when you introduced the profit motive into health care, the whole industry became permeated with greed." *Id.* at 299-300. This "uncontrolled greed" is the basis for any managed care situation that we must deal with today." *Id.* at 299.

²²See Wendy K. Mariner, *Business vs. Medical Ethics: Conflicting Standards for Managed Care*, 23 J. L., MED. & ETHICS 236, 240 (1995). A patient's legal relationship to her HMO is one that is based on contract principles. *Id.* See Joseph M. Perillo, *Corbin on Contracts*, (St. Paul: West, vol. 1, 1993). The elements that underlie and enforceable contract are: an exchange of promises; a fair bargaining process; and a meeting of the minds. See Mariner, *supra* note 23, at 240. According to Wendy Mariner, there are fundamental differences between the relationship created by contract principles and a relationship based on fiduciary obligations from doctor to patient. *Id.* For example, a doctor has a fiduciary responsibility to act in the best interests of her patient; whereas, in a contractual relationship, if an HMO does not provide care that is not set forth in the contract, it is not treating its patients unethically or unjustly, even if the patient, such as Mrs. Garvey, needs the care. *Id.*

²³See Mariner, *supra* note 22, at 240. "For decades, employers providing health insurance for the employee was like the employer buying them a mink coat every-year . . . we have created in this country an expectation that's very different than a lot of other countries in that the consumer expects the best, that they have the rights to be treated at the 'nth degree' until they draw their last breath . . . this isn't necessarily negative, but the fact remains, we have that expectation." *Id.* See also Alycia C. Regan, Note, *Regulating the Business of Medicine: Models for Integrating Ethics and Managed Care*, 30 COLUM. J.L. & SOC. PROBS. 635, 684 n.12 (1997). See also MARK A. RODWIN, *MEDICINE, MONEY & MORALS: PHYSICIANS' CONFLICTS OF INTEREST* 55-57 (1993). The vast majority of health care costs are paid through third-party payers. *Id.* at 13-14. Therefore, consumers do not have to assume any kind of substantive economic responsibility. *Id.* The only adverse economic effect to the patient comes through an annual increase in premium payments. *Id.*

²⁴See RANDOM HOUSE UNABR. DICTIONARY 1026 (Stuart Berg Flexner ed., 2d ed. 1993). See also Emily Friedman, *United States' Health Care System Called 'Irrational,'* 58 HOSPS. 33 (1984).

²⁵See Telephone interview with David Eubanks, manager, Benefits Administration for Marathon Oil Co. and chair of the National Employee Benefits Institute Foundation Policy Board (Feb. 26, 1999). [hereinafter Telephone interview with Eubanks].

On the other hand, patient and consumer-rights groups have their own substantive arguments. These advocates point out that while third-party payors predict that the elimination of the preemption clause will be too costly for their businesses, they neglect to inform the public that the CEOs of the third-party payor companies and corporations are making astronomical salaries.²⁶ Families USA, a consumer rights group, studied health care companies' filings with the Securities and Exchange Commission.²⁷ In 1997, it found:

The 25 highest paid executives in the 15 companies studied made \$128.6 million in annual compensation, excluding unexercised stock options. The average compensation for these 25 executives was over \$5.1 million per executive. The median compensation for these [same] 25 executives was \$3.5 million.²⁸

Jamie Court, director of Consumers for Quality Care, a California-based watchdog group states, '[f]or-profit HMOs take as much as thirty cents of every premium dollar for their own profit and overhead, so the real fear of HMOs is that reform legislation[, elimination of the preemption clause,] will cut profits and redirect dollars from companies' coffers to patients' care.'²⁹ Consumer-rights groups maintain that the idea of eliminating the preemption clause should not be squelched by a highly-suspect fear that third-party payors would be forced to fold their operations under the burden of resulting lawsuits and increased liability insurance.³⁰ Consumer-rights groups also posit that when a self-insured employer or HMO denies necessary medical treatment to the employee/patient, she could suffer irreparable damage—e.g., death or serious injury.³¹ Therefore, according to Terre McFillen Hall, executive director of the Center for Patient Advocacy: "If HMOs [or self-insured employers] are making medical decisions, and in essence that's what they're doing . . . then they should be held accountable just like any doctor who makes medical decisions."³² McFillen Hall further argues that since federal courts have predominantly refused to hold third-party payors liable until the ERISA preemption

²⁶See FAMILIES USA, CORPORATE COMPENSATION ON AMERICA'S HMOs, (Sept. 1998) <<http://www.familiesusa.org/ceo2htm>>.

²⁷See *Id.*

²⁸See *Id.* Stephen Wiggins, chairman and CEO of Oxford Health Plans, Inc. made \$30,735,093 in 1997. *Id.* Wilson Taylor, chairman and CEO of CIGNA Corp. made \$12,456,169 in 1997. *Id.* The report also found: "The 25 executives with the largest unexercised stock option packages in 1997 had stock options valued at \$290.4 million. The average value of unexercised stock options for these 25 executives was \$11.6 million. The median unexercised stock option package for these executives was \$7.3 million." *Id.*

²⁹See THE FOUNDATION FOR TAXPAYER AND CONSUMER RIGHTS, HMO INDUSTRY TAKES SCARE TACTICS ROAD: "JOB KILLER" RAP MEANT TO STOP HMO REFORMS, (visited Mar. 3, 1999) <http://www.consumerwatchdog.org/public_hts/medical/press/me/00137.htm> (quoting Jamie Court, director of Consumers for Quality Care).

³⁰*Id.*

³¹See AMERICAN PSYCHOLOGICAL ASSOCIATION, *supra* note 15.

³²See *Id.* (citing BUREAU OF NATIONAL AFFAIRS, HEALTH CARE POLICY REPORT (Apr. 20, 1998) (quoting Terre McFillen Hall)).

clause is altered or eliminated, it strengthens and intensifies the arguments for Congressional elimination of the clause.³³ Consumer advocates reason that the third-party payors must take a step back and “concede [that] there are fundamental problems which gave rise to the [patient’s] ‘bill-of-rights’ movement in the first place[, and, that] the failure of managed care in many instances [was its inability] to reconcile cost containment with more humane considerations.”³⁴ They conclude that the elimination of the preemption clause would be as good a beginning as any in initiating this reconciliation.

Pure guilt or innocence do not exist in the discussion about the fate of the preemption clause. To move into the next millennium with an efficient, but humane health care system, this article argues that the various entities—patient, provider, and third-party payor—must each assume responsibility in providing for and accepting quality health benefits at an affordable cost. For over twenty-years, the preemption clause has served our health care system for better or for worse. Although increasingly troubled by the preemption clause’s effect on patient’s health, the many federal courts hold that the preemption clause language is clear and that it is Congress’s responsibility to remedy the harm being inflicted on individuals such as Mrs. Garvey.³⁵

This article explores the arguments surrounding the fate of the preemption clause and argues that Congress must work to preserve self-insured employers’ accountability to its employees while concurrently retaining the services of self-insured employers in the health care business. Part II analyzes the federal government’s relationship with the health care industry, concentrating selectively on four episodes of federal regulation which helped create the health care crisis that we encounter today—the Hill-Burton Act, the Congressional amendments to the Health Professions Educational Assistance Act, the advent of Medicare, and ERISA.³⁶ Armed with this understanding, Congress’s evaluation of health care issues, specifically the elimination of the preemption clause from ERISA, may be able to avoid repeating history by committing the same mistakes as have been committed over the past fifty-years of federal regulation of the health care industry. Part III focuses on various arguments as to whether Congress should amend ERISA to allow participants to sue self-insured employers and HMOs for punitive damages under state tort law.³⁷ It explains why and how the preemption clause was drafted into ERISA, explores the federal courts’ interpretations of the clause and the arguments surrounding its abolition, and analyzes the possible repercussions that such a measure, if passed, would have on four major entities—patient, provider, self-insured employer, and health care entities. Part IV attempts to resolve the current

³³*See Id.*

³⁴*Patients’ Bill of Rights Deserves Consideration*, NATIONAL UNDERWRITER PROPERTY & CASUALTY-RISK & BENEFITS MANAGEMENT, Feb. 9, 1998, at 40.

³⁵*See supra* note 15.

³⁶Letter from M. Ruth Coleman, president and CEO of Health Design Plus, a national Health Care Managed Organization, to Damon H. Taylor, Article Author (Feb. 5, 1999) (on file with author).

³⁷*See* Bulletin from *The National Employee Benefits Institute Foundation* to all associate members on, WASHINGTON STATUS REPORT, (Jan. 29, 1999) (on file with author).

arguments on eliminating the ERISA preemption clause by providing some practical suggestions to manage our looming health care crisis.

II. SELECTIVE HISTORICAL ANALYSIS OF GOVERNMENTAL REGULATION OF AMERICA'S HEALTH CARE SYSTEM

For the last fifty-years, most American patients indulged themselves with the benefits of a quality health care system. Joseph Califano, an author and veteran of the health care industry, states, "Americans have gotten more tests, seen more physicians, spent more time in hospitals for minor medical procedures, taken more drugs, had more medical examinations, and been subjected to more unnecessary surgery than any other people in the world."³⁸ Furthermore, the patient has enjoyed the miracles of modern medicine at virtually no cost to herself or her family.³⁹ "By the late 1960s, approximately ninety-percent of the United States population had private-or public health insurance that reimbursed on a fee-for-service basis just about any care doctors and hospitals deemed necessary."⁴⁰ America's insatiable appetite for more and better health care has not, however, equated to a wonderful health care system today.⁴¹ What resulted were more problems: Congress's unwillingness to refuse the nation's health care desires; doctors want higher fees; hospitals more facilities and beds to fill; and patients demanding more services at a cheaper cost. For every law or regulation passed, it seemed, there was an undesirable outcome, a bigger and more formidable problem than the one addressed in the legislation. This section illustrates this point by selectively reviewing a series of legislative events: the Hill-Burton Act, Congressional amendments to the Health Professions Educational Assistance Act, the advent of Medicare, and the 1974 Employee Retirement Income Securities Act.

These legislative actions built the foundation for the current discussion on the fate of the ERISA preemption clause. Future deliberations must be grounded in past lessons learned rather than upon highly publicized, often anecdotal, instances of managed health care abuse.⁴²

A. The Hill-Burton Act

From 1789 through 1945, the United States government's involvement in health care was limited to creating a Marine Hospital Service in 1789, studying infectious

³⁸JOSEPH A. CALIFANO, JR., *AMERICA'S HEALTH CARE REVOLUTION: WHO LIVES? WHO DIES? WHO PAYS?* 56 (1984).

³⁹*See Id.*

⁴⁰*See* MILLENSON, *supra* note 20, at 289. *See also* Interview with Coleman, *supra* note 21. The fee-for-service system places a pre-prescribed price for each service provided to the patient. *Id.*

⁴¹*See* Coleman, *supra* note 20. *See also* CALIFANO JR., *supra* note 37, at 57. Califano states as a result of the early-dollar coverage, unlimited choices, and full benefits, the blessed benefit of health insurance is no longer viewed as a blessing, but as a credit card. *Id.* "The health insurance card that let us enter the third-party, fee-for-service, cost-plus health care reimbursement system provided only the illusion of a free lunch. In reality, we have all paid for this meal. And what we've paid has created a health industry colossus." *Id.*

⁴²*See* CALIFANO JR., *supra* note 38, at 57.

diseases in the early twentieth century, and Franklin D. Roosevelt's toying with the idea of inserting health benefits into the 1935 Social Security proposal.⁴³ This changed when Japan bombed Pearl Harbor on December 7, 1941. Immediately, the war inspired the nation to defend American freedom and world democracy from imperialists, fascists, and dictators alike. The war effort focused, in part, on creating an effective health care industry, one that could provide adequate health training and medical research to thousands of nurses and doctors who would be drafted into the armed forces.⁴⁴ By the end of the war, the federal government was funneling large sums of money into health care research and supporting this hot new focus.⁴⁵

In 1946, state and local governments did not possess the capital to continue building hospitals as fast as society needed them.⁴⁶ Therefore, the President Truman-led Congress passed the Hill-Burton Hospital Survey and Construction Act.⁴⁷ This began a massive buildup of hospitals and hospital beds.⁴⁸ During the initial stages, the program spent upwards of \$700 million on hospital expansion and created 170,000 new hospital beds.⁴⁹ By the time the Act expired, it had served as the

⁴³See *Id.* at 47.

⁴⁴See *Id.*

⁴⁵See *Id.* In 1930 the National Institute of Health (NIH) was provided with an annual budget of \$50,000. *Id.* Once the war ended the federal government needed a mechanism which could assume the newly fostered medical military system, they chose the National Institute of Health. *Id.* In 1947, the NIH had a budget of \$8 million. *Id.* Moreover, by 1960, the NIH budget stood at a hefty \$400 million, and in 1984 the budget hit \$4 billion. *Id.* In 1944, Congress decided to empower the U.S. Surgeon General with the ability to conduct research on both diseases and the disabilities of man (most likely, Congress was focused on providing care for the men wounded throughout the WWII). *Id.* "World War II GI Bill education benefits paid for graduate training of doctors to do research at hospitals. The postwar expansion of the Veterans Administration hospital system" created a need for federal dollars to support their research efforts. *Id.* at 48.

⁴⁶See MILLENSON, *supra* note 20, at 161

⁴⁷See J. ROGERS HOLLINGSWORTH & ELLEN JANE HOLLINGSWORTH, *CONTROVERSY ABOUT AMERICAN HOSPITALS: FUNDING, OWNERSHIP, AND PERFORMANCE* 33 (1987). In addition to the new found fervor for health care in this country, it became increasingly obvious that there were many communities, small towns, and rural areas especially, that could not support a public or voluntary hospital. *Id.* "Funds were made available under the Hill-Burton program for both new construction and renovation of existing facilities Hill-Burton funding was allocated to states according to their per capita income and health needs—the states that were most 'underbedded' received the largest sums of the money, and those with the most beds for their population received proportionately smaller sums. The legislation was intended not simply to provide beds but to provide them in areas of acute shortage." *Id.* The Hill-Burton Act had three simple, yet distinct goals: (1) to motivate the states to complete both a needs assessment and inventory of their hospital infrastructure; (2) to provide federal monies for the construction of new hospitals; and (3) to stimulate local investments, statutorily required by the federal government to receive federal assistance. *Id.*

⁴⁸See *Id.* See also CALIFANO, *supra* note 38, at 49. When the law expired in 1978 "the program had used \$4.4 billion in federal money as leverage to get state and local governments to ante an additional \$9.1 billion. These funds built almost half the hospital beds in use in 1985." *Id.*

⁴⁹See MILLENSON, *supra* note 20, at 161.

catalyst for creating more than 500,000 beds.⁵⁰ Overall, the Hill-Burton Act caused a 30% increase in voluntary hospitals and a 119% increase in hospital beds.⁵¹ Unfortunately, Congress miscalculated or rather, did not foresee, the possible repercussions of subsidizing the construction of large numbers of hospitals.

While the increase in hospital beds was instrumental in providing the public—urban and rural alike—with quality health care facilities, the Hill-Burton Act created a massive infrastructure needful of patients to occupy its newly-made beds.⁵² This legislation marked the first miscalculation, in a series of well-intentioned, but short-sighted, regulatory measures by Congress. Ironically, the second short-sighted attempt to regulate the health care system involved Congress's desire to solve the problem caused, in part, by its miscalculation in the Hill-Burton Act—the unused-bed dilemma.

B. Congressional Amendments to the Health Professions Educational Assistance Act

From the late-1940s through the early-1950s, the delivery of health care in America consisted of an increased number of hospitals supplying an increased number of services to patients who, as they learned more about their health, demanded an increased number of services.⁵³ Unfortunately, doctors were having serious difficulty handling the increased patient demand for health care.⁵⁴ This increased demand, coupled with the Hill-Burton Act's adverse impact on the health care infrastructure,⁵⁵ caused the traditional economic analysis to go awry—hospitals were not being used to their capacities, patient's health care needs were increasing, and as a result, doctors realized an opportunity and began to increase their fees.⁵⁶

The federal government intervened as Congress passed a "broad package of amendments to the Health Professions Educational Assistance Act to provide funds to encourage medical schools to double—from 8,000 to 16,000—the number of physicians graduating each year."⁵⁷ The hospital lobbying groups convinced Congress that training more doctors would increase competition, which would naturally decrease fees. Moreover, training more doctors would solve both the

⁵⁰See CALIFANO JR., *supra* note 38, at 49.

⁵¹See HOLLINGSWORTH & HOLLINGSWORTH, *supra* note 47, at 34.

⁵²See Interview with Coleman, *supra* note 20.

⁵³See CALIFANO JR., *supra* note 38, at 78.

⁵⁴See *Id.*

⁵⁵See Interview with Coleman, *supra* note 20.

⁵⁶See CALIFANO JR., *supra* note 37, at 78. Many in the federal government felt that the doctors had purposely limited the number of doctors graduating to keep their prices from decreasing. *Id.*

⁵⁷See *Id.* The then Secretary of the Department of Health and Human Services became very concerned with this increase in the number of doctors being trained. *Id.* at 79. The secretary requested the assistance of the Graduate Medical Education National Advisory Committee (GMENAC) to help in determining the number of doctors expected to be working in society up until the year 2000. *Id.* at 80. The GMENAC took three years to complete its study and concluded that by the turn of the century, this country would have considerably more doctors than we would need. *Id.*

increased demand for services and the unused-bed problem. Unfortunately, Congress, once again, miscalculated the effect their blanket regulation would have on the health-care industry.

Although the beds were beginning to fill up and the patients' health care needs were being addressed, the large infusion of physicians into the market place resulted in an increase, not a decrease in costs.⁵⁸ In retrospect, health care specialist, John Califano Jr. states:

More doctors meant decidedly higher costs, and more specialists meant a richer mix of medical services, a one-two punch ending with an uppercut that sent the cost of health care through the roof. In a system where doctors could charge reasonable, customary, and prevailing fees and specialists commanded a premium, doubling the number of physicians more than doubled what they billed, largely as a result of a disproportionate increase in the number of specialists, who got the highest fees.⁵⁹

The old adage, "for every action, there is an equal reaction and opposite reaction," should have been ringing in the ears of Congress and the nation. While the Hill-Burton Act and the amendments to the Health Professions Educational Assistance Act were classic actions of good faith, well-intentioned government regulation, they resulted in unexpected outcomes, thus contributing to our current health care crisis.⁶⁰

C. *The Advent of Medicare*

By no means were the Hill-Burton Act and the amendments to the Health Professions Educational Assistance Act the sole culprits in creating the present day health care crisis.⁶¹ In 1964, newly appointed president Lyndon B. Johnson entered the White House carrying with him a dream that Medicare legislation would be passed to provide health care for the elderly and the poor.⁶² He stated in his first

⁵⁸*See Id.* "In the economic upside-down cake of medicine . . . more doctors do not necessarily mean lower prices. Indeed, in a provider-controlled system, the more doctors, the more medical services; the more surgeons, the more surgery; the more psychiatrists, the more fifty minute patient hours on couches; the more specialists, the more referrals to specialists." *Id.* The federal government did not account for the reality that physicians controlled prices and services and drastic increase of specialization. *Id.*

⁵⁹*See Id.* at 80. Reasonable, customary, and prevailing fees are terms taken from the Medicare legislation discussed in section II(c) of this Article.

⁶⁰*See* Interview with Coleman, *supra* note 20. (The increase in beds combined with the increase in doctors created a huge increase in health care costs. This increase in costs continues to escalate as this article is being written). *Id.*

⁶¹*See Id.*

⁶²*See* CALIFANO JR., *supra* note 38, at 50. Johnson wanted a broad range of measures to be passed by Congress. *Id.* He wanted to provide health care for the elderly and the poor. *Id.* *See also* ROBERT D. MILLER, PROBLEMS IN HEALTH CARE LAW 72 (7th ed. 1996). Medicare was created when Title XVIII was added to the 1965 Social Security Act. *Id.* This title added a two part program for health insurance which covered the elderly citizens. *Id.* Part A dealt with hospital insurance programs and Part B dealt with supplementary medical insurance

speech to Congress, “We are going to fight for medical care for the aged as long as we have breath in our bodies.”⁶³ Unfortunately, while Johnson was rightfully concerned with access to medical care, he did not envision, and was not interested in, the long term ramifications that such a program would have on the future of health care. When Johnson demanded that the Medicare bill be moved out of the committee, lobbyists argued that the bill would cost “a half-billion dollars to make the changes in reimbursement standards to get the bill out of the Senate Finance Committee.”⁶⁴ Johnson was alleged to respond, “Five hundred million. Is that all?”⁶⁵

To win this fight, President Johnson made serious concessions to powerful lobbying groups—the American Medical Association (AMA), the American Hospital Association, Blue Cross and other insurance carriers, among others—in order to obtain support for Medicare.⁶⁶ When Medicare and Medicaid were finally passed, the legislation included provisions stipulating that the federal government must pay “hospitals on the basis of what their services cost, and doctors their reasonable, customary, and prevailing fees.”⁶⁷ It turns out, this payment scheme, while providing a consistent payment standard, also served as the catalyst for the creation of the first major national health care standard, thereby altering health care provision forever.⁶⁸ This standard-of-care permitted American jurisprudence to begin considering medical malpractice suits throughout the nation;⁶⁹ it motivated

dealing with physicians’ services, medical supplies, ambulance services, and other tests such as x-rays and lab tests. *Id.* at 73.

⁶³See MILLER, *supra* note 62, at 73.

⁶⁴See CALIFANO JR., *supra* note 38, at 52.

⁶⁵See *Id.*

⁶⁶See *Id.* In order to build enough support, Johnson had to make various concessions, including one that would come back to haunt the nation. *Id.* at 51. In order to persuade the American Hospital Association and some insurance providers to support his idea he acquiesced to a provision that stipulated hospitals would be paid their “reasonable costs” of providing health care to the elderly. *Id.* Furthermore, the legislation would also involve amending the Kerr-Mills program thereby creating what is known as Medicaid. *Id.* But again, Johnson had to include a provision which would also come back to haunt the federal government. *Id.* This time, the legislation was amended to appease the American Medical Association. *Id.* The provision stipulated that physicians fees would be paid for by the program when they “were ‘reasonable,’ ‘customary,’ and in line with those ‘prevailing’ in their community.” *Id.*

⁶⁷See *Id.* At the time congressman and senators rebuked doctors’ arguments that this was poor legislation by stating, “you’re free of government interference, even on your fees, and a lot of your nonpaying patients will now be sources of income to you.” *Id.* See also Interview with Coleman, *supra* note 20. Califano’s statement as to a doctor’s ability to “charge reasonable, customary, and prevailing fees” was referencing Medicare’s impact on the health care system. CALIFANO JR., *supra* note 38, at 51.

⁶⁸See CALIFANO JR., *supra* note 38, at 55.

⁶⁹See *Id.* Up through the mid-twentieth century, to avoid a malpractice suite, the physician needed only to abide by the standard-of-care set forth by the community in which she practiced. *Id.*

physicians to over-treated patients so that they could avoid liability; and it led to a drastic increase in malpractice-insurance premiums.⁷⁰

One must remember that Congress was still playing the traditional health care regulating game—the more doctors and hospitals, the more competition, the more efficient and less costly the services.⁷¹ Unfortunately, “Doctors’ fees rose rapidly and physicians enriched the treatment of many patients far beyond what was medically appropriate” because doctors were not being regulated and federal monies were distributed freely under Medicare through the “reasonable, customary and prevailing fee standard.”⁷² While Medicare can take much of the credit for improving America’s health—extending the life span and improving the quality of life for the senior citizen, and drastically improving the health care for the poor—an unwanted effect did result and involved the cost-based, fee-for-service reimbursement system.⁷³ According to author Michael Millenson: “[Medicare] became a blank-check for American hospitals and doctors, and they didn’t hesitate to draw on the account.” Although physicians earnings in 1965 were already five times the median average income, the rate of increase in their fees promptly doubled.⁷⁴

The advent of Medicare is yet another illustration of federal regulation designed to solve short-term dilemmas leading to negative long-term results. Medicare, although nobly providing health care for the elderly and the indigent, created a system that invited massive fraud, thereby drastically increasing health care

⁷⁰*See Id.* The establishment of national standards created a form of liability imposed on physicians and hospitals when they failed to reasonably conduct every possible test in treating the patient. *Id.* As a result, if a hospital’s or a physician’s behavior failed to meet the stringent national standard, they would be found negligent and often, the jury would award large monetary damages as compensation. *Id.* In 1984, doctors were paying approximately \$2 billion dollars in malpractice insurance and hospitals were paying around \$1.5 billion in payments. *Id.*

⁷¹*See* CALIFANO JR., *supra* note 38, at 53. Immediately following the passage of Medicare, Congress pushed through a number of bills to train more doctors and nurses and build more hospitals. *Id.* *See also supra* p. 9 and note 60. Remember, the Hill-Burton Act and the amendments to the Health Professions Educational Assistance Act were drafted with the belief that the health care industry operated via traditional economic rules. *See* CALIFANO JR., *supra* note 38, at 53.

⁷²*See* CALIFANO JR., *supra* note 38, at 55. *See also supra* p. 5 and note 31. *See generally* MILLENSON, *supra* note 20, at 163-166. “In 1974, a House subcommittee held the first hearing on inappropriate surgery and concluded that the number of unneeded procedures had grown about 20 percent.” (since 1966) *Id.* at 166. *See generally It’s Time to Operate*, FORTUNE, Jan. 1970.

⁷³*See* CALIFANO JR., *supra* note 38, at 55.

⁷⁴*See Id.* *See also* MILLENSON, *supra* note 20, at 163. “Despite doctors’ denunciations of “socialized medicine, “ the new system encouraged profit maximization. Before Medicare, many doctors essentially conducted their business according to the principles of Karl Marx, the father of communism: ‘From each according to his abilities, to each according to his needs.’ Physicians charged higher fees to patients who could afford to pay and smaller to those who could not. Medicare, though, promised to pay whatever fee was ‘usual.’ The penniless senior citizen was instantly upgraded from charity case to full-fare customer. *Id.*

premiums.⁷⁵ In sum, Medicare, the Hill-Burton Act, and the amendments to the Health Professions Educational Assistance Act, all evidence good-faith, blanket-regulation. In the short term, the legislation provided glimpses of a quality health care system. But in the long term it hindered the nation's ability to offer its citizens quality health care at affordable prices.⁷⁶ The evolution of Medicare, however, did not signal the conclusion of this trend. It continued when Congress passed the Employee Retirement Income Securities Act in 1974.⁷⁷

*D. The Employee Retirement Income Securities Act of 1974*⁷⁸

The Employment Retirement Income Securities Act of 1974 (ERISA) was principally designed to protect employees participating in their employer's pension plans.⁷⁹ ERISA also induced employers to self-insure their health benefits by securing the services of a health benefits administrator to fulfill the requisite administrative responsibilities while financing the benefits program.⁸⁰ Just as President Johnson acquiesced to doctors and hospitals to obtain support for Medicare,⁸¹ legislators yielded to powerful employer-funded lobbying groups to obtain support for the passage of the act.⁸² In an attempt to convince employers to

⁷⁵See generally CLARK C. HAVIGHURST, HEALTH CARE LAW AND POLICY: READINGS NOTES AND QUESTIONS 261-266 (1988) (discusses fraudulent activity related to Medicare and Medicaid and specifically concentrates on *United States v. Greber*, 760 F.2d 68 (3rd Cir. 1985)). See generally MILLER, *supra* note 62, at 66-69 (explains that those who are involved in providing services and supplies for Medicare and Medicaid patients are subject to anti-fraud and abuse requirements under 42 U.S.C.A. § 1320a-7b and are often litigated in cases such as *United States v. Kats*, 871 F.2d 105 (9th Cir. 1989)); accord *United States v. Greber*, 760 F.2d 68 (3rd Cir.), *cert. denied*, 474 U.S. 988 (1985); see also *United States v. Lipkis*, 770 F.2d 1447 (9th Cir. 1985); but see *United States v. Porter*, 591 F.2d 1048 (5th Cir. 1979).

⁷⁶See *infra* note 25.

⁷⁷See MILLENSON, *supra* note 20, at 171. See also MILLER, *supra* note 62, at 85. "ERISA applies to self-funded employer benefit plans. ERISA is designed to permit employers to offer uniform benefits nationwide. It preempts nearly all state regulation of such plans, so that ERISA-qualified plans are protected from most state law challenges to denial of payment." *Id.* There are three levels to any preemption analysis: "(1) all state laws that 'relate to' any covered employee benefit plan are preempted; (2) there is an exception so that state laws that 'regulate insurance, banking, or securities' are not preempted; (3) most employee-benefit plans cannot be deemed to be insurers or banks, so they cannot be subjected to state insurance or banking laws." *Id.* See also *Id.* at 252. (ERISA regulates most pension and benefit plans for employees—pension, profit sharing, bonus, medical benefits, disability, death benefits, and unemployment, among others). *Id.*

⁷⁸See Employee Retirement Income Securities Act of 1974, Pub. L. No. 93-406, § 88 Stat. 829 (codified as amended at 29 U.S.C. §§ 1001-1461 (1988 & Supp. V 1993)).

⁷⁹See generally David Gregory, *The Scope of ERISA Preemption of State Law: A Study in Effective Federalism*, 48 U. PITT. L. REV. 427, 443-45 (1987) (the author lists a number of instances which demonstrate why Congress felt it necessary to pass such an act).

⁸⁰See HAVIGHURST, *supra* note 75, at 1196.

⁸¹See CALIFANO JR., *supra* note 38, at 52.

⁸²See Telephone interview with Eubanks, *supra* note 25.

provide health benefits, legislators drafted and passed a new preemption clause that regulates employee-benefit plans and preempts state law applicable to them. Dave Eubanks, the manager of benefits administration for a large multi-national corporation, maintains that Congress said to large employers, if you assume more responsibility for your employees' welfare plans, this provision will, in effect, protect you from chaotic and inconsistent state standards as well as juries who are ready and willing to award large monetary judgments to the plaintiff employees.⁸³ Clark Havighurst, professor of law at Duke University, wrote in *HEALTH CARE LAW AND POLICY*:

The purpose of ERISA's preemptive clause was to give large national employers, newly subject to federal regulation of their retirement and welfare benefits plans, some assurance that they would face uniform requirements. With respect to employee health benefits, however, ERISA substitutes little federal regulation for the state regulation it preempts, thus tempting employers to self-insure as a way of escaping regulatory requirements.⁸⁴

While the preemption clause did nothing to curb self-insured employers from avoiding regulation it did, however, permit the self-insured employer to prepare for one uniform regulatory system. The preemption clause effectively shielded self-insured employers from state regulation in that ERISA preempted or superceded any state regulation.

Because the preemptive clause impedes citizens, like Mrs. Garvey's family, from bringing a state action for negligence, it has become one of the most contentious health care issues existing in the debate over patient's bill of rights legislation.⁸⁵ In the short term, the drafting of the clause seemed to be an appropriate measure to extend health care coverage to more employees. In the long term, however, the clause has legitimately become the subject of much anger, litigation, and confusion as to the rights of patients against self-insured employers' and HMOs' negligent behavior. Attorneys Robert Charrow and Lisa Greenlees argue that while preemption was thought to be the key to affording quality health benefits to employees, many patient advocates now view the provision as the third-party payor's shield against malpractice actions.⁸⁶

Admittedly, the Hill-Burton Act, the amendments to the Health Professions Educational Assistance Act, Medicare, and ERISA have helped create one of the most technologically advanced health care systems in the world. Nevertheless, with the passage of time, it has become equally apparent that this legislative behavior lacked foresight in that it created long-term adverse effects—large antiquated hospital facilities, higher health care costs, more expensive specialists, increased premiums, mass physician and hospital fraud, wildly expensive malpractice

⁸³*See Id.*

⁸⁴*See* HAVIGHURST, *supra* note 75, at 1197.

⁸⁵*See Id.*

⁸⁶*See* Robert P. Charrow & Lisa T. Greenlees, *ERISA Pre-Emption—A Law in Search of a Doctrine*, 27 *HEALTH L. DIG.* 3, 3 (Mar. 1999).

insurance, over-prescribed medications, and unjust liability shields for third-party payors, among many others.⁸⁷

Selective analysis of past federal regulation of health care illustrates that the federal government has, unfortunately, sacrificed long term stability for short term solutions.⁸⁸ Congress has been unwilling to say “no” to the American public’s unrealistic desires for more care and better care . . . for less money,⁸⁹ while simultaneously acquiescing, first, to large employers and managed care organizations, who claim that only through a free-market system will the cost of health care be controlled;⁹⁰ and, second, to employer, doctor, and hospital-lobbying groups who are concerned principally with profit margins, checking accounts, and dividend payments.⁹¹ Congress’s desire to “have it all” has led to the current health care crisis. Understanding that past federal efforts to reform health care, although instrumental in building our quality health care system, have not produced fairy tale outcomes, current members of Congress and the legal community should summon the objectivity necessary for fruitful deliberation on the fate of the preemption provision. This article further argues that another key to wisely deliberating on the fate of the preemption clause is to arrive at a substantive legal understanding of the clause’s ability to preclude state law from interfering with the relationship between self-insured employers, HMOs, and their employee/patients.

III. AN IN-DEPTH ANALYSIS OF THE PROPOSED AMENDMENT TO ERISA WHICH WOULD ALLOW PATIENTS TO SUE EMPLOYERS AND HMOs FOR MALPRACTICE UNDER STATE LAW

From 1974 to the late 1980s, the health care market was dominated by fee-for-service plans that were not covered by ERISA.⁹² As a result, the clause’s chilling effect on a patient’s ability to sue for punitive damages went untested and unnoticed. Not until HMOs and other managed care entities became more involved in health-benefits distribution in the mid-to-late 1980s, did Congress and the legal community begin to comprehend the clause’s adverse repercussions on the health care system. Legislative intent behind ERISA is one of many heavily debated issues surrounding the clause because, in 1987, the U.S. Supreme Court, in *Pilot Life Insurance*

⁸⁷See Interview with Coleman, *supra* note 20.

⁸⁸See generally Michael M. Weinstein, *In Health Care, Be Careful What You Wish For*, N.Y. TIMES, May 31, 1998, at D3. (the author discusses the fact that accountability clashes with choice. While the patient wants accountability within the health care system she also wants the ability to choose any provider she pleases.). See generally Albert R. Hunt, *Health Care Is Issue of the Decade: Anger with System Fuels Pressure for ‘Patient’s Bill of Rights’*, WALL STREET J., June 25, 1998, at A9 (Americans want what is not possible—better care, quality care, for less money).

⁸⁹See David S. Broder, *Patients’ Rights: No Pain, No Gain*, WASH. POST, July 29, 1998, at A21.

⁹⁰See *supra* notes 64-79.

⁹¹See HAVIGHURST *supra* note 75, at 1196.

⁹²See Charrow & Greenless, *supra* note 86, at 7. Fee-for-service plans are considered different than the third-party structure that finds protection from liability in ERISA’s broad umbrella of preemption. *Id.*

Company reasoned that Congress's legislative intent is the key to interpreting ERISA and its preemptive affect on state law actions.⁹³ Whereas, third-party payors argue Congress drafted the clause to protect third-party payors from inconsistent and expensive state law actions; therefore, Congress should not waiver from its original purpose and leave the federal preemption clause intact. Consumer advocates argue that times have changed. While Congress intended ERISA to protect America's employers through the preemption clause's effect on state actions, the clause is now used to protect third-party payors. Another controversial issue is how the lower federal courts' are interpreting the clause's language. To enable Congress and the legal community to find common ground on the fate of the preemption clause, this section briefly explores the nature of preemption, the clause itself, and whether third-party payors that conduct prospective-utilization reviews, similar to the one conducted by Barbara Garvey's HMO, can be held legally liable under state law.⁹⁴

Section A analyzes the language of the clause and discusses the legislative intent supporting the drafting of the ERISA preemption clause and offers three arguments, each taking a different slant on Congress's thought process in including the preemption clause. Section B reviews the federal courts' interpretations of the clause and its application to a patient's state law claim, highlighting the difficulty in balancing the rights of plan participants and the express language of the preemption clause by looking at the effects of the federal court rulings on the liability of four different entities—employers, plan administrators, managed care entities, and utilization review agents. Section C offers pro and con arguments on the elimination of the clause and specifically addresses the impact that the rescission would have on health care premiums, uninsured Americans, and the patient's ability to obtain legal redress through state law claims. Finally, Section D discusses the relationship between the preemption provision and four entities—the patient, the provider, the self-insured employer, and managed care entities.

A. Legislative Intent Behind the ERISA Preemption Clause

Preemption is a byproduct of the Supremacy Clause of the U.S. Constitution, which provides that federal law supercedes state laws that interfere with, or are contrary to federal law.⁹⁵ In 1974, Congress drafted a broad preemption provision

⁹³See *Pilot Life Ins. Co.* 481 U.S. 41, 41 (1987).

⁹⁴See Adrienne M. Zibelman, *The Practice Standard of Care and Liability of Managed Care Plans*, 27 J. HEALTH & HOSP. L. 204, 208 (1994) (citing Susan M.C. Payne, *Identifying and Managing Inappropriate Hospital Utilization: A Policy Synthesis*, 22 HEALTH SERVICES RES. 709 (1987)). "Utilization review (UR) evaluates the patient's medical record in light of predefined treatment criteria or expert opinion. UR is implemented primarily in three forms: [(1)] preadmission review [; (2)] concurrent review[;] and [(3)] retrospective review." *Id.* The pre-admission review is conducted by a registered nurse, who examines the patient's record as well as what the insurer's preferred treatment would be for the specific diagnosis. *Id.* The preadmission takes this information and determines what exactly should be done with the patient—hospitalization, testing, non-staff physician treatment, among others. *Id.* Concurrent review makes sure the treatment does not "exceed the limits of profitability." *Id.* "Retrospective review identifies costly patterns of treatment by physicians, diagnosis, or unit, and takes corrective action to prevent future losses." *Id.*

⁹⁵*Hillsborough County Fla. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 712 (1985) (quoting *Gibbons v. Ogden*, 9 Wheat. 1, 211 (1824)). See also U.S. Const., art VI, cl. 2. "This

into ERISA that was broken into three components—the preemption clause, the savings clause, and the deemer clause.⁹⁶ The preemption clause enables federal law—ERISA—“[to] supercede any and all State claims” if the claims “relate to any employee-benefit plan.”⁹⁷ The remaining two clauses—savings and deemer—deny the insurance, banking, and securities industries the opportunity to escape liability created by state law actions and clarify the effect of the savings clause by specifying that federal law does not supercede state law actions in cases dealing with insurance companies, other insurers, banks, trust companies, and investment companies.⁹⁸ In

Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.” *Id.*

⁹⁶See Robert Roth, *The Effect of ERISA Preemption on Tort Claims Against Employers, Insurers, Health Plan Administrators, Managed Care Entities, and Utilization Review Agents*, 7 HEALTH LAWYER 7, 8 (1994-95). See also Pittman, *supra* note 8, at 355, 356. Some members of Congress and employers sought to escape the very-real possibility of inconsistent judgments and standards created in state courts all over the nation and demanded the presence of a preemption clause. *Id.* The clause is codified as amended at 29 U.S.C. § 1144(a) 1988. *Id.* at 375, n. 124. The clause provides, “(e)xcept as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a).” § 1144(a). According to the author, a “saving clause” was drafted into the legislation so as to exempt state insurance laws from the ERISA umbrella of preemption. See Pittman, *supra* note 8, at 375, n. 125. It reads, “‘nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance.’” 29 U.S.C. § 1144(b)(2)(A) (1988). See Pittman, *supra* note 8, at 375, n. 125. This clause was consistent with the McCarran-Ferguson Act, ch. 20, 59 Stat. 33 (1945) (codified as amended at 15 U.S.C. §§ 1011-1015 (1988)). *Id.* It states, “‘the business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to regulation or taxation of such business.’” *Id.* (quoting 15 U.S.C. § 1012(a) (1988)). “The application of state statutes and common law regulating insurance is limited by the ‘deemer clause’ which provides that ‘(n)either an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies, [or] insurance contracts.’” Pittman, *supra* note 8, at 375 n.125 (quoting 29 U.S.C. § 1144(b)(2)(B) (1988)). The preemption clause has been successfully used to defend against employee’s claim for their personal injuries. Pittman, *supra* 8, at 376.

⁹⁷See 29 U.S.C. § 1144(a) (1998) The section states: “Except as provided in subsection (b) of this section, the provision of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a). . . .” *Id.*

⁹⁸See 29 U.S.C. § 1144(b)(2)(A) (1998). The clause states, “[e]xcept as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.” *Id.* See also 29 U.S.C. § 1144(b)(2)(B) (1998). This provision of the clause states, “[n]either an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title . . . , nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company.” *Id.*

the aggregate, the preemption provision commands that federal law supercede state actions if the actions “relate to any employee benefit plan,”⁹⁹ and, furthermore, provides that insurance companies, banks, trust companies, and investment companies are not to be construed as employee-benefit plans.¹⁰⁰ The federal court’s interpretation of the preemption-clause language—“relate to”—has been instrumental in dictating how broad, or how narrow, the federal courts apply the preemption clause to state law actions. As mentioned above, the U.S. Supreme Court stated that Congress’s intent, or purpose for drafting ERISA is crucial to interpreting the language, “relate to,” and central to the fate of the preemption clause.¹⁰¹

Arguably, Congress adopted ERISA to protect members of pension plans and health-benefit plans. ERISA sets forth, “‘standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.’”¹⁰² Today, Congress’s original intent for the scope of ERISA and its preemption clause is vigorously debated by lawyers, physicians, self-insured employers, and the courts.¹⁰³ Third-party payor lobbyists argue ERISA regulates pension plans and health plans sponsored by third-party payors, such as self-insured employers, who provide their employees with medical, surgical, or hospital care with a “‘purchase of insurance or otherwise.’”¹⁰⁴ Whereas consumer advocates argue that ERISA was created on behalf of employees.

Was ERISA passed solely for the protection of pension participants? If so, why did Congress include the preemption clause, thereby depriving patients, “who are injured by the negligent actions and decisions of ERISA-regulated managed care organizations [and self-insured employers], the right to hold these plans accountable for their actions[?]”¹⁰⁵

Patient advocates argue that ERISA was created to protect the interests of employees and their dependents; therefore, the preemption clause should not be deemed to preclude patients from holding third-party payors liable for their negligent decisions.¹⁰⁶ They posit that Congress wanted to protect pension participants and cite the ERISA legislative record for support.¹⁰⁷ For example, in 1974, Senator Biaggi,

⁹⁹See 29 U.S.C. § 1144(a) (1998).

¹⁰⁰See 29 U.S.C. § 1144(b)(2)(B) (1998).

¹⁰¹See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987).

¹⁰²See Roth, *supra* note 96, at 7-8 (quoting 29 U.S.C. § 1001(b)).

¹⁰³See Pittman, *supra* note 8, at 358-59.

¹⁰⁴See Roth, *supra* note 96, at 7 (quoting 29 U.S.C. § 1002(1)).

¹⁰⁵See AMERICAN PSYCHOLOGICAL ASSOCIATION, *ERISA Managed Care Organizations Should Be Held Accountable for Decisions That Harm Patients*, (visited Mar. 3, 1999) <<http://www.apa.org/practice/erisa.html>>.

¹⁰⁶See *Id.* See also Pittman, *supra* note 8, at 360. See generally Marilyn Klinger & James P. Diwik, *ERISA Preemption and the Surety*, 29 TORT & INS. L.J. 111, 112-13 (1993).

¹⁰⁷See Pittman, *supra* note 8, at 360.

celebrating the passage of the legislation, stated that ERISA was the “emancipation proclamation of workers.”¹⁰⁸

Third-party payors argue that although the interests of employees and their dependents was central to the legislation, Congress also wanted to make sure self-insured employers could economically live with the legislation.¹⁰⁹ In 1974, Senator Williams stated,

It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.¹¹⁰

As Dave Eubanks maintains, Congress desired to create legislation that was not too onerous on the employer—e.g., Congress did not want to force employers to prepare for fifty different sets of regulations.¹¹¹ Even more, Congress wanted to

¹⁰⁸See 120 Cong. Rec. 29, 193 (1974) (statement of Sen. Biaggi). “The benefits of this legislation for some 70 million working men and women will be far reaching and profound. Workers are receiving their own version of an emancipation proclamation. The Pension Reform Act will save the American worker from economic anxiety and uncertainty which in the past has accompanied retirement. It will free workers from servitude to unscrupulous employers, who seek to deprive their employees of the fundamental right to a pension.” *Id.* See also 120 Cong. Rec. 29, 197 (1974) (statement by Sen. Javits) (he likened the importance of ERISA to that of the development of Social Security, “[ERISA is the] greatest development in the life of the American worker since social security.” *Id.*

¹⁰⁹See 120 Cong. Rec. 29, 197 (1974) (statement of Rep. Dent). Dent felt that the preemption was the “crowning achievement” of the entire ERISA legislation. That it actually protects pension participants by eliminating any possibility “of conflicting and inconsistent state and local regulations” which could “affect any employee benefit plan” governed by ERISA. *Id.*

¹¹⁰See e.g. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987) (quoting 120 Cong. Rec. 29,933 (1974) (statement of Sen. William)).

¹¹¹See Telephone interview with Eubanks, *supra* note 25. Mr. Eubanks argues self-insured employers regulated by ERISA were, and are, concerned with the unfortunate, but true arbitrary nature of state courts. *Id.* They realize that state courts have judges whose election campaigns may be funded partially by plaintiffs lawyers; therefore, the judges might be biased against the multi-state companies. *Id.* See also Interview with Coleman, *supra* note 20. Furthermore, certain regions of the country are very protective of their own sons and daughters. Interview with Coleman, *supra* note 20. Therefore, a jury may be emotionally swayed to rule for their own son or daughter rather than the large, impersonal, but possibly, not guilty self-insured employer. *Id.* If the federal preemption was placed in the ERISA legislation, the liability resulting from arbitrary factors could lead to unjust legal decisions, thereby making an employers ability to provide health benefits an uneconomical decision. *Id.* See also, Charrow & Greenlees, *supra* note 86, at 3. Congress passed ERISA to create uniformity in the enforcement of employee benefits. *Id.*

provide the employer with the sanctity of the federal courts, where the damages awarded would be limited by the provisions laid out within ERISA.¹¹²

An increasing number of individuals—consumer advocates and physician providers, among others—rebuff third-party payor claims by reasoning that legislative intent is irrelevant.¹¹³ They claim that “ERISA’s preemption language is generating litigation that was never anticipated when the statute passed two decades ago, and therefore the preemption lawsuits contravene ERISA’s original purpose—the protection of participants in employee benefit plans.”¹¹⁴ More importantly, they argue that the influx of prospective utilization review procedures—evaluation of a patient’s medical record in light of predefined treatment criteria or expert opinion¹¹⁵—has altered the health care landscape so much that the preemption clause’s adverse effect on a patient’s ability to seek legal redress was totally unforeseen by Congress in 1974.¹¹⁶ Therefore, legislative intent is irrelevant and ERISA must be changed because it is unfair or unjust to deny a harmed patient any sort of compensation beyond that provided for in ERISA.¹¹⁷

¹¹²*Pilot Life Ins. Co.*, 481 U.S. at 52. The Court outlines three provisions within ERISA that serve as the enforcement mechanism for the legislation. *Id.* They are: (1) 29 U.S.C. § 1132 provides civil enforcement mechanisms for a variety of issues; (2) 29 U.S.C. § 1131 provides criminal penalties for violations of the disclosure and reporting provisions of ERISA; and (3) 29 U.S.C. § 1133 provides that notice must be given to the beneficiary or the plan participant for any claims denied and a reasonable review is offered on that decision to deny. *Id.* at 53. See also Roth, *supra* note 96, at 8. The civil action component, 29 U.S.C. § 1132(a), permits, in relative part, that a civil action may be brought by a participant or beneficiary for compensation for plan benefits, injunctions against refusals by plans to pay benefits, and attorney fees. *Pilot Life Ins. Co.*, 481 U.S. at 52. The Court in *Pilot Life* felt these three prongs of enforcement provided for a “careful balancing of the need for prompt and fair claims settlement procedures against public interest in encouraging the formation of employee-benefit plans. *Id.* The Court further felt that the precise inclusion of 29 U.S.C. § 1132(a) demonstrates that Congress did not intend to permit other remedies not included in the provision. *Id.* See also AMERICAN PSYCHOLOGICAL ASSOCIATION, *supra* note 15 (details a list of courts who have urged Congress to amend ERISA).

¹¹³See Robin Elizabeth Margolis, *Is ERISA Preemption the Health Insurance ‘Wrecking Ball?’*, 10 HEALTHSPAN 24 (Feb. 1993).

¹¹⁴See *Id.*

¹¹⁵See Zibelman, *supra* note 94, at 208.

¹¹⁶See Pittman, *supra* note 8, at 361. Up until the early 1980s, medical treatment was paid for retroactively. *Id.* Meaning, “physicians and hospitals submitted bills and received payments from the government, or from private insurance companies, after the medical treatment had already been received by the patient.” *Id.* Unfortunately, the retroactive system was not able to control the costs of health care because “the propriety of the treatment is considered after the treatment has been rendered and the cost of the care incurred.” *Id.* Because the Hill-Burton Act created a huge health care infrastructure to support, the amendments to the Health Professions Educational Assistance Act created too many doctors, and Medicare created a system which permitted incredible abuse. The cost of health care increased from 5% of the Gross National Product to 11% between 1960 and 1983, and then to 11.6% of the GNP in 1989. *Id.*

¹¹⁷See AMERICAN PSYCHOLOGICAL ASSOCIATION, *supra* note 105. See also Pittman, *supra* note 8, at 362. As a result, the federal government, private employers, and insurance companies created the utilization review mechanism as a vehicle to eliminate excess and

Legislative intent behind ERISA is one of many factors that Congress and the legal community might take into consideration when deliberating on the fate of the preemption clause. As the third-group of advocates question above, should it be? If the health care landscape has changed so much since the drafting of the preemption clause, should not Congress re-evaluate the relationship between third-party payors, their patients, and state law actions and leave legislative intent for the history books? The lower federal courts think so. The following section briefly examines the federal courts' analysis of the clause, its effect on a patient's state law actions, and how courts' analysis could serve as a catalyst for deliberation on the fate of the preemption clause.

B. The Federal Courts' Treatment of the ERISA Preemption Provision

If legislative intent is irrelevant, Congress's willingness to steer clear from its legacy of legislating long-term adverse impacts on the health care delivery system may lie in its ability to understand federal courts' interpretation of the clause and their effect on state law. As this section demonstrates, federal courts struggle with the language of the preemption clause and its impact on patients who are precluded from protecting themselves and others by using state law actions. This section explores the federal courts' analysis of the clause, and explores both tort actions against third-party payors and the difficulty federal courts are having balancing the rights of the patient with the express language of the clause. This section maintains that the discussion in our nation's federal court rooms can serve as background information for Congress as they currently deliberate on the fate of the preemption clause.

When determining the ERISA preemption clause's scope and reach, the federal courts generally conduct a two-part analysis. In *Pilot Life Insurance Co. v. Dedeaux*, the U.S. Supreme Court held that because ERISA contains express civil remedies within the statute, federal law preempts any state common law tort and contract causes-of-action asserting improper processing of claim for benefits under an insured employee's benefit plan.¹¹⁸ The Court reasoned that if it would allow state tort actions against ERISA regulated plans, its decision would undermine an expressed provision set forth by Congress that already covers remedies.¹¹⁹ The Court stated that the first step in determining whether a certain state action, such as a negligent claim against a self-insured employer, is preempted by the preemption clause is to analyze legislative intent.¹²⁰ Following a review of the Congressional record, the Court, in *Pilot Life*, determined that the preemption clause was drafted to be deliberately expansive, that it was designed to "establish pension-plan regulation

useless medical treatments and expenses. Pittman, *supra* note 8, at 362. While these review procedures are used to cut "the excess fat" from the health care industry, there is a real fear that self-insured employers and benefits managers will use the prospective utilization review to deny necessary medical treatments in the name of cost efficiency. *Id.* at 363. Furthermore, as long as the denial was made according to plan specifications, ERISA preempts any and all state claims. *Id.* at 364.

¹¹⁸See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57 (1987).

¹¹⁹*Id.* See also *Bast v. Prudential Ins. Co.*, 150 F.3d 1003, 1007 (9th Cir. 1998).

¹²⁰*Pilot Life Ins. Co.*, 481 U.S. at 44-45.

[and employee-benefit plan regulation] as exclusively a federal concern.”¹²¹ The Court came to this conclusion only after it discovered that the original draft of ERISA—which contained a too narrowly tailored preemption clause—had been rejected by Congress in favor of the present broadly-drafted version which affords third-party payors more protection state law liability.¹²²

The second part, also expressed in *Pilot Life*, requires federal courts to apply the U.S. Supreme Court’s expansive interpretation of this provision to the phrase ‘relates to’ as set forth in the preemption clause.¹²³ In *Bast v. Prudential Insurance Co.*, the United States Court of Appeals for the Ninth Circuit attempted to follow precedent and held that “a state law cause of action is [only] preempted by ERISA if it ‘relates to’ an employee-benefits plan.”¹²⁴ According to the court in *Bast*, since 1983, federal courts have interpreted state law relating to an employee-benefits plan, “‘if it has a connection with or reference to such plan.’”¹²⁵

The United States Supreme Court was subsequently called upon to define what exactly “relate to” meant. The Court, in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*,¹²⁶ held that “[courts] must go beyond the unhelpful text and the frustrating difficulty of defining its key term [relate to], and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.”¹²⁷ In *District of Columbia v. Greater Washington Board of Trade*, the Court added that the existence of the “connection with or reference to employee-benefit plans” is to be established by examining the “objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as the nature of the effect of the state law on ERISA [health] plans.”¹²⁸ For example, if Mrs. Garvey’s family had

¹²¹See *Id.* at 46 (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)).

¹²²See *Id.* at 46. “The bill that became ERISA originally contained a limited pre-emption clause, applicable only to state laws relating to the specific subjects covered by ERISA. The Conference Committee rejected those provisions in favor of the present language, and indicated that section’s pre-emptive scope was as broad as its language.” *Id.* (quoting H.R. Rep. No. 93-1280, at 383 (1974); S. Rep. No. 93-1090, at 383, (1974); see also *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98, (1983)).

¹²³See *Pilot Life Ins. Co.*, 481 U.S. at 47.

¹²⁴See *Id.* See also *Bast*, 150 F.3d at 1007 (citing 29 U.S.C. § 1144(a)); see, e.g. *Corporate Health Ins., Inc. v. Texas Dept. of Ins.*, 12 F. Supp. 2d 597, 607 (S.D. Tex. 1998); *Metroplex Infusion Care, Inc. v. Lone Star Container Corp.*, 855 F. Supp. 897, 900 (N.D. Tex. 1994).

¹²⁵*Bast*, 150 F.3d at 1007 (citing *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990) (quoting *Shaw v. Delta Air Lines, Ind.*, 463 U.S. 85, 97 (1983)).

¹²⁶*New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995).

¹²⁷See *Id.* at 656. See also *Operating Eng’rs Health & Welfare Trust Fund v. JWJ Contracting Co.*, 135 F.3d 671 (9th Cir. 1998) (“of late, the [Supreme] Court has come to recognize that ERISA pre-emption must have limits when it enters areas traditionally left to state regulation . . .”).

¹²⁸*District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 129 (1992). See also *California Div. of Labor Standards Enforcement v. Dillingham Constr., Inc.*, 519 U.S. 316, 317 (1997).

decided that the remedies provided for under ERISA were inadequate,¹²⁹ and sued the HMO in state court for negligently denying Mrs. Garvey a bone-marrow transplant in Hawaii, the HMO would likely have argued that Mrs. Garvey's state law claim was preempted by ERISA because Congress's objective was to protect self-insured employers. The federal court would have to follow precedent and look to the legislative intent supporting the preemption clause to evaluate if the denial of a bone-marrow transplant was "related to" or "connected to" the administration of the employee-benefit plan.¹³⁰ As long as the third-party payor's decision was based on an objective application of the benefit-plan restrictions and not a subjective medical decision, more likely than not, the federal court would deem that denying a bone-marrow transplant was "related to" the administration of an employee benefit plan and, therefore, that the state law claim was preempted by ERISA.

Attempting to provide clarity to ambiguous language in the 1974 ERISA act, the U.S. Supreme Court provided the basic outline for the controversial preemption analysis. The preemption clause's effect on state law, however, becomes most controversial when, similar to the Garvey incident, the denial of a patient's state law claim against self-insured employers and other third-party payor entities results in death. This section will begin by providing an overview of the federal courts' analysis of the preemption clause's effect on tort claims between self-insured employers and their plan participants. Part two of this section will conclude by outlining the general difficulty that many federal courts are having with the preemption clause's effect on a patient's ability to sue, specifically, self-insured employers, plan administrators, managed care entities, and utilization review agents.

1. Tort Claims Between Self-Insured Employers And Their Health Care Plan Participants

As mentioned earlier, in *Pilot Life Insurance Co.*,¹³¹ the Court held that because ERISA contains express civil remedies within the statute, federal law preempts any state common law tort and contract cause-of-action asserting negligent processing of claim for benefits under an insured employee's benefit plan.¹³² The Court held that if it would allow state tort actions against ERISA-regulated plans, its decision would render moot an expressed provision set forth by Congress.¹³³ Since *Pilot Life*, courts have expanded the Court's ruling to apply to other state tort actions.¹³⁴ In *Bast*, the United States Court of Appeals for the Ninth Circuit, held that causes of action for "breach of contract, breach of the duty of good faith and fair dealing, intentional infliction of emotional distress",¹³⁵ and wrongful death based on a third-party payor's

¹²⁹See 29 U.S.C. § 1131; 29 U.S.C. § 1132; 29 U.S.C. § 1133.

¹³⁰*Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987).

¹³¹See *Id.*

¹³²See *Id.*

¹³³See *Id.* see also *Bast v. Prudential Ins. Co.*, 150 F.3d 1003, 1007 (9th Cir. 1998).

¹³⁴See Roth, *supra* note 96, at 8.

¹³⁵See *Bast*, 150 F.3d at 1007-08.

negligent administration of a claim, were preempted.¹³⁶ Furthermore, and of great import to the Mrs. Garveys of the world, according to the Supreme Court, in *Massachusetts Mutual Life Insurance Co. v. Russell*, extra-contractual, compensatory, and punitive damages are also not permitted under ERISA.¹³⁷

Patients, politicians, and providers are understandably troubled by ERISA depriving a plaintiff of substantive state law remedies for alleged negligent actions by the self-insured employer's plan administrator, among others.¹³⁸ In the past, national issues such as abortion, civil rights, gender equality were handled within the federal court system. The public has, therefore, come to expect the federal courts to provide guidance when struggling with the many systemic problems that plague our nation. With respect to the preemption's adverse impact on patients' rights, the federal courts, despite minor deviations, refuse to bend and continue to stand steadfast in their interpretation of the preemption clause. In *Cannon v. Group Health Services*, a woman was diagnosed with leukemia and needed a bone-marrow transplant.¹³⁹ Her insurance company denied her request on the basis that the procedure was experimental.¹⁴⁰ Although the insurance company would later reverse its decision, it was too late, and the woman died shortly thereafter.¹⁴¹ The woman's spouse brought an action alleging the insurer negligently or in bad faith refused to authorize the procedure in a timely manner.¹⁴² The United States Court of Appeals for the Tenth Circuit ruled that ERISA preempts state law claims even if there is no alternative remedy under ERISA.¹⁴³ Similarly, the United States Court of Appeals for the Fifth and Sixth Circuits concurred with the Tenth Circuit when deciding that ERISA preempts state laws even if that means the plaintiff, or the plaintiff's dependents, obtain no remedy.¹⁴⁴

¹³⁶*See Id.* *See also* *Tingey v. Pingley-Richards West, Inc.*, 953 F.2d 1124 (9th Cir. 1992) ; *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir. 1993) (attorney's fees awarded because insurer agreed to pay for medical services only after plaintiff sued to compel coverage, even though the wrongful death action was preempted by ERISA).

¹³⁷*Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985); *Sokol v. Bernstein*, 803 F.2d 532 (9th Cir. 1986) (29 U.S.C. § 1144(a) does not permit extra-contractual damages, including damages for emotional distress).

¹³⁸*See* AMERICAN PSYCHOLOGICAL ASSOCIATION, *supra* note 103. Terre McFillen Hall, executive director of the Center for Patient Advocacy, stated: "If HMOs are making medical decisions, and in essence that's what they're doing . . . then they should be held accountable just like any doctor who makes medical decisions." *Id.* Also, Ronald F. Pollack, executive director of Families USA, stated, "there's no question that plans are practicing medicine. What plans are saying is: 'We can practice medicine until we make a mistake, then you shouldn't treat us as if we're practicing medicine.'" *Id.*

¹³⁹*Cannon v. Group Health Servs. of Okla., Inc.*, 77 F.3d 1270 (10th Cir. 1996).

¹⁴⁰*See Id.*

¹⁴¹*See Id.*

¹⁴²*See Id.*

¹⁴³*See Id.*

¹⁴⁴*Corcoran v. United Healthcare*, 965 F.2d 1321, 1333 (5th Cir. 1992) ("while we are not unmindful of the fact that our interpretation of the preemption clause leaves a gap in remedies within a statute intended to protect participants in employee-benefit plans, . . . the lack of

In general, the federal courts remain unified in finding that federal law preempts state law claims if they relate to employee-benefit plans. The courts, however, have become increasingly troubled with the preemption clause's chilling effect on harmed patients and their dependents' rights to punish the alleged wrongdoers.¹⁴⁵ As a result, some federal courts have begun to explore avenues to evade the preemption clause's adverse impact on a patient's ability to seek state law remedies.

2. The Difficulty In Balancing The Rights Of Plan Participants With The Express Language Of The Preemption Clause

In the United States Court of Appeals for the First, Fifth, Ninth, and Tenth Circuits, although proscribing federal preemption over state law claims, courts have expressed a sense of remorse in having to deny injured or deceased plaintiffs any recourse other than that provided for under ERISA.¹⁴⁶ The federal courts, nevertheless, maintain that if injustices are being committed as a result of federal law preempting state law, the judicial branch has no business interjecting its sense of justice into policy decisions.¹⁴⁷ They further maintain that policy discussions should not take place in the courtroom; rather, the Constitution stipulates that it is the responsibility of the people through their elected representatives in Congress.¹⁴⁸ For example, the Fifth Circuit, in *Corcoran v. United Healthcare*, stated,

the result ERISA compels us to reach means that the Corcorans . . . have no remedy, state or federal, for what may have been a serious mistake . . . Fundamental changes such as widespread institution of utilization review would seem to warrant a reevaluation of ERISA so that it can continue to

ERISA remedy does not affect a preemption analysis.”); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937, 943 (6th Cir. 1995) (that ERISA does not provide the full range of remedies available under state law in no way undermines ERISA preemption.”); *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272, 1276 (6th Cir. 1991) (nor is it relevant to an analysis of the scope of federal preemption that appellants may be left without a remedy).

¹⁴⁵See AMERICAN PSYCHOLOGICAL ASSOCIATION, *supra* note 103.

¹⁴⁶See *Id.*

¹⁴⁷See *Id.*

¹⁴⁸*Cannon v. Group Health Servs. Of Okla., Inc.*, 77 F.3d 1270, 1270 (10th Cir. 1996). (“although moved by the tragic circumstances of this case . . . we conclude that the law gives us no choice but to affirm the dismissal of the case on ERISA preemption grounds . . . Congress, not this court, is the appropriate forum for policy arguments.”); See *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49 (D. Mass. 1997) (“tragic events set forth . . . cry out for relief . . . Nevertheless, this Court had no choice but to [remove the case] out of state court . . . and then at the behest of the [defendants], to slam the courthouse doors in [their] face leaving [them] without a remedy. This case . . . becomes another illustration of the glaring need for Congress to amend ERISA to account for the changing realities of the modern health care system . . . ERISA has evolved into a shield of immunity that protects health insurers, utilization review providers . . . from potential liability for the consequences of their wrongful denial of health benefits.”); See *Bast v. Prudential Ins. Co.*, 150 F.3d 1003, (9th Cir. 1998) (“the Bast’s state claims are preempted by ERISA, and ERISA provides no remedy. Unfortunately, without action by Congress, there is nothing we can do to help the Basts and others who may find themselves in this same unfortunate situation.”)

serve its noble purpose of safeguarding the interests of employees. Our system, of course, allocates this task to Congress, not the courts.¹⁴⁹

While most lower federal courts adhere to the *Pilot Life* precedent and mirror the sentiments of the *Corcoran* court; federal courts have, in some rare instances, deviated from their strict application of the preemption clause.¹⁵⁰

Beginning with *Pilot Life*, federal courts have held that state laws that have a connection with or reference to health-benefit plans will be preempted.¹⁵¹ In *Shaw v. Delta Airlines*, however, the U.S. Supreme Court held that state laws that impact health-benefit plans in a “tenuous, remote, or peripheral” manner are not preempted.¹⁵² Since this decision, the task of determining when and what impact is “tenuous, remote, or peripheral” has proven difficult to apply to the many fact patterns that arise involving health plan participants. Within the federal courts, however, four categories are emerging in which the standard “tenuous, remote, or peripheral” has been applied and resulted in evasion of federal preemption.¹⁵³ To better able Congress and the reader to understand the issue of eliminating the ERISA preemption clause, this section examines how federal courts balance the affects of federal preemption with these same four categories: (a) self-insured employers; (b) administrators; (c) managed care companies; and, (d) utilization review agents.

a. Liability of Self-Insured Employers

The liability of a self-insured employer in state court is normally preempted by the preemption clause. The federal courts, nevertheless, have found self-insured employers liable under two theories—vicarious liability and direct negligence.¹⁵⁴ Vicarious liability assumes that the self-insured employer is able to control the behavior of the physician who cares for their employees.¹⁵⁵ Vicarious liability is difficult to prove and conditional upon the courts’ interpretation of several factors, among them: whether the self-insured employer serves as a gatekeeper (i.e., an individual who is to decide on whether a patient’s health care claim will be reimbursed by the self-insured employer); whether doctors are compensated through capitation (i.e., a system of pre-payment to physicians to care for an employee’s health); and, whether third-party payors actively evaluate the quality of care provided within their plans.¹⁵⁶ For example, United States Court of Appeals for the Fifth Circuit ruled, in *Cooney v. South Central Bell Telephone*, that an employee’s

¹⁴⁹*Corcoran v. United Healthcare*, 965 F.2d 1321, 1321 (5th Cir. 1992).

¹⁵⁰*See Roth, supra* note 96, at 8.

¹⁵¹*See Pilot Life Ins. Co. v. Dedeaux*, U.S. 41, 41 (1987).

¹⁵²*See Id.*

¹⁵³*See Roth, supra* note 96, at 8.

¹⁵⁴*See Charrow & Greenlees, supra* note 86, at 4.

¹⁵⁵*See Id.* at 5.

¹⁵⁶*See Id. See generally* Vicki L. MacDougall, *The “Shared Risk” of Potential Tort Liability of Health Maintenance Organizations and the Defense of ERISA Preemption*, 32 Val. U. L. Rev. 855 (1998).

state law claim of negligence and intentional tort was not preempted.¹⁵⁷ The court maintained that the self-insured employer's disregard for the employee's doctors advice and subsequent mandate that the employee return to work was not "related to," but rather "tenuously, remotely, or peripherally" related to, the health benefit plans covered by ERISA.¹⁵⁸

Federal courts also look to direct negligence if the plaintiff-employee can demonstrate that the self-insured employer "negligently supervised or negligently selected" a doctor to be included in its benefits network.¹⁵⁹ Federal courts maintain that the negligent selection of a physician to be included in the self-insured employer's health-benefit plan network is not "related to" the administration of a health-benefit plan, but rather tenuously, peripherally, or remotely connected.¹⁶⁰

b. The Liability of a Plan Administrator

As is the case with the liability of self-insured employers, the liability of a plan administrator in state court is almost always preempted by ERISA.¹⁶¹ Exceptions to the rule occurred in the United States Court of Appeals for the Eleventh Circuit.¹⁶² In *Lordmann Enterprises, Inc. v. Equicor Inc.*, the Eleventh Circuit stated that ERISA did not preempt a state claim for negligent misrepresentation of insurance coverage against a plan administrator.¹⁶³ The court argued that the state law action was not preempted for two reasons. First, preemption was not part of Congress' purpose for ERISA, rather it was designed to protect the interests of the employee covered by benefits.¹⁶⁴ Therefore, preemption of a patient's claim against a third-party provider would defeat rather than promote this goal.¹⁶⁵ Second, the court argued that health care providers were not foreseen as parties to the ERISA

¹⁵⁷Cooney v. South Cent. Bell Tel., 998 F.2d 1014 (5th Cir. 1993). See also Perry v. P.I.E. Nationwide, Inc., 872 F.2d 157 (6th Cir. 1989) (ERISA did not preempt an employee's claim for fraudulent inducement to participate in employee benefit plan).

¹⁵⁸See Cooney, 998 F.2d at 1014.

¹⁵⁹See Charrow & Greenlees, *supra* note 86, at 5.

¹⁶⁰See *Id.*

¹⁶¹See Roth, *supra* note 96, at 8. See Spain v. Aetna Life Ins. Co., 11 F.3d 129, 129 (9th Cir. 1993).

¹⁶²See Spain, 11 F.3d at 129.

¹⁶³See Lordmann Enters., Inc. v. Equicor, Inc., 32 F.3d 1529 (11th Cir. 1994); See also Hospice of Metro Denver, Inc. v. Group Health Ins. of Okla., Inc., 944 F.2d 752 (10th Cir. 1991). See also Kathleen Day, *Lawsuits: A Thorny Issue for HMOS; Patients May Find Limits on How They Can Sue, How Much They Can Collect*, WALL ST. J., Nov. 9, 1993, at Z15. The article discussed a similar cause of action which could escape preemption. *Id.* If a third-party payor contracts with a doctor who has a past history of malpractice and then harms a patient, the patient could argue that both doctor and the third-party payor were negligent. *Id.* Because the suit anchors on how the doctor was chosen, rather than how the plan was administered, the preemption clause does not apply. *Id.*

¹⁶⁴See Lordmann Enters., Inc., 32 F.3d at 1533.

¹⁶⁵See *Id.*

bargain.¹⁶⁶ The court reasoned that while ERISA provided federal causes of action for employers and employees, it did not “provide a cause of action for aggrieved health care providers that treat ERISA participants.”¹⁶⁷

c. Liability of Managed Care Entities

The overwhelming majority of cases that involve a patient’s state law claim against third-party payors—self-insured employers and managed care entities—are preempted by ERISA. The federal courts treat managed care entities the same as self-insured employers for purposes of preemption analysis.¹⁶⁸ Federal courts, nevertheless, have, at times, found managed care entities liable for state actions under vicarious liability.¹⁶⁹ But vicarious liability has turned out to be tenuous at best in providing avenues to evade the preemption clause’s grip over state law claims.

In *Independence HMO, Inc. v. Smith*, the United States District Court for the Eastern District of Pennsylvania ruled that a state tort claim of vicarious liability for money damages was not preempted by ERISA because it did not relate to ERISA and the plaintiff would otherwise be denied adequate relief.¹⁷⁰ The court viewed the U.S. Supreme Court decision in *Mackey v. Lanier Collections Agency & Service*—“run-of-the mill state law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan are relatively commonplace” and not preempted by ERISA—as support for its analysis.¹⁷¹ *Independence*, however, has been criticized.¹⁷² In *Ricci v. Goberman, M.D.*, the United States District Court for the District of New Jersey maintained that the court in *Independence* mistakenly interpreted the issue of vicarious liability as it pertains to managed care entities.¹⁷³ The New Jersey District Court argued that vicarious liability claims do relate to employee-benefit plans and furthermore, that it is inconsistent “to deny preemption in vicarious liability claims while allowing preemption in regular negligence claims.”¹⁷⁴ The federal courts deeming vicarious liability claims outside the scope of the ERISA preemption clause is really not a solution. Rather, the only consistent

¹⁶⁶*See Id.*

¹⁶⁷*See Id.*

¹⁶⁸*See* Roth, *supra* note 96, at 9. *See e.g.* Anderson v. Humana, Inc., 24 F.3d 889 (7th Cir. 1994) (employee’s claim for HMO fraudulently inducing participants to choose plan was preempted); *see also* Rollo v. Maxicare, 695 F.Supp. 245 (E.D. La. 1988) (patient’s state law claim for breach of contract, intentional infliction of emotional distress, consumer fraud, and tortious interference with physician-patient relationship was preempted because they were related to an employee benefit plan).

¹⁶⁹*See* Roth, *supra* note 96, at 9.

¹⁷⁰*Independence HMO, Inc., v. Smith*, 733 F. Supp. 983, 988 (E.D. Pa. 1990).

¹⁷¹*Mackey v. Lanier Collections Agency & Serv.*, 486 U.S. 825 (1988).

¹⁷²*Ricci v. Goberman*, 840 F. Supp. 316 (D. N.J. 1993).

¹⁷³*See Id.* at 317.

¹⁷⁴*See Id.* at 318.

federal court solution is to encourage Congress to re-visit the broad language of the clause itself.¹⁷⁵

d. Liability of Utilization Review Agents

Utilization review agents are similar to gatekeepers in that they are, often times, not medical professionals, but rather business persons who are responsible for deciding whether or not a medical procedure should be reimbursed by the third-party payor. Unlike the aforementioned categories, state law claims against a utilization review agent have been consistently found to be preempted by ERISA.

When analyzing the liability of prospective utilization review agents, the federal courts tend to follow the Fifth Circuit precedent in *Corcoran v. United HealthCare, Inc.*,¹⁷⁶ which stated that liability of a utilization review agent “arises when a treating physician believes that a more aggressive-and usually more-costly treatment is warranted, but the third-party payor does not.”¹⁷⁷ Because the U.S. Supreme Court has not provided a bright-line test with which to evaluate third-party payors’ and their utilization review agents’ liability under ERISA, the federal courts seem to base much of their decision-making on whether or not third-party payors are making medical decisions or “mere determinations regarding processing of benefits when denying coverage.”¹⁷⁸ That is, if the third-party payor is making a medical decision, the courts may hold that that behavior does not relate to an employee-benefit plan and is, therefore, not preempted from a state law action.¹⁷⁹ If the third-party payor is, however, making a determination regarding the processing of benefits, the courts will deem the utilization review agent’s action as being immune from state law actions.¹⁸⁰ Following the *Corcoran* decision, the Seventh, the Eighth, the Ninth, and the Tenth Circuits have found suits against the utilization review agent preempted, because rather than involving medical decisions, the suits were found to pertain to an issue of “negligent administration of benefit claims.”¹⁸¹

Despite the lower federal courts’ rare deviation, the preemption of state law claims has emerged largely unscathed as to the federal courts’ interpretation of the legislative intent supporting ERISA and the expressed language of the broad preemption clause. As a result, politicians, consumer advocates, and providers are vociferously calling for Congressional intervention. If one adds pleas for Congressional reform by the First, Fifth, Ninth, and Tenth Circuits, it seems there is

¹⁷⁵*See Id.*

¹⁷⁶*See* Roth, *supra* note 96, at 9. *See Corcoran v. United Healthcare*, 965 F.2d 1321, 1321 (5th Cir. 1992).

¹⁷⁷*See* Charrow & Greenlees, *supra* note 86, at 4.

¹⁷⁸*See Id.* at 10.

¹⁷⁹*See Id.*

¹⁸⁰*See Id.*

¹⁸¹*See also* Roth, *supra* note 96, at 9. *See* Bast v. Prudential Ins. Co., 150 F.3d 1003 (9th Cir. 1998); Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482(7th Cir. 1996); Kuhl v. Lincoln Nat’l Health Plan of Kansas City, Inc., 999 F.2d 298 (8th Cir. 1993); Spain v. Aetna Life Ins. Co., 11 F.3d 129 (9th Cir. 1993); Settles v. Golden Rule Ins. Co., 927 F.2d 505 (10th Cir. 1991).

a formidable movement afoot to urge Congress to, once again, meddle in the health care industry by eliminating the preemption clause. This movement could result in federal legislation that would create a reasonable balance between employee-patients rights and their third-party payors—self-insured employers and health-management entities—or exacerbate an already critical health care dilemma. The following section will explore the pros and cons of such an action.

C. Brief Exploration of the Politically-Charged Discussion Involving the Elimination of the ERISA Preemption Clause

Throughout the ongoing discussion as to whether Congress should meddle with health care through a patient's bill of rights, a consensus has formed among patient advocates, self-insured employers, politicians, and providers. They argue that the fate of the preemption clause is the key to the 106th Congress's deliberation on what would be the first health care reform bill of the new millennium.¹⁸² They point to the federal judicial system which has spoken loud and clear—holding that the fate of the preemption clause lies, not within the judicial branch, but, rather, within the legislative branch.¹⁸³ For patients, however, wishing to resolve the matter quickly, both within Congress and throughout the nation, there are two heavily-entrenched camps that diametrically oppose one another.

One side of this health care battle is chiefly controlled by self-insured employers, managed care entities, and defense trial attorneys, among others. The opposing side is spearheaded by physicians, consumer advocates, and plaintiff trial lawyers. The first coalition—self-insured employers, among others—is strongly opposed to eliminating the preemption clause. They argue that elimination of the clause will raise premium costs, limit coverage, reward the trial bar with unnecessarily large amounts of money, and lead to complex inconsistent systems of interpreting plan practices.¹⁸⁴ Therefore, if Congress is truly concerned with the delivery of quality health care at an affordable cost, the preemption clause should be left alone.¹⁸⁵ The second coalition—physicians and consumer advocates, among others—argues that the retention of the current broadly-construed preemption clause continues the trend of depriving patients, like Mrs. Garvey, the right to punish third-party payors for negligently disrupting the delivery of quality health care.¹⁸⁶ This coalition, in a resonating voice, argues that third-party payors, who commit negligent acts towards

¹⁸²See SOME MANAGED CARE REFORMERS CALL LIABILITY KEY TO BILL, NATIONAL JOURNAL'S CONGRESS DAILY, July 22, 1998. John Dingell, democrat from Michigan, stated, "without this right [right to sue third-party payors under state law] the bill will probably be vetoed . . . the lawsuit provisions are indispensable." *Id.*

¹⁸³See Interview with Coleman, *supra* note 20.

¹⁸⁴See HEALTH BENEFITS COALITION FOR AFFORDABLE CHOICE AND QUALITY, APPWP: EXPANSION OF ERISA LIABILITY WILL CAUSE EMPLOYERS TO DROP HEALTH BENEFIT PLANS, RAISE HEALTH COSTS AND LIMIT COVERAGE (visited Feb. 20, 1998) <<http://www.hbcweb.com/pospapers/member/posmem18.htm>>.

¹⁸⁵See Stephen Blakely, *The Backlash Against Managed Care; Impact On Small Business; Include Related Articles On Pending Legislation*, NATION'S BUS., July 1998, at 16.

¹⁸⁶See Sharon Lerner, *Damaged Care*, VILLAGE VOICE, Oct. 13, 1998, at 32.

their patients, must be held legally liable in state courts.¹⁸⁷ They conclude that in a time of cost-conscious health care provision, only through legal punitive actions in state court, will the patient be assured quality health care.¹⁸⁸

To best understand both perspectives, this section explores three possible repercussions of the elimination of the preemption clause: a large increase in health care premiums, a proliferation in the number of uninsured Americans, and an increase in the number of patient initiated state law claims against third-party payors.

1. Increase in Health Care Premiums

If the preemption clause is eliminated, an increase in health care premiums would result. The degree of increase, however, is another, more amorphous, issue. The third-party payor coalition argues that the elimination of the preemption clause will result in a drastic increase of health care premiums. On the flip side, consumer advocates maintain that the rise in premiums will be minimal and that this issue is nothing but a scare tactic used to persuade Congress not to eliminate the preemption clause.

Employers voluntarily provide health benefits as a means to recruit new employees and reward existing employees with quality health care.¹⁸⁹ The coalition of third-party payors maintains that if the preemption clause is eliminated, third-party payors will be exposed to unlimited financial liability for all coverage decisions, whether appropriate or inappropriate.¹⁹⁰ They argue that the increased liability costs can only be offset by increasing premiums.

A Congressional Budget Office (CBO) study of proposed legislation that would eliminate the preemption clause found that “health plans and [self-insured employers] would be sued along with the providers . . . more frequently . . . because of the plan’s [self-insured employer’s] deep pockets.”¹⁹¹ Self-insured employers

¹⁸⁷See generally *Id.*

¹⁸⁸See AMERICAN PSYCHOLOGICAL ASSOCIATION, *supra* notes 15 and 105. See also *ERISA Preemption: Remedies for Denied or Delayed Health Claims*, 1998: HEARING BEFORE THE SUBCOMMITTEE ON LABOR, HEALTH, AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES OF THE SENATE COMMITTEE ON APPROPRIATIONS, 105th Cong. (statement of Olena Berg, Assistant Secretary, Pension and Welfare Benefit Administrator).

¹⁸⁹See Telephone Interview with Eubanks, *supra* note 25.

¹⁹⁰See HEALTH BENEFITS COALITION FOR AFFORDABLE CHOICE AND QUALITY, *supra* note 184. If Congress eliminates the preemption clause, “employers would be faced with an endlessly complex problem of discerning appropriate practices that would be acceptable across different state jurisdictions.” *Id.* Furthermore, expanded liability will drive the cost of premiums up and possibly lead to employers dropping their voluntary provision of health benefits to their employees. *Id.* “Employers would be forced . . . to reduce benefits, increase premiums and co-payments or eliminate coverage altogether.” *Id.* See also Mary Jane Fisher, *Doctors Look to Protect ERISA Exemption; Physician Insurers Association of America Urges Congress Not to Repeal the Employee Retirement Security Act Preemption*, in NATIONAL UNDERWRITER PROPERTY AND CASUALTY-RISK AND BENEFITS MANAGEMENT 21, at 6, May 25, 1998. See also Letter from Clark Havighurst, William Neel Reynolds Professor of Law at the Duke University School of Law, to Charles D. Weller of Baker & Hostetler Law Firm (Oct. 21, 1997) (on file with author).

¹⁹¹See CONGRESSIONAL BUDGET OFFICE: COST ESTIMATE, *H.R. 3605/S. 1890 Patients’ Bill of Rights Act of 1998, Changes to The Employee Retirement Income Security Act* (visited July

argue this increased financial liability would require large sums of money to be spent on defending against the increased number of claims, thereby making it much less attractive, if not, unbearable, for self-insured employers to continue offering health benefits to their employees.¹⁹² They state that large sums of money spent on defending lawsuits from what they deem as baseless claims would be offset by increased premiums charged to plan participants. In addition to the increase in medical negligence suits, the CBO office estimates that the cost of liability insurance would also increase dramatically: "every judicial decision awarding damages to a plaintiff for a plan's coverage decision would increase the risk of suit for all other plans with similar coverage policies."¹⁹³ The CBO further estimates that the elimination of the preemption clause could increase liability costs by sixty- to seventy-five percent.¹⁹⁴ Third-party payors argue if their costs of providing health benefits increase, the cost of health care premiums will rise with it.¹⁹⁵ David Eubanks, the manager of benefits administration of a multinational corporation, maintains that "if the preemption clause is eliminated, a very complex system made up of inconsistent state interpretations of plan practices would result. This system would in effect create a chaotic and expensive regulatory system. One in which, multi-state employers could not afford to deal with."¹⁹⁶ Their ability to handle the estimated increased liability costs will be contingent on their ability to raise health care premiums.

The consumer coalition maintains that third-party payors' arguments are nothing but scare tactics, full of exaggerated fear mongering. This coalition proffers an assortment of counter-arguments, dispelling third-party payors' contentions on the bleak status of health care premiums if the preemption clause is eliminated. First, this coalition argues that there are considerable costs attributed to the fact that medical negligence is not effectively legally deterred. Jamie Court, director of Consumers for Quality Care, states, "Reforms that safeguard quality health care will save millions per year because it costs the health care system \$60 billion per year to

16, 1998) <<http://www.cbo.gov/showdoc.cfm?index=667&sequence=o&from=6.htm>>. In addition to the increase in medical negligence suits, the CBO office estimates that liability insurance would increase dramatically, "every judicial decision awarding damages to a plaintiff for a plan's coverage decision would increase the risk of suit for all other plans with similar coverage policies." *Id.*

¹⁹²See HEALTH BENEFITS COALITION FOR AFFORDABLE CHOICE AND QUALITY, *supra* note 184.

¹⁹³See CONGRESSIONAL BUDGET OFFICE: COST ESTIMATE, *supra* note 191. The Report mentions a recent case, *Fox v. Health Net*, *Jury Verdict Weekly*, Vol. 38, No. 18 (Dec. 28, 1993), as an example of the increase in coverage policies. *Id.* A jury awarded the plaintiff \$89 million dollars for denial of coverage suit. *Id.* Even though the eventual settlement was for much less, the coverage policies around the country sky-rocketed. *Id.*

¹⁹⁴*See Id.*

¹⁹⁵*See* Telephone interview with Eubanks, *supra* note 25.

¹⁹⁶*See Id.* What is ironic about this very real possibility is that this possible complex system is exactly what Congress was trying to avoid by including the preemption clause at 29 U.S.C. § 1144(a). *Id.*

care for injuries due to medical negligence according to the Harvard School of Public Health.”¹⁹⁷ Furthermore, according to Patricia M. Danzon, a noted economist:

The malpractice system is costly and imperfect, but these defects are often exaggerated. The cost of malpractice—the real social cost of injuries occurring because of medical negligence—is many times greater than the more visible costs of insurance premiums and wasteful defensive practices. Therefore in considering reform, the deterrence of malpractice must be considered at least as important as the cost of malpractice claims.¹⁹⁸

Moreover, assuming third-party payors’ liability costs will increase by “sixty-to-seventy-percent,”¹⁹⁹ the CBO conservatively estimates that this increase should only equate to a 1.4 percent increase in premium costs.²⁰⁰ Furthermore, a report on the impact of potential changes to ERISA, including elimination of the preemption clause, by the highly-regarded Kaiser Family Foundation, echoes the CBO’s sentiments and found that the increase in premiums would be minimal—0.03% to .011%.²⁰¹ While the Kaiser Family Foundation admits that these figures could be conservative, questions must arise about the validity of the third-party payor coalition’s claim that if the preemption clause is eliminated, we will experience an 8.6% increase in premiums.²⁰²

The Kaiser Family Foundation report does dispel some of the fear created by third-party payors; yet Congress must remember that the foundation’s figures are

¹⁹⁷See FOUNDATION FOR TAXPAYER AND CONSUMER RIGHTS, HMO INDUSTRY TAKES SCARE TACTICS ROAD: “JOB KILLER” RAP MEANT TO STOP HMO REFORM (visited Jan. 25, 1999) <http://www.consumerwatchdog.org/public_hts/medical/press/me100137.htm>.

¹⁹⁸See Patricia M. Danzon, *The Medical Malpractice System: Facts and Reform*, in THE EFFECTS OF LITIGATION ON HEALTH CARE COSTS 28 (Mary Ann Bailly & Warren I. Cikins, eds. 1985).

¹⁹⁹See CONGRESSIONAL BUDGET OFFICE: COST ESTIMATE, *supra* note 191.

²⁰⁰See *Id.*

²⁰¹See HENRY J. KAISER FAMILY FOUNDATION, IMPACT OF POTENTIAL CHANGES TO ERISA: LITIGATION AND APPEAL EXPERIENCE OF CALPERS, OTHER LARGE PUBLIC EMPLOYERS AND A LARGE CALIFORNIA HEALTH PLAN (visited Jan. 10, 1999) <http://www.kff.org/kff/library.html/?document_key=2090&data_type_key=367increasep.htm>. See also Laurie McGinley, *Lawsuits Have Little Effect on Premiums*, WALL ST. J., July 8, 1998, at B6. The figure published by the Coopers & Lybrand study was criticized as being much too conservative. “Richard Smith, vice president for policy at the American Association of Health Plans, said the study was deficient because it doesn’t include the cost of ‘defensive medicine’—the provision of services solely to avoid lawsuits. Such practices, would be the ‘largest cost driver’ resulting from the right-to-sue provision.” *Id.*

²⁰²See PATIENTS’ RIGHTS: HAS “HARMFUL SIDE EFFECTS,” HEALTH BENEFITS COALITION SAYS, AMERICAN HEALTH LINE, Jan. 6, 1999. A full page ad placed in the Washington Times urges Congress to consider carefully the elimination of the preemption clause. *Id.* The Health Benefits Coalition argues the increased number of claims would increase premiums by 8.6%. *Id.* See also McGinley, *supra* note 200, at B6. The HBC was using estimates that came from a study completed by the Barents Group, “which estimated that the right-to-sue provision could raise premium costs by 2.7% to 8.6%.” *Id.*

admittedly highly conditional. The foundation acknowledges the high level of uncertainty in determining how exactly the health care market will react to the introduction of patient initiated state law claims against third-party payors.²⁰³

In sum, third-party payors maintain that the elimination of the preemption clause will cause large increases in premiums and that these increases in premiums could heavily burden the nation's health care system. On the other hand, consumer activists counter by arguing that the fear of increased premiums is unfounded. They echo Patricia Danzon's comments in that the cost of deterrence of malpractice is as important as the deterrence of the cost of malpractice claims.²⁰⁴ While the increase in premiums argument remains unclear, it should be an important consideration that Congress takes into account when deciding the fate of the preemption clause. Congress must decide whether it deems a patient's right to obtain legal redress in state court worthy enough to call the possible bluff of the third-party payors—and, if the third-party payors' predictions are borne out, whether the federal government is willing to intervene and ensure that premiums do not rise too high so as to price the average patient out of the health care market altogether.

2. Proliferation of the Number of Uninsured Americans

If Congress eliminates the preemption clause, there will undoubtedly be an increase in the costs of providing health benefits.²⁰⁵ In dealing with this increase, self-insured employers maintain that they have three options—raise premiums,²⁰⁶ provide a lump sum of money every year to the employee rather than administer health benefits through the company,²⁰⁷ or eliminate health benefits altogether.²⁰⁸

Self-insured employers argue that if premiums increase, unquestionably, some Americans will forgo the high costs of health care in favor of more immediate needs,

²⁰³See KAISER FAMILY FOUNDATION PRESS RELEASE, LEADING HEALTH CARE CONSUMER PROTECTION PROPOSALS WOULD RESULT IN MODEST PREMIUM INCREASES FOR HMOs (Apr. 22, 1998) (visited Jan. 10, 1999) <http://www.kff.org:80/kff/library.html?document_key=2083&data_type_key=354.htm>.

²⁰⁴See Danzon, *supra* note 198, at 28.

²⁰⁵See *Id.*

²⁰⁶See Interview with Coleman, *supra* note 20. See also *supra* notes 175-85.

²⁰⁷See Interview with Coleman, *supra* note 20. The employer knows how much it spends on average for their employee for health care. *Id.* For discussion sake, let's estimate that the employer spends on average \$5000 per employee. *Id.* Self-insured employers are arguing that if the preemption clause is eliminated, they will simply give the employee that \$5000 and wipe their hands clean of the health care benefits business altogether. *Id.* Ruth Coleman states, "employees do not know much about buying insurance for themselves. It is a very complicated process. So how are they going to know how to make an educated decision? How many know what the difference between a best rating of A versus a best rating of B-? How many understand the nature of health care so that they can pace two plans side-by-side and compare the various plan options? Who is going to make those decisions? Furthermore, without the employers purchasing power, the employee will be forced to pay much higher prices and probably have to settle for lower quality. Because, with purchasing power comes an ability to demand quality. The employee is going to get the shaft [if the preemption clause is eliminated]." *Id.*

²⁰⁸See KAISER FAMILY FOUNDATION PRESS RELEASE, *supra* note 203.

such as housing and food. If self-insured employers decide that the cost of providing health care is too much to bear, yet still desire to remain in the health care benefits business, they might simply provide a lump sum each year to individual employees and encourage the employee to use this money for health insurance. This could create more uninsured Americans. Third-party payors claim that they fear that many employees will decline to use the money for health insurance.²⁰⁹ They fear that rather than care for their own health, they will spend the lump sum on the repayment of loans or a family vacation.²¹⁰ Third-party payors also claim to fear that if the employee takes the money and uses it to purchase her family's health insurance, without federal government intervention, she will be at a serious disadvantage in negotiating the prices and details of a health plan. Not only will she lack the expertise needed to maneuver through the complicated maze of health care plans she also will lack the purchasing power of a large plan in negotiating a reasonable price with providers. If self-insured employers exit the health care business altogether, this would unequivocally result in an increase in uninsured Americans.

Third-party payors claim that any angle the self-insured employer takes will result in an increase in the number of uninsured Americans.²¹¹ In a recent survey conducted by the U.S. Chamber of Commerce, 67% of the country's employers said they would be forced to drop health care coverage if Congress renders moot the preemption clause.²¹² Furthermore, 81% of employers reported that they would drop health benefits if the costs increased at all.²¹³ It goes without saying these figures are frightening. What is even more disturbing is the fact that this country already has over forty-one million non-elderly, uninsured citizens,²¹⁴ and over the past decade, this number has increased by a staggering ten million.²¹⁵ Even more, at this time, eight out of ten of the uninsured citizens are full-time workers.²¹⁶

²⁰⁹See Telephone interview with Eubanks, *supra* note 25.

²¹⁰*See Id.*

²¹¹*See* HEALTH CARE BENEFITS COALITION FOR AFFORDABLE CHOICE AND QUALITY, THE CASE AGAINST FEDERAL MANDATES (visited Jan. 10, 1999) <<http://www.hbcweb.com/pospapers/coalition/talkpl.htm>>. "Every time a mandate raises the cost of insurance by one percent, some 200,000 Americans lose their coverage. A Lewin Group study puts the estimate even higher with each one percent increase resulting in 400,000 persons without insurance." *Id.*

²¹²*See* HEALTH BENEFITS COALITION FOR AFFORDABLE CHOICE AND QUALITY, TWO-THIRDS OF EMPLOYERS WOULD DROP HEALTH CARE COVERAGE IF FACED WITH MEDICAL MALPRACTICE LAWSUITS (July 1998) (visited Jan. 10, 1999) <<http://www.hbcweb.com/pospapers/coalition/blastfax.htm>>.

²¹³*See Id.* The survey also revealed that eighty-seven percent of employers would be forced to require their workers to pay part of the additional health insurance increases. *Id.* Even more, sixty-six percent of employers said higher premiums would cause employees to drop their insurance. *Id.*

²¹⁴*See* HENRY J. KAISER FAMILY FOUNDATION, UNINSURED AND THEIR ACCESS TO HEALTH CARE (July 1998) (visited Jan. 10, 1999) <<http://www.kff.org/archive/health-policy/kcfm/access/access.txt.htm>>.

²¹⁵*See Id.*

²¹⁶*See Id.*

When deliberating on the fate of the preemption provision, the possibility of increasing the number of uninsured Americans is, or, if not, should be, a serious concern for Congress. According to the Kaiser Family Foundation report, health care directly relates to health outcomes and the financial well-being of families.²¹⁷ Even more, “[b]ecause [an uninsured citizen’s] primary health care needs are not addressed, the uninsured are more likely than those with insurance to be hospitalized for conditions that could have been avoided.”²¹⁸

Congress does, however, have choices when dealing with the current number of uninsured Americans and the disturbing predictions made by the self-insured employers. Consumer advocates argue universal care, a form of socialized medicine made famous by President Clinton’s 1992 health care initiative, would ensure that all Americans would receive basic health care. Uwe Reinhardt, James Madison professor of political economy at Princeton University, points out, Congress must look at universal care as a “real choice . . . between a government-run program that treats health care as an entitlement and a more conservative approach that treats health care as a private consumption good in which the rich are better off than the poor.”²¹⁹ Consumer advocates argue that if the nation is truly fearful of a drastic increase in the number of uninsured Americans, their concern should not punish patients by depriving them of their ability to hold third-party payors accountable; rather, their fear should fuel the debate supporting the need for universal care in this country.

3. Inflation in the Number of Patient Initiated State Law Claims Against Third-Party Payors

The third possible repercussion from the elimination of the preemption clause, indirectly related to the prospect of premium increases, is that the state courts will be inundated with frivolous and costly lawsuits by patients in search of dipping into the deep pockets of third-party payors.²²⁰ Third-party payors contend that this would not only tax the state courts’ infrastructure, it would also lead to a large increase in premiums.²²¹ Consumer advocates, however, argue that the introduction of state law claims against third-party payors covered by ERISA will not result in a large volume of cases, nor will it result in the predicted onslaught of state law claims against third-party payors.²²² They point to Texas, where no suits have been brought in the year since Texas became the first state to let people who have exhausted the available internal and external appeals sue third-party payors.²²³ As a result, Texas has

²¹⁷See KAISER FAMILY FOUNDATION, *supra* note 203.

²¹⁸See *Id.* “The uninsured are less likely to have a procedure that is relatively costly or where physicians exercise a great deal of discretion.” *Id.*

²¹⁹See Marybeth Burke, *Comprehensive vs. Incremental Reform: The Debate Intensifies; Health Care Reform*, 66 HOSPS., Mar. 20, 1992, at 38.

²²⁰See Telephone interview with Eubanks, *supra* note 25.

²²¹See *Id.*

²²²See Mary Lord, *Patience for a Bill of Rights: States Begin to Move on HMO Reforms While Congress Argues; Patient Protection Laws Being Passed By States; America’s Top HMO*, U.S. NEWS & WORLD REP., Oct. 5, 1998, at 74.

²²³See *Id.*

reported a rise in premiums at a paltry 0.1% per month.²²⁴ Third-party payors argue, however, that the number of suits brought in Texas will rise as soon as patients realize that they are able to sue third-party payors not covered by ERISA.²²⁵ With many of the arguments, predictions on the increase of state law claims and subsequent increase in premiums in Texas will only be borne out as time passes. Congress, however, cannot discount what is occurring in our nation's states as a symbol for what could lie ahead if the preemption clause is significantly altered or eliminated.

In sum, as the health care industry evolves, so must legislation and the legal system that regulates it. The elimination of the preemption clause will permit state courts to delve into the negligent conduct by third-party payors, thereby ensuring legal remedies for those wronged. Before acting prematurely, Congress should evaluate the cause and effect of such an action on the four central entities—patient, provider, self-insured employer, and managed care entities. To clarify the possible repercussions of rendering moot the preemption clause, the next section explores how the elimination of the preemption clause impacts these four key players.²²⁶

D. How The Elimination Of The Preemption Clause Would Affect Four Entities—The Patient, The Provider, the Self-Insured Employer, and Managed Care Entities.

Because they are impacted the most the four most important entities in the fate of the preemption provision are the patient, the provider, the self-insured employer, and the managed care entities.²²⁷ This section considers the impact of Congress passing a measure permitting patients to sue third-party payors for damages under state law, thereby disrupting the bargain made between Congress and employers in 1974.²²⁸

1. The Patient

The elimination of the preemption clause will, in the short term, enable the patient to enjoy a boon of newfound ability to access and receive quality health care, or sue if she doesn't. If the patient believed she was wronged, she would possess the ability to obtain monetary remedies for claims, such as negligent administration of a plan or wrongful death in state court.²²⁹ As a result, the patient would effectively gain another "check" in the checks and balances system of health care. Presumptively, this "check" should equate to a better opportunity for obtaining quality health care. For example, an individual in legitimate, medically-necessary need of treatment should receive the care without an overriding concern that the utilization review agent will deny the claim, unless it desires to subject itself to the risk of state law claims. While the short-term prospects look positive for patients, the long-term impact of such a measure is more suspect.

²²⁴*See Id.*

²²⁵*See* Telephone interview with Eubanks, *supra* note 25.

²²⁶*See* Interview with Coleman, *supra* note 20.

²²⁷*See Id.*

²²⁸*See Id.*

²²⁹*See supra* notes 136-38.

Larry Atkins, president of Health Policy Analysts, a Washington consulting group, states, "it's impossible to assess the real cost of liability, but its passage would end managed care's success in curbing health costs."²³⁰ As aforementioned, there is a real possibility that the introduction of state law liability will cause an increase in premiums, thereby making it more expensive to obtain quality health care.²³¹ More likely than not, the elimination of the preemption clause will create the same type of repercussions as was created by past government regulation of the health care industry.²³² Health care costs would skyrocket and, without more government intervention, employers would exit the business of health care benefits altogether and take with them their purchasing power and their expertise in the business of health care.²³³ Arguably, the free-market-based health care system would be thrown into chaos and the patient could ultimately "get the shaft."²³⁴ While this is one of many scenarios that could occur through blanket elimination of the preemption clause, by no means could it be the only outcome. Either way Congress decides to act, as this article demonstrates, the stakes are high for the patient.

2. The Provider

Senator Sibley from Waco, Texas, states, "why is it that doctors and nurses are accountable for their health care treatment decisions and managed care companies are not?"²³⁵ With this question, Senator Sibley touches the heart of what providers (doctors) gain from the elimination of the preemption clause. Doctors argue that the advent of utilization reviews and managed care has severely hampered their ability to provide ideal care.²³⁶ They advance legitimate concerns, such as a loss of control over medical decisions, increased restrictions on personal time, and the creation of financial incentives that strain their professional principles.²³⁷ If the preemption clause is eliminated, doctors believe that third-party payors would grow reluctant to interfere with the relationship between the physician and the patient, and they would regain some independence.²³⁸ Moreover, third-party payors would have to share the risk in providing medical care.²³⁹

Third-party payors argue, however, that an increase in provider earning power is not in the best interest of the patient, nor of the nation. They argue that if the clause is eliminated, doctors would gain in two ways. First, the provider would regain her

²³⁰See McGinley, *supra* note 201, at B6.

²³¹*See Id.*

²³²*See supra* pp. 7-15.

²³³*See also* Interview with Coleman, *supra* note 20.

²³⁴*See* Telephone interview with Eubanks, *supra* note 25.

²³⁵*See* Laurie McGinley, *Broad Battle to End HMOs' Liability for Treatment-Coverage Denials*, WALL ST. J., Jan. 12, 1998, at A22.

²³⁶*See Id.*

²³⁷*See Id.*

²³⁸*See* Interview with Coleman, *supra* note 20.

²³⁹*See* Jerome P. Kassirer, M.D., *Doctor Discontent*, 339 NEW ENG. J. MED. 1543, 1543 (Nov. 1998).

control over medical decisions.²⁴⁰ Second, by regaining control over their own practices providers would naturally be better able to earn more money which could mean that health care costs would again heavily burden our nation's pocket-books.²⁴¹

It should be noted that there are providers who argue that the elimination of the preemption clause would do nothing to address root problems inherent in our health care system, such as expensive medication and inadequate standards of physician care.²⁴² They maintain, therefore, at the cost of their own personal gains, the preemption clause should remain intact.²⁴³ This loose-fitting group of doctors state, "Allowing patients to sue health plans [and self-insured employers] . . . will . . . increase health care costs, further erode physician professional autonomy, encourage more lawsuits and make it harder to defend individual doctors in those lawsuits."²⁴⁴

In sum, the impact of the elimination of the preemption clause on the provider is unclear. On one hand, the provider could gain freedom and earning power. On the other hand, elimination could lead to "further erosion of [a doctor's] autonomy" and increased difficulty in defending oneself from state law litigation which, in the long run, would further subject doctors' expertise to that of someone who has no medical background.²⁴⁵

3. Self-Insured Employers

If self-insured employers are subjected to state law actions, they argue that they would lose much of their ability to offer health care benefits to their employees. Furthermore, they posit that if the clause is eliminated, their 1974 compromise with Congress would be destroyed and, as a result, the federal government would likely have to, again, legislate large sums of money to care for the increasing numbers of uninsured Americans.

The elimination of the preemption clause could lead to a mass exodus of self-insured employers from the health-benefits business and subsequent increases in patient's premiums. However, as this article has demonstrated, there are two sides to every argument. Self-insured employers readily admit that the provision of health benefits is basically a business decision, that benefits are both a means to ensure a productive work force and a means to recruit quality employees. While repealing the preemption clause could lead to an increase in health care costs and premiums, it would do nothing to stifle these free market desires. Despite the fact that self-insured employers could now be held liable under state law, the desire to recruit quality employees and the need to ensure a healthy and positive workforce would remain.

²⁴⁰*See Id.*

²⁴¹*See Id.*

²⁴²*See Fisher, supra* note 190, at 6.

²⁴³*See Id.*

²⁴⁴*See Id.*

²⁴⁵*See Id.*

4. Managed Care Entities

Third-party payor lobbyists argue that managed care entities create payment systems and serve as a delivery mechanism in today's health care landscape.²⁴⁶ They maintain that one would be hard-pressed to argue the benefits that have been brought to the table because of the introduction of the managed care entity into our health care system.²⁴⁷ For example, managed care entities have assisted our nation in stalling the ever-increasing costs of health care premiums. After rising nearly 15% annually from 1988 to 1992, because managed care entities have become a mainstay in the market, health care premiums increased only by 0.5% from 1995 to 1996.²⁴⁸ Managed care entities argue that if the preemption clause is eliminated, the positive effects gained over the past five years can be forgotten.

Consumer advocates, however, reason if the preemption clause is eliminated, managed care entities, being a product of the free-market system, will evolve with the changing landscape simply because there remains a large amount of money to be earned when creating payment systems and administering health benefits. Furthermore, self-insured employers and other employers will attempt, although begrudgingly, to blunt the possibility of increased premiums in order to keep their own health care costs down. Managed care entities, having responded to a market in search of health care premium stability, will once again respond to a market that also includes a possibility of liability in state courts.

In sum, the entire preemption provision question is clouded in uncertainty. The courts, the politicians, the patients, the providers, the self-insured employers, and managed care entities, are leery as to what exactly will happen, if and when Congress eliminates the preemption clause. No one is certain how the health care market will react. Even if the preemption provision was eliminated, it remains unclear what patient-employees' reactions would be to their newly-acquired right to sue their employers under state law for negligent provision of their health care.²⁴⁹ The only certainty is that the fate of the preemption clause lies within Congress and the legislative branch, not the judicial branch. Furthermore, it is a forgone conclusion that self-insured employers and managed care entities will be adversely impacted, and the patients and the providers would both win and lose.²⁵⁰

IV. CONCLUSION

For our nation to move into the future, it must know and appreciate where it has been. To know where it has been will enable the nation to navigate and succeed in the future. This article views history as a tool for current national trials and tribulations, namely, the fate of the ERISA preemption clause. It argues that when

²⁴⁶See Julie Welch, *Managed Care: The Dominant Paradigm in US Healthcare*, POL'Y COMM., (visited Mar. 14, 1999) <<http://www.policy.com/issuewk/98/0608/060898a.html>>.

²⁴⁷See *Id.*

²⁴⁸See *Id.*

²⁴⁹See HENRY J. KAISER FAMILY FOUNDATION, *supra* note 214. The study revealed despite mechanisms that permitted patients to sue third-party payors not covered by ERISA, litigation rates were very low—0.3 to 1.4 cases per 100,000 enrollees per year. *Id.*

²⁵⁰See *supra* pp. 31-34.

deliberating on the fate of the preemption clause, Congress's analysis must not be clouded by fear-mongering expressed by third-party payors and consumer advocates but rather, deliberation must be grounded in past regulatory lessons learned.

Congress's deliberation over the fate of the preemption clause is extremely important, impacting many different entities. While recently growing annoyed with ERISA's effect on patients, the federal courts, despite rare deviations, have remained anchored to their interpretation of the preemption clause. But still, third-party payors' decisions have life and death implications. Therefore, Congress must take into account the serious implications of eliminating the preemption clause and delicately evaluate the pros and cons of such an action. It must also analyze whether cases like Mrs. Garvey's symbolize a substantive breakdown of the relationship between third-party payors, providers, and patients, or whether they represent anecdotal events marketed to the public so that entities, such as doctors and consumers, could prosper at the expense of the others interests.

This article concludes by noting an age-old proverb of the Iroquois people. Their proverb maintains that for every deliberation, one must consider the next seven generations. In order to retain a quality health care system that provides care at an affordable price, Congress must consider the impact of eliminating the clause on "the next seven generations" rather than react to the third-party payors' lobbyists or the consumer advocates' emotions of the moment.

In 1994, many political pundits believed with the election of the Republicans to a majority of seats in Congress, the public effectively rejected the idea of universal health care and sent a message to Congress that health care should be regulated through the "market place."²⁵¹ Whereas in 1999, sparked by the 1994 Republican effort to fund tax cuts with huge chunks of money taken from Medicare,²⁵² the American public seems to have changed its mind on how exactly health care should be addressed.²⁵³ It appears that much of the public believes that the free-market system is not providing the checks and balances needed to ensure quality care at affordable costs; therefore, federal regulation may be necessary to ensure quality service at an affordable cost.²⁵⁴

In an effort to address the preemption clause's adverse impact on patient's rights, Congress could re-visit the idea of universal health care. This time, however, Congress could expand its vision of what universal health care could be. Congress could eliminate the preemption clause so as to permit patients to obtain legal

²⁵¹*Id.* See also Karen Tumulty, *Let's Play Doctor: Politicians of Both Parties Say Managed Care Is an Incredibly Hot Issue. The Question Now: Will They Just Fight Over It or Actually Try to Do Something?*, TIME, July 13, 1998, at 28. The GOP was embarrassed and accused of wanting to pay tax cuts with large chunks of money taken from Medicare. *Id.*

²⁵²See Julie Martin & Mark Blaine, *Patients Forcing New Laws on HMOs*, ASHEVILLE CITIZEN-TIMES, Apr. 8, 1998, at A1. Angry patients are inspiring their lawmakers to propose tough managed care regulatory laws, which would include a provision that would allow employees to sue their health plans for punitive and compensatory damages under state medical malpractice laws. *Id.* Adam Searing, the director of the North Carolina Health Access Coalition states, "if they (self-insured employers and HMOs) make negligent decisions, someone should be made accountable." *Id.*

²⁵³See RANDOM HOUSE UNABR. DICTIONARY, *supra* note 24, 1026.

²⁵⁴See *Id.*

remedies in state court. Congress must simultaneously, however, provide financial subsidies to third-party payors to persuade them to work diligently in controlling the possible meteoric rise in costs of premiums and liability insurance. If a third-party payor is abusing its discretion and committing an inordinate amount of negligent acts, the subsidy amount can be reduced accordingly. This dual approach will not only provide quality health care to patients, but it will also provide a safety-net for those citizens unable to access affordable health care. Admittedly, this proposal's downside is that the American people are not likely prepared to pay additional taxes necessary to support such a subsidizing system. Yet, when faced with the alternative, "the people" may have no choice.

Perhaps the most logical and reasonable solution requires Congress to complete two tasks. First, it must leave the preemption clause alone because its existence stems any chance of inconsistent standards and judgments. Furthermore, because the state courts never obtain jurisdiction, it stops any fear of an increase in state law claims that would be burdensome on state infrastructures. Second, Congress must amend the civil enforcement mechanism located within ERISA. As noted in the introduction, the civil enforcement mechanism currently provides the patient with compensation for refused medical procedures. There is, however, no reason why Congress could not draft a clause providing punitive damages with a stipulation that damages cannot exceed five million dollars. The cap will provide adequate remedy for the patient, serve as a punishment for negligent acts by third-party payors, and because federal courts retain jurisdiction, negate any possibility of inconsistent and biased state judgments. Capped punitive damages and retention of the consistent and dependable federal courts should contain any possibility of an extreme increase in the cost of health care premiums.

This proposal's downside is the monetary cap amount. For example, if this system was in place for Mrs. Garvey, how much should the cap allow for compensating her family for the loss of life? Her husband, like most, would argue that five million dollars is not enough to compensate her family for the loss of a mother, a wife, a care-giver. In sum, with regard to the monetary cap and third-party payors, the cap must be high enough to serve as a deterrent of future negligent actions, but low enough to permit third-party payors to withstand the health care business absent restrictive civil remedies.

While proposals can be drafted and the future of health care can be debated, whether Congress eliminates the preemption clause will not solve our health care crisis. Uwe Reinhardt states,

until the American public makes up its mind as to what it thinks health care is, the health- care system will remain irrational—[the public] want[s] an egalitarian health care system run by libertarian means” . . . “[T]he key question . . . is whether health care is a community service/public good or a private-consumer commodity.²⁵⁵

In the past, health care reform has been driven by excess—excess beds, excess doctors, excess capacity—created by a series of well-intentioned, but poorly thought

²⁵⁵See Interview with Coleman, *supra* note 20.

out, government mandates.²⁵⁶ Americans must understand that within our current health care system, medical ethics clash with business profits.²⁵⁷ While the American people cry out for more care and “better care . . . for less money,”²⁵⁸ they forget, and perhaps do not understand that more care and “better care . . . for less money” are “inextricably linked.”²⁵⁹ If we eliminate the preemption clause, as David Broder, the Washington Post journalist, suggests,

requiring insurers, providers (and employers) to do more inevitably means they will charge more. Under our bifurcated system, some of the people who pay the bills (employers) will decide that the happiness of those who receive the services (patients) has become too expensive a luxury and will stop insuring them.”²⁶⁰

Ruth Coleman states, “the words—managed health-care—is a misnomer . . . [rather] since World War II, what we have in this country is managed-health[care] finance, not managed-health care.”²⁶¹ Until the nation decides which way it desires its health care system to evolve—universal or not universal—Congress’s simple deletion of the preemption clause from ERISA will be another example of “managed

²⁵⁶See MILLENSON, *supra* note 20, at 236 “managed care, by its nature, places the good of the patient into conflict with . . . (1) the good of all the other patients served by the plan; (2) the good of the plan and the organization, themselves . . . ; and (3) the self-interest of the physician.” *Id.* Managed care organizations focus on disease prevention, health promotion, totality of an individual patient’s needs, and works very diligently to keep its customers premiums as low as possible. *Id.* Nevertheless, the desire to keep costs down and the provision of financial incentives to limit services often times clash with “managed care’s ability to achieve such benefits.” *Id.*

²⁵⁷See Hunt, *supra* note 88, at A9.

²⁵⁸See Broder, *supra* note 89, at A21.

²⁵⁹See *Id.* See also Interview with Coleman, *supra* note 20. If Congress passes legislation that includes a provision eliminating the 1974 ERISA preemption clause, the ramifications are immense. *Id.* If the employers pull out of the health care business, there is a very real possibility that when the smoke clears, patients will be on their own with only a few bucks in there pocket. *Id.* For some—the younger patient—this will not be that big of a deal. *Id.* Statistically, young adults do not need expensive medical treatment. *Id.* For others—the older patient—the cost of medical service will often be too much to handle. *Id.* The traditional notion of insurance—spreading the cost of the patients across the board will forever be changed. *Id.*

²⁶⁰See *Id.*

²⁶¹*Id.*

health care finance” passed in the name of managed health care and sure enough, the patient will once again lose out.

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