

# THE INADEQUACY OF STATE LEGISLATIVE RESPONSES TO ERISA PREEMPTION OF MANAGED CARE LIABILITY

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*Since 1997, several states have enacted legislation to increase patients' ability to sue their Managed Care Organizations (MCOs) for negligent acts. These statutes address the obstacle imposed by the Employee Retirement Income Security Act (ERISA) preemption clause, which severely limits the exposure of MCOs to tort liability. In this Note, Wendy Silver acknowledges the usefulness of these statutes, but posits that they inadequately address the ERISA preemption problem. Under these statutes, patients may bring suit only if their MCOs negligently denied, delayed, or modified their physicians' recommended course of treatment. Patients whose MCOs unduly and negligently influenced their physicians' recommendations, however, cannot seek recourse against their MCOs. Silver argues that this loophole permits MCOs to skirt the liability these statutes provide by altering the way in which MCOs influence doctors. Silver concludes by proposing a statutory scheme that would increase MCOs' exposure to liability, providing MCOs with sufficient financial incentives to maintain the proper quality of patient care.*

Recently, several states have enacted legislation designed to increase the accountability of Managed Care Organizations (MCOs)<sup>1</sup> to

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<sup>1</sup> This Note will use "MCO" as a catchall term to encompass all managed care programs. "Managed care" refers to a wide variety of arrangements between plan administrators, health care practitioners, and subscribers. Marc Rodwin provides a useful common description:

Managed care refers to health insurance combined with the controls over the delivery of health services. Managed care organizations (MCOs) exercise control over the kind, volume, and manner in which services are provided by choosing providers, or by controlling their behavior through financial incentives, rules, and organizational controls.

Under traditional indemnity insurance and fee-for-service medical practices, the insurers enter into a contract with the insured party and reimburse the individual for certain medical expenses that are incurred. The individual receives medical services from any provider he or she chooses and usually pays a fee for each service rendered, with the insurer having no control over the choice of provider or provision of services. Managed care changes this relationship either (1) by directly providing the contracted-for services; or (2) by exercising control over the services provided.

Marc A. Rodwin, *Managed Care and Consumer Protection: What Are the Issues?*, 26 *Seton Hall L. Rev.* 1007, 1009 n.1 (1996). For a description of the different types of MCOs,

patients injured by MCO negligence.<sup>2</sup> These statutes attempt to remedy the problem wrought by the preemption provision of the Employee Retirement Income Security Act (ERISA), which has largely insulated MCOs from liability for negligent management decisions that result in patient injury or death.<sup>3</sup>

ERISA is the exclusive remedy for individuals who receive MCO coverage through an employee benefit plan and seek to sue their MCOs for improper denial of benefits.<sup>4</sup> Plaintiffs suing under ERISA's civil-enforcement provision can only recover damages equal to the value of the improperly denied benefits.<sup>5</sup> In effect, ERISA bars many victims of MCO negligence from receiving compensation for any physical injury, pain and suffering, or even death directly caused by the negligent acts of MCOs.<sup>6</sup> However, plaintiffs and state legislatures recently have been finding ways to chip away at ERISA's preemptive shield.<sup>7</sup>

At least ten states have passed managed care liability laws: Arizona,<sup>8</sup> California,<sup>9</sup> Georgia,<sup>10</sup> Louisiana,<sup>11</sup> Maine,<sup>12</sup> New Jersey,<sup>13</sup>

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see William N. Tindall et al., *Guide to Managed Care Medicine* 8-12 (2000) (describing twelve models of managed care); Phoebe L. Barton, *The Health Services Delivery System: Managed Care*, in *Managed Care Essentials: A Book of Readings* 25, 31-41 (2000) (discussing eleven models of managed care).

<sup>2</sup> See Sharon J. Arkin, *Tort Actions Against Health Maintenance Organizations and Their Doctors*, 23 *Whittier L. Rev.* 609, 622-41 (2002).

<sup>3</sup> See *infra* Part I.B. This Note is not an Employee Retirement Income Security Act (ERISA) paper. This Note addresses ERISA only to the extent necessary to explain the ERISA preemption problem and why states have adopted MCO liability laws; any further discussion of ERISA is beyond the scope of this Note. For an overview of the evolution and scope of ERISA preemption, see generally Rand E. Rosenblatt et al., *Law and the American Health Care System*, 92-169 (Supp. 2001-2002); Phyllis C. Borzi, *Distinguishing Between Coverage and Treatment Decisions Under ERISA Health Plans: What's Left of ERISA Preemption*, 49 *Buff. L. Rev.* 1219 (2001).

<sup>4</sup> See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987) (holding state lawsuit claiming improper denial of benefits preempted by ERISA); see also 29 U.S.C. § 1144(a), (b)(2)(A) (2000).

<sup>5</sup> See § 1132(a)(1)(B). Reasonable attorney's fees may also be awarded at the court's discretion. § 1132(g)(1).

<sup>6</sup> See § 1132(a)(1)(B). See also Alice A. Noble & Troyen A. Brennan, *Managing Care in the New Era of "Systems-Think": The Implications for Managed Care Organizational Liability and Patient Safety*, 29 *J.L. Med. & Ethics* 292-93 (2001) (noting that ERISA provides "no meaningful remedy for those seeking significant compensatory damages, such as economic loss, pain and suffering, and punitive damages").

<sup>7</sup> See *infra* Parts I.C-D; see also Linda A. Johnson, *Parents Sue HMO in Baby's Death*, *Wash. Post*, Dec. 4, 2000, at A2 (discussing lawsuit brought by New Jersey couple against MCO over policy of discharging newborns from hospitals twenty-four hours after birth). Congress also attempted to solve the preemption problem in 1999 when it drafted the Patients' Bill of Rights. H.R. 2990, 106th Cong. (1999). While the bill passed in the House of Representatives, it failed in the Senate by one vote. See Johnson, *supra*.

<sup>8</sup> *Ariz. Rev. Stat. Ann.* § 20-3153 (West 2002).

Oklahoma,<sup>14</sup> Texas,<sup>15</sup> Washington,<sup>16</sup> and West Virginia.<sup>17</sup> Other states have passed legislation protecting patients from MCO abuses, and still others are contemplating new liability legislation.<sup>18</sup>

This Note examines the effectiveness of such state legislation, focusing on California's MCO-liability law in particular.<sup>19</sup> It concludes that although this legislation is an immense step in the right direction, state managed-care liability laws nevertheless fail to provide a comprehensive solution to the ERISA preemption problem.

California's statute holds an MCO liable when its actions "resulted in the denial, delay, or modification" of the service the treating doctor recommended.<sup>20</sup> Language like this ignores, however, more subtle means by which MCOs can affect adversely the level of care available to patients. MCOs influence physicians both directly and indirectly.<sup>21</sup> They not only interfere with the implementation of doctors' recommendations, but MCOs actually may influence the recommendations themselves. This Note refers to the former as *ex post* influence, and the latter as *ex ante* influence.<sup>22</sup>

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<sup>9</sup> Cal. Civ. Code § 3428 (West Supp. 2003). For further explanation of California's statute, see *infra* notes 95-104 and accompanying text; see generally Arkin, *supra* note 2, at 622-41.

<sup>10</sup> Ga. Code Ann. § 51-1-48 (LEXIS 1999).

<sup>11</sup> La. Rev. Stat. Ann. § 22:3085 (West Supp. 2003).

<sup>12</sup> Me. Rev. Stat. Ann. tit. 24-A, § 4313 (West Supp. 2002).

<sup>13</sup> N.J. Stat. Ann. § 2A:53A-33 (West Supp. 2002).

<sup>14</sup> Okla. Stat. Ann. tit. 36, § 6593 (West Supp. 2003) (employing language nearly identical to California's statute).

<sup>15</sup> Tex. Civ. Prac. & Rem. Code Ann. § 88.002 (West Supp. 2003) (codifying the Health Care Liability Act).

<sup>16</sup> Wash. Rev. Code Ann. § 48.43.545 (West Supp. 2003).

<sup>17</sup> W. Va. Code Ann. § 33-25C-7 (West Supp. 2003).

<sup>18</sup> For a list of current and pending legislation, see Nat'l Conference of State Legislatures, *Managed Care Insurer Liability*, at <http://www.ncsl.org/programs/health/liable.htm> (last modified Oct. 22, 2002).

<sup>19</sup> This Note evaluates California's liability law because it is representative of all the state laws and arguably one of the most progressive. Further, California's statute is representative of all of the state laws in that it does not provide a cause of action for negligent *ex ante* influence. See *infra* note 95.

<sup>20</sup> Cal. Civ. Code § 3428 (West Supp. 2003).

<sup>21</sup> See *infra* Part II.A.

<sup>22</sup> MCOs exert *ex post* influence through a process called "utilization review" in which MCOs evaluate doctors' recommended courses of action and decide whether that given action is compensable under the patient's benefit program. See Richard A. Spector, *Managed Health Care Liability Issues*, 32 *Cumb. L. Rev.* 311, 327-28 (2001-2002); see also *infra* Part I.A. MCOs wield *ex ante* influence by issuing guidelines and protocols. Doctors comply with these documents, either since they are explicitly required to do so by the MCO's terms or for financial reasons. L. Darnell Weeden, *An HMO Does Not Owe an ERISA Fiduciary Duty to Its Employee Beneficiaries: After Pegram v. Herdrich, Who Will Speak for the Working Class?*, 23 *W. New Eng. L. Rev.* 381, 384 (2002) (arguing that, in contrast

California's MCO liability law addresses only *ex post* influence, since the law applies only after the physician recommends a service that the MCO *then* denies, delays, or modifies. Under California's law, many victims of negligent *ex ante* MCO influence are left with no recourse against their MCOs. Thus, MCOs can skirt the liability California's statute imposes simply by shifting their influence from *ex post* to *ex ante*. This renders California's managed care liability law and similar statutes inadequate to protect patients.

Furthermore, this Note argues that while many victims of *ex ante* influence still will be able to sue their doctors for medical malpractice, a subset of these patients will face great difficulty obtaining any remedy at all.<sup>23</sup> Medical malpractice suits require plaintiffs to prove that their doctors deviated from the medical profession's standard of care.<sup>24</sup> MCOs, through their pervasive influence over medical care, have been gradually eroding this standard.<sup>25</sup> As a result of this erosion, many victims of *ex ante* influence will have difficulty proving that their doctors were negligent.<sup>26</sup> Such doctors will be able to defend themselves by offering proof that their actions comported with custom, as custom has grown more lax due to MCO pressure. This compounds the problem created by the inability of state legislation to address *ex ante* MCO influence.

Part I recounts the evolution of the ERISA preemption problem and the current solutions crafted by plaintiffs and state legislatures. Part II addresses the problem of *ex ante* MCO influence. It explains that current legislation contains a loophole that permits MCOs to reduce their exposure to statutory liability by shifting their influence from *ex post* to *ex ante*. Part II also describes how MCOs have eroded the standard of care, leaving some victims of *ex ante* MCO influence without recourse for their injuries. Finally, Part III urges the creation of a new cause of action against MCOs for negligent *ex ante* influence.

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to fee-for-service systems, MCOs pressure doctors to provide lower level of care); see also *infra* Part II.A.

<sup>23</sup> See *infra* Part II.C.

<sup>24</sup> See *infra* note 137 and accompanying text.

<sup>25</sup> See *infra* Part II.C.

<sup>26</sup> This Note acknowledges that victims of *ex ante* MCO influence whose doctors' recommended course of treatment grossly deviated from the standard of care still will be able to launch a successful medical malpractice suit against their doctors.

## I

## THE EVOLUTION OF THE ERISA PREEMPTION PROBLEM

State statutes designed to increase MCO liability confront the problem of ERISA preemption. To better understand why these state statutes are inadequate, this Part describes the evolution and extent of the ERISA preemption problem. Section A outlines why MCOs have gained steadily in popularity over the past few decades and how they control costs. Section B then explains how ERISA largely insulates MCOs from tort liability. Next, Section C addresses the various legal mechanisms plaintiffs have developed to chip away at ERISA's preemptive shield. Section D then discusses the state legislative responses to ERISA preemption.

*A. The Rise of MCOs and Their Cost-Containment Strategies*

At the time of ERISA's enactment, MCOs possessed a relatively small share of the overall health care insurance market. MCOs only first started gaining acceptance in the 1970s, especially after Congress encouraged their formation through legislation.<sup>27</sup> In 1972, approximately 3 million people were enrolled in MCOs.<sup>28</sup> By 1985, that number had increased to 18 million.<sup>29</sup> Today, there are at least 170 million people whose health care is managed by an MCO.<sup>30</sup>

MCOs grew in popularity largely because they were seen as a means to control the rapid increase in health care costs.<sup>31</sup> In 1960, health care expenditures accounted for a mere 5.2% of the U.S. Gross Domestic Product (GDP).<sup>32</sup> By 1970, that figure had risen to 7.3%.<sup>33</sup> By 1990, health care accounted for 12.6% of the GDP.<sup>34</sup> At that time, some analysts predicted that the figure could exceed 20% by 2000.<sup>35</sup>

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<sup>27</sup> See Health Maintenance Organization Act of 1973, Pub. L. No. 93-222 (codified at 42 U.S.C. §§ 280(c), 300(c)); see also Jeffrey W. Stempel & Nadia von Magdenko, *Doctors, HMOs, ERISA, and the Public Interest After Pegram v. Herdrich*, 36 *Tort & Ins. L.J.* 687, 705 (2001) (discussing congressional efforts to encourage MCO formation).

<sup>28</sup> Tom J. Manos, Comment, *Take Half an Aspirin and Call Your HMO in the Morning—Medical Malpractice in Managed Care: Are HMOs Practicing Medicine Without a License?*, 53 *U. Miami L. Rev.* 195, 202 (1998).

<sup>29</sup> *Id.*

<sup>30</sup> See Nat'l Conference of State Legislatures, *supra* note 18. This number does not reflect the total number of people who would suffer ERISA preemption if they tried to sue their MCOs; not all MCO participants are subject to ERISA preemption. See *infra* notes 147-148, 150 and accompanying text.

<sup>31</sup> See Ardyth J. Eisenberg, *When HMO Patients Can't Get No Satisfaction*, 4 *DePaul J. Health Care L.* 367, 370 (2001) (describing evolution from fee-for-service system to managed care).

<sup>32</sup> David Dranove, *The Economic Evolution of American Health Care* 28 (2000).

<sup>33</sup> *Id.*

<sup>34</sup> *Id.* at 65.

<sup>35</sup> *Id.*

Pervasive MCO influence has, however, held that figure to under 14%.<sup>36</sup>

MCOs seek to minimize three of the most important factors believed to drive skyrocketing health care costs: moral hazard, demand inducement,<sup>37</sup> and defensive medicine.<sup>38</sup> Moral hazard describes the way in which people respond to insurance; insured patients purchase more health care services because they pay less out of their own pockets for those services.<sup>39</sup> Unlike MCOs, traditional health insurance allows patients virtually unlimited access to medical treatment with complete coverage at minimal out-of-pocket cost.

Demand inducement occurs when health care providers have a strong financial incentive to order as many costly procedures as possible.<sup>40</sup> The fee-for-service system, the predominant payment method prior to the rise of MCOs, inherently encourages demand inducement. Under this system, doctors are free to order whatever tests and treatments they desire, receiving additional compensation for each service rendered.

The final factor driving the surge in health care costs is defensive medicine.<sup>41</sup> Physicians engage in defensive medicine when they perform tests and procedures that provide no marginal benefit to the patient solely to ward off potential malpractice liability.<sup>42</sup> The cost of this practice was estimated at \$13.7 billion per year in the mid-1980s.<sup>43</sup> Before the rise of MCOs, insurance payment policies encouraged doctors to take any and all actions that would be at least “infinitesimally beneficial” for their patients.<sup>44</sup>

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<sup>36</sup> *Id.*

<sup>37</sup> *Id.* at 28.

<sup>38</sup> Stempel & Magdenko, *supra* note 27, at 705 (attributing rising health care costs to inefficient delivery of care and defensive medicine).

<sup>39</sup> Dranove, *supra* note 32, at 29.

<sup>40</sup> *Id.* at 28; Stempel & Magdenko, *supra* note 27, at 705.

<sup>41</sup> Stempel & Magdenko, *supra* note 27, at 705.

<sup>42</sup> See E. Haavi Morriem, *Holding Health Care Accountable: Law and the New Medical Marketplace* 24 (2001) (describing relationship between defensive medicine and medical custom); Michelle M. Mello, *Of Swords and Shields: The Role of Clinical Practice Guidelines in Medical Malpractice Litigation*, 149 *U. Pa. L. Rev.* 645, 646 (2001) (exploring direct and indirect effects of malpractice liability on practice of medicine).

<sup>43</sup> Roger A. Reynolds et al., *The Cost of Medical Professional Liability*, 257 *JAMA* 2776, 2778 (1987). Defensive medicine is still a burden on the health care system today. “The Office of Technology Assessment recently found that up to 8% of diagnostic testing is ‘consciously defensive,’ while another study proposed that liability reform might save up to \$50 billion per year without compromising outcomes.” *Id.* (internal citations omitted). However, these estimates are all controversial since medical opinions vary as to what constitutes defensive medicine. David Klingman et al., *Measuring Defensive Medicine Using Clinical Scenario Surveys*, 21 *J. Health Pol. Pol’y & L.* 185, 186-87 (1996).

<sup>44</sup> See Robert M. Veatch, *A Theory of Medical Ethics* 285 (1981).

When selecting employee benefit plans, employers, faced with escalating health care costs, turned to MCOs to combat these three factors.<sup>45</sup> MCOs lower the cost of health care by managing its delivery, typically employing three major techniques: selective contracting, financial incentives, and utilization review.<sup>46</sup>

Selective contracting is the process by which MCOs negotiate and contract with only those hospitals and doctors willing to offer lower prices.<sup>47</sup> This technique reduces demand inducement, since physicians who recommend too many high-cost treatments may be denied access to their MCO's network. Given the large percentage of patients who are insured through MCOs, doctors may suffer enormous financial injury if they are unable to contract with MCOs.<sup>48</sup>

MCOs use financial incentives to address the problems of demand inducement and defensive medicine. While there are many types of financial incentives that MCOs use to reduce costs, the two most popular are capitation and withholds.<sup>49</sup> Capitation is a payment system by which each doctor is paid a fixed amount per patient under her care.<sup>50</sup> The physician is encouraged to cut costs since she captures any excess money not spent on patient care but loses out if the cost of patient care exceeds the allotted amount.<sup>51</sup> Withholds are contractual agreements whereby doctors permit the MCOs to withhold a certain percentage of their total compensation. This amount is then given to the doctors only if they achieve the desired performance outcomes.<sup>52</sup>

Finally, MCOs combat moral hazard, demand inducement, and defensive medicine through utilization review, which takes three forms: retrospective, concurrent, and prospective.<sup>53</sup> Under retrospective review, the MCO evaluates the treatment or procedure already rendered by the doctor and decides how much it will pay based on the benefits to which the patient is entitled.<sup>54</sup> Under prospective review,

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<sup>45</sup> See Eisenberg, *supra* note 31, at 370.

<sup>46</sup> See, e.g., Dranove, *supra* note 32, at 72 (discussing managed care strategies).

<sup>47</sup> *Id.* at 72-74. Some states have enacted "any willing provider" laws to limit selective contracting. Such laws force MCOs to accept into their networks any health care providers willing to accept the MCO's terms and conditions. Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 *Cornell L. Rev.* 1, 16 (1999) (describing incentive problems in managed care).

<sup>48</sup> See *infra* Part II.A.

<sup>49</sup> See Tindall, *supra* note 1, at 188-95 (discussing various methods of creating incentives in managed care).

<sup>50</sup> June M. Sullivan, *The Doctor Won't See You Now: ERISA Permits HMOs to Give Doctors Financial Incentives to Limit Health Care*, 77 *N.D. L. Rev.* 267, 274 (2001).

<sup>51</sup> *Id.*

<sup>52</sup> Tindall, *supra* note 1, at 191-92.

<sup>53</sup> Spector, *supra* note 22, at 327.

<sup>54</sup> *Id.*

however, the patient's benefits are considered even before the medical procedure is initiated.<sup>55</sup> Concurrent review occurs while the patient is receiving medical care. For example, an MCO might review the length of the hospital stay while the patient is still in the hospital.<sup>56</sup> Thus, under prospective and concurrent review, the MCO can directly delay, modify, or deny a doctor's recommended course of treatment.

### B. ERISA's Preemptive Shield

When Congress enacted ERISA in 1974, MCOs were neither as pervasive nor as influential as they are today.<sup>57</sup> It is, therefore, hard to imagine that Congress even contemplated ERISA's perverse effect of denying many victims of MCO negligence any legal remedy.<sup>58</sup>

Congress intended for ERISA to protect employees and their families from incompetent and injurious administration of employee benefit plans.<sup>59</sup> To this end, Congress included a preemption clause: ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."<sup>60</sup> ERISA, however, contains a savings clause which provides that nothing in the statute "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."<sup>61</sup>

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<sup>55</sup> *Id.*

<sup>56</sup> *Id.* at 327-28.

<sup>57</sup> See *supra* notes 27-30 and accompanying text.

<sup>58</sup> Margaret G. Farrell, *ERISA Preemption and Regulation of Managed Care: The Case for Managed Federalism*, 23 *Am. J.L. & Med.* 251, 273 (1997).

<sup>59</sup> See 29 U.S.C. § 1001(b) (2000).

<sup>60</sup> § 1144(a). The precise reason why Congress included a preemption provision is unclear. See generally Catherine L. Fisk, *The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 *Harv. J. on Legis.* 52 (1996) (arguing that sparse legislative history discussing preemption provision indicates that Congress did not give much thought to provision).

<sup>61</sup> § 1144(b)(2)(A). The savings clause itself is limited by the so-called "deemer" clause. The deemer clause prevents states from circumventing the prohibition on state regulation of employee benefits under the guise of regulating insurance. See § 1144(b)(2)(B) ([No] employee benefit plan . . . shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.). There is an exception to the deemer clause, but it is not relevant to this Note. For a Supreme Court interpretation of the deemer clause, see *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) (interpreting "deemer" clause to exempt self-funded ERISA plans from state laws that regulate insurance). For a view of how ERISA's three clauses concerning preemption interact, see, for example, *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739-47 (1985) (holding Massachusetts statute setting mandatory minimum health care requirements for general insurance policies not preempted). For an explanation of how courts determine whether a state statute regulates insurance for the purposes of the savings clause, see *infra* note 104.

Notwithstanding the savings clause, the Supreme Court has interpreted the scope of ERISA's preemption to be quite broad.<sup>62</sup> Thus, a person whose health insurance is provided as an employee benefit, and who seeks compensation for an improper denial of benefits, can only sue under ERISA's civil-enforcement provision.<sup>63</sup> This provision only permits a claimant "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."<sup>64</sup> A plaintiff forced to sue under ERISA cannot recover for consequential damages including pain, suffering, or even death.<sup>65</sup> ERISA also bars the award of punitive damages.<sup>66</sup>

Perhaps the best illustration of the inadequacy of ERISA's remedial provision is the real-life example of Cynthia Herdrich, a patient who received her health care insurance through her husband's employer.<sup>67</sup> Lori Pegram, a physician-owner of Ms. Herdrich's MCO, required Ms. Herdrich to wait eight days for an ultrasound to confirm that she did indeed have appendicitis. Dr. Pegram forced Ms. Herdrich to wait so that the ultrasound could be performed at a facility staffed by doctors affiliated with the MCO. Before the eight-day waiting period ended, Ms. Herdrich's appendix burst, causing peritonitis, a life-threatening condition that required a longer hospital stay and additional surgery.<sup>68</sup> Under ERISA's preemptive shield, Ms. Herdrich only could recover the improperly denied benefits: the cost of the ultrasound, extended hospital stay, and surgery. She could not, however, recover from her MCO for any physical injury, pain, or suffering.<sup>69</sup> Had Ms. Herdrich died as a result of the delayed ultrasound, her family could not have received any additional compensation beyond that already described.

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<sup>62</sup> See, e.g., *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987) ("[P]reemption provisions of ERISA are deliberately expansive.").

<sup>63</sup> This assessment is based upon the Supreme Court's early application of ERISA's preemption clause. See, e.g., *id.* As discussed *infra* Part I.D, plaintiffs and state legislation have found ways to limit the scope of ERISA's preemption.

<sup>64</sup> § 1132(a)(1)(B). The court has discretion to award reasonable attorney's fees and costs to either party. § 1132(g)(1).

<sup>65</sup> See *supra* note 6 and accompanying text.

<sup>66</sup> See *supra* note 6 and accompanying text.

<sup>67</sup> The facts are taken from *Pegram v. Herdrich*, 530 U.S. 211, 215-18 (2000), and *Herdrich v. Pegram*, 154 F.3d 362, 365-66, 374 (7th Cir. 1998), *rev'd*, 530 U.S. 211 (2000). For the legal significance of this ERISA case, see *infra* notes 86-94 and accompanying text.

<sup>68</sup> *Herdrich*, 154 F.3d at 374.

<sup>69</sup> Herdrich did successfully recover \$35,000 in a state medical malpractice claim against Dr. Pegram. *Joan Biskupic, Court Weighs Doctor's Bonus vs. Patient's Care*, *Wash. Post*, Feb. 17, 2000, at A1.

ERISA's preemption clause harms those patients who cannot hold their MCOs fully liable for negligent actions. The harm wrought by the statute, however, extends beyond those patients who seek tort recovery. ERISA's preemption provision reduces MCOs' financial incentives to provide quality care, thereby harming all MCO subscribers. Since the clause shields MCOs from complete accountability for their actions, MCOs are left with a relatively small financial incentive to maintain the quality of care at the optimal level.<sup>70</sup> Yet MCOs have very strong financial incentive to cut costs at the expense of quality.<sup>71</sup> This Note argues that in order to induce MCOs to provide the optimal level of care, they need to be made subject to tort liability to offset their incentives to eliminate costs.

### *C. Nonlegislative Solutions to the Problem Have Provided Only Limited Relief*

Plaintiffs have tried various means to avoid the ERISA preemption problem and have met with varying degrees of success. Plaintiffs' arguments for state recovery have been grounded in three theories: (1) vicarious liability; (2) distinguishing between coverage and treatment decisions; and (3) breach of fiduciary duty.

#### *1. Vicarious Liability*

Under the theory of vicarious liability, MCOs can be held liable when their employees or agents commit medical malpractice under state law.<sup>72</sup> Patients who received their treatment from health care providers directly employed by their MCO can allege that their MCO granted actual authority for the negligent medical treatment.<sup>73</sup> MCOs

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<sup>70</sup> While this Note does not attempt to define precisely the optimal standard of care, it takes the position that the ideal standard, in theory, eliminates costs associated with moral hazard, demand inducement, and defensive medicine, but eliminates no other costs from the system. See *infra* Part II.C.

<sup>71</sup> Although there is some evidence that MCOs do not provide a lower standard of care, see, for example, Richard A. Ippolito, *Freedom to Contract in Medical Care: HMOs, ERISA and Pegram v. Herdrich*, 9 *Sup. Ct. Econ. Rev.* 1, 25-26 (2001) (arguing that unrestrained freedom of contract, not exposure of MCOs to tort liability or federal regulation, will result in efficient health care standards), a study that focused on the quality of care MCOs provide elderly and poor patients showed that these patients fare worse under MCO systems than under fee-for-service systems, J.E. Ware, Jr. et al., *Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems*, 276 *JAMA* 1039, 1039-47 (1996). This is significant since the elderly and the poor stand to suffer most at the hands of MCOs. Members of these groups are least able to inform themselves and fight back against unfavorable MCO interference.

<sup>72</sup> See Aaron D. Twersky & Neil B. Cohen, *The Second Revolution in Informed Consent: Comparing Physicians to Each Other*, 94 *Nw. U. L. Rev.* 1, 33 (1999) (explaining MCO liability for physician's failure to obtain informed consent for medical treatment).

<sup>73</sup> *Id.*

can be held liable for exercising actual authority under a theory of respondeat superior.<sup>74</sup> MCOs that maintain an independent contractor relationship with health care practitioners are, however, immune from such liability.<sup>75</sup>

Faced with this impediment, some plaintiffs have successfully persuaded state courts to circumvent the independent contractor relationship by finding apparent authority under a theory of ostensible agency.<sup>76</sup> Courts may find apparent authority where an MCO has represented to the patient that her physician was an agent of the MCO.<sup>77</sup>

Plaintiffs successfully sued their MCO in Illinois state court under a vicarious liability claim in *Petrovich v. Share Health Plans of Illinois, Inc.*<sup>78</sup> While that case never reached a federal court, the Tenth Circuit later held that a vicarious liability claim against an MCO is not preempted by ERISA.<sup>79</sup> Despite this, few plaintiffs injured by MCO negligence take advantage of the theory, largely because not many states recognize a common law vicarious liability claim against MCOs; moreover, those that do impose a high burden of proof on plaintiffs.<sup>80</sup>

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<sup>74</sup> *Id.*

<sup>75</sup> Richard A. Epstein & Alan O. Sykes, *The Assault on Managed Care: Vicarious Liability, ERISA Preemption and Class Actions*, 30 *J. Legal Stud.* 625, 639 (2001) (“[A] physician who has an independent practice and his own malpractice coverage is likely to be deemed an independent contractor, and any hospitals or MCOs with which the physician is affiliated will ordinarily not be subject to vicarious liability.”).

<sup>76</sup> *Id.* at 34-35.

<sup>77</sup> *Id.*

<sup>78</sup> 719 N.E.2d 756, 766 (Ill. 1999) (holding MCO liable for independent-contractor physician’s failure to diagnose oral cancer).

<sup>79</sup> *Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151, 153 (10th Cir. 1995). Vicarious liability claims are not preempted because they are grounded in the medical malpractice of the treating physician. *Id.* at 154.

<sup>80</sup> For example, for an apparent authority claim, the Illinois Supreme Court requires that the MCO have held itself out to be the health care provider without informing the patient that care would actually be provided by independent contractors, and the patient justifiably relied on this information when looking to the MCO to provide health care. *Petrovich*, 719 N.E.2d at 766. It also should be noted, however, that two of the states with MCO liability laws create causes of action based upon vicarious liability: Maine, *Me. Rev. Stat. Ann. tit. 24-A, § 4313* (West Supp. 2002) (A carrier has the duty to exercise ordinary care when making health care treatment decisions . . . . A carrier is also liable for damages as provided in this section for harm to an enrollee proximately caused by the health care treatment decisions made by its agents who are acting on the carrier’s behalf and over whom the carrier exercised control or influence in the health care treatment decisions that result in the failure to exercise ordinary care.), and Texas, *Tex. Civ. Prac. & Rem. Code Ann. § 88.002* (West Supp. 2003) (providing that MCO owes duty of ordinary care when instituting health care treatment decisions made by employees, agents, or other representatives of MCO.)

## 2. *Treatment Versus Coverage Decisions*

In *Dukes v. U.S. Healthcare*, the Third Circuit recognized a distinction between treatment decisions, which concern the quality of care provided, and coverage decisions, which concern the quantity of care provided.<sup>81</sup> The court concluded that a claim concerning the “quality of the benefits received” is separate from a claim to recover benefits due under the plan. The court held that the latter was preempted by ERISA, while the former was not.<sup>82</sup> Subsequently, the Third Circuit characterized the *Dukes* holding as “embrac[ing] a distinction between claims pertaining to the quality of the medical benefits provided to a plan participant and claims that the plan participant was entitled to, but did not receive, a certain quantum of benefits under his or her plan.”<sup>83</sup>

While the distinction between quality and quantity offers plaintiffs some hope in their attempts to seek state tort recovery against their MCOs, this theory can be problematic in practice when the line between the two categories blurs. The Third Circuit acknowledged this problem in *Dukes*,<sup>84</sup> providing a hypothetical example of an MCO plan promising that every X-ray would be analyzed by a radiologist with a certain level of training.<sup>85</sup> It is not entirely clear whether an injured patient whose X-ray was negligently reviewed by a radiologist with a lower level of training would have a coverage or treatment decision claim.

## 3. *Breach of Fiduciary Duty*

In *Pegram v. Herdrich*,<sup>86</sup> the plaintiff tried to sue in state court under the innovative theory that the MCO had breached its fiduciary duty.<sup>87</sup> Ms. Herdrich claimed that by providing physicians with a financial incentive to limit medical care, the MCO had engaged in an inherent or anticipatory breach of ERISA’s fiduciary duty clause.<sup>88</sup>

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<sup>81</sup> 57 F.3d 350, 357 (3d Cir. 1995). In *Dukes*, the patient’s doctor ordered a blood test, but the hospital refused to perform the test and the patient died. *Id.* at 352. The patient’s blood-sugar levels were dangerously high at the time of his death—a condition that would have been diagnosed and treated had the initial test been performed. *Id.*

<sup>82</sup> *Id.* at 357.

<sup>83</sup> *In re U.S. Healthcare, Inc.*, 193 F.3d 151, 162 (3d Cir. 1999) (holding that negligence claim brought by parents of deceased infant who was released from hospital fewer than twenty-four hours after birth was not completely preempted).

<sup>84</sup> 57 F.3d at 358.

<sup>85</sup> *Id.*

<sup>86</sup> 530 U.S. 211 (2000). For a description of the facts of this case, see *supra* note 67 and accompanying text.

<sup>87</sup> 530 U.S. at 216.

<sup>88</sup> *Id.*

She contended that the MCO's policy created an incentive for the doctor to act out of self-interest, while ERISA requires that employee benefit programs be administered solely to further the interest of the plan participants.<sup>89</sup> Thus, Ms. Herdrich argued, mixed-eligibility decisions—those decisions requiring both coverage and treatment determinations—are fiduciary decisions for the purpose of ERISA.<sup>90</sup> The Seventh Circuit agreed with Ms. Herdrich,<sup>91</sup> but the Supreme Court reversed.<sup>92</sup> In a unanimous decision, the Court, examining congressional intent, squarely rejected the fiduciary duty theory. The Court recognized that if it affirmed the Seventh Circuit, “[r]ecovery would be warranted simply upon showing that the profit incentive to ration care would generally affect mixed decisions, in derogation of the fiduciary standard to act solely in the interest of the patient without possibility of conflict.”<sup>93</sup> The Court concluded that acceptance of Ms. Herdrich's theory would open up a floodgate of federal court litigation in violation of congressional intent.<sup>94</sup>

After *Herdrich*, breach of ERISA's fiduciary duty clause is no longer a viable theory under which plaintiffs can sue their MCOs for negligence. While plaintiffs can avoid ERISA preemption under a theory of vicarious liability or by drawing a distinction between treatment and coverage decisions, plaintiffs suing under either of these nonlegislative solutions face significant technical barriers.

#### D. State Legislative Responses to ERISA Preemption

This Note now turns to the state legislative responses to the ERISA preemption problem. Specifically, it addresses California's liability law, one of the most progressive of the state statutes.<sup>95</sup>

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<sup>89</sup> Id. at 216 n.3.

<sup>90</sup> See id.

<sup>91</sup> *Herdrich v. Pegram*, 154 F.3d 362, 373 (7th Cir. 1998). The Seventh Circuit limited its holding, noting that not all mixed decisions necessarily violate fiduciary duties. Id.

<sup>92</sup> *Pegram*, 530 U.S. at 237.

<sup>93</sup> Id. at 232-33.

<sup>94</sup> The Court recognized that this theory would not only expose MCOs to dramatically increased liability but also would expose physicians employed by the MCOs to increased liability. Id. at 236. Yet *Pegram*'s outcome was not entirely favorable to MCOs. The Court in *Pegram* recognized the distinction between pure coverage decisions, pure treatment decisions, and mixed eligibility/treatment decisions. See id. at 229-30. While actions based upon pure treatment decisions are not preempted by ERISA, the Court's acknowledgement of mixed decisions opened up the possibility for state negligence actions against MCOs engaging in these mixed decisions. Id. at 231.

<sup>95</sup> California's law is also representative of the other state statutes in that it does not permit recovery for ex ante negligence. See, e.g., Ariz. Rev. Stat. Ann. § 20-3153 (West 2001) (“A health care insurer is liable for any damages caused to the insurer's enrollee by the insurer's delay in authorizing or failure to authorize a request for medically necessary health care services covered under the health care plan or by the insurer's denial of pay-

California's managed care liability law became effective on January 1, 2001.<sup>96</sup> California's statute holds an MCO liable when its actions "resulted in the denial, delay, or modification" of the service recommended or provided by the treating doctor.<sup>97</sup> The statute expressly refuses to provide a cause of action for vicarious liability; it focuses solely on the MCO's conduct.<sup>98</sup>

To assert a successful claim against an MCO under California's managed care liability law, an enrollee must demonstrate five elements: (1) the MCO's "failure to exercise ordinary care resulted in the denial, delay, or modification of the health care service"; (2) "the health care service is a benefit provided under the plan"; (3) the denied, delayed, or modified service was initially recommended by a health care practitioner; (4) the enrollee suffered "substantial harm," meaning "loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss"; and (5) the independent review process was either exhausted or not required.<sup>99</sup> This statute applies, for example, when a doctor "recommends a hysterectomy for treatment of recurrent cervical cancer, but the MCO will only approve cervical cryosurgery" or when a "doctor recommends proton beam radiation for treatment of prostate cancer, but the MCO only approves surgery."<sup>100</sup>

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ment of benefits covered under the health care plan . . ."); Ga. Code Ann. § 51-1-48 (West 2000) ("Any claim administrator, health care advisor, private review agent, or other person or entity which administers benefits or reviews or adjusts claims under a managed care plan shall exercise ordinary diligence to do so in a timely and appropriate manner . . ."); W. Va. Code Ann. § 33-25C-7 (West Supp. 2003) ("[A] managed care plan must comply with the decision rendered in an external review under this article and may be held civilly liable for all damages proximately caused to an enrollee for its failure to so comply.").

<sup>96</sup> Cal. Civ. Code § 3428(a) (West Supp. 2003). For an overview of this statute, see Found. for Taxpayer & Consumer Rights, *The California Patient's Guide* 32-55 (2001) [hereinafter *California Patient's Guide*], available at <http://www.calpatientguide.org>.

<sup>97</sup> § 3428(a)(1); Arkin, *supra* note 2, at 624; see also *California Patient's Guide*, *supra* note 96, at 47 (stating that statute's intent is to "make the HMO responsible for injury caused when it makes health care and/or treatment decisions under the guise of 'cost management'").

<sup>98</sup> § 3428(g) ("[The statute] does not create any new or additional liability on the part of a health care service plan or managed care entity for harm caused that is attributable to the medical negligence of a treating physician or other treating health care provider."); see Arkin, *supra* note 2, at 625 (distinguishing California statute from Texas's vicarious liability-based statute). Compare § 3428, with Tex. Civ. Prac. & Rem. Code Ann. § 88.002 (West Supp. 2003) (providing for vicarious MCO liability).

<sup>99</sup> Cal. Civ. Code § 3428(a), (b), (k) (West Supp. 2003). For an overview of the independent review process, see, for example, *California Patient's Guide*, *supra* note 96, at 36-45; Arkin, *supra* note 2, at 627-40.

<sup>100</sup> *California Patient's Guide*, *supra* note 96, at 37.

Under California's statute, a plaintiff generally must exhaust the independent review process before seeking relief through the courts.<sup>101</sup> This process is administered by the California Department of Managed Health Care, which evaluates whether the MCO improperly denied treatment. If the Department concludes that the treatment should have been provided, the MCO must either provide the service or reimburse the patient if he paid for the treatment out of his own pocket.<sup>102</sup>

Patients who either have suffered or will suffer substantial harm prior to the completion of the applicable review are exempt from the independent review requirement.<sup>103</sup> The statute thus balances two interests: It allows patients who either already have suffered substantial injury or will face imminent injury to have their day in court as soon as possible, while minimizing the burden on the state's judicial system.

Although California's MCO liability law has not yet been subject to an ERISA preemption challenge, there is a high likelihood that the statute will not suffer preemption.<sup>104</sup> Assuming California's law and

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<sup>101</sup> See § 3428(k)(1). This independent review provision was a compromise between the California Legislature and Governor designed to reduce the amount of litigation brought under this statute. Arkin, *supra* note 2, at 626.

<sup>102</sup> See California Patient's Guide, *supra* note 96, at 36.

<sup>103</sup> See § 3428(k)(2) (defining substantial harm); see also California Patient's Guide, *supra* note 96, at 36-49.

<sup>104</sup> See Arkin, *supra* note 2, at 643-60; Borzi, *supra* note 3, at 1263-64 (arguing that statement in Supreme Court's unanimous opinion in *Pegram v. Herdrich* that "[i]t is true that in States that do not allow malpractice actions against HMOs the fiduciary claim would offer a plaintiff a further defendant to be sued," 530 U.S. 211, 235-36 (1999), provides evidence that Court assumes state liability laws are valid). Further evidence that California's statute will survive ERISA preemption lies in the Supreme Court's recent decision on whether state requirements mandating independent review are preempted. In *Rush Prudential HMO, Inc. v. Moran*, the Court clarified that such requirements solely regulate insurance and therefore fall under ERISA's savings clause. 122 S. Ct. 2151, 2171 (2002) (holding that Illinois state law mandatory review requirement was not preempted by ERISA); see also *Corporate Health Ins., Inc. v. Tex. Dep't of Ins.*, 215 F.3d 526, 538-39 (5th Cir. 2000) (holding that Texas statute allowing independent review of MCO decisions was preempted by ERISA), vacated, *Montemayor v. Corporate Health Ins.*, 122 S. Ct. 2617 (2002) (remanding dispute over Texas statute for consideration in light of *Rush*).

The California legislature designed the MCO liability law to avoid preemption by invoking this savings clause. See Managed Health Care Insurance Accountability Act of 1999, ch. 356, § 2, 1999 Cal. Legis. Serv. 3042 (West) (clarifying that MCOs regulated under California MCO liability statute are "engaged in the business of insurance in this state as that term is defined for purposes of the McCarran-Ferguson Act"). ERISA's savings clause exempts from preemption "any law of any state which regulates insurance." 29 U.S.C.A. § 1144(b)(2)(A) (2000). The Supreme Court has crafted a two-pronged approach to determine whether a state statute "regulates insurance." See *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 367 (1999) (holding that California's common law notice-prejudice law is not preempted by ERISA); see also *Rosenbaum v. UNUM Life Ins. Co. of Am.*, No. CIV.A. 01-6758, 2002 WL 1769899, at \*1 (E.D. Pa. July 29, 2002) (holding that Pennsylvania insurance statute was not preempted by ERISA). First, the court determines

similar state statutes survive ERISA preemption, plaintiffs will have an effective solution to the ERISA preemption problem. As will be discussed in Part II, however, California's statute is only ameliorative when a doctor's preferred method of treatment is delayed, modified, or denied by the MCO. The statute fails to address the problem of negligent ex ante influence.

## II

### EX ANTE MCO INFLUENCE: THE LOOPHOLE LEFT BY STATE LEGISLATIVE RESPONSES TO ERISA PREEMPTION

This Part will demonstrate that the drafters of California's MCO liability law left a loophole: The statute does not allow plaintiffs to recover against their MCOs for negligent ex ante influence. First, Section A will detail the nature and extent of ex ante influence. Section B then will explain how California's statute fails to address the problem of such influence. Finally, Section C will show that some of the victims of ex ante MCO influence will be unable to recover at all for their injuries, even from their physicians, thereby compounding the problem posed by the statutory loophole.

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whether "from a common-sense view of the matter" the statute indeed regulates insurance. *UNUM*, 526 U.S. at 367. California's MCO liability law seems to meet the first prong of the test; under a "common sense" view, the law regulates insurance. Arkin, *supra* note 2, at 643-44. The law provides liability for a tortious breach of contract—which happens to be a cause of action under California law applicable only to insurers. *Id.* Under the second prong, the court considers three factors to decide whether "the regulation fits within the business of insurance" as that term appears in the McCarran-Ferguson Act: "[F]irst, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." *UNUM*, 526 U.S. at 367 (citing 59 Stat. 33, codified as amended in 15 U.S.C. § 1011-1015 (2000)). A state statute need not satisfy all three elements to be exempt from preemption; these elements are simply "considerations to be weighed." *UNUM*, 526 U.S. at 373 (internal quote omitted); see also *Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. at 2154 (holding that Illinois statute requiring MCOs to provide independent review of disputes between health care provider and MCO and to cover services deemed medically necessary by independent reviewer was not preempted). The California statute arguably satisfies the second and third McCarran-Ferguson factors. First, the law is an integral part of the relationship between the insurer and the insured because it affects "the manner in which the insurer fulfills its contractual obligations to the insured." Arkin, *supra* note 2, at 645. Second, the law is limited to entities within the insurance industry because, as discussed above, the law provides liability for a particular tort only applicable under California law to insurers. *Id.*

### A. *The Nature and Extent of Ex Ante MCO Influence*

While MCOs impose ex post influence primarily through prospective and concurrent utilization review,<sup>105</sup> MCOs often exert ex ante influence by issuing guidelines and protocols.<sup>106</sup> Each MCO issues its own set of guidelines to its health care practitioners in “a stream of letters and booklets.”<sup>107</sup> According to Professors Rosenbaum and Kamoie, “[f]rom a legal point of view, treatment guidelines are the most significant effect of managed care on the management of medical care.”<sup>108</sup> Evidence shows that these guidelines are used “primarily by managed care ‘bean-counters’ to ration care and limit the doctor’s autonomy and judgment in providing for his or her patients what the patients actually need.”<sup>109</sup> Leading experts in managed care have recognized that practice guidelines actually serve to set the contractual standard of care.<sup>110</sup> Dr. David Eddy, one such expert, recognized that “[c]overage criteria [in insurance plans] constitute a contract between health plans and their members on how the members’ money will be spent.”<sup>111</sup>

While few MCOs explicitly require practitioners to follow these guidelines, those MCOs that do not impose mandatory treatment guidelines typically ask providers to adopt them voluntarily.<sup>112</sup> Physicians often embrace even voluntary guidelines due to market pressures to reduce costs.<sup>113</sup> Physicians are usually awarded financial incentives for their compliance, which direct doctors to provide “less care, not more.”<sup>114</sup> For many doctors, however, compliance is not about reaching for the carrot but rather about avoiding the stick. These guidelines are more than legally nonbinding suggestions en-

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<sup>105</sup> See *supra* notes 55-56 and accompanying text.

<sup>106</sup> See Clifton R. Cleaveland, *A Physician’s View from the Trenches*, in *The Challenge of Regulating Managed Care* 61, 65 (John E. Billi & Gail B. Agrawal eds., 2001) (explaining “micromanagement” by MCOs); Weeden, *supra* note 22, at 384.

<sup>107</sup> Cleaveland, *supra* note 106, at 65.

<sup>108</sup> Sara Rosenbaum & Brian Kamoie, *Managed Care and Public Health: Conflict and Collaboration*, 30 *J.L. Med. & Ethics* 191, 195 (2002) (discussing interaction between managed care cost control and adequacy of health care).

<sup>109</sup> Arnold J. Rosoff, *On Being a Physician in the Electronic Age: Peering into the Mists at Point-&-Click Medicine*, 46 *St. Louis U. L.J.* 111, 115-16 (2002).

<sup>110</sup> Rosenbaum & Kamoie, *supra* note 108, at 195-96.

<sup>111</sup> *Id.* at 195 (quoting David Eddy, *Benefit Language: Criteria that Will Improve Quality While Reducing Costs*, 275 *JAMA* 650, 650-51 (1996)).

<sup>112</sup> Dranove, *supra* note 32, at 98.

<sup>113</sup> *Id.*

<sup>114</sup> *Pegram v. Herdrich*, 530 U.S. 211, 219 (2000). For a discussion of the reward systems employed by MCOs, see Mary R. Anderlik, *The Ethics of Managed Care* 144-47 (David H. Smith & Robert M. Veatch eds., 2001).

forced through incentives.<sup>115</sup> As one doctor recently noted, “[t]he practitioner must try to adapt diagnosis and therapy to these varied protocols to avoid letters of reproof; their implied threat is that of being dropped from the list of approved physicians.”<sup>116</sup>

Most doctors participating in MCOs stand to suffer significant consequences if they are dropped. For example, those physicians who have many existing patients enrolled in MCOs risk losing a substantial part of their patient base if they do not remain one of the MCO’s preferred providers.<sup>117</sup> The system of selective contracting creates an “inherent incentive” for providers to follow MCO policies.<sup>118</sup> It is in the MCOs’ best interests to contract with only those health care providers who are willing to comport with the MCOs’ policies, and when provider contracts are terminable at will without cause, MCOs can easily terminate those doctors who do not behave as the MCOs desire.<sup>119</sup>

Physicians are constantly plagued by the implicit threat that their MCOs will drop them if they overtreat patients.<sup>120</sup> One could argue that this concern is counterbalanced effectively by a fear of malpractice litigation. This argument, however, underestimates the great influence MCOs wield over doctors. After all, MCO policies specifically aim to reduce costs associated with defensive medicine.<sup>121</sup> Concededly, malpractice concern does affect physician behavior. This does not, however, change the fact that *ex ante* MCO influence places doctors in a grim position and should be subject to reform.

*Ex ante* influence achieved through MCO treatment guidelines and protocols harms some patients significantly. These guidelines are usually implemented without sufficient evidence of their effects on pa-

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<sup>115</sup> See Mello, *supra* note 42, at 651-53 (suggesting that “[c]ompliance with [guidelines] may even be an explicit or implicit requirement of a physician’s participation in an HMO”).

<sup>116</sup> Cleaveland, *supra* note 106, at 65.

<sup>117</sup> Dean M. Harris, *Healthcare Law and Ethics: Issues for the Age of Managed Care* 255 (1999) (discussing risks doctors face due to selective contracting by MCOs).

<sup>118</sup> *Id.* at 271.

<sup>119</sup> *Id.* MCOs track the level of compliance with treatment guidelines through a process called provider profiling. Tindall, *supra* note 1, at 108-09. MCOs gather utilization data and measure the performance of individual practitioners on many levels, including rates of referral, average lengths of hospital stays, and number of brand prescriptions written. *Id.* Some MCOs also benchmark practitioners on their “adherence to treatment protocols, guidelines and algorithms.” *Id.* at 109. MCOs use this information to prepare “report cards” for all of the practitioners in their group. Those practitioners whose report card performance is *sub par* are notified of their status. *Id.*

<sup>120</sup> See Michael E. Ginsberg, *HMO Grievance Process*, 37 *Harv. J. on Legis.* 237, 249-50 (2000) (noting risks of punishment by MCOs if doctors administer costly treatments); see also Cleaveland, *supra* note 106, at 65 (same).

<sup>121</sup> See *supra* notes 41-44 and accompanying text.

tient care.<sup>122</sup> While some of the MCO guidelines are based on valid scientific studies, others are the product of less reliable data.<sup>123</sup> The remainder are not linked to science at all.<sup>124</sup> Further, even if the MCO does manage to produce a scientifically driven, fair guideline, it is extremely difficult to keep such a standard up to date with rapidly evolving medical knowledge.<sup>125</sup> Moreover, the adoption and application of these guidelines to individual treatment decisions is wholly unregulated.<sup>126</sup> Thus, MCOs are free to set arbitrary and unproven protocols that participating doctors are compelled to follow.

*B. State Legislative Responses to the ERISA Preemption Problem  
Fail to Address Ex Ante MCO Influence*

MCOs use ex ante influence to increase profits by reducing health care costs, which results in a decline in the standard of patient care.<sup>127</sup> While MCOs are justified in trying to eliminate costs associated with moral hazard, demand inducement, and defensive medicine,<sup>128</sup> they should be prevented from going too far in their cost-cutting measures. Unless MCOs are subject to full legal accountability for negligent acts committed pursuant to their protocols and guidelines, MCOs will have no direct countervailing financial interest to prevent this reduction in the quality of care below the optimal level. Without legal liability, as MCOs evaluate whether to implement a given protocol, their predominant financial consideration is the impact the protocol will have on the company's bottom line. MCOs lack any compelling financial incentive to implement only protocols supported by clinical research and only those protocols that eliminate undesirable costs from the health care system.

While ordinarily market forces serve to deter companies from excessive greed, the market for MCOs is atypical. For most goods and services sold on a market, the basic notions of supply and demand punish those companies that provide goods that least meet consumer needs. The market for MCOs, however, is unusual in that the purchasers of MCO policies are not the ultimate consumers of the MCO's

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<sup>122</sup> Rosenbaum & Kamoie, *supra* note 108, at 195 (quoting Eddy, *supra* note 111, at 651) (arguing that guidelines should not be disseminated without clinical research to support purported benefit). See generally S.H. Woolf, *Practice Guidelines: A New Reality in Medicine*, 153 *Archives Internal Med.* 2646 (1993) (discussing inherent risks of practice guidelines).

<sup>123</sup> Morriem, *supra* note 42, at 20, 68-69.

<sup>124</sup> *Id.*

<sup>125</sup> *Id.* at 69.

<sup>126</sup> See Rosenbaum & Kamoie, *supra* note 108, at 197.

<sup>127</sup> See *id.* at 196.

<sup>128</sup> See *supra* notes 37-45 and accompanying text.

services. While the level of care provided by the MCO is of great importance to the individual participants in the plan, employers that purchase the policies on behalf of their employees are most concerned with cost. Thus, under the present system, MCOs possess gripping incentives to reduce costs but no substantial countervailing incentive to achieve the optimal level of quality care.<sup>129</sup>

State managed care liability laws presently do not provide any countervailing pressure on guideline and protocol formulation. A plaintiff seeking to sue under California's managed care liability law will not succeed in a claim against her MCO for negligent ex ante influence because California's statute requires a plaintiff to show that the MCO's actions resulted in a "denial, delay, or modification" of the physician's recommended service.<sup>130</sup> A plaintiff whose doctor recommended a hysterectomy to treat her recurrent cervical cancer, but whose MCO modified that treatment through prospective utilization review and forced the doctor to perform cervical cryosurgery, could sue under California's law.<sup>131</sup> This is a clear case of ex post influence. By contrast, a plaintiff whose doctor would have liked to recommend a hysterectomy, but felt compelled to follow the MCO's clinical practice guidelines which stated that cryosurgery was the appropriate treatment, would not be able to sue under the statute.<sup>132</sup> The inherent unfairness of California's statute is clear: If the two plaintiffs described above were medically identical, and for each, cryosurgery would have been a negligent treatment decision, only the first plaintiff would be able to hold her MCO accountable under California's law.

It could be argued that the latter plaintiff more appropriately should seek recourse against her doctor instead of her MCO. After all, it was the plaintiff's doctor who chose to conform to the MCO's legally nonbinding treatment guidelines. Such an argument would, however, miss the point. The twin aims of tort law are compensation

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<sup>129</sup> See Jennifer L. Wright, *Unconstitutional or Impossible: The Irreconcilable Gap Between Managed Care and Due Process in Medicaid and Medicare*, 17 *J. Contemp. Health L. & Pol'y* 135, 117-72 (2000) (arguing that managed care is administered unconstitutionally in Medicaid and Medicare contexts).

<sup>130</sup> See Cal. Civ. Code § 3428(a)(1) (West Supp. 2003). For the remaining requirements, see *supra* note 99 and accompanying text.

<sup>131</sup> See *supra* note 100 and accompanying text.

<sup>132</sup> Moreover, the plaintiff in the latter situation would not be able to prove, and probably would have been ignorant of, the influence. Thus, such a plaintiff would have difficulty suing the MCO under a common law theory of negligence. Compounding this issue is the existence of gag rules—contractual provisions between MCOs and health care practitioners that limit providers' abilities to inform their patients. See Barton, *supra* note 1, at 47. Sometimes these rules prohibit providers from "making any communication that may adversely affect confidence in the health plan." *Id.*

and deterrence. Putting aside compensation for a moment,<sup>133</sup> statutes that permit improper influence by MCOs over doctors so long as the MCOs do so *ex ante*, but not *ex post*, do not provide effective solutions to the ERISA preemption problem. Such statutes serve merely to dissuade one form of improper behavior while encouraging another. The net effect is to encourage MCOs to shift their pressure on doctors from procedures such as utilization review to the imposition of stricter treatment guidelines enforced with stronger financial consequences. These statutes, therefore, fail to deter MCOs from undue influence, thereby condoning the continuing erosion of the standard of care to the detriment of all patients. Thus, this statutory loophole is quite problematic.

*C. The Eroding Standard of Care Compounds the Problem of Ex Ante MCO Influence Loophole*

Many patients injured by *ex ante* MCO negligence still will be able to succeed in malpractice suits against their doctors. Some of these patients, however, will not be able to obtain any redress at all for their injuries. This Section will show that because MCOs have eroded physicians' customary standard of care gradually by exerting *ex ante* influence, many doctors will be insulated from liability because their injurious conduct comported with the generally accepted medical practice.

Theoretically, the standard of care may be thought of as residing on a linear spectrum. At one end, cost is irrelevant: Patients receive any and all treatments, provided that the treatments offer even an infinitesimal benefit. At the other end, cost is determinative: Patients receive only treatments that are absolutely necessary for survival. Somewhere in between lies an optimal point that strikes an ideal balance between two goals: efficiently allocating limited resources available for health care while providing the best patient care possible.

Prior to the rise of MCOs, the forces driving the increase in health care costs—including moral hazard, demand inducement, and defensive medicine—set the standard of care above the optimal point.<sup>134</sup> MCOs' cost-containment techniques shifted the standard of care downward toward the optimal level. Unfortunately, this downward pressure did not cease at the optimal level of care. Given the lack of any significant countervailing financial interest, MCOs, by ex-

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<sup>133</sup> Compensation does factor in because an MCO will most likely have "deeper pockets" than an individual practitioner. The element of compensation is discussed further in Part II.C.

<sup>134</sup> See *supra* notes 37-45 and accompanying text.

erting *ex ante* influence, have shifted the standard of care below the optimal level.<sup>135</sup> It is this area—between the optimal point and the current point on the standard of care spectrum—that is problematic. Those patients who received a level of care above the optimal level should not succeed in a malpractice action since arguably such lawsuits are unmeritorious; those patients who received a level of care below the level implicitly set by the MCOs will prove malpractice easily on the part of their doctors. It is those patients who received care greater than MCO level, but still below the optimal level, who should be able to sue their doctors but have difficulty proving that their physicians deviated from the standard of care.

MCOs have eroded the standard of care by implementing treatment guidelines and protocols, limiting physician autonomy by directing doctors to apply certain procedures in certain situations. Since the primary motivation of MCOs is to increase profits by reducing costs, nearly all of the procedures MCOs advocate further erode the standard of patient care.

By lowering the standard of care in practice, the MCOs also have impacted the legal standard of care. The simple reason for this is that the clinical practice guidelines implemented by MCOs alter physician behavior. When courts try to determine whether a particular physician's behavior was negligent, they look to what other doctors would have done in that particular situation.<sup>136</sup> Since the influence of MCOs is pervasive, a defendant physician will have no trouble finding other doctors who have been equally manipulated by the MCO guidelines with respect to that particular decision. In essence, MCOs have altered custom over time through their guidelines and protocols.

While the burden of proof for medical negligence varies from state to state, "it is still fairly unusual for a court to strike down a professional custom as falling short of the standard of reasonable care."<sup>137</sup> Thus, as long as a defendant physician can find other doctors

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<sup>135</sup> See *supra* Part I.A.

<sup>136</sup> See, e.g., *Hawes v. Chua*, 769 A.2d 797, 806 (D.C. 2001) (acknowledging that standard of care focuses on "reasonably prudent doctor with the defendant's specialty" (internal quotation omitted)); *Johnson v. Riverdale Anesthesia Assocs.*, 563 S.E.2d 431, 432 (Ga. 2002) (declaring expert witness's opinion on proper treatment less important than general practice among doctors).

<sup>137</sup> Mello, *supra* note 42, at 658. Compare Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 *Wash. & Lee L. Rev.* 163, 164 (2000) (arguing that many states have been abandoning custom in favor of "reasonable physician" standard of care in malpractice litigation), with Peter D. Jacobson & Matthew L. Kanna, *Cost-Effectiveness Analysis in the Courts: Recent Trends and Future Prospects*, 26 *J. Health Pol. Pol'y & L.*, 291, 300 n.6 (2001) ("Even if Peters is correct, it is not clear how the emerging reasonable physician standard differs conceptually from professional custom and whether case outcomes are actually different in jurisdictions switching to the

who usually apply the same treatment in the same circumstances (i.e., per the guidelines and protocols of MCOs), the plaintiff is likely to lose.

In conclusion, plaintiffs injured by negligent *ex ante* influence, whose injuries occurred due to the eroding standard of care, are not likely to recover at all for their injuries.<sup>138</sup> This, however, is only a secondary effect of the larger problem of the *ex ante* influence loophole. Unless this loophole is closed, MCOs will continue to erode the standard of care to the detriment of patient welfare.

### III

#### A PROPOSAL TO CLOSE THE EX ANTE INFLUENCE LOOPHOLE

This Part proposes a new cause of action to hold MCOs legally accountable for *ex ante* MCO influence. It argues that current state MCO liability statutes should be amended to include this new cause of action. Section A outlines the proposal, while Section B addresses possible objections.

##### A. *The Proposal*

This proposal contains two elements: First, state legislatures should require MCOs to make available, to all subscribers, all treatment guidelines and protocols.<sup>139</sup> Second, injured patients should be able to challenge a specific policy as negligent.

The hypothetical cervical cancer patient discussed above can provide a useful illustration of this new cause of action. The patient who

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new approach.”). Cf. Morriem, *supra* note 42, at 26 (“If courts begin to see a significant backsliding of health care outcomes, it would not be surprising to see a flurry of new rulings [rejecting professional custom standard].”). Professor Morriem argues that the current tort system is ill-equipped to solve the problem faced by physicians: how to reduce system-wide health care costs without losing malpractice suits. *Id.* at 22-34. While this Note advocates the elimination of defensive medicine and other undesirable costs, Professor Morriem seeks to go beyond these costs and lower that standard of care:

Medicine has grown so lavish, and its cost has displaced so many other would-be spending priorities, that at a certain point we as individuals and as a society may want to spend less for health care, even if it means receiving less. Yet this is the very step that runs afoul of current tort doctrines.

*Id.* at 28. Thus, when Professor Morriem refers to a “backsliding of health care outcomes,” *id.* at 26, she is referring to the willful reduction in the quality of care that she urges, not to the gradual erosion of the standard of care implemented by MCOs that is described in this Note.

<sup>138</sup> This problem would worsen if the suggestion of some tort reformers is adopted. Some reformers argue that the legal standard of care should be set explicitly by clinical practice guidelines. See, e.g., Mello, *supra* note 42, at 646.

<sup>139</sup> This proposal does not advocate that all of the guidelines and proposals need to be provided directly to all subscribers; this would be overly burdensome and costly for the MCOs. Instead, this proposal requires MCOs to make this information publicly available.

was a victim of ex ante MCO influence now would be able to point to the treatment guidelines requiring cryosurgery for cervical cancer and say that her doctor followed the MCO's protocol and, in her situation, cryosurgery was a negligent treatment. If the patient can prove this, and the MCO cannot support the reasonableness of the protocol, then the patient would be able to recover for her injury from the MCO.

As a formal matter, this proposal would work in practice as follows: (1) A patient would need to suspect that she had been the victim of MCO negligence and seek an attorney; (2) the patient would need to establish actual injury; (3) the patient or her attorney would need to review the publicly available MCO protocols and find proof that the MCO advocated the particular treatment the patient received; and (4) the patient would need to show that the treatment she received fell below the standard of care, using the same standards of proof that are currently employed by the existing state MCO liability statutes.<sup>140</sup> If the patient accomplishes each of these tasks, she would then be able to state a claim under the statutory scheme proposed herein and shift the burden to the MCO to prove, using scientific evidence, that the protocol was reasonable.

The reason for this shift is twofold. First, the proposal's purpose is not to eliminate all MCO protocols and guidelines. Some ex ante influence is helpful in reducing the effects of moral hazard, demand inducement, and defensive medicine. The proposal merely serves to create a countervailing financial interest for MCOs such that when they contemplate implementing a given protocol or guideline, the decisionmakers are forced to conduct a proper and informed cost-benefit analysis. In other words, the goal is to exert influence on MCOs that brings the standard of care to the optimal point but not above it. Second, MCOs are in a better position than patients to prove that the given protocol or guideline was reasonable. Theoretically, if MCOs are implementing protocols and guidelines that restrict physician autonomy and affect the lives and welfare of their subscribers, MCOs should possess relevant statistics to support the implementation. It is therefore reasonable to require MCOs to defend themselves against a claim of negligent ex ante influence once plaintiffs have met their burden of proof.

### *B. Possible Objections and Responses to the Proposal*

Those who resist MCO tort-liability reform could assert two arguments against this proposal: (1) that the proposal would unduly bur-

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<sup>140</sup> This would be evaluated under a reasonableness standard. See *supra* note 137 and accompanying text.

den MCOs, thereby increasing system-wide health care costs that will be passed down to patients; and (2) that the proposal would be preempted by ERISA. Neither of these concerns diminishes the desirability of this proposal.

### *1. This Proposal Will Not Unduly Burden MCOs*

Those opposed to MCO liability reform might argue that this proposal would open the floodgates to lawsuits against MCOs, thereby driving up aggregate health care costs that MCOs simply will pass on to MCO subscribers.<sup>141</sup> This concern is mitigated by the fact that relatively few plaintiffs would be able to bring a successful lawsuit against their MCOs under the terms of this proposed cause of action because potential plaintiffs would need to clear several hurdles. Victims of *ex ante* MCO influence would need to realize that this new cause of action might apply to them, find lawyers willing to represent them, find proof in the MCO guidelines that they were the victims of negligent *ex ante* influence, and establish actual injury. Plaintiffs who clear these four hurdles would then be on par with those plaintiffs currently protected by state legislative responses to the ERISA preemption problem. Like plaintiffs suing under the respective state statutes, plaintiffs suing under this new cause of action would need to show that the given treatment amounted to negligence. Thus, the cause of action would not boundlessly expose MCOs to tort liability; rather, it merely would expand the pool of patients eligible to state a negligence claim against their MCOs.

A further limit on plaintiffs' abilities to succeed in lawsuits against their MCOs is the fact that MCOs have eroded the standard of care.<sup>142</sup> This erosion has made it more difficult for plaintiffs to prevail in malpractice lawsuits in general.<sup>143</sup> Since MCOs have altered the medical standard of care and therefore the legal standard of care, plaintiffs suing under this proposed cause of action will have difficulty proving that a given policy was unreasonable.

Thus, only a limited class of plaintiffs will be able to succeed in lawsuits against their MCOs under this new cause of action. This begs an important question: If few plaintiffs will be able to take advantage

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<sup>141</sup> This is a common concern raised by opponents to MCO liability reform. For example, this issue was a factor in the enactment of California's MCO liability law. The California legislature specifically tried to limit the number of people who could bring suit, by requiring that most plaintiffs first exhaust the independent review process. See *supra* note 101 and accompanying text.

<sup>142</sup> See *supra* Part II.C.

<sup>143</sup> See *supra* Part II.C.

of this proposed cause of action, how will it have any effect on the problem of the ex ante influence loophole?

Limiting the potential number of plaintiffs under the new right of action is a desirable feature of the proposal. The goal is not to expose MCOs to limitless liability, which will ultimately raise the cost of health care paid by individual patients. The proposal merely seeks to create a financial incentive to counterbalance the MCOs' current incentive to cut costs by reducing the standard of care further below the optimal level. This proposal is not expected to cure the problem of undue ex ante MCO influence; rather, it will halt the further erosion of the standard of care and, perhaps, shift the current standard back toward the optimal point.

Although it will be difficult for a patient to prove negligent ex ante influence, it will not be impossible where there is strong proof that an MCO guideline severely restricted physician autonomy and encouraged a substandard treatment. The threat of even a few large jury awards to victims of ex ante negligence will force MCOs to reconsider the way in which they implement ex ante influence. MCOs likely will recognize that a plaintiff who can clear all of the proposed cause of action's hurdles stands to receive sizeable awards from sympathetic juries. Any MCO slow to arrive at this conclusion will come around after a few painful losses.

Once MCOs come to terms with the financial threat imposed by this new cause of action, they will have two options. First, MCOs may stop issuing ex ante policy decisions altogether and solely reduce costs on an ex post basis, therefore becoming fully subject to state MCO liability statutes. It is, however, not likely that MCOs would pursue this option since it would serve to increase health care costs associated with moral hazard, demand inducement, and defensive medicine. The second option that MCOs may take is to reassess their ex ante policy decisionmaking methodology. Since MCOs will realize that they may be called into court to support the reasonableness of their protocols and guidelines, hopefully they will begin to implement only those protocols and guidelines that are supported by scientific evidence, for which any reasonable juror could see that the cost-benefit tradeoff made by the MCO was itself reasonable. If the costs of conducting extensive clinical research for each desired protocol are too burdensome, MCOs could turn to physicians for scientific input on which protocols are reasonable and which protocols unreasonably restrict physician autonomy to the detriment of patient care.<sup>144</sup> This would

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<sup>144</sup> See Clark C. Havighurst, *Vicarious Liability: Reallocating Responsibility for the Quality of Medical Care*, 26 *Am. J.L. & Med.* 7, 20 (2000) ("MCOs facing legal accounta-

also accomplish the goal of providing MCOs with a financial incentive to make more informed and balanced decisions about the guidelines and protocols they adopt.

## 2. *Preemption Is Possible, But Does Not Negate the Usefulness of the Proposal*

Objectors might argue that were state legislatures to enact this proposal, such a law would be preempted by ERISA and therefore of no use. While a relatively strong case can be made that California's MCO liability law regulates insurance and is therefore exempt from preemption under ERISA's savings clause,<sup>145</sup> it is less clear that the law proposed in this Note likely would be characterized as an insurance regulation. One could argue that the proposed law seeks to regulate insurance by policing the ability of MCOs, as insurers, to impose undue influence on physicians. Arguably, if the current state MCO liability statutes that police the ability of MCOs to alter physicians' recommendations<sup>146</sup> are held not to be preempted, the proposed law should not be preempted either.

Assuming, however, that preemption would occur does not mean that the proposal is not beneficial. If states do choose to enact such a law, not all MCO subscribers would be subject to preemption. ERISA only preempts laws relating to employee benefit plans.<sup>147</sup> Excluded from preemption are those MCO subscribers whose membership in the MCO is not employment based, as well as those whose membership is state-sponsored through Medicare or Medicaid.<sup>148</sup> Of the roughly 170 million Americans who receive their health coverage through MCOs,<sup>149</sup> more than thirty percent would not suffer preemption<sup>150</sup> and therefore could benefit from the creation of the proposed new cause of action.<sup>151</sup> Although the remaining seventy percent of MCO subscribers would be left without legal recourse

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bility for quality failings would probably find it a wise management strategy to rely upon the professionalism of their physicians, demanding and encouraging their collaborative efforts to improve patient outcomes and cure deficiencies that invite future lawsuits.")

<sup>145</sup> See supra notes 61 & 104.

<sup>146</sup> See supra notes 8-17 and accompanying text.

<sup>147</sup> 29 U.S.C. § 1144(a) (2000).

<sup>148</sup> David L. Leitner et al., *Law and Practice of Insurance Coverage Litigation* § 57.4 (2002).

<sup>149</sup> See supra note 30 and accompanying text.

<sup>150</sup> As of 2001, 124 million Americans were subscribed in MCOs governed by ERISA. S. Rep. No. 107-11, at 19 (2001).

<sup>151</sup> MCO subscribers immune to ERISA preemption could technically sue their MCOs for ex ante negligence absent a state statute authorizing the proposed cause of action. However, it is unlikely that they would succeed in such suits given the absence of common law precedent to support such a claim.

against their MCOs for ex ante negligence, these people might still benefit from the state legislation. The threat of large damage awards from the thirty percent of subscribers who are permitted to sue their MCOs for ex ante negligence might serve as an adequate deterrent for MCOs to reduce the incidence of such negligence.

Of course, for a comprehensive solution to the problem of ex ante negligence that allows *all* MCO subscribers to sue their MCOs, Congress would need to enact legislation correcting the ERISA preemption problem. Congress has tried to do so on numerous occasions by passing a patient's bill of rights, but has not yet succeeded.<sup>152</sup> Hopefully, if and when Congress passes such a bill, lawmakers will address the problem of ex ante MCO negligence and will include a cause of action similar to the one proposed in this Note.<sup>153</sup>

### CONCLUSION

California's managed care liability law and similar state statutes fully address the problem of ex post MCO influence. Ideally, these statutes will survive all preemption challenges and analogous statutes will be passed in the remaining states. Under these conditions, a good portion of the damage wrought by ERISA will be remedied. However, statutory solutions that ignore ex ante MCO influence leave open a tremendous loophole, permitting MCOs to continue to exert undue pressure on physicians by shifting their influence from ex post to ex ante. To fully address the problem of ERISA preemption, a new cause of action must be created to close the ex ante loophole.

The cause of action advocated in this Note seeks to impose a countervailing interest for MCO policymakers, thus providing an incentive for decisionmakers to make informed and balanced decisions concerning the implementation of treatment guidelines and protocols. The goal of this proposal is to permit MCOs to continue eliminating undesirable health care costs, while making sure that the standard of care erodes no further due to MCO profit-seeking at the expense of patient welfare.

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<sup>152</sup> See 147 Cong. Rec. S6463-6464 (daily ed. June 20, 2001) (statement of Sen. Kennedy) ([T]his is not a new legislative proposal. We have had very extensive debates on the provisions which are included in the Patients' Bill of Rights. We have had good debates on the provisions when we passed the Frist bill about 2 years ago. And we had additional kinds of debates when we took up the Norwood-Dingell bill a little over a year ago . . . . They are matters that have been discussed repeatedly in this Chamber by a number of us over a very considerable period of time.); see also *supra* note 7.

<sup>153</sup> Unfortunately, the most recent congressional proposal, introduced on February 5, 2003, wholly ignores the problem. See Patient Protection Act, H.R. 597, 108th Cong. (2003).

Hopefully either Congress or state lawmakers will realize that the current state legislative responses to the ERISA preemption problem are inadequate and will respond by enacting legislation addressing ex ante MCO influence. While a congressional enactment surely would avoid ERISA preemption, state legislative solutions might be preempted. This risk, however, should not dissuade state legislators from amending the current crop of MCO liability statutes. Even if the state legislative solutions are held to be preempted, MCOs still will face lawsuits brought by the thirty percent of MCO subscribers immune to ERISA liability. This increase in liability exposure will force the MCOs to embark on the path towards the optimal standard of care.

