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THE TEXAS HEALTH CARE LIABILITY ACT: TEXAS IS THE FIRST STATE TO LISTEN TO THE CONCERNS OF ITS HEALTH CARE CONSUMERS, BUT HOW MUCH HAS IT HEARD?

*Kristin M. McCabe**

INTRODUCTION

In 1989, several months after becoming pregnant, Florence Corcoran was ordered to bed rest until she delivered her baby.¹ When her physician subsequently determined that the pregnancy was at high risk and the fetus required constant monitoring, he ordered her hospitalized.² Because Mrs. Corcoran's insurance plan mandated advance approval for overnight monitoring at a hospital, her hospitalization was presented to the party responsible for making such determinations.³ When the responsible party denied certification, Mrs. Corcoran was forced to return home where she later miscarried.⁴ Mr. and Mrs. Corcoran filed suit against the insurance company and the medical review organization, seeking damages for the wrongful death of their child, but the United States Court of Appeals for the Fifth Circuit found the claims to be pre-empted by the Employee Retirement Income Security Act (ERISA).⁵ The Corcorans were left without a remedy against the responsible parties.

In contrast, when Darryl Dukes attempted to obtain post-operative blood tests on the orders of his doctor, the hospital rejected his pre-

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1. *See Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1322 (5th Cir. 1992).

2. *See id.* at 1322-23.

3. *See id.* at 1324.

4. *See id.*

5. *See id.* at 1331-35.

scription for the laboratory tests; Mr. Dukes did not obtain these tests until a day later, at which time his condition had already worsened.⁶ Dukes later died, the level of sugar in his blood at the time of his death was extremely high.⁷ Mrs. Dukes filed suit, seeking to hold the health maintenance organization (HMO), among others, liable for failing to exercise reasonable care in selecting and monitoring its medical personnel.⁸ Unlike the Corcorans, who were left without a remedy, the United States Court of Appeals for the Third Circuit granted Mrs. Dukes, at a minimum, access to a remedy when it held ERISA did not pre-empt her claims.⁹

The lawsuits brought by the Corcorans and Mrs. Dukes are just two of the many cases health plan participants have brought against their insurance companies within the last ten years, in efforts to gain some measure of protection and remedy against managed care entities.¹⁰ The mistrust and skepticism by health care consumers of the managed care system is evidenced in a survey conducted by the Kaiser Foundation and Harvard University.¹¹ The survey revealed that seventy-eight percent of participants favored requiring health plans and insurers to provide more consumer protections.¹² The survey also indicated that the

6. See *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 352 (3rd Cir. 1995).

7. See *id.*

8. See *id.*

9. See *id.* at 356.

10. See cases discussed *infra* Part I. C.

11. See American Political Network, Vol. 6, Sept. 17, 1998.

12. See *id.* In addition, The Commonwealth Fund Survey of Patient Experiences with Managed Care conducted in 1994, revealed that of those health care consumers who were enrolled in employer-provided health insurance and had an option of enrolling in a managed care plan had higher levels of dissatisfaction and lower quality of care than those enrolled in plans with services paid for by insurance companies. See *Managed Care Quality: Hearing Before the Subcomm. on Health and Environment of the House Comm. on Commerce*, 105th Cong. 67 (1998) (statement of Karen Davis, President, The Commonwealth Fund). A greater number of patients with managed care found the quality of services and physicians to be worse than those not in managed care organizations. See *id.* A 1997 poll of 1,000 Americans revealed that seventy-four percent were concerned that managed care plans often delayed or denied treatment to patients. See *Managed Care Quality: Hearing Before the Subcomm. on Health and Environment of the House Comm. On Commerce*, 105th Cong. 108 (1998) (statement of David E. Herbert on behalf of The Patient Access to Responsible Care Alliance). Furthermore, this poll showed that eighty-

prevalent issue on the minds of American voters during 1998 mid-term elections was the regulation of HMOs and other health plans.¹³ Forty-two percent of respondents characterized HMOs as "bad."¹⁴ A desire to gain more regulation and control over the managed care system also was apparent.¹⁵ In a similar survey conducted by *CNN* and *Time*, sixty-three percent of the respondents stated they favored the right to sue health plans.¹⁶

Despite a strong desire to sue health plans over medical treatment decisions made by managed care entities, many health plan members find themselves encountering problems similar to the Corcorans.¹⁷ Texas legislators listened to its citizens¹⁸ by enacting the Texas Health Care Liability Act (Act) in 1997.¹⁹ One year later, the United States District Court for the Southern District of Texas partially upheld the protection granted to health plan members by ruling that enrollees could sue their HMOs for its health care treatment decisions.²⁰ Although the court's decision permitted a health plan member to sue his

nine percent favored the passage of congressional legislation allowing health care consumers to appeal the decisions of the managed care organization. *See id.*

13. *See* American Political Network, Vol. 6, Sept. 17, 1998.

14. *See id.*; *see also* Barbara A. Noah, *The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment*, 48 MERCER L. REV. 1219, 1220 (1997) (stating that most Americans view the care provided by managed care entities as inferior to care rendered by traditional means).

15. *See* American Political Network, *supra* note 13. Fifty-four percent of the respondents stated that they would support giving health plan members the right to sue their health plans, even if such regulation would result in increased costs. *See id.*

16. *See* American Political Network, Vol. 6, July 7, 1998.

17. *See* cases discussed *infra* Part I C.

18. *See Texas: HMOs Would Be Liable for Negligent Decisions Under Proposed Legislation*, 6 HEALTH L. REP. (BNA) 6, at d26 (Feb. 6, 1997).

19. TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-88.003 (West 1998).

20. *See* *Corporate Health Ins., Inc. v. Texas Dep't of Insurance*, 12 F. Supp. 2d 597 (S.D. Tex. 1998). Note that both the plaintiffs and the state have filed notices of appeal with respect to the decision issued by the United States District Court for the Southern District of Texas. *See* Wayne J. Guglielmo, *A Court Muddies the Water for HMO Liability*, MEDICAL ECONOMICS, Jan. 11, 1999, at 41. Many anticipate that this case will eventually be heard by the United States Supreme Court. *See* Karen Foerstel, *Texas' HMO Liability Law: The Jury is Still Out*, 57 CONG. Q. 381, 384 (1999).

or her HMO for damages under the Act resulting from the quality of medical care, it also held that a legal claim based upon a denial of a benefit could not be brought under the Act.²¹ The question thus remains as to how much protection health care consumers in Texas truly have been afforded, compared to how much protection they truly want.

This Note is generally concerned with the status of ERISA pre-emption and medical malpractice claims in Texas as a result of the Texas Health Care Liability Act. Part I examines the shield protecting the HMOs, beginning with a focus upon the structure of an HMO. Next, this Note examines ERISA and how HMOs have used the federal law as a source of immunity. The Note then discusses various court decisions on the issue of HMO liability based on claims addressing the quality of care or the quantity of benefits rendered by the HMO. Part II of the Note analyzes how the Act subjects managed care entities to liability for the medical treatment decisions they make. This discussion will also examine the district court's holding in *Corporate Health Ins. Inc. v. Texas Dep't of Ins.*²² where a managed care entity sought a declaration that ERISA pre-empt s the Act. In addition, this Note parses the facts of the first case filed against an HMO under the Act. Finally, Part III explores the effects that the Act and the decision upholding the Act may have on affording protection to health care consumers and predicts the likely outcome of the first case brought under the Act. The Note concludes by suggesting that Texas health care consumers have not received the protections they have demanded.

I. THE SHIELD OF PROTECTION FOR THE HMO

A. The Structure of the HMO

The liability that may be imposed upon a managed care²³ entity²⁴

21. See *Corporate Health Ins., Inc.*, 12 F. Supp. 2d at 597.

22. 12 F. Supp. 2d 597 (S.D. Tex. 1998).

23. See Denise Chan, *ERISA Pre-emption: Immunity for HMOS*, 98 U. ILL. L. REV. 199, 200 (1998) (stating that managed care "refers to the incorporation of various administrative procedures to limit consumption of health care.").

24. See Amy K. Fehn, *Are We Protected From HMO Negligence?: An Examination of Ohio Law, ERISA Pre-emption, and Legislative Initiatives*, 30 AKRON L. REV. 501, 505 (1997) ("A managed health care organization is a general term used to define any healthcare insurer which seeks to 'manage' the health care decisions of its patient/insured and physician/provider."). The

for its decisions is closely connected to the type of entity to which that member belongs.²⁵ The HMO,²⁶ one of the various types of managed care organizations,²⁷ became increasingly prevalent within the health care industry between 1970 and 1990.²⁸ During that time, enrollment in HMOs grew from approximately 3.6 million persons to more than thirty-five million.²⁹ As of 1996, approximately sixty million Americans were enrolled in HMOs.³⁰ More recently, enrollment in managed

managed health care system and organization is in contrast to the traditional "fee-for-service" model, in which the insurer does not take part in the decision process regarding medical treatment for the patient. *See id.*

25. See William A. Chittenden, III, *Malpractice Liability and Managed Health Care: History and Prognosis*, 26 TORT & INS. L.J. 451, 452 (1991); Noah, *supra* note 14, at 1223.

26. The typical HMO commonly falls into one of three categories. *See* Chittenden, *supra* note 25, at 452-53. An HMO may be characterized as a "staff model," in which the HMO employs its own physicians, pays the salaries of these physicians and often owns or leases the health care facilities in which the treatment by these physicians is rendered. *See id.* at 452; Chan, *supra* note 23, at 203. Secondly, the "Independent Practice Association" (IPA) model-HMO typically contracts with a specific association of physicians; the physician members of this association render treatment to the HMO enrollees while also dedicating a portion of their practice to patients who are not enrollees in that particular HMO. *See* Chittenden, *supra* note 25, at 452; Chan, *supra* note 23, at 203. Finally, in the group model HMO, the HMO will often contract with individual medical groups, which may also treat non-HMO enrollees, to provide treatment for the HMO members. *See* Chittenden, *supra* note 25, at 452; Chan, *supra* note 23, at 203.

27. *See* Chan, *supra* note 23, at 200. Other managed care organizations include preferred provider organizations (PPOs) and private insurance plans that utilize specific structures to control the distribution of services. *See id.*

28. *See* Ryan Steven Johnson, *ERISA Doctor in the House? The Duty to Disclose Physician Incentives to Limit Health Care*, 82 MINN. L. REV. 1631, 1638 (1998).

29. *See id.* at 1638.

30. *See id.*; Amy Stoeckl, *Refusing to Follow Doctor's Orders: Texas Takes the First Step in Holding HMOs Liable for Bad Medical Decisions*, 18 N. ILL. U. L. REV. 387, 389 (1998) (stating that because of the increased cost of medical care, the number of managed care organizations has simultaneously increased with approximately 150 million people enrolled in such organizations). Other estimates have the number of people enrolled in ERISA plans at 124 million. *See* Karen A. Jordan, *Pre-emption of a State "Legislatively Created" Right to Sue HMOs for Negligence*, HEALTH CARE LAW MONTHLY, April 1999, at 13. Central to the purpose behind the implementation and increase in

care organizations continues to increase.³¹ Approximately seventy-three percent of Americans are enrolled in such organizations.³²

The transition from the traditional fee-for-service model³³ of health care not only changed the way patients receive health care, but also changed the physician's role in rendering treatment.³⁴ Specifically, under HMOs, patients have lost the freedom to choose a physician.³⁵ At the same time, physicians have lost the freedom to choose which treatments to render and to control the cost of those treatments.³⁶ The

HMOs and other managed care organizations is the effort to restrict or contain the costs associated with the delivery of health care and medical treatment. *See Fehn, supra* note 24, at 505. The HMO's cost reduction elements are why many HMOs are facing lawsuits. *See id.* Specifically, in an effort to contain health care costs, many HMOs rely on methods such as utilization review, gatekeeping and physician incentives. *See id.* Utilization review requires that a treating physician submit the recommended treatment for review; and the HMO determines whether such treatment is proper and necessary. *See Chan, supra* note 23, at 204; *see Fehn, supra* note 24, at 505. The process of gatekeeping involves primary care physicians who decide when more advanced medical care is necessary. *See id.* at 506. These primary care physicians are often subject to financial incentives implemented by the HMO to keep the level of medical services to a minimum. *See id.* at 507. However, the efforts to contain the costs associated with health care may result in medical services not being rendered to a deserving patient in an effort to save money; this may have dire and legal consequences for the managed care organization. *See Chan, supra* note 23, at 205.

31. *See Johnson, supra* note 28, at 1638.

32. *See id.* Furthermore, approximately sixty percent of American physicians have contracted with HMOs to provide medical services. *See id.*

33. The "fee-for-service" model involves the doctors receiving compensation from the insurer after the service has been rendered to the patient. *See id.* at 1635, n. 26.

34. *See id.* at 1635.

35. *See id.*

36. *See id.* HMOs are both paying for the medical care and becoming managers of the medical care. *See Angela M. Easley, A Call to Congress to Amend ERISA Pre-emption of HMO Medical Malpractice Claims: The Dissatisfactory Distinction Between Quality and Quantity of Care*, 20 CAMPBELL L. REV. 293, 314 (1998). The general concept behind the HMO places the plan in a dual role of acting as both the insurer and the health care provider. *See Noah, supra* note 14, at 1223. Specifically, one who enrolls in an HMO pays a fee in exchange for primary care and acute care for a specific period of time. *See id.* This fee is set and does not vary with the amount of services that the enrollee may receive during that period. *See id.* The treatment to the enrolled patient is

loss of the active roles for both the patient and the physician reflects the rationing of health care that often causes patients to become critical of the managed care organization system.³⁷ In addition, because managed care organizations have entered into the arena of medical decision-making, the question arises whether an HMO should be held liable when its decisions affect the treatment a patient receives.³⁸

B. ERISA Pre-emption Protection

Congress enacted ERISA in 1974 to protect employees from abusive tactics in the management of employee pension plans.³⁹ Until ERISA, such abusive tactics included inadequate minimum standards, insufficient funds from which employee benefits could be paid, and the termination of a plan prior to the accumulation of funds.⁴⁰ Although ERISA applies to the maintenance of employee benefit plans and imposes standards and obligations on those plans, it does not require employers to implement such benefit plans.⁴¹ ERISA's stated purpose was "to protect employees by requiring disclosure and reporting, setting forth standards of conduct for fiduciaries, requiring vesting of benefits, setting minimum standards of funding, and requiring plan termination insurance."⁴² ERISA permits an employee to bring suit against an employee benefit plan and allows the federal government to regulate and oversee these plans.⁴³

Congress' desire to provide uniform regulation and close monitoring of employee benefit plans is clearly evident in the pre-emption

rendered by a physician or other health care entity that has contracted with that particular HMO to provide care. *See id.*

37. *See* Michelle M. Kwon, *Move Over Marcus Welby, M.D. and Make Way for Managed Care: The Implications of Capitation, Gag Clauses, and Economic Credentialing*, 28 TEX. TECH. L. REV. 829, 830-31 (1997). Some critics of this rationing of health care argue that it is in direct contrast to the health care system. *See id.* at 831.

38. *See* Chan, *supra* note 23, at 205.

39. *See id.* at 207.

40. *See* L. Frank Coan, Jr., *You Can't Get There From Here — Questioning the Erosion of ERISA Pre-emption in Medical Malpractice Actions Against HMOs*, 30 GA. L. REV. 1023, 1037 (1996).

41. *See id.* at 1037-38.

42. Chan, *supra* note 23, at 208.

43. *See* Coan, *supra* note 36, at 1037-38.

provision.⁴⁴ The statute provides that ERISA "shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan . . ."⁴⁵ In order to determine whether ERISA pre-empts a state law, a court must conduct a two-step inquiry.⁴⁶ First, the court must determine whether the specific plan under attack by the employee is an employee benefit plan, thus rendering ERISA applicable to the matter.⁴⁷ If the court determines that an ERISA plan is at issue, the second inquiry is whether the cause of action brought before the court "relate[s] to" that employee benefit plan as defined by ERISA.⁴⁸

Regarding the first prong of the ERISA analysis, ERISA defines an employee welfare benefit plan, which includes health benefits plans, as:

any plan, fund, or program which was heretofore or is hereinafter established or maintained by an employer or by an employee organization, or by both to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability . . .⁴⁹

In essence, this inquiry involves determining whether "from the surrounding circumstances a reasonable person can ascertain the intended benefits, class of beneficiaries, the source of financing, and the procedures for receiving benefits."⁵⁰ Further, the court must determine whether that particular plan is part of an employment relationship by examining how much participation the employer has on the imple-

44. See *id.* at 1038.

45. *Corporate Health*, 12 F. Supp. 2d at 607 (citing 29 U.S.C.A. § 1144(a) (West 1985)).

46. See Coan, *supra* note 40, at 1038; The *Corporate Health Insurance* court followed this two-step process in evaluating whether ERISA pre-empts the Act. See *Corporate Health*, 12 F. Supp. 2d at 608-612.

47. See *Corporate Health*, 12 F. Supp. 2d at 608; Coan, *supra* note 40, at 1038.

48. See *Corporate Health*, 12 F. Supp. 2d at 610; Coan, *supra* note 40, at 1038.

49. *Corporate Health*, 12 F. Supp. 2d at 608 (citing 29 U.S.C.A. § 1002(1) (West Supp. 1998)).

50. *Id.* (quoting *Donovan v. Dillingham*, 688 F.2d 1367, 1371, 1373 (11th Cir. 1982)).

mentation and management of the benefit plan.⁵¹

The United States District Court for the Southern District of Texas, in evaluating ERISA's application to the Act, noted a comprehensive analysis for the first prong of the pre-emption test subsequently used by the Fifth Circuit.⁵² The test required an examination of whether a plan: "(1) exists; (2) falls within the safe-harbor provision established by the Department of Labor (DoL); and (3) satisfies the primary elements of an ERISA 'employee benefit plan' – establishment or maintenance by an employer intending to benefit employees."⁵³ If the court finds that any of these requirements are not met, the plan does not fall within ERISA's provisions.⁵⁴ In making this analysis, the court must examine the statutory language, Congress' intent in enacting this language, and any interpretation by the DoL.⁵⁵

The second prong of the pre-emption analysis entails examining whether the state law relates to the ERISA plan.⁵⁶ Specifically, the court must look to whether the state law is connected with or references the plan at issue.⁵⁷ ERISA pre-emption may occur even though the state law does not directly affect or make specific reference to the plan at issue.⁵⁸

In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers' Ins. Co.*,⁵⁹ the United States Supreme Court addressed the approach required to evaluate whether a state law relates to an ERISA plan for pre-emption purposes.⁶⁰ The Court noted that because the language of ERISA was not helpful in determining its meaning, it must look to Congress' objectives and intentions to determine whether a state law relates to a plan.⁶¹ The *Travelers'* Court stated Congress'

51. *See id.* (quoting *Peckham v. Gem State Mut. of Utah*, 964 F.2d 1043, 1049 (10th Cir. 1992)).

52. *See id.* (citing *In Meredith v. Time Ins. Co.*, 980 F.2d 352, 355 (5th Cir. 1993)).

53. *Id.*

54. *See Corporate Health*, 12 F. Supp. 2d at 610.

55. *See id.*

56. *See id.*

57. *See id.* (citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983)).

58. *See id.* (quoting *CIGNA Healthplan of La., Inc. v. Louisiana*, 82 F.3d 642, 647 (5th Cir. 1996)).

59. 514 U.S. 645 (1995).

60. *See id.*

61. *See Corporate Health*, 12 F. Supp. 2d at 611 (citing *New York State*

objective was to assure that employers would not be subject to conflicting or non-uniform state regulations.⁶²

Whether a plaintiff's claim can survive ERISA pre-emption depends largely on the type of action or the theory of liability on which the case is brought.⁶³ Traditionally, plaintiffs have sought to hold HMOs liable for medical malpractice under two broad theories:⁶⁴ (1) negligence of their medical personnel under *respondeat superior* or "ostensible agency" (if a patient receives care under the belief he or she is receiving that care from the HMO),⁶⁵ or (2) HMOs negligence resting upon the plan's cost-containment mechanisms (such as utilization review or the use of financial incentives to keep the level of treatment to a minimum).⁶⁶

C. The Issue of ERISA Pre-emption Before the Courts

Plaintiffs often bring medical malpractice actions alleging the HMO's actions caused injury.⁶⁷ Court decisions focus on the precise type of medical malpractice theory to answer the threshold question of whether ERISA pre-empt s the claims of HMO members.⁶⁸ In particular, malpractice claims will center upon the quality of care the HMO

Conference of Blue Cross & Blue Shield Plans v. Travelers' Ins. Co., 514 U.S. 645, 654-57 (1993)).

62. See *id.* (citing New York State Conference of Blue Cross & Blue Shield Plans v. Travelers' Ins. Co., 514 U.S. 645, 656 (1993)). In essence, "[t]he basic thrust of . . . [ERISA's] pre-emption clause . . . was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Id.* at 611 (citation omitted). The ERISA provision that requires pre-emption of the state law relates to a plan that is not entirely expansive. Congress did not remove the initial presumption when analyzing a pre-emption question, namely that state law is traditionally left to the state's control. See *id.* (citing *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813 (1997) (citations omitted)).

63. See Fehn, *supra* note 24, at 518.

64. See Chan, *supra* note 23, at 205-207. For a detailed discussion of the theories of direct and vicarious liability for managed care organizations, see Corrine P. Parver & Kimberly Alyson Martinez, *Holding Decision Makers Liable: Assessing Liability Under a Managed Care System*, 50 ADMIN. L. REV. 199, 207-24 (1999).

65. See Chan, *supra* note 23, at 205-207.

66. See Chittenden, *supra* note 25, at 487.

67. See cases discussed *infra* I. C.

68. See Chan, *supra* note 23, at 217.

member received or the benefit denied by the HMO.⁶⁹ If the court determines the claim is based upon the alleged negligence of the HMO in denying access to benefits, it often will not survive ERISA pre-emption.⁷⁰ On the other hand, if it is based upon the alleged negligence of the HMO with respect to the quality of medical care given to the HMO member, the claim is more likely to survive.⁷¹

The actions brought by the Corcorans and Mrs. Dukes with respect to the alleged malpractice of their respective insurers received very different treatment by the courts.⁷² These cases illustrate the distinction between claims alleging negligence in quality of care and those alleging negligence in the administration of benefits.⁷³ Courts addressing medical malpractice claims based upon the denial of benefits generally have held such claims to be related to the employee benefit plan and, therefore, pre-empted by ERISA.⁷⁴ The *Corcoran* case is particularly illustrative of this distinction.⁷⁵ This action was brought by the parents of a deceased unborn child.⁷⁶ The benefit plan to which Mrs. Corcoran belonged implemented utilization review, a cost-containment mechanism,⁷⁷ and the party conducting the review found

69. *See id.*

70. *See id.*; Parver & Martinez, *supra* note 64, at 227-31 (discussing the pre-emption of claims based on coverage decisions and those based on the quality of care rendered).

71. *See* Chan, *supra* note 23, at 217; *see* cases discussed *infra* I. C.

72. *See* Dukes v. U.S. Healthcare, Inc., 57 F.3d 350 (3rd Cir. 1995); Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992); Chan, *supra* note 23, at 217-24.

73. *See* Dukes, 57 F.3d at 350; Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992); Chan, *supra* note 23, at 217-24.

74. *See* Corcoran, 965 F.2d at 1321; Lancaster v. Kaiser Found. Health Plan of Mid-Atlantic States, Inc., 958 F. Supp. 1137 (E.D. Va. 1997); Rodriguez v. Pacificare of Texas, Inc., 980 F.2d 1014 (5th Cir. 1993); Andrews-Clarke v. Travelers' Ins. Co., 984 F. Supp. 49 (D. Mass. 1997).

75. *See* Chan, *supra* note 23, at 217 (also noting that *Corcoran* is the leading case in this genre of cases).

76. *See* Corcoran, 965 F.2d at 1324.

77. Utilization review consists of "external evaluations that are based on established clinical criteria and are conducted by third party payors, purchasers, or health care organizers to evaluate the appropriateness of an episode, or series of episodes, of medical care." *Id.* at 1323 (quoting Blum, *An Analysis of Legal Liability in Health Care Utilization Review and Case Management*, 26 HOUS. L. REV. 191, 192-93 (1989)).

that hospitalization was not medically necessary.⁷⁸ The pregnant Mrs. Corcoran returned home and days later, she and her husband lost their child.⁷⁹

The Corcorans filed suit against Blue Cross and Blue Shield of Alabama, which administered Mrs. Corcoran's benefit plan, and United Healthcare, the utilization review entity.⁸⁰ The district court granted the defendants' motions for summary judgment, holding ERISA pre-empted the Corcorans' state law claims which related to the employee benefit plan at issue.⁸¹

On appeal, the Fifth Circuit was presented with the issue of whether the plaintiffs could obtain relief under either state law or ERISA.⁸² The Court of Appeals focused upon both Congress' intent in enacting ERISA and the express language of the statute.⁸³ United Healthcare argued for ERISA pre-emption because the utilization review was simply a determination regarding benefits due under the plan.⁸⁴ The Corcorans argued that United Healthcare made an improper medical decision rather than an administrative benefits determination.⁸⁵ The court assessed both parties' arguments and concluded that "United makes medical decisions – indeed, United gives medical advice – but it does so in the context of making a determination about the availability of benefits under the plan."⁸⁶ Accordingly, the court held that ERISA pre-empted the state action brought by the Corcorans.⁸⁷

In reaching its holding, however, the court noted that the utilization review process, as described in the benefit plan booklet, lends some support to the claim that United Healthcare does make medical deci-

78. *See Corcoran*, 965 F.2d at 1324.

79. *See id.*

80. *See id.*

81. *See id.* at 1325.

82. *See id.* at 1326. On appeal, the plaintiffs only challenged the district court's findings with respect to United Healthcare; the claims against United Healthcare alleged that the HMO wrongfully denied medical care recommended by their physician and wrongfully found that home care presented sufficient treatment. *See id.*

83. *See Corcoran*, 965 F.2d at 1328-29.

84. *See id.* at 1329.

85. *See id.* at 1330.

86. *See id.* at 1331.

87. *See id.*

sions.⁸⁸ The court recognized the possibility that United Healthcare by its actions did in fact make medical judgments.⁸⁹ It noted the system of prospective decision-making, in which the beneficiary is likely to refuse treatment based upon the insurer's refusal to pay for the treatment, is very different from the traditional retrospective review process.⁹⁰ The court declared that when United Healthcare performed its utilization review, it made a medical recommendation.⁹¹ Nonetheless, although it recognized that the process implemented by United Healthcare involved medical decisions, the court was not willing to acknowledge that United did not make any benefits determinations.⁹²

Although United Healthcare made medical judgments, the *Corcoran* court declared that it did so in the process of deciding what benefits were available to the members under that particular plan.⁹³ Furthermore, the court recognized the potential implications if it were to hold United subject to state liability laws.⁹⁴ The court noted that forcing insurers to comply with different state utilization review standards would drive up the costs associated with such reviews, thus decreasing the funds available to plan participants.⁹⁵ Finally, the court acknowledged that the fact there is no remedy available cannot affect its interpretation of ERISA.⁹⁶

Other courts have followed the distinction drawn between the administration of benefits, the rendering of medical decisions, and quality of care.⁹⁷ In *Lancaster v. Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.*,⁹⁸ the United States District Court for the Eastern District of Virginia faced the issue of whether medical malpractice claims stemming from an HMO's use of financial incentives⁹⁹ for phy-

88. *See id.*

89. *See Corcoran*, 965 F.2d at 1331.

90. *See id.* at 1331-32.

91. *See id.*

92. *See id.* at 1332.

93. *See id.*

94. *See Corcoran*, 965 F.2d at 1333.

95. *See id.*

96. *See id.*

97. *See Lancaster v. Kaiser Found. Health Plan of Mid-Atlantic States, Inc.*, 958 F. Supp. 1137 (E.D. Va. 1997); *Rodriguez v. Pacificare of Texas, Inc.*, 980 F.2d 1014 (5th Cir. 1993); *Andrews-Clarke v. Travelers' Ins. Co.*, 984 F. Supp. 49 (D. Mass. 1997).

98. 958 F. Supp. 1137 (E.D. Va. 1997).

99. In this case, financial incentive programs involved programs where the

sicians were pre-empted by ERISA.¹⁰⁰ The minor plaintiff, who suffered from recurring headaches, was placed on pain medication.¹⁰¹ The doctors, who were employees of the corporation that was contracted by Kaiser, failed to order any diagnostic tests, such as a magnetic resonance image (MRI).¹⁰² Four years later, an MRI revealed a tumor had invaded over forty percent of Paige Lancaster's brain.¹⁰³ Among other counts and allegations,¹⁰⁴ Paige's mother, individually and on behalf of her daughter, alleged Kaiser was negligent in its implementation of the financial incentive program.¹⁰⁵

The *Lancaster* court, in addressing whether ERISA pre-empted consideration of the incentive program, noted that the financial incentive program was very similar to pre-certification and utilization review requirements.¹⁰⁶ It found the financial incentive program affected the quantity of benefits given to a beneficiary.¹⁰⁷ Accordingly, the court held that ERISA pre-empted the claims against Kaiser stemming from the incentive program.¹⁰⁸

Regarding the pre-emption of claims involving the quantity or administration of benefits to a beneficiary, the Fifth Circuit, in *Rodriguez v. Pacificare of Texas, Inc.*,¹⁰⁹ addressed the claims of a plan member when his HMO denied a referral¹¹⁰ to an orthopedic

physicians allegedly received bonus money if they did not utilize excessive treatments and tests. See *Lancaster*, 958 F. Supp. at 1140.

100. See *id.* at 1140-41.

101. See *id.* at 1139-40.

102. See *id.* at 1139-40.

103. See *id.* at 1140.

104. Plaintiffs' complaint contained five counts: Counts I and II alleged that the doctors deviated from the accepted standard of care and did not act as reasonably prudent physicians. Counts III and IV alleged that Kaiser and the physicians' corporation were liable under a theory of vicarious liability and direct liability for the financial incentive policies. Count V alleged that each defendant made material misrepresentations to the plaintiff when, while they were using this incentive program, the doctors represented to the plaintiff that she was receiving quality care. See *id.* at 1141.

105. See *Lancaster*, 958 F. Supp. at 1146.

106. See *id.* at 1147.

107. See *id.* The Court also noted that such program could affect the quality of benefits. See *id.*

108. See *id.* at 1148.

109. 980 F.2d 1014.

110. Pacificare, the HMO, required referral letters before reimbursing pa-

specialist.¹¹¹ The plaintiff alleged the HMO did not provide prompt and adequate care and coverage.¹¹² In assessing his claims, the court noted that ERISA pre-empted the state law claims against the HMO because they were largely connected to the plaintiff's problem in handling medical claims and were thus related to an employee benefit plan.¹¹³

The United States District Court for Massachusetts also scrutinized the utilization review processes in *Andrews-Clarke v. Travelers' Ins. Co.*¹¹⁴ In this case, a Travelers' insurance policy beneficiary was denied coverage for a thirty-day inpatient alcohol rehabilitation program.¹¹⁵ The beneficiary, after a series of drinking binges and suicide attempts, eventually killed himself.¹¹⁶ Although the court noted that the decedent died as a result of the failure to pre-approve the needed treatment, it still held that ERISA pre-empted the state law claims because they stemmed from the alleged improper processing of the claims for benefits.¹¹⁷ The court recognized, however, that Congress should amend ERISA and consider the recent changes in health care.¹¹⁸

When the issue centers upon the quality of medical care that the enrollee receives, courts have reached a different result from the cases involving the quantity of benefits.¹¹⁹ The decision rendered by the Third Circuit in *Dukes v. U.S. Healthcare, Inc.*¹²⁰ is particularly indicative of how some courts deal with ERISA pre-emption regarding the quality of medical care.¹²¹ In *Dukes*, the court examined ERISA pre-emption when it consolidated two cases involving medical treatment resulting in the deaths of beneficiaries.¹²² A primary care physi-

tients for treatment from a specialist. *See id.* at 1016.

111. *See id.*

112. *See id.*

113. *See id.* at 1017.

114. 984 F. Supp. 49.

115. *See id.* at 51-53.

116. *See id.*

117. *See id.* at 52, 54.

118. *See id.* at 53.

119. *See Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3rd Cir. 1995); *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Bauman v. U.S. Healthcare, Inc.*, 1 F. Supp. 2d 420 (D. N.J. 1998).

120. 57 F.3d 350 (3rd Cir. 1995).

121. *See Chan, supra* note 23, at 221.

122. *See Dukes*, 57 F.3d at 352-53.

cian ordered blood studies for Darryl Dukes,¹²³ but when he presented the prescription to a hospital, the hospital refused to perform such tests.¹²⁴ After another doctor subsequently ordered the tests, the hospital finally performed them, but not before Dukes' condition had already worsened.¹²⁵ He eventually died and final tests indicated an abnormal blood sugar level.¹²⁶ Dukes' wife sued the HMO under the theories of agency and direct negligence of the HMO by failing to monitor medical personnel.¹²⁷ The other claim addressed by the *Dukes* court involved a stillborn child.¹²⁸ Linda Visconti's obstetrician allegedly failed to recognize typical symptoms of pre-eclampsia during her pregnancy.¹²⁹ The Viscontis received HMO-provided health care and sued the HMO, based on theories similar to Mrs. Dukes'.¹³⁰

Both claims alleged the quality of care and benefits were improper.¹³¹ The plaintiffs did not complain about the HMO's failure to provide certain benefits under the plans¹³² but rather, "complain[ed] about the low quality of the medical treatment that they actually received and argued that the U.S. Healthcare HMO should be liable under agency and negligence principles."¹³³ The court noted Congress' concern in enacting ERISA was essentially the administration and payment of benefits.¹³⁴ The legislative history of ERISA does not indicate Congress' intent to assure quality of care.¹³⁵ Accordingly, the court held ERISA did not pre-empt such claims.¹³⁶ However, the court recognized that the distinction between the quality and quantity of care will not always be clear, particularly in cases involving health services.¹³⁷

123. *See id.* at 352.

124. *See id.*

125. *See id.*

126. *See id.*

127. *See id.*

128. *See Dukes*, 57 F.3d at 353.

129. *See id.*

130. *See id.*

131. *See id.* at 355.

132. *See id.* at 356-57.

133. *Dukes*, 57 F.3d at 357.

134. *See id.*

135. *See id.*

136. *See id.* at 356.

137. *See id.* at 358.

The *Dukes* court distinguished *Corcoran*,¹³⁸ noting that the HMO in *Corcoran* did not provide for, supervise, or monitor the physicians, and was only responsible for the utilization review, an administrative function.¹³⁹ By contrast, the HMO in *Dukes* was responsible for arranging and providing medical treatment.¹⁴⁰ The plaintiffs in *Dukes* did not allege they were denied benefits, and only sought to hold the HMO liable as the arranger and provider of the treatment, thus affording a remedy for the wrong.¹⁴¹

II. TEXAS LISTENS TO THE CONCERNS OF ITS HEALTH CARE CONSUMERS

A. *The Texas Health Care Liability Act*

In May 1997, Texas became the first state to allow patients to sue their HMOs for medical malpractice.¹⁴² Members of the Senate Interim Committee on Managed Care and Consumer Protections introduced Texas Senate Bill 386 on January 30, 1997.¹⁴³ The legislation was part of a package of six bills¹⁴⁴ generated by the Committee's rec-

138. See *Dukes*, 57 F.3d at 359-361.

139. See *id.* at 360-61.

140. See *id.* at 356-61.

141. See *id.* at 361.

142. See Sarah Lunday, *Suicide Victim's Family Sues HMO Under New Texas Law*, FT. WORTH STAR-TELEGRAM, Oct. 20, 1998, at 1; see Stoeckl, *supra* note 30, at 399 (stating that Texas became the first state to change the protection that HMOs had previously enjoyed). Efforts to enact and pass the legislation were successful because of a number of publicized managed care scandals that occurred in Texas. See Bob Carlson, *Managed Care Reform: How Texas Pulled Off What Washington Can't*, MANAGED CARE, Feb. 1999, at 23. A similar version of the Act entitled the Texas Medical Association's Patient Protection Act was vetoed by Governor George W. Bush in 1995. See *id.*

143. See *Texas: HMOs Would be Liable for Negligent Decisions Under Proposed Legislation*, 6 HEALTH L. REP. (BNA) 6, at d26 (Feb. 6, 1997).

144. Although the five other bills are not pertinent to this Note, they included the removal of "gag clauses" which prohibit a doctor from informing his or her patient of the following: all treatment options, the implementation of a standardized utilization review procedure, the prohibition of retaliation against preferred provider organizations; an increase in the surplus requirement for HMO basic service, and the use of a rating system by consumers in order to compare health plans. See *id.*

ommendations in a December 1996 report.¹⁴⁵ The purpose of the bills, according to Texas Senator David Sibley, was to provide protection for health care consumers in an ever-expanding health care industry and to hold managed care organizations liable for their medical mistakes, just as physicians are accountable for their negligence.¹⁴⁶ The Texas legislature's effort stemmed from the public's worry that with the growth of the managed care industry, insurers rather than doctors were becoming more active in the medical decision-making process.¹⁴⁷ The public was concerned it would have no remedy against the insurers if such decisions did in fact cause injury to the patient.¹⁴⁸

The bill seeking to hold HMOs liable for medical malpractice was met with both a sense of welcome and a sense of skepticism.¹⁴⁹ On the one hand, employer groups and HMOs opposed the bill, citing concerns that the legislation would result in a large increase in health care costs.¹⁵⁰ Kelli Brady, the regional public relations manager for Aetna

145. See *id.* (recommending that managed care organizations be held accountable for the decisions they make where such decisions cause the patient to become injured); *Impact of Texas, Missouri Laws in Health Plan Liability Uncertain*, 7 HEALTH L. REP. (BNA) 41 (Jan. 1, 1998). The committee issued the report after holding public hearings throughout the state of Texas. See David Coleman, *Health Plan Liability*, HEALTHPLAN, Mar./Apr. 1997, at 77, 81. Texan health care consumers, such as Elizabeth Hilsabeck, whose HMO denied payment for physical therapy for her infant son after six months, actively lobbied the Texas legislature to pass legislation preventing managed care organizations from using ERISA as a means of protection. See Karen Foerstel, *Texas' HMO Liability Law: The Jury is Still Out*, 57 CONG. Q. 381, 382 (1999).

146. See *Texas: HMOs Would be Liable for Negligent Decisions Under Proposed Legislation*, 6 HEALTH L. REP. (BNA) 6, at d26 (Feb. 6, 1997). Senator Sibley's concern focused on situations in which an HMO refuses to pay for a treatment that was recommended by the physician. See Coleman, *supra* note 145, at 81.

147. See *Impact of Texas, Missouri Laws in Health Plan Liability Uncertain*, 6 HEALTH L. REP. (BNA) 14, at d3 (Jan. 1, 1998).

148. See *id.*

149. See *Texas: HMOs Would be Liable for Negligent Decisions Under Proposed Legislation*, 6 HEALTH L. REP. (BNA) 6, at d26 (Feb. 6, 1997) (describing the various reactions to the legislation); Stoeckl, *supra* note 30, at 401.

150. See Stoeckl, *supra* note 30, at 401. The executive director of the employer-lead coalition, Texans for Quality Health Care, stated that the members of this group "have already experienced 'a decade of double-digit inflation in health care costs and defensive medicine and are scared they'll be forced back

Health Plans of Texas, predicted "litigation stemming from the new law could drive up costs by \$550 million to \$1 billion a year."¹⁵¹

On the other hand, the legislation received a great deal of support from the Texas Medical Association (TMA).¹⁵² TMA lent its full support to the bill, citing its belief that medical decisions should be left to physicians rather than HMO employees concerned largely with maximizing profit.¹⁵³ Despite the conflicting viewpoints, Senate Bill 386 passed in May 1997 and the Texas Health Care Liability Act went into effect on September 1, 1997.¹⁵⁴ The Act is expected to serve as an example and model for other states, thirty of which have considered similar liability legislation.¹⁵⁵

The Act arms patients with the ability to sue their HMOs for breaches¹⁵⁶ of two duties imposed upon managed care organizations.¹⁵⁷ First, the Act provides that the managed care entity has a duty to exercise ordinary care when it makes a health treatment decision; the entity may be liable for any damages resulting from the failure to exercise this ordinary care.¹⁵⁸ The Act defines a "health care treatment de-

into it by the year 2000.'" *Texas: HMO Would Be Liable for Negligent Decisions Under Proposed Legislation*, 6 HEALTH L. REP. (BNA) 6, at d26 (Feb. 6, 1997).

151. *Texas: Aetna Files Suits Against State to Block New HMO Liability*, 6 HEALTH L. REP. (BNA) 26, at d20 (June 26, 1997). Two other opponents to the legislation, Texas HMO Association and Texans for Quality Health Care, also contended that the measure would lead to the increased filing of frivolous lawsuits and would increase HMO costs by five percent. . See Ken Ortolon, *Coming In First*, TEXAS MEDICINE, Sept. 1997, at 26, 27.

152. See *Texas*, *supra* note 150, at d26; See Stoeckl, *supra* note 30, at 401.

153. See *Texas*, *supra* note 150, at d26. Specifically, Hugh Lamensdorf, the president of the Texas Medical Association, stated that "[d]ecisions must be made by the physician who is involved with the patient as a person and not by the accountant whose job it is to maximize profit." *Id.*

154. See Stoeckl, *supra* note 30, at 401-402. The bill became law in Texas without the signature of Governor George W. Bush. See *id.*

155. See *Did Court in Texas Split the Baby in HMO Liability Decision?*, 7 HEALTH L. REP. 1694 (Oct. 22, 1998).

156. See Stoeckl, *supra* note 30, at 402; *Impact of Texas, Missouri Laws on Health Plan Liability Uncertain*, 7 HEALTH L. REP. (BNA) 41 (Jan. 1, 1998).

157. See Stoeckl, *supra* note 30, at 402; *Impact of Texas, Missouri Laws on Health Plan Liability Uncertain*, 7 HEALTH L. REP. (BNA) 41 (Jan. 1, 1998).

158. TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (West 1999); see also Stoeckl, *supra* note 30, at 402; *Impact of Texas, Missouri Laws on Health*

cision" as "a determination made when medical services are actually provided by the health plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees."¹⁵⁹ It holds HMOs liable for their decisions regarding treatments covered by the plan¹⁶⁰ and also establishes a standard of care applicable to HMOs in making coverage decisions.¹⁶¹

Second, the Act holds the managed care entity liable for damages incurred by a patient as a result of health care treatment decisions made by employees, agents, ostensible agents or representatives on its behalf.¹⁶² This liability extends not only to medical care rendered by the employees or agents, but also to medical coverage decisions made by such persons.¹⁶³ One commentator suggests this second cause of action is particularly applicable to holding a physician and managed care entity liable for damages caused by the implementation of a utilization review process or a pre-certification requirement.¹⁶⁴

B. The Texas Health Care Liability Act Is Challenged

Due to the Act's potential negative effects on the managed care industry, Aetna Health Plans of Texas filed suit against the State of Texas on June 16, 1997, in an effort to block the law.¹⁶⁵ The plaintiffs sought declaratory relief arguing ERISA pre-empted the Texas Health Care Liability Act, and injunctive relief by seeking to enjoin the enforcement of the Texas legislation as it relates to plans covered by ERISA.¹⁶⁶ The plaintiffs alleged that:

Plan Liability Uncertain, 7 HEALTH L. REP. (BNA) 41 (Jan. 1, 1998).

159. TEX. CIV. PRAC. & REM. CODE ANN. § 88.001(5) (West 1999).

160. See Stoeckl, *supra* note 30, at 403; *Impact of Texas, Missouri Laws on Health Plan Liability Uncertain*, 7 HEALTH L. REP. (BNA) 41 (Jan. 1, 1998).

161. See Stoeckl, *supra* note 30, at 403; *Impact of Texas, Missouri Laws on Health Plan Liability Uncertain*, 7 HEALTH L. REP. (BNA) 41 (Jan. 1, 1998).

162. See TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(b) (West 1999).

163. See *Impact of Texas, Missouri Laws on Health Plan Liability Uncertain*, 7 HEALTH L. REP. (BNA) 41 (Jan. 1, 1998).

164. See Stoeckl, *supra* note 30, at 403.

165. See *Corp. Health Ins., Inc. v. Texas Dep't of Ins.*, 12 F. Supp. 597 (S.D. Tex. 1998); see also *Texas: Aetna Files Suit Against State to Block New HMO Liability Law*, 6 HEALTH L. REP. (BNA) 26, at d20 (June 26, 1997).

166. See *Corp. Health*, 12 F. Supp. at 602; *Texas: Aetna Files Suit Against State to Block New HMO Liability Law*, 6 HEALTH L. REP. (BNA) 26, at d20

[t]he Legislature has sought . . . to change the terms of employee benefit plans and restrict the ability of plans to deny claims based upon medical necessity as defined by the terms of the employee benefit plans . . . This attempt to mandate or alter benefits available under ERISA employee benefit plans improperly interferes with the administration of those plans when medical necessity determinations are made, and is fundamentally at odds with Congressional intent to minimize the need for employers to administer their plans differently in each state where they have employees.¹⁶⁷

The plaintiffs moved for summary judgment contending the Act seeks to impose liability on ERISA entities and attempts to interfere with an area reserved for Congress.¹⁶⁸

In response to the plaintiffs' motion, the State of Texas¹⁶⁹ filed a motion to dismiss for failure to state a claim.¹⁷⁰ Defendants argued that dismissal was appropriate because the Act does not try to regulate or control the administration of benefits, but rather, attempts to regulate the quality of care and medical treatment rendered by an HMO in Texas.¹⁷¹ The defendants requested that in the alternative, if the court found ERISA pre-empted any portion of the Act, these portions should simply be severed.¹⁷²

The court began its analysis by examining what constitutes an ERISA plan and whether the Act relates to an employee benefit plan.¹⁷³ The court found the plaintiffs and the services they provided were not ERISA plans because the coverage was not maintained by an employer.¹⁷⁴ The plaintiffs argued that even though Aetna was not an

(June 26, 1997).

167. *Texas: Aetna Files Suit Against State to Block New HMO Liability Law*, 6 HEALTH L. REP. (BNA) 26, at d20 (June 26, 1997).

168. *See Corp. Health*, 12 F. Supp. 2d at 603.

169. The defendants were the Texas Department of Insurance, the Commissioner of the Texas Department of Insurance and the Attorney General of the State of Texas. *See id.* at 602.

170. *See id.* at 603. The motion to dismiss was eventually converted by the court into a motion for summary judgment. *See id.*

171. *See id.* at 603. The defendants also alleged that the Department of Insurance and its Commissioner were not proper parties to this action. *See id.*

172. *See Corp. Health*, 12 F. Supp. 2d at 603.

173. *See id.* at 608.

174. *See id.* at 609.

ERISA plan, this was irrelevant to the ERISA pre-emption analysis.¹⁷⁵ Since the court found that certain severable portions of the Act did relate to ERISA employee benefit plans, it concluded that whether plaintiffs in this matter were ERISA plans is irrelevant.¹⁷⁶

The court next analyzed whether the Act was related to an ERISA plan.¹⁷⁷ This analysis examined Congress' objectives and intentions in enacting the ERISA pre-emption provisions.¹⁷⁸ The court noted Congress' intention to create a uniform set of regulations to prevent administrative burdens on entities complying with state regulations.¹⁷⁹ The court also noted that the Act imposed "a standard of ordinary care directly upon health insurance carriers and health maintenance organizations when making health care treatment decisions, regardless of whether the commercial coverage or membership therein is ultimately secured by an ERISA plan."¹⁸⁰ The Act expressly excluded from applicability employers purchasing coverage for their employees and, as such, does not make any reference to ERISA plans.¹⁸¹ Plaintiffs argued that, because the Act used certain terms, such as "health care plan" and "health maintenance organization" that refer to ERISA plans, there should be ERISA pre-emption.¹⁸² The court rejected this argument, finding that although there was reference to such plans, the existence of these ERISA plans was not essential to the Act and it was not based on the existence of these plans.¹⁸³ Furthermore, the entities listed in the Act are not ERISA plans and thus, the court reasoned the Act cannot be said to make reference to ERISA plans.¹⁸⁴

As long as a state law has a connection with ERISA plans, ERISA may still pre-empt that law even if it does not make a specific refer-

175. *See id.* at 610.

176. *See id.*

177. *See Corporate Health*, 12 F. Supp. 2d at 610-11.

178. *See id.* at 611.

179. *See id.* (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers' Ins. Co.*, 514 U.S. 645, 656 (1995) (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990))).

180. *Corp. Health*, 12 F. Supp. 2d at 612.

181. *See id.*

182. *See id.*

183. *See id.* at 613.

184. *See id.* at 614 (quoting *New York State Conference of Blue-Cross & Blue Shield Plans v. Travelers' Ins. Co.*, 514 U.S. 645, 656 (1995)).

ence to ERISA.¹⁸⁵ Consequently, the court examined whether the Act had a connection with ERISA plans.¹⁸⁶ Here, the plaintiffs argued that, among other ways,¹⁸⁷ the Act was connected with ERISA plans because it imposed state liability on ERISA plans.¹⁸⁸ To support their theory, the plaintiffs cited the Fifth Circuit's holdings in *Corcoran v. HealthCare* and *Rodriguez v. Pacificare of Texas*.¹⁸⁹ After examining the facts and holding in *Corcoran*, the court concluded it was clearly distinguishable from the case at hand.¹⁹⁰ It noted that while the *Corcoran* plaintiffs filed suit based upon the denial of certain plan benefits, a suit brought under the Act would relate to the quality of benefits when distributed rather than when the benefits are denied.¹⁹¹ The express language of the Act reiterates this when it defines a "health care treatment decision" as occurring when medical services are actually provided and the decision affects the quality of the treatment.¹⁹² In response to the plaintiffs' contention that the Fifth Circuit's holding in *Rodriguez* mandates pre-emption, the court once again looked at the particular facts and holding in *Rodriguez*.¹⁹³ The Court noted that Rodriguez's claims against the HMO stemmed from his dissatisfaction with the way his claim was handled, and for this reason, the Fifth Circuit held that the claims were related to the plan.¹⁹⁴ However, a claim brought under the Act may "challenge the quality of benefits actually received without challenging a denial of benefits or the handling of a medical claim."¹⁹⁵

The court in *Corporate Health Insurance* found the case of *Dukes*

185. See *Corp. Health*, 12 F. Supp. 2d at 614 (quoting California Div. of Labor Standards Enforcement v. Dillingham Constr., 519 U.S. 316, 325 (1997)).

186. See *id.*

187. See *id.* The plaintiffs also argued that the Act was connected with ERISA plans because it "impermissibly mandates the structure of plan benefits and their administration, unlawfully binds plan administrators to particular choices, and wrongfully creates an alternate enforcement mechanism." *Id.*

188. See *id.*

189. See *Corporate Health*, 12 F. Supp. 2d at 614.

190. See *id.* at 617.

191. See *id.*

192. See *id.*

193. See *id.* at 617-18.

194. See *Corp. Health*, 12 F. Supp. 2d at 618.

195. *Id.*

v. *U.S. Healthcare*¹⁹⁶ to be more relevant, because it addressed the quality of care actually rendered and received by the patient.¹⁹⁷ The court focused on the distinction in *Dukes* between the denial of benefits and the quality of benefits actually rendered.¹⁹⁸ In *Dukes* the court noted that the plaintiffs alleged negligence was based upon the poor quality of medical treatment rather than the withholding of benefits.¹⁹⁹ Under the Act, a claim which contests the quality of the benefits received, rather than the benefit determination itself, is valid.²⁰⁰ Furthermore, the court focused upon the dual role an HMO plays as either the coordinator of health benefits or simply as a utilization reviewer.²⁰¹ Accordingly, a person suing under the Act may seek to hold the HMO liable as the coordinator of poor quality treatment rather than for its role in denying benefits.²⁰² The court did acknowledge the distinction between quality of care and the denial of benefits is not always clear.²⁰³

The court ultimately concluded the Act specifically relates to the quality of benefits, an issue not addressed in any manner in ERISA.²⁰⁴ Therefore, the Act did not "constitute an improper imposition of state law liability on the enumerated entities."²⁰⁵

C. The First Claim under the Texas Health Care Liability Act

On October 19, 1998, the family of a Fort Worth man became the first plaintiffs to seek a remedy under the Act when it filed suit against NYLCare of Texas alleging the HMO contributed to the man's death.²⁰⁶ The plaintiffs alleged HMO representatives required All

196. 57 F.3d 350.

197. *See Corp. Health*, 12 F. Supp. 2d at 618-19.

198. *See id.* at 619.

199. *See id.* at 619 (quoting *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 357 (3rd Cir. 1995)).

200. *See id.*

201. *See id.*

202. *See Corp. Health*, 12 F. Supp. 2d at 619.

203. *See id.* at 619 n. 12.

204. *See id.* at 620.

205. *Corp. Health*, 12 F. Supp. 2d at 620.

206. *See Texas: Family of Fort Worth Suicide First to Test HMO Liability Law*, 7 HEALTH L. REP. (BNA) 1721 (Oct. 29, 1998). Although the suit was filed in a state court of Texas, the defendant, NYLCare moved the case to federal court where the amount of damages are more limited. *See Foerstel, supra*

Saints Hospital to discharge Joseph Plocica, who had a very long history of depression and repeated suicide attempts, from the psychiatric ward.²⁰⁷ Dr. Harold Eudaly, Jr., Mr. Plocica's physician, opposed the discharge and recommended that he remain hospitalized until "his condition stabilized, his medications were adjusted, and he no longer expressed suicidal thoughts."²⁰⁸ Despite this recommendation, Dr. Gary K. Neller, who was employed by Merit Behavioral Care Systems Corporation, which managed the mental health cases involving NYLCare members on a capitated basis, ordered Mr. Plocica's discharge from the hospital.²⁰⁹ The following evening, Mr. Plocica drank a half-gallon of antifreeze.²¹⁰ He died nine days later after being removed from life support systems because his doctors determined that he would never regain brain or bodily functions.²¹¹

Mr. Plocica's wife and four children filed a suit in Tarrant County, Texas,²¹² alleging NYLCare failed to provide adequate quality of care.²¹³ They argued the cost-containment mechanisms used by NYLCare, together with the failure to implement quality control policies and Dr. Neller's negligence, caused Mr. Plocica's death.²¹⁴ The complaint stated "Joe Plocica had 'used up his days' according to whatever 'cookbooks' or protocols for psychiatric treatment that NYLCare

note 145, at 382. The Plocica's attorney has made attempts to move the case back to state court. *See id.*

207. *See Texas: Family of Fort Worth Suicide First to Test HMO Liability Law*, 7 HEALTH L. REP. (BNA) 1721 (Oct. 29, 1998).

208. *Id.*

209. *See id.*

210. *See Texas: Family of Fort Worth Suicide First to Test HMO Liability Law*, 7 HEALTH L. REP. (BNA) 1721 (Oct. 29, 1998); David Koenig, *Family Sues Over Man's Suicide-Attorney Says Companies Decide About Payments, Not About When to Release Patients*, AUSTIN-AMERICAN STATESMAN, Oct. 21, 1998, at B1; Lunday, *supra* note 142, at 1.

211. *See Texas: Family of Fort Worth Suicide First to Test HMO Liability Law*, 7 HEALTH L. REP. (BNA) 1721 (Oct. 29, 1998); David Koenig, *Family Sues Over Man's Suicide-Attorney Says Companies Decide About Payments, Not About When to Release Patients*, AUSTIN-AMERICAN STATESMAN, Oct. 21, 1998, at B1; Lunday, *supra* note 142, at 1.

212. *See* Lunday, *supra* note 142, at 1.

213. *See Texas: Family of Fort Worth Suicide First to Test HMO Liability Law*, 7 HEALTH L. REP. (BNA) 1721 (Oct. 29, 1998).

214. *See id.*

and Merit were using at the time."²¹⁵ Although he declined to discuss this particular suit, NYLCare's attorney, Bill Blunt, stated that an HMO does not decide whether to discharge a patient, but rather merely decides the question of payment for the hospital stay.²¹⁶ Because the suit brought by the Plocica family could set the stage for future cases against HMOs, the family's lawyers were especially careful in selecting which case would be the first brought under the Act.²¹⁷

III. ANALYSIS: HOW MUCH HAS TEXAS HEARD?

Texas responded to its health care consumers' concerns about protection against the increasing role of managed care entities and the treatment decisions they make.²¹⁸ Yet, whether these consumers are really protected as a result of the Act remains in question.²¹⁹ This question is of particular importance in light of the Texas court's ruling on the right to sue, and whether that ruling increases the likelihood of other state legislatures introducing similar measures.²²⁰

One commentator has suggested that, despite the Act's movement towards managed care liability, the state law will not afford sufficient protection because managed care entities will continue to find a defense in ERISA.²²¹ One solution to this problem would be to call upon

215. *See id.*

216. *See* Koenig, *supra* note 211, at B1. NYLCare has denied the allegations set forth by the Plocica family and has stated that such claims are barred as a result of the plaintiffs' own negligence. *See* Foerstel, *supra* note 145, at 382.

217. *See* Lunday, *supra* note 142, at 1. George Young, the attorney for the Plocica family, stated that because the first lawsuit filed under the Act would set precedent, he carefully selected the first case to file and turned away ten other clients before selecting the Plocica suit as the first to file. *See* Foerstel, *supra* note 145, at 382.

218. *See Impact of Texas, Missouri Laws on Health Plan Liability Uncertain*, 7 HEALTH L. REP. (BNA) 41 (Jan. 1, 1998).

219. *See* Stoeckl, *supra* note 30, at 409 (questioning how much the Act has truly provided). While very few lawsuits have been filed, the legislation has created a sense of distrust of the physician by the patient and increased insurance premiums possibly related to the Act. *See* Foerstel, *supra* note 145, at 382.

220. *See Texas: Court Upholds Patient Right to Sue HMOs; Strikes Down Other Portions of Texas Statute*, 7 HEALTH L. REP. (BNA) 1483 (Sept. 24, 1998).

221. *See* Stoeckl, *supra* note 30, at 409. When plaintiffs attempt to sue

Congress to amend ERISA so that HMOs will no longer be able to hide behind this shield of immunity.²²² It may be necessary for Congress to change the remedies available under ERISA or define how processes such as utilization review figure into ERISA so that consistent pre-emption decisions are made by courts throughout the United

their HMOs, it presents an uphill battle and the effect of the Act is uncertain. See Douglas H. Ustick, *Texas: The New Accountability*, HEALTH SYSTEMS REVIEW, Nov./Dec. 1997, at 30, 31.

222. See Stoeckl, *supra* note 30, at 409; Parver & Martinez, *supra* note 64, at 235-236 (suggesting reforming ERISA so as to expand patients' rights against HMOs).

The House of Representatives passed a bill on October 7, 1999, which would allow patients to sue federally regulated health plans in either state court or federal court for unlimited damages. See Amy Goldstein & Juliet Eilperin, *House Votes to Increase Rights of HMO Patients*, WASH. POST, October 8, 1999, at A1. The version of the bill passed by the Senate in July 1999 did not include a provision that would allow a patient to sue his or her federally regulated health plan. See *id.* Because the two bills are very different, many have predicted that the House bill will not be entirely successful. See *id.* During the preparation for the House vote, many partisans gave discouraging predictions of what the result may be if Americans were able to sue their health plans but the Texas law which allows Texans to file such suits has seen a mild effect with only five of which had been filed by September 1999. See Amy Goldstein, *'Patients' Rights' Case Study: So Far, Benign*, WASH. POST, Sept. 28, 1999, at A1.

The process of negotiation of the bills will likely be even more difficult in light of the fact that Republican leaders in the House, who had strongly opposed the House bill, named to the committee which will negotiate with the Senate were not supporters of the bill. See David E. Rosenbaum, *Not Quite Business As Usual in House on Managed Care*, N.Y. TIMES, Nov. 4, 1999, at A1. In fact, of the twelve Republican conferees named by House Speaker J. Dennis Hastert, ten had voted against the bill while one had supported it and the other had been absent. See *id.* Two leading Republican supporters, Representative Charles Norwood of Georgia and Representative Greg Ganske of Iowa were both denied seats at the conference committee. See *id.* The eight Democratic House conferees had voted for the bill. See *id.* Seven Republican senators who voted for the weaker Senate bill and five Democratic senators who support the House version make up the Senate conferees. See *id.* In order for the bill to be approved by the conference committee, a majority of the Senate conferees and House conferees voting separately must be in favor. See *id.* The actions by the Republican leaders in naming the conferees was seen by others as a way to weaken the House bill. See Juliet Eilperin, *Speaker Excludes 2 From Talks*, WASH. POST, Nov. 4, 1999, at A10.

States.²²³

Although the United States District Court for the Southern District of Texas upheld the right to sue managed care entities under the Act, health care consumers of Texas still have not been afforded the protection they deserve and desire.²²⁴ The court's decision, in effect, was simply an extension of the *Dukes* holding and not really a new source of protection for American health care consumers.²²⁵ In holding that a suit may be brought under the Act if it challenges the quality of benefits received rather than a benefit determination itself, the court focused primarily on *Dukes*' distinction between quality of care and benefit determinations.²²⁶ The court allows for managed care entities to be held liable under the Act for the quality of benefits that it renders to its members.²²⁷ The court in *Corporate Health Insurance* noted the potential problems that may develop in attempting to distinguish between claims centering on the quantity of benefits under the plan and the quality of benefits rendered.²²⁸ Since the holding is actually very limited, this distinction could weaken the Act's effectiveness in providing a remedy for Texas health care consumers.²²⁹ In particular, one commentator noted that utilization review, the most criticized managed care abuse, still remains unrestricted and ERISA still pre-empt s

223. See Stoeckl, *supra* note 30, at 409.

224. See *id.* (noting that the managed care entities are still protected by ERISA); Chan, *supra* note 23, at 223 (describing the false distinction between quality and quantity of benefits). It has been stated that the Court's reasoning in the *Corporate Health* case is flawed because there is no distinction between quality and quantity of benefits and the Court's decision actually narrowed the scope of the Act. See Jordan, *supra* note 30, at 17-18.

225. See Chan, *supra* note 23, at 223-24 (describing the slippery slope that develops when a plaintiff attempts to recover for poor quality of treatment and noting the unclear distinction between the quality of care and the denial of benefits as recognized by the *Dukes* court); Jordan, *supra* note 30, at 17-18.

226. See Brenda T. Strama, *Did Court in Texas Split the Baby in HMO Liability Decision?*, 7 HEALTH L. REP. (BNA) 1694 (Oct. 22, 1998).

227. See *Corp. Health*, 12 F. Supp. 2d at 619-620.

228. See *id.* at 619 n. 12; see also Strama, *supra* note 226, at 1694. The Court noted that whether the claim related to the quality or quantity of benefits, which affects whether the claim will be pre-empted by ERISA, must be case-by-case specific. See *id.*

229. See Strama, *supra* note 226, at 1694; Chan, *supra* note 23, at 223 (describing the false distinction between quality and quantity of benefits).

claims challenging utilization review.²³⁰

In addition to recognizing the difficulty in distinguishing between the quality and quantity of benefits,²³¹ the court also recognized that it will be difficult for a plaintiff to bring such actions and obtain an adequate remedy under the Act.²³² This contention, coupled with the court's suggestion that the Act addresses the quality of benefits, not the quantity, make the remedy available under the Act very narrow in scope.²³³ As many commentators have suggested, because the quality and quantity decisions are intertwined, many claims of poor quality of treatment will also involve quantity of benefits issues, thus calling for pre-emption.²³⁴ Accordingly, there exists a slippery slope when distinguishing between claims based on quality of care and the quantity of benefits due.²³⁵ Even when a plaintiff is successful in characterizing his or her claim as that which deals with the quality of care, the managed care entity could win pre-emption by arguing that the quality of care was so low that it constituted a denial of benefits.²³⁶

The medical care a patient receives, and the quality of that care, will depend in part on an HMO's decision regarding benefits afforded to that patient.²³⁷ Although the managed care entity is simply deciding whether to permit and pay for the benefit, the treatment the patient receives will be greatly affected by this decision primarily because a patient will usually refuse treatment that he or she must pay for out of pocket.²³⁸ Accordingly, plaintiffs injured due to a denial of benefits

230. See Strama, *supra* note 226, at 1694.

231. See *Corp. Health*, 12 F. Supp. 2d at 619 n.12.

232. See *id.*

233. See Chan, *supra* note 23, at 223 (describing the false distinction between quality and quantity of benefits); Strama, *supra* note 226, at 1694 (noting that the Court's holding is limited).

234. See Chan, *supra* note 23, at 215-24 (stating that the distinction between claims for denial of benefits and claims challenging the quality of care is a false distinction); Stoeckl, *supra* note 30, at 390 (medical treatment received by a patient depends both on the decisions made by the physician and those of the HMO regarding the type and amount of care to be given); Easley, *supra* note 36, at 314-16; Chittenden, *supra* note 25, at 489 (the distinction between claims on the administration of a benefit plan and those based on the quality of care is artificial).

235. See Chan, *supra* note 23, at 223.

236. See *id.*

237. See Stoeckl, *supra* note 30, at 390.

238. See *id.* at 403; Chan, *supra* note 23, at 221.

will not be permitted to pursue their claim under the Act, thus contributing to the Act's inability to protect Texas health care consumers.²³⁹ Patients injured because the quantity of benefits determination affected the quality of care they received may be unable to bring suit against the HMO under the Act.²⁴⁰

In accordance with the recent decision in the Southern District Court of Texas, and in light of the ambiguous distinction between quality and quantity of care claims, it is likely that the case brought by the Plocica family will fail.²⁴¹ Although the complaint alleges poor quality of medical treatment, it can be argued that what is apparently at issue is the managed care entity's decision that the benefit of a longer hospital stay was unavailable.²⁴² Because this decision appears to be a quantity of benefits determination, NYLCare will likely argue (and the court is likely to agree), that the plaintiffs may not sue under the Act.²⁴³ This is a likely result even though the benefit denial had a great impact upon the quality of care Mr. Plocica received.²⁴⁴

IV. CONCLUSION

Although many have viewed the Act as the model of managed care entity liability for other states considering such legislation, the model does not provide the full protection consumers have sought from the managed care industry.²⁴⁵ By taking the first step to impose liability upon managed care entities, Texas has started to address the concerns of health care consumers and, at a minimum, Texas has started the long process of stripping managed care entities of the defenses and immunities they have enjoyed.²⁴⁶ The question likely to be addressed

239. See Stoeckl, *supra* note 30, at 403-09; Chan, *supra* note 23, at 221-23.

240. See Stoeckl, *supra* note 30, at 403-09; Chan, *supra* note 23, at 221-23.

241. See Stoeckl, *supra* note 30, at 403-09; Chan, *supra* note 23, at 223-24.

242. See Chan, *supra* note 23, at 223-24 (noting that this distinction may actually be false).

243. See *id.* This case also presents the typical situation in which it is difficult to distinguish the quality from the quantity of benefits. See Jordan, *supra* note 30, at 18.

244. See Chan, *supra* note 23, at 223-24.

245. See Stoeckl, *supra* note 30, at 403-09 (noting that the Act is not full protection); Chan, *supra* note 23, at 223-24 (noting problems in distinguishing between quality and quantity of benefits).

246. See Stoeckl, *supra* note 30, at 403-09 (noting that the Act does not provide full protection); Jordan, *supra* note 30, at 18 (noting that because

and answered by the court in *Plocica* is that, although Texas seems to be listening to the concerns of its health care consumers, how much has it really heard?

ERISA law already generally recognized that a denial of benefits claim is pre-empted while a quality of benefits claim is not, the *Corporate Health* decision did not afford new protection).

