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UTILIZATION REVIEW AS THE PRACTICE OF MEDICINE: SCALING THE WALL OF ERISA

JUDITH FEINBERG

INTRODUCTION

*Florence Corcoran was an employee of South Central Bell Telephone ("Bell"), a self-insured, ERISA-qualifying health plan for employees. Bell uses a "quality care program" ("QCP"), administered by an outside agency, to make utilization review determinations of medical necessity. Ms. Corcoran became pregnant, and her doctor ("Collins") classified the pregnancy as high-risk for miscarriage. Collins admitted her to the hospital on October 3, 1989. Using a QCP evaluation, Bell determined that her hospitalization was not necessary and refused payment. Bell stated that it would only provide payment for 10 hours per day of home nursing care. On October 25, 1989, while Ms. Corcoran was at home and unattended, the fetus went into distress and died. Although the Corcorans filed suit against Bell and the QCP utilization review agent, the court found that suit was pre-empted by the Employee Retirement Income Security Act of 1972, and held that "the Corcorans have no remedy, state or federal, for what may have been a serious mistake."*¹

Managed care organizations ("MCO's") determine which medical services are medically necessary and appropriate in a process called "Utilization Review" ("UR").² Many UR determinations of medical necessity require the development, application, and maintenance of clinical review criteria.³ UR can create a cost-control hurdle to care delivery if it is used to pre-authorize the next step in medical care.⁴ Some MCO's will make affirmative recommendations of treatment plans

¹ See generally *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1338 (5th Cir. 1992).

² See Jonathan Stevens & Scott P. Smith, *Utilization Management Within a Network Context: A Significant Enhancement over Traditional Utilization Review*, in *DRIVING DOWN HEALTH CARE COSTS* 131-132 (Aspen 1995). See also SOPHIE M. KORCZYK & HAZEL A. WITTE, *THE COMPLETE IDIOT'S GUIDE TO MANAGED HEALTH CARE* 10 (1998) (explaining basic aspects of managed care structures to consumers).

³ See Peter R. Kongsvedt, *Authorization Systems*, in *THE ESSENTIALS OF MANAGED HEALTH CARE* 348 (Paul Kongsvedt ed., Aspen Publishers 1997).

⁴ See Stevens & Smith, *supra* note 2, at 131-132. See also KORCZYK & WITTE, *supra* note 2, at 10.

that they are willing to reimburse.⁵ UR is designed to control the content of treatment plans for patients.⁶ The courts have considered UR decisions to be administrative acts which “relate to” employee benefit plans.⁷ Claims arising from UR, therefore, have been pre-empted by the Employee Retirement Income Security Act of 1974 (“ERISA”).⁸

The United States Congress enacted ERISA under the Commerce Clause to support interstate commerce and to stabilize employee pension plans.⁹ Congress

⁵ See *Corcoran*, 965 F.2d at 1331. “United [an MCO] . . . gives medical advice—but it does so in the context of making a determination about the availability of benefits . . .” *Id. Accord Long v. Great Western Life and Annuity Insurance Co.*, 957 P.2d 823 (Wyo. 1998) (holding MCO liable for medical malpractice).

⁶ See S. BRIAN BARGER ET AL., *THE P.P.O. HANDBOOK* 104 (1985) [hereinafter *HANDBOOK*].

The objective of the review process is primarily education. Physician performance is compared with expected standards. Those physicians persistently at variance with quality and efficiency standards are identified and . . . encouraged to . . . ‘clean up their act’ . . . the review process . . . attempts to bring physicians whose performance is characterized as poor . . . or by excessive use of resources . . . to a level of desired medical outcome using appropriate amounts of services.

Id.

⁷ See generally *Jass v. Prudential Health Plan*, 88 F.3d 1482 (7th Cir. 1996).

⁸ See *id.*

⁹ See Employee Retirement Income Security Act of 1972 (codified in scattered sections of 29 U.S.C.A.) (1985).

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans . . . that they have become an important factor in commerce because of the interstate character of their activities . . . and that it is therefore desirable in the interests of employees and their beneficiaries . . . and to provide for the free flow of commerce. . . that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

29 U.S.C.A. § 1001 (a).

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans . . . by requiring disclosure and reporting . . . of financial and other information . . .

Id. § 1001(b).

It is hereby further declared to be the policy of this chapter to protect interstate commerce . . . and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees . . .

Id. § 1001(c).

designed ERISA to protect these plans from abuse and unfair practices, as well as to harmonize their administration under a uniform federal statute.¹⁰ ERISA, as originally enacted, did not expressly address health insurance plans.¹¹ Congress later amended the statute to apply to “group health plans” as a type of employee welfare plan.¹² Plans provided by the employer, or by an employee group, are “ERISA-qualifying,” or within the scope of the ERISA statute.¹³ ERISA contains a clause pre-empting state law.¹⁴ Courts have interpreted that pre-emption broadly to include pre-emption not only of state statutes, but also of state law claims.¹⁵ The clause has also been held to pre-empt state law claims arising from the managed care practice of UR.¹⁶

Part I of this Note discusses the origins and evolution of managed care cost-containment and UR. Part II discusses the ERISA statute, focusing on how ERISA has been used to shield MCO’s from liability. Part III discusses traditional and

¹⁰ See *id.*; see generally *Corcoran*, 965 F.2d at 1329 (holding that intent of Congress was to construct a uniform federal regime by pre-empting even laws of general application, if as applied they have a connection with the administration of an ERISA plan).

¹¹ See generally Employee Retirement Income Security Act of 1974 (codified in scattered sections of 29 U.S.C.A.).

¹² 29 U.S.C.A. §§ 1002 (1); 1161-1169 (1985).

¹³ 29 U.S.C.A. §§ 1161-1169; 1181-1191(c). (1985). “The term “group health plan” means an employee welfare benefit plan providing medical care . . . to participants or beneficiaries” 29 U.S.C.A. § 1167 (1) (1985). “In accordance with regulations prescribed by the Secretary . . . the group health plan shall provide . . . written notice to each covered employee . . . of the rights provided under this subsection.” *Id.* § 1166 (a)(1).

¹⁴ See 29 U.S.C.A. § 1144 (1985). “[T]he provisions of this chapter shall supersede any and all State laws insofar as they now or hereafter relate to any employee benefit plan.” *Id.* § 1144 (a).

¹⁵ See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 42, 54 (1987) (“ERISA’s civil enforcement remedies were intended to be exclusive”); *Kuhl v. Lincoln Nat’l Health Plan*, 999 F.2d 298, 301 (8th Cir. 1993) (holding that ERISA pre-emption is to be construed broadly, and includes the pre-emption of state law claims). “Consistent with the decision to create a comprehensive, uniform federal scheme for regulation of employee benefit plans, Congress drafted ERISA’s pre-emption clause in broad terms . . . [s]tatutory mandates, court decisions, and state law from all other sources are included” *Id.* See also *Shaw v. Int’l Ass’n. of Machinists and Aerospace Workers*, 563 F.Supp. 653, 659 (D.Cal. 1983). “The Ninth Circuit has ruled that common law causes of action for breach of contract are pre-empted. . . .” *Id.* (citing *Lafferty v. Solar Turbines Int’l*, 666 F.2d 408 (9th Cir.1982)).

¹⁶ See *Corcoran*, 965 F.2d at 1331.

United [an MCO] makes medical decisions [incident to benefit determinations]—indeed, United gives medical advice—but it does so in the context of making determinations about the availability of benefits under the plan. Accordingly, we hold that the . . . tort action . . . resulting from United’s erroneous medical decision is pre-empted by ERISA.

statutory definitions of the practice of medicine, and contends that UR decisions of medical necessity are in fact a form of medical practice.¹⁷ This Note concludes that regulating medical practice through tort deterrence is a traditional area of state activity that does not “relate to” an employee benefits plan. ERISA pre-emption deprives the plaintiff of adequate compensation for medical malpractice. Furthermore, ERISA deprives the states of their ability to regulate this type of medical practice within their borders. Such pre-emption was not within ERISA’s legislative intent, and therefore, state tort claims for erroneous UR decisions should not be pre-empted.

I. UTILIZATION REVIEW: COST-CONTAINMENT BY ELIMINATION OF “MEDICALLY UNNECESSARY” CARE

A. *The Origins of the MCO*

MCO’s developed and flourished by focusing on cost-control.¹⁸ Aggressive UR programs are MCOs’ predominant tool to contain cost.¹⁹ Although most people think of managed care as a recent invention, the industry actually began on a small scale in this country at the turn of the century. The first medical practice organized on a pre-paid basis (pre-payment being a hallmark of MCO’s) was established in Washington state in 1910.²⁰ A cooperative health plan for rural farmers was developed in Oklahoma in 1929.²¹ A physician founded a network to serve employees of Kaiser Construction Corporation in California in 1937; this became Kaiser Foundation Health Plans, one of the largest MCO’s today.²² It was not until

¹⁷ See ME. REV. STAT. ANN. tit. 32, § 3270 (1995); MASS. REGS. CODE tit. 243 § 2.01 (1985); R.I. GEN. LAWS 5-37-1 (1995); VT. STAT. ANN. tit. 26, § 1311 (1985); accord SAMUEL L. MASSENGIL, A SKETCH OF MEDICINE AND PHARMACY, (2d ed. 1942) (tracing the history of Western medicine from its Greco-Roman beginnings).

¹⁸ See HANDBOOK, *supra* note 6, at 3.

The early 1980s have been a time of many changes for the health care system in the United States. The ways of the past decades have been and continue to be involuntarily discarded. A new set of ground rules is being incrementally planted in their place. This revolution has been given many different labels. It has been called competition; it has been referred to as a price sensitivity . . . At the center of this revolution is the Preferred Provider Organization (PPO) [a type of MCO]. This price-competitive health delivery arrangement . . . is considered by some to be the panacea for controlling medical care inflation.

Id.

¹⁹ See *id.* at 102.

²⁰ See Peter D. Fox, *An Overview of Managed Care*, in ESSENTIALS OF MANAGED HEALTH CARE 3-4 (Paul Kongsvedt ed., Aspen Publishers 1997) (explaining managed care structures to health plan administrators).

²¹ See *id.*

²² See *id.* at 5.

the 1980's, however, that MCO's became a significant force for change in health care.²³

The Social Security Act of 1965 (codified in scattered sections of 42 U.S.C.A.) increased access to health care for the poor and the elderly poor.²⁴ During the post-war era, this initiative, combined with the Hill-Burton Act's financing for building of new hospitals, put significant federal dollars into hospital expansion.²⁵ MCO's, responding to a changing health care economy, became influential by offering alternatives to paying physicians on a cost-insensitive, "fee-for-service" basis.²⁶

B. UR as a Cost-Control Mechanism

MCO's used UR as a primary tool to focus on the cost factor in the equation of health-care economics.²⁷ The goal of UR is to control medical care costs by preventing patients from receiving care the MCO deems unnecessary.²⁸ Although the language cites "quality" as the motivating factor, controlling the cost of medical care is in fact the primary motivating force in UR.²⁹ UR may be used prospectively, concurrently, or retrospectively to review and approve (or disapprove) costly patient care.³⁰ Through UR, MCO plans have the power to limit or deny payment to the provider.³¹ This has significant impact on what care the patient actually receives.³²

Prior to hospitalization, patients receive prospective review, also called "pre-admission certification."³³ Most MCO's also require prospective review for routine care or for diagnoses they deem to be over-treated.³⁴ For example, in *Wilson v. Chesapeake Health Plan Inc.*, an MCO applying prospective review denied coverage for Mr. Wilson's liver transplant.³⁵ When Mr. Wilson tried to check into

²³ See *id.* at 8, fig. 1-1.

²⁴ See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 374 (1982) (describing the social and political dynamics driving health care development in the United States).

²⁵ See *id.* at 376.

²⁶ See *id.* at 424-25.

²⁷ See HANDBOOK, *supra* note 6, at 22. "[T]he primary cost control mechanism employed by preferred provider organizations is utilization review." *Id.*

²⁸ See *supra* text accompanying note 6.

²⁹ See *id.*

³⁰ See HANDBOOK, *supra* note 6, at 22.

³¹ See DRIVING DOWN HEALTH CARE COSTS, *supra* note 2, at 131-132. See also KORCZYK & WITTE, *supra* note 2, at 10.

³² See HANDBOOK *supra* note 6, at 104. See also *supra* text accompanying note 28.

³³ See *id.*

³⁴ See *id.* "Typically, the pre-admission certification process is applied to all elective hospital admissions or to more focused groups of . . . categories frequently associated with inappropriate hospitalization." *Id.*

³⁵ See *Presbyterian Univ. Hosp. v. Wilson*, 654 A.2d 1324, 1325 (Md. 1995) (summarizing the facts of the unreported trial court decision below in *Wilson v. Chesapeake Health Plan, Inc.*, No. 88019032/ CL 76201 (Md. Cir.1988)).

the hospital for transplant surgery while seeking alternative means of payment, the hospital refused to admit him, basing their refusal on the fact that his MCO notified them that they would not reimburse them for the procedure.³⁶ Mr. Wilson later died after being admitted to the emergency room in acute liver failure.³⁷

Concurrent review occurs while the patient is being treated, and often involves doctors' requests to MCO's to continue a patient's hospital stay, or to transfer a patient to a different hospital facility.³⁸ For instance, in *Wilson v. Blue Cross of California*, the MCO refused to pay for patient Wilson's continued stay in a mental hospital, calling it "not justified or approved".³⁹ After Mr. Wilson was discharged, he committed suicide.⁴⁰

UR may also be retrospective, with MCO's evaluating the "medical necessity" of services and procedures after they have already been rendered and the provider is requesting payment.⁴¹ This type of UR is common in post-admission cases, where specific services are provided ancillary to a hospital admission.⁴² Some MCO's may actually recommend alternative treatment plans that fall within their cost guidelines; these recommendations cross the line into direct control of medical care.⁴³

The MCO reviewer makes decisions of medical necessity by using algorithms or guidelines developed by the MCO itself.⁴⁴ The algorithmic concept is intended to reduce individual physician variations, which can lead to patient care costs that the MCO deems unnecessary.⁴⁵ These "medical necessity" decisions are cost-based, despite being sufficiently technical and intensive to require clinical education in order for a doctor to make them.⁴⁶ Therefore, MCO's routinely employ physicians and nurses to make UR decisions.⁴⁷

³⁶ See *id.* at 1324.

³⁷ See *id.*

³⁸ See HANDBOOK, *supra* note 6, at 106.

³⁹ *Wilson v. Blue Cross of California*, 222 Cal.App.3d 660, 669 (1990).

⁴⁰ See *id.*

⁴¹ See HANDBOOK, *supra* note 6, at 107.

⁴² *Id.* at 107-108. "From a cost-containment perspective, costly ancillary services . . . are a major focus of this review activity. Even though an admission is justified and the patient's stay was within prescribed standards, the excessive and unnecessary use of costly ancillary services can . . . escalate . . . cost." *Id.*

⁴³ See *Corcoran*, 965 F.2d at 1331. "United [an MCO] gives medical advice—but it does so in the context of making determinations about the availability of benefits . . ." *Id.* Accord *Long*, 957 P.2d 823 (Wyo. 1998) (holding the MCO liable for medical malpractice).

⁴⁴ See *Kongsvedt*, *supra* note 3, at 348.

⁴⁵ See HANDBOOK, *supra* note 6, at 104; see also *supra* text accompanying note 28.

⁴⁶ See *Kongsvedt*, *supra* note 3, at 348.

⁴⁷ See *id.*

C. Public Response to UR

Although the average consumer may not understand the details of UR, they have developed the potentially accurate perception that physicians no longer make health care decisions without cost-sensitive oversight and that MCO's profit from denying medically necessary care to their members.⁴⁸ State legislatures have responded by setting constraints on how and when MCO's conduct UR.⁴⁹ Such measures include:

⁴⁸ <<http://www.hmo.page.org>> (home page of consumer group seeking increased control of MCO's) (visited 11/01/1998).

⁴⁹

All adverse utilization review determinations relied upon by a health carrier in denying benefits to a covered person are subject to the appeals procedures set forth in section 8G. A person whose section 8G appeal results in an adverse decision has a right to a second level grievance review as set forth in section 9D.

ME. CODE R. c. 850, § 3 (1985);

[An HMO] shall file an Access Plan for approval . . . Access Plans must include: 1) the HMO's current enrollment . . . and projected annual enrollment . . . 3) [a] description of the HMO's physician . . . recruitment plan, 4) [a] description of the HMO's plan for providing services for rural and underserved populations

Id. at § 7;

A health carrier shall : (a) [e]stablish written policies and procedures for credentialing verification of all health care professionals . . . (b) verify the credentials of a health care professional before [that professional] . . . provides health services

N.H. REV. STAT. ANN. § 420-J:4 (1983);

A health carrier shall provide standard review of adverse determinations as follows: (a) [w]ritten procedures for a standard review of an adverse determination shall be available to a covered person and to the provider . . . (b) standard reviews shall be evaluated by an appropriate clinical peer or peers

Id. § 420-J: 5;

A health carrier shall maintain a network that is sufficient in numbers, types, and geographic location

Id. § 420-J:7;

The department shall adopt regulations including . . . the requirement that the review agent provide patients and providers with a summary of its utilization review plan including a summary of standards, procedures and methods to be used in evaluating proposed or delivered health care services; the type and qualifications of personnel authorized to perform utilization review, including a requirement that only a licensed practitioner with the same licensing status as the ordering practitioner . . . in the same or similar general specialty as

detailing procedures for decision-making in UR, requiring specific composition of reviewing boards, stipulating quality control mechanisms within the MCO, and mandating the content and format of decision explanations provided to members.⁵⁰ The Massachusetts State Legislature has drafted The Managed Care Omnibus Bill, which was lobbied heavily by both consumer groups and the managed care industry.⁵¹ While consumer groups advocate for increasingly tighter controls on MCO's, MCO trade groups argue that increased constraints on cost control mechanisms will raise premiums and increase the number of uninsured Americans.⁵² The impact of any legislation enacted may be blunted, however, given overbroad judicial interpretation of exactly what "relates to" employee welfare plans.⁵³ For example, ERISA has been interpreted to pre-empt not only state statutes, but also state law tort claims. This interpretation leaves plaintiffs without state legal remedies, compensation or vindication, and leaves the states with limited mechanisms for regulating this form of medical practice.⁵⁴

typically manages the medical condition . . . be permitted to make a final determination . . .

R.I. GEN. LAWS §23-17.12-3 (f)(1)(94)(1985).

Managed care plans shall ensure that health care services provided to their members are consistent with prevailing professionally recognized standards of medical practice . . . (B) [e]ach managed care plan shall have an internal quality assurance program that monitors and evaluates the full range of its health care services . . . (G) [e]ach managed care plans quality assurance program shall include . . . the following: (1) [a] peer review committee . . . (2) [a]ccountability of the peer review committee . . . to the board of directors . . . (3)[p]articipation in the quality assurance program by the appropriate providers . . .

VT. CODE R. §10.100-10.102 (1998).

⁵⁰ See ME. CODE R. c. 850, §§ 3, 7 (1985); N.H. REV. STAT. ANN. §§ 420-J:4, 420-J:5, 420-J:7(1983); R.I. GEN. LAWS § 23-17.12-3 (f)(1)(94) (1985); VT. CODE R. § 10.100-10.102 (1998).

⁵¹ See H.R. 4637, 108th Cong. (1997).

⁵² See <<http://www.mahmo.org/mahmo.omnibuspage.html>> (homepage of the Massachusetts Association of Health Maintenance Organizations) (visited 11/02/98).

⁵³ See *Travelers Ins. Co. v. Cuomo*, 14 F.3d at 708 (2nd Cir. 1993) (holding pre-empted by ERISA sections of the New York Omnibus Revenue Act of 1992 which affected rate-setting and stop-loss provisions for all insurers, including ERISA plans). For a discussion of this case, reversed on appeal, see *infra* notes 85-87 and accompanying text.

⁵⁴ See *Corcoran*, 965 F.2d at 1338. See also *Pilot Life Ins.*, 481 U.S. at 55-7; *Jass*, 88 F.3d at 1493, 1482; *Kuhl*, 999 F.2d at 304-05.

II. ERISA AS A SHIELD FROM LIABILITY

A. *The Evolution of ERISA*

In enacting ERISA, Congress had two goals: 1) to protect the benefit rights of employees, and 2) to promote and protect commerce.⁵⁵ Accordingly, Congress created a uniform scheme of obligations, remedies and fiduciary duties.⁵⁶ ERISA applies broadly to all employee benefit plans provided by an employer or employee organization, unless expressly exempted.⁵⁷ For example, government plans, church plans, worker's compensation compliance plans, plans maintained outside the United States and "excess benefit plans" (as defined by ERISA) are exempt.⁵⁸ In addition, ERISA was amended and expanded in 1986 to expressly apply to employer sponsored health plans.⁵⁹

B. *The Structure of the Pre-emption Clause*

ERISA contains a clause pre-empting all state laws that "relate to any employee benefit[s] plan."⁶⁰ The "savings clause" that follows this pre-emption nonetheless allows states to apply insurance laws and regulations to these plans despite the pre-emption.⁶¹ However, self-insured plans are exempt from the savings clause under

⁵⁵ See 29 U.S.C.A. § 1001 (a)-(c) (1985). See also *supra* text accompanying note 9.

⁵⁶ See 29 U.S.C.A. § 1001 (b) (1985).

⁵⁷ See 29 U.S.C.A. § 1003 (a) (1)-(3) (1985).

(T)his subchapter shall apply to any employee benefit plan if it is established and maintained . . . by an employer engaged in any commerce or in any industry or activity affecting commerce; or . . . by any employee organization . . . representing [such an industry]; or . . . by both.

Id.

⁵⁸ 29 U.S.C.A. § 1003 (b) (1)-(5) (1985).

The provisions of this subchapter shall not apply to any employee benefit plan . . . [which is] a governmental plan; . . . a church plan; [a] plan . . . maintained solely for the purpose of complying with . . . workmen's compensation . . . unemployment . . . or disability laws; [a] plan maintained outside of the United States . . . [an] excess benefit plan . . . [which is] unfunded.

Id.

⁵⁹ See 29 U.S.C.A. §§ 1002(1)(a); 1161-1169; 1181-1191(c) (1985) (as amended by PL 93-406), *supra* note 13 and accompanying text.

⁶⁰ See 29 U.S.C.A. § 1144 (a).

⁶¹ See *id.* § 1144(b)(2)(A). "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities." *Id.* See also Frances H. Miller, *Medical Discipline in the 21st Century: Can Purchasers Do It?*, 60 LAW AND CONTEMP. PROB. 31, 55 (1997) (exploring the applicability of ERISA pre-emption and the interaction of the "deemer" and "savings" clauses) [hereinafter, Miller, *Medical Discipline*].

the “deemer” exception.⁶² Self-insured plans are those plans completely funded by the employer, and are no longer considered “insurance.”⁶³ The “deemer” clause exempts these plans from all state insurance laws and regulations.⁶⁴

Courts have interpreted ERISA’s pre-emption provision broadly, reading it to pre-empt both state statutes *and* state common law claims relating to any employee benefit plan.⁶⁵ While ERISA provides only narrow exceptions to the pre-emption provision, it does allow for the application of state criminal law.⁶⁶ By interpreting the term “relating to” as a “sweeping” provision, courts have left ERISA itself as the only civil enforcement remedy for qualifying plans.⁶⁷ These interpretations have included pre-emption of statutory and common law that are not intended to affect ERISA plans, and have only an indirect effect on issues covered by ERISA.⁶⁸

⁶² See 29 U.S.C.A. § 1144(b)(2)(B) (1985). “Neither an employee benefit plan described in section 1003(a) of this title . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . .” *Id.*; see also Miller, *Medical Discipline*, *supra* note 61, at 55.

⁶³ See Miller, *Medical Discipline*, *supra* note 61, at 55.

⁶⁴ See 29 U.S.C.A. § 1144(b)(2)(B) (1985); see also *supra* text accompanying note 61.

⁶⁵ See *Kuhl*, 999 F.2d at 301; *Shaw*, 563 F.Supp. at 658. See also *Corcoran*, 965 F.2d at 1331, *supra* note 5 and accompanying text.

⁶⁶ See 29 U.S.C.A. § 1144 (b)(4) (1985). See also *Nat’l Metal Crafters v. McNeil*, 602 F.Supp. 232 (D. Ill. 1985) (holding that Illinois Labor Payment Act provided criminal penalty and was thus exempt from ERISA pre-emption). *Contra Calhoon v. Bonnabel*, 560 F.Supp. 101 (D. N.Y. 1982) (holding that no state law may be interpreted to provide a civil remedy where none was intended under ERISA).

⁶⁷ See *Pilot Life*, 481 U.S. at 54.

In sum, the detailed provisions of [ERISA] set forth a comprehensive civil enforcement scheme that represents a careful balancing . . . [this] would be completely undermined if ERISA plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA . . . [t]he deliberate care with which ERISA’s civil enforcement remedies were drafted . . . argue strongly for the conclusion that ERISA’s civil enforcement remedies were intended to be exclusive.

Id.

⁶⁸ See generally *Trustees of the Plumbers and Pipefitters Nat’l Pension Fund v. Mar-Len Inc.*, 864 F.Supp. 599 (E.D. Tex. 1994) (holding state single business enterprise theory of liability pre-empted by ERISA).

Plaintiffs . . . fail to comprehend the breadth of the statutory scheme of ERISA and the Supreme Court’s even broader interpretation of the terms ‘relate to’ . . . Congress deliberately created ERISA to ‘establish pension plan regulation as exclusively a federal concern’ (quoting *Pilot Life*, 481 U.S. at 45-46) . . . [t]his liberal interpretation of ‘relates to’ pre-empts state law, even if the law is not designed to affect ERISA plans or if the effect is indirect.

Id. at 607.

C. *The Statutory ERISA Remedy*

ERISA does provide a private cause of action and a remedy.⁶⁹ An ERISA beneficiary may bring an appeal under ERISA to recover the cost of the benefit denied by his or her MCO.⁷⁰ If the plan contains language giving discretion to the administrator, judicial review is limited to an analysis for arbitrary and capricious action not supported by substantial evidence on the record as a whole; in the absence of such language, the court will review an administrator's decision *de novo*.⁷¹ This arbitrary and capricious standard mirrors the deference federal courts pay to federal administrative agencies.⁷² If the plaintiff's appeal does succeed, recovery is limited to the amount of the benefit alone, without compensatory or punitive damages.⁷³ As in the *Corcoran* case, this can leave an injured health plan beneficiary grossly undercompensated.⁷⁴

D. *A Key Question: "Relates To"*

The ERISA pre-emption clause pre-empts any state law which "relate[s] to any employee benefit[s] plan."⁷⁵ The statute does not provide any further guidance

⁶⁹ See 29 U.S.C.A. § 1132(a)(1)(B) (1985).

⁷⁰ See *id.* "A civil action may be brought by a participant or beneficiary . . . to recover benefits due to him under the terms of the plan . . . or to clarify his rights to future benefits under the terms of the plan . . ." *Id.*

⁷¹ See *Firestone Tire and Rubber Co. v. Burch*, 489 U.S. 101, 115 (1989) (holding that ERISA plan decisions are generally reviewed *de novo*, but that if a plan gives discretion to the plan administrator review may be limited to substantial evidence on the record as a whole). See also *Farrow, et. al.*, 1 HEALTH LAW 821 (1997).

⁷² Compare *Beggs v. Mullins*, 499 F.Supp. 916, 919 (D.W.Va. 1980) ("The court cannot now say that . . . the action of Trustees is not supported by substantial evidence as a matter of law"), with *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 414 (1971) ("Review under the substantial-evidence test is authorized only when the agency action is taken pursuant to a rule making provision of the Administrative Procedure Act itself, or when the agency action is based on a public adjudicatory hearing.")

⁷³ See *Mertens v. Hewitt Ass'n.*, 508 U.S. 248 (1993) (holding that ERISA does not provide for damages, but only for equitable relief).

ERISA . . . permits plan participants to bring civil actions to obtain 'appropriate equitable relief' . . . What petitioners in fact seek is the classic form of legal relief . . . damages . . . We have held that similar language used in another statute precludes awarding damages. And the text of ERISA leaves no doubt that Congress intended 'equitable relief' to include only those types of relief that were typically available in equity, such as injunction, mandamus, and restitution.

Id.

⁷⁴ See *Corcoran*, 965 F.2d at 1338. "The result ERISA compels us to reach means that the *Corcorans* have no remedy, state or federal, for what may have been a serious mistake." *Id.* For a discussion of the facts in *Corcoran*, see *supra* note 1 and accompanying text.

⁷⁵ 29 U.S.C.A. § 1144(a) (1985).

explaining what “relates to” may mean.⁷⁶ Judicial interpretation of what “relates to” ERISA plans for pre-emption purposes has never been uniform.⁷⁷ The United States Supreme Court has held that ERISA pre-emption does not apply to some state laws with only a remote connection to ERISA.⁷⁸ However, the Court has also held that ERISA pre-emption was intended to be broad.⁷⁹ In *Ingersoll Rand v. McClendon*, the Court seemed to imply that state laws of broad general applicability might survive ERISA pre-emption.⁸⁰ Federal and state courts have continued to struggle in the wake of these decisions, finding creative ways around the sweep of “relates to” and generating conflicting precedent along the way.⁸¹ Courts without specific precedent about ERISA and UR followed the sweeping nature of general ERISA precedent.⁸² Even if an MCO affirmatively recommended a course of medical treatment in the context of benefits determination, courts felt uncomfortably compelled to find the claim pre-empted.⁸³ Particularly significant is the evolving judicial perception that UR is not an administrative act “relating to” an ERISA plan, but is actually the practice of medicine.⁸⁴ Recent cases in Arizona, the

⁷⁶ See *id.*

⁷⁷ See *Traveler's Insurance Co.*, 14 F.3d at 716 (referring to ERISA pre-emption law as “a veritable Sargasso Sea of obfuscation”).

⁷⁸ See *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 100 n. 21 (1983). “Some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner . . .” *Id.*

⁷⁹ See *Pilot Life*, 481 U.S. 41, 47. “[Relates-to should be given] its broad common-sense meaning.” *Id.*

⁸⁰ See *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 139 (1990) (holding that a state law regarding pension plans was pre-empted by ERISA). “We have recognized limits to ERISA’s pre-emption clause . . . we are not dealing here with a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan.” *Id.*

⁸¹ Compare *Schiffli Embroidery Workers Pension Fund v. Ryan, Beck and Co.*, 869 F. Supp. 278, 282 (D.N.J. 1994) (holding that claims against outside professionals providing services to an ERISA plan are not always pre-empted); *Estate of Frappier v. Wishnov*, 678 So.2d 884 (Fla. Dist. Ct. App. 1996) (holding vicarious liability by ostensible agency not “related to” employee benefit plan, and therefore not pre-empted); *Pappas v. Asbel v. United States Healthcare Systems of Pa.*, 675 A.2d 711 (Pa. Super. Ct. 1996) (holding indemnity action based on negligence theory, and therefore not “related to” an employee benefit plan) and *Boyd v. Einstein Medical Center*, 547 A.2d 1229 (Pa. Super. Ct. 1988) (holding level of control in HMO cost containment mechanisms may create ostensible agency in contracted primary care physician), with *Corcoran*, 965 F.2d at 1331, and *Jass*, 88 F.3d at 1482 (holding tort claims pre-empted).

⁸² See *Corcoran*, 965 F.2d at 1331.

⁸³ See *supra* note 74.

⁸⁴ See generally *Murphy v. Board of Medical Examiners*, 949 P.2d 530 (Ariz. Ct. App. 1997) (upholding Board of Registration in Medicine finding that physician engaged in prospective UR is practicing medicine without a license in the state of Arizona); *Morris v. District of Columbia Board of Medicine*, 701 A.2d 364 (D.C. 1997) (holding that a physician who regularly engages in medical review may reasonably be found to be practicing medicine); *Long v. Great West Life and & Annuity Insurance Co.*, 957 P.2d 823 (Wyo.

District of Columbia, and Wyoming have held that MCO's or physicians working for MCO's are "practicing medicine" when performing UR.⁸⁵

The United States Supreme Court recently ruled that ERISA does not pre-empt some laws of "indirect," "relative" effect that do not "relate to" employee benefit plans.⁸⁶ In *New York Blue Cross v. Travelers Ins. Co.*, the Court upheld a state rate-setting decision that forced ERISA plans to contribute to a state uncompensated care pool for the poor.⁸⁷ The Court noted that because such activity was in fact an area of traditional state regulation, it was not clearly pre-empted by ERISA.⁸⁸ *New York Blue Cross* thus may prove a useful compass for navigating between the conflicting holdings of previous decisions.

Additionally, the Supreme Court has subjected federal statutes under the Commerce Clause in other areas of traditional state regulation to increasing scrutiny in its recent holdings.⁸⁹ ERISA pre-emption of state law claims regarding UR decisions must be re-evaluated against this backdrop.

1998) (holding MCO liable for medical malpractice in treatment plan prescribed under UR; medical practice decisions not pre-empted by ERISA). *See also* GAIL B. AGRAWAL, AMERICAN ASSOCIATION OF HEALTH PLANS, HOW MANY CASES DOES IT TAKE TO MAKE A TREND? UTILIZATION MANAGEMENT AS THE PRACTICE OF MEDICINE (1998).

⁸⁵ *See Murphy*, 949 P.2d at 530; *Morris*, 701 A.2d at 364; *Long*, 957 P.2d at 825.

⁸⁶ *See New York Blue Cross v. Travelers Ins. Co.*, 514 U.S. 645, 668 (1995).

[A] State law might produce such acute . . . indirect economic effects . . . as to force an ERISA plan to adopt a certain scheme of coverage or . . . restrict its choice of insurers . . . such a state law might indeed be pre-empted . . . [but New York State surcharges] . . . affect only indirectly the relative prices of insurance policies, a result no different from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate.

Id.

The existence of other common state actions with indirect economic effects on a plan's cost—such as quality control standards and workplace regulation—leaves the intent to pre-empt even less likely, since such laws would have to be superseded as well. New York's surcharges leave plan administrators where they would be in any case, with the responsibility to choose the best overall coverage for the money, and thus they do not bear the requisite 'connection with' ERISA plans to trigger pre-emption.

Id. at 646.

Any conclusion other than the one drawn here would have the unsettling result of barring any state regulation of hospital costs on the theory that all laws with indirect economic effect on ERISA plans are pre-empted. However, there is no hint in ERISA's legislative history or elsewhere that Congress intended to squelch the efforts of several states that were regulating hospital charges . . . at the time ERISA was passed.

Id. at 647.

⁸⁷ *See id.*

⁸⁸ *See id.* *See also supra* text accompanying note 85.

⁸⁹ *See United States v. Lopez*, 514 U.S. 549, 567 (1995).

III. UTILIZATION REVIEW AS THE PRACTICE OF MEDICINE: IMPLICATIONS FOR LIABILITY

Although Congress designed ERISA to create sole federal regulation of pension plans under the Commerce Clause,⁹⁰ ERISA now also applies to health plans.⁹¹ The regulation of health care is traditionally a state endeavor under the police power.⁹² UR has a profound impact on the timing, type, and quantity of health care provided to MCO members.⁹³ UR was established to act as a cost-containment mechanism, but it does so by controlling medical care rendered. Two questions are crucial to re-evaluating the impact of ERISA pre-emption on state-law claims involving UR: 1) Does UR constitute the practice of medicine; and 2) If UR constitutes the practice of medicine, does it no longer “relate to” employee benefit plans within the meaning of ERISA pre-emption?

A. *The Nature of Medical Practice*

Webster’s College Dictionary defines the practice of medicine as “2. the art, science or profession of preserving health and of curing or alleviating disease . . . 3a. the art or science of treating disease . . . [3]b. the branch of the medical profession concerned with this.”⁹⁴ The practice of medicine encompasses aspects of both science and art.⁹⁵ The technical focus of medical practice defines the science of medicine.⁹⁶ The interpersonal skills of compassion, empathy, and communication define the art of medicine.⁹⁷

Under the theories that the Government presents in support of [the challenged legislation], it is difficult to perceive any limitation on federal power, even in areas . . . where States historically have been sovereign . . . to uphold the Government’s contentions here, we would have to pile inference on inference in a manner that would bid fair to convert congressional authority under the Commerce Clause to a general police power of the sort retained by the States.

Id. at 577 (concurring opinion of Justice O’Connor). “Federalism serves to assign political responsibility, not to obscure it.” (citations omitted). “Were the Federal Government to take over entire areas of traditional state concern, areas having nothing to do with the regulation of commercial activities, the boundaries between the spheres of federal and state authorities would blur and political responsibility would become illusory.” (citations omitted).

⁹⁰ See *Kuhl*, 999 F.2d at 301 (“Consistent with the decision to create a comprehensive, uniform federal scheme for regulation of employee benefit plans, Congress drafted ERISA’s pre-emption clause in broad terms . . . Statutory mandates, court decisions, and state law from all other sources are included . . .”).

⁹¹ See 29 U.S.C.A §§ 1002 (1); 1161-1169; 1181-1191(c).

⁹² See *New York Blue Cross*, 514 U.S. at 645.

⁹³ See DRIVING DOWN HEALTH CARE COSTS, *supra* note 2, at 131-132. See also KORCZYK & WITTE, *supra* note 2, at 10.

⁹⁴ WEBSTER’S COLLEGE DICTIONARY 842 (3d. ed. 1995).

⁹⁵ See ALAIN ENTHOVEN, HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COSTS OF HEALTH CARE 9 (2d. ed. 1981).

⁹⁶ See AVEDIS DONABEDIAN, THE DEFINITION OF QUALITY AND APPROACHES TO ITS

Most states create a Board of Registration in Medicine ("Board") to regulate medical practice directly.⁹⁸ These Boards are generally empowered to draft substantive regulations governing medical practice.⁹⁹ For example, in New England, states have regulated medical practice for over one-hundred years.¹⁰⁰ In Massachusetts, Board regulations directly and broadly define the "practice of medicine" as "[encouraging the] reliance of another person on the individuals' knowledge or skill in the maintenance of human health."¹⁰¹ In other states, enabling statutes themselves contain the definition.¹⁰²

These statutory definitions of the "practice of medicine" are broad as well. For example, the state of Vermont does not define medical practice specifically, but requires that anyone who "direct[s], recommend[s], or advise[s] treatment . . ." hold a medical license.¹⁰³ Maine statutes define the practice of medicine as "attempting to diagnose, relieve, or cure a human disease . . . by attendance or advice."¹⁰⁴ Rhode Island statutes defining the practice of medicine include "prescribing [care] by any method."¹⁰⁵ Further, in Maine and Massachusetts, anyone who uses the title "M.D." is practicing medicine.

Additionally, state tort law indirectly regulates medical practice by encouraging potential tortfeasors to conform their conduct to a desired norm.¹⁰⁶ Even if the actual number of tort actions is low, the deterrent effect of existing tort laws is extensive.¹⁰⁷ Specifically, tort claims encourage physicians and other health care

ASSESSMENT 73 (1980).

⁹⁷ See *id.*

⁹⁸ See ME. REV. STAT. ANN. tit. 32 (West 1983); MASS. GEN. LAWS ch. 112 (West 1985); R.I. GEN. LAWS § 5-37-1; VT. STAT. ANN. tit. 26 (Equity 1981).

⁹⁹ See *id.*

¹⁰⁰ See, e.g., MASS. GEN. LAWS ch. 112, § 2 (original version at c. 458, §§ 1-12, 1894 Mass. Acts 371).

¹⁰¹ MASS. REGS. CODE tit. 243 § 2.01.

¹⁰² See, e.g., ME. REV. STAT. ANN. tit. 32 § 3270; R.I. GEN. LAW § 5-37-1.

¹⁰³ VT. STAT. ANN. tit. 26 § 1311.

¹⁰⁴ ME. REV. STAT. ANN. tit. 32, § 3270.

¹⁰⁵ R.I. GEN. LAWS § 5-37-1.

¹⁰⁶ See Steven Shavell, *Strict Liability Versus Negligence*, 9 JOURNAL OF LEGAL STUDIES 1, 2-3 (1980).

¹⁰⁷ See Michael J. Saks, *Do We Really Know Anything About the Behavior of the Tort Litigation System, and Why Not?*, 140 U. PA. L. REV. 1147, 1286 (1992).

[T]he tort liability system may be doing a better job as a deterrent than it usually receives credit for . . . [T]he data strongly suggest[s] that our tort system hits infrequently and lightly. Yet, it has nevertheless somehow succeeded in frightening a great many potential defendants, who seem to go to considerable lengths to avoid becoming actual defendants . . . [P]erhaps the tort system achieves what deterrence it does by the unpleasantness of its operation—at least as that is experienced or imagined by defendants. The tort system is a mouse with an otherworldly roar.

Id.

providers to avoid malpractice.¹⁰⁸ Tort laws generally hold employers liable for the torts of an employee committed within the scope of employment.¹⁰⁹ Hospitals have been held liable for the negligence of physicians who are independent contractors.¹¹⁰ This theory of "corporate liability" can also be used to hold an HMO liable for the medical decisions of a physician under contract with them.¹¹¹ Some commentators have found this deterrent function to be particularly important in the context of MCO's, due to the high level of control which they exert over the care received by their members.¹¹² In fact, the high level of control which MCO's exert over medical care has compelled some state courts to hold that ERISA pre-emption did not apply to tort suits for UR functions.¹¹³ Even in *Corcoran v. United Healthcare*, which held that a tort action predicated on UR was in fact pre-empted, the court found the negative deterrent impact "troubling."¹¹⁴

¹⁰⁸ See generally Peter A. Bell, *Legislative Intrusion into the Common Law of Medical Malpractice: Thoughts About the Deterrent Effect of Tort Liability*, 35 SYRACUSE L. REV. 939 (1984).

¹⁰⁹ See W. PAGE KEETON, ET AL., PROSSER AND KEETON ON THE LAW OF TORTS, § 70 (West ed. 1984).

¹¹⁰ See *Darling v. Charleston Mem'l Hosp.*, 211 N.E.2d 253, 257 (Ill. 1965).

The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act on their own responsibility no longer reflects the fact . . . [c]ertainly, the person who avails himself of 'hospital facilities' expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility.

Id.

¹¹¹ See *Wickline v. California*, 239 Cal. Rptr. 810, 817 (Cal. Ct. App. 1996) (stating that UR agent for state managed care plan could be liable for overriding physician recommendation for patient care if the override was a breach of the standard of care); *Boyd v. Eisenstein Medical Ctr.*, 547 A.2d 1229, 1235 (Pa. Super. 1988) (holding HMO liable for action of physician who refused to authorize transfer of patient).

¹¹² See Jim Perdue and Stephen Baxley, *Cutting Costs - Cutting Care: Can Texas Managed Care Systems and HMOs Be Liable for the Medical Malpractice of Physicians?*, 27 ST. MARY'S L. J. 23, 67 (1995).

Texas courts utilize many legal tools to protect citizens from unreasonable risks of harm . . . Further, given the high degree of control the HMO's exercise over patient care, subscribers face additional threats of harm due to improper action by the HMO itself. Texas courts have been vigilant in their efforts to protect hospital patients from both the malpractice of physicians practicing in hospitals and from the wrongful actions of the hospital itself . . . [t]he minor financial burden . . . created by finding liability for medical negligence is vastly outweighed by the deterrent effects . . . [t]his reasoning is also appropriate in the HMO context.

Id.

¹¹³ See generally *Boyd*, 547 A.2d at 1235 (Pa. Super Ct. 1988); *Bush v. Dake*, No. 86-25767 NM-2 (Mich. Ct. App. 1989), reprinted in BARRY FURROW, ET AL., HEALTH LAW 292 (1997).

¹¹⁴ See *Corcoran*, 965 F.2d at 1338. ("The result . . . is troubling . . . it eliminates an

B. UR as the Practice of Medicine

UR is in fact a form of medical practice. Although UR serves as a cost-containment mechanism by discouraging care which the MCO deems "medically unnecessary" or excessive,¹¹⁵ its primary goal is to decrease "practice variation." UR decreases "practice variation" by encouraging provider physicians to "toe the line."¹¹⁶ The MCO seeks to apply UR to "bring the physician . . . to a level of desired medical outcome using appropriate amounts of services."¹¹⁷ In some cases, MCO's make direct recommendations for a clinical course of care.¹¹⁸ Furthermore, the limitation or denial of reimbursement to providers influences physician practice patterns, and the type and quantity of care which patients receive.¹¹⁹ Indeed, this is precisely what the MCO strives to achieve.¹²⁰ The effect in practice, which is the desired effect designed by the MCO, is the control of patient care.¹²¹

This practice falls within the common dictionary definition of practicing "medicine," encompassing "the art or science of treating disease"¹²² MCO's control the technical aspect, or "science" of medical practice by deeming certain diagnostic procedures, treatment regimes, surgical interventions or courses of hospitalization to be "unnecessary." Therefore, the MCO's control decreases their utilization.¹²³ MCO's also control the interpersonal aspect of medical practice by inserting "gag clauses" in physician contracts, limiting what physicians may tell MCO patients about treatment options.¹²⁴ Thus, the MCO uses UR to shape the

important check on the thousands of medical decisions routinely made in the burgeoning utilization review system." *Id.*

¹¹⁵ See HANDBOOK, *supra* note 6, at 104; see also *supra* text accompanying note 28.

¹¹⁶ See HANDBOOK, *supra* note 6, at 104; see also *supra* text accompanying note 28.

¹¹⁷ *Id.*

¹¹⁸ See *Corcoran*, 965 F.2d at 1331; accord *Long*, 1998 WL 181968; see also text accompanying note 43.

¹¹⁹ See HANDBOOK, *supra* note 6, at 104; see also text accompanying note 28.

¹²⁰ See *id.*

¹²¹ See *id.*

¹²² WEBSTER'S COLLEGE DICTIONARY 842 (3d. ed. 1995).

¹²³ See HANDBOOK, *supra* note 6, at 104; see also *supra* text accompanying note 28.

¹²⁴ See JOE BAKER, PRACTICING LAW INSTITUTE, *Basic Elder Law: Medicare HMO's and the Medicare Choice Program* 109, 123 (1998) ("Gag rule: . . . [S]ome HMO's explicitly prohibited their network physicians from informing patients about treatments which are not contained in the HMO's treatment protocol."); Mark Hall and Robert Berenson, *The Ethics of Managed Care: A Dose of Realism*, 28 CUMBERLAND L. REV. 287, 312 (1998) ("Even worse, a few HMOs for a while actively promoted secrecy using 'gag clauses' intended to protect their public image . . . [t]hese clauses . . . were intended to prevent physicians from discussing with anyone, including patients, the . . . utilization review guidelines imposed by the HMO"); David Mechanic, *The Function and Limitation of Trust in the Provision of Medical Care*, 23 JOURNAL OF HEALTH, POLITICS, POLICY AND LAW 661, 673 (1998) ("A third area related to disclosure involves 'gag rules'—where HMO's or managed care companies' contracts with doctors forbid them from . . . discussing treatment options with patients before the treatment options have been approved by administrative reviewers.").

treatment plans of its members, and is therefore “practicing medicine” within the common understanding of that term.

UR schemes also fall under many state statutory definitions of the practice of medicine.¹²⁵ For instance, Maine defines the practice of medicine as “attempting to diagnose, relieve, or cure any human disease”¹²⁶ UR includes decisions about what procedures are appropriate and necessary for diagnosing and treating patients.¹²⁷ The Commonwealth of Massachusetts defines the practice of medicine as “[encouraging the] reliance of another person on the individuals’ knowledge or skill in the maintenance of human health.”¹²⁸ When MCO’s construct treatment plans that delineate what is and is not “medically necessary,” the provider is encouraged by financial incentives to accept the UR decision as sound.¹²⁹ Rhode Island defines the practice of medicine as “prescribing care by any method.”¹³⁰ This is precisely what MCO’s do when they use UR decisions of medical necessity to influence physician prescribing practices, or make direct recommendations for development of a care plan.¹³¹ The state of Vermont requires anyone who “direct[s], recommend[s], or advise[s] . . . treatment . . .” to hold a medical license.¹³² “Directing, recommending and advising treatment” is precisely the goal of UR.¹³³ MCO’s are actively “practicing medicine” within the meaning of many state statutes and regulations.¹³⁴ Indeed, MCO’s hire licensed physicians and nurses to make UR decisions.¹³⁵ Each of these states also defines the use of the title “M.D.” to constitute the practice of medicine.¹³⁶ The physicians hired by MCO’s to oversee decisions of medical necessity are therefore “practicing medicine” by using their title on the MCO’s behalf.¹³⁷ UR activity in fact constitutes a form of medical practice.¹³⁸

¹²⁵ See ME. REV. STAT. ANN. tit. 32 § 3270; MASS. REGS. CODE tit. 243 § 2.01; R.I. GEN. LAWS § 5-37-1; VT. STAT. ANN. tit. 26 § 1311.

¹²⁶ ME. REV. STAT. ANN. tit. 32 § 3270.

¹²⁷ See DRIVING DOWN HEALTH CARE COSTS, *supra* note 2, at 131-132. See also KORCZYK & WITTE, *supra* note 2, at 10.

¹²⁸ MASS. REGS. CODE tit. 243 § 2.01.

¹²⁹ See HANDBOOK, *supra* note 6, at 104.

¹³⁰ R.I. GEN. LAWS § 5-37-1

¹³¹ See HANDBOOK, *supra* note 6, at 104.

¹³² VT. STAT. ANN. tit. 26, § 1311.

¹³³ See HANDBOOK, *supra* note 6, at 104.

¹³⁴ See ME. REV. STAT. ANN. tit. 32, § 3270; MASS. REGS. CODE tit. 243 § 2.01; R.I. GEN. LAWS § 5-37-1; VT. STAT. ANN. tit. 26, § 1311.

¹³⁵ See Kongsvedt *supra* note 3, at 348.

¹³⁶ See ME. REV. STAT. ANN. tit. 32, § 3270; MASS. REGS. CODE tit. 243, § 2.01; R.I. GEN. LAWS § 5-37-1; VT. STAT. ANN. tit. 26, § 1311.

¹³⁷ See ME. REV. STAT. ANN. tit. 32, § 3270; MASS. REGS. CODE tit. 243, § 2.01; R.I. GEN. LAWS § 5-37-1; VT. STAT. ANN. tit. 26, § 1311.

¹³⁸ See ME. REV. STAT. ANN. tit. 32, § 3270; MASS. REGS. CODE tit. 243, § 2.01; R.I. GEN. LAWS § 5-37-1; VT. STAT. ANN. tit. 26, § 1311. See also WEBSTER’S COLLEGE DICTIONARY 842 (3d. ed. 1995).

C. The Effect of ERISA Pre-emption

Congress clearly intended for ERISA to homogenize the administration of employee pension plans in the United States.¹³⁹ Included in that intent was the pre-emption of state tort laws relating to the administration of employee benefit plans, and the creation of a uniform ERISA remedy.¹⁴⁰ Nevertheless, overbroad judicial interpretations of ERISA remove the ability of states to use tort deterrence in regulating MCO's who engage in the practice of medicine through UR. As noted in *Corcoran v. United Healthcare*, MCO's whose UR practices constitute gross medical malpractice are completely insulated from liability.¹⁴¹ *New York Blue Cross v. Travelers Ins. Co.* has narrowed ERISA's pre-emption of state law by holding that state laws which have an indirect, relative economic effect on the administration of an employee benefit plan need not be pre-empted by ERISA.¹⁴² The Court found that Congress did not intend to pre-empt collateral areas of traditional state regulation.¹⁴³ The Supreme Court has also recently held that federal legislation predicated on the Commerce Clause is particularly suspect when directed at areas of traditional state regulation.¹⁴⁴

An ERISA action restoring deprived pension accrual may be sufficient to make a plaintiff whole in most cases. However, when health insurance benefits are denied, remittal of the benefit is often grossly inadequate to redress the harms to the plaintiff. The erroneous denial of health care benefits can have grievous consequences, creating true tragedy for individuals and families. For example, in *Corcoran v. United Healthcare*, an insured woman was denied hospitalization during a high-risk pregnancy.¹⁴⁵ Her MCO prescribed home-care, and less than two weeks later, while unattended, she miscarried her fetus at home.¹⁴⁶ The *Corcoran*

¹³⁹ See 29 U.S.C.A. § 1001(a); see also *supra* text accompanying note 9.

¹⁴⁰ See 29 U.S.C.A. §§ 1132(a)(1)(B); 1144 (providing limited civil remedy and pre-empting state law); see also *Pilot Life*, 481 U.S. at 54 (underscoring uniform nature of ERISA civil remedy).

¹⁴¹ See generally *Corcoran*, 965 F.2d at 1331.

¹⁴² See *New York Blue Cross v. Travelers Ins. Co.*, 514 U.S. 645, 668

[W]e do not hold today that ERISA pre-empts only direct regulation of ERISA plans, nor could we do that with fidelity to the views expressed in our prior opinions on the matter [citing to *Pilot Life* and others]. We acknowledge that a state law might produce such acute, albeit indirect, economic effects . . . as to force an ERISA plan to adopt a certain scheme of substantive coverage . . . and that such a law might indeed be pre-empted . . . But [the New York laws in issue] do not fall into either category; they affect only indirectly the relative prices of insurance policies, a result no different from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate.

Id.

¹⁴³ See *id.* at 645.

¹⁴⁴ See *Lopez*, 514 U.S. at 564. See also *supra* text accompanying note 85.

¹⁴⁵ See *Corcoran*, 965 F.2d at 1322.

¹⁴⁶ See *id.*

court found that the MCO had been "giving medical advice," but that any tort claim against them was pre-empted by ERISA.¹⁴⁷ ERISA operates to deprive states of the ability to regulate medical practice (an area of traditional state regulation) through deterrent tort function. MCO's have little incentive to provide costly care when first approached, and know that they are sheltered from liability for poor UR decisions later under ERISA. Similarly, overbroad pre-emption also deprives plaintiffs who are denied medical benefits of just compensation for resulting harm. After paying out-of-pocket costs, the value of the benefit denied to the Corcoran family, 10 days of inpatient care, may not even be enough to bury their child.¹⁴⁸ This is not within the legislative intent to "protect interstate commerce and the interests of participants in employee benefit plans."¹⁴⁹ In fact, this use of pre-emption can be said to directly contravene "the interests of participants in employee benefit plans."¹⁵⁰

IV. CONCLUSION

ERISA was designed to harmonize the administration of employee benefit plans. The statute pre-empts state laws relating to plan administration. The judicial interpretation of the ERISA statute as pre-empting any state law or state tort claim, no matter how remotely, incrementally, or tangentially related to the administration of employee benefit plans is overbroad and contravenes legislative intent. *New York Blue Cross v. Travelers Ins. Co.* provides guidance to courts in re-evaluating the breadth of ERISA pre-emption.

When MCO's engage in UR activities, they are not acting as plan administrators. They are practicing medicine. Therefore, liability stemming from such activities should not be pre-empted by ERISA. ERISA pre-emption leaves the plaintiff without adequate compensation, and prevents the state from regulating the practice of medicine through deterrent tort function. The Supreme Court has held that Congress never intended to pre-empt areas of traditional state regulation. The practice of medicine is precisely such an area. State law claims for negligence deter medical practice which falls below the standard of care. Medical malpractice claims against MCO's have an indirect, relative economic effect on the administration of a health plan as an employee benefit plan, and should not be pre-empted by ERISA.

¹⁴⁷ See *id.* at 1331.

¹⁴⁸ See Contract for Funeral Goods and Services, Beales-Geake & Magliozzi Funeral Home, on file with journal (quoting basic funeral service at \$5,700).

¹⁴⁹ 29 U.S.C.A. § 1001(b).

¹⁵⁰ *Id.*