NEW YORK CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS V. TRAVELERS INSURANCE CO.: VICARIOUS LIABILITY MALPRACTICE CLAIMS AGAINST MANAGED CARE ORGANIZATIONS ESCAPING ERISA'S GRASP

> [P]atients enjoy the right to be free from medical malpractice regardless of whether or not their medical care is provided through an ERISA plan.[1]

In February of 1992, Katie Haas visited her HMO and complained of a "closed feeling" in her ears.[2] Ms. Haas had health coverage through Group Health Plans, Inc. ("GHP"), which she had obtained as part of a benefits package from her employer.[3] Roger Young, a nurse practitioner for GHP, concluded that Ms. Haas's ears suffered from wax build-up and decided to clean her ears by injecting a solution from a syringe into her ear canals.[4] As a GHP technician injected the solution into Ms. Haas's left ear, Ms. Haas heard a loud popping sound and felt a sharp jolt of pain.[5] Several days later, Ms. Haas visited a physician, complaining of persistent pain in her left ear.[6] The physician informed her that her eardrum was punctured and that she would suffer from permanent disability as a result.[7]

Ms. Haas brought suit in Illinois state court seeking recovery from GHP for the negligence of its health care providers.[8] She brought her claim under a theory of vicarious liability, a state common law doctrine by which an employer or principal may be liable for the negligent acts of his or her employee or agent.[9] Because Ms. Haas's health coverage was part of an employee benefit plan, GHP claimed that the Employee Retirement Income Security Act ("ERISA"), a federal statute governing

---

[1] Dukes v. United States Healthcare, Inc., 57 F.3d 350, 358 (3d Cir. 1995).
[2] Haas v. Group Health Plan, Inc., 875 F. Supp. 544, 546 (S.D. Ill. 1994).
[3] *Id.*
[4] *Id.*
[5] *Id.*
[6] *Id.*
[7] *Haas*, 875 F. Supp. at 546.
[8] *Id.*
[9] *Id.*

employee benefit plans, preempted her state law claim.[10] GHP subsequently removed the claim to the United States District Court for the Southern District of Illinois for resolution of the preemption issue.[11] Although ERISA contains a civil remedy provision allowing plaintiffs to bring a variety of claims against employee benefit plans, Ms. Haas's common law malpractice claim was not among the claims allowed by the statute.[12] Fortunately for Ms. Haas, the court rejected GHP's argument and held that ERISA does not preempt vicarious liability malpractice claims brought against managed care organizations.[13] The court allowed Ms. Haas to proceed in her common law suit and to pursue a full and complete recovery from GHP.[14]

Catherine Ricci, by contrast, was not as fortunate.[15] In 1990, Ms. Ricci visited South Jersey Radiology for a mammogram.[16] The radiologist who performed the mammogram, Dr. Hikan Chon, checked the incorrect box on the test result sheet so as to indicate that the mammogram showed normal results.[17] Her mammogram, however, actually showed a small mass of tissue in her left breast.[18] Had Ms. Ricci had an immediate follow-up visit, she could have had a lumpectomy performed to remove the tissue build-up.[19] Instead, nearly one year later, Ms. Ricci developed breast cancer and was forced to undergo a mastectomy.[20]

Ms. Ricci subsequently brought a malpractice suit directly against Dr. Chon, Dr. Gooberman, who reviewed but failed to detect the incorrectly completed report, and South Jersey Radiology.[21] She also brought a vicarious liability claim against the managed care organization, U.S. Healthcare.[22] As with Ms. Haas, Ms. Ricci's health coverage was part of an employee benefit plan provided by her employer.[23] And

---

[10] *Id.* (citing 29 U.S.C. §§ 1001–1461 (1994)). The provision of ERISA preempting state laws is found at 29 U.S.C. § 1144. See *infra* notes 108–33 and accompanying text for an overview of ERISA.

[11] *Id.*

[12] *See* 29 U.S.C. § 1132.

[13] *Haas*, 875 F. Supp. at 549.

[14] *See id.* at 546.

[15] *See* Ricci v. Gooberman, 840 F. Supp. 316, 318 (D.N.J. 1993).

[16] Barbara Gotthelf, *$1M Medical Malpractice Verdict*, N.J. LAW., Jan. 23, 1995, at 7.

[17] *Id.*

[18] *Id.*

[19] Dana Coleman, *HMOs Are Protected From Vicarious Liability Claims*, N.J. LAW., Jan. 24, 1994, at 5.

[20] *Id.*

[21] *Ricci*, 840 F. Supp. at 316.

[22] *Id.*

[23] *Id.*

as did the managed care organization in *Haas*, U.S. Healthcare removed the case to federal court, claiming that ERISA preempted the vicarious liability claim.[24] Unlike the district court in *Haas*, however, the United States District Court for the District of New Jersey held that ERISA did indeed preempt her vicarious liability claim.[25] Ms. Ricci therefore was unable to proceed in her claim against U.S. Healthcare for the negligence of its physicians.[26] Consequently, her only avenue of recovery was the direct negligence action against the radiology facility and the physicians personally.[27] This result limited Ms. Ricci's recovery to the negligent physicians' personal assets and insurance coverage—sources inadequate to sufficiently compensate her for the permanently disabling injury they inflicted.[28]

To date, United States district courts have been unable to agree on whether ERISA preempts vicarious liability claims brought against managed care organizations.[29] Disagreement on this issue has led to inconsistent results among different districts as well as contradictory

---

[24] *Id.*

[25] *Id.* at 318.

[26] *See Ricci*, 840 F. Supp. at 318.

[27] *See id.*

[28] Although Ms. Ricci was unable to recover from U.S. Healthcare, she was ultimately able to recover from her physician and the facility at which the original mammogram was performed. Gotthelf, *supra* note 16, at 7. She was able to recover because both the negligent physician and the facility carried adequate malpractice insurance. *See id.* Surprisingly, however, medical malpractice insurance is not mandatory in many states. For example, one 1990 study estimated that a full 40% of all physicians in one southern Florida county did not carry any malpractice coverage at all. Rick Eyerdam, *More Physicians Lack Malpractice Coverage*, S. FLA. BUS. J., Aug. 27, 1990, at 5. Some physicians find the cost of malpractice insurance to be prohibitively high and therefore carry only limited coverage or no coverage at all. James M. Rilkin and B. Andrew Rilkin, *When Doctors Go Bare: Compensation Beyond the Underinsured Physician*, 73 MICH. B.J. 1080, 1080 (1994). If faced with a damage award greater than their coverage plus what they can afford out of pocket, those physicians who chose to practice with little or no coverage may simply declare bankruptcy to avoid meeting the recovery obligation. *Id.* The loser of the physician's gamble, of course, is the injured plaintiff left bearing substantial injury. *Id.* For example, consider Rosa Rodriguez's baby daughter, Ana. *See* Harvey Wachsman, *New York Forum About Medicine: Abu Hayat's Free Ride*, NEWSDAY, Mar. 15, 1993, at 40. During a botched abortion, Dr. Abu Hayat severed Ana's arm, leaving her in need of physical therapy for the rest of her life. *Id.* Because Dr. Hayat carried no malpractice insurance, Ana and her mother will be left to bear the onerous and costly burden of his negligence. *Id.* Thus, although many medical malpractice plaintiffs will be able to recover some amount against negligent physicians, others will be left without recourse because they had the misfortune of visiting an uninsured physician. *See id.*

[29] *Compare* Pomeroy v. Johns Hopkins Medical Serv., 868 F. Supp. 110, 114 (D. Md. 1994) (holding for ERISA preemption of vicarious liability malpractice claims brought against managed care orgainizations) *and* Visconti v. United States Health Care, 857 F. Supp. 1097, 1105 (E.D. Pa. 1994) (same), *rev'd sub nom.* Dukes v. United States Healthcare, Inc., 57 F.3d 350 (3d Cir. 1994) *and* Butler v. Wu, 853 F. Supp. 125, 129 (D.N.J. 1994) (same) *and* Nealy v. United States Healthcare HMO, 844 F. Supp. 966, 975 (S.D.N.Y. 1994) (same) *and Ricci*, 840 F. Supp. at 318

decisions within individual districts.[30] In July of 1995, in *Pacificare of Oklahoma, Inc. v. Burrage*, the United States Court of Appeals for the Tenth Circuit issued the first circuit court decision addressing this specific issue and held that vicarious liability malpractice claims against managed care organizations do not trigger ERISA preemption.[31]

This Note explores the arguments in favor of preemption as well as those opposing preemption of vicarious liability claims against managed care organizations and concludes that the arguments against preemption are ultimately more persuasive.[32] Further, this Note argues that a 1995 unanimous decision by the United States Supreme Court, *New York Conference of Blue Cross & Blue Shield v. Travelers Insurance Co.*, bolsters the argument against preemption.[33] Part I of this Note provides a general background on managed care and reviews state common law theories of liability of managed care organizations.[34] Part II introduces and explains the history of ERISA and then discusses the United States Supreme Court's interpretation of ERISA's preemption clause in a variety of settings.[35] Part III presents the reasoning of district courts' decisions finding that ERISA preempts common law vicarious liability claims against managed care providers.[36] Part IV discusses the decisions holding against preemption of such claims.[37] Part V argues that, in *Travelers*, the United States Supreme Court bolstered the argument against preemption of vicarious liability claims against managed care organizations.[38]

(same) *with* Jackson v. Roseman, 878 F. Supp. 820, 826 (D. Md. 1995) (holding against ERISA preemption of vicarious liability malpractice claims brought against managed care organizations) *and* Haas v. Group Health Plan, Inc., 875 F. Supp. 544, 549 (S.D. Ill. 1994) (same) *and* Kearney v. United States Healthcare, Inc., 859 F. Supp. 182, 187 (E.D. Pa. 1994) (same) *and* Smith v. HMO Great Lakes, 852 F. Supp. 669, 672 (N.D. Ill. 1994) (same) *and* Elsesser v. Hospital of Phila. College, 802 F. Supp. 1286, 1290 (E.D. Pa. 1992) (same) *and* Independence HMO, Inc. v. Smith, 733 F. Supp. 983, 989 (E.D. Pa. 1990) (same).

[30] The Eastern District of Pennsylvania has issued conflicting decisions. *Compare Visconti*, 857 F. Supp. at 1105 (holding in favor of preemption) *with Elsesser*, 802 F. Supp. at 1290 (holding against preemption). The District of Maryland has also issued conflicting decisions. *Compare Pomeroy*, 868 F. Supp. at 114 (holding in favor of preemption) *with Jackson*, 878 F. Supp. at 826 (holding against preemption).

[31] 59 F.3d 151, 155 (10th Cir. 1995).

[32] *See infra* Parts I–V.

[33] 115 S. Ct. 1671 (1995). *See infra* notes 378–404 and accompanying text.

[34] *See infra* notes 39–107 and accompanying text.

[35] *See infra* notes 108–220 and accompanying text.

[36] *See infra* notes 221–76 and accompanying text.

[37] *See infra* notes 277–349 and accompanying text.

[38] *See infra* notes 350–416 and accompanying text.

I. Background

A. *An Overview of Managed Care*

Over the last several years, the popularity of managed care has increased dramatically as an alternative to conventional fee-for-service medical insurance.[39] Traditionally, if a person were ill or injured, that person would visit any physician that he or she desired and would send the bill to his or her insurance company, which would then simply pay the bill for whatever services the physician had provided.[40] Under this traditional fee-for-service method of payment, however, health care costs increased rapidly over the past quarter century.[41] Whereas the Consumer Price Index ("CPI") increased 235.5% from 1971 to 1991, health care expenditures increased 398.9%, a rate of increase seventy percent greater than that of the CPI.[42] Furthermore, between 1980 and 1993, United States national health expenditures increased from $251.1 billion to $884.2 billion.[43] As a percentage of gross domestic product, health care expenditures increased from 9.3% to 13.9% over the same time period.[44]

The structure of the traditional fee-for-service method of providing medical care has contributed significantly to this rapid increase.[45] Under the fee-for-service model, insurance companies pay physicians for whatever procedures they prescribe.[46] Under this system, physicians have an incentive to over-prescribe care: if a physician's income is tied to the number and costs of procedures he or she performs, it follows a physician can increase his or her income by prescribing more (and more expensive) procedures.[47] This incentive to over-prescribe is manifested in several ways.[48] Freed from the burden of cost consideration, a physician may perform procedures or tests in borderline cases, "just

---

[39] *See* Laura A. Scofea, *The Development and Growth of Employer-Provided Health Insurance*, 117 Monthly Lab. Rev. 3, 7 (Mar. 1994).

[40] *Wasted Health Care Dollars*, Consumer Rep., July 1, 1992, at 436.

[41] Scofea, *supra* note 39, at 7.

[42] *Id.*

[43] National Center for Health Statistics, U.S. Dep't of Health and Human Services, Health, United States 219 (1995).

[44] *Id.*

[45] *Wasted Health Care Dollars*, *supra* note 40, at 436.

[46] *Id.* A consequence of the fee-for-service method of payment has been that physicians may not consider the costs of a given procedure in deciding whether or not to prescribe it. *Id.* at 438. Several studies have concluded that physicians frequently do not know the costs of the procedures that they prescribe. *Id.*

[47] *See id.* at 438–39.

[48] *See id.* at 439.

to be on the safe side."[49] Physicians may also engage in the practice of "defensive medicine," performing services that are of little or no value to the patient, but are recommended as a precaution against medical malpractice claims.[50] Physicians may also refer patients for treatment in facilities in which they have financial interests.[51] Or, physicians may prescribe patently unnecessary, at times even unhealthy, procedures.[52] One 1992 estimate put the cost of unnecessary care at more than two hundred million dollars.[53]

Managed care attempts to reduce health care costs in part by changing the system of incentives under which physicians operate.[54] Generally, managed care organizations compensate physicians on a per patient rather than a fee-for-service basis.[55] The organization grants the physician a set fee for each patient on a monthly basis, regardless of the care provided.[56] Because the physician's income is not tied to the number, type or expense of the procedures performed, he or she will be less likely to prescribe unnecessary and wasteful procedures, thus decreasing the costs of health care.[57] Ideally, the patient's needs—and not the potential income stemming from those needs—will dictate the physician's prescription of treatment.[58] In the managed care setting, primary care physicians typically serve as "gatekeepers" to higher levels of care.[59] All patients must first visit a primary care physician, who will refer only those patients whose condition warrants more expensive, specialized care.[60] As a further means of cutting health care costs, managed care organizations engage in "utilization review" to monitor

---

[49] Victor R. Fuchs, *No Pain, No Gain: Perspectives on Cost Containment*, 269 JAMA 631, 631 (1993).

[50] *Id.*

[51] *Wasted Health Care Dollars*, *supra* note 40, at 439. This practice is known as "self referral." *Id.* A Florida State University study estimated that in Florida, physician-owned laboratories performed twice as many tests per patient as independently owned labs. *Id.* A University of Arizona study estimated that physicians who had diagnostic imaging equipment, such as computerized tomography ("CT scan") or magnetic resonance imaging ("MRI") machines, in their offices order four times more imaging exams than physicians who referred patients elsewhere for tests. *Id.*

[52] Fuchs, *supra* note 49, at 631. For example, various researchers have estimated that up to 50% of caesarian sections, 27% of hysterectomies and 16% of tonsilectomies are performed unnecessarily. *Wasted Health Care Dollars*, *supra* note 40, at 441.

[53] *Wasted Health Care Dollars*, *supra* note 40, at 435.

[54] *See* Scofea, *supra* note 39, at 7.

[55] BARRY R. FURROW ET AL., 2 HEALTH LAW 53 (1995).

[56] *See* John K. Iglehart, *Health Policy Report: The American Health Care System, Managed Care*, 327 NEW ENG. J. MED. 742, 743 (1992).

[57] *See* Scofea, *supra* note 39, at 7; *Wasted Health Care Dollars*, *supra* note 40, at 436.

[58] *See Wasted Health Care Dollars*, *supra* note 40, at 438–39.

[59] Iglehart, *supra* note 56, at 745.

[60] *Id.*

and evaluate the medical necessity and appropriateness of their physicians' prescriptions of treatment.[61]

Managed care refers to care delivery systems that provide comprehensive health care services to an enrolled membership for a fixed fee.[62] Three types of health maintenance organizations ("HMOs") constitute major vehicles of managed care delivery—the staff model, the group model and the independent practice association ("IPA") model.[63] A staff model HMO employs its own salaried physicians, treating only HMO patients in a facility owned and operated by the HMO.[64] A group model HMO contracts with a group of physicians, generally a practice association, to devote much of its time to caring for HMO members at the group's facilities for a fixed monthly fee per covered individual.[65] In the IPA model, the HMO contracts with an independent association of physicians which in turn contracts with each of its dependent physicians to provide care to HMO members in his or her own office.[66] In both the group and IPA model, the participating physicians may also see patients that do not belong to the HMO.[67] A 1990 study found that 8.8% of HMO participants were enrolled in staff model HMOs, 21.6% in group model HMOs and 67.1% in IPAs.[68]

An equally popular managed care delivery system is the preferred provider organization ("PPO"). In 1994, the American Medical Care and Review Association estimated that nearly fifty-five million Americans were enrolled in PPOs.[69] A PPO is typically a network of physicians and hospitals that contracts to provide care to a defined group of

---

[61] *How to Put a Lid on Health Plan Costs Without Giving Up All Your Options*, PROFIT-BUILDING STRATEGIES FOR BUSINESS OWNERS, Sept. 1, 1990, at 6, *available in* WESTLAW, PROFBLDGST, File No. 2516483. Utilization review has been somewhat controversial and may be another source of liability for managed care organizations engaging in the process. *See* Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1326 (5th Cir. 1992), *cert. denied*, 113 S. Ct. 812 (1992) (plaintiff sued a managed care organization, alleging that the organization's utilization review process deprived her of medically necessary treatment which led to the death of her fetus); *infra* notes 225–34 and accompanying text for discussion of the case. In *Corcoran*, the United States Court of Appeals for the Fifth Circuit held that ERISA preempted plaintiff's action. *Id.* at 1334.

[62] FURROW ET AL., *supra* note 55, at 53.

[63] *See* Diana Joseph Bearden & Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 BAYLOR L. REV. 285, 292 (1995).

[64] *Id.*

[65] *Id.* at 292–93.

[66] *Id.* at 293.

[67] FURROW ET AL., *supra* note 55, at 54.

[68] *Id.*

[69] Paul J. Kenkel, *PPOs Pursue New Links with Providers*, MOD. HEALTHCARE, Mar. 14, 1994, at 42.

patients on a fee-for-service basis.[70] PPOs are able to offer discounts of approximately twenty percent to subscribers using plan-designated hospitals and physicians because the PPO system provides an assured volume of business and prompt payment.[71] PPOs also assess penalties in the form of higher deductibles and co-payments against subscribers who use non-designated hospitals and physicians.[72] Recently, managed care systems have grown in popularity as a means of providing more cost-effective yet still medically comprehensive health care.[73] In 1994, the Group Health Association of America found that in the last fifteen years the number of persons enrolled in HMOs increased five-fold, from less than ten million in 1982 to an expected fifty-six million in 1995.[74] In 1995, the Wall Street Journal estimated that managed care health plans cover sixty-three percent of the under sixty-five employee market, twenty-three percent of Medicaid recipients and nine percent of Medicare recipients.[75] It is estimated that at least half of all practicing physicians are involved in a managed care organization.[76]

Although the long-term cost effects of managed care are highly speculative and equally highly disputed, some recent studies have indicated that managed care has reduced health care costs.[77] For example, a 1995 study conducted by KPMG Peat Marwick, a management consulting firm, calculated that in 1993, hospital costs in areas with high levels of managed care were 11.5% lower than the national average, whereas such costs in areas with only moderate levels of managed care were 3.6% higher than the average.[78] The study further found that in areas with high levels of managed care, hospital stays were 16.9% shorter than expected for patients with similar medical conditions, whereas in areas with low levels of managed care, hospital stays were 17.5% longer than expected.[79]

---

[70] *How to Put a Lid on Health Plan Costs*, *supra* note 61, at 6.

[71] *Id.*

[72] *See* John Lewis Smith III and Lawrence L. Lamade, *Preferred Provider Plans Break New Legal Ground*, LEGAL TIMES, Nov. 21, 1983, ed. 1, at 27.

[73] *See* Bearden & Maedgen, *supra* note 63, at 287; Scofea, *supra* note 39, at 7.

[74] *See* Marie Gordon, *HMOs Post Member Growth*, BOSTON HERALD, Dec. 8, 1994, at 45.

[75] George Anders & Laurie McGinley, *Managed Eldercare: HMOs are Signing Up New Class of Member: The Group in Medicare*, WALL ST. J., Apr. 27, 1995, at A1. A 1993 article estimated that managed care systems will cover between 70% and 80% of insured persons by 1997. George Anders, *Robust Profits Seen for HMOs in 2nd Quarter*, WALL ST. J., July 6, 1993, at A7A.

[76] Iglehart, *supra* note 56, at 743.

[77] *See, e.g.*, *Hospital Costs, Patient Stays Lower in Managed Care Settings*, 1 Managed Care Rep. (BNA) 20 (July 5, 1995).

[78] *Id.*

[79] *Id.*

With the rise of managed care has come a corresponding rise in the frequency of malpractice suits against managed care organizations.[80] Prior to the emergence of managed care, courts had applied traditional notions of agency and tort to vicarious liability malpractice claims against hospitals and other medical care institutions.[81] The common law adapted to the rise of managed care by applying much of the same reasoning in vicarious liability malpractice suits against managed care organizations that it had applied to similar suits against hospitals.[82]

B. *Common Law Theories of Recovery Against Managed Care Organizations for the Malpractice of Their Physicians and Other Health Care Personnel*

The common law of many states allows a victim of malpractice to recover from a managed care organization for the negligence of its health care providers.[83] Under the doctrine of vicarious liability, a managed care organization may be held liable for the negligent acts of its employees and agents.[84] Plaintiffs bringing suit under the doctrine of vicarious liability typically proceed under one of two general theories: respondeat superior or ostensible agency.[85]

Under the theory of respondeat superior, a plaintiff must prove that the provider performed negligently, that there was a direct employment relationship between the managed care organization and the provider, and that the provider was acting within the scope of his or her employment when the alleged malpractice occurred.[86] The availability of respondeat superior theory is limited to plaintiffs participating in staff model HMOs, because the staff model HMO is the only system where the provider is in a direct employment relationship with

---

[80] William A. Chittenden III, *Malpractice Liability and Managed Health Care: History and Prognosis*, 26 TORT & INS. L.J. 451, 453 (1991).

[81] *See id.* at 454.

[82] *Id.*

[83] *See, e.g.*, Boyd v. Albert Einstein Med. Ctr., 547 A.2d 1229, 1235 (Pa. Super. Ct. 1988) (holding that HMO may be liable for negligent treatment of an affiliated physician); Sloan v. Metropolitan Health Council, 516 N.E.2d 1104, 1109 (Ind. Ct. App. 1987) (holding that HMO may be liable for negligent treatment of staff physician).

[84] *See* RESTATEMENT (SECOND) OF AGENCY § 251 (1958) ("A principal is subject to liability for physical harm to the person or the tangible things of another caused by the negligence of a servant or non-servant. . . ."); WILLIAM L. PROSSER, THE LAW OF TORTS §§ 69–74, at 458–93 (4th ed. 1971).

[85] O. Mark Zamora, *Medical Malpractice and Health Maintenance Organizations: Evolving Theories and ERISA's Impact*, 19 NOVA L. REV. 1047, 1048 (1995).

[86] Chittenden *supra* note 80, at 453–54.

the organization.[87] For example, the Indiana Court of Appeals determined in *Sloan v. Metropolitan Health Council, Inc.*, that a direct employment relationship arguably existed where a staff model HMO engaged physicians by written "employment contracts" that referred to the HMO as "Employer" and provided for an annual salary as well as a benefits package.[88] Furthermore, the HMO exercised control over the physicians by means of a medical director who set policy and monitored medical services.[89] Because these features could create a reasonable inference that an employment relationship existed between the HMO and its physicians, the court denied the HMO's motion for summary judgment and held that the HMO could be liable for the malpractice of its physicians.[90]

Conversely, in group or IPA model HMOs and in PPOs, which constitute the majority of managed care organizations, the health care providers are usually independent contractors, not employees, of the organization.[91] Participants in such plans have therefore relied upon the doctrine of "ostensible agency," which allows recovery from a principal for the actions of an independent contractor if the independent contractor is an apparent agent of the principal.[92] Under the ostensible agency doctrine, a patient may recover from a managed care organization for the malpractice of its independent contractor physicians where (a) there is a likelihood that patients will look to the managed care organization rather than the individual physician for care, and (b) the managed care organization "holds out" the physician as its employee.[93] When determining whether the patient looks to the or-

---

[87] *See* Bearden & Maedgen, *supra* note 63, at 299, 300–01.

[88] 516 N.E.2d 1104, 1105, 1109 (Ind. Ct. App. 1987).

[89] *Id.* at 1109.

[90] *Id.*

[91] *See* Bearden & Maedgen, *supra* note 63, at 301, 305–06.

[92] *Id.* at 310. WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 1597 (1986) defines ostensible agency as "agency by estoppel arising when a principal has intentionally or negligently caused a third person to believe and rely upon the apparent authority of his supposed agent even though it has not been given." The RESTATEMENT (SECOND) OF TORTS § 429 (1965) provides:

> One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or his servants, is subject to liability for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as though the employer were supplying them himself or by his servants.

The RESTATEMENT (SECOND) OF AGENCY § 267 (1958) similarly provides:

> One who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.

[93] *See, e.g.*, Boyd v. Albert Einstein Med. Ctr., 547 A.2d 1229, 1232 (Pa. Super. 1988).

ganization for care, courts consider factors such as the degree of control the plan exerts over physician selection and whether the physician's malpractice arose out of "the performance of an inherent function" of the plan.[94] Whether the organization "holds out" the physician as its employee depends on representations made by the organization to the patient.[95]

In *Boyd v. Albert Einstein Medical Center*, the Superior Court of Pennsylvania denied a defendant HMO's motion for summary judgment and allowed a plaintiff to bring suit against the HMO for the malpractice of two participating physicians.[96] In performing a biopsy of Chardella Boyd's breast tissue, Dr. Erwin Cohen perforated her chest wall with the biopsy needle.[97] Two months later, Ms. Boyd consulted Dr. David Rosenthal, who had originally referred her to Dr. Cohen for the biopsy, and Dr. Perry Dornstein about persistent chest pains.[98] After performing a series of tests, Dr. Rosenthal sent Ms. Boyd home to rest.[99] Later that day she was found dead of a myocardial infarction.[100] Because the defendant HMO restricted physician selection to a limited list, received payment directly from plan participants and used its primary care physicians as gatekeepers to higher level care, the court denied the defendant HMO's motion for summary judgment and concluded that a reasonable jury could infer that the HMO had held out the physicians as its employees.[101] The court also reasoned that a reasonable jury could infer that Ms. Boyd looked to the defendant HMO rather than to the individual physicians for care.[102] Holding that the physicians in question arguably were ostensible agents of the HMO, the court concluded that the HMO may be liable for the physicians' negligence.[103]

Prior to the early 1990s, managed care organizations defended vicarious liability malpractice claims under the common law available to them.[104] Over the past five years, however, a new trend has emerged

---

[94] Chittenden, *supra* note 80, at 454, 459.

[95] *Id.* at 460.

[96] 547 A.2d at 1235.

[97] *Id.* at 1230.

[98] *Id.*

[99] *Id.*

[100] *Id.*

[101] *Boyd*, 547 A.2d at 1235.

[102] *Id.*

[103] *Id.*

[104] Presently, because ERISA only controls employee benefit plans, state common law continues to control claims brought by plaintiffs who are insured through means other than their employer. *See* 29 U.S.C. § 1003(a). Such persons, however, represent only a minority of those who

in the way managed care organizations defend such suits.[105] Managed care organizations that administer health care as part of an employee benefits package have increasingly defended such claims by arguing that ERISA completely preempts vicarious liability malpractice claims.[106] This argument has been widely successful for defendant managed care organizations and has sparked great debate among federal district courts.[107]

II. ERISA AND THE UNITED STATES SUPREME COURT'S INTERPRETATION OF THE "PREEMPTION CLAUSE"

Responding to what it perceived as a rapid "growth in size, scope and numbers" of private employee benefit plans, in 1974, Congress enacted the Employee Retirement Income Security Act ("ERISA").[108] Because of the wage freezes during World War II and the Korean War, employers had increasingly looked towards employee benefit plans as a form of deferred compensation.[109] During the post-World War II years, the use of such plans expanded significantly: whereas in 1940 approximately four million employees were covered by private employee benefit plans, that number had risen to more than thirty million by the early 1970s, a figure representing almost half of the nation's private non-agricultural work force.[110]

By the early 1970s, Congress had found that its previous attempts to regulate private employee benefit plans had proven wholly insufficient.[111] One such attempt, its 1958 Welfare and Pension Plans Disclosure Act ("WPPDA"), required plan administrators to file with the Secretary of Labor and furnish to plan participants and their beneficiaries, upon written request, a description and annual report of the plan.[112] The WPPDA, however, made no substantive demands upon plan administrators regarding plan accounting procedures, admini-

---

are insured. *See* Karen Davis et al., *Choice Matters: Enrollees' Views on Their Health Plans*, 14 HEALTH AFF. 99, 100 (Summer 1995). Indeed, as of 1994 an estimated 63% of the non-elderly population was covered by employee benefit plans. *Id.*

[105] *See* Chittenden, *supra* note 80, at 485.

[106] *Id.*

[107] *Id.* at 485 n.171; *see also infra* notes 221–349 and accompanying text.

[108] 29 U.S.C. § 1001.

[109] H.R. REP. No.93–533, at 2 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4640. In 1942, Congress enacted the Stabilization Act, which limited employee wage increases but allowed employee insurance plans. Scofea, *supra* note 39, at 6.

[110] H.R. REP. No. 93–533, at 3, *reprinted in* 1974 U.S.C.C.A.N. 4639, 4641.

[111] *Id.* at 4642.

[112] *Id.*

stration or vesting rights.[113] In 1962, Congress amended the WPPDA and established as federal crimes theft, embezzlement, bribery and kickbacks occurring in connection with welfare and pension plans.[114]

Despite this legislation, employee benefit plans were still subject to widespread and relatively unchecked abuse.[115] Furthermore, because the amended WPPDA only required disclosure at the request of employees, employees bore the burden of policing their own individual plans.[116] Consequently, employees with many years of service often found that their benefits had not vested for some undisclosed reason.[117] Many employees and their dependents similarly lost benefits upon the premature termination of plans by plan administrators or their employers.[118]

In addition to finding the amended WPPDA ineffective, Congress in the early 1970s also recognized that the total value of assets in private benefit plans was more than $150 billion, the largest amount of private money to have thus far escaped effective federal regulation.[119] Such a large sum of money had the potential power of influencing national savings levels, the operation of capital markets, the financial security of millions of individuals and the flow of interstate commerce.[120] Recognizing the magnitude of money controlled by private employee benefit plans, the millions of lives affected by the plans and the failure of past legislation which provided "only indirect, partial, or sporadic protection of participants, pensioners, and their beneficiaries," Congress enacted ERISA to bring the entire field of employee benefit plans under a uniform federal statutory scheme.[121]

ERISA covers all employee benefit plans "maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise" medical

---

[113] *See id.*; Act of Aug. 28, 1958, Pub. L. No. 85–836, 72 Stat. 997, 997–1003, *repealed by* Employee Retirement Income Security Act, 29 U.S.C. § 1031(a)(1) (1994).

[114] H.R. REP. No. 93–533, at 4, *reprinted in* 1974 U.S.C.C.A.N. 4639, 4642; Act of Mar. 20, 1962, Pub. L. No. 87–420, 76 Stat. 35, 41–42, *repealed by* Employee Retirement Income Security Act, 29 U.S.C. § 1031(a)(1) (1994).

[115] *See* H.R. REP. No. 93–533, at 4, *reprinted in* 1974 U.S.C.C.A.N. 4639, 4642.

[116] *Id.*

[117] *See* 29 U.S.C. § 1001(a).

[118] *Id.*

[119] H.R. REP. No. 93–533, at 3, *reprinted in* 1974 U.S.C.C.A.N. 4639, 4641.

[120] *Id.* at 2, *reprinted in* 1974 U.S.C.C.A.N. 4639, 4640.

[121] *Id.*; Jay Conison, *ERISA and the Language of Preemption*, 72 WASH. U. L. REV. 619, 642 (1994).

or other benefits.[122] Congress's avowed purpose in enacting ERISA was to "protect interstate commerce . . . and the interests of participants in employee benefit plans" by initiating reporting and disclosure requirements and by establishing federal standards of conduct for those running such benefit plans.[123] Congress further sought to establish uniform minimum standards regarding requirements of the vesting of plan benefits, fiscal responsibility of plan administrators and disclosure of plan specifics.[124] Concerned that a full one-half of all non-agricultural private employees remained without the coverage of any sort of retirement plan, Congress hoped that ERISA's clear and uniformly regulated statutory scheme would encourage employers to further expand their use of employee benefit plans.[125]

In furtherance of its goal of "providing for appropriate remedies, sanctions, and ready access to the Federal courts,"[126] ERISA provides a civil remedy provision that enumerates causes of action by which various plaintiffs may bring suit against employee benefit plans.[127] Under the civil remedy provision, a plan beneficiary may sue the plan for, among other things, refusal to provide required information, denial of benefit rights, breach of fiduciary duty and enforcement of ERISA's provisions.[128] The civil remedy provision provides no cause of action for vicarious liability claims brought against managed care organiza-

---

[122] 29 U.S.C. §§ 1002(1), 1003. 29 U.S.C. § 1003(a) further defines a plan covered by the statute as

> [a]ny employee benefit plan if it is established or maintained–
> (1) by any employer engaged in commerce or in any industry or activity affecting commerce; or
> (2) by any employee organization or organizations representing employees engaged in commerce or in any industry affecting commerce; or
> (3) by both.

Id. 29 U.S.C. § 1003(b) exempts from ERISA coverage

> [a]ny employee benefit plan if–
> (1) such plan is a governmental plan . . . ;
> (2) such plan is a church plan . . . ;
> (3) such plan is maintained solely for the purposes of complying with applicable workmen's compensation laws or unemployment compensation or disability laws;
> (4) such plan is maintained outside of the United States primarily for the benefit of persons substantially all of whom are nonresident aliens; or
> (5) such plan is an excess benefit plan . . . and is unfunded.

Id.

[123] *Id.* § 1001(c).

[124] *Id.* § 1001(b).

[125] S. REP. NO. 93–383, at 9 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4890, 4900; H.R. REP. NO. 93–533, at 2, *reprinted in* 1974 U.S.C.C.A.N. 4639, 4640.

[126] 29 U.S.C. § 1001(b).

[127] *Id.* § 1132.

[128] *Id.*

tions affiliated with an ERISA plan and is thus of no help to a plaintiff attempting to bring such a claim.[129]

To ensure uniform regulation of employee benefit plans, Congress included in ERISA a broad preemption clause.[130] ERISA section 514(a) provides that the act "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under 1003(b) of this title."[131] Yet Congress also expressly limited this broadly worded proclamation, stating in section 514(b)(2), the "savings clause," that the preemption clause "shall [not] be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities."[132] Recognizing, however, that states might attempt to pass laws regulating employee benefit plans under the guise of regulating insurance, Congress also included section 514(b)(2)(B), the "deemer clause," which states that neither employee benefit plans nor trusts established under such plans "shall be deemed to be an insurance company . . . for the purposes of State law purporting to regulate insurance companies . . . ."[133]

ERISA's definition of "State law" includes "all laws, decisions, rules, regulations, or other State action having the effect of law, of any State" and encompasses both state statutes and common law causes of action, such as vicarious liability malpractice claims.[134] Consequently, the preemption clause has become a major source of confusion as to whether a plaintiff may recover from a managed care organization for the negligence of its physicians.[135] Courts deciding this issue must determine exactly what sorts of state laws Congress intended ERISA to preempt.[136] Prior to 1995, federal district courts had been unable to look to higher courts for guidance on the specific issue of whether ERISA preempts vicarious liability malpractice claims against managed

---

[129] *See id.*

[130] H.R. REP. No. 93-533, at 17, *reprinted in* 1974 U.S.C.C.A.N. 4639, 4655 ("Because of the interstate character of employee benefit plans, . . . it [is] essential to provide for a uniform source of law . . . in lieu of burdensome multiple" administration.).

[131] 29 U.S.C. § 1144(a).

[132] 29 U.S.C. § 1144(b)(2)(A).

[133] *Id.* § 1144(b)(2)(B).

[134] *See id.* § 1144(c)(1).

[135] *Compare* Pomeroy v. Johns Hopkins Medical Serv., 868 F. Supp. 110, 114 (D. Md. 1994) (holding that ERISA preempts vicarious liability malpractice claims against managed care organizations) *with* Haas v. Group Health Plan, 875 F. Supp. 544, 549 (S.D. Ill. 1994) (holding that ERISA does not preempt vicarious liability malpractice claims against managed care organizations).

[136] *See, e.g.*, Airparts Co. v. Custom Benefits Serv. of Austin, Inc., 28 F.3d 1062, 1064-65 (10th Cir. 1994); United Wire v. Morristown Memorial Hosp., 995 F.2d 1179, 1195 (3d Cir. 1993).

care organizations.[137] The United States Supreme Court and the circuit courts of appeals, however, had developed a sizable body of case law on ERISA preemption in a variety of other settings.[138] Therefore, district courts have looked to this body of law for guidance in determining whether ERISA preempts vicarious liability malpractice claims.[139]

In 1981, in *Alessi v. Raybestos-Manhattan, Inc.*, the United States Supreme Court held that ERISA preempted a New Jersey statute that prohibited private pension plans from reducing a retiree's benefits by the amount the retiree received in workers' compensation awards subsequent to retirement.[140] The Court stated that respect for the separate spheres of federal and state authority established by the federalist system should govern determinations of federal preemption of state law.[141] Therefore, absent persuasive reasons, such as a clear expression of congressional intent, the Court should be reluctant to hold a federal statute to preempt a state law.[142] The Court found, however, the explicit congressional statement about the preemptive effect of section 514(a) to be a great help in determining Congress's intent in enacting ERISA, thus significantly simplifying its task.[143] The Court interpreted the preemption clause's proclamation that ERISA shall "supersede any and all State laws insofar as they . . . relate to any employee benefit plan" as a clear indication that Congress intended to establish the regulation of employee benefit plans as "exclusively a federal concern."[144]

In *Alessi*, the Court reasoned that the statute at issue "related to" ERISA plans within the meaning of section 514(a) because the statutory provisions prohibiting benefit offsets based on workers' compensation benefits effectively eliminated one method of calculating pension benefits permitted by federal law.[145] The Court concluded that upholding a statutory provision that precluded on the state level a

---

[137] *See* Pacificare of Okla., Inc. v. Burrage, 59 F.3d 151, 153 (10th Cir. 1995).

[138] *See infra* notes 140–234 and accompanying text.

[139] *See infra* notes 219–349 and accompanying text.

[140] 451 U.S. 504, 507, 526 (1981). Whereas the 1977 amendments to the state's Workers' Compensation Act allowed plans to reduce disability benefits or payments by the amount of worker's compensation received by the plan participant, they expressly precluded such reduction of retirement benefits. *Id.* at 508 (citing N.J. STAT. ANN. § 34:15–29 (West Supp. 1980–1981) (as amended by N.J. Laws, ch. 156)).

[141] *Id.* at 522.

[142] *Id.*

[143] *Id.*

[144] *See id.* at 523; *see also* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 45–46 (1987) (holding ERISA to preempt state common law tortious breach of contract, breach of fiduciary duties and fraud in inducement claims).

[145] *Alessi*, 451 U.S. at 524.

method of accounting acceptable at the federal level would be inconsistent with Congress's explicitly articulated desire to bring the regulation of employee benefit plans under a uniform federal system.[146] The Court held that ERISA therefore preempted the state statute.[147]

In 1983, in *Shaw v. Delta Airlines, Inc.*, the United States Supreme Court held that ERISA preempted provisions of two New York statutes, the Human Rights Law and the Disability Benefits Law, which forbade discrimination based on pregnancy in employee benefit plans and required employers to pay benefits to employees unable to work because of pregnancy.[148] The Court first explained that defining what Congress meant by the phrase "relate to" is the key to determining the extent of the preemption clause's reach, and ultimately to determine whether ERISA preempts a state law.[149] The Court noted that the broad scope of ERISA's preemption clause is evident from the plain language of the statute.[150] The Court characterized section 514(a) as an explicit articulation of Congress's intention to ensure governance of employee benefit plans by a uniform body of federal law.[151] The Court stated that Congress aimed to minimize the burden, confusion and expense that complying with conflicting state and federal laws would impose upon plan administrators.[152] The Court reasoned that the explicit statutory language "relate to" reflects Congress's desire to preempt not only state laws that directly affect employee benefit plans, but also state laws that indirectly infringe upon ERISA's exclusive control over the field of employee benefit plans.[153] Although recognizing that some state laws might "affect employee benefit plans in too tenuous, remote or peripheral a manner to warrant a finding that the law 'relates to' the plan," the Court stated that it would construe the phrase extremely broadly and hold that a law relates to an employee benefit plan "if it has a *connection with* or *reference to* such a plan."[154]

---

[146] *See id.* at 524–25.

[147] *Id.* at 526.

[148] 463 U.S. 85, 88, 89, 108–09 (1983). New York's Human Rights Law, a general anti-discrimination statute, forbade discrimination based on a variety of conditions or characteristics, including pregnancy. *Id.* at 88 (citing N.Y. Exec. Law §§ 290–301 (McKinney 1982 and Supp. 1982–1983)). New York's Disability Benefits Law required employers to pay benefits to employees unable to work because of a variety of non-occupational illnesses, including pregnancy. *Id.* at 89 (citing N.Y. Work. Comp. Law §§ 220–242 (McKinney 1965 and Supp. 1982–1983)).

[149] *See id.* at 96.

[150] *Id.*

[151] *See id.* at 105 & n.25 (citing *Alessi*, 451 U.S. at 523).

[152] *Id.* at 105 n.25, 107–08.

[153] *See Shaw*, 463 U.S. at 98.

[154] *Id.* at 96–97, 100 n.21 (emphasis added).

The *Shaw* Court found support for its expansive interpretation of "relate to" in ERISA's legislative history.[155] In hearings prior to enacting ERISA, both the House and Senate sponsors underscored the broad scope of the preemption clause; Representative John H. Dent hailed the reservation of exclusive power over employee benefit plans to the federal government as "ERISA's crowning achievement," while Senator Harrison A. Williams stated that the preemption clause was "intended to apply in its broadest sense to all actions of State or local governments . . . which have the force and effect of law."[156] The *Shaw* Court noted that while the bills originally introduced into the House and the Senate both limited preemption to the subject matters directly regulated by ERISA, the version later enacted contained no such restriction.[157] Moreover, the Court reasoned that if Congress intended to limit the scope of preemption to only those statutes dealing directly with ERISA, it would not have exempted from preemption state laws regulating insurance or generally applicable state criminal laws, nor would it have included a civil enforcement provision.[158]

The Court found that the Human Rights Law "related to" ERISA plans because the statute, which prohibited employers from structuring their benefit plans in such a way as to discriminate based on pregnancy, made reference to such plans.[159] Limiting its holding to preempt the Human Rights Law only insofar as it pertained to ERISA plans, the Court pointed out that ERISA preemption had no effect on the statute's prohibition of employment discrimination in hiring, promotion and salary.[160] Finally, the Court held that New York's Disability Benefits Law "related to" ERISA plans because the statute required employers to pay specific benefits to employees.[161] Although the Court did not hold ERISA to preempt the Disability Benefits Law, it did hold that New York could not enforce the statute by means of regulating ERISA plans.[162]

The Supreme Court has had little trouble applying the portion of the *Shaw* decision that defined the scope of "relate to" as including

---

[155] *Id.* at 98–99.

[156] *Id.* at 99.

[157] *Id.* at 98.

[158] *Shaw*, 463 U.S. at 98. See *supra* notes 130–39 and accompanying text for discussion of § 514(b) exemptions from the preemption clause. See *supra* notes 126–29 and accompanying text for coverage of § 502, the civil remedies provision.

[159] *See Shaw*, 463 U.S. at 97.

[160] *Id.* at 97 n.17.

[161] *Id.* at 97.

[162] *Id.* at 109.

state laws that make "reference to" employee benefit plans.[163] For instance, in 1988, in *Mackey v. Lanier Collection Agency & Services, Inc.*, the Court held that ERISA preempted a Georgia statute proscribing garnishment of employee benefits.[164] The statute at issue in *Mackey* specifically exempted from all garnishment proceedings benefits of an employee benefit plan subject to the provisions of ERISA except those based upon a judgment for child support.[165] Emphasizing that the statute not only made specific reference to ERISA plans, but applied exclusively to them, the Court reasoned that the statute necessarily "related to" ERISA plans.[166] ERISA, therefore, preempted the statute.[167]

In 1990, in *FMC Corp. v. Holliday*, the United States Supreme Court held that ERISA preempted a Pennsylvania statute that prohibited employee benefit plans from subrogating a claimant's tort recovery.[168] In *FMC Corp.*, an employee and his family were members of FMC Salaried Health Care Plan, an employee benefit plan under the terms of ERISA.[169] When the employee's daughter was seriously injured in an automobile accident, FMC paid a portion of her medical expenses.[170] The daughter later recovered damages in a negligence action that she brought against the other driver involved in the accident, and FMC brought suit seeking reimbursement for the amount it had expended.[171] Pennsylvania's Motor Vehicle Financial Responsibility Law, however, precluded employee benefit plans from exercising subrogation or reimbursement rights on a plan participant's tort recovery.[172] Yet, the Supreme Court held that the Pennsylvania statute "related to" ERISA plans because it referred to benefit plans which may be governed by ERISA.[173] Therefore, the Court held that ERISA preempted the anti-subrogation statute and allowed FMC to proceed in its subrogation action.[174]

---

[163] *See id.* at 96–97 (stating that a law "'relates to' an employee benefit plan . . . if it has a connection with or *reference to* such a plan") (emphasis added).

[164] 486 U.S. 825, 830 (1988).

[165] *Id.* at 828 & n.2 (citing GA. CODE ANN. § 18–4–22 (1982)).

[166] *Id.* at 829, 830.

[167] *Id.*

[168] 498 U.S. 52, 55, 65 (1990).

[169] *Id.* at 54.

[170] *Id.* at 54–55.

[171] *Id.* at 55.

[172] *Id.* at 55 & n.1 (citing PA. CONS. STAT. § 1720 (1987).

[173] *FMC*, 498 U.S. at 59, 65. The statute protected from subrogation all benefits received through "[a]ny program, group contract or other arrangement for payment of benefits." *Id.* at 55 (citing PA. CONS. STAT. § 1719 (1987)).

[174] *Id.* at 65.

In 1992, in *District of Columbia v. Greater Washington Board of Trade*, the United States Supreme Court held that ERISA preempted a District of Columbia statute requiring employers who provide health coverage to also provide equivalent coverage to injured employees eligible for workers' compensation benefits.[175] The Court concluded that the the District of Columbia statute referred to ERISA plans as a baseline for determining the level of coverage the statute mandated for injured workers.[176] Therefore, the Court reasoned that the statute's mere reference to such plans provided a sufficient relationship between the statute and the plan to mandate preemption.[177]

In contrast to the consistency with which the Court has applied *Shaw*'s holding that ERISA preempts statutes referring to ERISA plans, the Court has had much more difficulty applying the portion of the *Shaw* decision that interprets "relate to" to include state laws that have a "connection with" employee benefit plans.[178] In 1987, in *Pilot Life Insurance Co. v. Dedeaux*, the United States Supreme Court held that ERISA preempted a plaintiff's state law claims against his insurer's tortious breach of contract, breach of fiduciary duties and fraud in the inducement.[179] The plaintiff alleged that his insurer had improperly processed his claim for permanent disability stemming from a back injury, resulting in a loss of benefits.[180] In reaching its decision, the Court relied upon the expansive sweep of the preemption clause established in *Shaw*.[181] The Court reasoned that the plaintiff's common law claims amounted to allegations of improper processing of a claim and thus attacked plan administration.[182] Actions challenging plan administration, the Court concluded, necessarily "relate to" plans and therefore are subject to preemption.[183] The Court further reasoned

---

[175] 113 S. Ct. 580, 582 (1992). The District of Columbia Workers' Compensation Equity Amendment Act of 1990 provided in relevant part: "Any employer who provides health insurance coverage for an employee shall provide health insurance coverage equivalent [to the employee's existing coverage] while the employee receives or is eligible to receive workers' compensation benefits . . . ." *Id.* (citing D.C. CODE ANN. § 36–307(a–1)(1) (Supp. 1992)).

[176] *Id.* at 584. ERISA § 3(1) defines plans covered by the statute in part as "any plan, fund, or program which [is] maintained by an employer . . . for the purpose of providing [benefits] for its participants and their beneficiaries." 29 U.S.C § 1002(1) (1994).

[177] *Greater Wash. Bd. of Trade*, 113 S. Ct. at 583.

[178] *See* Shaw v. Delta Airlines, 463 U.S. 85, 96–97 (1983) (stating that a law "'relates to' an employee benefit plan . . . if it has a *connection with* or reference to such a plan") (emphasis added).

[179] 481 U.S. 41, 43, 57 (1987).

[180] *Id.* at 43.

[181] *Id.* at 47.

[182] *See id.* at 48.

[183] *See id.* at 47–48.

that Congress intended that the civil remedy provisions set forth in ERISA section 502(a) to be the exclusive vehicle by which plan participants may sue to recover benefits due under the plan, to enforce rights under the plan or to clarify rights to future benefits.[184] The Court concluded that allowing varying state law remedies to supplement the remedies provided in ERISA would undermine Congress's goal of uniform regulation.[185] The Court thus barred the plaintiff's common law suit.[186]

Conversely, in 1987, in *Fort Halifax Packing Co. v. Coyne*, the United States Supreme Court, by a five-to-four majority, held that ERISA did not preempt a Maine statute requiring employers to provide a one-time severance payment to employees in the event of a plant closing.[187] The Court determined that the purpose of the preemption clause was to prevent fragmented state-by-state regulation of employee benefit plans in favor of a uniform system of federal regulation.[188] Because the statute did not establish any substantive requirements that would affect plan administration in such a way as to undermine Congress's goal of uniform regulation, the Court concluded that the statute did not "relate to" ERISA plans for the purposes of preemption.[189] Reasoning that a one-time, lump-sum payment that the employer may never have to make required no particular administrative scheme to comply with the statute, the Court held that ERISA did not preempt the statute.[190]

The dissenting opinion attacked the majority's reliance on the fact that the statute did not burden plan administration.[191] The dissent argued that any state law requiring employers to pay benefits to employees necessarily "relates to" ERISA plans.[192] The dissent further maintained that the statute actually created a benefit plan within the meaning of ERISA because it established a mechanism by which employers had to pay benefits to employees.[193] Reasoning that the major-

---

[184] *Pilot Life*, 481 U.S. at 52 & n.3.

[185] *Id.* at 56.

[186] *Id.* at 57.

[187] 482 U.S. 1, 5, 23 (1987). The statute at issue provided that "[a]ny employer who relocates or terminates a covered establishment shall be liable to his employees for severance pay at the rate of one week's pay for each year of employment by the employee in that establishment." *Id.* at 4 n.2 (quoting ME. REV. STAT. ANN. tit. 26, § 625-B (West Supp. 1986–1987)).

[188] *Id.* at 11.

[189] *Id.* at 12, 23.

[190] *Id.* at 12.

[191] *Id.* at 23 (White, J., dissenting).

[192] *Fort Halifax*, 482 U.S. at 24 (White, J., dissenting) (citing *Shaw*, 463 U.S. at 97).

[193] *See id.* (White, J., dissenting).

ity's administrative scheme rationale would be inconsistent with Congress's intent, as clearly articulated in section 514(a), to preempt all state laws that relate to ERISA plans, the dissent argued that ERISA should preempt the statute.[194]

In 1988, in *Mackey v. Lanier Collection Agency & Services, Inc.*, the United States Supreme Court upheld Georgia's general garnishment statute against a preemption challenge while holding ERISA to preempt another Georgia statute barring garnishment of funds due to participants in ERISA plans.[195] Although the operation of the statute would lead to burdens on plan administration costs in that the statute would force the plan to act as garnishee of its participants' benefits, the Court, in a five-to-four portion of the opinion, reasoned that such burdens were not sufficiently related to plans to trigger preemption.[196] The Court pointed to other provisions in ERISA allowing for actions against employee benefit plans that would affect administrative costs as indicative of Congress's intent not to preclude state law judgments against ERISA plans.[197] For example, ERISA section 502, the civil remedy provision, expressly allows for civil enforcement actions against ERISA plans.[198] Moreover, section 502(d)(1) provides for the enforcement of money judgments against ERISA plans.[199] The Court thus concluded that Congress did not intend to preempt such commonplace "run-of-the-mill state-law claims" against employee benefit plans for actions such as unpaid rent, debts or torts committed by the plan.[200] Concluding that Georgia's general garnishment was a permissible mechanism of recovery from ERISA plans, the Court held that ERISA did not preempt the statute.[201]

The dissenting opinion in *Mackey* argued that Georgia's general garnishment statute should have been preempted.[202] The dissent emphasized that garnishment statutes require plans to act as garnishees, a responsibility which significantly burdens plan administration and cost.[203] A plan acting as garnishee would have to determine each debtor participant's entitlement, determine how much each participant owed

---

[194] *Id.* at 26 (White, J., dissenting).

[195] 486 U.S. 825, 830, 841 (1988). See *supra* notes 163–67 and accompanying text for a discussion of the Court's preemption of the anti-garnishment statute.

[196] *Id.* at 831, 841.

[197] *Id.* at 831–32.

[198] *Id.* at 832. See *supra* note 126–29 and accompanying text for a discussion of § 502.

[199] *Id.* at 832–33 (citing 29 U.S.C. § 1132(d)(1)).

[200] *Mackey*, 486 U.S. at 833.

[201] *Id.* at 841.

[202] *Id.* (Kennedy, J., dissenting).

[203] *Id.* at 842 (Kennedy, J., dissenting).

garnishing creditors, and make payments to a state court.[204] Therefore, the dissent argued that a state law having such a direct impact on plan administration necessarily "relates to" the plan and therefore should be preempted.[205]

In 1990, in *Ingersoll-Rand Co. v. McClendon*, the United States Supreme Court held that ERISA preempted a state common law claim for wrongful discharge.[206] In *Ingersoll-Rand*, the Company fired an employee as part of a company-wide reduction in force, four months before his pension benefits would have vested.[207] The Court reasoned that the plaintiff's subsequent common law action for wrongful discharge "related to" the plan simply because the action was premised on the existence of such a plan.[208] Had the employee not subscribed to an employee benefit plan, the Court reasoned, he simply would not have had a claim.[209] The Court also looked to Congress's intent in enacting the preemption clause and concluded that Congress desired:

> [t]o ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government. [The development by states of differing standards governing the same employer conduct] is fundamentally at odds with the goal of uniformity that Congress sought to implement.[210]

The Court reasoned that allowing the plaintiff to proceed with his common law claims would be contrary to Congress's goal of uniformity because state courts are apt to reach differing common law standards applying to the same employer conduct and consequently might subject employee benefit plans to conflicting legal standards.[211] The Court noted that the plaintiff's state law claim conflicted directly with a cause of action provided in ERISA section 510, which prohibits interference with a participant's attainment of benefits.[212] Concluding that ERISA provided the exclusive remedy

---

[204] *Id.* (Kennedy, J., dissenting).
[205] *Mackey*, 486 U.S. at 841 (Kennedy, J., dissenting).
[206] 498 U.S. 133, 140 (1990).
[207] *Id.* at 135–36.
[208] *Id.* at 140.
[209] *See id.*
[210] *Id.* at 142.
[211] *Ingersoll-Rand*, 498 U.S. at 142.
[212] *Id.* at 142–43 (citing 29 U.S.C. § 1140).

for such a claim, the Court barred the plaintiff from bringing his state common law suit.[213]

In sum, the Supreme Court has consistently focused on the phrase "relate to" as the key to determining the extent of the preemption clause's reach.[214] Because of section 514(a)'s explicit language, the Court has interpreted the scope of ERISA preemption extremely broadly.[215] The Court uniformly has held that ERISA preempts any state law that explicitly refers to ERISA plans.[216] Furthermore, the Court has held that ERISA preempts most state laws having a connection with ERISA plans.[217] Although recognizing that there are some state laws whose relation to ERISA plans is "too tenuous, remote or peripheral" to trigger preemption, the Court generally has held most state laws preempted if they in any way affect the administration or expense of an employee benefit plan.[218] In practice, the Court has only upheld two state laws against ERISA preemption challenges.[219] Against this background of case law interpreting ERISA's preemptive reach, federal district courts have split over whether ERISA preempts vicarious liability malpractice claims against managed care providers.[220]

III. The Argument In Favor of ERISA Preemption

District courts holding that ERISA preempts vicarious liability claims against managed care providers uniformly emphasize the broad preemptive sweep of section 514(a).[221] Such courts rely heavily on the Supreme Court's expansive interpretation of section 514(a)'s lan-

---

[213] *Id.* at 140, 144. The Court thus concluded that the plaintiff should have brought an action in federal court as specified in section 502(a). *Id.* at 145.

[214] *Id.* at 138; Shaw v. Delta Airlines, 463 U.S. 85, 96 (1983); Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 522 (1981).

[215] District of Columbia v. Greater Wash. Bd. of Trade, 113 S. Ct. 580, 583 (1992) ("[A] law 'relates to' a covered employee benefit plan for the purposes of § 514(a) 'if it has a connection with or reference to such a plan.'" (quoting *Shaw*, 463 U.S. at 96–97)).

[216] *See, e.g., id.*; FMC Corp. v. Holliday, 498 U.S. 52, 59 (1990); Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 829 (1988).

[217] *See, e.g.*, Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 43, 57 (1987); *Shaw*, 463 U.S. at 97; *Alessi*, 451 U.S. at 507.

[218] *See, e.g., Ingersoll-Rand*, 498 U.S. at 142; *Alessi*, 451 U.S. at 524.

[219] *See Mackey*, 486 U.S. at 830; Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 23 (1987).

[220] *Compare* Pomeroy v. Johns Hopkins Medical Serv., 868 F. Supp. 110, 114 (D. Md. 1994) (holding that ERISA preempts vicarious liability malpractice claims against managed care organizations) *with* Haas v. Group Health Plan, Inc., 875 F. Supp. 544, 549 (S.D. Ill. 1994) (holding that ERISA does not preempt vicarious liability malpractice claims against managed care organizations).

[221] *See, e.g., Pomeroy*, 868 F. Supp. at 111; Visconti v. United States Health Care, 857 F. Supp. 1097, 1101 (E.D. Pa. 1994), *rev'd sub nom.* Dukes v. U.S. Healthcare, Inc., 37 F.3d 350 (3d Cir.

guage, stressing that Congress intended ERISA to preempt any state law that "has a connection with or reference to such a plan."[222] Strictly interpreting the statutory language and the Supreme Court's subsequent explanation of that language, these courts reason that vicarious liability claims necessarily "relate to" ERISA plans because such claims are derived primarily from medical care provided through a plan.[223] These courts argue that if large benefit plans were subject to liability suits based on individual state common law standards, they would lose the protection of the uniform federal regulation intended by Congress.[224]

Addressing the issue of direct liability rather than vicarious liability, in 1992, the United States Court of Appeals for the Fifth Circuit, in *Corcoran v. United Healthcare, Inc.*, issued a decision that influenced lower courts subsequently holding for preemption of vicarious liability malpractice claims.[225] *Corcoran* reinforced a broad application of the preemption clause by holding that ERISA preempted direct liability claims.[226] In *Corcoran*, Florence Corcoran's physician, detecting the possibility of complications, recommended that she spend the final weeks of her pregnancy in the hospital so that a machine could monitor her fetus twenty-four hours each day.[227] The defendant health plan determined that a hospital stay was not necessary, however, and refused to pay for it, authorizing only ten hours per day of home nursing care.[228] Two weeks later, during a period in which the nurse was not on duty, Ms. Corcoran's fetus went into distress and died.[229] Ms. Corcoran subsequently brought a direct negligence suit against United Healthcare for its refusal to pay for hospitalization.[230] The United States District Court for the District of Louisiana granted a motion for summary judgment in favor of United Healthcare, holding that ERISA

1995) (holding vicarious liability claims should not be subject to removal to federal courts); Ricci v. Gooberman, 840 F. Supp. 316, 317 (D.N.J. 1993).

[222] *See, e.g.*, Nealy v. United States Healthcare HMO, 844 F. Supp. 966, 971 (S.D.N.Y. 1994) (quoting Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47 (1987)). For a discussion of *Pilot Life*, see *supra* notes 179–86 and accompanying text.

[223] *See, e.g.*, Butler v. Wu, 853 F. Supp. 125, 129 (D.N.J. 1994).

[224] *Nealy*, 844 F. Supp. at 970–71 (citing Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990)). For a discussion of *Ingersoll-Rand*, see *supra* notes 206–13 and accompanying text.

[225] *See* Corcoran v. United States, 965 F.2d 1321, 1334, 1339 (5th Cir.), *cert. denied*, 113 S. Ct. 812 (1992).

[226] *See id.*

[227] *Id.* at 1324.

[228] *Id.*

[229] *Id.*

[230] *Corcoran*, 965 F.2d at 1324.

preempted the Corcoran's claims.[231] On appeal, the Fifth Circuit observed that Congress enacted in ERISA "a preemption clause so broad and a statute so comprehensive that it would be incompatible with the language, structure and purpose of the statute to allow tort suits against entities so integrally connected to a plan."[232] The court thus held that ERISA preempted Ms. Corcoran's suit because her malpractice claim necessarily implicated plan administration.[233] This broad prohibition of tort suits against plan-related entities, such as managed care providers, has influenced several courts' determinations of vicarious liability suits.[234]

For example, other courts holding in favor of preemption emphasize that the majority rule is that ERISA preempts direct liability claims against managed care organizations.[235] These courts reason that to preempt direct liability claims while not preempting vicarious liability claims would result in the anomalous situation in which a managed care organization's liability would be inversely proportional to the level of its involvement in providing care.[236] To illustrate this point, consider the following comparison. In the 1994 case of *Butler v. Wu*, the United States District Court for the District of New Jersey held that ERISA precluded a deceased patient's estate from bringing a vicarious liability malpractice claim against a managed care organization for the negligence of one of its affiliated physicians.[237] The managed care organization's involvement was limited to putting the patient in contact with the negligent physician.[238] Conversely, in *Corcoran*, discussed *supra*, the managed care organization's express denial of coverage of the plaintiff's hospitalization led directly to the death of her fetus.[239] Logic seemingly would dictate that based on level of involvement and consequent responsibility, if the *Corcoran* HMO was not subject to liability,

---

[231] *Id.* at 1325.

[232] *Id.* at 1334.

[233] *See id.* at 1332, 1339.

[234] *See, e.g., Visconti*, 857 F. Supp at 1101; *Butler*, 853 F. Supp. at 129; *Ricci*, 840 F. Supp. at 317.

[235] *See, e.g., Visconti*, 857 F. Supp. at 110. Indeed, several district courts holding that ERISA does not preempt vicarious liability claims against managed care organizations have done so in spite of their recognition that ERISA preempts direct liability claims arising from plan administration or challenging the level of benefits received under the plan. *See, e.g.*, Jackson v. Roseman, 878 F. Supp. 820, 825 (D. Md. 1995) (citing *Corcoran*, 965 F.2d at 1332); Haas v. Group Health Plan, Inc., 875 F. Supp. 544, 547–48 (S.D. Ill. 1994).

[236] *See Visconti*, 857 F. Supp. at 1103; Ricci v. Gooberman, 840 F. Supp. 316, 317–18 (D.N.J. 1993).

[237] 853 F. Supp. at 129.

[238] *See id.* at 127.

[239] *See Corcoran*, 965 F.2d at 1324.

then the *Butler* HMO certainly should not be.[240] If the *Butler* court had held that ERISA did not preempt vicarious liability claims, however, the reverse would be true.[241] Courts ruling in favor of preemption reason that Congress could not have intended such an incongruous result.[242]

Several courts have bolstered their holdings by reasoning that the distinction between direct liability claims assailing plan administration and vicarious liability malpractice claims is, in practice, artificial.[243] Courts reason, for instance, that when managed care organizations provide medical care to participants, the organizations are actually *administering benefits.*[244] These courts reason that the benefit is the medical care.[245] Thus, the courts reason, malpractice claims challenging the quality of medical care are actually challenging "a constructive denial of [the quality of] benefits" promised.[246] In 1994, the United States District Court for the Eastern District of Pennsylvania employed this reasoning, in *Dukes v. United States Health Care Systems of Pennsylvania, Inc.* [hereinafter *Dukes I*], and held that ERISA preempted a plaintiff's vicarious liability claim against a managed care organization.[247] Cecilia Dukes brought suit against U.S. Health Care after an affiliated facility refused to give her husband a blood test ordered by another physician affiliated with the organization.[248] Ms. Dukes's husband died three days later of a condition that could have been easily diagnosed and treated through a timely blood test.[249] The court reasoned that although the plaintiff pled her claim as a vicarious liability malpractice action, in actuality, her claim amounted to a complaint that the benefits that her husband had received did not live up to the benefits that U.S. Health Care had contracted to provide.[250] The court

---

[240] *See Visconti*, 857 F. Supp. at 1103; *Ricci*, 840 F. Supp. at 317–18. For a discussion of *Visconti*, see *infra* notes 252–57 and accompanying text. For a discussion of *Ricci*, see *supra* notes 15–28 and accompanying text.

[241] *See Visconti*, 857 F. Supp. at 1103; *Ricci*, 840 F. Supp. at 317–18.

[242] *Visconti*, 857 F. Supp. at 1103; *Ricci*, 840 F. Supp. at 317–18.

[243] *See* Pomeroy v. Johns Hopkins Medical Serv., Inc., 868 F. Supp. 110, 113–14 (D. Md. 1994); Dukes v. United States Health Care Syst. of Penn., Inc., 848 F. Supp. 39, 42 (E.D. Pa. 1994), *rev'd*, 37 F.3d 350 (3d Cir. 1995) (holding vicarious liability malpractice claims improperly removed to federal court, remanded to state court).

[244] Chittenden, *supra* note 80, at 489.

[245] *Id.*

[246] *Id.*

[247] 848 F. Supp. at 43.

[248] *Id.* at 40.

[249] Dukes v. United States Healthcare, Inc., 57 F.3d 350, 352 (3d Cir. 1995) [hereinafter *Dukes II*].

[250] *Dukes I*, 848 F. Supp. at 42.

held that such a claim, calling into question the determination of benefits, necessarily related to the administrative duties of an ERISA plan and was therefore preempted.[251]

In 1994, in *Visconti v. United States Health Care*, the United States District Court for the Eastern District of Pennsylvania held that ERISA preempted all malpractice claims against managed care organizations because an ERISA plan was the source of the relationship between the plaintiff and the defendant HMO.[252] During the third trimester of her pregnancy, Linda Visconti's vital signs and fetal weight became abnormal and her baby daughter was subsequently stillborn.[253] In a vicarious liability suit against U.S. Health Care, Ms. Visconti contended that her physician ignored her condition, allowed it to deteriorate drastically and caused her baby to be stillborn.[254] The district court reasoned that if the plaintiff had not had medical insurance as part of an employee benefit plan, the plaintiff would not have visited the negligent physician.[255] In other words, absent the employee benefit plan, the plaintiff Ms. Visconti would have had no claim.[256] Accordingly, the district court concluded that because the plan served as the source of the affiliation between a plan participant and a managed care provider, it furnished enough of a connection or relationship to meet the United States Supreme Court's low standard for triggering preemption.[257]

Courts holding that ERISA preempts vicarious liability claims against managed care organizations also reason that because courts deciding vicarious liability claims would have to inquire into the terms of employee benefit plans, such claims necessarily "relate to" ERISA plans.[258] In order to prove that an allegedly negligent physician was an "ostensible agent" of the managed care organization, for example, a plaintiff would have to prove both that he or she reasonably looked to the institution rather than the individual physician for care and that the organization held out the physician as its employee.[259] In *Visconti*, the court observed that deciding whether the plaintiff had proven the presence of an ostensible agency relationship would require the court to inquire into what representations the managed care provider had

---

[251] *See id.*; Chittenden, *supra* note 80, at 489.

[252] 857 F. Supp. at 1101, 1105.

[253] *Id.* at 1099.

[254] *Id.*

[255] *Id.* at 1101.

[256] *Id.*

[257] *Visconti*, 857 F. Supp. at 1101, 1104.

[258] *See, e.g., Pomeroy*, 868 F. Supp. at 114; *Visconti*, 857 F. Supp. at 1102.

[259] See *supra* notes 91–103 and accompanying text for an explanation of the "ostensible agency" doctrine.

made to the participant.[260] Such an inquiry might require inspection of brochures, the directories of participating physicians and the terms of the relevant contracts between the provider, physician and participant, all of which relate to the plan.[261] After establishing the presence of "ostensible agency," a court would have to determine whether the benefits actually received measured up to the benefits to which the participant was entitled.[262] This balancing, the court reasoned, would require an active inquiry into the benefits of the plan, an activity necessarily related to the plan.[263] The Eastern District of Pennsylvania consequently concluded that reference to employee benefit plans in the course of deciding vicarious liability claims against managed care organizations provides a relationship significant enough to trigger preemption.[264]

Courts holding in favor of ERISA preemption further reason that allowing liability suits against benefit plans would adversely affect such plans by increasing their costs.[265] In 1993, the United States District Court for the District of New Jersey, in *Ricci v. Gooberman*, concluded that the expense associated with defending against liability suits and carrying malpractice insurance would increase the cost of running managed care organizations.[266] The court reasoned that the managed care organization would assuredly pass any resultant increase on to the employee benefit plan, thereby depleting plan assets.[267] Plan participants, the court reasoned, would ultimately bear the brunt of this chain reaction in the form of lower wages and reduced benefits.[268] The court explained that because vicarious liability claims would result in increased costs to the plan and plan participants, they necessarily "relate to" the plans and plan administration.[269] The court therefore concluded that ERISA must preempt such claims.[270]

In sum, emphasizing the United States Supreme Court's broad interpretation of section 514(a)'s preemptive reach, district courts

---

[260] 857 F. Supp. at 1102; *see also Dukes I*, 848 F. Supp. at 42.

[261] *Visconti*, 857 F. Supp. at 1102.

[262] *Id.* at 1103.

[263] *Id.* at 1102; *see also Dukes I*, 848 F. Supp. at 42; Nealy v. United States Healthcare HMO, 844 F. Supp. 967, 972 (S.D.N.Y. 1994).

[264] *Visconti*, 857 F. Supp. at 1102; *see also Pomeroy*, 868 F. Supp. at 114; *Butler*, 853 F. Supp. at 128, 129; *Dukes I*, 848 F. Supp. at 42; *Nealy*, 844 F. Supp. at 972.

[265] *Dukes I*, 848 F. Supp. at 43; *Ricci*, 840 F. Supp. at 318.

[266] 840 F. Supp. at 318. *See also* Chittenden, *supra* note 80, at 489.

[267] *Ricci*, 840 F. Supp. at 318.

[268] *Id.*; *see also Dukes I*, 848 F. Supp. at 43; Chittenden, *supra* note 80, at 489.

[269] *Dukes I*, 848 F. Supp. at 43; *Ricci*, 840 F. Supp. at 318.

[270] *Ricci*, 840 F. Supp. at 318.

which hold that ERISA preempts vicarious liability malpractice claims against managed care organizations advance several arguments in support of preemption.[271] First, these courts argue that to preempt direct liability claims while not preempting vicarious liability claims would result in the anomalous situation in which a managed care organization's liability would be inversely proportional to the level of its involvement in providing care.[272] Second, malpractice claims challenging the quality of care administered by the organization are better classified as claims based "upon a constructive denial of [the quality of] benefits" promised and thus, like direct liability claims, should be preempted.[273] Third, these courts reason that ERISA should preempt all malpractice claims against managed care organizations because ERISA plans are the source of the relationship between the plaintiff and the defendant HMO.[274] Fourth, the level of inquiry that deciding such claims would require of courts necessitates a conclusion that such claims relate to benefit plans.[275] Finally, courts holding in favor of ERISA preemption reason that allowing liability suits against benefit plans would adversely affect such plans by increasing their costs.[276]

IV. The Argument Opposing ERISA Preemption

Although courts holding against preemption appreciate that Congress intended section 514(a) to ensure a uniform federal scheme of regulating employee benefit plans, they also recognize that the preemption clause is not without limits.[277] These district courts have looked to the Circuit Courts of Appeals for general guidance in determining what types of state laws ERISA preempts and what types it does not.[278] Several circuit court decisions have limited ERISA's preemptive reach to certain defined types of state laws.[279]

---

[271] *See, e.g.*, *Pomeroy*, 868 F. Supp. at 112; *Visconti*, 857 F. Supp. at 1100 ; *Ricci*, 840 F. Supp. at 316–17.

[272] *See Visconti*, 857 F. Supp. at 1097, 1103; *Ricci*, 840 F. Supp. at 317–18.

[273] Chittenden, *supra* note 80, at 489.

[274] *Visconti*, 857 F. Supp. at 1101, 1105.

[275] *See, e.g.*, *Pomeroy*, 868 F. Supp. at 114; *Visconti*, 857 F. Supp. at 1102.

[276] *See, e.g.*, *Dukes I*, 848 F. Supp. at 43; *Ricci*, 840 F. Supp. at 318.

[277] *See, e.g.*, Jackson v. Roseman, 878 F. Supp. 820, 823–24 (D. Md. 1995) (quoting Shaw v. Delta Airlines, 463 U.S. 85, 100 n.21 (1983) (ERISA does not preempt state law relating to ERISA plans in "too tenuous, remote or peripheral a manner.")); Smith v. HMO Great Lakes, 852 F. Supp. 669, 671 (N.D. Ill. 1994) (citing District of Columbia v. Greater Wash. Bd. of Trade, 113 S. Ct. 580, 583 n.1 (1992)).

[278] *See, e.g.*, *Jackson*, 878 F. Supp. at 825–26; Kearney v. United States Healthcare, Inc., 859 F. Supp. 182, 186 (E.D. Pa. 1994).

[279] Airparts Co. v. Custom Benefits Serv. of Austin, Inc., 28 F.3d 1062, 1064–65 (10th Cir. 1994); United Wire v. Morristown Memorial Hosp., 995 F.2d 1179, 1195 (3d Cir. 1993).

For instance, in 1993, in *United Wire v. Morristown Memorial Hospital*, the United States Court of Appeals for the Third Circuit upheld a New Jersey statutory hospital rate-setting scheme against a preemption attack.[280] The statute at issue mandated that hospitals compute charges based on "diagnostic related groups" ("DRGs"), or on average costs incurred by hospitals throughout the state to treat various conditions rather than on treatment received by the patient.[281] The plan provided for a discount of 2.2% below the DRG rate to high volume plans such as Blue Cross/Blue Shield and a discount of 11% below the DRG rate to plans with open enrollment.[282] To ensure that hospitals would recover the income lost through these discounts, the statute allowed hospitals to bill patients not belonging to plans receiving the discount at a rate higher than the DRG rate.[283] A group consisting of several self-insured employee benefit plans and individual plan participants brought suit seeking an injunction against application of the statutory scheme to them as well as restitution of moneys paid under the terms of the statute.[284]

The Third Circuit determined that a state law "relates to an ERISA plan if it is specifically designed to affect employee benefit plans, if it singles out such plans for special treatment, or if the rights or restrictions it creates are predicated on the existence of such a plan."[285] The court reasoned that a state law that does not directly relate to ERISA plans nevertheless may be subject to preemption if its effect is "to dictate or restrict the choices of ERISA plans with regard to their benefits, structure, reporting and administration, or if allowing states to have such rules would impair the ability of a plan to function simultaneously in a number of states."[286] The court characterized the New Jersey statute as a law of "general applicability" that was not designed to affect ERISA plans and did not single out such plans for

---

[280] *United Wire*, 995 F.2d at 1189, 1195.

[281] *Id.* at 1189. The statute at issue, the New Jersey Health Care Facilities Planning Act of 1971, as amended by the Health Care Cost Reduction Act of 1978, N.J. STAT. ANN. § 26:2H-1 and its regulations, N.J. Admin. § 8:31B, is very similar in structure and effect to the New York statute upheld by the Supreme Court in New York Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 115 S. Ct. 1671, 1674 (1995), discussed *infra* notes 351–54 and accompanying text.

[282] *United Wire*, 995 F.2d at 1190. The purpose of the variable charge rate was to compensate those insurers willing to insure high-risk subscribers whom traditional commercial insurers would be reluctant to enroll. *See id.* at 1189.

[283] *Id.*

[284] *Id.* at 1188.

[285] *Id.* at 1192.

[286] *Id.* at 1193.

attention.[287] Rather, the court reasoned, the statute functioned regardless of the existence of such plans.[288] Thus, the court concluded that the statute was unlike those state laws that courts have held ERISA to preempt.[289] The court gave little weight to the fact that the New Jersey statute resulted in increased costs for certain plans, reasoning that such an indirect economic effect did not in any way infringe upon internal administration or benefit structure, nor make interstate operation of the plan more difficult.[290] The court concluded that ERISA preempts only those state laws that directly relate to plans and affect plan administration or ability to operate uniformly in several states.[291] Therefore, the Third Circuit upheld the New Jersey statute because the statute was not the type of claim that Congress intended to preempt with section 514(a).[292]

In 1994, in *Airparts Co. v. Custom Benefits Services of Austin, Inc.*, the United States Court of Appeals for the Tenth Circuit enumerated a similar set of limited and defined classes of state laws that are subject to ERISA preemption.[293] In *Airparts*, a corporation and the co-trustees of an ERISA plan brought state law negligence, fraud and implied indemnity claims against an actuarial firm that the plaintiff corporation had employed as a consultant.[294] The defendant actuarial firm asserted that ERISA preempted all state law claims brought by the plaintiff corporation and plan.[295] The court recognized that the preemptive sweep of ERISA, though broad, is not unlimited,[296] and, relying on its 1992 decision in *National Elevators Industries v. Calhoun*, explicitly enumerated four categories of claims having a sufficient nexus to ERISA plans so as to trigger preemption:

> First, laws that regulate the type of benefits or terms of ERISA plans. Second, laws that create reporting, disclosure, funding, or vesting requirements for ERISA plans. Third, laws that provide rules for the calculation of the amount of benefits to

---

[287] *United Wire*, 995 F.2d at 1192.

[288] *Id.*

[289] *See id.*

[290] *Id.* at 1193.

[291] *Id.*

[292] *United Wire*, 995 F.2d at 1195.

[293] 28 F.3d 1062, 1064–65 (10th Cir. 1994).

[294] *Id.* at 1064.

[295] *See id.*

[296] *Id.* at 1065 ("What triggers ERISA preemption is not just any indirect effect on administrative procedures but rather an effect on the primary administrative functions of benefit plans, such as determining an employee's eligibility for a benefit and the amount of that benefit.").

> be paid under ERISA plans. Fourth, laws and common-law rules that provide remedies for misconduct growing out of the administration of the ERISA plan.[297]

The *Airparts* court then added to this list those laws that affect relations among the principal ERISA entities—the employer, the plan, the plan fiduciaries and the beneficiaries.[298] Conversely, the court reasoned, ERISA tends not to preempt laws of general applicability involving traditional areas of state regulation whose effect on ERISA plans is fortuitous.[299] According to the court, the state law claims at issue, although likely resulting in increased plan costs due to litigation, were claims of general applicability and did not fall into any of the categories that it found ERISA usually to preempt.[300] Thus, as did the Third Circuit in *United Wire*, the Tenth Circuit held that state law claims having only a tangential effect on ERISA plans, such as increased plan costs due to litigation, do not rise to the level of relatedness required to trigger ERISA preemption.[301]

Courts holding against preemption of vicarious liability malpractice claims against managed care providers reason that such claims are unlike the types of claims that the circuit courts have held ERISA to preempt.[302] For example, in 1990, in *Independence HMO, Inc. v. Smith*, the United States District Court for the Eastern District of Pennsylvania concluded that a malpractice victim's vicarious liability claim against her HMO for the malpractice of a physician affiliated with the organization had nothing to do with a denial of benefits under a plan.[303] Rather, the court concluded, such a victim simply seeks redress for physical injuries stemming from a physician's malpractice.[304] The district court therefore held that ERISA did not preempt the claim because it was unlike the types of state law that Congress intended ERISA to preempt.[305]

---

[297] *Id.* 1064–65 (quoting National Elevator Indus. v. Calhoon, 957 F.2d 1555, 1558–59 (10th Cir.), *cert. denied*, 113 S. Ct. 406 (1992)).

[298] *Airparts*, 28 F.3d at 1065.

[299] *Id.*

[300] *Id.* at 1066.

[301] *Id.*; *see also United Wire*, 995 F.2d at 1193.

[302] *See, e.g.*, Pacificare of Okla., Inc. v. Burrage, 59 F.3d 151, 154 (10th Cir. 1995); Jackson v. Roseman, 878 F. Supp. 820, 825–26 (D. Md. 1995); Kearney v. United States Healthcare, Inc., 859 F. Supp. 182, 186 (E.D. Pa. 1994).

[303] 733 F. Supp. 983, 988 (E.D. Pa. 1990).

[304] *Id.*

[305] *Id.*

Similarly, in 1994, in *Kearney v. United States Healthcare, Inc.*, the United States District Court for the Eastern District of Pennsylvania differentiated between the characters of vicarious and direct liability claims when it allowed a malpractice claim to proceed under a theory of vicarious liability.[306] In *Kearney*, the plaintiff alleged that a physician affiliated with U.S. Healthcare had misdiagnosed her husband, resulting in his death.[307] The district court held that ERISA preempted the plaintiff's direct liability claims against U.S. Healthcare, which were premised on common law theories of misrepresentation, negligence and breach of contract, because those claims challenged the administration of the plan and the level of benefits that the plan provided.[308] By contrast, her vicarious liability claims against the HMO, the court reasoned, did not challenge plan administration of the level of benefits provided.[309] The court further distinguished between direct and vicarious liability claims by reasoning that, whereas direct liability claims are premised on the existence of an ERISA plan and therefore have a significant connection with such plans, vicarious liability claims operate without regard to ERISA plans and indeed may be directed at any managed care organization irrespective of whether it is affiliated with an ERISA plan.[310] Therefore, the court held that ERISA did not preempt the plaintiff's vicarious liability malpractice claims against the HMO.[311]

Courts holding against preemption of vicarious liability malpractice claims directly refute the notion that such claims amount to actions to collect benefits that ultimately challenge plan administration.[312] In 1994, in *Haas v. Group Health Plan, Inc.*, the United States District Court for the Southern District of Illinois noted that vicarious liability claims, unlike direct liability claims, are not alternative actions to collect benefits.[313] Rather, the court reasoned, such claims merely provide a means by which a beneficiary may recover for injuries stemming from medical malpractice by a managed care provider that may or may not be affiliated with an ERISA plan.[314] The United States District Court for the Northern District of Illinois reached a similar conclusion

---

[306] *See Kearney*, 859 F. Supp. at 186, 187.

[307] *Id.* at 184.

[308] *Id.* at 185, 186.

[309] *Id.* at 187.

[310] *Id.*

[311] *Kearney*, 859 F. Supp. at 188.

[312] Haas v. Group Health Plan, Inc., 875 F. Supp. 544, 548 (S.D. Ill. 1994); Smith v. HMO Great Lakes, 852 F. Supp. 669, 671–72 (N.D. Ill. 1994).

[313] *Haas*, 875 F. Supp. at 548. For a discussion of *Haas*, see *supra* notes 2–14 and accompanying text.

[314] *See id.*

in *Smith v. HMO Great Lakes*.[315] In *Smith*, Charles and Peggy Smith brought suit individually and as parents of their daughter, Ginny Smith, alleging that several physicians affiliated with the defendant HMO had failed to properly deliver and care for their daughter.[316] Mr. and Mrs. Smith claimed that their daughter Ginny suffered from severe disabilities stemming from fetal distress during her birth.[317] The court reasoned that the Smiths' claims against the defendant HMO were based not on plan benefits, but rather on the principles of professional malpractice and contractual relationship.[318] Consequently, the court reasoned, the claims were not the functional equivalent of claims for benefit and thus did not trigger ERISA preemption.[319]

Courts holding against preemption tend to characterize vicarious liability claims as laws of "general applicability" that do not "single out ERISA plans for special treatment" and function regardless of the existence of such plans.[320] Because vicarious liability is a valid theory of liability in most states, these courts reason, malpractice claims based on that theory would not drastically affect the ability of a plan to operate simultaneously in different states.[321] Further, as professional malpractice claims are an area traditionally covered by state law, courts argue that they should be reluctant to conclude that Congress intended to preempt such claims, absent clear indicia of such intent.[322] In sum, these courts maintain that ERISA should not preempt vicarious liability malpractice claims because such claims fall under the rubric of "run-of-the-mill state-law claims" that Congress did not intend to preempt.[323]

In 1994, in *Kearney v. United States Healthcare, Inc.*, the United States District Court for the Eastern District of Pennsylvania rejected the notion that allowing recovery based on a theory of vicarious liability while not allowing recovery based on a theory of direct liability would create an anomalous situation.[324] The court explained that vi-

---

[315] 852 F. Supp. at 671–72.

[316] *Id.* at 670.

[317] *Id.*

[318] *Id.* at 671–72.

[319] *Id.* at 672.

[320] *Haas*, 875 F. Supp. at 548; *see also* United Wire v. Morristown Memorial Hosp., 995 F.2d 1179, 1192 (3d Cir. 1993). For a discussion of *United Wire*, see *supra* notes 280–92 and accompanying text.

[321] *See, e.g.*, *United Wire*, 995 F.2d at 1193; *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983, 988 (E. Pa. 1990).

[322] *Haas*, 875 F. Supp. at 549; *Smith*, 852 F. Supp. at 672.

[323] *See Independence HMO*, 733 F. Supp. at 989 (quoting Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 833 (1988)). For a discussion of *Mackey*, see *supra* notes 164–67 and 195–201 and accompanying text.

[324] 859 F. Supp. 182, 187 (E.D. Pa. 1994). For a discussion of *Kearney*, see *supra* notes 306–11

carious liability malpractice claims may target any managed care organization, regardless of whether the plaintiff secured his or her coverage through an employee benefit plan.[325] The court concluded that it would be more anomalous to allow plaintiffs with privately secured health coverage to proceed in suits while not allowing recovery for plaintiffs who have secured coverage through their employers.[326] In this court's view, to allow such a distinction based solely on whether the managed care organization is affiliated with an employee benefit plan would allow ERISA plans to operate in a fully insulated legal world.[327] Consequently, the court reasoned, ERISA should not preempt the plaintiff's vicarious liability malpractice claims.[328]

In 1995, in *Pacificare of Oklahoma, Inc. v. Burrage*, the United States Court of Appeals for the Tenth Circuit reasoned that contrary to the argument put forth by district courts holding in favor of preemption, vicarious liability claims do not really require a court to inquire heavily into an ERISA plan.[329] In *Pacificare of Oklahoma*, an HMO sought a writ of mandamus from the Tenth Circuit ordering a district judge to rescind his order remanding to state court two vicarious liability claims against the HMO.[330] The Tenth Circuit observed that courts deciding vicarious liability claims rely solely on common law concepts of agency and tort to determine the two issues relevant to such claims: whether the treating physician's conduct was negligent and whether an agency relationship existed between the physician and the managed care organization.[331] Malpractice claims do not assert that the plaintiff was denied benefits; rather, they assert merely that the plaintiff received the benefit from a provider who performed negligently.[332] The court further reasoned that a court can determine whether a physician performed negligently without referring to the

---

and accompanying text. For a discussion of district courts that have held for preemption in part because of the anomalous situation that would result from allowing recovery based on vicarious liability but not based on direct liability, see *supra* notes 235–42 and accompanying text.

[325] *See id.* at 187.

[326] *Id.* at 187 n.7.

[327] *Id.* at 187 (citing United Wire v. Morristown Memorial Hosp., 995 F.2d 1179, 1193 (3d Cir. 1993)).

[328] *Id.* at 188.

[329] *See* Pacificare of Oklahoma, Inc. v. Burger, 59 F.3d 151, 154 (10th Cir. 1995). For a discussion of courts holding ERISA to preempt vicarious liabilty malpractice claims because of the level of inquiry into employee benefit plans that such a determination would require of the deciding court, see *supra* notes 258–64 and accompanying text.

[330] *Id.* at 152.

[331] *See id.* at 154.

[332] *Id.* See also *Kearney*, in which the court noted that if a physician were to sue a plan for services rendered, the physician would necessarily make reference to the plan in order to prove

plan.[333] Denying the petition for a writ of mandamus, the Tenth Circuit concluded that such a determination demands only that the court look into what transpired between the physician and the plaintiff, and whether in providing the covered medical care, the physician acted with the knowledge and skill required by professional and societal standards of conduct.[334]

The Tenth Circuit also refuted the argument that ERISA should preempt vicarious liability claims because such claims would affect the costs of ERISA plans.[335] Relying on the Tenth Circuit's 1994 decision in *Airparts Co. v. Custom Benefits Services of Austin, Inc.*, the court reasoned that so long as "a state law does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the [law] has some economic impact on the plan does not require that the [law] be invalidated."[336] The Tenth Circuit concluded that the fact "that a plan is potentially liable for a judgment 'is not enough to relate the action to the plan.'"[337] Thus, a mere indirect economic effect on an employee benefit plan does not provide a sufficient relationship between the state law and a plan to trigger preemption.[338]

In 1995, the United States Court of Appeals for the Third Circuit reversed and remanded to state court two of the leading cases in support of the position that ERISA preempts vicarious liability claims.[339] In *Dukes v. U.S. Healthcare*, (*"Dukes II"*), the Third Circuit consolidated *Visconti v. U.S. Health Care* and *Dukes I* on appeal and reversed both on the grounds that they had been improperly removed to federal court.[340] The court in *Dukes II* reasoned that state law causes of action

---

the specifics of the relationship between the physician and the plan. 859 F. Supp. at 186–87. Concluding that an inquiry into the relationship between the physician and the plan in such a setting certainly would not trigger preemption, the court found that there was no reason to preempt a vicarious liability malpractice claim because it involves the same level of inquiry. *Id.* at 187. Thus, any reference to a plan to resolve the issue of whether an agency relationship existed would implicate ERISA "in too tenuous, remote or peripheral" a manner to warrant a finding that the law relates to the plan. *See id.* For a discussion of *Kearney*, see *supra* notes 306–11 and accompanying text.

[333] *Pacificare of Okla.*, 59 F.3d at 154.

[334] *Id.* (quoting *Kearney*, 859 F. Supp. at 186).

[335] *Id.*

[336] *Id.* (quoting Airparts Co. v. Custom Benefits Serv. of Austin, Inc., 28 F.3d 1062, 1065 (10th Cir. 1994)). For a discussion of *Airparts*, see *supra* notes 293–301 and accompanying text.

[337] *Id.* at 154 (quoting *Airparts*, 28 F.3d at 1065).

[338] *Pacificare of Okla.*, 59 F.3d at 154; *Airparts*, 28 F.3d at 1065.

[339] Dukes v. United States Healthcare, Inc., 57 F.3d 350, 361 (3d Cir. 1995).

[340] *Id.* at 353, 356. See *supra* notes 247–51 and accompanying text for a discussion of *Dukes I*, 848 F. Supp. 39 (E.D. Pa. 1994) and notes 252–57 and accompanying text for discussion of *Visconti*, 857 F. Supp. 1097 (E.D. Pa. 1994).

that do not fall under the scope of section 502, ERISA's civil remedy provision, are not removable and should remain in state court.[341] Although the court did not decide the specific issue of whether ERISA should preempt such claims, its decision highlighted the differences between vicarious liability and direct liability claims.[342] The Third Circuit directly refuted the notion that vicarious liability malpractice claims call into question plan administration or the level of benefits due, stating that vicarious liability plaintiffs "are not attempting to define 'new rights under the terms of the plan': instead, they are attempting to assert their already-existing rights under the generally-applicable state law of tort and agency."[343] Rebutting the proposition that vicarious liability malpractice plaintiffs seek to enforce benefits under the plan, the court instead characterized vicarious liability claims as attacking only the quality of the benefits received.[344] Noting that "patients enjoy the right to be free from medical malpractice regardless of whether or not their medical care is provided through an ERISA plan," the Third Circuit held that such claims do not fall within the scope of section 502 and therefore are not removable to federal court.[345]

In sum, courts holding that ERISA does not preempt vicarious liability claims against managed care organizations assert several arguments in favor of their position.[346] These courts reason that such claims are unlike any of the types of claims that courts have held ERISA to preempt and are not equivalent to actions to collect benefits that ultimately challenge plan administration.[347] Furthermore, these courts reason that the level of judicial inquiry into benefit plans that deciding vicarious liability malpractice claims would require does not sufficiently relate to ERISA plans because such claims require only that the court look into what transpired between the physician and the plaintiff and whether, in providing the covered medical care, the physician acted according to professional and societal standards of conduct.[348] Courts holding against preemption conclude that a mere indirect economic effect on an employee benefit plan does not provide a sufficient rela-

---

[341] *Dukes II*, 57 F.3d at 355.

[342] *See id.* at 358.

[343] *Id.*

[344] *Id.*

[345] *Id.* at 356, 358.

[346] *See, e.g.*, *Pacificare of Okla.*, 59 F.3d at 154; *Kearney*, 859 F. Supp. at 187; Smith v. HMO Great Lakes, 852 F. Supp. 669, 672 (N.D. Ill. 1994).

[347] *See, e.g.*, Haas v. Group Health Plan, Inc., 875 F. Supp. 544, 548 (S.D. Ill. 1994); *Smith*, 852 F. Supp. at 672.

[348] *Pacificare of Okla.*, 59 F.3d at 154.

tionship between the state law and an ERISA plan so as to trigger preemption.[349]

V. The Effect of *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*

A. New York Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.

In 1995, the United States Supreme Court raised, or at least clarified, the threshold level of "connection" that a state law must have to an ERISA plan in order to trigger preemption.[350] In *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, a unanimous Court held that ERISA did not preempt a New York statute that required hospitals to collect surcharges from patients covered by a commercial insurer, but not from patients insured by Blue Cross/Blue Shield, and that subjected HMOs to surcharges varying with the number of Medicaid recipients enrolled.[351] The New York statute required hospitals to calculate patient charges based on the average cost of treating someone with that patient's medical problem rather than on the actual cost of an individual patient's treatment.[352] The statute provided that while hospitals had to bill patients covered by Blue Cross/Blue Shield, Medicaid and HMOs at the rate based on average costs of treatment, they had to bill patients covered by traditional fee-for-service commercial insurance plans at the average rate plus a thirteen percent surcharge.[353] The statute also required HMOs to pay a variable surcharge of up to nine percent directly to the state.[354]

---

[349] *See id.*; Airparts Co. v. Custom Benefits Serv. of Austin, Inc., 28 F.3d 1062, 1065 (10th Cir. 1994).

[350] *See* New York Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 115 S. Ct. 1671 (1995).

[351] *Id.* at 1674, 1680. The New York rate-setting statute at issue, N.Y. Pub. Health Law. § 2807-c(1)(a), is similar in concept to the New Jersey rate-setting statute upheld by the Third Circuit Court of Appeals in United Wire v. Morristown Memorial Hosp., 995 F.2d 1179, 1189–90 (3d Cir. 1993). See *supra* notes 281–84 and accompanying text.

[352] *Travelers*, 115 S. Ct. at 1674. The Court noted with approval that the primary reason the statute singled out Blue Cross/Blue Shield for preferential rate treatment was to compensate those plans for their practice of open enrollment. *Id.* at 1678. Open enrollment means that those insurers provide coverage to many subscribers whom commercial insurers would refuse to cover as unacceptable risks. *Id.*

[353] *Id.* at 1674.

[354] *Id.*

The Court began its opinion by stressing that the principles of federalism should govern its preemption analysis.[355] The Court stated that "where a federal law is said to bar state action in fields of traditional state regulation, . . . we have worked on the assumption that the historic police powers of the state were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress."[356] Although noting the broad scope that it had given ERISA's preemption clause in its prior decisions, the Court explained that the scope of ERISA preemption is not limitless and does not extend to state laws which have "only a tenuous, remote or peripheral connection with covered plans, as is the case with many laws of general applicability."[357] Focusing on the language of section 514(a), the Court observed that taken to their logical and literal extremes, both the "relate to" and "connection with" phrases would extend infinitely and therefore do little in the way of delineating which state laws do and do not "relate to" or have a "connection with" ERISA plans.[358] The Court explained that because resolving whether a state law has a "connection with" an ERISA plan is no less difficult than determining whether a state law "relates to" an ERISA plan, "connection with" is no less limiting than "relate to" and thus does little to define the phrase.[359]

After thus concluding that the text of the statute does not adequately or consistently define what actions do and do not "relate to" ERISA plans, the Court looked to the purpose of ERISA for an indication of whether Congress intended preemption to reach the New York statute in question.[360] The Court reasoned that Congress intended ERISA to establish the regulation of employee benefit plans "as exclusively a federal concern," and thus create a nationally uniform system of regulating employee benefit plans.[361] The preemption clause, the Court reasoned, serves this overall purpose by avoiding multiplicitous

---

[355] *See id.* at 1676.

[356] *See id.*

[357] *Travelers*, 115 S. Ct. at 1680 (citing District of Columbia v. Greater Wash. Bd. of Trade, 113 S. Ct. 580, 583 n.1 (1992)). See *supra* notes 175–177 and accompanying text for a discussion of *Greater Wash. Bd. of Trade.*

[358] *Id.* at 1677. The issue may be framed another way:

> [C]onsider . . . a grain of sand, for example. It requires little imagination to find some relationship or some connection between the sand grain and anything else in the world. True, the relationship or connection in a given case might be strained or farfetched, but it is some relationship or connection nonetheless . . . . What can be said for a grain of sand can be said for any law.

Conison, *supra* note 121, at 626.

[359] *See Travelers*, 115 S. Ct. at 1677.

[360] *Id.*

[361] *Id.*

regulation of plans that would undermine the goal of uniform regulation.[362]

The Court next characterized the types of state laws that it had held ERISA to preempt in the past: laws that dictated or precluded certain methods of plan administration, frustrated plans' abilities to operate efficiently in several states or provided alternate methods of plan enforcement.[363] The Court concluded that New York's hospital rate-setting statute was distinct in both purpose and effect from the types of state laws it had traditionally held ERISA to preempt.[364] The purpose of the New York statute, the Court observed, was to compensate health plans, like Blue Cross/Blue Shield, willing to insure high-risk subscribers.[365] Insuring high-risk subscribers, the Court explained, necessarily costs more than selectively insuring only low-risk subscribers because high-risk subscribers tend to file more claims than their low-risk counterparts.[366] The New York statute imposed surcharges on commercial insurers and HMOs unwilling to insure high-risk subscribers in an effort to make Blue Cross/Blue Shield more price-competitive and thus more attractive to subscribers than they otherwise would be.[367] These surcharges, according to the Court, neither regulated plans nor in any way affected plan administration.[368]

The Court further reasoned that the New York statute, which led to rate differentials favoring the Blue Cross/Blue Shield plans, had only an indirect economic effect on the costs of various employee benefit plans.[369] The Court observed that the rate-setting statute had a particularly unremarkable impact on benefit plans in light of the fact that even absent such legislation, hospitals routinely engage in rate-setting practices that impose surcharges on commercial insurers.[370] The Court reasoned that Congress did not intend to preempt state laws calling for rate differentials among competing plans any more than it intended to preempt other forms of state regulation that indirectly affected competing rates, such as quality control or workplace regula-

---

[362] *Id.* at 1677–78.

[363] *Id.* at 1678 (citing FMC Corp. v. Holliday, 498 U.S. 52, 60 (1990); Shaw v. Delta Airlines, 463 U.S. 85, 97 (1983); Alessi v. Raybestos-Manhattan, 451 U.S. 504, 524 (1980)). *See supra* notes 168–74, 148–62, 140–47 and accompanying text.

[364] *Travelers*, 115 S. Ct. at 1678.

[365] *Id.*

[366] *See id.*

[367] *Id.* at 1678, 1679.

[368] *Id.* at 1679.

[369] *Travelers*, 115 S. Ct. at 1679.

[370] *Id.*

tion.[371] The Court further noted that hospitals on their own initiative commonly impose surcharges on patients with commercial insurance in an effort to compensate for their financial shortfalls, resulting in rate differentials similar to those mandated by the statute.[372] Moreover, the Court observed, the statute's economic effects do not substantially influence plan administration so as to alter, for example, substantive plan coverage or to restrict a plan's choice of insurers.[373] The Court reasoned that to interpret section 514(a) as preempting state laws whose only impact on an ERISA plan is an indirect effect on cost would read the limiting "relate to" language out of the statute.[374]

Moreover, the Court noted that such a limitless interpretation would "violate basic principles of statutory interpretation and could not be squared with our prior pronouncement that '[p]reemption does not occur . . . if the state law has only a tenuous, remote or peripheral connection with covered plans, as is the case with many laws of general applicability.'"[375] The Court further reasoned that "nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern."[376] Concluding that a state law with an indirect economic effect does not rise to the level of the "conflicting directives" that Congress intended to preempt, the Court thus held that such laws do not sufficiently relate to ERISA plans as to trigger section 514(a) preemption.[377]

B. Travelers*'s Effect on the Preemption of Vicarious Liability Malpractice Claims*

The United States Supreme Court's reasoning in *Travelers* should provide a boost to the movement opposing preemption of vicarious liability claims against managed care organizations. By upholding a state hospital rate-setting statute against an ERISA preemption challenge, a unanimous Court implicitly raised the threshold level of connection between a state law and an employee benefit plan necessary to trigger the preemption clause.[378] Because the nature of vicarious

---

[371] *Id.*

[372] *Id.*

[373] *Id.*

[374] *Travelers*, 115 S. Ct. at 1679.

[375] *Id.* at 1679–80 (quoting District of Columbia v. Greater Wash. Bd. of Trade, 113 S. Ct. 580, 583 n.1 (1992) (in turn quoting Shaw v. Delta Airlines, 463 U.S. 85, 100 n.21 (1983))).

[376] *Id.* at 1680.

[377] *Id.*

[378] *See id.*

liability claims is similar to the New York statute upheld by the Supreme Court in *Travelers*, courts should follow the *Travelers* reasoning to reject preemption of such claims.[379]

As with the statute upheld by the Supreme Court in *Travelers*, the only tangible effect of vicarious liability claims against managed care providers is an indirect economic effect on overall plan cost.[380] The Supreme Court's reasoning in *Travelers* explicitly refutes the argument that ERISA should preempt vicarious liability claims against managed care organizations because allowing such suits will affect the cost of administering employee benefit plans.[381] In upholding New York's hospital rate-setting statute against a preemption challenge, the Supreme Court implicitly upheld every state's authority to enact similar legislation.[382] The Court did not require that all hospital rate-setting statutes should conform to New York's statutory scheme. Conversely, the Court's reasoning left open the possibility that each individual state could enact hospital rate-setting legislation widely differing in terms and rates from similar legislation enacted in other states.[383] As a result, benefit plans operating on a national level could face as many as fifty different rate-setting schemes, each imposing its own surcharge. The Court reasoned, however, that such a diversity of plan costs among states would not contravene ERISA's goal of establishing a uniform scheme of federal regulation of employee benefit plans.[384] Rather, the Court observed that "cost uniformity was almost certainly not an object of preemption."[385] Moreover, the Court concluded that allowing ERISA to preempt state law simply because such law may have an indirect economic impact on ERISA plans would be tantamount to reading section 514(a) as being limitless in scope and thus would "violate the basic principles of statutory interpretation."[386]

As with the New York hospital rate-setting statute at issue in *Travelers*, the primary relation between vicarious liability claims against

---

[379] *See Travelers*, 115 S. Ct. at 1674, 1678.

[380] *See id.* at 1679.

[381] *See id.*

[382] *See id.* at 1680.

[383] For instance, in 1993, the Third Circuit Court of Appeals upheld New Jersey's hospital rate-setting statute against a preemption challenge. United Wire v. Morristown Memorial Hosp., 995 F.2d 1179, 1195 (3d Cir. 1993). For a discussion of *United Wire*, see *supra* notes 280–92 and accompanying text. Although the New Jersey statute was similar in effect to the New York statute upheld by the Court in *Travelers*, the specifics of the plan were not the same. *Compare United Wire*, 995 F.2d at 1189–90 *with Travelers*, 115 S. Ct. at 1674.

[384] *See Travelers*, 115 S. Ct. at 1680.

[385] *See id.*

[386] *Id.* at 1679–80.

managed care providers and ERISA plans is an indirect effect on costs.[387] Courts that hold in favor of preemption of vicarious liability claims focus on this indirect effect and reason that the impact such claims have on plan costs establishes a relationship between the claims and the plans sufficient to trigger preemption.[388] Potential liability to subscribers for the malpractice of affiliated physicians would certainly force managed care organizations to carry liability insurance to cover such a contingency.[389] Just as various states are likely to enact differing rate-setting legislation, state common law standards for proving the presence of an ostensible agency relationship between a managed care organization and an affiliated physician will likely vary. Premiums for malpractice coverage that managed care organizations would carry to protect against liability consequently would reflect the level of difficulty of proving such a claim in each state—the easier it is for a plaintiff to sustain the burden of proving the elements of the claim, the higher the malpractice premiums are likely to be. As a result, employee benefit plans probably would have to pay varying amounts to secure health coverage for their subscribers depending upon the states in which they operate. Such a result, however, would be no different from the interstate cost variation stemming from hospital rate-setting statutes upheld by the Supreme Court in *Travelers*.[390] Following the Supreme Court's reasoning, such an indirect economic influence as an increase in overall plan costs due to malpractice insurance certainly does not rise to the level of those "'conflicting directives' from which Congress meant to insulate ERISA plans."[391]

Like the statute at issue in *Travelers*, vicarious liability malpractice claims neither call into question plan administration nor seek to enforce or create rights under the plan.[392] Rather, victims of medical malpractice seek only to redress injuries arising from medical treatment which fell below the standards of the medical profession.[393] Thus,

---

[387] *See id.* at 1679; *see also* Pacificare of Okla., Inc. v. Burrage, 59 F.3d 151, 154 (10th Cir. 1995).

[388] *Dukes I*, 848 F. Supp. 39, 43 (E.D. Pa. 1994), *rev'd* 37 F.3d 350 (3d Cir. 1995); Ricci v. Gooberman, 840 F. Supp. 316, 318 (D.N.J. 1993).

[389] *Ricci*, 840 F. Supp. at 318.

[390] *See Travelers*, 115 S. Ct. at 1680. See *supra* notes 351–77 and accompanying text for a description of the statute at issue in *Travelers*.

[391] *See Travelers*, 115 S. Ct. at 1680.

[392] *See id.* at 1678.

[393] *See, e.g.*, Haas v. Group Health Plan, Inc., 875 F. Supp. 544, 548 (S.D. Ill. 1994) ("A vicarious liability medical malpractice action based solely upon substandard treatment is not an alternative action to collect benefits. . . ."); see *supra* notes 2–14 and accompanying text for a discussion of *Haas*.

vicarious liability malpractice claims are grounded in the generally-applicable common law concepts of tort and agency.[394] Moreover, vicarious liability claims operate independently of ERISA plans; plaintiffs may and do direct such claims at managed care providers regardless of whether they are affiliated with an ERISA plan.[395] Consequently, absent an express indication of congressional intent, courts should be reluctant to find that ERISA preempts such claims which are traditionally subject to state law.[396] As the Supreme Court reasoned in *Travelers*, nothing in the language of ERISA or in its legislative history indicates that Congress chose to displace such a matter which has traditionally been a matter of local concern.[397] Conversely, vicarious liability claims are best characterized as "run-of-the-mill state-law claims" that Congress did not intend ERISA to preempt.[398]

Moreover, vicarious liability malpractice claims are analogous to state law mechanisms of regulating the quality of health care of which the Supreme Court implicitly approved in *Travelers*.[399] The common law theory of vicarious liability, whether in the form of respondeat superior or ostensible agency, seeks to compensate parties for injuries that they have suffered as a result of the negligent or intentional conduct of another's agent or employee.[400] Often, the agent or employee will lack sufficient means to fully compensate victims for harm suffered as a result of the agent or employee's actions.[401] In the realm of medical malpractice, the agent or employee may have neglected to carry sufficient malpractice coverage to cover the victim's loss.[402] Vicari-

---

[394] *Dukes II*, 57 F.3d 350, 358 (3d Cir. 1995).

[395] *See* Kearney v. United States Healthcare, 859 F. Supp. 182, 187 (E.D. Pa. 1994). For a discussion of *Kearney*, see *supra* notes 324–28 and accompanying text.

[396] Smith v. HMO Great Lakes, 852 F. Supp. 669, 672 (N.D. Ill. 1994); Elsesser v. Hospital of Phila. College of Osteopathic Medicine, 802 F. Supp. 1286, 1290 (E.D. Pa. 1992) ("[S]tate law has traditionally prescribed the standards of professional liability and, in the absence of clear indicia in the act or legislative history, we are reluctant to ascribe to Congress an intention to intrude into this area.") (quoting Painters of Phila. Dist. Council No. 21 Welfare Fund v. Price Waterhouse, 879 F.2d 1146, 1152–53 (3d Cir. 1991) (holding that ERISA did not create implied cause of action for professional malpractice)).

[397] *See Travelers*, 115 S. Ct. at 1680.

[398] Independence HMO, Inc. v. Smith, 733 F. Supp. 983, 989 (E.D. Pa. 1990) (citing Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 833 (1987)).

[399] *See Travelers*, 115 S. Ct. at 1680 ("[N]othing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation. . . .").

[400] *See, e.g., Dukes II*, 57 F.3d at 357 ("Instead of claiming that the [plans] in any way withheld some quantum of plan benefits due, [vicarious liability malpractice plaintiffs] . . . complain about the low quality of medical treatment they actually received . . . ."); see *supra* notes 340–345 and accompanying text.

[401] *See supra* note 28.

[402] *Id.* Note that in *Haas v. Group Health Plan, Inc.*, the negligent provider was a nurse

ous liability malpractice claims thus allow plaintiffs to hold health care entities that proffer negligent providers as their agents or employees accountable for the wrongs of those providers.[403] In this sense, vicarious liability malpractice claims may act as a state common law method of assuring the quality of medical care.[404]

At least one court has looked to *Travelers* for guidance in deciding a vicarious liability malpractice claim against a managed care organization. In August of 1995, the United States District Court for the District of Maryland, in *Chaghervand v. CareFirst*, correctly held that ERISA should not preempt such an action.[405] In *Chaghervand*, Constance Chaghervand, a member of the defendant HMO, CareFirst, through her employer, claimed that CareFirst and affiliated physicians failed to properly diagnose and treat her back condition.[406] She claimed that she suffered permanent neurological damage.[407] The court noted that Ms. Chaghervand's vicarious liability claim was different from the Supreme Court's characterization of the types of state laws that it has held ERISA to preempt.[408] The court observed that her vicarious liability claim did not implicate any of ERISA's objectives: it did not seek benefits, allege improper administration, or attempt to enforce the plan in any way.[409] Rather, the court concluded, her claim was simply seeking damages stemming from treatment which fell below professional standards.[410] Although the court recognized that vicarious liability claims such as Ms. Chaghervand's may increase the costs of operating benefit plans, the court relied upon the Supreme Court's holding that such an indirect economic influence was insufficient to trigger preemption.[411]

The *Chaghervand* court therefore properly relied on the Supreme Court's reasoning from *Travelers* in holding that ERISA should not

---

practitioner. 875 F. Supp. 544, 546 (S.D. Ill. 1994). Absent a claim against the defendant HMO, the plaintiff in that case could have been left with only a claim against a nurse practitioner and a technician. *See supra* note 28. The plaintiff's recovery for a permanently disabling injury could then have been limited to the personal assets of the practitioner coupled with any malpractice coverage that the practitioner may or may not have decided to carry. *See id.*

[403] *See* Chittenden, *supra* note 80, at 453–54.

[404] *See Travelers*, 115 S. Ct. at 1679.

[405] 909 F. Supp. 304, 312 (D. Md. 1995).

[406] *Id.* at 307.

[407] *Id.*

[408] *See id.* at 311.

[409] *Id.*

[410] *Chaghervand*, 909 F. Supp. at 311.

[411] *Id.*

preempt Ms. Chaghervand's vicarious liability malpractice claim against CareFirst.[412] Recognizing that although vicarious liability malpractice claims do have an indirect economic impact on ERISA plans, the court correctly appreciated that such claims in no way affect plan administration or otherwise impede any of ERISA's objectives.[413] Further, the court properly applied *Travelers* in reasoning that the potential for increased plan costs stemming from vicarious liability malpractice claims was not sufficient to warrant preemption.[414] In the future, courts faced with the issue of ERISA preemption of vicarious liability malpractice claims should look to the *Chaghervand* court's application of the *Travelers* decision and similarly hold that ERISA should not preempt such claims.[415]

VI. Conclusion

Over the past several years, district courts have rendered conflicting opinions as to whether ERISA preempts vicarious liability malpractice claims against managed care providers. The resultant uncertainty has led to a situation in which a plaintiff bringing a malpractice suit against a managed care organization might find that his or her recovery depends upon the fortuity of living in a particular judicial district—or indeed, appearing before a particular judge within that judicial district who is amenable to such suits. If a malpractice victim happens to bring suit in a court that holds ERISA to preempt vicarious liability malpractice claims against managed care providers, that plaintiff can only recover fully if the negligent provider carries adequate malpractice insurance.[416] If, however, the negligent physician carries insufficient coverage, the plaintiff may not recover enough to fully compensate him or her for injuries suffered at the hands of the negligent physician or other health care provider. Whereas a plaintiff belonging to a managed care organization who has secured his or her health insurance independently would be able to bring a vicarious liability suit, another plaintiff belonging to the same managed care organization but who secured his or her insurance through an employee

---

[412] *See id.* at 312.

[413] *See id.* at 311.

[414] *See id.*

[415] CareFirst has decided not to appeal this decision. Telephone Interview with David E. Manoogian, attorney for CareFirst (Mar. 20 1996). Consequently, the case is currently on remand in the Maryland state court system. *Id.*

[416] *See supra* note 28.

benefit plan would not. With its 1995 decision in *New York Conference of Blue Cross & Blue Shield v. Travelers Insurance Co.*, the United States Supreme Court unanimously provided lower courts with much needed guidance that should help to resolve this indeterminacy. Courts in the future are likely to hold more consistently that ERISA does not preempt vicarious liability malpractice suits against managed care organizations.

F. CHRISTOPHER WETHLY