Managed Care and ERISA: Synopsis and Case Law Review

Joan B. Gerbasi, JD, MD

Managed care organizations (MCOs) have become the predominant health care model in the United States. Through cost containment arrangements with providers, incentives for patients to pursue less costly care and reductions in the provision of unnecessary care, MCOs are more intimately involved in the delivery of health care than their former fee-for-service insurance company counterparts. However, this new role has not implied increased liability, largely because of The Employee Retirement Income Security Act of 1974 (ERISA). This article provides an overview of ERISA and a review of the important legal cases in this area, including the three most recent Supreme Court cases. Courts have struggled with interpreting ERISA, and decisions have been difficult to reconcile. Frustration with this statute and the failure of the U.S. Congress to amend it, has led to more liberal interpretations of ERISA in recent years.

J Am Acad Psychiatry Law 31:364–71, 2003

Over the past several decades, managed care organizations (MCOs) have become the predominant health care model in the United States. Ideally, an MCO seeks to deliver appropriate care to its members while simultaneously controlling costs. Costs are controlled through several methods, including reductions in the provision of unnecessary care through a prospective or concurrent review of care. Typically through a precertification utilization review process, MCOs prospectively analyze medical recommendations and then contain costs by denying requests that are not medically necessary.

This precertification process was a radical shift from the former fee-for-service model. Under that model, patients received the care their doctors thought was necessary and, retrospectively, the insurance company made a payment decision. All that was at stake was money: the care was already delivered. Under the new system, however, care is not delivered until it is approved. This obviously can result in a decrease in the amount of care actually delivered, as patients forego care that is not approved.

Through utilization review and other cost containment measures such as care protocols and arrangements with providers, MCOs are more intimately involved in the delivery of health care than their former fee-for-service insurance company counterparts. Many argue that MCOs do not merely make benefit determinations, but actually determine medical care. This is troubling, because it could result in a source of liability for MCOs. In an effort to prevent this liability and encourage the development of MCOs, states passed health maintenance organization (HMO) laws. That is just the beginning of the story, however. The largest obstacle to MCO liability has been The Employee Retirement Income Security Act of 1974 (ERISA).[1]

This article provides an overview of ERISA and a review of the important legal cases in this area. As will be seen, the statute is complicated, difficult to understand, and has questionable applicability to health care benefits. Courts have struggled with interpreting the statute, and decisions have been difficult to reconcile. Frustration with this statute and the failure of the U.S. Congress to amend it, has led to more liberal interpretations of ERISA in recent years.

The Employee Retirement Income Security Act of 1974

Congress enacted ERISA in 1974 to protect pension benefits. Traditionally, the states, not the federal government, regulated the insurance industry, which includes pension plans. State laws, however, were ineffective in preventing employees from losing their pensions. To remedy this, ERISA established federal

Dr. Gerbasi is Assistant Clinical Professor of Psychiatry and Director of the Forensic Psychiatry Residency, Department of Psychiatry, University of California, Davis, Sacramento, CA. Address correspondence to: Joan B. Gerbasi, JD, MD, Department of Psychiatry, University of California, Davis, 2230 Stockton Blvd., Sacramento, CA 95817. E-mail: joan.gerbasi@ucdmc.ucdavis.edu

standards for the funding and payment of employee pensions. The new federal law superseded all state laws (including state tort law) regarding pensions. Instead of being subject to sometimes conflicting and inadequate state laws, ERISA plans are governed exclusively by the provisions of ERISA. Although ERISA was designed primarily to deal with the administration of monetary rather than service benefits, its language was drafted broadly to cover all employee benefits, including health care.

On its face, including health care benefits under ERISA's umbrella seems to be a good thing. However, ERISA was not drafted with service benefits in mind, and its provisions do not adequately address health care benefits. For pension benefits, ERISA works quite well; it contains uniform and relevant standards. For health plans, however, ERISA is problematic. As originally drafted, ERISA did not contain separate provisions designed for health care benefits. Instead, the provisions drafted with monetary benefits in mind also apply to health care plans. And so, for example, as originally enacted, ERISA required only that a health plan provide employees with a brief summary of the main terms and conditions of the plan, invest its funds prudently, and report to the Department of Labor.[2] In recent years, ERISA has been amended to include certain limited provisions specifically aimed at health care. For example, there is now a provision requiring mental health parity,[3] provisions regarding continuation coverage and preexisting exclusion periods,[4] and a provision prohibiting discrimination in enrollment eligibility.[5] However, ERISA remains largely deficient in provisions for health care and does not provide relevant standards, including standards for medical necessity decisions. The result is a law that precludes state regulation of ERISA health plans without substituting federal standards, leaving the ERISA plans in a "regulatory vacuum" (Ref. 6, p 1987).

A health care plan is covered by ERISA if it is: "a plan fund, or program, established or maintained by an employer. . .for the purpose of providing medical, surgical, hospital care. . .benefits to participants or their beneficiaries."[7] A few specific types of plans are exempted from ERISA, including state and federal government plans.[8] However, of the 146 million employees with employer-based health plans, more than 125 million are plans covered by ERISA.[9] Under ERISA, covered plans can be divided into two types: those purchased by employers from insurance companies and those "self-funded" by the employer. Self-funded plans are plans in which the employer assumes the financial risk of the insurance, but the care itself is still delivered by outside agencies. As we shall see, under ERISA, self-funded plans are immune from many forms of state regulation. If an employer purchases a health plan from an insurance company, however, ERISA's preemption is not as broad, and certain state laws can be enforced against the plans.[10]

The ERISA Preemption Provisions

An understanding of ERISA and its application to health care benefits requires knowledge of the two ERISA preemption provisions: the complete preemption provision and the conflict preemption provision.[11]

Section 502(a): the Complete Preemption Provision

The doctrine known as complete preemption involves ERISA's civil enforcement provisions under § 502 and confers federal jurisdiction over litigation on ERISA plans. The complete preemption clause is an exception to what is known as the well-pleaded complaint rule. Under this rule, unless a federal question appears on the face of a properly pleaded complaint, a defendant cannot remove the case to federal court. However, pursuant to § 502 of ERISA, Congress totally preempted certain causes of action and mandated that those causes of action be brought in federal courts.

Section 502(a) states, "[A] civil action may be brought. . .by a participant or beneficiary. . .to recover benefits due to him under the terms of his plan. . .or to clarify his rights to future benefits under the terms of the plan."[12] This section has been interpreted as declaring that whenever a plaintiff's complaint even implies recovery, enforcement, or clarification of a benefit that ERISA preempts, the case is subject to removal to federal court.[13]

Although removal to federal court, on its face, does not appear to be a bad thing, once in federal court, a plaintiff's remedies are limited to those provided by § 502 of ERISA. ERISA § 502(a)(1)(B) states that claims may be brought to recover benefits due under the terms of the plan or to enforce or clarify the plaintiff's rights under the plan. This means that a patient is entitled to recover the monetary amount of the benefit denied (i.e., the actual cost of the treatment) or the actual benefit itself. No re-

covery for losses resulting from personal injury such as medical expenses, lost wages, death or disability, pain and suffering, emotional distress, or other harm that a patient may suffer as a result of the improper denial of care is permitted. In addition, ERISA precludes punitive damages and plaintiffs are not entitled to a jury trial.

Consider the following hypothetical case example: a 20-year-old, married man with an ERISA health plan goes to an emergency room with sudden onset of nausea, shortness of breath, diaphoresis, and palpitations. Because of the patient's young age, lack of family history, and atypical presentation (e.g., no overt chest pain, no radiation of pain), the MCO algorithm does not require an electrocardiogram (EKG) or screening of cardiac enzymes. The patient is discharged from the emergency room with a diagnosis of panic attack, a prescription for lorazepam and directions to seek psychiatric follow-up. Five hours later he dies at home. Autopsy shows that he suffered a massive myocardial infarction (MI).

If the patient's wife sues the HMO, arguing that her husband did not receive proper care and died because of the HMO algorithm, the first step the defendant will take is to remove the case to federal court under the complete preemption provision. Once in federal court, the relief the wife can recover will be limited to the cost of the benefit her husband did not receive. In this case it would be the cost of an EKG or cardiac enzymes that would have diagnosed his MI. This is likely to be less than $100. The wife will not be able to recover from the insurance company any other costs normally associated with negligence, including pain and suffering or loss of future earnings. This vignette is an oversimplification, created to illustrate in stark terms the limits of ERISA liability. Note, however, that the doctors could be sued in their individual capacities and the normal rules of malpractice (tort law) would apply.

Section 514: the Conflict Preemption Clause

The second preemption provision is known as the conflict preemption clause. ERISA § 514(a), states that ERISA's provisions "shall supersede any and all State laws insofar as they. . .relate to any employee benefit plan" covered by the statute.[14] The significant phrase within the clause is "relate to any employee benefit plan." The U.S. Supreme Court has stated that a law relates to an ERISA plan if it "has a connection with or reference to" ERISA in the "normal sense of the phrase."[15]

This section protects ERISA plans from liability for negligent injury by prohibiting the application of state law in any form (including common law tort law) to ERISA plans if the state law relates to an activity of the plan. However, under a statute known as The McCarran-Ferguson Act,[16] states retain regulatory control over the "business of insurance." In enacting ERISA, Congress did not intend to take this authority away from the states. Thus, ERISA's preemption stops short of "any law of any State which regulates insurance."[17] This provision, § 514(b)(2)(A), is referred to as the saving clause, because it saves insurance regulation for the states. If a state passes a law that regulates insurance, it can be saved from preemption and enforceable.

A further provision—the so-called deemer clause contained in § 514 (b)(2)(B)—limits this exception by providing that an employee welfare benefit plan may not "be deemed to be an insurance company. . .or to be engaged in the business of insurance,"[18] merely because it is self-funded. The effect of this provision is to shield self-funded plans from nearly all state regulation. Even if a state law that regulates insurance is saved from preemption under the saving clause, the law will not be enforceable against self-funded plans, because they are not deemed to be in the "business of insurance."

The conflict preemption clause is the real killer of ERISA. Recall that the complete preemption clause forces a plaintiff into federal court and then limits potential recovery, but does not cause the action to be dismissed. If a cause of action is preempted under § 514, however, the claim will be subject to complete dismissal. The plaintiff will be forced either to rewrite the claim as one that falls under ERISA, which offers only reduced recovery options, or to have the entire case dismissed.

The mechanics of § 514 of ERISA are illustrated nicely by the 1985 Supreme Court case of *Metropolitan Life Insurance Co. v. Massachusetts*,[10] a case that dealt with a Massachusetts statute mandating that all health plans provide mental health benefits. The issue before the Supreme Court was whether the law was enforceable against a company's self-funded ERISA plan, or whether application of the law was preempted by § 514. The Court found that the statute was a state law aimed at the insurance industry and therefore was saved from preemption by the sav-

ing clause. However, the Court further held that the law did not to apply to self-funded plans. Under the deemer clause, self-funded plans are not deemed to be in the business of insurance, and so a state law such as the one at issue in this case that regulates insurance would not be enforceable against self-funded plans.

ERISA and Managed Care: Case Law

When a plaintiff who has a health plan covered by ERISA files suit against an HMO, the HMO's response is predictable:

1. The HMO will move to remove the case to federal court, arguing that it is a claim to recover benefits due or to clarify rights to future benefits within the meaning of the complete preemption provision.

2. Once in federal court, the defendant will argue that the plaintiff is suing pursuant to state law (statute or common law such as medical malpractice) and that the law "relates to" an employee benefit plan within the meaning of the conflict preemption clause. As such, the defendant will argue that the claim is preempted by ERISA and will move for summary judgment and dismissal.

3. Another common defense argument is that the suit should be dismissed because the relief sought is beyond that available under ERISA. Remember that the only relief available is the benefit itself or the cost of that benefit, rather than the panoply of recovery usually available under tort law.

In response, the plaintiff can offer several arguments:

1. The plaintiff can argue that the suit is not one to "recover benefits. . .or clarify benefits" under an ERISA plan. If this argument succeeds, the plaintiff is entitled to bring the suit in state court and ERISA has no application to the claim.

2. The plaintiff can argue that the state law is saved from preemption by the saving clause. Note, however, that if this argument succeeds, self-funded plans will still be exempt from the state law because of the deemer clause.

3. Alternatively, the plaintiff can argue that the state law is not "related to" an employee benefit plan and therefore is not preempted by the conflict preemption provision. The effect of this argument is to bring the claim entirely outside the scope of ERISA. The law would therefore be enforceable against all ERISA plans, including self-funded plans.

Obviously, these arguments quickly become very complicated, and outcomes are not predictable. Because ERISA was not designed specifically for health care plans, its application to disputes about plan benefits is often problematic. Pursuant to the Separation of Powers doctrine mandated by the U.S. Constitution, legislatures enact and courts interpret laws. Courts have no power to change a statute such as ERISA. They must interpret its provisions in light of the dispute before the court, but can go no further. Congress has the power to amend ERISA, but courts cannot. In the early years, courts tended to interpret the provisions of ERISA strictly and literally, and outcomes that some viewed as unjust were common.

An example of such a case is *Corcoran v. United Healthcare, Inc.*[19] The plaintiff, Florence Corcoran, had a high-risk pregnancy. Her obstetrician recommended hospitalization for the last month of her pregnancy. United Healthcare, her HMO, denied the request and instead authorized home nursing care. While at home without a nurse, Mrs. Corcoran's fetus went into distress and died. Corcoran filed a wrongful death action against United Healthcare in state court. United Healthcare, under the complete preemption provision, removed the case to federal court and then filed a motion for summary judgment. They argued that the case should be dismissed under the conflict preemption provision and, alternatively, because it sought relief not authorized by the provisions of ERISA. The district court granted the motion and Corcoran appealed.

The court of appeals affirmed the district court's decision and ruled that ERISA both preempted the plaintiff's medical malpractice claim and precluded recovery of emotional distress damages. With respect to conflict preemption, the court of appeals reasoned that the suit was "related to" an ERISA plan because United Healthcare was making decisions about benefit availability. They noted that United Healthcare made medical decisions, but held that the action was preempted by ERISA because the medical decisions were made only incident to making benefit determinations. They also said that the Corcorans were seeking a form of extracontractual damages (emotional distress) that are not available under ERISA. The court of appeals further recognized that Mrs. Corcoran was harmed by the managed care restriction on her medical care, but observed that, under ERISA, they were compelled to conclude that the Corcorans had "no remedy, state or federal, for what may have

been a serious mistake" (Ref. 19, p 1338). The court further observed:

> [C]ost containment features such as the one at issue in this case did not exist when Congress passed ERISA. While we are confident that the result we have reached is faithful to Congress's intent neither to allow state-law causes of action that relate to employee benefit plans nor to provide beneficiaries in the Corcorans' position with a remedy under ERISA, the world of employee benefit plans has hardly remained static since 1974. Fundamental changes such as the widespread institution of utilization review would seem to warrant a reevaluation of ERISA so that it can continue to serve its noble purpose of safeguarding the interest of employees. Our system, of course, allocates this task to Congress, not the courts, and we acknowledge our role today by interpreting ERISA in a manner consistent with the expressed intentions of its creators [Ref. 19, pp 1338–9].

Since that time, however, Congress has not amended ERISA. Promise of change is kept alive in various versions of the Patient's Bill of Rights that have been introduced in Congress. None have passed, however. As time has gone by and Congress has not acted, courts have begun to interpret ERISA more liberally, and outcomes have begun to change. Consider, for example, the case of *Dukes v. U.S. Healthcare*,[20] a consolidation of two related claims. One of the plaintiffs, Mr. Dukes, received his health care through U.S. Healthcare as part of an ERISA plan. He died with a high blood sugar level after the blood tests were not provided by U.S. Healthcare. Mr. Dukes' widow brought suit in state court alleging negligence. The case was removed from state court to federal district court. When the case was heard in federal court, the judge granted summary judgment on the grounds that the claims were preempted by the conflict preemption clause.

The Third Circuit Court of Appeals, however, held that the removal of these claims from state court was improper. The court distinguished *Corcoran*, in which the defendant merely provided utilization review services, from the HMO in *Dukes* that actually supervised the medical care. The court focused on the complete preemption provision of ERISA and held that the case did not even belong in federal court—that is, that the plaintiffs could sue in state court under relevant state law. They reasoned that a claim is subject to removal to federal court if it is a claim to "recover benefits due, enforce rights under the plan, or clarify rights to future benefits." However, Mrs. Dukes was not arguing that Mr. Dukes did not get care. She was arguing that the benefit he got was negligently performed. The court characterized the claims as claims about the "quality of benefits." Viewed this way, the suit did not fall under the scope of ERISA.

Similarly, in *New York State Conference of Blue Cross and Blue Shield Plans et al. v. Travelers Insurance Co.*[21] the U.S. Supreme Court also employed a more pragmatic and liberal interpretation of ERISA. New York's Prospective Hospital Reimbursement Methodology regulated hospital rates for inpatient care. Blue Cross and Medicaid patients were billed at Diagnostic Related Group (DRG) rates but patients served by commercial insurers were billed at the DRG rate plus a surcharge. Several commercial insurers brought suit in federal court arguing that the surcharge law was preempted by ERISA and therefore unenforceable. The U.S. Supreme Court held that surcharges did not "relate to" ERISA plans within the meaning of § 514(a) and that the law could be enforced. The Court reasoned that Congress intended in ERISA to insure that benefit plans would be subject to a uniform body of law and that the purpose of New York's statute was unrelated to this purpose. The purpose of the New York law was to encourage Blue Cross and Blue Shield to provide coverage to many subscribers whom the commercial insurers would reject. Because the charge differentials made Blue Cross and Blue Shield more attractive, they did have an indirect economic effect on choices made by insurance buyers, including ERISA plans. However, the Court opined that cost uniformity was not an object of ERISA. In addition, the surcharges had only an "indirect economic effect" on ERISA plans, and this connection was insufficient to satisfy the "relates to" clause (Ref. 21, p 661).

Recent Supreme Court Cases

The U.S. Supreme Court has heard three ERISA cases since 2000. Their pragmatic and more liberal interpretation of ERISA has continued in two of the three. This section will review each of these cases.

The first case involved Lori Herdrich, who developed pain in her groin and sought care from Dr. Pegram. Dr. Pegram discovered an inflamed mass in Herdrich's abdomen and ordered an ultrasound. However, instead of ordering the ultrasound at a local nonaffiliated hospital, he arranged for Herdrich to have the ultrasound eight days later at an HMO-affiliated hospital 50 miles away. Before the test could be conducted, Herdrich's appendix ruptured,

causing peritonitis. She brought suit in state court against Dr. Pegram and the HMO.

After the case was removed to federal court, Herdrich amended her claim to allege a breach of fiduciary duty by the HMO. She argued that the HMO's system of financial incentives motivated physician-owners to increase profits by being frugal with patient care expenses and caused her physician to place his own interests ahead of hers, in violation of the terms of ERISA.

The district court dismissed Herdrich's claim, and the Seventh Circuit Court of Appeals reversed. The U.S. Supreme Court granted *certiorari* on the issue of whether treatment decisions made by an HMO through employee providers are fiduciary acts within the meaning of ERISA § 404. In a unanimous decision, the Court held that physician treatment decisions are not fiduciary acts under ERISA.

Section 404 of ERISA defines a fiduciary as someone "acting in a capacity of a manager, administrator, or financial advisor to a plan."[23] The Court reasoned that, given that definition, the only decisions that should be considered fiduciary acts under ERISA are eligibility decisions. It next analyzed the different types of decisions made by HMOs. Pure eligibility decisions are those dealing with whether the plan covers certain medical conditions. Treatment decisions are those regarding diagnosis and therapy schemes. The Court ruled that mixed treatment and eligibility decisions made by an HMO physician do not constitute "fiduciary acts" within the meaning of ERISA. Moreover, the Court effectively held that a health plan does not violate ERISA's statutory duty to "act solely in the interest of plan beneficiaries"[24] when it gives physicians financial incentives to control health care costs.

This case provides an excellent example of the problems of applying ERISA to health benefit plans. The fiduciary provisions of ERISA were drafted with monetary benefits in mind. With pensions, the fiduciary invests employees' money and safeguards it until retirement. The definition of a fiduciary as a "manager, administrator or financial advisor" has no applicability to the doctor-patient or patient-HMO relationship. The Supreme Court, working with the language of ERISA had little choice but to reject Herdrich's claim. If the Court accepted Herdrich's assertion that ERISA's fiduciary provisions prohibited health plans from pursuing cost containment, then it would bring down all of managed care. *Pegram* does leave undecided, however, whether it is a breach of fiduciary duty under ERISA not to disclose to plan members the plan's financial arrangements and incentives.

In recent years, a growing number of states have passed legislation that increases MCOs' duties to patients and increases patients' rights. Of course, MCOs have argued that these statutes are preempted by ERISA. Last year, in the case of *Rush Prudential HMO, Inc. v. Moran et al.*[25] the Supreme Court reviewed an Illinois law that provided for independent review of certain MCO care denials. Moran got her health care from Rush, an HMO, under an ERISA plan. She experienced pain and numbness in her right shoulder. After conservative treatments were unsuccessful, her primary care physician recommended that Rush approve surgery by an unaffiliated specialist. Rush denied the request on the ground that the procedure was not medically necessary.

Moran made a written demand for an independent medical review of her claim, as guaranteed by the Illinois HMO Act.[26] The Act provides that in the event of a dispute between a primary care physician and the HMO regarding the medical necessity of a service proposed by the primary care physician, an unaffiliated physician shall review the case and if that physician determines the proposed service to be medically necessary, the HMO shall provide the covered service. Rush refused Moran's demand, and Moran sued in state court to compel compliance with the state act. The state court ordered the review, which found the treatment necessary, but Rush again denied the claim. While the suit was pending, Moran had the surgery at her own expense and amended her complaint in state court to seek reimbursement for the surgery as medically necessary under the Illinois HMO Act.

Rush removed to federal court, alleging complete preemption, and then had the suit dismissed on the ground that ERISA preempted Illinois's independent review statute. The Seventh Circuit Court of Appeals reversed. It held that the law was saved from preemption because it is a state law that regulates insurance.

The U.S. Supreme Court, in a five-to-four decision, affirmed the decision of the Seventh Circuit and held that the independent review provision of the Illinois HMO Act is not preempted by ERISA. The Court held that the Illinois HMO Act regulates insurance within the meaning of the saving clause of ERISA. It found that the law was specifically directed toward the insurance industry and that the law de-

fined an HMO with respect to the spreading and underwriting of risk, the components of insurance. The Court acknowledged that an HMO is both an insurer and a health care provider and held that the savings clause of ERISA does not require an either/or choice between health care and insurance in deciding a preemption question. The Court stated that in a conflict between the congressional policies of exclusively federal remedies and the reservation of the business of insurance to the states, the state insurance regulation will lose out if it allows plan participants to obtain remedies that Congress rejected in ERISA.

Rush argued that the independent review procedure in this case is a form of binding arbitration that replaces judicial review and the remedies available under ERISA. The Court disagreed, however. It opined that the Illinois law provided no new cause of action under state law and authorized no new form of ultimate relief. Moran was asking only for reimbursement of her expenses and not other types of recovery precluded by ERISA. It is unlikely that the statute would have been saved from preemption if it had provided for extracontractual remedies.

Earlier this year, the U. S. Supreme Court heard another case involving a state statute directed toward MCOs. *Kentucky Association of Health Plans, Inc. et al. v. Miller*[27] involved Kentucky's any-willing-provider (AWP) statutes. Under the terms of these statutes, health insurers are prohibited from discriminating against any provider "who is. . .willing to meet the terms and conditions for participation established by the health insurer."[28] A similar provision applies to chiropractors.[29] One cost containment method that HMOs frequently use is to contract with an exclusive network of providers who agree to deliver care at a discounted rate. The *quid pro quo* for this discounted rate is assurance of patient volume. This assurance can be made because the network membership is limited; AWP statutes would undermine this.

The Kentucky AWP laws were challenged by the Kentucky Association of Health Plans, Inc. and other MCOs. The MCOs argued that the laws were preempted by ERISA and were therefore unenforceable against ERISA plans. In a unanimous opinion, the U.S. Supreme Court disagreed and held that the statues are saved from preemption by the saving clause of the conflict preemption provision of ERISA.

In its ruling, the Court clarified its previous rulings in the area and set forth a simple, clear inquiry for conflict preemption. It stated that laws that regulate insurance within the meaning of the saving clause of ERISA must fulfill two requirements. They must be "specifically directed toward entities engaged in insurance. . .[and] must substantially affect the risk pooling arrangement between the insurer and the insured" (Ref. 27, 123 S. Ct. at 1479).

The HMOs contended that the laws were not "specifically directed toward" insurers because they also had an effect on doctors who seek to become providers for the HMOs. The Court rejected this argument, stating that the statutes are violated only by the action of a health benefit plan excluding a provider and further, that "regulations 'directed toward' certain entities will almost always disable other entities from doing, with the regulated entities, what the regulations forbid; this does not suffice to place such regulation outside the scope of ERISA's savings [*sic*] clause" (Ref. 27, 123 S. Ct. at 1476–7).

On whether the law regulates "insurance practices," the HMOs argued that the AWP laws do not meet this requirement because they focus on relationships with third-party providers and not the actual terms of the insurance policies. The Court also rejected this argument. It reasoned that the AWP laws "regulate" insurance by imposing conditions on the right to engage in the business of insurance. On risk-pooling arrangements, the Court held that the AWP laws serve to expand the number of providers and alter the "scope of permissible bargains between insurers and insureds. . . . No longer may Kentucky insureds seek insurance from a closed network of health care providers in exchange for a lower premium. The AWP prohibition substantially affects the type of risk pooling arrangements that insurers may offer" (Ref. 27, 123 S. Ct. at 1478).

Like *Rush Prudential*, *Kentucky Association of Health Plans* has a major limitation on its impact. Recall that self-insured plans are not deemed to be in the business of insurance under ERISA. This means that, although the Kentucky law was saved from preemption, self-insured plans will still be shielded from the law by ERISA. The significance of this cannot be overstated, because self-funded plans are used by most Fortune 500 companies.

Conclusion

Managed care has had a tremendous effect on health care in the United States. The laws regarding managed care are complex and often vary from state

to state. ERISA further complicates this area of the law. ERISA is a difficult, dense law that was drafted primarily to protect monetary employee benefits. Although it also covers service benefits, it does not contain provisions that adequately address these benefits and it has provided much protection against liability for MCOs. In recent years, courts have explicitly recognized that ERISA is not well suited to govern disputes between MCOs and their members. However, because of the separation of powers doctrine, courts have been unable to address these problems adequately.

In the absence of congressional action, two things have happened: courts have begun to employ more liberal interpretations of ERISA that lead to more equitable outcomes, and states have enacted their own laws, which have been upheld by courts. For now, this will have to do. The only real answer to the ERISA problem is congressional action. The danger of these other efforts is that Congress will begin to believe that action is not necessary. Without action, however, patients' rights and MCO duties will be neither predictable nor assured.

References

1. 88 Stat. 832, as amended, 29 U.S.C.S. §§ 1001 *et seq*. (2003)
2. 29 U.S.C.S. §§ 1021–1031, 1110–1114 (2003)
3. 29 U.S.C.S. § 1185(a) (2003)
4. 29 U.S.C.S. §§ 1161–1168, 1181 (2003)
5. 29 U.S.C.S. § 1182 (2003)
6. Mariner WK: State regulation of managed care and the Employee Retirement Income Security Act. N Engl J Med 335:1986–90, 1996
7. 29 U.S.C.S. § 1002(1) (2003)
8. 29 U.S.C.S. § 1003(b) (2003)
9. Benjamin GC: Managed care liability. Phys Exec Mar/Apr;77–99, 1999
10. Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985)
11. 29 U.S.C. §§ 1132, 1144 (2003)
12. 29 U.S.C. § 1132(a)(1)(A)-(B) (2003)
13. Kearney v. U.S. Healthcare, Inc., 859 F.Supp. 182 (E.D. Pa. 1994)
14. 29 U.S.C. § 1144(a) (2003)
15. Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983)
16. 59 Stat. 34, 15 U.S.C.S. § 1012 (2003)
17. 29 U.S.C. § 1144(b)(2)(A) (2003)
18. 29 U.S.C. § 1144(b)(2)(B) (2003)
19. Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992)
20. Dukes v. U.S. Healthcare, 57 F.3d 350 (3d Cir. 1995)
21. New York State Conference of Blue Cross & Blue Shield Plans, et al. v. Travelers Ins. Co., 514 U.S. 645 (1995)
22. Pegram v. Herdrich, 530 U.S. 211 (2000)
23. 29 U.S.C.S. § 1002(21)(A)(i)–(iii) (2003)
24. 29 U.S.C.S. § 1104(a)(1) (2003)
25. Rush Prudential HMO, Inc. v. Moran, et al., 536 U.S. 355 (2002)
26. Illinois Health Maintenance Organizations Act, 215 Ill. Comp. Stat., Ch. 125, 410 (2000)
27. Kentucky Ass'n of Health Plans, Inc., et al. v. Miller, 123 S. Ct. 1471 (2003)
28. Ky. Rev. Stat. Ann. § 304.17A–270 (West 2001)
29. Ky. Rev. Stat. Ann. § 304.17A–171(2) (West 2001)