ATTACKING ERISA PREEMPTION:
NOT THE EFFECTIVE PRESCRIPTION FOR MENTAL HEALTH CARE

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INTRODUCTION

During the last ten years, managed care, a health service delivery system, has come to dominate the health care industry. Managed care has expanded especially rapidly in the area of mental health care. In response to this growth, newspaper columnists, health care providers, legislators, patient groups, and judges have formed a "Greek chorus" condemning managed care organizations (MCOs). Perhaps the biggest condemnation of managed care is in the area of accountability. The Greek chorus perceives managed care as getting too much protection from the Employee Retirement Income Security Act of 1974 (ERISA), a federal statute that preempts state laws that regulate employee benefit plans, including

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1 COMMITTEE ON QUALITY ASSURANCE AND ACCREDITATION GUIDELINES FOR MANAGED BEHAVIORAL HEALTH CARE, INSTITUTE OF MEDICINE, MANAGING MANAGED CARE: QUALITY IMPROVEMENT IN BEHAVIORAL HEALTH 1 (Margaret Edmonds et al. eds., 1997) [hereinafter COMMITTEE ON QUALITY ASSURANCE] (noting that over sixty percent of the surveyed United States population belonged to a managed health care plan in 1995).

2 Id. (detailing that managed care provided behavioral health benefits for 142 million people by the end of 1995).

3 David A. Hymen, Consumer Protection in a Managed Care World: Should Consumers Call 911?, 43 Vt. L. Rev. 409, 410-11 (1998) (discussing the increase in public hostility towards managed care efforts over the past few years).

4 See generally Tom Miller & Gregory Cooke, Getting Beyond the Managed Care Backlash, 21 Regulation 67, 52 (1998) (describing the various types of MCOs and offering solutions for the numerous problems that arise in managed care).

employee health benefit plans. Critics argue that while Congress passed ERISA to protect patients, ERISA instead shields MCOs from liability. Consequently, patients, particularly mental health patients, do not receive the quality of care they need. Critics advocate altering state statutes, narrowing judicial interpretations of ERISA, and even amending ERISA itself to improve the quality of care and provide accountability.

But what if the Greek chorus is wrong? Perhaps ERISA preemption is in fact providing needed protection that allows managed care to deliver quality care to a greater number of mental health patients. Advocacy groups point to a growing body of research and anecdotal information to support that proposition. This paper examines the interaction of managed care and ERISA and the effect on mental health care. Part I of this paper explores the background of mental health care, managed care, and ERISA. Part II examines problems with managed care in the context of mental health and sets forth various solutions to these problems. Part III is a counterpoint to Part II. Here, I will juxtapose industry change doctrines and models to the managed care industry to highlight benefits of ERISA protection to suggest that attacking ERISA preemption may not be the effective prescription for quality mental health care.

7 Miller, supra note 4, at 52 (noting that courts usually hold that insurers and other third parties are protected from tort liability by ERISA when they perform services on behalf of employer health plans).
8 See TEXAS DEPARTMENT OF INSURANCE, REPORT TO THE TEXAS LEGISLATURE, HEALTH INSURANCE REGULATION IN TEXAS: THE IMPACT OF MANDATED HEALTH BENEFITS 42 (1998) [hereinafter HEALTH INSURANCE REGULATION IN TEXAS] (arguing that Texas insurance policy makers, ever aware of ERISA, may design health plans that prevent participants from receiving adequate care).
9 Miller, supra note 4, at 52-53 (discussing several proposed methods of improving the likelihood that patients will receive an improved quality of care and that MCOs will be held accountable).
10 HEALTH INSURANCE REGULATION IN TEXAS, supra note 8, at 41-42 (noting that a survey conducted by KPMG showed that self-funded plans are more likely to offer commonly mandated provisions and other benefits that are not typically mandated by fully insured plans, and arguing that the ERISA preemption is necessary so employers can design health care packages that are cost effective.).
tions yet both provide some coverage for mental health issues. Medicare pays for mental health care evaluations, but strictly limits practitioner reimbursement. Medicaid covers a wide array of mental health services and supports approximately one-third of community-based mental health programs.

Traditionally, a fee-for-service (FFS) system dominated the health care arena. Under FFS, (1) patients chose their own physicians; (2) physicians freely decided what medical treatment to offer their patients; and (3) after treatment was delivered, insurers determined benefits to apply toward the physician’s fee. This delivery method has changed radically in recent years. Managed care delivery systems have become more popular than the FFS system, noted by the fact that managed care provided behavioral health benefits to millions of people by the end of 1995. Although more popular, it is important to note that the managed care system is very different from the FFS system.

As delivery methods have thus changed, so too have the definitions of mental health and mental illness. Initially, all mental health characterizations were subsumed under the term “insanity.” However, our umbrella generalization of insanity has evolved into a more comprehensive understanding of the condition. During November 1999, the U.S. Surgeon General, Dr. David Satcher, issued a report defining mental health and mental illness. The report correctly illustrates that mental health and mental illness are really two points on a continuum. The report defines the terms in the following manner:

Mental Health: the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem.

Mental Illness: the term that refers collectively to all mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination therefore) associated with distress and/or impaired functioning.

These definitions, however, are not ideal and thus precipitate much controversy. For instance, what causes mental illness? How are people properly diagnosed? Can people recover from mental illness? Perhaps these inadequate definitions are the result of inconsistent models used to assess mental illness. For example, the “medical model” presupposes that a person’s mental state results from an organic or chemical condition within the body. The “psy-
choanalytic model” asserts that patterns established through interactions with family and other environmental influences determine an individual’s mental health.35 The “behavioral model” states that aversive or reinforcing events produce behaviors and perceptions that can be modified.36 The “social model” maintains that all environmental factors influence the outcome.37 These various theories on mental health tend to add complexity, invariably resulting in additional controversy.38

The myriad models is not ideal for the enormous range of mental health disorders.39 Nor are the models ideal, as people may suffer from a wide variety of symptoms that are characteristic of a number of mental health disorders.40 Numerous traits and causes may factor into an individual’s overall mental health.41 Moreover, only a small percentage of individuals with mental disorders actu-

35 Anne C. Dailey, Symposium, The Hidden Economy of the Unconscious, 74 Chi.-Kent L. Rev. 1599, 1644-15 (2003) (commenting, “the important point is that the psychoanalytic model recognizes that the rationality of the secondary process develops in the context of the more primitive, primary thought processes characteristic of the infantile periods. Psychoanalysis teaches that the adult capacity for rational thought never entirely replaces more primitive modes of thinking and feeling. . . . On the whole, psychoanalysis adheres to ‘the persistence of the primary process throughout life,’ a condition most evident at times of stress such as serious conflict, physical illness, romantic disillusion, and religious ecstasy.’”). But see Mark P. Goodman, The Right to a Partisan Psychiatric Expert: Might Futility Preclude Incompetency, 61 N.Y.U. L. Rev. 703, 734 n.32, citing P. HILL ET AL., ENCYCLOPEDIA OF POSTGRADUATE PSYCHIATRY 58 (1979) (noting within the psychiatric community the variety of different diagnostic theories that lead to diagnoses that are incapable of being consistently accurate).

36 Dailey, supra note 35, at 1603-04 (observing that scholars deem the behavioral model as bundles of stimulus-response reflexes and that the behavior model advocates are not oblivious to the existence of irrational behavior, “but they believe that most of what we classify as ‘irrational’ results from malfunctions in cognitive processes brought about by biases, heuristics, computational limitations, and informational barriers.”).

37 Goodman, supra note 35 (detailing that the social model attributes mental illness to environmental influences rather than an underlying physical disease).

38 See AEA, 470 U.S. at 81 (demonstrating the court’s concern for the complexity of the issue and recognizing that there is often not an accurate psychiatric conclusion on a single set of facts).

39 U.S. Department of Health and Human Services, Mental Health: A Report of the Surgeon General 1999, at 44 [hereinafter HHS Mental Health Report] (noting that the American Psychiatric Association recognizes sixteen major diagnostic classes of each mental disorder and several disorders may be in one class).

40 Id. at 46 (describing how people with mental health disorders may suffer from symptoms that include “inappropriate anxiety, disturbances of thought and perception, dysregulation of mood, and cognitive dysfunction”).

41 Id. at 225 (arguing that self-esteem, optimism, and resilience contribute to mental health; also noting that “stressful life events in adulthood include the breakup of intimate romantic relationships, death of a family member or friend, economic hardship, role conflict,
posed to the FFS system where decisions on payment are made after treatment.51

An average definition for managed care is a "system that, in varying degrees, integrates the financing and delivery of medical care through contracts with selected physicians and hospitals that provide comprehensive health care services to enrolled members for a predetermined monthly premium."52 Though managed care plans vary greatly, they all make arrangements with selected providers to furnish a specific set of health care services, establish standards that providers must meet, maintain programs for quality improvement, and provide financial incentives for members.53 The uniform theme, however, is cost containment.

HMOs need a vehicle for implementation, thus the Health Maintenance Organizations (HMOs) emerged vigorously in the late 1970s.54 There continues to be an increase in the number of individuals enrolled in HMOs even today.55 This is especially true for employer sponsored ERISA plans.56 Additionally, non-HMO private insurers also implemented managed care principles to contain burgeoning health care costs.57 Medicare and Medicaid programs have also joined the managed care bandwagon,58 with substantial por-

51 Peregown v. Herdrich, 550 U.S. 211, 218-219 (2000) (stating that the HMO "assumes the financial risk of providing the benefits promised; if a participant never gets sick, the HMO keeps the money regardless, and if a participant becomes extensively ill, the HMO is responsible for the treatment agreed upon even if its cost exceeds the participant's premiums.").

52 Id. (discussing the rapid growth of managed care; also noting that the term managed care encompasses health maintenance organization, preferred-provider organizations, and point-of-service financing and delivery systems).

53 COMMITTEE ON QUALITY ASSURANCE, supra note 1, at 41 (discussing the changes in the health care system and the limitations on the utilization of health care services by managed care).

54 Id. at 100-01 (indicating that Congress increased the amount of funding for HMO development after it was found that the amount of hospital expenses for employees in HMO plans were one-third the national average; this revelation led to an increase in those enrolled in HMOs to four percent of the United States population).

55 Id. at 31 (observing that between 1991 and 1993 there was a forty-six percent increase in HMO enrollment).

56 John K. Iglehart, Physicians and the Growth of Managed Care, 331 NEW ENG. J. MED. 1167 (1994) (noting that "employees enrolled in managed-care plans now constitute fifty-one percent of all people with employer-sponsored insurance, up from twenty-nine percent in 1988.").

57 Id. (indicating that many insurance companies, including Metropolitan Life, BlueCross BlueShield, Cigna, and Prudential, have developed their own managed care plans).

58 Id.

59 C. Merger of Mental Health Care and Managed Care

Before 1985, mental health care and managed care were two separate and evolving health care concerns.60 They began to merge in the mid-1980s by mutually seeking cost containment.61 Under the traditional FFS system, health care providers had little incentive to limit their costs,62 and in the mid-1980s, costs for psychiatric hospitalization skyrocketed as a result.63 In-patient psychiatric care costs rose from three billion dollars in 1969 to approximately twenty-one billion dollars in 1986.64 Employers, the government, and insurers responded with a call for managed care to contain costs.65 As a result of this growing integration, managed care systems became increasingly more sophisticated and employed several different approaches including: (1) limiting insurance coverage for mental health services; (2) directly monitoring health care providers through utilization review of inpatient and outpatient service by applying treatment guidelines, protocols, and professional judgment through prior review (are services appropriate and necessary) and high-cost case management (a review of high expenditure cases to facilitate less costly care) to reduce the expense of care and to enhance the consistency and quality of care”; and (3) changing the

60 Id. (stating that "in the public sector in 1995, approximately one third of Medicaid eligible individuals and close to ten percent of Medicare beneficiaries were enrolled in managed care plans.").

61 Jesse A. Goldner, Managed Care and Mental Health: Clinical Perspectives and Legal Realities, 35 Hous. L. REV. 1457, 1466 (1999), citing MARY JANE ENGLISH, FROM FEE-FOR-SERVICE TO ACCIDENTAL HEALTH PLANS, IN ALLIES AND ADVERSARIES: THE IMPACT OF MANAGED CARE ON MENTAL HEALTH SERVICES 3, 4 (Robert K. Scherzer et al. eds. 1994).

62 COMMITTEE ON QUALITY ASSURANCE, supra note 1, at 40 (commenting that "[t]he evidence supports that ability of health maintenance organizations to control the costs of behavioral health care").

63 Peregown v. Herdrich, 550 U.S. 211 (2000) (recognizing that the physicians' incentive is to provide more care in a FFS as long as the patient or insurer is able to pay for the treatment).

64 Id.

65 HHS Mental Health Report, supra note 39, at 423 (illustrating that one managed care goal is to reduce cost by removing the excesses of over utilization and increasing the number of individuals treated with cost-effective care).
reimbursement method for service providers such as assigning financial risk to the providers.66

D. ERISA

Given the history of the merger between mental health care and managed care, this paper turns now to outline the foundation of ERISA. Congress enacted ERISA 67 in 1974 to protect private employee pensions and welfare benefit plans.68 ERISA was enacted in response to the enormous growth in employee benefit plans that began during World War II.69 The purposes of ERISA include: (1) the protection of interstate commerce; (2) the protection of the interests of participants and their beneficiaries in employee benefit plans; and (3) the establishment of uniform standards for the administration of benefit plans.70

Employee health benefit plans must comply with the reporting and disclosure requirements, fiduciary obligations, and enforcement and remedial measures of ERISA.71 These provisions reflect congressional intent to protect employees’ interests.72 Congress sought to extend ERISA application by preempting state laws relating to employee benefit plans.73 ERISA preempt s many state laws that adversely affect uniform operation of employee benefit plans.74 While petitioners with claims against their employer sponsored health care

plan likely will be forced into federal court under ERISA, claims filed under non-employer sponsored health plans are typically filed in state courts.75

There are three key provisions within the ERISA statute: (1) the preemption clause;76 (2) the savings clause;77 and (3) the deemer clause.78 This paper is primarily concerned with the preemption clause. The preemption clause is significant because federal court remedies are more limited compared to remedies available under most state law.79 For instance, if an employee sues and the claim is removed to federal court under ERISA, then the only recoverable remedies are reinstatement in the plan, reimbursement of benefits, making the plan whole, or provision of a benefit that should have been given but was wrongfully withheld.80 The petitioner must be living and seeking reimbursement after paying for the benefit.81 The limitations of ERISA in federal court contrast sharply with state tort remedies that, depending on the state, may include pain and suffering, lost wages, and costs of future medical services.82

There are two ways preemption under ERISA occurs.83 First, a state claim may be subject to “complete preemption” under the civil enforcement section of ERISA.84 In Metropolitan Life Insurance Com-

66 See Ellis, supra note 65, at 34.
68 29 U.S.C. § 1101(b)-(c) (2000) (defining the policy of ERISA as “to protect . . . the interests of participants in employee benefit plans and their beneficiaries”; also noting that ERISA contains protections which help guarantee the “equitable character and the soundness of [private pension] plans”).
69 29 U.S.C. § 1101(a) (2000) (stating that “Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial.”).
71 Aetna Life Ins. Co. v. Borges, 869 F.2d 142, 144 (2d Cir. 1989) (reporting that ERISA does not mandate that employers must provide particular benefits to employees; however, ERISA does impose participation, funding, and vesting requirements on employers that provide certain pension and welfare benefits; also noting that various rules pertaining to reporting, disclosure, and fiduciary responsibility are imposed on these employers).
76 Id. (providing, “except as provided in subsection (b) of this section, the provisions of [ERISA] shall supersede any and all state laws whatsoever as they may now or hereafter relate to any employee benefit plan.”).
77 29 U.S.C. § 1144(b)(2)(A) (2000) (stating, however, that unless otherwise provided for, “nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates, insurance, banking, or securities.”).
78 29 U.S.C. § 1144(b)(2)(B) (2000) (declaring that an employee benefit plan under ERISA, or a trust under such plan “shall not be deemed to be an insurance company or other insurer, bank, trust, company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies”).
79 Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987) (noting that the intent of ERISA would be completely undermined if participants were free to obtain state law remedies that were rejected by Congress in ERISA).
81 Id.
82 Amy Sack, Refusing to Follow Doctor’s Orders: Texas Takes the First Step in Holding HMO’s Liable for Bad Medical Decisions, 18 N. Ill. U.L. Rev. 387, 395 (1998) (discussing ERISA pre-emption and acknowledging that the ERISA remedies are far more limited than the state tort remedy).
84 Id.
pany v. Taylor, the United States Supreme Court determined that Congress intended complete preemption to apply to state law causes of action that are covered exclusively by ERISA civil enforcement provisions.

If a state claim does not fall within the civil enforcement section, the "conflict preemption" provision of ERISA may still preempt the state claim. If the state law in question "relates to" an employee benefit plan, then the claim is preempted. This is limited by the "savings clause," which preserves state laws that regulate insurance, banking, and securities.

In Shaw v. Delta Airlines, Inc., the Supreme Court broadly defined the phrase "relates to," and concluded that two New York state laws related to employee benefit plans. Any law "relates to" an employee benefit plan if it has "a connection or reference to that plan." Absent a clear congressional intent to apply a restrictive meaning to the term "relates to," the Court reasoned that it must look at the plain meaning in determining whether an employee benefit plan relates to a law.

The Supreme Court narrowed its interpretation of the ERISA preemption clause and the breadth of "relates to" in Blue Cross and Blue Shield Plans v. Travelers Insurance Company. The Court held that the New York law in question had no connection with employee benefit plans and therefore did not trigger ERISA preemption. The Court reasoned that the objectives of the ERISA statute

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69 Id. at 66 (stating that "Congress has clearly manifested an intent to make causes of action within the scope of the civil enforcement provisions of § 502(a) removable to federal court.").
70 Id.
71 Id.
74 Id. at 96-97 (holding that New York's Human Rights Law and Disability Benefits Law "relates to" employee benefit plans; also stating that "the Human Rights Law, which prohibits employers from structuring their employee benefit plans in a manner that discriminates on the basis of pregnancy, and the Disability Benefits Law, which requires employers to pay employees specific benefits, clearly relate to benefit plans.").
75 Id.
76 Id.
77 514 U.S. 645, 655 (1995) (stating that "our prior attempt to construe the phrase 'relate to' does not give us much help drawing the line here.").
78 Id. at 668 (involving state statutes that imposed surcharges on patients covered by commercial insurers other than the Blue Plans and also on certain HMO's, holding that New York's surcharges affect the prices of insurance policies indirectly and that such an area has traditionally been subject to state regulation).
79 Id. at 656 (holding that "[w]e simply must go beyond the unhelpful text and the frustrating difficulty of defining [relates to] and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.").
81 Id. at 729, 758 (noting that the Massachusetts law is typical of many mandated benefit laws and that it requires general insurance policies that provide hospital and surgical coverage to offer a certain minimum of mental health protection, and holding that a Massachusetts statute setting forth minimum mandatory health benefits for inclusion in insurance policies is a "law which regulates insurance" and is not preempted by either ERISA or the National Labor Relations Act).
82 Id. at 727.
83 Id. at 727.
84 Id. at 758.
85 Metropolitan Life, 471 U.S. at 733 (noting that the insurance savings clause qualifies ERISA's broad preemption of state laws).
86 Id. at 747 (stating that "[w]e are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By doing so we merely give life to a distinction created by Congress in the 'group clause,' a distinction Congress is aware of and one it has chosen not to alter.").
87 Id. (noting that the lack of consistency between insured and uninsured plans is the result of the congressional decision to preserve local insurance regulation).
To summarize, ERISA preemption involves a two-part analysis. The initial issue is whether a state law "relates to" an employee benefit plan. If a state law is found to relate to an employee benefit plan, the next question is whether the law "regulates the business of insurance," and is thereby "saved" from the preemption. ERISA thus has the potential to significantly impact mental health treatment and MCOs.103 ERISA preempted claims against HMOs include, but are not limited to, claims for breach of contract, tort,107 negligence,108 and medical malpractice.109 The question then becomes whether ERISA preemption is helpful or detrimental to mental health care.

II. HOW ERISA PREEMPTION NEGATIVELY IMPACTS MENTAL HEALTH CARE

As discussed above, the primary purpose of managed care is to contain costs of delivering health care services.110 Critics contend that cost management is diametrically opposed to delivery of quality care.111 Critics also argue that the cost containment methods alone hurt the patient, but when combined with the ERISA preemption, the patient is left with limited options for claims.112 This section will examine how managed care functions within the mental health care context and then apply ERISA layers to determine how ERISA negatively impacts mental health care.

A. Utilization Review

Utilization review, a major tool of managed care, is a system put in place by insurers to monitor the level, length, and intensity of covered treatment, thus containing costs by limiting demand.113 One form of utilization review is pretreatment review, which pre-reviews the need for service and maximizes the use of less costly providers.114 This can have devastating effects on mental health patients in desperate need of care that does not "fit" the utilization review profile.

In Andrews-Clarke v. Travelers Insurance Company,115 a utilization review agent approved neither an extended hospital stay nor a rehabilitation program, even though both were covered under the mental health patient’s medical policy and such care was critical for this alcoholic patient who was suicidal.116 The reviewer approved an less-expensive therapy program and the patient then committed suicide.117 The deceased’s spouse brought claims against the insurance company for breach of contract, medical malpractice, wrongful death, loss of parental and spousal consortium, and intentional and negligent infliction of emotional distress.118

ERISA does not authorize recovery for wrongful death or personal injury caused by improper refusal to authorize treatment.119 The court found that the practical impact of ERISA preemption was to immunize HMOs, which "thwarts the legitimate claims of the

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103 See, e.g., Jacoby v. Coming Group Ins., 785 F. Supp. 94, 96 (N.D. Ohio 1992) (upholding judgment for insurance company, even though the plaintiff received treatment from a mental health care provider who was not covered by plaintiff’s insurance plan and insurance company denied reimbursement claim).

104 See, e.g., Kuhl v. Lincoln Nat'l Health Plan, 599 F.2d 296, 302 (8th Cir. 1979) (holding that contract claims against insurer were preempted by ERISA).

105 See, e.g., Settles v. Golden Rule Ins. Co., 927 F.2d 907, 909 (10th Cir. 1991) (holding that the cause of action alleging claims of breach of contract, fraudulent denial of insurance coverage, the tort of outrage, and wrongful death were preempted by ERISA).

106 See, e.g., Jax v. Prudential Health Care Plan, 88 F.3d 1492, 1495 (7th Cir. 1996) (holding that vicarious liability claims for negligence of plan physician were preempted by ERISA).

107 See, e.g., Corcoran v. United Healthcare, Inc., 965 F.3d 1331, 1331 (6th Cir. 1995) (holding that ERISA preempted a medical malpractice claim based on negligence).

108 COMMITTEE ON QUALITY INSURANCE, supra note 1, at 42 (commenting that managed care plans, as compared to indemnity plans, have lowered the rates of inpatient hospitalization and discretionary testing while increasing the use of preventive services with mixed results on quality outcomes).

109 Id. at 40 (noting that quality of care and access to health care have long been a concern of policymakers).

110 Miller, supra note 4, at 52 (observing that ERISA limits damages and protects insurers and other third parties from tort liability).

111 BARRY FURROW, ET AL., HEALTH LAW: CARE, MATERIALS AND PROBLEMS 700 (2d ed. 1991) (stating that "utilization review refers to external case by case evaluation conducted by third-party payers, purchaser, health care organizations, or utilization review contractors to evaluate the necessity and appropriateness (and sometimes the quality) of medical care. It is a strategy that attempts to control costs by limiting demand.").

112 Id. at 700-01 (indicating that case managers create individualized treatment plans which often reward compliance with the plan by paying for services not covered by the insurer but less costly than covered alternatives).


114 Id. at 51 (noting that a utilization review provider authorized only a five-day hospital stay for detoxification even though the policy allowed for at least thirty days per year; the patient was discharged with a diagnosis of alcohol dependence and withdrawal symptoms, low hemoglobin, and elevated liver function).

115 Id. at 52.

116 Id.

117 Id. at 54-55.
very people ERISA was designed to protect.120 Courts have consistently either denied that utilization review decisions are medical121 or have recognized the hybrid nature of utilization review but hold that the administrative aspect trumps the medical aspect.122

B. Public Mental Health and Managed Care Problems

Mental health patients under public coverage systems can also be negatively impacted. Managed care techniques are integrated into public health systems that historically have served a population with a greater proportion of adults with severe and persistent mental illnesses and children with serious emotional disturbances.123 Problems identified by senior officials of state and local governments in the use of managed care include: (1) an incentive in a risk-based contract to under-treat, particularly to under-serve, people with serious disorders; (2) an undue focus on acute care and neglect of rehabilitation and other services with significant long-term payoff in improved functioning; (3) potential difficulties created by Medicaid managed care contracts in serving the non-Medicaid population; (4) frequent billing and payment difficulties during start-up; and (5) difficulties in ensuring quality and outcomes consistently across regions.124

Although these difficulties are public insurance specific, many of the issues are just as applicable to private insurance; moreover, ERISA preemption equally threatens both because mental health patients may have limited recourse.

C. Problems Reported from Users

The National Alliance for the Mentally Ill (NAMI) also identified problems with managed care programs.125 Its report identified that managed care plans failed to deliver on the following expecta-

120 Andrus-Clarks, 984 P. Supp. at 56.

121  See e.g., Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482, 1489 (7th Cir. 1996) (holding that utilization review qualifies as a benefits determination under ERISA).


123 NAMI Mental Health Report, supra note 39, at 408.

124 Bazelon Center for Mental Health Law, Effective Public Management of Mental Health Care: Views from States on Medicaid Reforms that Enhance Service Integration and Accountability, 8-9 (May 2000).


D. Physicians as Gatekeepers

Another problem with managed care in the mental health context is that the primary care physician takes on the role of primary care gatekeeper.111 This managed care tool is designed to reduce patient referrals to specialists and thereby reduce costs.126 Studies have shown that the gatekeeper system initially produced cost reductions:

126 Id.

127 Barry R. Furrow et al., Health Law 415 (5th ed. 1997) (explaining that “ERISA obligates employee benefit plans to fulfill their commitments to their beneficiaries, and provides a federal cause of action when they fail to do so.”).


129 NATIONAL ALLIANCE FOR THE MENTALLY ILL, NATIONAL MANAGED CARE PATIENT BILL OF RIGHTS, WHERE WE STAND 3 (2000).

130 Id.

131 Thomas Bodenheimer et al., Primary Care Physicians Should Be Coordinators, Not Gatekeepers, 281 JAMA 2045 (1999) (asserting that the practice of primary care is troubled because the public, specialists, and primary care providers themselves are dissatisfied with the gatekeeper role).

132 Id. at 2045-46 (relating that a costly cascade of diagnostic and therapeutic interventions resulted when patients visited multiple specialists before visiting general physicians).
of three to five percent but currently reduces costs by only one to two percent. 135 The gatekeeper approach is a major change from the FFS system where there was unrestricted access to specialists. 136 Gatekeeping can be dangerous as financial incentives may influence medical decisions. 137 These incentives range from risk sharing techniques, including the use of capitation or withhold, to bonuses for providers who carefully control use on their provision of services, thereby decreasing the need for external utilization review. 138 This gatekeeper approach significantly impacts mental health care in several ways.

First, the gatekeeper approach places far greater responsibility on primary care physicians to appropriately identify mental health problems. 139 With the brief time allotted to each patient, these physicians do not have time for thorough assessments of complicated and sensitive mental health cases. 138 Additionally, the physician is usually not specifically trained in mental health. 139 Second, the approach significantly increases the likelihood that primary care physicians will attempt to treat mental health conditions. 140 Third, referrals may be made to less competent individuals to reduce costs. 141 Finally, the primary care physician may approve or deny the patient's request for a referral or specific type of treatment. 142


136 Bodenheimer, supra note 131, at 2046 (distinguishing the former FFS system in which Americans were free to choose as many physicians of whatever specialty they wished from the new gatekeeping system in which individuals rely on general physicians to direct their care).

137 Michael S. Jellinek & Barry Nurcombe, Two Wrongs Don't Make a Right: Managed Care, Mental Health, and the Marketplace, 270 JAMA 1737, 1737-38 (1993) (asserting that unopposed incentives to cut services contributed to the mental health delivery two-stage evolution).

138 Furrow, supra note 113, at 717 (arguing that HMOs provide cost savings attributable to incentives created by per capita fixed fees). See also Golner, supra note 60, at 1453 (listing incentives as risk sharing techniques and the use of capitation).

139 Golner, supra note 60, at 1453 (analyzing the gatekeeping effect on mental health services).

140 Id.

141 Id.

142 Id.

143 Bodenheimer, supra note 131, at 2046 (pointing that gatekeeping also acts as a drudge, “everlastingly mired in the tedious process of obtaining authorization for referrals.”).
ERISA. If deterrence and compensation are the goals of tort law, what effect does ERISA preemption have? ERISA often shields defendants from full liability, and plaintiffs receive less than full compensation. Perhaps the impact of ERISA preemption is the same as no-fault compensation because the restorative process for plaintiffs is less than complete.

Lee Taft, acting Assistant Dean for Student Life at the Harvard Divinity School, touched on this aspect in his article on apology when he said, "[o]ver the years, I have become convinced that something was missing, an essential element the absence of which disrupted my clients' healing... I began to think that the missing, necessary piece for healing was an apology from the offender... a restoration of an equality of regard" to restore the moral imbalance. Similarly, preemption by ERISA may indirectly disrupt the restoration of a mental health patient's equality of regard.

Mental health patients are already disadvantaged because of their limited patient autonomy to exercise free will, to choose from various options, and to independently manage their own health care. Two factors compound patient autonomy in individuals afflicted with mental illnesses. First, the nature and course of an illness influence a patient's capacity to make sound decisions. Second, mentally ill patients are among the poorest and most disenfranchised in terms of housing and support systems in our society.

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182 Goldner, supra note 60, at 1487.

183 See Daniel W. Shuman, The Psychology of Compensation in Tort Law, 43 U. Kaufman Rev. 29, 65-66 (1994) (arguing that one way to restore plaintiffs is to require defendants to personally fund a part of plaintiffs' compensation; otherwise, complete liability insurance distributes the cost of compensation to society and frustrates plaintiffs' restoration).


185 COMMITTEE ON QUALITY ASSURANCE, supra note 1, at 69.

186 Id. (summarizing that respect for patient autonomy assumes that a patient is capable of self-determination).

187 An Interview with Commissioner Preeti: Mental Health System Reform, 5 Mdz. Pol'y Rev. 21 (1990) [hereinafter Mental Health System Reform].

188 HHS Executive Summary, supra note 29, at vii. See also Mental Health System Reform, supra note 157.

F. Federal Response

When ERISA preempts mental health patients' claims, their "equality of regard" may not be restored. Mental health patients possess a great need for such restoration because not only are they among the poorest and most disenfranchised in our society, but they may also not recover from their injuries with the same ease as patients who are financially, socially, and mentally uncumbered. Thus, ERISA preemption may have a disparate effect on mental health patients.

Advocacy groups, legislatures, and patients have now recognized this unequal treatment of mental health patients on federal and state levels.

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190 Mental Health System Reform, supra note 157.

191 The Managed Care Liability Project (relaying that patients suffering from mental illness require longer to recover), at http://www.protectionandsadvocacy.com/mckup.htm (last visited Mar. 21, 2001).


194 Id. (citing the federal legislation's response to managed care organizations' unaccountability, and listing proposed bills such as the Promoting Responsible Managed Care Act of 1999, the Patient Protection Act of 1999, the Access to Quality Care Act of 1999, and four versions of the Patient's Bill of Rights Act of 1999).


a limited right to remain under a provider's care when switching plans; and requires plans to pay for more types of emergency treatments. The Dingell-Norwood Bill controversially allows patients to sue their health plans in state court for wrongful denials of care. Under the Dingell-Norwood Bill, patients may recover damages for personal injury or death against an insurer or plan administrator. Punitive damages are available if permitted by state law, but only when a plan failed to comply with an external review panel's recommendations.

Senate Bill 1344 proposes a more moderate change in mental health care protection. Senate Bill 1344 neither incorporates the right to sue plans in state court nor extends patient protections for enrollees in fully insured plans. Further, Senate Bill 1344 fails to protect patients in a number of ways. First, Senate Bill 1344 protection only extends to self-insured Americans exempted from state regulations. Such protection is limited and leaves millions of Americans without sufficient protection. Second, Senate Bill 1344 allows insurers to veto a physician's recommended course of treatment. Third, patients are not allowed to access providers outside the managed care network. Finally, Senate Bill 1344 prohibits specialists from functioning as primary care providers. At this time, the Congressional Conference Committee has not convened to reconcile the two bills.

Congress also introduced House Bill 2723. House Bill 2723 has controversially been linked to House Bill 2990. House Bill 2990 guarantees protection for approximately 161 million Americans with private health insurance and provides direct access to specialty care such as mental health professionals. House Bill 2723 includes similar positive protections as House Bill 2990, however, House Bill 2990 also incorporates negative, harmful provisions for mental health patients. House Bill 2990 would permit small employers and individuals to avoid state mandated benefits, including mental health benefits, by utilizing arrangements such as medical savings accounts (MSAs) for individuals, Association Health Plans (AHPs), and HealthMarts.

Current legislation illustrates Congress' reaction to consumer dissatisfaction with the managed care system and health care providers' lack of accountability. Although the Dingell-Norwood Bill provides a number of protections for mental health patients, its passage remains doubtful. The Clinton Administration voiced concerns about the Bill's enormous 48.6 billion dollar cost over ten years in comparison to the meager one percent tax provision benefits for individuals presently uninsured.

G. State Reactions

State legislatures also are reacting to the same issues and constituents' concerns as Congress, but with an additional motivation. State legislatures are generally protective of their state powers and

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167 Id.
168 Id.
172 National Managed Care, supra note 166.
173 Bazelon Center for Mental Health Law, Support Needed for a Sound Patients' Bill of Rights, (noting the scope of the Patient's Bill of Rights Act would leave millions of Americans without proper protections because the bill is largely limited to the forty-eight million Americans under self-insured plans, which are exempted from state regulations), available at http://www.bazelon.org/2008Bills.html (last visited Mar. 8, 2003).
174 Id.
175 Id.
176 Id.
177 Id.
178 Id.
179 National Managed Care, supra note 166.
180 Id.
shy from federal encroachment on their autonomy. Accordingly, states disapprove of ERISA preemption because it threatens their autonomy by restricting a state’s ability to provide injured citizens with compensation.

Texas has led the charge by passing legislation altering HMO protection in medical malpractice suits. Texas enacted Senate Bill 386 in September 1997 to provide its citizens a remedy against HMOs. Now codified in the Texas Civil Practice and Remedies Code, the Act allows plaintiffs to sue managed care plans for medical malpractice where managed care treatment decisions cause injury. Patients may bring an action when managed care organizations fail to exercise ordinary care when deciding medical decisions, and such conduct proximately causes an injury. The Act holds HMOs liable for treatment decisions covered by the plan and establishes a standard of care for HMOs making coverage decisions. Patients may also sue HMOs for poor health care treatment decisions made by employees, agents, ostensible agents, or representatives on its behalf. Further, physicians or health care providers may not be removed from the managed care plan or denied status renewal because they advocate appropriate and medically necessary treatment on behalf of patients.

At the time, Senate Bill 386 encountered strong opposition from managed care organizations such as Aetna Health Plans of Texas, Inc., Aetna Plans of North Texas, Inc., and Aetna Life Insurance Company. These companies filed suit against the State of Texas to challenge Senate Bill 386. The Fifth Circuit held the liability provisions and independent review provisions of the statute not preempted under ERISA because Senate Bill 386 allowed suit only for health services actually delivered, not for coverage disputes. Furthermore, the anti-indemnity and anti-retaliation provisions escaped ERISA preemption because they addressed state concerns regarding the quality of health care, and not the structure and administration of health care plans. However, the court clauses relating to and requiring independent review of adverse determinations by managed care entities and compliance with the independent organization’s determination of medical necessity, holding them preempted by ERISA.

Courts draw boundaries between medical malpractice actions alleging injuries caused by benefit denials and injuries caused by poor quality of care. Claims regarding quality of care escape ERISA preemption whereas claims of wrongful benefit denials fall victim to ERISA preemption. For instance, in Corcoran v. United States Healthcare, Inc., the Fifth Circuit Court held that ERISA preempts claims of wrongful benefit denials. U.S. Healthcare denied Corcoran’s disability benefits after her physician recommended complete bed rest during the final months of her pregnancy. The court held that the managed care organization extended medical advice, but did so in the context of making a determination about benefits available under the plan rather than in the treatment of the illness. As a result, the court held ERISA preempted the Corcorans’ tort action.

187 U.S. Const. amend. X (stating “The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.”).
188 Charles Duke, Implementing the Tenth Amendment: State Sovereignty Evolution, at http://www.sweetliberty.org/tenhomand.htm (last visited June 1, 2001) discussing the Tenth Amendment’s assurance against federal usurpation of state power and detailing state legislatures’ frustration with feeling little choice but to implement federal mandates.
190 Id. at § 88.001(a).
191 Id.
192 Id. at § 88.001(10) (defining ordinary care as “the degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice” or similar circumstances would exercise).
193 Tex. Civ. Prac. & Rem. Code §§ 88.02(3)(a); 88.02(4).
194 See Corporate Health Ins., Inc. v. Texas Dep’t of Ins., 215 F.3d 526, 531 (5th Cir. 2000).
against U.S. Healthcare for the wrongful death of their child caused by the denial of benefits.  

Conversely, in *Dukes v. United States Healthcare,* the Third Circuit Court held that ERISA does not preempt actions claiming poor quality of care.  

Plaintiff’s physician ordered blood tests after his ear surgery, but the hospital refused to perform the tests.  

A second test was ordered and performed the day after the refusal, but plaintiff’s condition worsened and he soon died.  

At the time of his death, his blood sugar level was extremely high.  

Plaintiff alleged that his condition would or could have been discovered with a timely blood test.  

The court held that plaintiff’s medical malpractice claim stemmed from poor quality of care, and not from the wrongful denial of benefits.  

*Dukes* therefore reemphasized that unlike administrative claims, claims of poor quality of care escape ERISA preemption.  

**H. Amici Briefs**

The Secretary of the Department of Labor has filed nineteen amici briefs addressing ERISA preemption of medical malpractice claims other than benefit denials against HMOs.  

These briefs argue that ERISA does not preempt negligence or medical malpractice claims outside the context of benefit denials.  

The Secretary’s briefs also address whether preemption claims may be removed from state court to federal court under complete preemption, a doctrine of federal question jurisdiction.  

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208 Id.

209 57 F.3d 399 (3d Cir. 1995).

210 Id. at 353-58.

211 Id. at 382 (accounting that the record does not state its reasons for denying the blood tests).

212 Id.

213 Id.

214 Id.

215 *Dukes,* 57 F.3d at 352.

216 Id. at 388 (explaining that the distinction between the quantity of benefits due under a welfare plan and the quality of those benefits is sometimes muddy especially when the benefits contracted for are health care services, and not money to pay for such services).

217 Id.

218 U.S. Department of Labor, *The Secretary’s Amicus Briefs on ERISA Preemption of Medical Malpractice Claims Against HMOs* at 1 (Sept. 2000) (providing a list of relevant cases regarding ERISA preemption).  

219 Id.

220 Id.
HMOs. As a result, managed care began to flourish in specific regions of the country. By the late 1980s, health care delivery shifted from an industry dominated by medical professionals and non-market-based (charitable) considerations to an industry guided by traditional market rules and arrangements.

Regarding the second step of doctrinal mismatch, many problems exist with "fitting" managed care modalities within legal frameworks. Managed care primarily encounters doctrinal mismatches when competing with other delivery systems, namely FFS. The third stage is a period of immunization and strong growth. As applied, the ERISA statute provides immunization from accountability, which helps managed care to grow. Moreover, the courts too typically favor managed care attendant cost containment objectives based on the assumption that MCOs are legal, socially desirable, and in the best interest of public policy.

Fourth, managed care has suffered a backlash. Patient dissatisfaction with managed care has increased and concerns that corporate profits overcome quality care have surfaced. Also, fairly recent legislation such as the Patient Access to Responsible Care Act of 1997 threatens managed care immunity. The Act prohibits courts "from precluding any State cause of action to recover [personal injury or wrongful death] damages against any person that provides insurance or administration to or for an employee benefit plan." Courts have also expressed their dismay with managed care and the effects of ERISA preemption.

The fifth stage involves a new doctrine with new accountability. A developing body of case law has emerged to encourage managed care accountability. For example, in New York State Conference of Blue Cross and Blue Shield v. Travelers Insurance Company, the Supreme Court rejected the argument that a New York statute was preempted by ERISA. The Court scaled back the broad interpretation of ERISA preemption by finding that the surcharges only indirectly affect relative prices of insurance policies "which Congress could not possibly have intended to eliminate." Although the managed care industry fits the five stage model indicating change, thus far, this analysis has highlighted much that impacts mental health care negatively. On what basis do we embrace this industry and its changes to say that this is a benefit to mental health patients? Market theorists posit that managed care is fine because it integrates insurance and provider functions that correct market inefficiencies and imperfections of FFS medicine financed through third-party indemnity payments. In other words, managed care (coupled with the ERISA preemption) saves money, a

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223 Barry R. Furrow, Managed Care Organizations and Patient Injury: Rethinking Liability, 33 Ga. L. Rev. 419, 429 (1997) (reporting that prior to the enactment of Medicare, critics derided the American health care system as unfairly distributed and ineffectively administered).

224 FAULK, STARK, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 415 (1997) (noting the flourish in managed care in specific regions of the country such as California, the upper Midwest, and certain cities in the Northeast).


226 Jacobson, supra note 122, at 820, 844 (arguing that most often there is a mismatch between established doctrine and new reality).

227 Id. at 844 (summarizing that traditional legal doctrines in health care litigation stem from FFS regimes, where a patient's proueminent concern is for the individual rather than the allocation of plan resources).

228 Id. at 844-45.

229 Id. (discussing Weiss v. Cigna Healthcare, Inc., 972 F. Supp. 748 (S.D.N.Y. 1997), in which the court rejected the argument that physician incentive arrangements were violate of ERISA because such arrangements would render managed care illegal; the court found the argument absurd considering the existence of federal and state laws encouraging managed care).

230 Id. at 851 (proposing that the managed care system is currently in stage four of the model of doctrinal change).


233 Id. at § 4(a).

234 Andrews-Claude, 984 F. Supp. at 52-53 (declaring that ERISA’s preemptive effect on Andrews-Claude’s outcry for relief was ridiculous; under traditional notions of justice, the harms that Andrews-Claude alleged should have entitled plaintiff to a legal remedy: "[n]evertheless, [the court had no choice but to pluck] Diane Andrews-Claude’s case out of the state court in which she sought relief (and where relief to other litigants is available), and then, at the behest of Travelers and Greenspring, to slam the courthouse doors in her face and leave her without any remedy.").

235 Jacobson, supra note 122, at 892.


237 Id. at 649 (summarizing the New York statute as requiring hospitals to collect surcharges from commercial insurers’ patients, but not from Blue Cross and subjecting certain HMO’s to surcharges depending on the number of Medicaid enrollment).

238 Id. at 668.

239 Sullivan v. Payton, Managed Care: The First Chapter Comes to a Close, 52 U. Micr. J.L. Rev. 573 (1999) (arguing that the conventional wisdom of health care policy holds that the integration of insurance and provider functions also stimulates provisions of medically effective quality care at a desirable consumer price).
phenomenon supported by recent studies. The issue then becomes do these cost savings result in quality mental health care or do cost savings come at the expense of quality mental health care? If cost savings can go hand-in-hand with quality care then the issue becomes "not whether to manage care but how to manage it more effectively and more in the interests of the patients." If, however, cost savings come at the expense of quality mental health care then the issue becomes how to change the system, perhaps even by eliminating the ERISA preemption.

A. Positive Impact

Long-term studies indicate positive impacts from managed care on mental health and substance abuse services. Over a five-year period using managed care, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) found that overall costs for mental health and substance abuse services were reduced by forty percent while the quality of care delivered remained high.

Another study concluded that persons enrolled in managed care plans are no longer less likely to be admitted to hospitals than are individuals covered by non-managed care health plans. This does not apply to mental health care per se, but it does reflect an overall trend. Research on utilization of preventative, long-term, and acute care services of a local Texas Medicaid managed care program, STARPLUS, illustrates a similar trend of managed care systems reducing acute services expenses (such as emergency room

21 Payton, supra note 239, at 588.
23 Id. (concluding that inpatient care has declined by thirty-four percent whereas outpatient mental health visits have increased by five percent).
25 Id. at 181.
26 Health and Human Service Commission, Chapter 7: Utilization at 2, 7, available at http://www.hhsc.state.tx.us/medicaid/mmc_pdf/ct_utilization.pdf (last visited Mar. 22, 2001) (reporting on a STAR+PLUS and STAR managed care study; also referring to STAR+PLUS as a managed care program implemented in Harris County in 1998 to provide preventative, primary, and long-term care services to the elderly or disabled).

services) by assuring access to preventative and primary care. The study also shows that in the state fiscal year of 1999, primary home care utilization was higher than projected. The higher primary home care utilization may have contributed to the lower utilization of expensive emergency services in 2000 than in 1998.

National advocacy groups too have noted positive aspects of managed care on mental health care. The Bazelon Center for Mental Health Law lists a number of mental health benefits that state officials attribute to Medicaid managed care programs: (1) increased access; (2) decreased use of inappropriate inpatient care; (3) expanded array of services; (4) more flexibility in service delivery; more consistency in clinical decision making; more focused, goal-directed treatment; and (4) an increased emphasis on accountability and outcomes.

Thus, it would appear that the managed care industry is progressing through the five-stage model. Perhaps the Supreme Court was correct in its recent decision in Pegram v. Herdrich. This case involved a woman who sued her HMO for maintaining financial incentives that gave doctors an annual bonus for minimizing the use of diagnostic tests. In a unanimous decision, the Court held that patients may sue their doctors for malpractice in state court, but that patients cannot attack the HMO simply for its being too cost-conscious. Justice Souter proposed that if patients can sue and win damages merely by showing that HMO administrators were driven by a profit incentive, that it would mean nothing less than the elimination of the for-profit HMO. He also reasoned that ERISA did not give employees a promise to all the medical care that unlimited money could buy.
One could limit Pegram to its facts and the specific type of managed care contract and ERISA are doing what Congress envisioned, and until Congress changes the law this is what the result should be. Thus, the outcome of Pegram is telling.

**B. Eliminating ERISA Preemption**

Despite the model of industry change and the conflicting reports of whether managed care is indeed beneficial or harmful for mental health patients, the alternative of eliminating ERISA preemption might not be palatable either. Congress implemented ERISA for a number of compelling reasons. Among them is to provide a national standard that eliminates cumbersome and expensive regulations for each state that might divert funds from the delivery of services. Yet another is cost containment, a factor that complies with an underlying theory of ERISA: that there is a finite amount of money to spend on health care services. The Supreme Court succinctly espoused the cost containment notion in *Pilot Life Insurance Company v. Dolezal*. The Court held that ERISA sets forth a comprehensive civil enforcement scheme that represents a careful balance of the need for prompt and fair claims settlement.

Care is curated by a physician’s reasonable skill and judgment in the patient’s interest, as well as the HMO’s scrutiny of requested services against contractual provisions. See also Savage, supra note 253, at 10 (countering Souter’s statement that if claims alleging doctors receive bonuses for not ordering diagnostic tests are allowed to go forward, they would drive a stake into the heart of the managed care system).

259 Id. at 213.

260 Pegram, 520 U.S. at 232-33 (emphasizing that there is no ERISA preemption without clear manifestation of congressional purpose and the court refuses to create a new federal cause of action for breach of fiduciary duty when the decision is a mixed administrative and medical decision, and commenting that the federal judiciary would be acting contrary to the congressional policy of allowing HMO organizations if it were to entertain an ERISA fiduciary claim against existing HMOs solely because of their structure and without claims of injury).

261 29 U.S.C. § 1101(b) (2000) (stating that the purpose of ERISA includes: (1) the protection of interstate commerce; (2) the protection of the interests of participants and their beneficiaries in employee benefit plans; and (3) the establishment of uniform standards for the administration of benefit plans).

262 Purkiss, supra note 113, at 543.


265 Kennedy

procedures against the public interest in encouraging the formation of employee benefit plans. David A. Hyman, University of Maryland Professor of Law, offers other intriguing observations about ERISA coverage and the effect its absence would have on managed care plans. He concludes: (1) alternative institutional arrangements are a more effective way of accomplishing objectives than doing away with ERISA preemption; (2) even if there is not legal accountability because of ERISA, there are other forces; (3) there seems to be widespread enthusiasm for tort reform; (4) ERISA preemption has not been proven to have any effect on the quality or value of the medical services provided; (5) changing ERISA protection can have profound impact on underlying institutional arrangements; (6) Congress has insulated government operated health care programs for good reason; (7) there are many trade-offs to taking away ERISA preemption; (8) the doctor groups advocating this change have a vested interest; (9) taking away ERISA preemption will make the health care system again unaffordable; and (10) lawyers could insist on tort-based suits in their own ranks.

Professor Hyman implies that there are perhaps more effective means of solving the managed care issue than removing ERISA preemption and that removal itself creates new problems.

266 Id. at 54.

267 Hyman, supra note 163, at 785.

268 Id. at 786-802.

269 Id. at 809-10 (analagizing ERISA plans and HMOs to software manufacturers who have disclaimed all liability for their products and noting the irony of different legislation for both industries; the National Conference of Commissioners on Uniform State Laws has reached an agreement on model legislation authorizing liability disclaimers for software, but Congress considers amending ERISA to strip HMOs of similar protection).


C. Other Options

If eliminating ERISA is not the answer then perhaps a look at other forces for legal accountability will be useful. In Texas, for example, Aetna U.S. Healthcare and the State recently signed an agreement that is a radical departure for managed care operations in Texas. The agreement was signed partially because of legal ac-
tions brought by the State and partially to mend strained physician relationships and add flexibility to the strict managed care policies that plagued the insurer in battles with doctors, consumers, and legislators. In the agreement, Aetna waives ERISA preemption and promises among other things: (1) to improve the quality and integrity of determinations of medical necessity and covered benefits by HMOs; (2) to improve quality and integrity of member choices and access to health care services; (3) to improve the quality and integrity of the physician-patient relationship; and (4) to create an Office of Ombudsman to educate Aetna members, to act as independent advocate on behalf of members, and to report to the attorney general on compliance. Other Texas HMOs are expected to follow.

Settlement agreements are not the only avenue for making managed care responsive to patients. Last November, the Department of Labor was scheduled to promulgate rules that will establish

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267 J. C. Cofrkin, Despite Skeptics, Aetna Sively Regaining Doctors' Trust: Insurer Releases Risk-Management Study as More Physicians Return to its Contracts, DALLAS MORNING NEWS, 2000, at III.

Texas Attorney General, supra note 266 (detailing that improvement of the quality and integrity of medical necessity determinations and covered HMO benefits can be met by assuring that medical necessity determinations are (1) based solely on state of the art medical standards after reviewing all relevant medical information; (2) made by reference to a clearly stated and broad definition of medical necessity that is made available to members, physicians, providers, and plan sponsors; (3) ultimately decided by qualified medical professionals licensed in Texas; and (4) not confused with determinations of covered health care services.

269 Id. (stating that improving the quality and integrity of member choices and access to health can be accomplished by (1) prohibiting physicians from discriminating against any Aetna member based on the member's medical condition; (2) strengthening Aetna's ability to take steps to detect and prevent under utilization of health care services, especially as under utilization affects women, minorities, and members with serious health conditions; (3) providing Aetna members increased protections for their choice or primary care physicians; (4) assuring Aetna members access, if medically necessary, to care outside the network of physicians normally made available to the member; (5) making sure that Aetna gives advance notice of any changes in the prescription drugs Aetna will cover on its published formulary list in the next plan year; and (6) broadening Aetna member access to Aetna's external review process.

270 Id. (declaring that improving the quality and integrity of the physician-patient relationship can be ensured if Aetna's contractual and financial arrangements with physicians and providers: (1) are disclosed; (2) include provisions that require physicians to provide the same standard of care for all Aetna members regardless of any financial incentive arrangements; (3) be designed to encourage and provide adequate compensation for all medically necessary covered services; (4) contain protections for Aetna members from financial documents to limit medically necessary covered services; (5) permit physicians and providers more freedom in choosing the types of Aetna health care plans they accept; and (6) promote broad access consumers to a large number of available physicians and providers.

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D. Therapeutic Impact

Thus far, this paper has addressed systems, case law, legislation, and theories that seem removed from an actual person seeking mental health care. One way of reintroducing the mental health patient back into the equation is through therapeutic jurisprudence theory. Therapeutic jurisprudence involves analyzing the consequences of these legal rules and attempting to incorporate this information in legal decision-making. The overarching goal of therapeutic jurisprudence is to ensure that mental health law real-

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271 Robert Pear, Administration to Set Standards for Insurance Patients, DALLAS MORNING NEWS, Oct. 9, 2000, at 4A.

272 Id.


275 Daniel W. Shuman, Making the World a Better Place Through Tort Law?: Through the Therapeutic Looking Glass, 10 N.Y.L. Sch. J. HUM. Rts. 729, 741, 748 (indicating that many mental health law scholars applied therapeutic looking glasses to issues and relationships previously studied in the traditional mental health law scholarship tradition).

izes its potential to advance therapeutic outcomes, at least when it is possible to do so without violating other important principles (such as constitutional principles). It is the study of how substantive rules, legal procedures, and the roles of lawyers and judges produce therapeutic or anti-therapeutic consequences.

The impact of ERISA preemption on a mental health patient can be viewed in two ways. First, I will examine how the absence of ERISA preemption, which would enable patients to sue in state court, may not be therapeutic. Second, I will look at ways to bolster the existing system, thereby making the health care provided more therapeutic.

The opportunity to sue in state court may not necessarily be therapeutic. When people attribute their injury to some external cause they are more likely to institute litigation. Attributing fault to others, rather than empowering a mental health patient, might increase feelings of helplessness. Often, trial is a stressful and confusing experience, with many incomprehensible rules and procedures for non-lawyers. Additionally, an adverse judgment could be devastating to a patient already feeling diminished. The legal process may ultimately make the patient feel more helpless rather than empowered.

On the other hand, there is no reason to risk unwanted consequences of removing ERISA preemption when bolstering the existing system may make it more therapeutic. There are a number of ways to accomplish this objective ranging from narrower readings of ERISA preemption to the introduction of new legislation that protects patient’s rights.

One commentator has developed a number of ideas that could bolster the existing system therapeutically. For instance, discontent with managed care stems from the lack of trust created by inadequate communication and reduced patient autonomy to make treatment and provider choices. Under ERISA, plan administrato

276 Shuman, supra note 276, at 741, 752.
277 Wesler, supra note 277, at 225.
278 Id.
279 Id.
280 Id.
281 Id.
283 Id. at 357 (emphasizing that patients lose trust in employers, health care plans, caregivers, and legislators when they lack information).

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tors have specific statutory duties such as the duty to disclose information and to disseminate reports and documentation to plan participants. Some court decisions have even clarified these duties under ERISA, emphasizing “there is a duty to communicate any material facts which could adversely affect a plan member’s interests.” Another commentator posits that companies should disclose complete and accurate information about the plan in easily understandable terms. MCOs should provide training programs at treatment centers to empower and partner with the patient, thus diffusing hostility between the patient and the MCO.

In addition to information, employees should be given choices. If managed care companies together with employers would develop health care plans that give the patient the ability to choose more options themselves, then their client base would feel more empowered and satisfied. To illustrate this point, consider mental patients who are subject to involuntary civil confinement. Psychological analysis of these individuals indicates that trust is reinforced if providers afford due process protections that permit patient participation and preserve dignity. It is arguable that having choices enhances mental patients’ willingness to follow rules and to subject themselves to treatment during commitment.

Perhaps therapeutic jurisprudence analysis can be applied at the macro-analytic level. One macro-analytic suggestion is to re-

277 Cermak, supra note 283, at 337 (suggesting that admissions of mistakes, up-front disclosures, and publication of understandable, consumer targeted information helps to prevent the erosion of patients’ trust). See also Doctors Urged to Admit Errors, ThirdAge.com, at http://www.thirdage.com/cgi-bin/NewsPrint.cgi (2000) (summarizing a new study urging doctors to admit their mistakes) (last visited Mar. 12, 2001).
278 Cermak, supra note 283, at 337.
279 M. (proposing that with information comes power; with understandable information about their health care plans, patients feel less coerced into receiving the type of health care coverage they have).
280 Id.
281 See Albert Wu et al., Ethical and Practical Issues in Disclosing Medical Mistakes to Patients, at http://www.sph.unc.edu/info/ldo/article4.html (finding that a physician’s disclosure of a mistake will promote trust and suggesting that a patient’s dignity can be preserved through disclosure; otherwise, uninformed patient’s feel angry, betrayed, and violated) (last visited Mar. 12, 2001).
282 Cermak, supra note 283, at 337.
283 Wesler, supra note 277, at 229.
place publicly held for-profit corporations that combine insurer and provider functions with employer-based health benefit plans and nonprofit medical care organizations. These organizations and their incentives should be more generally aligned with the patients.

CONCLUSION

Based on the application of a five-stage model for industry change, it appears that managed care may be at the end of an evolutionary process. It may also appear that managed care is undergoing a doctrinal change wherein new accountabilities are created. Problems with mental health managed care abound, especially regarding application of the ERISA preemption clause. It is important to remember, however, that there are myriad compelling reasons for retaining ERISA preemption, some of which are positive for mental health patients. By removing ERISA preemption, legislators may in fact create more problems for mental health patients. Finally, there are other positive ways of solving the problems—attacking ERISA preemption may not be the effective prescription for mental health care.

294 See Payton, supra note 239, at 611-12 (suggesting that the task is to create not merely a service, but also a value for customers within the market’s price competition and also to provide an institutional framework in which the government may participate).

295 See id. at 591.

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THE WILD WILD WEST:
INADEQUATE REGULATION OF ASSISTED
REPRODUCTIVE TECHNOLOGY

Alexander N. Hecht

The law addresses any new question by relying on precedent. When cars were introduced, the wisdom from cases dealing with horses and buggies governed. . . . If it was difficult to find precedents to deal with human embryos, Were they property or people? . . . The doctors called me because the attorneys for their clients respond to each of their questions by saying, “There is no law in this state that covers that.”

INTRODUCTION

Recent advances in Assisted Reproductive Technology (ART) have spawned an exciting industry that aids thousands of American couples in conceiving their own children. While promoting the “traditional” values of raising a natural family, ART has unlocked a Pandora’s box of ethical concerns and policy issues that current health law seems unprepared to resolve. Prenatal genetic screening

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2 For purposes of this paper, Assisted Reproductive Technology (ART) is defined as any medical technique that, through advances in biomedicine, facilitates or enables human reproduction. This definition includes artificial insemination by donor, surrogacy, in vitro fertilization (IVF), embryo transfer, and human cloning. See generally Sandra Anderson Garcia, Socio-cultural and Legal Implications of Creating and Assisting Life Through Biomedical Technology, 17 J. LEG. MENT. 469 (1996) (providing a history of biotechnology development).
