[J-158-00]
IN THE SUPREME COURT OF PENNSYLVANIA
EASTERNEASTERN DISTRICT

BASIL PAPPAS AND THEODORA PAPPAS, H/W	:	No. 98 E.D. Appeal Dkt. 1996
v.	:	Appeal from the Judgment of Superior Court entered on 3/15/96 at No. 2617 PHL 1995 reversing and remanding the Order entered 6/7/94 in the Court of Common Pleas, Philadelphia County, Civil Division at No. 92-3903
DAVID S. ASBEL, D.O. AND PENNSYLVANIA HOSPITAL INSURANCE CO. (PHICO), THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND (CAT FUND)	:	
v.	:	
UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.	:	
APPEAL OF: UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.	:	Submitted: August 30, 2000

DISSENTING OPINION

MR. JUSTICE SAYLOR **DECIDED: April 3, 2001**

In response to the United States Supreme Court's remand directive for this Court to reconsider its prior decision in Pappas v. Absel, 555 Pa. 342, 724 A.2d 889 (Pa. 1998)("Pappas I"),[1] in light of Pegram v. Herdrich, 530 U.S. 211, 120 S. Ct. 2143 (2000)("Pegram II"), the majority concludes that Pegram II establishes that the third-

[1] I did not participate in the decision in Pappas I, as it was argued prior to my induction onto this Court.

party cause of action against Appellant United States Healthcare Systems of Pennsylvania, Inc. ("U.S. Healthcare") is not preempted by ERISA, and that such cause should therefore be resolved according to state medical malpractice law. In so holding, the majority finds that Pegram II's conclusion that ERISA does not establish a cause of action for breach of fiduciary duty predicated upon a managed care organization's "mixed eligibility" decisions, see Pegram II, 530 U.S. at ___, 120 S. Ct. at 2154-55, equally establishes that such decisions are fully exposed to state tort law.

While I agree with the majority that nothing in Pegram II requires a full reversal of its prior disposition, I note that other courts have been more circumspect concerning the implications of Pegram II in relation to conflict preemption pursuant to ERISA. See, e.g., Corporate Health Ins., Inc. v. Texas Dep't of Ins., 220 F.3d 641, 643-44 (5th Cir. 2000)(stating that "we do not read Pegram to entail that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment, and [our own precedent] held otherwise"). Accordingly, there remains a division of authority regarding the appropriate construct pursuant to which ERISA preemption of laws regulating the decisions of managed care organizations should be determined,[2] although further examination of this divide is beyond the scope of our

[2] Compare Bauman v. U.S. Healthcare, Inc., 193 F.3d 151 (3d Cir. 1999), cert. denied, ___ U.S. ___, 120 S. Ct. 2687 (2000); Dukes v. U.S. Healthcare, Inc., 57 F.3d 350 (3d Cir. 1995); Pacificare of Oklahoma v. Burrage, 59 F.3d 151 (10th Cir. 1995), with Hull v. Fallon, 188 F.3d 939 (8th Cir. 1999), cert. denied, 528 U.S. 1189, 120 S. Ct. 1242 (2000); Canca v. Private Health Care Systems, Inc., 185 F.3d 1, 5-7 (1st Cir. 1999); Parrino v. FHP, Inc., 146 F.3d 699, 705 (9th Cir.), cert. denied, 525 U.S. 1001, 119 S. Ct. 510 (1998); Turner v. Fallon Community Health Plan, 127 F.3d 196 (1st Cir. 1997); Jass v. Prudential Healthcare Plan Inc., 88 F.3d 1482 (7th Cir. 1996); Tolton v. American Biodyne, Inc., 48 F.3d 937 (6th Cir. 1995); Kuhl v. Lincoln Nat'l Health Plan, 999 F.2d 298 (8th Cir. 1993); Corceran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992). Although it has been suggested that the reasoning from Pegram II has effectively overruled the latter line of decisions, reserving ERISA preemption exclusively for the (continued...)

mandate on remand. I do believe, however, that two points derive from Pegram II that are worthy of present consideration.

First, in my view, Pegram II gives cause for the exercise of a degree of caution on the part of state courts and legislators in terms of defining the duties of managed care organizations (or at least those that are deemed to perform administrative functions under ERISA) for purposes of tort jurisprudence. Second, I question whether a full, fair, and final resolution of the conflict preemption inquiry can be effected unless and until some more precise definition is afforded to any duties being ascribed to U.S. Healthcare under state tort law.

Regarding the first of these points, if ERISA preemption issues can arise only in connection with a specific exercise of fiduciary duty, the majority is correct that, once U.S. Healthcare's decision is deemed to be a mixed eligibility determination,[3] Pegram II

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narrow category of claims implicating pure eligibility determinations by an HMO unrelated to medical diagnosis and decision making, the assessment in the aftermath of Pegram II has remained mixed. See, e.g., Corporate Health, 220 F.3d at 643-44; Schusteric v. United Healthcare Ins. Co., 2000 WL 1263581 (N.D. Ill. Sept. 5, 2000).

[3] While U.S. Healthcare has argued that its decision to deny precertification of Mr. Pappas' transfer was a pure eligibility determination, the majority's conclusion that it was in fact a "when-and-how" sort of decision within the contemplated scope of the United States Supreme Court's framing of mixed eligibility decisions, see Pegram II, 530 U.S. at ___, 120 S. Ct. at 2154, finds a degree of support in Pegram. It should be noted, however, that the decision made in Pappas was far closer on the continuum to the eligibility form than that which was at issue in Pegram, since, under U.S. Healthcare's modified-IPA-style structure, the decision was not made by the actual treating physician as was the case under the capitated arrangement at issue in Pegram. Indeed, arguably an IPA-style HMO's decision whether to pay for out-of-network services touches the eligibility end of the spectrum, since in relation to out-of-network providers, the HMO no longer itself functions as a service provider through its pre-arranged contracts, but rather, is relegated to a traditional fee-for-service insurance function. See generally Pryzbowski v. U.S. Healthcare, Inc., ___ F.3d ___, 2001 U.S. (continued...)

establishes the absence of a fiduciary duty under ERISA, and preemption cannot apply. Certainly, however, the preemption clause itself is more broadly phrased; further, ERISA's civil enforcement provision, 29 U.S.C. §1132, would appear to have been designed to protect the interests of plan participants more generally. Thus, while it is clear that the United States Supreme Court now subscribes to a narrower concept of preemption than that reflected in its earlier decisions, I am not so certain that the question of whether a state law claim challenges a fiduciary act is the sole, remaining, pertinent inquiry relative to preemption, particularly where the defendant may otherwise perform servicing functions integral to plan administration.

Accordingly, I would examine Pegram II's analysis more broadly than merely to identify the construct which it ultimately devised to determine fiduciary status. I view as significant the Supreme Court's deliberate, measured reasoning addressing and rejecting the central conclusions of the Seventh Circuit concerning an HMO's obligations under federal law,[4] with the Court's analysis subsuming the assessment that the duty of a managed care organization as stated by the Seventh Circuit was inimical to Congressional intent in fostering the health maintenance organization paradigm. See generally Phyllis C. Borzi and Marc I. Machiz, ERISA and Managed Care Plans: Key

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App. LEXIS 4903 (3d Cir. Mar. 27, 2001)(holding that a delay-in-approval claim against U.S. Healthcare fell squarely within the realm of the HMO's administrative function).

[4] The Seventh Circuit had determined that an HMO's cost control incentive system or structure could serve as the predicate for a claim of breach of fiduciary duty under ERISA. See Herdich v. Pegram, 154 F.2d 362, 373 (7th Cir. 1998). In so holding, the majority employed strong language that was condemnatory of various HMO practices. See, e.g., id. at 375 (stating that "[i]n order to minimize health care costs and fatten corporate profits for HMOs, primary care physicians face severe restrictions on referrals and diagnostic tests, and at the same time, must contend with ever-shrinking incomes").

Preemption and Fiduciary Issues, SF28 ALI-ABA 371 (ALI-ABA Course of Study Oct. 2000)(stating that "[t]he Court in Pegram believed it faced an irreducible challenge to the essence of managed care"). Such rejection should not be overlooked, since, although the United States Supreme Court was discussing the issue of duty according to the federal fiduciary standard embodied in ERISA, state law duties which operate similarly would be no less disruptive. Moreover, the persistence of multiple state law standards broadly affecting otherwise permissible "rationing" decisions of managed care organizations, to the extent that such entities are viewed as serving as an important tool of plan administration, would also operate contrary to a central purpose of ERISA preemption, namely, to "avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 657, 115 S. Ct. 1671, 1677-78 (1995). Thus, although certainly the dicta employed by the United States Supreme Court concerning preemption would appear to evidence its conclusion that ERISA may embody a degree of tolerance for some divergence among the legal standards applicable to managed care organizations across jurisdictions, see, e.g., Pegram II, 530 U.S. at ___, 120 S. Ct. at 2158,[5] such passages should not be read as

[5] Differing causes of action which have been asserted against managed care organizations across the nation include medical malpractice, negligence, breach of contract, breach of implied covenant of good faith and fair dealing, intentional/negligent infliction of emotional distress, wrongful death, unfair business practices, defamation, interference with contractual relations between physician and patient, antitrust violations, ostensible agency, and vicarious liability. See Comment, The Ultimate Jigsaw Puzzle: ERISA Preemption and Liability in the Utilization Review Process, 28 CUMB. L. REV. 403, 410 (1997-1998).

completely independent of the Court's disapproval of standards that would penalize HMOs based solely upon their structure and/or system for doing business.[6]

As the United States Supreme Court recognized, fundamentally, managed care organizations ration treatment (or at least payment for treatment); assuming treatment is generally of positive effect, less treatment equates to greater risk (also assuming that

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[6] In Pryzbowski, the Third Circuit recently made the above point as follows in relation to a delay-in-approval claim against an HMO:

> A holding that Pryzbowski's claims against U.S. Healthcare are not completely preempted would open the door for legal challenges to core managed care practices (e.g., the policy of favoring in-network specialists over out-of-network specialists), which the Supreme Court eschewed in Pegram. Cf. 120 S. Ct. at 2156-57 (rejecting claims attacking financial incentives behind HMO structure, in light of congressional policy of promoting HMOs).

Pryzbowski, ___ F.3d at ___.

It should be noted that Pegram II tied various of its conclusions to the observation that the plaintiff had not alleged physical injury in the pertinent count of her complaint. Although this factor creates a substantial distinction between the claim under consideration in Pegram and that at issue here, I do not believe that the Court's concerns regarding allowance of the managed care form of business are completely inapposite when considering state law duties. Significantly, the particular framing of the count at issue in Pegram would appear to have been a consequence of the plaintiff's attempt to state a damages claim under ERISA (notably the plaintiff's overall complaint included allegations of concrete physical injury, including peritonitis). But just as a state law negligence claim can be recast in the form of a claim under ERISA, so the form of claim that the Supreme Court rejected as a matter of ERISA fiduciary analysis can effectively be restyled as a state law claim, and it is not a difficult matter to include an allegation of proximate harm in a forum with general jurisdiction to redress such injury. Indeed, several circuit courts of appeals have viewed various efforts to craft state law causes of action in just such a manner. See, e.g., Jass, 88 F.3d at 1489; Schusteric, 2000 WL 1263581.

patients cannot or will not fund treatment for which managed care will not pay);[7] and greater risk means higher incidence and more detrimental effect of injury and illness. If state law duties are imposed such that managed care organizations must provide compensation for all harm which can be proximately related to rationing, their viability will be determined by whether the cost of such harm ultimately exceeds the savings achieved by rationing in the first instance. Although certainly this is one form of risk spreading, it would not seem to be the form that Congress likely envisioned by sanctioning the managed care paradigm. Further, assuming that the managed care concept that has become integral as a service to ERISA plan administration is actually beneficial (as Congress appears to have believed), if costs ultimately exceeded savings in this particular equation, such benefit would be undermined. It would be difficult, then, to characterize state laws regulating rationing determinations which do not provide some reasonable mechanism for distinguishing between acceptable and unacceptable decisions as having only a "tenuous, remote, or peripheral connection" with covered plans, Travelers, 514 U.S. at 661, 115 S. Ct. at 1680, assuming that the element of plan administration extends to managed care services to ERISA plans.

This leads to my second point, namely, that before a matter of conflict preemption can be finally determined in relation to a common law duty, the state courts should define, with reasonable particularity, the pertinent duty with which the managed

[7] I recognize that various managed care strategies such as preventative care are designed to decrease costs by providing timely interventions which may obviate the need for more expensive treatment in the long term. Obviously, it would be ideal if such strategies sufficiently reduced the cost of health care to maintain profitability without other forms of more direct rationing. The Supreme Court's opinion seemed to accept, however, that, at least in the short term, broader forms of rationing are necessary to the managed care concept.

care organization is to be charged.[8] Here, the third-party complaint frames a cause of action for "refus[ing] to authorize transfer of husband-plaintiff to a hospital selected by physicians at Haverford Community Hospital as being able to minister to husband-plaintiff's condition." Pertinent to such claim, the majority merely indicates that the United States Supreme Court has sanctioned the application of general principles of medical malpractice to managed care organizations. The result is to insulate the majority's holding that preemption is unwarranted within the United States Supreme Court's analysis from Travelers that "nothing in the language of [ERISA] or in the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." Travelers, 514 U.S. at 661, 115 S. Ct. at 1680. It should be recognized, however, that the asserted obligation of U.S. Healthcare to telephonically precertify out-of-network care on an emergency basis as selected by Haverford Community Hospital is not easily susceptible to measurement according to the general standard of care prevailing in the medical community pertaining to the rendition of medical services. In the first instance, medical personnel are not generally obligated to pay for medical services.[9] Further, U.S.

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[8] In contrast, when the doctrine of complete preemption is asserted pursuant to Section 502 of ERISA in order to invoke federal jurisdiction, the plaintiff's well-pleaded complaint controls, since the analysis entails a comparison between a specific, federal cause of action and one asserted under state law. See generally Bauman, 193 F.3d at 160. A claim of conflict preemption under Section 514, however, asserted as a defense in a state court, questions whether a state law relates to ERISA, see id. Therefore, it is critically important in the Section 514 context that the pertinent state law obligation at issue be reasonably identified.

[9] The conclusions that physicians (or at least those not operating under a capitated arrangement) would not generally make decisions committing to payment responsibility finds at least colloquial support in the deposition testimony of the emergency-room physician who treated Mr. Pappas, who stated as follows:

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Healthcare's obligations in respect to payment arise, at least initially, from its written commitments pertaining to the provision of health care services rather than from the general nature of a physician/patient relationship; thus, while managed care coverage is frequently comprehensive and must include access to emergency treatment, an HMO may not always commit (or pre-commit) to provide full payment for any and all services rendered on precisely the terms that may be dictated by the patient, a treating physician, or circumstance.[10] Additionally, by virtue of a managed care organization's

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> A: My role as an emergency room physician is during an emergency to provide the best care, and I did not pay attention and did not concern myself with what would limit that care.
>
> I was trying to provide the best care for this patient. So did I, in an emergency situation, wonder whether the insurance was one over another? No.
>
> Q: Well, was it your understanding that whether or not a patient has coverage doesn't affect whether or not a patient is treated, it just affects who pays for it after treatment is rendered?
>
> A. From my point of view, the medicine comes first and the paperwork will be figured out later.

[10] One commentator argues this point as follows:

> [T]here is powerful reason to recognize that a denial of funding does not ipso facto mean denial of care, nor is it necessarily the practice of medicine. . . .
>
> "[A]n adverse determination by a health insuring corporation means that the health insuring corporation will not pay for, reimburse, provide, deliver, arrange for, or otherwise make available the service in question. . . . It does not mean that the physician is precluded from providing the service or that

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assumption of the role of provider of or arranger for medical services, it may in fact assume additional duties giving rise to direct or indirect claims based in tort. In this regard, however, in Pennsylvania, the determination of duty in relation to a negligence cause of action is one of law subject to the following analysis:

> [T]he legal concept of duty of care is necessarily rooted in often amorphous public policy considerations, which may include our perception of history, morals, justice and society. The determination of whether a duty exists in a particular case involves the weighing of several discrete factors which include: (1) the relationship of the parties; (2) the social utility of the actor's conduct; (3) the nature of the risk imposed and foreseeability of the harm incurred; (4) the consequences of imposing a duty upon the actor; and (5) the overall public interest in the proposed solution.

Althaus v. Cohen, 562 Pa. 547, 553, 756 A.2d 1166, 1169 (2000).[11] While suggesting the direct application of medical malpractice principles to a non-traditional provider of

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> the patient is precluded from obtaining the service from another source or through other means. . . . A physician or other provider retains authority to provide whatever services are deemed appropriate for the patient, even if the services are not included under the plan of the health insuring corporation."

Morreim, Managed Care Financial Structures, 35 TORT & INS. L.J. at 709 (citation omitted). These comments, of course, must be read in light of constraints which may be imposed by legislative enactments and agency regulations establishing a floor for the HMO's duties, by the health care infrastructure, and by individual financial resources. The point here is only that the conclusion that full payment is always required solely upon proof of appropriateness should not be treated by courts as a foregone one.

[11] As the foundation for this summary, Mr. Justice Castille quoted from the Court's prior decision in Sinn v. Burd, 486 Pa. 146, 404 A.2d 672 (1979), as follows:

> In determining the existence of a duty of care, it must be remembered that the concept of duty amounts to no more than the "sum total of those considerations of policy which

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insurance and medical services making mixed eligibility/treatment decisions, this Court has not undertaken the requisite duty analysis in Pappas I or presently. Indeed, aside from the Court's general categorization of precertification of emergency care as "intertwined with the provision of safe medical care," Pappas I, 555 Pa. at 351, 724 A.2d at 893, the question remains one of first impression in this Court.[12]

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> led the law to say that the particular plaintiff is entitled to protection" from the harm suffered . . . . To give it any greater mystique would unduly hamper our system of jurisprudence in adjusting to the changing times. The late Dean Prosser expressed this view as follows:
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> These are shifting sands, and no fit foundation. There is a duty if the court says there is a duty; the law, like the Constitution, is what we make it. Duty is only a word with which we state our conclusion that there is or is not to be liability; it necessarily begs the essential question. When we find a duty, breach and damage, everything has been said. The word serves a useful purpose in directing attention to the obligation to be imposed upon the defendant, rather than the causal sequence of events; beyond that it serves none. In the decision whether or not there is a duty, many factors interplay: The hand of history, our ideas of morals and justice, the convenience of administration of the rule, and our social ideas as to where the loss should fall. In the end the court will decide whether there is a duty on the basis of the mores of the community, "always keeping in mind the fact that we endeavor to make a rule in each case that will be practical and in keeping with the general understanding of mankind."

Althaus, 562 Pa. at 552-53, 756 A.2d at 1169 (quoting Sinn, 486 Pa. at 164, 404 A.2d at 681 (citations omitted)).

[12] A proper resolution of the duty question may depend upon a myriad of factors, including the nature and incentive structure of the managed care entity; the applicable legislative and regulatory requirements for services; the specific promises made at the (continued...)

Thus, it can be seen that Pennsylvania's traditional construct for determining duty entails a much more precise inquiry than merely repositing such obligations within the rubric of "negligence laws," or "general healthcare regulation." Pappas I, 555 Pa. at 349, 352, 724 A.2d at 892, 894. Once fairly undertaken (and to the extent that the third-party plaintiff is asserting a duty on U.S. Healthcare's part in favor of the original plaintiff consistent with our joinder rules), the pertinent analysis should inform the conflict preemption determination (assuming, again, that something more is required than the mere identification of whether a fiduciary act was involved), with the final resolution to the question depending ultimately upon the manner in which the jury is charged on the subject.

It cannot escape notice that the above analysis, when applied to managed care organizations, necessarily entails precisely the sorts of judgments about socially acceptable medical risks that the United States Supreme Court declined to make in Pegram II for purposes of ERISA fiduciary analysis. See Pegram II, 530 U.S. at ___, 120 S. Ct. at 2150. It is difficult to disagree with the Supreme Court's assessment that the legislative branch presents a superior forum for the resolution of such duties, particularly in an arena as significant as managed care;[13] nevertheless, where scant

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outset of the contractual relationship; and whether and to what extent the policy and incentive structure operate to deprive patients of the option of making an informed decision as to whether to fund services themselves. In making such inquiries, our trial courts would be advised to consider the scope of the civil enforcement provisions of ERISA, 29 U.S.C. §1132, since, in appropriate cases, transgression into this area may lead to the assertion of federal jurisdiction under the doctrine of complete preemption. Compare generally Corporate Health, 215 F.3d at 537, with Bauman, 193 F.3d at 161-62.

[13] In fashioning a legislative solution, Congress could also consider the existing disparity between the treatment of claims against managed care organizations providing services (continued...)

guidance is presented to courts of general redress, they remain charged with the obligation to address claims according to established paradigms.[14] This is particularly the case in the health care arena, since clearly states have a fundamental interest in ensuring quality of care, and it is therefore appropriate for them to implement measures to assure a degree of accountability on the part of managed care organizations. However, given a legislatively sanctioned system which allows for the rationing of treatment, the interest should be balanced against the purpose of managed care organizations to avoid effectively eliminating the infrastructure designed to enhance accessibility to medical resources.[15]

Contrary to the majority's footnote 7, I make no suggestion that this Court should presently articulate the duty or standard of care applicable to U.S. Healthcare's conduct. Rather, my point is that the Court should refrain at this juncture from directing that the

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to ERISA plans and those that do not. See generally Karen A. Jordan, Coverage Denials in ERISA Plans: Assessing The Federal Legislative Solution, 65 MO. L. REV. 405, 406-07 (Spr. 2000).

[14] In Pennsylvania, the process of development and refinement of applicable duties as a matter of common law may be slow and cumbersome. Our trial courts, as courts of general jurisdiction, are responsible for the determination in the first instance, and cases filter through the intermediate appellate courts, with review being granted by this Court on a discretionary basis, such that the opportunity is provided for careful, informed developments. To the extent that departures from traditional forms are sanctioned, this may occur incrementally, as they will occur in the context of specific cases, rather than in the broader spectrum of the legislative process.

[15] Whether existing managed care organizations are effective in this regard is subject to differing interpretations. What is important here, however, is that Congress at least believed that there was a sufficient potential benefit to warrant express statutory authorization, see generally Pegram II, 530 U.S. at ___, 120 S. Ct. at 2156-57, and the central role which managed care occupies as a service provider to ERISA plan administration.

cause of action against U.S. Healthcare must necessarily be assessed according to medical malpractice precepts and,[16] correspondingly, resolving the preemption inquiry on such basis. I fully acknowledge that any development concerning applicable duties would necessarily occur in the first instance at the common pleas level, see supra note 14, and would simply not foreclose any additional preemption assessment to the extent that a further consideration of duty would be appropriate in this case.

In summary, I agree with the majority that in the aftermath of Pegram II and Travelers, state laws having general application and relating to areas traditionally subject to state regulation are more likely to survive preemption challenges. I am not as certain, however, that the Supreme Court would confine the possibility of preemption solely to those cases involving pure eligibility determinations, and I believe that the reasoning of Pegram II contains at least inferential evidence to the contrary. In my view, Travelers' alteration in the course of ERISA preemption jurisprudence, which was

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[16] In its rebuttal to this dissent, the majority appears to ameliorate this difficulty by noting, "[w]hether the element of duty or the standard of care to which U.S. Healthcare should be held when third party plaintiffs attempt to prove their case differs from the duty or standard of care that Pennsylvania law imposes on non-HMO physicians is an issue that may remain for another day." However, the majority has not altered its textual assertion to the effect that "[U.S. Healthcare's decision] was a mixed eligibility and treatment decision, the adverse consequences of which, if any, are properly redressed . . . through state medical malpractice law." In my view, these statements simply are not reconcilable. Moreover, the former statement appears to concede that there may be something left of the preemption inquiry, since it would be exceedingly difficult to determine whether a state-law duty is preempted unless and until the nature of such duty can be discerned.

Thus, in answer to the final characterization provided by the majority in its footnote 7, I am not advocating that "all roads lead to preemption." My concern is, rather, the avoidance of categorical statements regarding preemption until the road which is to be taken (that is, state law duties with which the defendant is being charged) can be identified for purposes of assessing the potential for conflict with the pertinent federal statutes and interests involved.

emphasized by this Court in Pappas I, may evidence more than the fact of a stricter preemption construct. It may also demonstrate that the preemption inquiry may not be presently capable of distillation into questions answerable in a simple "yes" and "no" fashion. Rather, in absence of an appropriate legislative solution, the inquiry may have to endure a degree of further evolution in the law, perhaps substantial, at both the state and federal levels, particularly as it applies to an industry which occupies a societal role that touches the citizenry at large and is itself rapidly evolving.

In light of the above, I would modify this Court's original order to be without prejudice to U.S. Healthcare's ability to assert preemption arguments after such time as the trial court devises appropriate jury instructions.