

## **An Analysis of Recent ERISA Preemption Jurisprudence in Anticipation of CIGNA HealthCare of Texas v. Calad and Aetna Health, Inc. v. Davila**

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# AN ANALYSIS OF RECENT ERISA PREEMPTION JURISPRUDENCE IN ANTICIPATION OF CIGNA HEALTHCARE OF TEXAS V. CALAD AND AETNA HEALTH, INC. V. DAVILA

## I. INTRODUCTION

### A. *The Challenge*

The Supreme Court agreed in November 2003 to hear a challenge by two health maintenance organizations<sup>1</sup> (HMOs) to lower court rulings<sup>2</sup> allowing injured patients and their families to sue HMOs in state court for medical malpractice without being preempted by the Employee Retirement Income Security Act of 1974 (ERISA).<sup>3</sup> The suits in state courts had been authorized under a Texas statute,<sup>4</sup> similar to those passed in a number of

<sup>1</sup> Aetna Health, Inc. and CIGNA HealthCare of Texas.

<sup>2</sup> See *Roark v. Humana, Inc.*, 307 F.3d 298, 311 (5th Cir. 2002) (stating that ERISA should not be interpreted to preempt state malpractice laws or to create federal common law of medical malpractice); *Aetna Health Inc. v. Davila*, 307 F.3d 298 (5th Cir. 2002), *appeal docketed*, No. 02-1845, [www.supremecourtus.gov/docket/02-1845.htm](http://www.supremecourtus.gov/docket/02-1845.htm) (showing case on Supreme Court docket); *CIGNA HealthCare of Texas, Inc v. Calad*, 307 F.3d 298 (5th Cir. 2002), *appeal docketed*, No. 03-83, [www.supremecourtus.gov/docket/03-83.htm](http://www.supremecourtus.gov/docket/03-83.htm) (showing case on Supreme Court docket).

<sup>3</sup> Employee Retirement Income Security Act of 1974, 29 U.S.C.S. § 1001, (1974) (declaring that Act is intended to protect interstate commerce and interests of participants in employee benefit plans and their beneficiaries by requiring disclosure and reporting to participants and beneficiaries of financial and other information, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the federal courts); see *Aetna Health Inc. v. Davila*, 124 U.S. 2488, 2492 (2004) (reviewing decision of Fifth Circuit, stating claim was not preempted by ERISA); *CIGNA HealthCare of Texas Inc. v. Calad*, 124 S. Ct. 1493, 1493 (2004) (hearing challenge to lower court rulings); see also *Supreme Court to Decide if HMOs May Be Sued in State Court*, LIAB. & INS. WEEK, Nov. 9, 2003, (noting underlying facts of companion cases and quoting lower courts' holdings).

<sup>4</sup> Texas was the first state in the nation to adopt legislation creating liability for negligence in health care decisions made by health care providers. On September 1, 1997, Senate Bill 386 (SB 386) became effective, amending Title 4 of the CIVIL PRACTICE AND

other states,<sup>5</sup> allowing participants to bring negligence claims against the companies if they are denied medically necessary<sup>6</sup> care.<sup>7</sup> Previously, circuit courts had continuously held that the ERISA preemption clause<sup>8</sup> shields employee-sponsored health care plans from such claims based on state law.<sup>9</sup> The preemption clause states that "the provisions of this title . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."<sup>10</sup>

REMEDIES CODE by adding Chapter 88. Texas Health Care Liability Act, Tex. Civ. Prac. & Rem. Code § 88.001-.003 (2004) and Organization of Insurers and Related Entities, TEX. INS. CODE ANN., arts. 20A.09, 20A.12, 20A.12A, 21.58A, 21.58C (2004).

<sup>5</sup> See e.g., Illinois Health Maintenance Organization Act, 215 ILL. COMP. STAT. ANN. 125/4-10 (2000). This act states that the statute requiring HMOs to submit to independent physician review when there is disagreement between patient's primary care physician and HMO over whether course of treatment is medically necessary is not preempted by ERISA. *Id.* Cicio v. Vytra Healthcare, 208 F.Supp.2d 288, 294 (E.D.N.Y. 2001). Plaintiffs' spouse sued their HMO after her husband died, following a medical director's refusal to allow a procedure recommended by their physician. *Id.* See also Karene M. Boos & Eric J. Boos, *Killing The Fatted Calf: Managed Care Liability In A Post-Pegram World*, 24 N. ILL. U. L. REV. 63, 65 (2003). The author discusses the Wisconsin approach to facilitating plaintiffs' challenges, where rather than reforming medical malpractice statutes, the state requires that medical directors be licensed physicians, and, as such, they must carry medical malpractice insurance. This statutory provision presupposes that medical directors are making use of their medical knowledge when reviewing benefits decisions and therefore are acting as physicians who should be subject to medical malpractice standards. *Id.*

<sup>6</sup> See TEX. CIV. PRAC. & REM. CODE § 88.001 (2004) (defining "appropriate and medically necessary" as standard for health care services as determined by physicians and health care providers in accordance with prevailing practices and standards of medical profession and community).

<sup>7</sup> The Texas Health Care Liability Act authorizes an insured to sue an HMO, other managed care entities or the managed care entity's employees and agents for damages proximately caused by the failure to "exercise ordinary care when making health care treatment decisions." See Act of May 22, 1997, 75th Leg., R.S., ch. 163, 1997 TEX. GEN. LAWS 317 (codified at TEX. CIV. PRAC. & REM. CODE ANN. 88.001-.003 (Vernon Supp. 1999) and TEX. INS. CODE ANN., arts. 20A.09, 20A.12, 20A.12A, 21.58A, 21.58C (Vernon Supp. 1999)); see also Susan Borreson, *Judge Oks Law Allowing HMO Malpractice Suits*, Sept. 28, 1998, TEX. LAW., at 1 (1998); Tex. S.B. 386, 75th Leg., R.S. (1997). The author discusses the changes made to TEX. INS. CODE ANN., arts. 20A, 21.58A & C as part of the Act.

<sup>8</sup> 29 U.S.C. § 1144(a) (preempting injured patients from suing HMOs in state court).

<sup>9</sup> See e.g., Marks v. Watters, 322 F.3d 316, 319 (4th Cir. 2003) (affirming district court decision that claim was preempted by ERISA); Pryzbowski v. U.S. Healthcare, 245 F.3d 266, 278 (3rd Cir. 2001) (stating that suits against HMOs and insurance companies for denial of benefits, even when couched in terms of common law negligence or breach of contract, have been held to be preempted by ERISA); Tolton v. Biodyne Inc., 48 F.3d 937, 943 (6th Cir. 1995) (upholding preemption); McManus v. Traveler's Health Network, 742 F. Supp 377, 379 (W.D. Tex. 1990) (explaining that preemption provision of ERISA is expansive). But see Cicio v. Does, 321 F.3d 83, 104 (2nd Cir. 2003) (holding that by denying one treatment and authorizing another that decedent's doctor had not specifically requested, medical director seemed to have been engaged in patient-specific proscription of appropriate treatment, and, ultimately, medical decision regarding appropriate treatment for decedent, which could implicate state law medical malpractice claim under New York law).

<sup>10</sup> 29 U.S.C. § 1144(a) (discussing the preemptive effect of ERISA on state laws).

This Article will examine the Supreme Court's previous rulings in ERISA cases, specifically focusing on the doctrine of fiduciary duty<sup>11</sup> and the application of the concept of "areas of traditional state concern."<sup>12</sup> Allowing patients' claims, under state statutes, to be preempted by ERISA has left an enormous void in the rights patients would have if they were not covered by an ERISA plan.<sup>13</sup> The federal court remedies provided by ERISA<sup>14</sup> do not address a problem that Congress not only created, arguably intentionally,<sup>15</sup> in order to alleviate the administrative burden of

<sup>11</sup> *Pegram v. Herdrich*, 530 U.S. 211, 222 (2000). "Fiduciary" is described as someone acting in the capacity of manager, administrator, or financial adviser. *Id.* *Varity Corp. v. Howe*, 516 U.S. 489, 506 (1996). ERISA requires fiduciary to discharge his duties with respect to plan solely in interest of participants and beneficiaries. *Id.* *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 251-52 (1993). Fiduciary's duties include the proper management, administration, and investment of assets, the maintenance of proper records, the disclosure of specified information, and the avoidance of conflicts of interest. *Id.* 29 USCS § 1109 (2004). ERISA allows a participant or beneficiary to sue under § 1109 for breach of fiduciary duty. § 1109(a) states that "any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this title shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary." *Id.*

<sup>12</sup> See generally Stanley H. Friedelbaum, *Traditional State Interests and Constitutional Norms: Impressive Cases in Conventional Settings*, 64 ALB. L. REV. 1245, 1283 (2001) (surveying variety of cases where "traditional state concern" is at issue, subsequently noting federalist revival on Supreme Court and existing opportunity for reinvented activism arising in conventional contexts).

<sup>13</sup> See Suzanne Carter, *Health Care and ERISA*, 36 HARV. J. ON LEGIS. 561, 561 (1999) (advocating Patients' Bill of Rights that would hold HMOs accountable, contain legal and medical costs and allow malpractice victims to be duly compensated); Jason A. Glodt, *Watch Out HMOs: The Future Of Patients' Rights Will Soon Be Determined*, 45 S.D. L. REV. 640, 640 (2000) (explaining that patients are demanding accountability and want right to sue their HMOs in state court, and, as a result, once-impermeable ERISA preemption shield is under heavy fire from Congress, state legislatures and courts); see also Tiffany F. Theodos, *The Patients' Bill Of Rights: Women's Rights Under Managed Care and ERISA Preemption*, 26 AM. J.L. AND MED. 89, 90 (2000) (stating American Medical Association strongly supports passage of Patients' Bill of Rights that would cover all 161 million privately insured Americans, give patients stronger, wider range of rights and allow patients to sue their health plans for damages in state courts if denial of care results in injuries).

<sup>14</sup> See generally 29 U.S.C. § 1132, § 1144. Federal remedies under ERISA includes actions by the employee to recover the cost of denied benefits, enforcement of rights under the policy, clarification of rights to future benefits, damages for breach of fiduciary duty or an injunction to halt unfair practices by the ERISA provider. Under ERISA's remedial scheme, a plan participant cannot recover for personal injury, lost wages or punitive damages. *Id.*

<sup>15</sup> 120 CONG. REC. 29197, 29933 (1974). Statement by bill sponsor, Senator Williams: [I]t should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is

complying with a vast multitude of different state laws<sup>16</sup> as explained in PART III, but has since failed to remedy.<sup>17</sup> Without any far-reaching congressional action addressing this issue of vast constitutional magnitude, it remains in the hands of the Supreme Court to decide whether the Fifth Circuit has properly applied the Supreme Court's oft-confusing, and hotly debated, prior holdings.<sup>18</sup> It is the purpose of this Article to formulate a navigable and concise path through ERISA legislation and case law,<sup>19</sup> supporting the theory that the preemption clause of ERISA should have no bearing on state legislation allowing patients to hold their managed care organizations (MCOs)<sup>20</sup>

intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.

*Id.* See also *Aetna Health*, 124 U.S. at 2495. Congress enacted ERISA to protect interests of participants by setting out substantive regulatory requirements for employee benefit plans and to provide for appropriate remedies, sanctions and ready access to the federal courts. *Id.* Authier v. Ginsberg, 757 F.2d 796, 802 (6th Cir. 1985). Congress desired to create uniform federal law governing enforcement of ERISA. *Id.*

<sup>16</sup> See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 745-46 (1985) (setting forth legislative history of ERISA's preemption provision); see also *Stott v. Bunge Corp. & Beatrice Co.*, 800 F Supp. 567, 572 (E.D. Tenn. 1992) (declaring general rule that state law claims are preempted by ERISA); Karen A. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-Emption*, 13 YALE J. ON REG. 255, 269 (Winter 1996) (stating *Mackey* holding reflects Court's practical approach to assessing congressional intent regarding the scope of ERISA preemption).

<sup>17</sup> See, e.g., Morton Kondracke, *Underachieving Congress Will Eventually Compromise*, NEW HAVEN REG., Oct. 20, 2002 at B3 (arguing that "[p]robably the starkest area of failure is in the health field . . . the lawyer issue has torpedoed patients' rights legislation"); Robert Pear, *White House and Senate Hit Impasse on Patients' Rights*, N.Y. TIMES, Aug. 2, 2002, at A17 (citing collapse of talks between White House and Senate on a bill to define patients' rights); see also Thomas R. McLean and Edward P. Richards, *The 'Aetna Health' Ruling*, NATIONAL L.J., Aug. 30, 2004, at 12 (stating that Court could broaden ERISA remedies, but that health policy choices should be made by Congress).

<sup>18</sup> See *Roark v. Humana, Inc.*, 307 F.3d 298, 315 (5th Cir. 2002) (expressing doubt that one of Congress' goals in passing ERISA was to put medical judgments in hands of plan administrators instead of doctors); see also Lorraine Schmall and Brenda Stephens, *ERISA Preemption: A Move Towards Defederalizing Claims For Patients' Rights*, 42 BRANDEIS L.J. 529, 549 (Spring 2004) (explaining that, in *Roark*, Fifth Circuit stated that it was "unimaginable that Congress intended ERISA to create a federal common law medical malpractice"). But see Matthew J. Binette, *Patients' Bill of Rights: Legislative Cure-All or Prescription for Disaster?* 81 N.C. L. REV. 653, 689 (January 2003) (stating that action in federal courts or Congress could drastically change state patient protection acts, positively or negatively).

<sup>19</sup> It is outside the scope of this Article to discuss the entirety of earlier ERISA litigation or the development and subsequent judicial treatment of any number of theories of liability, particularly the vast array of lower level federal court decisions. It is sufficient to note, for the purpose of this Article, that the large majority of lower courts have consistently held that the administrator of an ERISA health care plan was a fiduciary, but that health care service providers, such as physicians and hospitals, were not. See, e.g., William E. Mattingly, *Employer Liability for a Medical Plan*, 16 TAX MGMT. COMP. PLANNING J. 159 (1989).

<sup>20</sup> Blaire S. Osgood, *The Treachery of ERISA Preemption: Ceci N'est Pas une Benefits Determination*, 81 B.U. L. REV. 867, 892 (October 2001) (arguing that in order to bring

responsible for negligent coverage decisions via state common law tort and breach of contract actions.<sup>21</sup>

### *B. Constitutional Preemption*

Where Congress exercises a granted power, federal law supersedes<sup>22</sup> a conflicting state law and preempts state authority over the subject matter by the operation of the Supremacy Clause<sup>23</sup> of the United States Constitution. Article VI, Clause 2 of the Constitution<sup>24</sup> states that all laws made by Congress in pursuance of the Constitution “shall be the supreme Law of the Land.”<sup>25</sup> Congress has virtually unfettered authority to preempt state power to regulate a certain subject matter through express preemption, field preemption or conflict preemption.<sup>26</sup> Congress

federal legislation up to date with state legislation, ERISA’s preemption provision should not be interpreted to include state regulation of practice of medicine, including judgments made by all MCO medical directors); see also Phyllis C. Borzi, *The Evolving Role of ERISA Preemption and Managed Care: Current Issues of Importance to Employers, Fiduciaries and Providers*, Q286 A.L.I.-A.B.A. 17, 19 (1999) (noting that U.S. Department of Labor statistics reveal that 72 percent of workforce, nearly two-thirds of entire non-elderly population, is covered under group health plans subject to ERISA); Heather Hutchinson, *The Managed Care Plan Accountability Act*, 32 IND. L. REV. 1383, 1385 (1999) (determining managed care is experiencing widespread growth across United States with more than 45 million Americans enrolled in managed care organizations, and pointing to escalating number of Americans affected by MCOs, and their administration of healthcare, as more than 70 percent of American workers and their families covered by managed care health plans).

<sup>21</sup> See *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825 (1988) (holding that ERISA doesn’t preempt “run of the mill state law claims”). But see, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (concerning Mississippi common law breach of contract and tort claims held to be preempted by ERISA). Cf. *Butler v. Wu*, 853 F. Supp. 125, 129 (D. N.J. 1994) (concluding that ERISA “preempts state law tort claims brought against an HMO for the negligence of one of its participating physicians . . .”).

<sup>22</sup> *Arizona v. McMurry*, 184 Ariz. 447, 449 (Ariz. Ct. App. 1995) (listing six situations in which federal law may preclude state law, including when state law is an obstacle to the accomplishment of full objectives of Congress); *Maryland v. Louisiana*, 451 U.S. 725, 746-47 (1981) (explaining that purpose to displace state law may be demonstrated when state policy might produce a result that is inconsistent with federal statute); see also *McCulloch v. Maryland*, 17 U.S. 316, 427 (1819) (declaring that constitutional command of Supremacy Clause requires all state provisions in conflict with Federal law to be without effect).

<sup>23</sup> U.S. CONST. art. VI, § 1, cl. 2.

<sup>24</sup> *Id.*

<sup>25</sup> Article VI, § 1, cl. 2 states:

This Constitution, and the Laws of the United States which shall be made in pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

*Id.*

<sup>26</sup> See *Hughes v. AG of Florida*, 377 F.3d 1258, 1265 (11th Cir. 2004) (stating that Supreme Court has defined three types of preemption: express, field, and conflict); *Cliff v.*

may structure a federal law to govern a cause of action ("conflict preemption"), or it may structure a federal law to "occupy the field" in which causes may arise ("complete preemption").<sup>27</sup> Congress will only articulate an express intent to completely preempt state law in a certain area when it has a "clear and manifest purpose" for infringing upon the traditional police powers of the states.<sup>28</sup>

When Congress incorporates a statement into a federal statute that expressly preempts state action, the only remaining issue for judicial review is whether the state statute falls within the area preempted.<sup>29</sup> The crux of an implied preemption case is whether Congress intended to occupy the regulatory field,<sup>30</sup>

Payco Gen. Am. Credits, Inc., 363 F.3d 1113, 1122 (11th Cir. 2004) (distinguishing three types of preemption, one express and two types of implied); *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947) (citations omitted) (defining three types of preemption as follows: "The scheme of federal regulation may be so pervasive as to make reasonable the inference that Congress left no room for the States to supplement it. Or the Act of Congress may touch a field in which the federal interest is so dominant that the federal system will be assumed to preclude enforcement of state laws on the same subject. Likewise, the object sought to be obtained by the federal law and the character of obligations imposed by it may reveal the same purpose. Or the state policy may produce a result inconsistent with the objective of the federal statute").

<sup>27</sup> *English v. Gen. Elec. Co.*, 496 U.S. 72, 79 (1990) (explaining difference between field preemption and conflicting preemption); Boos, *supra* note 5, at 71 (explaining that, historically, Congress rarely articulates express intent to preempt state law because it does not want to interfere with state police powers without manifest purpose). See generally S. Candice Hoke, *Preemption Pathologies and Civil Republic Values*, 71 B.U. L. REV. 687, 694 (1991) (describing effects of federal preemption ruling as revoking local power and affirming that only federal government may exercise that power).

<sup>28</sup> *Rice*, 331 U.S. at 230 (listing several ways in which intention to preempt may be evidenced, including regulation being so insidious that it can be reasonably inferred that Congress left no room for states to legislate it, and act of Congress being in a field where federal legislation is so dominant that it is assumed to preclude state laws on that subject); *Hillsborough County v. Automated Med. Labs, Inc.*, 471 U.S. 707, 715 (1985) (citing *Jones v. Rath Packing Co.*, for proposition that preemption will not be assumed without a clear manifestation of intent by Congress); *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977) (explaining that reasoning behind requiring manifest purpose is to ensure separation of powers between state and federal government not disturbed).

<sup>29</sup> See *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 517 (1992) (assessing whether a federal statute expressly preempts a state law claim by determining whether federal statute explicitly articulates an intent to displace state regulation). See generally, Brannan v. United Student Aid Funds, Inc., 94 F.3d 1260, 1267 (9th Cir. 1996) (explaining that express provisions in statute preempting state law illustrate that Congress did not preempt state law in any other matters than those addressed); Michael J. Jackson Jr., *Considerations in Medicare Reform: The Impact of Medicare Preemption on State Laws*, 29 ANN. HEALTH L. 179, 196 (Winter 2004) (distinguishing judicial role in interpretation of express and implied preemption).

<sup>30</sup> See *Gade v. Nat'l Solid Wastes Mgt. Ass'n*, 505 U.S. 88, 96 (1992) (examining explicit statutory language and structure and purpose of statute to discern Congress' intent); *Cipollone* 505 U.S. at 516 (stating that congressional intent can be determined by examining statute's structure and purpose); see also *Arkansas v. Oklahoma*, 503 U.S. 91, 98 (1992) (noting importance of maintaining state sovereignty).

which requires a clear showing of congressional intent.<sup>31</sup> Even where Congress has not entirely displaced state regulation in a specific area, "state law is pre-empted to the extent that it actually conflicts with federal law."<sup>32</sup> A subsequent federal preemption ruling revokes state and local governmental power over the subject matter and effectively affirms that such power may be exercised solely by the national government.<sup>33</sup>

## II. ERISA AND THE SUPREME COURT

The foremost task of a court tackling a preemption case is to "ascertain Congress' intent in enacting the federal statute at issue."<sup>34</sup> The plain language of ERISA, its legislative history and the context in which it was enacted<sup>35</sup> have all been taken into account by various courts reaching entirely different conclusions.<sup>36</sup> The stated purpose of ERISA's preemption clause

<sup>31</sup> See *Rice*, 331 U.S. at 230 (stating that states' powers cannot be superceded unless it is clear purpose of Congress); *Napier v. Atlantic Coast R. Co.*, 272 U.S. 605, 611 (1926) (explaining that Congress' intent to preempt must be clearly manifested); *Reid v. Colorado*, 187 U.S. 137, 148 (1902) (holding that Congress' intent to supercede cannot be implied without clear evidence of purpose).

<sup>32</sup> *Exxon Corp. v. Eagerton*, 462 U.S. 176, 182 (1983) (quoting *Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 142-43 (1963) and *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941)) (stating further that "[s]uch a conflict arises when 'compliance with both federal and state regulations is a physical impossibility,' or where state law 'stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress'").

<sup>33</sup> See Kurt Chadwell, *Automobile Passive Restraint Claims Post-Cipollone: An End to the Federal Preemption Defense*, 46 BAYLOR L. REV. 141, 151 (1994) (stating that preemption indicates congressional intent to close an area of law to state regulation); Jason Crawford, *Overcoming Tobacco Immunity: Cipollone Clears an Uncertain Path*, 27 GA. L. REV. 253, 267 (1992) (stating that allowance of federal regulations to supercede state law without clear congressional intent creates "regulatory vacuum"); Hoke, *supra* note 27, at 694-95 (discussing regulatory vacuum that may exist if questions have not been addressed by national legislation or agency regulations and is not on current national political agenda).

<sup>34</sup> *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 95 (1983).

<sup>35</sup> See, e.g., *Hines* 312 U.S. at 62, 66 (creating inferred intent based on surrounding circumstances, namely dominance of federal interest in foreign affairs because "the supremacy of the national power in the general field of foreign affairs . . . is made clear by the Constitution," and regulation of that field is "intimately blended and intertwined with responsibilities of the national government"); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 364-65 (2002) (reasoning that when "ordinary language" of statute appears uncertain, it must be examined with qualification that historic police powers of states are not to be displaced without clear congressional intent); *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99 (1993) (finding that preemption and savings clauses of ERISA "are not models of legislative drafting" and, further, that legislative history is sparse).

<sup>36</sup> See *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 67 (1987) (noting that, though suit purported to raise only state law claims, ERISA superceded state law regarding benefit plans in this case); *Roark v. Humana, Inc.*, 307 F.3d 298, 311 (5th Cir. 2002)



was to "enhance the ability of participants and beneficiaries to enforce their rights to their promised ERISA benefits and to set baseline rules by which to measure the conduct of plan sponsors and fiduciaries."<sup>37</sup> The specific language of ERISA that has required such an inordinate amount of judicial interpretation states: "the provisions of this title . . . shall supersede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan."<sup>38</sup>

The 'related to' language was initially interpreted in a broad, almost sweeping, manner by the courts.<sup>39</sup> In 1983, the Supreme Court defined 'relate to' (and therefore preempted) as having "a connection with or reference to such a plan."<sup>40</sup> If the state law in question has no connection with or reference to an ERISA plan, the claim will not be preempted and will be adjudicated in state court under the applicable statute.<sup>41</sup>

(stating that ERISA does not preempt state malpractice laws); *see also* N.Y.S. Conf. Of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 655 (1995) (questioning whether plain language of ERISA provides for any real limits to its preemptive power).

<sup>37</sup> JANE E. ZANGLEIN & SUSAN J. STABILE, ERISA LITIGATION, 282 (2003); *see Travelers*, 514 U.S. at 657 (noting congressional objective of establishment of "nationally uniform administration of employee benefit plans," heralding that goal as "basic thrust of the preemption clause"). *See generally* RAND E. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM, 173-77 (1997) (analyzing legislative history and policy significance of ERISA preemption).

<sup>38</sup> 29 U.S.C. § 1144(a) (emphasis added).

<sup>39</sup> *See* ZANGLEIN, *supra* note 37, at 282 (acknowledging that early U.S. Supreme Court decisions applied literal interpretation of 'relate to' language in § 514, resulting in substantial weakening of right of participants and beneficiaries to sue ERISA plan); *see also* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47 (1987) (discussing broad and "common sense" meaning that Supreme Court has given to phrase 'relates to,' and interpreting it to include state law that has any connection or reference to a plan); *Shaw* 463 U.S. at 98 (stating that committees found that scope of ERISA was as broad as its language suggests).

<sup>40</sup> *Shaw*, 463 U.S. at 97.

<sup>41</sup> *See* Bauman v. U.S. Healthcare, Inc., 193 F.3d 151, 161-62 (3rd Cir. 1999) (noting that claims against quality of care are not subject to complete preemption); *Shaw*, 463 U.S. at 100 n.1 (stating that "[s]ome state actions may affect employee benefit plans in too tenuous, remote or peripheral a manner to warrant a finding that the law 'relates to' the plan"); Jacqueline B. Penrod, *Rationing Health Care, Rationing Liability - Imposing Liability Against Health Maintenance Organizations Through State Legislation*, 74 TEMPLE L. REV. 507, 519-24 (Summer 2001) (discussing various cases remanded from federal to state courts).

### A. The "Connection With" Test

To determine whether a state law has "the forbidden connection,"<sup>42</sup> we look to "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive."<sup>43</sup> This focus on intent did not originate in the recent decisions this Article concentrates on, but is instead found in the entirety of healthcare-related ERISA case law, starting with *Shaw v. Delta Air Lines*.<sup>44</sup> Laws that "plainly order the administration of employee benefit structures"<sup>45</sup> have the requisite connection discussed and are immediately preempted.<sup>46</sup> In *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*,<sup>47</sup> Justice Souter explicitly narrowed the effect of the Court's earlier decisions,<sup>48</sup> which had found that even state laws that *indirectly* affect employee benefit plans have a sufficient connection with ERISA and are thereafter preempted.<sup>49</sup> This landmark holding narrowed the scope of prior

<sup>42</sup> *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) (quoting *N.Y.S. Conf. Of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*).

<sup>43</sup> *Id.*

<sup>44</sup> 463 U.S. 85 (1983). The *Shaw* court held that two state laws prohibiting discrimination on the grounds of pregnancy and requiring employers to provide sick leave to employees disabled by pregnancy fell within ERISA's "relate to" language. *Id.* at 108-09. As a matter of course, the Court held that the meaning of the phrase "relates to" is unambiguous and that it necessarily requires broad preemption. *Id.* at 98-99.

<sup>45</sup> ZANGLEIN, *supra* note 37, at 288.

<sup>46</sup> See *Shaw*, 463 U.S. at 97 (stating that Court must "give effect to this plain language unless there is good reason to believe Congress intended the language to have some more restrictive meaning"); see also Patricia Mullen Ochmann, *Managed Care Organizations Manage to Escape Liability: Why Issues of Quantity vs. Quality Lead to ERISA's Inequitable Preemption of Claims*, 34 AKRON L. REV. 571, 597 (2001) (citing *Travelers*, noting holding that state law was not related to an employee benefit plan because it did not make any specific reference to ERISA plans and because its "connection with" employee benefit plans was not such that would disrupt uniform federally administered employee benefit plan); *Varr v. Olimpia*, 45 Cal. App. 4th 675, 681 (6th Dist. 1996) (noting that "state law is preempted by ERISA so long as it has connection with or reference to employee benefit plan").

<sup>47</sup> 514 U.S. 645 (1995) (discussing pre-emption provision of ERISA).

<sup>48</sup> See e.g., *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981) (holding state statutes in question, though creating only an indirect infringement, constituted impermissible intrusion on federal regulatory scheme); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990) (stating that, "even if the law is not specifically designed to affect such plans, or the effect is only indirect," preemption will occur); cf. *Int'l Brotherhood of Teamsters, C.W. & H. v. Oliver*, 358 U.S. 283, 296 (1959) (holding that when federal law operates in "area where its authority is paramount, to leave the parties free, the inconsistent application of state law is necessarily outside the power of the state").

<sup>49</sup> Compare *Travelers*, 514 U.S. 645 (changing rule regarding indirect state action) with *Alessi*, 451 U.S. at 525 (stating "even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern" and therefore fall within the "relate to" provision of ERISA). See *Scotti v. Los Robles Reg'l Ctr.*, 117 F.

ERISA interpretation,<sup>50</sup> by reasoning that infinite connections would stretch preemption in ways unintended by Congress,<sup>51</sup> noting that "relations stop nowhere"<sup>52</sup> and that this approach characterized by limitless "indeterminacy" would fail completely as the measure of preemption.<sup>53</sup>

### B. The "Reference To" Test

Laws that "act immediately and exclusively upon ERISA plans, or schemes where the existence of ERISA plans is essential to the law's operation,"<sup>54</sup> have been held by the Supreme Court to have "reference to"<sup>55</sup> ERISA so as to be preempted. If and when such a law is capable of functioning "irrespective of the existence of an ERISA plan," it is not subject to preemption.<sup>56</sup> The *Traveler's* line

Supp.2d 982, 986 (C.D. Cal. 2000) (finding that "a direct relationship to a plan need not be established because an indirect relation to a plan is sufficient to establish preemption") (citations omitted).

<sup>50</sup> See e.g., *California Div. of Labor Stds. Enforcement v. Dillingham Constr.*, 519 U.S. 316, 325 (1997) (describing the 'connection with' analysis, where a court "looks both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans") (citations omitted); see *Lyons v. Fairfax Props.*, 2002 U.S. Dist. LEXIS 17615, \*8 (D. Conn. 2002) (explaining that "to overcome the anti-preemption presumption, a party challenging a statute must convince a court that there is something in the practical operation of the challenged statute to indicate that it is the type of law that Congress specifically aimed to have ERISA supersede"); cf. *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947) (stating assumption "that the historic police powers of the States were not to be superseded by [a] Federal Act unless that was the clear and manifest purpose of Congress").

<sup>51</sup> See ROSENBLATT, *supra* note 37 (discussing congressional intent in enacting ERISA); *Wright Elec., Inc. v. Minn. State Bd. of Elec.*, 322 F.3d 1025, 1029 (8th Cir. 2003) (quoting *Travelers*, 514 U.S. at 655) (noting that "although the 'governing text of ERISA is clearly expansive[,] . . . if 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course"); cf. *Pilot Life*, 481 U.S. at 46 (arguing ERISA was intended to increase employee rights in pension and benefit plans and to ease regulatory burden on employers by replacing all state laws relating to pension and benefit plans with new federal law).

<sup>52</sup> See *Travelers*, 514 U.S. at 655 (explaining why infinite connections stop nowhere).

<sup>53</sup> See *id.* (noting that it is "necessary to recognize that [the Court's] prior attempt to construe the phrase 'relate to' does not give [them] much help drawing the line [in this case]"); see also *Aetna Cas. & Sur. Co. v. William M. Mercer, Inc.*, 173 F.R.D. 235, 237 (N.D. Ill. 1997) (noting that *Travelers* has exemplified difficulties of divining proper scope of preemption from such broad-brush language); cf. *Morstein v. Nat'l Ins. Servs. Inc.*, 93 F.3d 715, 721 (11th Cir. 1996) (noting that *Travelers* "essentially turned the tide on the expansion of the preemption doctrine").

<sup>54</sup> See *Dillingham*, 519 U.S. at 325.

<sup>55</sup> *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 n.16 (1983) (citing Black's Law Dictionary 1158 (5th ed. 1979)) (defining "Relate: 'To stand in some relation; to have bearing or concern; to pertain; refer; to bring into association with or connection with'").

<sup>56</sup> See *Forbus v. Sears Roebuck & Co.*, 30 F.3d 1402, 1405 (11th Cir. 1994) (stating that "the mere existence of a plan governed by the Employee Retirement Income Security Act of 1974 (ERISA) is not enough for preemption," and further noting that "the state law

of cases,<sup>57</sup> although drastically altering the “connection with” prong of the “relates to” test,<sup>58</sup> as illustrated above, retained the *Shaw* court’s interpretation of “reference to.”<sup>59</sup> However, in a separate line of cases<sup>60</sup> following the Supreme Court’s decision in *Pilot Life Insurance Co. v. Dedeaux*,<sup>61</sup> federal courts ruled that ERISA provided exclusive remedies for employer violation of plan requirements<sup>62</sup> and preempted state causes of action in tort for

in question must make reference to or function with respect to the ERISA plan in order for preemption to occur”) (*citations omitted*); see also *United Ass’n of Journeymen & Apprentices of the Plumbing & Pipefitting Indus. v. Grove, Inc.*, 105 F. Supp. 2d 1129, 1132 (D. Nev. 2000) (stating that “if state law has only ‘tenuous, remote, or peripheral’ connection with covered plans, as is with many laws of general applicability, preemption will not occur”); cf. *Carpenter v. CNA*, 2001 U.S. Dist. LEXIS 25264 at \*1, \*6 (D. Ohio 2001) (stating “the traditional rule of preemption is that where it is arguable that a federal law preempts a state law, that argument is properly raised as a defense to the state cause of action, in state court”).

<sup>57</sup> See e.g., *Cicio v. Vytra Healthcare*, 321 F.3d 83, 94 (2nd Cir. 2003) (explaining that “where a State’s law acts immediately and exclusively upon ERISA plans . . . or where the existence of ERISA plans is essential to the law’s operation . . . that ‘reference’ will result in pre-emption,” noting that state laws invoked by Ms. Cicio, such as that respecting medical malpractice doctrine, act neither immediately nor exclusively on ERISA plans and because such plans are not “essential to” law’s operation) (*citations omitted*); *California Div. of Labor Stds. Enforcement*, 519 U.S. at 325 (noting that court must look both to general objectives of ERISA statute and to effect of state law in question on ERISA plans) (*internal citations omitted*); *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) (acknowledging that ‘connection with’ is scarcely more restrictive than ‘relate to,’ and cautioning “against an ‘uncritical literalism’ that would make preemption turn on ‘infinite connections’”).

<sup>58</sup> See N.Y.S. Conf. Of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 655-56 (1995) (noting that “Section 514(a) [currently § 1144] marks for pre-emption ‘all state laws insofar as they . . . relate to any employee benefit plan’ covered by ERISA, and one might be excused for wondering, at first blush, whether words of limitation (‘insofar as they . . . relate’) do much limiting”); *Shaw*, 463 U.S. at 96-97 (noting that “a law ‘relates to’ an employee benefit plan, in normal sense of the phrase, if it has a connection with or reference to such a plan”); see also Ochmann, *supra* note 46, at 583 (noting that Justice Souter reformulated “relate to” analysis as used in *Shaw*).

<sup>59</sup> See Blaine Hummel, *The Duty of Ordinary Care for HMOs: Can Texas Senate Bill 386 Weather the Storm of ERISA Preemption?*, 18 REV. LITIG. 649, 659 (Summer 1999) (pointing out that from its discussion of “reference to” up until “connection with” analysis in *Travelers*, Court remained faithful to *Shaw* analysis of which state laws might “relate to” an employee benefit plan).

<sup>60</sup> See *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1332 (5th Cir. 1992) (noting that “moreover, allowing the Corcorans’ suit to go forward would contravene Congress’ goals of ‘ensuring that plans and plan sponsors would be subject to a uniform body of benefit law’ and ‘minimizing the administrative and financial burdens of complying with conflicting directives among States or between States and the Federal Government’”); *Rice v. Panchal*, 65 F.3d 637, 644 (7th Cir. 1995) (indicating that “where the state law has the effect of creating a qualitative standard . . . by which the performance of the contract is evaluated, then that state law is completely preempted”); see also *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 942 (6th Cir. 1995) (rejecting as preempted malpractice claim against utilization review decision because defendants “were determining what benefits were available . . . under the plan”).

<sup>61</sup> 481 U.S. 41 (1987).

<sup>62</sup> See, e.g., *Rush Prudential HMO v. Moran*, 536 U.S. 355, 392 (2002) (Thomas, J., dissenting) (citing *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990)) (comparing

negligence and bad faith breach of contract against employee welfare benefit plans and the commercial insurers that funded these plans.<sup>63</sup> The Court concluded that a plan participant or beneficiary may recover benefits under the civil enforcement provisions of ERISA § 1132(a).<sup>64</sup>

### C. The Savings Clause

The plaintiffs in these cases, who bring medical malpractice claims against insurance companies based on their negligent coverage decisions, proffer the argument that their claims are not preempted, based on ERISA's savings clause.<sup>65</sup> ERISA

Illinois statute contested in *Rush* with Texas' tort of wrongful discharge at issue in *Ingersoll-Rand*, which was held to have conflicted with ERISA enforcement because, while state law duplicated elements of claim available under ERISA, it converted remedy from equitable one into legal one); *Rhodes v. Metropolitan Life Ins. Co.*, 2003 U.S. Dist. LEXIS 11779 at \*1, \*17 (2003) (stating that "when beneficiaries seek to recover benefits from a plan covered by ERISA, their exclusive remedy is provided by ERISA"); see also Stephanie Reinhart, *Rush Prudential HMO Inc. v. Moran: 21 or Bust! Does ERISA Preemption Give HMOs the power to gamble with our health?* 19 AKRON TAX J. 99, 143 (2004) (noting that Pennsylvania federal court held Pennsylvania statute "preempted by virtue of ERISA's exclusive remedial scheme").

<sup>63</sup> See Eleanor D. Kinney, *Tapping And Resolving Consumer Concerns About Health Care*, 26 AM. J. L. & MED. 335, 376 (2000) (discussing *Pilot Life's* expansive interpretation of preemption clause and subsequent supporting case law). See generally Amy K. Fehn, *Are We Protected From HMO Negligence?: An Examination of Ohio Law, ERISA Preemption and Legislative Initiatives*, 30 AKRON L. REV. 501, 516 (1997) (observing that "ERISA's preemption provisions bar state courts and legislatures from holding HMOs liable for negligence"); Ochmann, *supra* note 46, at 588 (stating that "ERISA preemption harms individuals by largely shielding MCOs from negligence liability").

<sup>64</sup> See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 53 (1987) (asserting that "under the civil enforcement provisions of § 502(a), a plan participant or beneficiary may sue to recover benefits due under the plan, to enforce the participant's rights under the plan, or to clarify rights to future benefits" and further that "[r]elief may take the form of accrued benefits due, a declaratory judgment on entitlement to benefits, or an injunction against a plan administrator's improper refusal to pay benefits"); *Slice v. Sons of Norway*, 34 F.3d 630, 631-32 (8th Cir. 1994) (describing that ERISA § 1132(a), formerly ERISA § 502(a), provides remedy for "participants or beneficiaries seeking to enforce their rights under an ERISA plan"); see also *Thompson v. Abbott Labs*, 309 F. Supp. 2d 165, 171 (D. Mass. 2004) (stating that ERISA § 1132 authorizes participants, beneficiaries or fiduciaries to bring civil actions to redress violations of ERISA or to enforce any provisions of ERISA or ERISA plan). See generally ZANGLEIN, *supra* note 37, at 68 (stating that ERISA § 502(a) [currently ERISA § 1132(a)] creates civil cause of action to recover benefits, to enforce rights under plan or to clarify rights to future benefits under terms of plan and allows participant, beneficiary or fiduciary to bring suit to enjoin any act or practice that violates Title I of ERISA, to obtain appropriate equitable relief or to enforce the terms of the plan).

<sup>65</sup> See J. Bradley Buckhalter, Comment, *ERISA Preemption of Medical Malpractice Claims: Can Managed Care Organizations Avoid Vicarious Liability?*, 22 Seattle Univ. L. Rev. 1165, 1165-1167 (1999) (addressing dilemma that faces plaintiffs when they file in state court, expecting state court malpractice trial before state jury, and then face removal to federal court by defendants); see also Douglas J. Witten, *Regulation of "Downstream" and Direct Risk Contracting by Health Care Providers: The Quest for Consumer Protection and a Level Playing Field*, 23 AM. J. L. & MED. 449, 464 (1997)

§1144(b)(2)(A) states that “nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.”<sup>66</sup> The savings clause is qualified by the “deemer clause” which follows, stating in ERISA §1144(b)(2)(B), that “[n]either an employee benefit plan. . . nor any trust established under such a plan, shall be deemed to be an insurance company. . . for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.”<sup>67</sup> The Court in *Pilot Life* addressed the plaintiff’s assertion that because the “Mississippi law of bad faith . . . is a law ‘which regulates insurance,’ it is thus saved from pre-emption by § 514(b)(2)(A) [currently § 1144(b)(2)(A)].”<sup>68</sup> Mississippi law of bad faith “regulated insurers,”<sup>69</sup> such as the defendant,<sup>70</sup> and they were thus spared preemption.<sup>71</sup> However, the Court construed the ERISA preemption clause much more broadly than it construed the savings clause,<sup>72</sup> determining that in order for a

(stating that “the savings clause of ERISA exempts from preemption [state laws regulating] insurance”). *But see* FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990) (analyzing ERISA’s “deemer” clause which provides exception to the savings clause).

<sup>66</sup> 29 U.S.C. § 1144 (b)(2)(A).

<sup>67</sup> 29 U.S.C. § 1144 (b)(2)(B).

<sup>68</sup> *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48 (1987).

<sup>69</sup> Torrin A. Dorros & T. Howard Stone, *Implications of Negligent Selection and Retention of Physicians in the Age of ERISA*, 21 AM. J. L. & MED. 383, 402 (1995) (stating that state laws regulating insurance are exempt from preemption); *see* Thomas R. McLean & Edward P. Richards, *Health Care’s “Thirty Years War”: The Origins and Dissolution of Managed Care*, 60 N.Y.U. ANN. SURV. AM. L. 283, 311 (2004) (stating that state law that is specifically targeted toward entities engaged in insurance, and that substantially affect risk pooling arrangement between insurer and insured, is saved from ERISA preemption); *see also* Witten, *supra* note 65, at 464 (stating that “the saving clause of ERISA exempts from preemption [state laws regulating insurance]”).

<sup>70</sup> *See Pilot Life*, 481 U.S. at 43 (stating that plaintiff relied on state law claims to receive disability benefits from defendant Pilot Life Insurance Company instead of claims that were available to him under ERISA).

<sup>71</sup> Larry J. Pittman, *ERISA’s Preemption Clause and the Health Care Industry: An Abdication of Judicial Law Creating Authority*, 46 FLA. L. REV. 355, 385 (1994) (stating that Supreme Court “held that the plaintiff’s state law claim under the Mississippi law of bad faith was preempted”); Michael J. Jacksonis, Jr., *Considerations in Medicare Reform: The Impact of Medicare Preemption on State Laws*, 13 ANN. HEALTH L. 179, 214 (2004) (noting that Supreme Court denied plaintiff’s state law claims of bad faith breach of contract, breach of fiduciary duty and fraud on ground of preemption); *see also* Howard Shapiro, Rene E. Thorne & Edward F. Harold, *To Infinity and Beyond and Back Again?: A Historical Review of Supreme Court Jurisprudence*, 58 LA. L. REV. 997, 1008 (1998) (hereinafter *To Infinity*) (comprehensively analyzing facts of *Pilot Life* and the Court’s reasoning for holding plaintiff’s claim was not spared preemption by savings clause).

<sup>72</sup> McLean, et al., *supra* note 69, at 311 (stating that state law that is specifically targeted toward entities engaged in insurance is saved from ERISA preemption); *see* Reinhart, *supra* note 62, at 110-12 (discussing factors that must be met by state law to avoid preemption); *see also* Dennis K. Schaeffer, *Insuring the Protection of ERISA Plan*

state law to be spared preemption, it must not simply have an impact on the insurance industry, but "must be specifically directed toward that industry."<sup>73</sup> Even state laws of generally applicability<sup>74</sup> were deemed preempted and outside the scope of the now narrowed savings clause by the holding in *Pilot Life*.<sup>75</sup>

Because the "roots of the law of bad faith were firmly planted in the general principles of tort and contract law,"<sup>76</sup> and not limited to breach of an insurance contract, the Court determined the law did not regulate insurance<sup>77</sup> within the meaning of the saving clause.<sup>78</sup>

#### D. Recent Supreme Court Jurisprudence

The Supreme Court, in this series of rulings after the passage of ERISA, made it seemingly clear that states were not permitted to exercise any authority in the course of regulating employer-sponsored health plans.<sup>79</sup> However, two recent cases have

*Participants: ERISA Preemption and the Federal Government's Duty To Regulate Self-Insured Health Plans*, 47 BUFF. L. REV. 1085, 1098 (1999) (noting Court's narrow interpretation of savings clause as applicable only when laws were "specifically directed toward [the insurance] industry").

<sup>73</sup> See *Pilot Life*, 481 U.S. at 50.

<sup>74</sup> Scott W. Breedlove & Victoria S. Salzmann, *The Devil made me do it: The Irrelevance of Legislative Motivation Under the Establishment Clause*, 53 BAYLOR L. REV. 419, 453 (2001) (noting that criminal laws are generally applicable); Paul Hayden, *Religiously Motivated "Outrageous" Conduct: International Infliction of Emotional Distress as a Weapon Against "Other People's Faiths"*, 34 WM. & MARY L. REV. 580, 677 (1993) (stating that tort laws are "generally applicable laws"); Molly Shaffer Van Houweling, *Cyberage Conflicts Law: Enforcement of Foreign Judgments, The First Amendment and Internet Speech: Notes for the next Yahoo! v. Licra*, 24 MICH. J. INT'L L. 697, 702 (2003) (describing contract law as generally applicable law).

<sup>75</sup> See *Pilot Life*, 481 U.S. at 48 (holding that plaintiff's claims of tort and breach of contract under Mississippi common law for petitioner's failure to pay benefits under policy were preempted by ERISA).

<sup>76</sup> *Id.*

<sup>77</sup> See *id.* at 45 (holding "saving clause" excepts laws that regulate insurance from preemption); see also McCarran-Ferguson Act, 15 U.S.C.S. § 1012(b) (requiring that business of insurance be subject to state regulation, and, subject to certain exceptions, mandating that no Act of Congress shall be construed to invalidate any law enacted by any state for purpose of regulating business of insurance).

<sup>78</sup> See *Pilot Life*, 481 U.S. at 50 (holding that "understanding of the phrase 'regulates insurance' does not support the argument that the Mississippi law of bad faith falls under the saving clause"); see also Jana K. Strain & Eleanor D. Kinney, *The Road Paved with Good Intentions: Problems and Potential for Employer-Sponsored Health Insurance Under ERISA*, 31 LOY. U. CHI. L.J. 29, 56 (1999) (noting Court's holding that "in order to regulate insurance within the requirements of the clause, the law must not only have an impact on insurance, but must also be specifically directed toward insurance").

<sup>79</sup> See *Pilot Life*, 481 U.S. at 46 (holding that enforcement of provisions eliminated threat of conflicting or inconsistent state regulation of employee benefit plans). See generally Nicole Weisenborn, *ERISA Preemption and its Effect on State Reform*, 5 KAN.

ostensibly tilted the scales of preemption litigation in favor of injured plaintiffs, and away from the MCOs hoping to perpetuate their string of preemption successes.<sup>80</sup> The Supreme Court's analyses in *Pegram v. Herdrich*<sup>81</sup> and *Rush Prudential HMO, Inc. v. Moran*<sup>82</sup> indicate a willingness to limit the formerly sweeping breadth of ERISA's preemption clause.<sup>83</sup>

J.L. & PUB. POL'Y 147, 147 (Fall 1995) (claiming that ERISA regulates financing, vesting and administration of private employee benefit plans); Barbara J. Zabawa, *Breaking through the ERISA Blockade: The Ability of States to Access Employer Health Plan Information In Medicaid Expansion Initiatives*, 5 QUINNIPIAC HEALTH L.J. 1, 12 (2001) (stating that ERISA generally preempts state laws that relate to any employee benefit plans).

<sup>80</sup> See *Pegram v. Herdrich*, 530 U.S. 211, 237 (2000) (holding that "mixed eligibility decisions by HMO physicians are not fiduciary decisions under ERISA"); *Rush Prudential HMO v. Moran*, 536 U.S. 355 (2002) (finding Illinois statute not subject to preemption, Court noted, "that regulating insurance tied to what is medically necessary is probably inseparable from enforcing the quintessentially state-law standards of reasonable medical care"). See generally *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 339-40 (2003) (stating that use of McCarran-Ferguson case law in ERISA context had "misdirected attention, failed to provide clear guidance to lower federal courts, and, as this case demonstrates, added little to the relevant analysis").

<sup>81</sup> See *Pegram* 530 U.S., at 215-16. Cynthia Herdrich sued under a negligence theory to recover for injuries that her MCO allegedly caused by her physician's failure to order an ultrasound that would have revealed appendicitis. *Id.* Her physician had scheduled her ultrasound at an MCO-affiliated facility that was less expensive, yet further away than the local hospital. *Id.* Herdrich claimed that the third-party administrator, a physician-owned MCO, failed to provide medically necessary treatment and thereby breached its fiduciary duty under ERISA. *Id.*

<sup>82</sup> See *Rush*, 536 U.S., at 360-61, 386-91. Moran suffered a shoulder affliction for which her primary care physician recommended an unconventional treatment by a specialist not affiliated with Rush HMO. *Id.* at 360. Her request for coverage was denied on the grounds that it was not medically necessary. *Id.* The Court subsequently held that the Illinois act entitling her to exercise her right to an independent external review of Rush's finding that the requested surgery was not medically necessary, regulates insurance under the common sense test because it is directed at HMOs that perform the essential function of the insurance business—underwriting and spreading risk among its participants. *Id.* at 386-87. Justice Thomas noted in his dissenting opinion that the insurer's decision to deny benefits to the plaintiff in this case was entirely informed, consulting numerous other physicians and literature. *Id.* at 390-91.

<sup>83</sup> See Christine Flood, *Supreme Court Holds ERISA Does Not Preempt Illinois Independent Review Law—Rush Prudential HMO, Inc. v. Moran*, 28 AM. J. L. & MED. 509, 512-13 (2002) (stating that "the *Moran* decision marks a victory for states in their attempt to regulate HMOs and protect patients' rights without running afoul of ERISA"); Thomas R. McLean, M.D. & Edward P. Richards, *Managed Care Liability for Breach of Fiduciary Duty After Pegram v. Herdrich: The End of ERISA Preemption for State Law Liability for Medical Care Decision Making*, 53 FLA. L. REV. 1, 28-29 (2001) (stating that *Pegram* ratifies view that "ERISA's preemption shield is not available for administrative malfeasance in the delivery of health care"); Jackson, *supra* note 29, at 216-17 (noting that *Pegram* partially exposed MCOs to state law malpractice claims while *Moran* clarified status of HMOs as both health care providers and insurers).



## 1. Pegram v. Herdich

The Supreme Court held, in part, in *Pegram* that mixed eligibility decisions – those that are both medical and administrative – by health maintenance organization physicians are not fiduciary decisions<sup>84</sup> under ERISA,<sup>85</sup> and thus are not preempted. As Justice Souter explained on behalf of the unanimous *Pegram* Court, the threshold question the court must address is whether the “person employed to provide services under a plan. . . was acting as a fiduciary when taking the action subject to complaint.”<sup>86</sup> Claims of breach of fiduciary duty are traditionally preempted.<sup>87</sup> This creates a regulatory vacuum<sup>88</sup> where claims in state law tort and contract actions are preempted by ERISA when the preemption clause is interpreted broadly,<sup>89</sup> yet they are limited if any available remedies under

<sup>84</sup> *Pegram*, 530 U.S. at 217 (holding that “mixed eligibility decisions by HMO physicians are not fiduciary decisions under ERISA”). *But see* *Mertens v. Hewitt Assoc.*, 508 U.S. 248, 251-52 (1993) (finding that anyone “who exercises discretionary control or authority over the plan’s management, administration, or assets. . . is an ERISA fiduciary”); *Varity Corp v. Howe*, 516 U.S. 489 (1996) (holding fiduciaries may be liable to plan participants or managed care enrollees for coverage decisions and selection and monitoring of members of the provider network).

<sup>85</sup> *See Pegram*, 530 U.S. at 237 (holding that Herdrich’s mixed administrative ERISA complaint fails to state ERISA claim).

<sup>86</sup> *Id.* at 226.

<sup>87</sup> *See* *Smith v. Provident Bank*, 170 F.3d 609, 613-14 (6th Cir. 1999) (preempting claim for fiduciary breach but allowing claims against non-fiduciaries); *Kramer v. Smith Barney*, 80 F.3d 1080, 1083-84 (5th Cir. 1996) (noting that ERISA requires fiduciaries to discharge their duties solely in interest of participants and beneficiaries, using care, skill, prudence and diligence, and provides civil enforcement remedies for breach of such duty); *see also* *Rutledge v. Seyfarth, Shaw, Fairweather & Geraldson*, 201 F.3d 1212, 1217 (9th Cir. 2000), *opinion amended*, 208 F.3d 1170 (9th Cir. 2000), *cert. denied*, 531 U.S. 992 (2000) (holding that state law claims alleging excessive fees are preempted because receipt of such fees would constitute a prohibited transaction).

<sup>88</sup> *See* Wendy K. Mariner, *State Regulation of Managed Care and the Employee Retirement Income Security Act*, 335 NEW ENG. J. MED. 1986 (1996) (discussing ERISA’s lack of substantive regulation and obstruction of certain state regulation); *see also* Flood, *supra* note 83, at 512 (noting that “ERISA’s lack of substantive regulation, coupled with broad preemption of state laws, relegates ERISA plans to a regulatory vacuum”). *See generally* Dawn Marie Kelly, *The Effect of Pegram v. Herdrich on HMO Liability*, 17 *TOURO L. REV.* 841, 852 (Summer 2001) (stating that Supreme Court utilized two-part test to determine whether state law was intended to be preempted by ERISA).

<sup>89</sup> *See, e.g.,* *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 49-50 (1987) (discussing claims brought by petitioner under Mississippi common law tort and breach of contract theories). *See generally* Kelly, *supra* note 88, at 851 (stating that Congress used language that can be interpreted to connect almost any law to employee benefit plan); Heather E. Rochet, *Trilogy of Cases Narrow Scope of ERISA Preemption: Survival of State Law Claims Regarding Negligent Quality of Care Under ERISA Plans in Light of Travelers, Dukes, and Herdrich*, 40 *BRANDEIS L.J.* 827, 834 (Spring 2002) (claiming that preemption clause was originally construed broadly by Supreme Court).

ERISA are for non-fiduciaries.<sup>90</sup> By holding that “mixed eligibility decisions”<sup>91</sup> by medical directors are not preempted by ERISA, the *Pegram* Court paved the way for patients to challenge benefit denials made by medical professionals who deny coverage, even in spite of contrary recommendations made by primary care physicians intimately acquainted with a patient’s medical history.<sup>92</sup> It is important to note the relatively narrow context of the *Pegram* decision, which held only that challenges to adverse benefits decisions, in which a medical director’s decision involved an analysis of the “how” and “when” of a proposed treatment, were not preempted by ERISA, and should be pursued under state medical malpractice or other relevant common law tort theories.<sup>93</sup>

## 2. Rush Prudential HMO, Inc. v. Moran

The Supreme Court’s decision in *Rush* marked the third time in four years that the Court considered an ERISA preemption

<sup>90</sup> See ZANGLEIN, *supra* note 37, at 318 (citing *Mertens v. Hewitt Assoc’s*, 508 U.S. 248 (1993)) (noting that money damages against nonfiduciary service providers are not available under ERISA, even where such service providers participate in plan fiduciary’s breach of duty); Boos, *supra* note 5, at 83-84 (noting Court’s ruling that “administrators working through their doctors when making mixed eligibility decisions are not acting as fiduciaries”). See generally Weisenborn, *supra* note 79, at 150 (establishing that ERISA’s preemption is not unlimited).

<sup>91</sup> See *Pegram v. Herdrich*, 530 U.S. 211, 237 (2000) (holding mixed eligibility decisions by health maintenance organization physicians are not fiduciary decisions under ERISA); see also Osgood, *supra* note 20, 877-82 (quoting *Pegram*) (examining the *Pegram* Court’s ruling that fiduciary decisions or obligations “can apply to managing, advising, and administering an ERISA plan,” which includes exercising “discretionary authority or discretionary responsibility in the administration of [an ERISA] plan,” and holding that medical necessity decision is an “inextricably mixed” medical administrative decision, and that such “mixed eligibility” decisions that MCO makes through its physicians are not fiduciary decisions under ERISA).

<sup>92</sup> See Boos, *supra* note 5, at 65 (noting that Supreme Court’s decision in *Pegram* has created new line of attack against MCOs); see also *Pegram*, 530 U.S. at 228-29 (acknowledging that pure eligibility decisions, “simple yes-or-no questions, like whether appendicitis is a covered condition,” are likely rare, and defining mixed decisions as more common, such as “whether one treatment option is so superior . . . and needed so promptly, that a decision to proceed would meet the medical necessity requirement”); Scott M. Riemer, *HMOs Face a Post-Pegram World*, 224 N.Y.L.J. 1, 1 (July 13, 2000) (stating that patient may challenge denial to receive 24 hours of care).

<sup>93</sup> See *Pegram*, 530 U.S. at 236-37 (stating Court’s position that Congress did not have in mind, nor is there anything to be gained, by opening federal courthouse doors to fiduciary malpractice claims); Boos, *supra* note 5, at 65 (stating that fear of flood of new litigation was unfounded); Riemer, *supra* note 92 (asserting that *Pegram* states that to extent state malpractice actions do not assert claims challenging “eligibility,” they are not preempted).

case.<sup>94</sup> *Rush* is the most recent case to address where the seemingly endless ERISA preemption wanes and where permissible state regulation begins.<sup>95</sup> Writing for the majority,<sup>96</sup> Justice Souter appropriately noted that ERISA “seems simultaneously to preempt everything and hardly anything,”<sup>97</sup> declaring simply that the Court has “no choice” but to temper the assumption that “the ordinary meaning . . . accurately expresses the legislative purpose.”<sup>98</sup> The *Rush* court held that the state law at issue did not create an alternate state remedy that conflicted with ERISA’s federal remedies, and was therefore saved from preemption.<sup>99</sup>

<sup>94</sup> See *Supreme Court Agrees to Consider Another ERISA Preemption Case*, MANAGED CARE WEEK, Nov. 10, 2003, at 4 (noting, in April 2003, Supreme Court upheld Kentucky “any willing provider” law in *Kentucky Assn. of Health Plans, Inc., et al. v. Miller*; in June 2002 upheld Illinois “external review” law in *Rush Prudential HMO, Inc. v. Moran* and in June 2000 ruled in *Pegram v. Herdrich* that HMOs could not be sued over use of physician financial incentives to limit care); Marcia Coyle, *50 Laws on HMOs? Arguments Coming Today on Whether Federal Acts Preempts States’ Right to Order Reviews of Disputed Medical Decisions*, MIAMI DAILY BUS. REV., Jan. 16, 2002, at A9 (stating that Supreme Court is once again venturing into managed health care arena in *Rush* decision); Marcia Coyle, *Health Firms Lose a Big Case Ruling is a Boost to State Regulation*, NAT’L L.J., Apr. 7, 2003, at A1 (stating that *Rush* and *Kentucky* cases will be end of managed health care era “as we know it”).

<sup>95</sup> See Flood, *supra* note 83, at 511 (noting that Court considered whether Illinois Act satisfied McCarran-Ferguson three-factor test, which determines that “a state law regulates insurance if the practice it regulates (1) transfers or spreads policyholders’ risk; (2) is an integral part of the relationship between insurer and insured because it affects the substantive terms of the policy; or (3) is limited to entities within the insurance agency”); Don R. Sampen, *States Have Authority to Protect HMO Patients*, CHICAGO DAILY L. BULL., July 16, 2002, at 16 (stating that Supreme Court recently held that Illinois Health Maintenance Organization Act provision is not preempted by ERISA); *Who Governs the HMOs?*, BROWARD DAILY BUS. REV., Nov. 25, 2002, at A15 (noting that on June 20, 2002, Supreme Court recognized that states have more freedom than formerly assumed to regulate HMOs that serve ERISA plans).

<sup>96</sup> See *Rush Prudential HMO v. Moran*, 536 U.S. 355, 358 (2002) (Justice Souter was joined by Justices Stevens, O’Connor, Ginsburg and Breyer).

<sup>97</sup> *Rush*, 536 U.S. at 389.

<sup>98</sup> *Id.* (expressing frustration with occupation of court’s time by “unhelpful drafting of these antithetical clauses,” citing *Egelhoff v. Egelhoff*, 532 U.S. 141, 149 (2001); *California Div. of Labor Standards Enforcement v. Dillingham Constr., N. A., Inc.*, 519 U.S. 316 (1997); and *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985)).

<sup>99</sup> *Rush*, 536 U.S. at 387 (stating that as health care is traditionally relegated to state realm, “there is no ERISA preemption without clear manifestation of congressional purpose”); see David L. Trueman, *Will the Supreme Court Finally Eliminate ERISA Preemption?*, 13 ANN. HEALTH L. 427, 461–62 (Summer 2004) (noting that *Rush* lends support to “the contention that health care regulation is a matter of traditional state interest”); Joseph DeMarzo & Michael H. Zhu, *The Impact of Rush on Independent External Review of HMO Care Decisions*, MED. MAL. LAW & STRATEGY, Sept. 2002, at 1 (analyzing briefly, but comprehensively, majority’s application of McCarran-Ferguson factors to independent review law, as well as Court’s initial use of ‘common sense test’).

Here, the Court determined that a portion of an Illinois Act<sup>100</sup> requiring HMOs<sup>101</sup> to submit benefit denials to an independent<sup>102</sup> physician reviewer “in the event of a dispute between the primary care physician and the [HMO] regarding the medical necessity<sup>103</sup> of a covered service proposed by a primary care physician”<sup>104</sup> was a permissible state regulation of insurance<sup>105</sup> with which Rush Prudential had to comply.<sup>106</sup>

<sup>100</sup> Illinois Health Maintenance Organization Act, 215 ILL. COMP. STAT. ANN. 125/4-10 (2000).

<sup>101</sup> See Illinois Health Maintenance Organization Act, 215 ILL. COMP. STAT. 125/1-2(9) (2000) (defining “Health Maintenance Organization” as any organization formed under laws of Illinois or another state “to provide or arrange for one or more health care plans under a system which causes any part of the risk of health care delivery to be borne by the organization or its providers”); see also *Rush*, 536 U.S. at 371–72 (noting general definition of HMO under Illinois law includes not only organizations that “provide” health care plans, but those that “arrange for” them to be provided, so long as any part of risk of health care delivery rests upon organization or its providers); *An Overview of Illinois Insurance Licensure Issues in Provider Network Development*, ILL. HEALTH L. UPDATE, Mar. 1995, at 1 (stating that under narrow construction of HMO Act, HMO is any organization which accepts capitated payments with HMO license).

<sup>102</sup> See *Rush*, 536 U.S. at 361–62 (defining “independent physician reviewer” as unaffiliated with HMO and jointly selected by HMO and patient, and further noting that if independent reviewer decides that treatment is medically necessary covered service under contract, HMO must provide covered service); *Highest U.S., MD Courts Ok State Independent Review Laws*, DAILY RECORD, Mar. 15, 2003, at 1 (noting that independent physician review must be conducted to determine what is medically necessary); Don R. Sampen, *7th Circuit Cracks Open Door for Illinois HMO Patients*, CHICAGO DAILY L. BULL., Nov. 7, 2000, at 6 (discussing *Rush* decision upholding Illinois requirement that HMOs submit to independent physician review procedure).

<sup>103</sup> See *Rush*, 536 U.S. at 361. It is important to note that the Illinois statute only required review of a decision made on the basis of a treatment or service’s “medical necessity.” *Id.* It did not require review of an HMO’s decision that the treatment or surgery is not covered by the contractual terms of the agreement between the patient and the HMO. *Id.* See *Highest U.S., MD Courts Ok State Independent Review Laws*, *supra* note 102, at 1. The author emphasized that, under Illinois law, independent review is limited to a consideration of what is medically necessary. *Id.* Patricia Manson, *Ruling Against HMO Spurs Protest by 4 Appeals Judges*, CHICAGO DAILY L. BULL., Oct. 20, 2000, at 3. The article noted that Illinois law requires HMO to provide coverage if independent physician who conducts review determines that treatment is medically necessary. *Id.*

<sup>104</sup> *Rush*, 536 U.S. at 361.

<sup>105</sup> See 29 U.S.C. § 1144(b)(2)(A) (stating that nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities) (*emphasis added*); see also Flood, *supra* note 83, at 511 (analyzing majority’s application of McCarran-Ferguson test which states that “a state law regulates insurance if the practice it regulates (1) transfers or spreads policyholders’ risk” (which is a characteristic inherent in an HMO as well as an insurance company); “(2) is an integral part of the relationship between insurer and insured because it affects the substantive terms of the policy; or (3) is limited to entities within the insurance agency,” subsequently noting that Illinois Act satisfied later two of these factors, and that satisfaction of only one is required in order for statute to be deemed regulation of insurance). *But see* Kentucky Assoc. of Health Plans v. Miller, 538 U.S. 329, 480 (2003) (believing that Court’s use of McCarran-Ferguson case law in ERISA context has misdirected attention, failed to provide clear guidance to lower federal courts and . . . added little to the relevant analysis).

Justice Souter announced that ERISA merely requires plans to provide internal appeals of benefits denials,<sup>107</sup> a process in which the Illinois statute played no role, instead "providing for extra review once the internal process is complete."<sup>108</sup>

Further, the Court noted that when an HMO provides a contractual guarantee of medically necessary care, "determinations of coverage cannot be untangled from physicians' judgments about reasonable medical treatment."<sup>109</sup> The Court concluded that the prevailing "combination of insurer and provider" remains a "dominant feature" of managed care.<sup>110</sup> The majority held that HMOs financial risk-bearing brings their coverage decision-making within the scope of the savings clause.<sup>111</sup> Justice Souter wrote, "Rush cannot checkmate common sense by trying to submerge HMOs' insurance features beneath an exclusive characterization of HMOs as providers of health care."<sup>112</sup>

The ultimate effect of this landmark decision is that HMOs are now forced to seriously consider those state independent review laws<sup>113</sup> that have yet to be litigated in federal courts,<sup>114</sup> as well

<sup>106</sup> See *Rush*, 536 U.S. at 364, 387 (discussing and ultimately affirming 7th Circuit holding that Illinois HMO Act regulated insurance and that "independent review requirement [was not that] different from a state-mandated contractual term" that Court "had held to survive ERISA preemption"); see also *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959 (7th Cir. 2000) (citing *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 375-376 (1999)).

<sup>107</sup> ERISA 29 U.S.C. § 1133(2).

<sup>108</sup> See *Rush*, 536 U.S. at 385.

<sup>109</sup> *Id.* at 383 (citing *Pegram v. Herdrich*, 530 U.S. 211, 229 (2000)) (noting that according to Illinois Act independent examiners must be physicians with credentials similar to those of primary care physicians, and are expected to exercise independent medical judgment in deciding what medical necessity requires).

<sup>110</sup> See *Rush*, 536 U.S. at 370.

<sup>111</sup> See *id.* at 355, 372 (explaining that Congress, prior to ERISA's passage, "demonstrated an awareness of HMOs as risk-bearing organizations subject to state insurance regulation," while Illinois law defines HMOs, in terms of risk bearing, as having taken over much business formerly performed by traditional indemnity insurers, and are almost universally regulated as insurers).

<sup>112</sup> *Id.* at 370.

<sup>113</sup> See DeMarzo, *supra* note 99, at 1 (emphasizing importance of legitimization of legislative initiatives in 40 other states (and District of Columbia) where similar independent review panels were established to review HMO decisions); see also Lindsey Gastright Churchill, *Rush Prudential HMO v. Moran: Federal Intervention Looms as Supreme Court Rules That ERISA Does Not Preempt State Laws Requiring Independent Review of Medical Necessity Decisions and Lays Groundwork for Different Independent Review Provisions From All Fifty States*, 19 GA. ST. U.L. REV. 535, 562 (2002) (stating that benefit administrators will have to make determinations based on independent review laws). See generally Jake Griffin, *HMO Lawsuit Ruling Paves Way for Second Opinions*,

as those that had been held to be preempted prior to the *Rush* decision,<sup>115</sup> and are now unable to rely solely on preemption to rescue any number of negligent coverage decisions from the rarely forgiving grip of state courtrooms obeying state laws.<sup>116</sup> However, *Rush* is not as sweeping a decision as it may seem on its face. The Court's ruling does not cover approximately fifty million Americans<sup>117</sup> who get their insurance through employers who self-fund health benefits.<sup>118</sup> ERISA's "deemer clause"

CHI. DAILY HERALD, June 21, 2002, at 1 (noting that patients will now have opportunity to seek second opinions in independent review boards).

<sup>114</sup> See, e.g., *Connecticut General Life Insurance Co. v. Maryland*, 123 S. Ct. 1964 (2003) (dismissing petition filed by CIGNA, subsidiary Connecticut General Life, seeking review of Maryland's external review law where petitioner alleged that ERISA preempted internal and external review processes required under 1998 Maryland law, and Maryland Court of Appeals held law fell within savings clause as regulating insurance); see also George A. Lyden, *HMO Liability In New York: How Pegram v. Herdrich and Right-to-Sue Statutes Have Created New Alternatives For HMO Enrollees*, 7 QUINNIPIAC HEALTH L.J. 43, 54-55 (2003) (noting that, after *Pegram* and *Rush*, cases against HMOs will be increasingly decided in state rather than federal courts). But see Churchill, *supra* note 113, at 565 (arguing that congressional patient rights legislation is imminent and will provide for uniform independent review mechanism).

<sup>115</sup> See, e.g., *Supreme Court Agrees to Consider External Review Law in January*, STATE HEALTH MON., Dec. 1, 2001, at 1 (noting, prior to *Rush*, that there were independent review laws for commercial enrollees in place in some 40 states and nationally for Medicare+Choice program); *The Fifth Circuit Court of Appeals Refused to Reconsider its Decision to Strike Down the Independent Review Portion of Texas' HMO Liability Law*, MANAGED MEDICARE & MEDICAID, Aug. 14, 2000 (presenting Fifth Court's holding that ERISA preempts Texas independent review law); see also Sarah Lueck, *Court Backs Patient Appeals in Battle over HMO Coverage*, WALL STREET J., June 21, 2002, at A1 (stating that 42 states and District of Columbia had adopted independent review laws by 2002).

<sup>116</sup> See *Dearmas v. Av-Med, Inc.*, 865 F. Supp. 816, 818 (S.D. Fla. 1994) (finding that action seeking to hold health plan vicariously liable for negligent actions of physician is not preempted by ERISA, and ultimately remanding case for lack of jurisdiction to state court); see also *Nealy v. US Healthcare HMO*, 93 N.Y.2d 209, 221 (N.Y. 1999) (quoting *Boggs v. Boggs*, 520 U.S. 833, 841 (1997)) (stating that there is nothing about plaintiff's claims [for medical malpractice and breach of contract] that "conflict[] with the provisions of ERISA or operates to frustrate its [objectives];" to the contrary, plaintiff's claims are consistent with ERISA's "principal object": protection of plan participants and beneficiaries); *Pappas v. Asbel*, 675 A.2d 711, 717 (Pa. Super. Ct. 1996) (reasoning that because ERISA was enacted prior to advent of cost-containment and HMOs, Congress could not have envisioned nor intended resultant foreclosure of recovery to plan beneficiaries injured by negligent medical decisions, subsequently holding that HMOs may be sued in state court on negligence claims).

<sup>117</sup> See *DeMarzo*, *supra* note 99, at 1 (speculating that fifty million Americans now get insurance through employers who self-fund health benefits). See generally Fred J. Hellinger, *The Expanding Scope of State Legislation*, 276 JAMA 1065, 1066 (1996) (noting that in 1993 roughly forty-four million people were enrolled in self-funded employee health plans governed by ERISA); *Supreme Court Solicits Input on Self-funded Health Plan Case*, DALLAS MORNING NEWS, Nov. 11, 1997 (stating that at least 44 million employees are covered by self funded employee health plans).

<sup>118</sup> See Edward Albuoro Morrissey, *Deem and Deemer: ERISA Preemption Under the Deemer Clause as Applied to Employer Health Care Plans with Stop-Loss Insurance*, 23 J. LEGIS. 307, 308-09 (1997) (explaining any state law purporting to regulate insurance, as applied to health care plan "established or maintained by an employer," would fall within

provides an exception to its savings clause that forbids states from regulating self-funded plans as insurers.<sup>119</sup> Nor does the decision standardize external review rules, which still may vary from state to state.<sup>120</sup>

It is impossible, however, to ignore that the *Rush* decision, unlike *Pegram*, was the result of a deep divide within the Court. Justice Thomas issued a dissent<sup>121</sup> in which he noted that despite the "panoply of remedial devices"<sup>122</sup> available to Ms. Moran under ERISA, she decided to "short circuit"<sup>123</sup> those remedies through the "arbitral-like mechanism"<sup>124</sup> under the

scope of deemer clause and thus be preempted by ERISA); see also *Some Small Firms Embrace Self-Funding, But Experts Warn That Risks Abound*, MANAGED CARE WEEK, Oct. 27, 2003, at 1 (acknowledging "certain state mandates that apply to insured programs do not apply to self-insured programs because the Employee Retirement Income Security Act exempts self-funded plans from many state insurance regulations"). See generally Edward A. Zelinsky, *Against a Federal Patients' Bill of Rights*, 21 YALE L. & POL'Y REV. 443, 464 (2003) (arguing that ERISA § 514 (currently § 1144) should be amended to allow for state regulation of self-funded plans).

<sup>119</sup> See *Rush Prudential HMO v. Moran*, 536 U.S. 355, 372 n.6 (2002), (citing *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990)) (remarking that ERISA's "deemer" clause provides exception to its savings clause that forbids states from regulating self-funded plans as insurers and thus, that Illinois' Act would not be "saved" as insurance law to extent it applied to self-funded plans); see also Zelinsky, *supra* note 118, at 464 (stating that deemer clause prevents state regulation of self-funded plans). See generally Morrissey, *supra* note 118, at 308-09 (noting that deemer clause applies to self-funded plans).

<sup>120</sup> See DeMarzo, *supra* note 99, at 1 (stating that external review rules vary from state-to-state); see also McLean, *supra* note 69, at 319 (stating that *Rush* authorizes states to impose administrative due process (e.g., third-party review of the MCOs' decisions) on MCOs, but sets no standards for review). See generally Churchill, *supra* note 113, at 565 (arguing for congressional patient rights legislation that would provide a uniform independent review mechanism).

<sup>121</sup> *Rush*, 536 U.S. at 388 (presenting Justice Thomas' dissent joined by Chief Justice Rehnquist, Justice Scalia and Justice Kennedy); see also *Rush Pru Decision Leaves Health Plans With Broadly Varied State Appeals Laws*, MANAGED CARE WEEK, June 24, 2004, at 1 (describing arguments of dissent by Justice Thomas that ERISA was designed to protect employer benefit plans from widely varying state regulation); Matkov, Salsman, Madoff & Gunn, *HMO ruling may raise health care costs*, ILL. EMP. L. LETTER, Oct. 2002, at 1 (analyzing Thomas' arguments that Court's decision disintegrates uniformity of ERISA that Congress intended).

<sup>122</sup> *Rush*, 536 U.S. at 394 n.5 (Thomas, J., dissenting) (citing *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)) (noting that "commonly included in the panoply constituting part of this enforcement scheme are: suits under § 502(a)(1)(B) [currently 29 U.S.C. § 1132(a)(1)(B)] (authorizing an action to recover benefits, obtain a declaratory judgment that one is entitled to benefits and to enjoin an improper refusal to pay benefits), suits under § 502(a)(2) [currently § 1132(a)(2)] and 409 (authorizing suit to seek removal of the fiduciary), and a claim for attorney's fees under § 502(g) [currently § 1132(g)]").

<sup>123</sup> *Id.* at 389.

<sup>124</sup> *Id.* at 394-96 (arguing that "as a binding decision on the merits of the controversy the § 4-10 review resembles nothing so closely as arbitration" because "the decision of the § 4-10 medical reviewer is ultimately enforceable through a suit under § 502(a) of ERISA,"

Illinois act.<sup>125</sup> The crux of the dissent's objection to the statute was that it added to or supplemented the remedies available under ERISA, and should therefore be preempted.<sup>126</sup>

After the recent *Travelers*, *Rush* and *Pegram*<sup>127</sup> decisions, there remains a complex and evolving body of law regarding HMO liability and ERISA preemption. Liability may depend on any number of theories,<sup>128</sup> as well as upon whether the plan is an ERISA-qualified plan, whether the plan is self-funded<sup>129</sup> and, mostly, upon prevailing judicial attitudes towards ERISA

and "[l]ike the decision of any arbitrator, it is enforceable through a subsequent judicial action" following limited judicial review).

<sup>125</sup> See *id.* at 392, 395 (2002). Justice Thomas asserted that "although a contractual agreement to arbitrate – which does not constitute a 'state law' relating to 'any employee benefit plan' – is outside § 514(a) of ERISA's preemptive scope, states may not circumvent ERISA preemption by mandating an alternative arbitral-like remedy as a plan term enforceable through an ERISA action. *Id.* at 395. In addition, Justice Thomas conceded that "the majority [was] correct that § 4-10 [of the Illinois statute] does not mirror all procedural and evidentiary aspects of 'common arbitration.'" *Id.*

<sup>126</sup> See *id.* at 401 (stating that § 4-10 is perfect example of state law that should be "pre-empted in accordance with ordinary principles of conflict preemption" because it "provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme"); see also *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987) (declaring that "[t]he expectations that a federal common law of rights and obligations under ERISA - regulated plans would develop . . . would make little sense if the remedies available to ERISA participants and beneficiaries could be supplemented or supplanted by varying state laws"); *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985) (stressing that Congress did not "intend to authorize other remedies that it simply forgot to incorporate expressly").

<sup>127</sup> *Accord Ky. Ass'n of Health Plans v. Miller*, 538 U.S. 329, 333-34, 341-42 (2003) (upholding Kentucky's 'any willing provider law' in spite of HMOs' claims that ERISA preempted state's regulation of providers, who were held to be incidental to regulation of insurance and therefore saved from preemption).

<sup>128</sup> See *Yanez v. Humana Med. Plan, Inc.*, 969 F. Supp. 1314, 1316 (S.D. Fla. 1997) (announcing that "courts have found that tort actions that seek to hold defendant health maintenance organizations vicariously liable for medical malpractice are not preempted by ERISA"); see also Gail B. Agrawal & Mark A. Hall, *Health Law Symposium: What If You Could Sue Your HMO? Managed Care Liability Beyond the ERISA Shield*, 47 ST. LOUIS L.J. 235, 236 (2003) (maintaining that ERISA's ability to prevent state laws depends on which theory of liability is asserted); Peter J. Hammer, *Pegram v. Herdrich: On Peritonitis, Preemption, and the Elusive Goal of Managed Care Accountability*, 26 J. HEALTH POL. POL'Y & L. 767, 771 n.2 (2001) (posing question "[f]or what theory should the plan be held accountable" and listing several possible theories).

<sup>129</sup> See Hammer, *supra* note 128, at 771 n.2 (articulating that liability depends on ERISA qualification and funding); *Ky. Ass'n of Health Plans*, 538 U.S. at 336 n.1 (2003) (asserting that "ERISA's savings clause does not require that a state law regulate 'insurance companies' or even 'the business of insurance' to be saved from preemption; it need only be a 'law . . . which regulates insurance,' and self-insured plans engage in same sort of risk pooling arrangements as separate entities that provide insurance to employee benefit plan.") (*emphasis in original*). See generally *Hutchinson v. Benton Casing Serv., Inc.*, 619 F. Supp. 831, 835 (S.D. Miss. 1985) (reiterating that ERISA's savings clause prevents preemption of state law which "regulates insurance").



preemption.<sup>130</sup> That body of law is expected to be narrowed, if not relieved from its burden of complexity, by the Supreme Court's decision in *CIGNA Healthcare of Texas v. Calad* and *Aetna Healthcare Inc. v. Davila*.<sup>131</sup>

### III. CONSIDERATIONS OF FEDERALISM AND PUBLIC POLICY

#### A. Areas of Traditional State Concern

An important premise of preemption jurisprudence is that the Supreme Court has never "assumed lightly that Congress has derogated state regulation,"<sup>132</sup> but instead has begun each preemption analysis with the traditionally strong presumption<sup>133</sup> that Congress does not intend to supplant state law.<sup>134</sup> In cases

<sup>130</sup> See Hammer, *supra* note 128, at 771 n.2 (detailing system's 'patchwork nature' and stating near impossibility of answering legal questions concerning managed care liability with any level of specificity, other than "it depends"); Friedelbaum, *supra* note 12, at 1245-47 (explaining "contemporary judicial federalism has passed through several phases, revealing its remarkable pliancy and adaptability"); see also Harris v. Mut. of Omaha Cos., 1992 U.S. Dist. LEXIS 21393, at \*1 (S.D. Ind. 1992) (highlighting that "[d]espite rumors to the contrary, those who wear judicial robes are human beings, and as persons, are inspired and motivated by compassion as anyone would be").

<sup>131</sup> See *Aetna Health Inc. v. Davila*, 124 S. Ct. 462 (2003) (granting certiorari), *rev'd*, 124 S. Ct. 2488 (2004); *CIGNA HealthCare of Tex., Inc. v. Calad*, 124 S. Ct. 463 (2003) (providing grant of certiorari), *rev'd*, 124 S. Ct. 2488 (2004); see also Edward F. McArdle, 2002-2003 Survey of New York Law: Health Law, 54 SYRACUSE L. REV. 1179, 1230 (2004) (suggesting that these decisions will allow Supreme Court to decide whether "state law medical malpractice and personal injury actions . . . survive ERISA preemption"); *Supreme Court to decide if HMOs May Be Sued in State Court*, *supra* note 3 (describing arguments from both sides and noting that "the cases . . . are being closely watch by insurers and employer groups").

<sup>132</sup> N.Y.S. Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 654 (1995)..

<sup>133</sup> *Id.* (specifying that this ERISA analysis begins with a "presumption that Congress does not intend to supplant state law"); see also Boos, *supra* note 5, at 91 (reiterating existence of "starting presumption" in dealing with issues that involve fields traditionally 'occupied' by states). See generally Susan Raeker-Jordan, *A Study in Judicial Sleight of Hand: Did Geier v. American Honda Motor Co. Eradicate the Presumption Against Preemption?*, 17 BYU J. PUB. L. 1, 36 (2002) (emphasizing Egelhoff Court's statement that "there is indeed a presumption against preemption in areas of traditional state regulation such as family law . . . [b]ut that presumption can be overcome where . . . Congress has made clear its desire for preemption").

<sup>134</sup> See *Travelers*, 514 U.S. at 654 (expressing starting presumption that "Congress does not intend to supplant state law"); see also *Maryland v. Louisiana*, 451 U.S. 725, 746 (1981) (establishing that judicial analysis "under the Supremacy Clause starts with the basic assumption that Congress did not intend to displace state law"); *Reid v. Colorado*, 187 U.S. 137, 148 (1902) (stating that "[i]t should never be held that Congress intends to supersede or by its legislation suspend the exercise of the police powers of the states, even when it may do so, unless its purpose to effect that result is clearly manifested").

where federal law is said to bar state action<sup>135</sup> in fields of traditional state regulation,<sup>136</sup> the Court quite naturally assumes that “the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.”<sup>138</sup> Throughout the vast history of judicial preemption analysis, the Supreme Court has balanced the need for “national uniformity of regulation, the free flow of interstate commerce, and representative government, against the states’ interests in regulating to promote the health and safety of the local community.”<sup>139</sup> Both healthcare<sup>140</sup> and insurance

<sup>135</sup> See *Egelhoff v. Egelhoff*, 532 U.S. 141, 144, 151 (2001) (holding that ERISA preempted state statute which revoked designation of spouse as beneficiary automatically following divorce because it “conflicted with ERISA’s requirements” and “interfered with nationally uniform plan administration”); see also *Boggs v. Boggs*, 520 U.S. 833, 837, 844 (1997) (concluding that Louisiana’s community property and succession laws are preempted by ERISA due to “th[e] direct clash between [the] state law and the provisions and objectives of ERISA”). See generally Friedelbaum, *supra* note 12, at 1283 (surveying variety of cases where ‘traditional state concern’ is at issue, subsequently noting federalist revival on Supreme Court and existing opportunity for reinvented activism arising in conventional contexts).

<sup>136</sup> See *De Buono v. Nysa-Ila Med. & Clinical Servs. Fund*, 520 U.S. 806, 814 (1997) (affirming that “historic police powers of the State include the regulation of matters of health and safety”); see also *Hillsborough County v. Auto. Med. Lab. Inc.*, 471 U.S. 707, 719 (1985) (identifying plasmapheresis regulation as regulation of health and safety matters, and therefore “primarily, and historically, a matter of local concern”); *Napier v. Atl. C.L.R. Co.*, 272 U.S. 605, 610 (1926) (finding state requirements which promoted health and safety “proper exercise[s] of [the state’s] police power”).

<sup>138</sup> *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947). See e.g., *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 741 (1985) (declaring that presumption is against preemption, and we are not inclined to read limitations into federal statutes in order to enlarge their preemptive scope without indication in legislative history that Congress had such distinction in mind); *Jones v. Rath Packing Co.*, 430 U.S. 519 (1977) (noting that one field which Congress is said to have preempted – particular aspects of commerce – has been traditionally occupied by states, and as such requires showing that clear and manifest purpose of Congress was to preempt state authority); *Napier v. Atlantic Coast Line R. Co.*, 272 U.S. 605, 611 (1926) (theorizing that Congress’ intention to exclude states from exerting their police power in field of regulation of locomotive equipment must be clearly manifested in order for State authority to be preempted).

<sup>139</sup> Margaret J. Farrell, *ERISA Preemption and Regulation of Managed Health Care: The Case for Managed Federalism*, 23 AM. J. L. AND MED. 251, 259 (1997).

<sup>140</sup> See *Pegram v. Herdrich*, 530 U.S. 211, 237 (2000) (stating that in field of health care, which is traditionally regulated by states, there is no ERISA preemption without clear manifestation of congressional purpose); see, e.g., *N.Y.S. Conf. Of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654-56 (1995) (acknowledging that health care is historically a matter of state concern); *Hillsborough County v. Auto. Med Labs, Inc.*, 471 U.S. 707, 719 (1985) (noting that regulation of health and safety matters constitute primary and historical matters of local concern).

regulation<sup>141</sup> have long been considered areas of traditional state concern.<sup>142</sup>

### *B. Legislative Intent*

It is widely acknowledged that the enactment of ERISA was a congressional reaction to the failure of states to regulate corruption in union-dominated pension and benefit plans.<sup>143</sup> ERISA's purpose was "to protect interstate commerce and the interests of participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to Federal Courts."<sup>144</sup> The legislative history of the ERISA preemption provision<sup>145</sup> and its exceptions,

<sup>141</sup> See McCarran-Ferguson Act, codified at 15 U.S.C. §1011 (2004) (declaring that "continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States"); see, e.g., *Prudential Ins. Co. v. Benjamin*, 328 U.S. 408, 415-18 (1946) (discussing history of local insurance regulation); J. Haakon Knutson, *Credit Scoring in the Insurance Industry: Discrimination or Good Business?*, 15 LOY. CONSUMER L. REV. 315, 318-19 (2003) (noting traditional state law primacy in insurance industry regulation).

<sup>142</sup> See *California Div. of Labor Enforcement v. Dillingham Constr.*, 519 U.S. 316 (1997) (arguing that "reading of the preemption clause resulting in the preemption of traditionally state-regulated substantive law in those areas where ERISA has nothing to say would be 'unsettling'"); see, e.g., *Massachusetts v. Morash*, 490 U.S. 107, 119 (1989) (noting Congress' reluctance to interfere in traditional state matters); *Hillsborough County*, 471 U.S. at 719 (implying congressional deference for matters typically governed by states).

<sup>143</sup> See *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987) (stating ERISA's preemption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with task of coordinating complex administrative activities: a patch-work scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them.); see also Ochmann, *supra* note 46, at 581 (noting Congress' primary intent was to safeguard workers pension plan assets from corporate and union misappropriation as legislative provisions encompassed all employer-sponsored health benefit plans, except where employer is governmental or church entity); Rosenbaum, *supra* note 37, at 171 (asserting that ERISA resulted from congressional concern about states' inaction in regulating pension plans).

<sup>144</sup> Hummel, *supra* note 59, at 651.

<sup>145</sup> See generally *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 745-46 (1985) (setting forth legislative history of ERISA's preemption provision); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98-99 (1983) (discussing legislative debates over preemption clause and asserting that Congress rejected limited preemption clause for a broader one); Daniel M. Fox & Daniel Schaffer, *Health Policy and ERISA: Interest Groups and Semipreemption*, 14 J. HEALTH POL., POL'Y & L. 239 (1989) (summarizing ERISA's legislative history).

although often cited and hotly debated, is almost skeletal.<sup>146</sup> There is no discussion in that history of “the relationship between the general pre-emption clause and the saving clause, and indeed very little discussion of the saving clause at all.”<sup>147</sup>

In the early drafts of ERISA, the preemption clause<sup>148</sup> preempted only those state laws dealing with subjects regulated by ERISA.<sup>149</sup> The clause was inexplicably expanded ten days before congressional action<sup>150</sup> (and after the savings clause was authored in its present form) to state that the Act covered “any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.”<sup>151</sup> Even those courts broadly construing the preemption clause acknowledge “the change was made with little explanation by the Conference Committee, and there is no indication in the legislative history that Congress was aware of the new prominence given the saving clause in light of

<sup>146</sup> See *Shaw*, 463 U.S. at 98-99 (highlighting legislative concerns and intent for ERISA’s preemption clause); see also SUBCOMM. ON LABOR OF THE SENATE COMM. ON LABOR AND PUB. WELFARE, 94TH CONG., LEGISLATIVE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, 4771 (Comm. Print 1976) (stating “it is also intended that a body of Federal substantive law will be developed by the courts to deal with issues involving the rights and obligations under the private welfare and pension plans”); Rosenbaum, *supra* note 37, at 173 (acknowledging sparse legislative history of ERISA is revealed in *Shaw* and *Metropolitan Life*).

<sup>147</sup> *Metropolitan Life*, 471 U.S. at 745 (citing S 3589, 91st Cong., 2d Sess., § 14, 116 CONG. REC. 7284 (1970)). The Court theorizes that preemption clause was broadened out of fear that “state professional associations” would otherwise hinder development of such employee-benefit programs as “prepaid legal service programs.” *Id.* at 745. See 120 CONG. REC. 29197, 29933, 29949 (1974). Remarks regarding the preemption provision of Rep. Dent, Sen. Williams and Sen. Javits were recorded. *Id.* There is no suggestion that the preemption provision was broadened out of any concern about state regulation of insurance contracts, beyond what Sen. Javits stated was a general concern about “potentially conflicting State laws.” *Id.* at 29942.

<sup>148</sup> ERISA § 1144(a). In its current form, the preemption clause states that “the provisions of this sub-chapter . . . shall supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.” *Id.*

<sup>149</sup> See *Metropolitan Life*, 471 U.S. at 745-46 (noting that in ERISA’s early drafts, only state laws dealing with subjects regulated by ERISA were preempted); see also H. R. CONF. REP. NO. 93-1280, at 383 (1974) (stating “[T]he preemption provisions of title I are not to exempt any person from any State law that regulates insurance.”); Rosenblatt, *supra* note 37, at 173-74 (examining phrasing of prior bills [which had contained insurance savings clause, inserted to ensure consistency with McCarran-Ferguson Act] declaring that “nothing in the Act shall be construed to exempt or relieve any person from any law of any state which regulates insurance.”).

<sup>150</sup> See *Metropolitan Life*, 471 U.S. at 745 (stating that preemption clause was broadened at last minute with little explanation); Rosenblatt, *supra* note 37, at 174 (noting that House-Senate conference committee proposed two major changes 10 days before final congressional action on ERISA). See generally *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987) (describing preemption clause’s legislative history).

<sup>151</sup> 29 U.S.C. § 1144(a).

the rewritten preemption clause.”<sup>152</sup> The end result of this complicated last-minute modification was the creation of a statute that exempts state insurance laws from preemption, and then exempts ERISA plans themselves from state insurance regulation.<sup>153</sup> Since ERISA's enactment in 1974, the growth of managed care<sup>154</sup> has become an unbridled phenomenon that can only be described as unforeseeable.<sup>155</sup> It would be foolish to assume that Congress anticipated this burst of managed care activity<sup>156</sup> in the early 1970s and instituted ERISA with any anticipation or expectancy of the cost-containment measures,<sup>157</sup>

<sup>152</sup> *Metropolitan Life*, 471 U.S. at 745.

<sup>153</sup> See Rosenblatt, *supra* note 37, at 174 (noting conferees' failure to address why "a century of state insurance law and doctrine should be abandoned with no substantive federal standards being put in their place"); see also Farrell, *supra* note 139, at 265 (highlighting that self-insuring employers are legally free from both state laws relating to ERISA plans and state insurance regulation). See generally Howell E. Jackson, *Regulation in a Multisectoral Financial Services Industry: An Exploration Essay*, 77 WASH. U.L.Q. 319, 361 (1999) (explaining that Congress' decision to exempt ERISA plans from state insurance regulation has received "considerable criticism").

<sup>154</sup> See John G. Day, *Managed Care and the Medical Profession: Old Issues and Old Tensions The Building Blocks of Tomorrow's Health Care Delivery and Financing System*, 3 CONN. INS. L.J. 1, 22 (1996/1997) (describing rise of HMO membership from 3 million in 1970, to 9 million in 1980, to 34 million in 1990); see also Glodt, *supra* note 13, at 641 (explaining that HMO enrollment totaled over sixty million in 2000). See generally Nina J. Crimm, *Evolutionary Forces: Changes in For-Profit and Not-For-Profit Health Care Delivery Structures; A Regeneration of Tax Exemption Standards*, 37 B.C.L. REV. 1, 27-28 (1995) (explaining that, from 1970s and into 1990s, dramatic changes in health care industry have resulted from focus on managed care).

<sup>155</sup> See Rosenblatt, *supra* note 37, at 12 (emphasizing that 53 million more people were insured or self-insured by HMOs in 1990 than were in 1980); see also Marion Crain, *The Transformation of the Professional Workforce*, 79 CHI.-KENT. L. REV. 543, 581 (2004) (describing managed care as "phenomenon"). See generally Tracey Epps and Colleen M. Flood, *Have We Traded Away the Opportunity for Innovative Health Care Reform? The Implications of the NAFTA for Medicare*, 47 MCGILL L.J. 747, 785 (2002) (describing how HMO enrollment increased "dramatically" from 1980 to 1990).

<sup>156</sup> See Day, *supra* note 154, at 3 (explaining how health care expenditures have grown five times faster than gross domestic product); see also Vernellia R. Randall, *Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 PUGET SOUND L. REV. 1, 21-22 (1993) (exploring unexpected growth of 1980's HMOs, possibly by expansion of health maintenance to cover Medicaid and Medicare eligibles, despite discontinued government loans). See generally Domenick C. DiCicco, Jr., *HMO Liability for the Medical Negligence of Member Physicians*, 43 VILL. L. REV. 499, 502-03 (1998) (describing dramatic and "explosive" growth of HMOs as subsequent to enactment of the Health Maintenance Organization Act of 1973).

<sup>157</sup> See Ochmann, *supra* note 46, at 599 (describing how cost-containment practices can actually "trigger foreseeable injuries" when patients are denied medically necessary treatment); see also Jeffrey W. Stempel, *Recent Case Developments*, 6 CONN. INS. L.J. 207, 216 (1999/2000) (explaining case law that examines whether Congress was unaware of cost-containment measures utilized by HMOs when drafting ERISA). See generally Kenneth R. Wing, *The Impact of Reagan-Era Politics on the Federal Medicaid Program*, 33 CATH. U.L. REV. 1, 24 (1983) (noting that Carter's mandatory hospital cost-containment plan was "resoundingly defeated").

such as utilization review,<sup>158</sup> that would eventually result in the sort of coverage denials<sup>159</sup> that patients seek to question in state courts today.<sup>160</sup>

#### IV. ERISA AND THE FIFTH CIRCUIT<sup>161</sup>

##### A. Background

Ruby Calad became a member of CIGNA HealthCare of Texas, Inc., a Texas HMO, through her husband's employer.<sup>162</sup> Calad underwent a hysterectomy with rectal, bladder and vaginal repair, performed by a physician participating in the CIGNA network.<sup>163</sup> Although her treating physician recommended a longer stay, CIGNA's hospital discharge nurse, acting as a

<sup>158</sup> See Pittman, *supra* note 71, at 379 (purporting that Congress could not have predicted "interjection into the ERISA 'system' of the medical utilization review process"); see also Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1338 (5th Cir. 1992) (clarifying that many cost-containment features did not exist when Congress passed ERISA and that utilization review is "fundamental change" since implementation of ERISA). See generally Carla Jensen Hamborg, *Medical Utilization: The New Frontier for Medical Malpractice Claims?*, 41 DRAKE L. REV. 113, 138 (1992) (noting that pre-administration review of proposed treatments plays important role in cost containment function of HMOs).

<sup>159</sup> See Aetna Health Inc. v. Davila, 124 U.S. 2488, 2498 (2004) (holding that respondents' state law claims against an HMO based on injuries resulting from wrongful denials of benefits were preempted by ERISA); see also Corcoran, 965 F.2d at 1322-23 (finding that plaintiffs' wrongful death claim based on HMO's refusal to cover hospitalization which resulted in loss of her unborn child was preempted by ERISA). See generally Sharon Reece, *The Circuitous Journey to the Patients' Bill of Rights: Winners and Losers*, 65 ALB. L. REV. 17, 58 (2001) (commenting that ERISA "eliminates an important check on . . . medical decisions" and fosters "less deterrence of substandard medical decision making" by preempting state law claims based on coverage denials while not providing federal remedies).

<sup>160</sup> See, e.g., Davila, 124 U.S. at 2498 (highlighting respondents' claim that HMO's wrongful denial of coverage benefits caused them injury); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 56 (1987) (noting ERISA preemption of plaintiff's common law claim that HMO denied them benefits); Roark v. Humana, Inc., 307 F.3d 298, 302 (5th Cir. 2002) (illuminating how plaintiff's HMO negligently refused to cover doctor recommended treatment).

<sup>161</sup> See Corcoran, 965 F.2d at 1323 (holding ERISA preempts state law wrongful death claim, in which parents allege medical necessity coverage determination proximately caused death of unborn child, exemplifying Fifth Circuit's role as relative hotbed of ERISA litigation both prior to and after passage of the Texas Health Care Liability Act); see also Corporate Health Ins. Inc. v. Texas Dep't of Ins., 220 F.3d 641, 643-44 (5th Cir. 2000) (refusing to 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"). But see Roark, 307 F.3d at 305 (holding that plaintiffs' claims were not completely preempted by ERISA and noting that district court should have remanded such claims for further review).

<sup>162</sup> See Roark, 307 F.3d at 302 (relaying the facts of each plaintiff's complaint).

<sup>163</sup> *Id.* (describing plaintiff's surgery).

utilization reviewer,<sup>164</sup> made the ultimate decision that the standard, one day hospital stay would be sufficient.<sup>165</sup> Calad suffered a medical emergency that caused her to be readmitted a few days later.<sup>166</sup> She attributes these complications to her early release.<sup>167</sup>

Juan Davila received Aetna HMO coverage through his employer's health plan.<sup>168</sup> He is a post-polio patient who suffers from diabetes and arthritis.<sup>169</sup> His primary care physician prescribed Vioxx for Davila's arthritis pain.<sup>170</sup> The Court noted that studies have shown that Vioxx has a lower rate of gastrointestinal toxicity (e.g., bleeding, ulceration, perforation of the stomach) than do the other arthritis drugs on Aetna's formulary.<sup>171</sup> Before filling the prescription, Aetna required Davila to enter its "step program."<sup>172</sup> Davila would first have to try two different medications; only if he suffered a "detrimental reaction to the medications or failed to improve would Aetna evaluate him for Vioxx use."<sup>173</sup>

<sup>164</sup> *Id.* (noting action despite alternative recommendation); *see also* Ochmann, *supra* note 46, at 577 (defining utilization review as "external evaluations of medical decisions"); *see also* Reece, *supra* note 159, at 33 (explaining that HMOs perform utilization reviews to assess necessity of medical treatment, pre-treatment, that sometimes conflict with medical judgment). *See generally* Wickline v. State of California, 239 Cal. Rptr. 810, 811 (Cal. Rptr. 2d1986) (noting that, in utilization review, "authority for the rendering of health care services must be obtained before medical care is rendered").

<sup>165</sup> *Roark*, 307 F.3d at 302 (describing nurse's decision).

<sup>166</sup> *See id.* (specifying that Calad suffered from "complications").

<sup>167</sup> *See id.* (noting Calad's complaint that, as reviewed, "CIGNA had failed to use ordinary care in making its medical necessity decisions, CIGNA's system made substandard care more likely, and CIGNA acted negligently when it made its medical necessity decisions").

<sup>168</sup> *Id.* at 303 (discussing lawsuit brought by Davila against HMO).

<sup>169</sup> *Id.* (noting medical conditions suffered by Mr. Davila).

<sup>170</sup> *Id.* (stating medications prescribed for Mr. Davila's medical conditions).

<sup>171</sup> *Id.* (discussing studies have shown Vioxx's lower rate of gastrointestinal toxicity): *see also* My Dr., *Prescription Medications for Rheumatoid Arthritis*, available at <http://www.mydr.com.au/default.asp?article=2750> (last visited Oct. 28, 2004) (stating that two COX-2 specific inhibitors (coxibs) are available, celecoxib (e.g. Celebrex) and rofecoxib (e.g. Vioxx), and that coxibs are non-steroidal anti-inflammatory agents shown to have much lower rates of gastric ulcer associated with them than conventional, older NSAIDs). James F. Graumlich, *Preventing gastrointestinal complications of NSAIDs*, POST GRADUATE MEDICINE, May 2001, at 17 (suggesting that there are reasons to believe celecoxib and rofecoxib might be safer and thus reduce risk for clinically relevant gastrointestinal toxicity when compared with older NSAIDs).

<sup>172</sup> *See Roark*, 307 F.3d at 303 (informing Davila that he must follow "step program" where he "first would have to try two different medications" before he could even be considered for Vioxx use). *See generally* Tamar Terzian, *Director-to-Consumer Prescription Drug Advertising*, 25 AM. J. L. & MED. 149, 159-61 (1999) (discussing MCO's drug formularies and treatment methods).

<sup>173</sup> *Roark*, 307 F.3d at 303.

As part of the step program, Davila was first given naprosyn (a less expensive pain reliever). After three weeks, Davila suffered from bleeding ulcers, which caused a near heart attack and internal bleeding.<sup>174</sup> He was rushed to the hospital for emergency treatment, where he was given seven units of blood and kept in critical care for five days.<sup>175</sup> Davila can no longer ingest any pain medication that is absorbed through the stomach.<sup>176</sup>

Both Calad and Davila brought suit against their respective HMOs in Texas state court, seeking damages for their personal injuries<sup>177</sup> under the Texas Health Care Liability Act.<sup>178</sup> Calad alleged CIGNA had “failed to use ordinary care in making its medical necessity decisions, CIGNA’s system made substandard care more likely and CIGNA acted negligently when it made its medical necessity decisions.”<sup>179</sup> Davila alleged the same against Aetna.<sup>180</sup> Both HMOs removed the cases to federal court asserting that these claims were preempted by ERISA.<sup>181</sup>

<sup>174</sup> See *id.* at 303 (noting symptoms suffered by Mr. Davila after being placed on program).

<sup>175</sup> *Id.* (stating further medical treatment required by Mr. Davila).

<sup>176</sup> *Id.* (noting continued medical problems suffered by Mr. Davila).

<sup>177</sup> *Id.* at 302-03 (discussing background of Calad’s and Davila’s respective suits); Trueman, *supra* note 99, at 442 (stating that “in the cases of Ruby Calad and Juan Davila, the issue was whether section 502(a) [currently 29 U.S.C. § 1132(a)] of ERISA preempted claims under a Texas statute that authorized causes of action against a managed care entity”). See generally Agrawal, *supra* note 128, at 236 (arguing ERISA has significantly restricted abilities of plan beneficiaries to seek damages for conduct of managed care organizations, including medical necessity decisions, medical management policies or other coverage determinations that affect care received by beneficiary).

<sup>178</sup> See TEX. CIV. PRAC. & REM. CODE ANN. § 88.0002(a)-(b) (2004).

(a) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care.

(b) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan is also liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by its: (1) employees; (2) agents; (3) ostensible agents; or (4) representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control which result in the failure to exercise ordinary care.

*Id.* at § 88.0002(a)-(b).

<sup>179</sup> *Roark*, 307 F.3d at 302.

<sup>180</sup> See *id.* at 303 (discussing similarities of allegations Davila made against Aetna to those made against CIGNA by Calad).

<sup>181</sup> *Roark*, 307 F.3d at 304 (noting “well-pleaded complaint rule” limits federal courts’ original jurisdiction to those cases in which plaintiff’s complaint states cause of action arising under federal law; a federal defense will not do, . . . including defense of preemption, . . . recognizing an exception to rule for those few statutes whose “preemptive force . . . is so powerful as to displace entirely any state causes of action”) (citations



### B. Preemption Analysis

The Fifth Circuit Court of Appeals in *Roark v. Humana, Inc.*<sup>182</sup> held that Calad and Davila's claims involved the sort of mixed eligibility and treatment decisions<sup>183</sup> at issue in *Pegram*, and were therefore free from the formerly all-encompassing grasp of ERISA preemption.<sup>184</sup> It is widely acknowledged that ERISA provides two types of preemption: complete preemption under 29 U.S.C. § 1132(a), and conflict preemption under 29 U.S.C. § 1144.<sup>185</sup> The court noted that §1132, by providing a civil enforcement cause of action,<sup>186</sup> completely preempts any state cause of action *seeking the same relief*.<sup>187</sup> However, complete

omitted); see *Calad v. CIGNA Healthcare of Texas*, 2001 U.S. Dist. LEXIS 8538, at \*1, \*4-\*6 (N.D. Texas 2001), (noting that CIGNA was to bear burden of showing its removal was proper and to establish court's jurisdiction over case); *Davila v. Aetna U.S. Healthcare*, 2001 U.S. Dist. LEXIS 24648, at \*1, \*3-\*4 (N.D. Texas 2001), (noting that defendants, as removing parties, have burden of establishing jurisdiction over plaintiffs' claims and that "question of whether federal jurisdiction exists is generally determined according to the 'well-pleaded-complaint rule'"). See generally Richard E. Levy, *Federal Preemption, Removal Jurisdiction, and the Well-Pleaded Complaint Rule*, 51 U. CHI. L. REV. 634, 634 (1984) (analyzing mechanics of well-pleaded complaint rule and noting that plaintiff often relies on state law while defendant often claims federal preemption and moves for removal).

<sup>182</sup> 307 F.3d 298 (5th Cir. 2002).

<sup>183</sup> See *Roark*, 307 F.3d at 307-08 (discussing *Pegram* decision on "mixed eligibility decisions" and concluding that § 502(a)(1)(B) [currently 29 U.S.C. § 1132] did not preempt Calad's and Davila's claims).

<sup>184</sup> See *id.* at 307 (acknowledging *Pegram* did not decide precise issue in *Roark* – whether, under § 502(a)(2) [currently 29 U.S.C. § 1132(a)(2)], a patient can hold HMO directly liable for its own medical malpractice, but arguing that its holding is broad enough to apply).

<sup>185</sup> See *id.* at 305 (citing *McClelland v. Gronwaldt*, 155 F.3d 507, 515-17 (5th Cir. 1998)); see also *Giles v. Nylcare Health Plans, Inc.*, 172 F.3d 332, 336-37 (5th Cir. 1999) (finding that there are two types of preemption under ERISA, field or complete preemption, and ordinary or conflict preemption); Schmall, *supra* note 18, at 543-44 (discussing complete preemption as situation where Congress has left no room for state action, and conflict preemption as situation where there is room for both state and federal law, but, if there is conflict between them, federal law controls).

<sup>186</sup> See 29 U.S.C. § 1132(a), § 1144 (providing federal remedies including actions by employee to recover cost of denied benefits, enforcement of rights under policy, clarification of rights to future benefits, damages for breach of fiduciary duty, or an injunction to halt unfair practices by ERISA provider); see also *Kramer v. Smith Barney*, 80 F.3d 1080, 1083 (5th Cir. 1996) (noting that ERISA requires fiduciaries to discharge their duties solely in interest of participants and beneficiaries, using care, skill, prudence and diligence, and provides civil enforcement remedies for breach of such duty). See generally Curtis D. Rooney, *The States, Congress, or the Courts: Who Will Be First To Reform ERISA Remedies?*, 7 ANN. HEALTH L. 73, 83 (1998) (stating that § 502 [currently 29 U.S.C. § 1132] "provides a comprehensive civil enforcement scheme and generally preempts state law").

<sup>187</sup> See *Roark*, 307 F.3d at 305-06 (*emphasis added*) (describing narrow effect of § 502 [currently 29 U.S.C. § 1132(a)(2)]); see also *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 519 (1992) (assessing whether federal statute expressly preempts state law claim by

preemption is less a principle of substantive preemption<sup>188</sup> than it is a rule of federal jurisdiction.<sup>189</sup> Courts do not ask “whether the state law conflicts with or frustrates a congressional purpose, but whether the state law duplicates or falls within the scope of an ERISA § 502(a) [currently 29 U.S.C. § 1132] remedy.”<sup>190</sup> States may not duplicate the causes of action listed in ERISA § 1132.<sup>191</sup> This is essentially the test employed for “complete preemption.”<sup>192</sup>

In contrast, the court notes that §1144 provides for ordinary conflict preemption.<sup>193</sup> As a result, state law claims (such as the

determining whether federal statute explicitly articulates intent to displace preexisting form of state regulation).

<sup>188</sup> See *Rice v. Panchal*, 65 F.3d 637, 640 (7th Cir. 1995) (examining difference between preemption under § 502(a) [currently 29 U.S.C. § 1132(a)(2)] and conflict preemption under § 514(a) [currently 29 U.S.C. § 1144(a)], noting that distinction is important because “complete preemption is an exception to the well-pleaded complaint rule that has jurisdictional consequences”); see also Alison M. Sulentic, *Happiness and ERISA: Reflections on the Lessons of Aristotle’s Nicomachean Ethics for Sponsors of Employee Benefit Plans*, 5 EMPL. RTS. & EMPLOY. POL’Y J. 7, 41 (2001) (explaining that “cases regarding complete preemption leave open the possibility that a state court might still face the substantive preemption of claims that have been remanded for failure to meet the strict standards for complete preemption under Section 502(a)(1)(B) [currently 29 U.S.C. § 1132(a)(1)(B)]”). See generally *Lazorko v. Pennsylvania Hosp.*, 237 F.3d 242, 250 (3d Cir. 2000) (ruling against complete preemption, but noting that “the state court will also have the task to determine to what extent, if any, Lazorko’s claims against U.S. Healthcare are substantively preempted under § 514 [currently 29 U.S.C. § 1144]”).

<sup>189</sup> See *Metropolitan Life v. Taylor*, 481 U.S. 58, 65-67 (1987) (holding that under ERISA § 502(a)(1)(B) [currently 29 U.S.C. § 1132(a)(1)(B)], complete preemption of certain state law claims satisfies “arising under” requirement of federal question jurisdiction); see also Churchill, *supra* note 113, at 540 (acknowledging that complete preemption under ERISA § 502 [currently 29 U.S.C. § 1132] “is actually a rule of federal jurisdiction that acts as an exception to the well-pleaded complaint rule”); Reece, *supra* note 159, at 44 (recognizing that “[c]omplete preemption is actually a jurisdictional concept”).

<sup>190</sup> See *Roark*, 307 F.3d at 305 (citing *McClelland v. Gronwaldt*, 155 F.3d 507, 515 (1998)).

<sup>191</sup> See *id.* at 310-11 (establishing “narrow” rule for complete preemption “that states may not duplicate the causes of action listed in ERISA § 502(a) [currently 29 U.S.C. § 1132(a)]”); see also Boos, *supra* note 5, at 81 (stating that, in areas such as general health care regulation, “state action is not preempted so long as it does not duplicate the causes of action listed in ERISA section 502(a) [currently 29 U.S.C. § 1132(a)]”); Trueman, *supra* note 99, at 443 (acknowledging rule set forth in *Roark*).

<sup>192</sup> See Matthew Cross, *The Fifth Circuit Provides a Reproducible Framework for the Application of the Complete Preemption Doctrine*, 50 BAYLOR L. REV. 205, 208 (1998) (expressing reluctance of courts to declare that federal statute has extraordinary preemptive force required for court to declare it completely preemptive, and noting that, in rare cases, court may determine federal law “completely” preempts plaintiff’s state-based claims, converting plaintiff’s state law claims to federal claims even for purposes of removal jurisdiction).

<sup>193</sup> See *Roark*, 307 F.3d at 305 n.6 (noting that “ERISA § 514(a) [currently 29 U.S.C. § 1144(a)] preempts ‘all State laws insofar as they may now or hereafter relate to an employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.’”); see also Cal. Div. of Labor Stds. Enforcement v. Dillingham Constr., 519 U.S. 316, 322 n.3 (1987) (recognizing preemptive effect of ERISA § 514(a)

statutory tort created by the Texas Health Care Liability Act) that fall outside § 1132(a), even though preempted by §1144, follow the "well-pleaded complaint rule and do not confer original or removal jurisdiction,"<sup>194</sup> requiring such claims to be heard in state courts. The court's finding that the decisions made regarding the treatment of Calad and Davila were 'mixed eligibility'<sup>195</sup> (after analyzing the facts in light of the *Pegram* holding and noting that fiduciaries, after *Pegram*, do not make mixed eligibility decisions) illustrates that §1132(a)(2) cannot completely preempt their personal injury claims under the Texas Health Care Liability Act.<sup>196</sup>

Section 1132(a)(1)(B) allows a plan participant or beneficiary to bring a civil action "to recover benefits due him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."<sup>197</sup> Federal courts have held in the past that § 1132(a)(1)(B) creates a claim for breach of contract when a decision is made by a plan administrator construing the terms of the plan.<sup>198</sup>

[currently 29 U.S.C. § 1144(a)]. See generally Cynthia Ransburg-Brown, *The Ultimate Jigsaw Puzzle: ERISA Preemption and Liability in the Utilization Review Process*, 28 CUMB. L. REV. 403, 420 (1998) (observing that, "[c]urrently, the Supreme Court appears to be interpreting ERISA preemption using ordinary conflict preemption or complete preemption").

<sup>194</sup> See *Roark*, 307 F.3d at 305 (citing *Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1 at 23-27 (1983)).

<sup>195</sup> See *id.* at 307-08 (determining that Calad's and Davila's claims did not present "simple yes-or-no coverage questions," but rather "the type of 'when and how' medical necessity questions. . . that fall within *Pegram's* rule").

<sup>196</sup> See *id.* at 311 (using *Rush Prudential* as tool to narrow *Pilot Life's* expansive test of complete preemption: states may not duplicate causes of action listed in ERISA § 502(a) [currently 29 U.S.C. § 1132(a)], and THCLA does not provide action for collecting benefits, so, therefore, it is not preempted by § 502(a)(1)(B) [currently 29 U.S.C. § 1132(a)(1)(B)] under *Pilot Life*). See generally Richard D. Leigh, *Physician Incentives and ERISA Fiduciary Liability After Pegram v. Herdrich: What Solutions Are Available to HMO Patients Harmed by Non-Disclosure of Incentive Compensation Schemes?*, 106 DICK. L. REV. 415, 441 (2001) (recognizing that mixed eligibility decisions are not made by fiduciaries); Osgood, *supra* note 20, at 878-79 (noting that, in wake of *Pegram*, "if a mixed eligibility decision involves exercising medical judgment, then the decision-maker engages in the practice of medicine and is subject to state medical board regulation, and the decision does not fall under ERISA's preemptive shield").

<sup>197</sup> 29 U.S.C. § 1132(a)(1)(B) (establishing cause of action to recover benefits under health care plan).

<sup>198</sup> See *Jones v. Am. Gen. Life & Acc. Ins. Co.*, 370 F.3d 1065, 1069 (11th Cir. 2004) (noting that "the remedies explicitly authorized in Section 502(a)(1)(B) [currently 29 U.S.C. § 1132(a)(1)(B)]. . . are akin to common law breach of contract causes of action"); see, e.g., *Gosselink v. Am. Tel. & Telegraph, Inc.*, 272 F.3d 722, 726 (5th Cir. 2001) (stating that "[w]hen an ERISA benefits plan provides the plan administrator with discretionary authority to construe the terms of the Plan, the plan administrator's denial of benefits is reviewed for abuse of discretion"). See generally *Wildbur v. ARCO Chem.*

However, the claims made by Calad and Davila were statutorily created causes of action based on decisions concerning the “medical necessity”<sup>199</sup> of treatment decisions made by their attending physicians.

Notably, Ruby Calad did not bring suit to force CIGNA to compensate her for the cost of her emergency treatment, and Juan Davila did not seek to force Aetna to pay for the medication it initially refused to cover.<sup>200</sup> Lastly, the *Roark* court assuaged any doubts it might have had about the potential preemption of state malpractice law by acknowledging *Pegram*’s admonition<sup>201</sup> that “ERISA should not be interpreted to preempt state malpractice laws or to create a federal common law of medical malpractice.”<sup>202</sup> The court declined to issue a holding in *Roark* that would do exactly what the Supreme Court properly refused to do in *Pegram*.<sup>203</sup>

## V. CONCLUSION

If a physician’s own negligence is the proximate cause of injury to a patient, the patient may bring a tort claim against that physician for medical malpractice, recovering damages in varying forms for the resulting personal injury.<sup>204</sup> If a patient purchases

Co., 974 F.2d 631, 636 (5th Cir. 1992), *modified*, 979 F.2d 1013 (5th Cir. 1992) (highlighting that “a denial of benefits challenged under § 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B), is reviewed under a *de novo* standard unless the plan gives the administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan”).

<sup>199</sup> See *Roark*, 307 F.3d at 309 (noting Calad’s and Davila’s assertion of tort claims: “they have not sued their ERISA plan administrator, nor do they challenge his interpretation of the plan”); see also *Pegram v. Herdrich*, 530 U.S. 211, 228 (2000) (defining mixed decisions as more common, such as “whether one treatment option is superior . . . and needed so promptly, that a decision to proceed would meet the medical necessity requirement”).

<sup>200</sup> See *Roark*, 307 F.3d at 302 (noting that both patients sought damages from respective HMOs involved).

<sup>201</sup> See *id.* at 311.

<sup>202</sup> See *Pegram*, 530 U.S. at 236-37.

<sup>203</sup> Compare *Roark*, 307 F.3d at 311 (holding ERISA § 502(a) [currently 29 U.S.C. § 1132(a)] did not completely preempt the plaintiffs’ state claims since Section 502(a)(2) [currently 29 U.S.C. § 1132(a)(2)] did not address claims against HMOs that were not acting as plan fiduciaries in denying medical treatment), with *Pegram*, 530 U.S. at 236-37 (refusing to apply ERISA since mixed eligibility decisions by HMO physicians are not fiduciary decisions under ERISA); see also Trueman, *supra* note 99, at 443 (highlighting that, in *Roark*, “[t]he Fifth Circuit relied on *Pegram* and identified the plaintiffs’ claims as mixed eligibility and treatment decisions subject to state medical malpractice law”).

<sup>204</sup> See Christopher Vaeth, *Allowance of Punitive Damages in Medical Malpractice Action*, 35 A.L.R.5th 145, 2a (2004) (noting that “[i]t is the general rule that one who has been injured by the negligence of a physician or a surgeon in the course of treatment is

health insurance for himself and his family from an MCO (entirely unrelated to his employment), and the MCO itself employed the physician, the patient would have a vicarious liability claim against the MCO.<sup>205</sup> If that same patient was the victim of a negligent treatment decision made by a physician serving as a "utilization reviewer"<sup>206</sup> employed by the MCO rather than by the primary care physician, the patient would have a direct liability claim for negligence against the MCO.<sup>207</sup> If a state legislature passed a law requiring the external review of any decision made regarding the medical necessity of a physician-recommended treatment,<sup>208</sup> the patient has a cause of action against an MCO for damages when that MCO fails to provide her with such a state-mandated review.<sup>209</sup>

entitled to recover compensatory damages"); see, e.g., Lisa Petrilli, *Lost Chance In Illinois? That May Still Be The Case*, 36 J. MARSHALL L. REV. 249, 250 (2002) (highlighting that "[i]n order to have a medical negligence claim in Illinois, the plaintiff must show that the doctor had a duty, that the doctor breached that duty, and that the breach proximately caused the plaintiff's injury"). See generally *Barberito v. Western Queens Community Hosp.*, 707 N.Y.S.2d 348, 349 (N.Y. App. Div. 1988) (stating that "[a] medical malpractice cause of action may be based on allegations that a physician negligently gave advice to his patient as to what course of treatment to pursue").

<sup>205</sup> See *Pegram*, 530 U.S. at 237 (holding that plaintiff had stated claim against MCO that employed her physician who negligently failed to order test that could have prevented her appendix from rupturing); see also Ochmann, *supra* note 46, at 605 (noting that "[s]ome federal courts have held MCOs vicariously liable for a physician's negligence under the doctrines of respondeat superior and ostensible agency"). See generally Dorros, *supra* note 69, at 391 (highlighting that "[n]ot until recently have courts imposed liability on MCOs for the negligence of the physicians whom they employed or with whom they contracted").

<sup>206</sup> See Ochmann, *supra* note 46, at 612 n146.

<sup>207</sup> See Russell Korobkin, *The Failed Jurisprudence of Managed Care, and How to Fix It: Reinterpreting ERISA Preemption*, 51 UCLA L. REV. 457, 459 (2003) (stating that if negligent treatment decisions were made by physician serving as "utilization reviewer" for MCO rather than by primary physician, patient would have direct liability claim against MCO); compare Lyden, *supra* note 114, at 47 (noting that patient may bring direct liability claim for negligent utilization review on part of MCO), with Fehn, *supra* note 63, at 512 (noting that patient may only hold HMO vicariously liable for negligent acts of member physicians and must, therefore, establish that physician was acting as agent for HMO).

<sup>208</sup> See Lori K. Amano, *Erisa and Federal Preemption Following Rush Prudential HMO, Inc. v. Moran: Preemptive Effects Felt in Hawaii*, 25 HAWAII L. REV. 593,605 (2003) (highlighting that "[a]pproximately forty states have enacted independent review laws that provide for independent or external review of an MCO's denial of a treating physician's medical necessity decision"); see also *Supreme Court to Decide Extent of Health Care Plan Liability*, MED. MAL. L. & STRATEGY, Jan. 8, 2004, at 5 (stating at present, Arizona, California, Georgia, Maine, New Jersey, North Carolina, Oklahoma, Oregon, Texas, Washington and West Virginia allow patients to sue health plans that deny coverage for physician-recommended treatments); see, e.g., Illinois Health Maintenance Organization Act, 215 ILL. COMP. STAT. ANN. 125/4-10 (2000) (providing for statutorily mandated review of service proposed by primary care physician but denied by HMO).

<sup>209</sup> See *Rush Prudential HMO v. Moran*, 536 U.S. 355, 363 (2002) (holding that plaintiff had cause of action under Illinois statute that mandated independent external

However, if this same patient were the beneficiary of an ERISA plan through the course of his employment, the result would be strikingly different.<sup>210</sup> That patient, who relied on the Supreme Court's holding in *Pilot Life*, has suffered as a result of a physician's (or otherwise medically trained utilization reviewer's) negligence and, up until now, had no possibility of recourse.<sup>211</sup> In some federal courts, the patient is caught in the inequitable regulatory vacuum where state law tort and contract actions are preempted by ERISA, and yet ERISA provides no remedy to redress the injury the plaintiff has suffered.<sup>212</sup> It is entirely true that jury awards in personal injury and medical malpractice

review by unaffiliated physician in case recommended treatment, as well as external review, were denied by HMO); see also Wendy K. Mariner, *Slouching Toward Managed Care Liability: Reflections on Doctrinal Boundaries, Paradigm Shifts, and Incremental Reform*, 29 J.L. MED. & ETHICS 253, 260 (2001) (noting that "[w]ithout ERISA preemption, it is fair to say that all managed care organizations would be subject to state common law liability to their patients, as are other insurers and corporations"). But see Agrawal, *supra* note 128, at 236 (stating that "it is undeniable that ERISA has significantly restricted the abilities of plan beneficiaries to seek damages for the conduct of managed care organizations, including medical necessity decisions, medical management policies, or other coverage determinations that affect the care received by a beneficiary").

<sup>210</sup> See Frank J. Vandall, *An Examination Of The Duty Issue In Health Care Litigation: Should HMOs be Liable In Tort For "Medical Necessity" Decisions?*, 71 TEMPLE L. REV. 293, 310 (1998) (highlighting that ERISA beneficiaries, whose benefits are typically funded by employers, may not bring state suit for failure to review physician's medical necessity claim, because such claims are preempted by federal ERISA guidelines for grievance procedures and judicial review); see also Churchill, *supra* note 113, at 561 (stating that "the legislative intent and the public policies behind ERISA support a determination that state laws requiring independent review of medical necessity decisions are ultimately preempted by ERISA"). But see Jacksonis, *supra* note 29, at 218-19 (highlighting proposed legislation that would ensure ERISA does not preempt state cause of action arising from an insurer's determination of medical necessity).

<sup>211</sup> See *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1332 (5th Cir. 1992) (noting that *Pilot Life* asserts principle that ERISA preempts state law claims alleging improper handling of benefit claims); see also *Tolton v. Am. Bidyne, Inc.*, 48 F.3d 937, 942 (6th Cir. 1995) (rejecting malpractice claim as preempted against utilization review decision because defendants "were determining what benefits were available . . . under the plan"); *Rice v. Panchal*, 65 F.3d 637, 644 (7th Cir. 1995) (holding that "where the state law has the effect of creating a qualitative standard . . . by which the performance of the contract is evaluated, then that state law is completely preempted").

<sup>212</sup> See Shannon Turner, *ERISA Preemption of Direct Liability Claims: Texas Throws Down the Gauntlet*, 78 TEX. L. REV. 211, 216 (1999) (highlighting that ERISA creates tremendous barrier to recovery for employees who have self-insured, employer-provided health benefit plans and wish to sue for negligent delay or denial of treatment because ERISA preempts state law claim against HMO for negligent utilization review decision and plaintiff has no alternative remedy under ERISA). See generally Martin V. Klein, *Quality v. Quantity: Will ERISA Preemption Survive The Third Circuit Test In Re U.S. Healthcare*, 34 CREIGHTON L. REV. 1069, 1103 (2001) (noting that "[g]enerally courts find that ERISA preempts any direct negligence claim regarding utilization review that result from a denial of benefits"); Mariner, *supra* note 88, at 1986 (discussing ERISA's lack of substantive regulation and obstruction of certain state regulation).

cases have steadily risen.<sup>213</sup> However, the often-cited policy argument espousing the need for cost containment does not overcome the need for redress to injured plaintiffs.<sup>214</sup> It certainly does not overcome the need for a constitutionally mandated holding by the Supreme Court<sup>215</sup> that claims of state common law (or statutory) medical malpractice were not intended to be preempted by ERISA.

In light of the Supreme Court's recent grant of certiorari in these cases, most discussion of congressional inaction and ERISA reform has seemingly fallen by the wayside.<sup>216</sup> However, there is nothing preventing Congress from creating new legislation or amending ERISA in order to clarify the now virtually dichotomous body of law. Unfortunately, partisan bickering has

<sup>213</sup> See Michael D. Brophy, *Multi-Million Dollar Verdicts: Time for a Second Opinion*, MED. MALPRACTICE LAW & STRATEGY, May 30, 2004, at 1 (discussing significant number of seven and eight figure verdicts returned over past decade in medical malpractice cases); Sally Peters, *Physicians Concerned About Situation as Malpractice Premiums Continue to Rise*, FAM. PRAC. NEWS, Jan. 15, 2002, at 1 (noting median medical malpractice jury award more than doubled between 1994 and 1999, rising from \$375,000 to \$800,000, according to Jury Verdict Research, Horsham, PA); *Tillinghast Finds Nation's Tort Costs Increase by 13.3% in 2002*, LIAB. & INS. WEEK, Dec. 15, 2003 (commenting on record jury awards in medical malpractice cases in recent years).

<sup>214</sup> See Catherine M. Hedgeman, *The Rationing of Medicine: Herdrich v. Pegram*, 10 ALB. L.J. SCI. & TECH. 305, 322 (2000) (arguing standard of medical expertise is different from standard of resource-use allocation, which must be variable standard.); Alissa J. Rubin, *Justices to Hear Challenge to HMO Shield: Health Case is One of Several Involving Responsibility for Injuries to Patients*, N.Y. TIMES, Sept. 29, 1999, at A14 (stressing importance of rulings in ERISA preemption cases, noting that "MCOs viewed the lower court's ruling as potentially harmful to the industry because it could undermine many plans' arrangements for controlling costs and providing standard patient care"); see also Ochmann, *supra* note 46, at 604 (calling cost-containment mechanisms "the very heart of managed care organizations' success").

<sup>215</sup> See *Roark v. Humana, Inc.*, 307 F.3d 298 (5th Cir. 2002), *cert. granted*, *Aetna Health Inc. v. Davila*, 124 S. Ct. 462 (Nov. 3, 2003) (No. 02-1845) (granting petition for writ of certiorari from United States Court of Appeals for Fifth Circuit); *Roark v. Humana, Inc.*, 307 F.3d 298 (5th Cir. 2002), *cert. granted*, *CIGNA HealthCare of Texas, Inc. v. Calad*, 124 S. Ct. 463 (Nov. 3, 2003) (No. 03-83) (granting petition for writ of certiorari from United States Court of Appeals for Fifth Circuit); see also *Supreme Court to Decide if HMOs May Be Sued in State Court*, *supra* note 3 (noting underlying facts of companion cases and quoting lower courts' holdings).

<sup>216</sup> See generally Linda Greenhouse, *Supreme Court Roundup; Court to Review Suits on H.M.O. Policies*, NY TIMES, Nov. 4, 2003, at 18 (highlighting significance of Supreme Court's grant of certiorari to decide whether HMOs can be sued for damages for refusing to cover necessary medical treatment in light of congressional deadlock over patients' rights and absence of new federal legislation addressing evolution of managed care); Dennis Kelly, *Supreme Court Agrees To Hear HMO Lawsuit Cases*, BESTWIRE, Nov. 4, 2003 (arguing *Davila* and *Calad* cases present opportunity for Supreme Court to clarify role of health plan administrative decisions as covered under ERISA); Gary Young, *HMO Suits: All Smell Final Victory; Pre-Emption Issue Again at High Court*, NAT'L LAW JOURNAL, Nov. 10, 2003, at 1 (noting expectations riding on Supreme Court's grant of certiorari in *Davila* and *Calad* to clarify questions regarding ERISA's pre-emption of state-law claims).

stalled the enactment of federal legislation to potentially resolve ERISA's inequitable preemption of claims.<sup>217</sup> Supporters of a Federal Patients' Bill of Rights advocate congressional action forcing MCOs to take responsibility for their incredible breadth of authority in medical decision-making,<sup>218</sup> while compensating malpractice victims whose claims would otherwise be preempted by ERISA.<sup>219</sup> As a result of Congress' failure to clarify ERISA's complicated and poorly drafted preemption provisions, the Supreme Court is again faced with the task of retrospectively analyzing antiquated congressional 'intent.'<sup>220</sup>

It seems clear that Congress, in 1974, did not intend to preempt the most ordinary state law tort claims in the hopes of

<sup>217</sup> See Laura B. Benko, *Final Appeal; High Court to Rule Over Right to Sue for Failure to Cover Doctor-Ordered Care*, MOD. HEALTHCARE, Nov. 10, 2003, at 18 (acknowledging legislative void left last year when House and Senate deadlocked on federal patients' bill of rights); Greenhouse, *supra* note 216, at 18 (noting that congressional deadlock over patients' rights and absence of new federal legislation addressing evolution of managed care since 1974 have made ERISA, due to its broad and confusing language preempting some state laws, focus of litigation); David S. Senoff, *Recent Ruling is Bad News for Bad Faith Litigation*, LEGAL INTELLIGENCER, Sept. 27, 2004, at 5 (noting that although "Congress could simply act to amend or clarify the preemptive effect of ERISA, given the politics involved in passing such legislation and the current climate of tort reform at all levels of government, that result is unlikely").

<sup>218</sup> See generally Suzanne M. Grosso, *Rethinking Malpractice Liability and ERISA Preemption in the Age of Managed Care*, 9 STAN. L. & POL'Y REV. 433, 436-40 (1998) (advocating creation of enterprise liability system); Robert A. Clifford, *High Court Decision Keeps Patients from Suing HMOs*, CHI. LAWYER, Aug. 2004, at 23 (quoting Sen. Edward Kennedy, supporter of Federal Patients' Bill of Rights, "[w]hen HMOs make medical decisions that injure or kill patients, they should be held accountable"); *No Right to Sue*, INTELLIGENCER JOURNAL, June 23, 2004, at A12 (arguing it is time to enact Federal Patients' Bill of Rights to make managed care providers as accountable as doctors they manage).

<sup>219</sup> See Carter, *supra* note 13, at 561 (advocating Patients' Bill of Rights that would hold HMOs accountable, contain legal and medical costs and allow malpractice victims to be duly compensated); Clifford, *supra* note 218, at 23 (quoting Sen. Edward Kennedy, supporter of Federal Patients' Bill of Rights, "under current law, HMOs can escape accountability for their harmful conduct. Congress must act to correct this injustice by passing a patients' bill of rights that will allow seriously injured patients to seek compensation from the HMOs that caused their injuries"); *A Free Ride For HMOs; There's Still Time For Congress to Enact a Patient's Bill of Rights*, NEWSDAY, June 24, 2004, at A44 (arguing federal patients' bill of rights is necessary due to Supreme Court's decision preventing patients from suing managed-care plans for damages that result when they deny treatment, even when decision amounts to medical judgment).

<sup>220</sup> See Greenhouse, *supra* note 216, at 18 (noting that, in their appeals, Aetna and CIGNA called on Supreme Court to correct mistake of lower court in ignoring statute's language and Supreme Court precedents that made it clear Congress intended ERISA breach-of-contract remedy to be exclusive, not supplemented by state remedies). See generally Clifford, *supra* note 218, at 23 (noting that antiquated laws no longer protect patients); Pillsbury & Levinson Warns Consumers of a Federal Law that Restricts Recovery of Insurance Benefits, BUSINESS WIRE, Dec. 17, 2003 (quoting Arnold Levinson stating "ERISA is one of the worst and most poorly understood laws ever passed by Congress" and that "Congress is failing to protect the rights of working Americans by refusing to adequately address and reform the inherent flaws of ERISA").



containing rising damage awards threatening HMOs and MCOs which, in fact, were in their infant stages at that time.<sup>221</sup> If the Court does rule as expected based on the recent decisions in *Pegram* and *Rush*, both narrowing the previously enormous breadth of the preemption clause, MCOs operating nationwide will be faced with the overwhelming task of obeying a variety of different state laws. However, these proposed and enacted laws, such as the Texas Health Care Liability Act, are not regulatory in nature.<sup>222</sup> The only state law that MCOs and their utilization reviewers may now be compelled to obey, by a decision in favor of *Davila* and *Calad*, is the law prohibiting negligence in the practice of medicine.<sup>223</sup> If the legal framework of the states creates an unbearable burden on MCOs, then MCOs are clearly incapable, as a class, of making medical decisions best left to treating physicians.

\* Notably, this article was authored in advance of the Supreme Court's decision in *Aetna Health Inc. v. Davila*, 124 S. Ct. 2488 (2004), where it was held that the beneficiaries' causes of action fell within the scope of

<sup>221</sup> See generally Clifford, *supra* note 218, at 23 (noting that ERISA predates dawn of managed care and entirely different way in which health-care decisions are made); Senoff, *supra* note 217, at 5 (arguing that "ERISA has evolved into a shield that insulates HMOs from liability for even the most egregious acts of dereliction committed against plan beneficiaries, a state of affairs that I view as directly contrary to the intent of Congress."); Young, *supra* note 216, at 1 (stating that patient rights advocates argue that ERISA, which was enacted before managed care became norm, must make room for state-law remedies because it does not adequately protect rights of participants).

<sup>222</sup> See Lyden, *supra* note 114, at 43-47 (describing nature of the Texas Health Care Liability Act); see also *Out of Order*, TEX. LAWYER, Nov. 10, 2003, at 33 (noting "Texas is one of 14 states that allow patients to sue their HMOs, although insurance companies often argue that ERISA pre-empts the state law"). See generally Janice G. Inman, *Supreme Court Deals Blow to Malpractice Plaintiffs*, MED. MALPRACTICE L. & STRATEGY, July 30, 2004, at 1 (explaining ERISA is meant to provide uniform regulatory regime over employee benefit plans and, accordingly, any state-law cause of action that duplicates, supplements, or supplants ERISA civil enforcement remedy is preempted).

<sup>223</sup> See Julie Appleby, *Patients' Fight for Right to Sue Insurers Goes to Top Court*, USA TODAY, Mar. 22, 2004, at 9B (stating that question before Supreme Court in *Davila* and *Calad* is whether patients should be able to sue insurers for medical negligence); Robert A. Clifford, *High Court to Review Patients' Right to Sue*, CHI. LAWYER, Feb. 2004, at 16 (arguing that, at very least, Supreme Court's decision in *Davila* and *Calad* will "offer some guidelines on challenging managed care organizations' decisions when negligence occurs involving the eligibility questions under a plan, the appropriateness of a treatment and the delivery of care, and what happens when these elements intermingle"); Marcia Coyle, *High Court to Weigh HMO Suits*, LEGAL INTELLIGENCER, Mar. 8, 2004, at 4 (noting Supreme Court in *Davila* and *Calad* will decide whether HMOs can be sued in state courts for negligence and medical malpractice, resolving current split among circuits as to whether state law claims against HMOs for negligence or medical malpractice are pre-empted by ERISA).

(and, as such, were completely pre-empted by) § 502(a)(1)(B), and thus were removable to a District Court. Justice Thomas, writing for a unanimous Court, noted that duties imposed by the state statute in the context of these beneficiaries' cases did not arise independently of ERISA or the plan terms, as:

(1) A managed-care entity could not be subject to liability under the state statute if the entity denied coverage for any treatment not covered by the health care plan that it was administering.

(2) The beneficiaries' causes of action were not entirely independent of the federally-regulated plan contracts.

(3) The beneficiaries (i) had brought suit only to rectify a wrongful denial of benefits promised under ERISA-regulated plans, and (ii) were not attempting to remedy any violation of a legal duty independent of ERISA.

The crux of this paper is embodied by Justice Ginsburg's concurrence, joined by Justice Breyer, expressing the view that Congress and the Supreme Court ought to revisit what was an unjust and increasingly tangled ERISA regime, "as the court's coupling of an encompassing interpretation of ERISA's pre-emptive force with a cramped construction of the 'equitable relief' allowable under § 502(a)(3) had created a regulatory vacuum in which (1) virtually all state-law remedies were pre-empted, but (2) very few federal substitutes were provided.

