

ARTICLES

ERISA'S PREEMPTION CLAUSE: PROGRESS TOWARDS A MORE EQUITABLE PREEMPTION OF STATE LAWS

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Introduction	208
I. Relevant Statutory Provisions	210
II. From a Literal Interpretation of ERISA's Preemption Clause to an Interpretation That Gives Deference to States' Police Power Regulations and ERISA's Underlying Objectives	212
A. <i>Equitable Construction and Blue Cross v. Travelers</i>	214
B. <i>California Division of Labor Standards Enforcement v.</i> <i>Dillingham Construction, Inc.</i>	218
C. <i>De Buono v. NYSA-ILA Medical and Clinical Services Fund</i> ...	220
III. Continuing Indeterminacy of ERISA Preemption	221
IV. <i>Pegram v. Herdrich</i> as an Extension of <i>Travelers</i>	229
V. <i>Travelers</i> as a Limitation on ERISA's Preemption of State Medical Malpractice Laws and Lawsuits	232
A. <i>Low Quality Benefits Versus Denied Benefits—A Direct Liability</i> <i>Claim Against the Treating Physicians</i>	234
B. <i>Low Quality Benefits Versus Denied Benefits—Vicarious Liability</i> <i>Claims Against HMOs and Health Plans</i>	237
C. <i>ERISA Administrators' Negligent Utilization Review Decisions</i> <i>and Negligent Medical Treatment Decisions</i>	241
D. <i>States' Quality of Care Statutes</i>	252
E. <i>Negligence in the Creation of Health Plans</i>	259
VI. The Future of ERISA's Preemption	269
A. <i>Equity Preemption</i>	271
B. <i>First Step of an Equity Preemption Analysis</i>	274
C. <i>The Second Step of an Equity Preemption Analysis</i>	277
D. <i>Negligent Utilization Review Decisions</i>	277
E. <i>Responses to Potential Arguments Against the Use of</i> <i>Equity Preemption</i>	280
Conclusion	292

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INTRODUCTION

Health care expenditures consume a substantial portion of the gross national product of the United States.¹ In the 1980s, to curb escalating health care costs, both public and private purchasers of health care turned to managed care organizations for the arrangement and financing of health care.² These organizations used several managed care procedures to reduce health care costs, including prospective utilization review to evaluate the medical necessity of treatments and financial incentives to control physicians' treatment decisions.³ Presently, approximately seventy-five percent of Americans who have health care protection from their employers obtain their benefits through managed care organizations.⁴

Managed care has been successful in reducing health care costs.⁵ However, many consumers have joined in a backlash protest against managed care organizations and their cost cutting procedures.⁶ This debate has centered around the fear that, in an effort to cut health care costs, managed care organizations use procedures and strategies that either cause or have the potential of causing a reduction in the quality of health care.⁷ In response to such concerns, states have

1. See Edward B. Hirshfeld et al., *Structuring Provider-Sponsored Organizations: The Legal and Regulatory Hurdles*, 20 J. LEGAL MED. 297, 299 (1999) (asserting that "[h]ealth care spending accounted for 7.1% of the gross national product in 1996, 9% in 1979, and nearly 14% in 1996. Some economists expect health care to account for almost 18% of the gross national product by 2005.").

2. See e.g., Alice A. Noble & Troyen A. Brennan, *The Stages of Managed Care Regulation: Developing Better Rules*, 24 J. HEALTH POL. POL'Y & L. 1275 (1999) (discussing the development of managed care and state law regulation of managed care).

3. See William M. Sage, *Regulating Through Information: Disclosure Laws and American Health Care*, 99 COLUM. L. REV. 1701, 1704 n.5 (1999) (asserting that "[m]ost care management is accomplished using one or more of four basic mechanisms: financial incentives, direct review of service utilization, structural features that affect the availability of services, and the normative environment in which physicians work").

4. See Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 5 (1999) (asserting that "[b]y 1995, nearly seventy-five percent of Americans with employer-provided private insurance, and more in some part of the country, received their medical care from [managed care organizations]").

5. See Korobkin, *supra* note 4, at 5 ("Although it is not clear whether the trend will be sustainable in the long run, the market penetration of managed care has reduced health care inflation in recent years.").

6. See Marc A. Rodwin & Atoz Okamoto, *Physicians' Conflicts of Interest in Japan and the United States: Lessons for the United States*, 25 J. HEALTH POL. POL'Y & L. 343, 367 (2000) ("Having rejected major health care reform during the first Clinton administration, public policy was laissez-faire and promoted the growth of for-profit health care and MCOs. The result: a public backlash and both state and federal regulation of managed care during Clinton's second term.").

7. See David A. Hyman, *Regulating Managed Care: What's Wrong with a Patient Bill of*

passed approximately one thousand different laws to protect consumers from managed care's perceived abuses,⁸ including "any willing provider" laws, anti-gag clause laws, "maternity length-of-stay bills," "direct access" to emergency and specialist care laws, and laws regulating the deselection of physicians from preferred list of providers.⁹ Similarly, the federal government has enacted several laws, including one allowing mothers to remain in the hospital at least forty-eight hours after child birth.¹⁰ However, special interest groups have prevented the federal government from passing comprehensive national legislation to regulate managed care organizations and managed care strategies.¹¹

Although states have more proactively regulated managed care organizations,¹² the Employment Retirement Income Security Act (ERISA) has been a substantial limitation on states' abilities to protect their citizen-employees.¹³ This limitation is primarily effectuated through managed care organizations' use of ERISA's preemption clause to preempt state laws that attempt regulation of managed care organizations. For example, substantial uncertainty exists over whether, as a part of its protection of citizens from negligent medical decisions, a state like Texas can regulate the quality of medical decisions that a managed care organization makes during its utilization review process of granting or denying medical treatment.¹⁴ The answer to this question, and other related questions regarding the types of state laws that are acceptable regulations of managed care organizations, primarily depends on federal courts' interpretations of ERISA's preemption clause. Issues surrounding ERISA's preemption of state health care laws are important because, in light of the federal government's special interest-induced paralysis, state governments appear to be the only real protectors of consumers against managed care abuses. Fortunately, recent Supreme Court and lower-level federal court decisions have, through their construction of ERISA's preemption clause, given more protection to state law regulation of managed care organizations and their cost-cutting strategies.

Part I discusses the relevant ERISA statutory provisions. Part II shows that the Court's decision in *New York State Conference of Blue Cross & Blue Shield*

Rights, 73 S. CAL. L. REV. 221, 241 (2000) ("This literature convincingly demonstrates that MCOs perform at least as well, and often better than fee-for-service health care.").

8. See Korobkin, *supra* note 4, at 2 (asserting that "[s]tate legislatures have enacted perhaps as many as 1000 patient protection laws nation wide").

9. See generally Noble & Brennan, *supra* note 2, at 1283-87.

10. See Korobkin, *supra* note 4, at 3.

11. See *id.* at 3-4 (discussing federal bills to regulate managed care organizations).

12. See *id.* at 2-4.

13. 29 U.S.C. § 1000 (1994). ERISA is applicable because a substantial number of employees obtain their health care benefits from their employers, thereby bringing them under ERISA's coverage.

14. See generally *Corporate Health Ins., Inc. v. Tex. Dep't of Ins.*, 12 F. Supp. 2d 597 (S.D. Tex. 1998), *aff'd in part and rev'd in part*, 215 F.3d 526 (5th Cir. 2000), and *petition for cert. filed*, 69 U.S.L.W. 3317 (U.S. Oct. 24, 2000) (No. 00-665).

*Plans v. Travelers Insurance Co.*¹⁵ is a shift in the Court's interpretation of ERISA's preemption clause, one that gives deference to states' police power regulations and that emphasizes ERISA's statutory objectives. Part III concludes that, despite a new approach to the interpretation of the preemption clause, much indeterminacy persists surrounding ERISA's preemption of state laws and lawsuits. Part IV connects the Court's decision in *Pegram v. Herdrich*¹⁶ to an ERISA preemption analysis and shows how that case is an extension of the Court's efforts to narrow the scope of ERISA's preemption. Part V analyzes lower-level federal courts' application of the *Travelers* case to state law claims. Among other things, this part not only shows a narrowing of ERISA's preemption when courts find no preemption of state law claims challenging managed care organizations' negligent decisions when the organizations are acting as medical arrangers and providers, but Part V also shows that some courts continue to find preemption of state law claims that challenge managed care organizations' utilization review decisions. This part also explains how some courts deny ERISA's preemption of state lawsuits challenging the quality of provided medical benefits, but find preemption when the complaint is about either denied benefits or the quantity of benefits. Part VI discusses the future of ERISA's preemption of state laws and lawsuits, and it proposes a new approach to ERISA's preemption by offering the "equity preemption" concept.

I. RELEVANT STATUTORY PROVISIONS

Several of ERISA's statutory provisions play an important part in the issues raised in this Article. For example, ERISA is applicable to employee welfare benefit plans that employers provide to their employees. In relevant part, section 1002(1)(A) of ERISA defines an employee welfare benefit plan as a plan that is maintained

for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services.¹⁷

This Article primarily involves ERISA plans that provide medical benefits to employees and their beneficiaries. These plans frequently arrange for medical care by entering into contracts with HMOs and other managed care organizations that assume the responsibility of paying for and providing necessary medical providers.¹⁸

15. 514 U.S. 645 (1995).

16. 530 U.S. 211 (2000).

17. 29 U.S.C. § 1002(1)(A) (1994).

18. See Patricia C. Kuszler, *Financing Clinical Research and Experimental Therapies: Payment Due, but from Whom?*, 3 DEPAUL J. HEALTH CARE L. 441, 470 n.218 (2000) ("ERISA

Employees and beneficiaries, who complain that an ERISA plan has improperly denied medical treatment, can bring a claim under section 502(a) of ERISA's civil enforcement provisions, which provides that

[a] civil action may be brought (1) by a participant or beneficiary (A) for the relief provided for in subsection (c) of this section, or (B) to recover benefits due to 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; (2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under the section 1109 of this title; (3) by the participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.¹⁹

However, because of a narrow Supreme Court interpretation, one who brings claims under section 502(a) can obtain only denied benefits and not compensatory damages.²⁰ In other words, an employee with an injured right leg, who sues an ERISA plan because the plan denied a treating physician's recommendation that the employee needed three days of hospitalization, cannot obtain compensatory damages if the denial of the hospitalization worsens the employee's condition and causes the employee's death; the only damages under a section 502(a) claim is the monetary value of the denied three days of hospitalization.

Given the absence of an adequate compensatory damage remedy under section 502(a), many employees and beneficiaries have brought state law claims under various common law and statutory theories. However, some courts have held that section 514(a) of ERISA, the infamous preemption clause, preempts many of the state law claims that employees and beneficiaries have filed against ERISA plans and some of the claims that they have filed against HMOs and other managed care organizations. The preemption clause provides that

[e]xcept as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a).²¹

The following discussion shows the current status of the Court's and lower-level federal courts' interpretation of the preemption clause.

plans may contract with an insurer, third party administrator, or most commonly, managed care plan to administer the benefits and process claims, while the employer retains the risk of losses.").

19. 29 U.S.C. § 1132(a) (1988 & Supp. V 1993).

20. See generally *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993); *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985).

21. 29 U.S.C. § 1144(a) (1994).

II. FROM A LITERAL INTERPRETATION OF ERISA'S PREEMPTION CLAUSE TO AN INTERPRETATION THAT GIVES DEFERENCE TO STATES' POLICE POWER REGULATIONS AND ERISA'S UNDERLYING OBJECTIVES

Elsewhere I have argued that the Supreme Court, when interpreting ERISA's preemption clause, "should establish and consistently apply a presumption against the preemption of state laws of general application that are not specifically designed to regulate ERISA's welfare benefit plans,"²² and that ERISA's underlying objectives and purposes should govern the application of ERISA's preemption clause.²³ This Article will show that the Supreme Court's decisions in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*,²⁴ in *California Division of Labor Standards Enforcement v. Dillingham Construction*²⁵ and in *De Buono v. NYSA-ILA Medical and Clinical Services Fund*²⁶ have made substantial progress in changing the Court's ERISA preemption analysis. In these cases, the Court indicated that it will give paramount importance to a presumption against the preemption of state laws in areas of traditional state regulation²⁷ and that it has a preference against the preemption of state laws that do not intrude on either ERISA's general purpose or its preemption clause purpose.²⁸ One could say that *Travelers*, *Dillingham Construction*, and *De Buono* are the Court's "presumption-objectives trilogy,"²⁹ and that they evidence a new direction in the Court's analysis of ERISA's preemption clause. These cases, and lower-level federal court cases interpreting *Travelers*, employ an "equitable construction" or "equitable interpretation" approach when analyzing whether ERISA's

22. Larry J. Pittman, *ERISA's Preemption Clause and the Health Care Industry: An Abdication of Judicial Law-Creating Authority*, 46 FLA. L. REV. 355, 409 (1994). This suggestion stemmed from the fact that the Supreme Court's interpretation of ERISA's preemption clause has historically vacillated between a literal application of the *Black's Law Dictionary* definition of "relate to" ("a connection with and a reference to") and an objectives-purposes interpretation that imposes preemption only when a state law has an impermissible impact on ERISA's underlying objectives and purposes. *See id.* at 384-412.

23. *See id.* at 401, 410.

24. 514 U.S. 645 (1995).

25. 519 U.S. 316 (1997).

26. 520 U.S. 806 (1997).

27. *See De Buono*, 520 U.S. at 813; *Dillingham Constr.*, 519 U.S. at 331; *Travelers*, 514 U.S. at 654.

28. *Travelers*, 514 U.S. at 655.

29. This label is a short hand indication of the substance of the Court's new approach to ERISA's interpretation. Primarily, the trilogy establishes that in analyzing an ERISA preemption issue, the Court will take a quick look to see if the challenged state law has either a "reference to" or a "connection with" an ERISA plan. If the state law does not meet these tests, the Court will apply the presumption against the preemption of traditional state law regulation and determine whether the state law interferes with ERISA's preemption clause objectives. It appears that ERISA will not preempt the state law if it does not interfere with the preemption clause objectives.

preemption clause preempts state laws and lawsuits.³⁰ Conceptually, the use of equitable construction means that, instead of relying upon a strict textualist interpretation of ERISA's preemption clause, the Court will give the preemption clause an interpretation that effectuates ERISA's general purposes and its preemption clause purposes.³¹

Arguably, the Court's use of equitable construction in *Travelers* has two implications. First, ERISA's purposes and objectives are to be the predominate factors in determining when ERISA preempts state laws.³² Second, federal courts are free to use other equitable principles when interpreting ERISA's preemption clause.³³ Therefore, as argued in Part VI, federal courts should draw on their equity jurisprudence, including its principles and maxims, when interpreting ERISA's preemption clause.³⁴ This argument is based on the notion that a court's interpretation of ERISA's preemption clause falls within the court's equity jurisdiction in part because trust law principles are applicable to an interpretation of ERISA's statutory provisions.³⁵ Therefore, as a matter of equity, courts should interpret the preemption clause to achieve equitable and fair results.³⁶ Thus, a major conclusion from this Article is that the Court and lower-level federal courts, when interpreting ERISA's preemption clause, should use the equity maxim that "equity will not suffer a wrong without a remedy."³⁷ This is a principle that will help courts obtain fairer and more equitable results when interpreting ERISA's preemption clause.

This Article labels the use of courts' equity jurisdiction during an ERISA

30. Basically, equitable construction or equitable interpretation means that, when interpreting and applying a statute to a particular case before the court, the court will use the purposes and objectives underlying the statute to determine how the statute should be applied to the case before the court, instead of relying on a plain meaning or textualist interpretation of the statute. For a discussion of equitable construction, see generally Raymond B. Marcin, *Epieikeia: Equitable Lawmaking in the Construction of Statutes*, 10 CONN. L. REV. 377 (1978); Robert J. Martineau, *Craft and Technique, Not Canons and Grand Theories: A Neo-Realist View of Statutory Construction*, 62 GEO. WASH. L. REV. 1 (1993).

31. See *Travelers*, 514 U.S. at 655-56.

32. See *id.*

33. Although the Court in *Travelers* did not speak on this issue, the Court's conclusion that ERISA's objectives and purposes are important in the interpretation of ERISA's preemption clause leads to the conclusion that the principle of equity construction should be used, which further leads to the conclusion that equity principles that are designed to achieve a fair and equitable interpretation of the preemption clause should also be used.

34. See *infra* notes 295-325.

35. See *infra* note 294.

36. Although the Court in *Travelers* did not state that ERISA's preemption clause should be interpreted in a manner to achieve equitable and fair results, it is doubtful that the Court would argue that the preemption clause should be interpreted so as to achieve inequitable and unfair results.

37. JOHN NORTON POMEROY, 2 EQUITY JURISPRUDENCE § 423 (Spencer W. Symons ed., Lawyers Coop. Publ'g Co. 1941) (1881).

preemption analysis as “equity preemption,” and argues that *Travelers*, *Dillingham Construction*, and *De Buono* have started the Court’s journey towards the use of “equity preemption.”³⁸

A. *Equitable Construction and Blue Cross v. Travelers*³⁹

Blue Cross v. Travelers is the first case in the Court’s trilogy. In *Travelers*, the Court held that ERISA’s preemption clause did not preempt a New York law mandating that commercial insurers pay surcharges on hospital bills,⁴⁰ when Blue Cross/Blue Shield plans did not have to pay the surcharges.⁴¹ Although the surcharges created an incentive for cost conscious ERISA plans to choose the Blue Cross/Blue Shield plans over commercial insurers,⁴² the Court held that such an indirect economic influence did not justify preemption under ERISA’s preemption clause.⁴³

38. “Equity preemption” is a name developed by this Author to suggest that equity’s principles and maxims should be used to control courts’ interpretation of ERISA’s preemption clause.

39. *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995).

40. The total effect of the surcharge (including the portion maintained by the hospitals and the portion given to the state) meant that commercial insurers were charged twenty-four percent more per affected hospital bill (the DRG rate plus a twenty-four percent surcharge) than Blue Cross and Blue Shield service plans that had to pay only the established DRG rate. *See id.* at 650.

41. *See id.* at 667-68.

42. *See id.* at 659. Presumably, if an ERISA plan chooses Blue Cross it would pay a smaller premium because Blue Cross did not have to increase their premiums or fees to offset the loss of profits caused by having to pay the twenty-four percent surcharge. The Second Circuit held that the surcharge was a “purposeful interference with the choices that ERISA plans make for health care coverage . . . [and was] sufficient to constitute [a] ‘connection with’ ERISA plans’ triggering preemption.” *Id.* at 654 (quoting *Travelers*, 14 F.3d 708, 719 (2d Cir. 1994)). The gist of the Second Circuit’s opinion was that “‘the three surcharges ‘relate to’ ERISA because they impose a significant economic burden on commercial insurers and HMOs’ and therefore ‘have an impermissible impact on ERISA plan structure and administration.’” *Id.* (quoting *Travelers*, 14 F.3d at 721). The Supreme Court did not find such reasoning to be persuasive. *See id.*

43. *See id.* at 659. The indirect economic influence at issue in *Travelers* occurred because the New York law imposed the surcharge on only the hospital bills that commercial insurers paid on behalf of those receiving benefits under ERISA plans and not on the bills of those ERISA beneficiaries whose bills were paid by Blue Cross and Blue Shield. *See id.* at 654. The alleged impermissible effect would be experienced when the surcharges would drive up the cost of obtaining insurance coverage and health benefits from commercial insurance carriers and HMOs in that they, being the only one required to pay the surcharges, would pass the cost of the surcharges to ERISA plans, thereby increasing the expenses of the ERISA plans that wanted to offer coverage through commercial insurers and HMOs. As such, the surcharges would indirectly influence the sources of benefits that the ERISA plans would offer to their beneficiaries, which in effect would be an indirect influence on the structure and administration of ERISA plans. *See id.* at 653-54.

To get a sense of how the Court arrived at its decision that ERISA did not preempt New York's surcharge law, the Court's use of equitable construction is instructive. The Court had to use equitable construction because ERISA's preemption clause did not specifically refer to or cover New York's surcharges, unless one applies a broad, textualist interpretation of "relate to."⁴⁴ However, instead of relying on a textualist interpretation, the Court employed a three-step equitable construction analysis: (1) the Court recognized a "start[ing] presumption" against ERISA's preemption of state laws that are a part of a state's "historical police power" regulation unless there is a congressional intent that preemption should occur;⁴⁵ (2) the Court examined the language of ERISA's preemption clause for a "clear and manifest purpose" to rebut the "startling presumption";⁴⁶ and (3) because the language did not clearly show a congressional intent to preempt the state law, the Court examined "the structure and purpose" of ERISA to see whether they showed a congressional intent to preempt the state law.⁴⁷ The Court's use of the three-step analysis is informative.

First, having recognized the "startling presumption" against the preemption of state law regulation in areas of traditional state concern,⁴⁸ the Court gave its strongest criticism of ERISA's preemption clause's language. The Court recognized the dangers of a too expansive interpretation of "relate to,"⁴⁹ emphasizing its indeterminacy and that a literal, plain meaning interpretation of the phrase would mean that "for all practical purposes pre-emption would never run its course, for '[r]eally, universally, relations stop nowhere.'"⁵⁰

44. However, the Court was critical of the broad scope of "relate to," asserting that a broad interpretation would mean that almost any state law affecting the cost of an ERISA plan would have some relation to the plan. *See id.* at 655.

45. *Id.* at 654-55. First, the Court restricted the scope of federal preemption by reaffirming its commitment to "the start[ing] presumption that Congress does not intend to supplant state law," especially when the state law is an exercise of a state's "historical police powers" regulation. *Id.* at 655. This presumption applies to all three types of federal preemption of state laws. *See id.* at 654. The three types are "express preemption," where a federal law expressly indicates a preemption of state law; preemption by implication where, although not expressly preempted, a state law is implicitly preempted by either a federal law's language or its policies or purposes; and conflict preemption where there is "a conflict between federal and state law." *Id.* at 654 (citing *Pac. Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm'n*, 461 U.S. 190, 203-04 (1983)).

The "startling presumption" means that the Court will not find preemption unless Congress had a "clear and manifest purpose" to preempt the state law. *Id.* at 655 (quoting *Rice v. Sante Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). If Congress's intent is not clearly expressed in a federal statute's language, the Court will examine "the structure and purpose of" the law to ascertain whether congressional intent is in favor of preemption. *Id.*

46. *Id.* at 665-66.

47. *Id.* at 655.

48. *Id.* at 654.

49. *Id.* at 656.

50. *Id.* at 655 (quoting H. JAMES, RODERICK HUDSON, at xli (New York ed., World's Classics 1980)). The Court stated:

Despite the indeterminacy of “relate to,” the Court took a quick look at the definition of the phrase to ascertain whether it preempted New York’s surcharges.⁵¹ First, the Court held that the “reference to” prong of “relate to” was not applicable because the surcharges were imposed on patients’ medical bills regardless of whether the medical services were provided through commercial insurers, HMOs, or ERISA plans.⁵² Second, the Court stated that the “connection with” prong of “relate to” was just as indeterminate and unhelpful as “relate to” itself given its “infinite connections.”⁵³ Therefore, eschewing an “uncritical literalism” in interpreting “relate to,”⁵⁴ the Court went to the third step in its analysis, stating that “[w]e simply must go beyond the unhelpful text and the frustrating difficulty of defining [ERISA’s] key term, and look instead to the objectives of [] ERISA” to control the scope of ERISA’s preemption of state laws.⁵⁵ The relevant objective was the preemption clause objective of “avoid[ing] a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.”⁵⁶ That objective is primarily

The governing text of ERISA is clearly expansive. Section 514(a) 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 the words of limitation (“insofar as they . . . relate”) do much limiting. 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, for “really, universally, relations stop nowhere,” But that, of course, would be to read Congress’s words of limitation as mere sham, and to read the presumption against pre-emption out of the law whenever Congress speaks to the matter with generality. That said, we have to recognize that our prior attempt to construe the phrase “relate to” does not give us much help drawing the line here.

Id. at 655 (internal citation omitted).

51. *See id.* at 655-56.

52. *See id.* at 656.

53. *Id.*

54. *Id.*

55. *Id.*

56. *Id.* at 657. Implicit in the preemption clause objective is the notion that Congress intended “to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . , [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.” *Id.* at 656-67 (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990)).

In referencing the congressional comments by Senator Williams, the Court opened up the possibility that field preemption of state laws might be one means of dealing with ERISA’s preemption issues:

Senator Williams made the same point, that “with the narrow exceptions specified in the bill, the substantive and enforcement provisions . . . 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.”

implicated when a state law changes either the structure or the administration of an employee benefit plan.⁵⁷ In *Travelers*, the Court did not find preemption because the surcharge law did not alter either the structure or the administration of ERISA benefits, even though it would have given ERISA plans an "indirect economic influence" to choose cheaper Blue Cross health plans over commercial insurers' and HMOs' plans.⁵⁸ However, that indirect economic influence was insufficient to warrant preemption.⁵⁹ The Court reasoned that a finding of preemption due to the surcharge's indirect economic influence would mean that ERISA would preempt a host of other state law regulations with indirect economic influences, including state quality control standards that also increase ERISA plans' cost of providing welfare benefits.⁶⁰

Id. at 657 (citation omitted). Justice Scalia subsequently opined that field preemption would be the appropriate way of resolving ERISA preemption issues. See *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., Inc.*, 519 U.S. 316, 334 (1997) (Scalia, J, concurring).

57. See *Travelers*, 514 U.S. at 657-58. The Court relied on three of its prior preemption cases. First, the Court discussed *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983). The case involved preemption of a New York "Human Rights Law, which "prohibit[ed] employers from structuring their employee benefit plans in a manner that discriminate[d] on the basis of pregnancy, and the [New York] Disability Benefits Law, which require[d] employers to pay employees specific benefits." *Id.* at 97. The laws related to ERISA plans because they would have prevented the plans from structuring and administering their benefits in a uniform manner throughout the United States. See *id.* Further reference was made to *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), where preemption was found because the Pennsylvania antisubrogation law would have prevented ERISA plans from obtaining subrogation of beneficiaries' monetary recoveries from third-parties, thereby mandating the structure of an ERISA plan's administration of its benefits obligations. Finally, the Court cited *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), regarding preemption of a New Jersey state law that would have prevented ERISA plans from "setting workers' compensation payments off against employees' retirement benefits or pensions, because doing so would prevent plans from using a method of calculating benefits permitted by federal law. *Travelers*, 514 U.S. at 658. The Court concluded: "In each of these cases, ERISA pre-empted state laws that mandated employee benefit structures or their administration. Elsewhere, we have held that state laws providing alternative enforcement mechanisms also relate to ERISA plans, triggering pre-emption." *Id.* (citing *Ingersoll-Rand*, 448 U.S. at 133).

58. *Id.* at 659-60. Regarding the impact of the surcharges on ERISA plans' selection of health benefit providers, the Court stated: "It is an influence that can affect a plan's shopping decisions, but it does not affect the fact that any plan will shop for the best deal it can get, surcharges or no surcharges." *Id.* at 660.

59. The Second Circuit is in compliance with *Travelers* to the extent that in *Connecticut Hospital Ass'n v. Weltman*, 66 F.3d 413 (2nd Cir. 1995), the court held that ERISA did not preempt a Connecticut state law surcharge on the hospital bills of private patients, which the State used to pay for "uncompensated care." *Id.* at 414. As was the case in *Travelers*, the court, in part, held that the state law's indirect economic effect (to the extent that the surcharge was imposed on patients and not on a self-insured ERISA plan) did not either "force an ERISA plan to adopt a certain scheme of substantive coverage or to effectively restrict its choice of insurers." *Id.* at 415.

60. See *Travelers*, 514 U.S. at 660-61. The Court asserted at least two other reasons, each

B. California Division of Labor Standards Enforcement v. Dillingham Construction, Inc.⁶¹

Dillingham Construction is the second case in the Court's trilogy. In that case, certain ERISA plans, including Dillingham Construction, raised an ERISA preemption challenge against California's prevailing wage law, which required that contractors on public work projects pay their workers the location's prevailing wages unless the workers were participating in an approved apprenticeship program.⁶² Writing for the Court, Justice Thomas continued the

bearing on ERISA's objectives and purposes why ERISA did not preempt the surcharges. First, rate differentials in medical cost, such as New York's surcharges, existed at the time of ERISA's enactment, an indication that Congress did not intend that ERISA would preempt such cost differentials. The Court stated:

There is, indeed, nothing remarkable about surcharges on hospital bills, or their effects on overall cost to the plans and the relative attractiveness of certain insurers. Rate variations among hospital providers are accepted examples of cost variation, since hospitals have traditionally "attempted to compensate for their financial shortfalls by adjusting their price . . . schedules for patients with commercial health insurance." Charge differentials for commercial insurers, even prior to state regulation, "varied dramatically across regions, ranging from [thirteen] to [thirty-six] percent," presumably reflecting the geographically disparate burdens of providing for the uninsured.

If the common character of rate differentials even in the absence of state action renders it unlikely that ERISA pre-emption was meant to bar such indirect economic influences under state law, the existence of other common state action with indirect economic effects on a plan's costs leaves the intent to pre-empt even less likely. Quality standards, for example, set by the State in one subject area of hospital services but not another would affect the relative cost of providing those services over others and, so, of providing different packages of health insurance benefits. Even basic regulation of employment conditions will invariably affect the cost and price of services.

Id. at 660 (internal citations omitted). Similarly, the Court asserted that Congress' enactment of a federal law, approximately one month after ERISA's enactment, that provided federal funding for state agencies engaged in a similar type of health care rate setting as New York's surcharges, is evidence that Congress did not intend to preempt the surcharges. *See id.* at 666-67.

61. 519 U.S. 316 (1997).

62. *See id.* at 319-21. In *Dillingham Construction*, the general contractor for a Sonoma County detention facility subcontracted the electronic installation work to respondent Sound Systems Media, which in compliance with its collective bargaining agreement with a union, affiliated itself with an apprenticeship program, Communications Systems Joint Apprenticeship Training Committee (Communications Systems); however, the latter failed to obtain approval of its program from the relevant California apprenticeship approval agency. *See id.* at 321. Communications Systems was an ERISA plan under 29 U.S.C. § 1002 (1), which, in part, defines ERISA's welfare benefit plan as an "apprenticeship or other training programs."

Court's criticism of ERISA's preemption clause's "unhelpful text."⁶³ As in *Travelers*, the Court rejected a strict application of the two analytical prongs of "relate to" (a "reference to" and a "connection with") as "offer[ing] scant utility" in determining the scope of ERISA's preemption.⁶⁴ In lieu of a textualist interpretation of the preemption clause, the *Dillingham Construction* Court, as in *Travelers*, looked to ERISA's objectives and followed a presumption against the preemption of states' traditional police power regulations.⁶⁵

However, even with its criticism of the preemption clause's "unhelpful text," the Court initially employed a textualist evaluation of the California prevailing wage law to ascertain whether it made a "reference to" the ERISA plans. There was no "reference to" because the wage law was applicable to non-ERISA apprenticeship programs and it did not explicitly mention ERISA plans.⁶⁶ Similarly, there was no "connection with" an ERISA plan.⁶⁷ First, the prevailing wage law, like *Travelers*' surcharges, "d[id] not bind ERISA plans to anything" since a contractor on a California public works project "need not hire [workers] from an approved [apprenticeship] program," although ERISA plans had an indirect economic incentive to do so to pay lower apprenticeship wages instead of higher prevailing wages.⁶⁸ Second, given that the state wage law did not mandate ERISA plan structure or plan choices when hiring workers, the Court held that ERISA did not preempt the state law.⁶⁹

63. *Dillingham Constr.*, 519 U.S. at 328

64. *Id.* at 325.

65. *See id.*

66. *See id.* at 325-26. Had the California law been applicable only to ERISA plans (apprenticeship plans funded through a separate fund, instead of through an employer's general assets), the Court implied that the state law would be preempted under the "reference to prong" of "relate to." *Id.* However, the wage law "function[ed] irrespective of . . . the existence of an ERISA plan." *Id.* at 328.

67. "Connection with" would have existed if the prevailing wage law had bound "plan administrators to any particular choice and thus function[ed] as a regulation of an ERISA plan itself." *Id.* at 329. Moreover, "connection with" would have been satisfied if the law had "preclude[d] uniform administrative practice or the provision of a uniform interstate benefit package if a plan wished[d] to provide one," or "mandated employee benefit structures or their administration." *Id.* at 328-29. Mandating benefits or changing the structure of an ERISA plan has resulted in the Court finding preemption of state laws. *Id.* at 328 (citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981)).

68. *Id.* at 332.

69. *See id.* at 333. The Court stated:

The prevailing wage statute alters the incentives, but does not dictate the choices, facing ERISA plans. In this regard, it is "no different from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate." We could not hold pre-empted a state law in an area of traditional state regulation based on so tenuous a relation without doing grave violence to our presumption that Congress intended nothing of the sort. We thus conclude that California's prevailing wage laws and apprenticeship standards do not have a

In one sense, the Court's analysis in *Dillingham Construction* was an application of the "startling presumption" against the preemption of state laws. Like the surcharges at issue in *Travelers*, the prevailing wage laws in *Dillingham Construction* have traditionally been a province of states' police power regulation.⁷⁰ Although *Travelers* did not limit ERISA's preemption to areas specifically regulated by ERISA,⁷¹ *Dillingham Construction* recognized that preempting state law in areas that ERISA does not regulate would be "unsettling."⁷²

C. *De Buono v. NYSA-ILA Medical and Clinical Services Fund*⁷³

De Buono is the third case in the Court's trilogy. In *De Buono*, trustees administering a self-insured, employee benefit plan, which owned and operated three medical care facilities, filed suit against New York challenging a state law that assessed a 0.6 percent tax on the gross receipts of health care facilities.⁷⁴ The trustees sought ERISA preemption, contending that the state law "related to" the plan because it increased the plan's operating expenses by forcing it to pay more taxes on plan-owned medical facilities.⁷⁵ In resolving the preemption issue, the Court, as in *Travelers* and in *Dillingham Construction*, relied upon ERISA's objectives and the "startling presumption" against the preemption of state law in areas of traditional state regulation.⁷⁶

As the hospital revenue taxes were a part of states' traditional regulations, and since the ERISA plan trustee failed to overcome the presumption against the preemption of state police power regulation, the Court held that ERISA did not

"connection with," and therefore do not "relate to," ERISA plans.

Id. at 334.

70. *See id.* at 330.

71. *See id.* Those areas are "reporting, disclosure, fiduciary responsibility, and the like." *Id.* (quoting *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995)).

72. *Id.* The full parameters or limits of the Court's "unsettling" concerns might not provide any indication of the manner in which the Court will resolve disputes in the future, given *Travelers*'s commitment to following prior precedents finding preemption of state laws in areas that are not directly regulated by ERISA. *See Travelers*, 514 U.S. at 663-64.

73. 520 U.S. 806 (1997).

74. *See id.* at 810.

75. *See id.*

76. *Id.* at 813 (citing *Travelers*, 514 U.S. at 655; *Dillingham Constr.*, 519 U.S. at 323-24). Several cases have cited *De Buono*'s reference to the presumption against the preemption of health care regulations. *Philip Morris, Inc. v. Harshbarger*, 122 F.3d 58, 68 (1997) ("[T]here exists an assumption that federal law does not supersede a state's historic police powers unless that [is] the clear and manifest purpose of Congress."). This presumption is applicable to health and safety regulations. *See id.* (citing *Hillsborough County v. Automated Med. Labs*, 471 U.S. 707, 715 (1985) (noting the "presumption that state or local regulation of matters related to health and safety is not invalidated under the Supremacy clause"))).

preempt the state tax law.⁷⁷ Although the revenue law “impos[ed] some burdens on the administration of ERISA plans,”⁷⁸ the Court reasoned that those burdens were the same ones that would have been incurred if the ERISA plan had not owned the medical facilities, but instead was forced to suffer the detriment of the tax revenue when other owners of the facilities increased their fees.⁷⁹ In effect, *De Bono* is like *Travelers* to the extent that it reaffirmed that a potential reduction of an ERISA plan’s funds, through either a direct or indirect influence, respectively, alone is not sufficient to warrant preemption, especially in areas traditionally regulated by states.

III. CONTINUING INDETERMINACY OF ERISA PREEMPTION

When taken together, the Court’s recent decisions in the “presumption-objectives trilogy” do not definitively set the parameters of ERISA preemption. However, these cases disclose certain principles that are important to an ERISA preemption analysis. One implication from *Travelers* is that, although abandoning a literal, textualist application of “relate to,”⁸⁰ the Court still takes

77. See *De Buono*, 520 U.S. at 814. The Court reached its decision primarily by distinguishing the revenue law from some of those state laws that ERISA has preempted. See *id.* The revenue laws did not

forbid[] a method of calculating pension benefits that federal law permits, or require[] employers to provide certain benefits. Nor [was] it a case in which the existence of a pension plan is a critical element of a state-law cause of action, or one in which the state statute contains provisions that expressly refer to ERISA or ERISA plans.

Id. (citation omitted).

78. *Id.* at 815.

79. See *id.* at 815-16. The Court stated:

HFA is a tax on hospitals. Most hospitals are not owned or operated by ERISA funds. This particular ERISA fund has arranged to provide medical benefits for its plan beneficiaries by running hospitals directly, rather than by purchasing the same services at independently run hospitals. If the Fund had made the other choice, and had purchased health care services from a hospital, that facility would have passed the expense of the HFA onto the Fund and its plan beneficiaries through the rates it set for the services provided. The Fund would then have had to decide whether to cover a more limited range of services for its beneficiaries, or perhaps to charge plan members higher rates. Although the tax in such a circumstance would be “indirect,” its impact on the Fund’s decisions would be in all relevant respects identical to the “direct” impact felt here. Thus, the supposed difference between direct and indirect impact—upon which the Court of Appeals relied in distinguishing this case from *Travelers*—cannot withstand scrutiny. Any state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute.

Id.

80. See *De Buono*, 520 U.S. at 813; *Dillingham Constr.*, 519 U.S. at 325; *Travelers*, 514 U.S.

a look at the relationship between a disputed state law and an ERISA benefit plan to see whether the law has a "reference to" or a "connection with" the plan.⁸¹ There will be no "reference to" if the state law is applicable to all health plans and not just to ERISA plans, especially if the language of the state law does not specifically refer to or mention ERISA plans.⁸² There will be no "connection with" unless the state law (1) binds ERISA plan administrators' choices and thereby functions as a regulation of the plan; (2) prevents an ERISA plan from having uniform administrative practices or from offering an interstate uniform benefit package; or (3) "mandate[s] employee benefit structures or their administration."⁸³

If neither a "reference to" nor a "connection with" is found, the Court will ascertain whether the state law interferes with ERISA's preemption clause objectives.⁸⁴ The primary objectives appear to be: (1) "ensur[ing] that plans and plan sponsors would be subject to a uniform body of benefits law," (2) "minimiz[ing] the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government," and (3) "prevent[ing] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction."⁸⁵ In sum, one can reasonably conclude that ERISA will not preempt a state law that either does not make a specific reference to an ERISA plan, does not have a "connection with" an ERISA plan, or does not interfere with ERISA's preemption clause objectives.

A second implication from the "presumption-objectives trilogy" involves the Court's recognition of the "startling presumption" against the preemption of state

at 656.

81. See *Dillingham Constr.*, 519 U.S. at 325-27.

82. See *Travelers*, 514 U.S. at 656.

83. *Dillingham Constr.*, 519 U.S. 327-29.

84. See *Travelers*, 514 U.S. at 656.

85. *Id.* at 656-57. The trilogy does not delineate the degree to which ERISA's general purpose will be considered when resolving preemption issues. This general purpose is the protection of beneficiaries from "the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds." *Dillingham Constr.*, 519 U.S. at 327-28. The Court considered these purposes in *Dillingham Construction* in deciding whether the California prevailing wage law had a "reference to" ERISA plans to the extent that it was applicable only to ERISA plans. *Id.* As the law was also applicable to non-ERISA plans, the Court did not find a "reference to" an ERISA plan. *Id.*

Somehow, the Court must reconcile the preemption clause purposes with ERISA's general purpose to establish the circumstances under which the general purpose will trump the preemption clause purposes. See Pittman, *supra* note 22, at 357-61 (discussing ERISA's primary purposes). Presently, the Court's cases have primarily involved an analysis of state laws' impact on the preemption clause purposes. See *Travelers*, 514 U.S. at 656-57.

At bottom, the biggest impact of the "presumption-objectives trilogy" is the cases' indication that the Court is grappling with approaches to limit the scope of ERISA preemption. The full ramification of the "presumption-objectives trilogy" remains open.

laws unless Congress has expressed a clear and manifest intent that preemption should occur.⁸⁶ The strength and boundaries of this presumption are not clear.

86. See *Travelers*, 514 U.S. at 654. An analysis of the history of this “startling presumption” is important in ascertaining whether the presumption has a congressional source or whether it is a rule of statutory construction that the Court uses as an aid when interpreting a statute. If the latter is true, then the “startling presumption” is nothing but a principle of equitable construction that the Court uses to fill gaps between the language of a federal statute and a specific state law when the Court is considering whether the federal law preempts the state law.

Apparently, the Court’s use of the “startling presumption” is simply a conclusive statement that the Court uses when considering whether a federal law preempts a state law. The Court generally cites to an earlier case that has stated the same proposition without much analysis regarding the legal source of the presumption. Therefore, it might be useful to trace *Travelers*’ reference to the “startling presumption” back to the earlier cases that stated the presumption. For example, without much analysis of the legal source of the presumption, *Travelers* cites *Maryland v. Louisiana*, 451 U.S. 725, 746 (1981), for the proposition that there is a “startling presumption against the preemption of state law.” *Travelers*, 514 U.S. at 654-55. *Maryland* cites *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947), for the proposition that “[c]onsideration under the Supremacy Clause starts with the basic assumption that Congress did not intend to displace state law.” *Maryland*, 451 U.S. at 746. *Rice* cites *Napier v. Atlantic Coast Line Railroad Co.*, 272 U.S. 605, 611 (1926), and *Allen-Bradley Local v. Wisconsin Employment Relations Board*, 315 U.S. 740, 749 (1942), that “we start with the assumption 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.” *Rice*, 331 U.S. at 230. *Napier* cites *Reid v. Colorado*, 187 U.S. 137, 148 (1902), and *Savage v. Jones*, 225 U.S. 501, 533 (1912), for the proposition that “[t]he intention of Congress to exclude states from exerting their police power must be clearly manifested.” *Napier*, 272 U.S. at 611. In *Reid* the Court stated:

It 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. This court has said—and the principle has been often reaffirmed—that ‘in the application of this principle of supremacy of an act of Congress in a case where the state law is but the exercise of a reserved power, the repugnance or conflict should be direct and positive, so that the two acts could not be reconciled or consistently stand together.

Reid, 187 U.S. at 148.

In *Savage*, the Court stated:

This question must, of course, be determined with reference to the settled rule that a statute enacted in execution of a reserved power of the state is not to be regarded as inconsistent with an act of Congress passed in the execution of a clear power under the Constitution, unless the repugnance or conflict is so direct and positive that the two acts cannot be reconciled or stand together.

Savage, 225 U.S. at 535 (1912).

Therefore, a review of relevant Court opinions shows that the “startling presumption” is but a Court imposed rule of statutory construction without any congressional sources. Furthermore, the scope and the meaning of this presumption have changed. In latter cases such as *Travelers*, and some of its Supreme Court progeny, the Court stated the presumption as “the startling presumption

However, *Dillingham Construction* seems to restrict the presumption against preemption by either establishing or reaffirming that, even in areas of traditional police power regulation, preemption is proper if the affected state law has either a "reference to" or a "connection with" an ERISA plan, or if the state law interferes with ERISA's preemption clause purposes.⁸⁷

that Congress does not intend to supplant state law" and "the assumption 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." *Travelers*, 514 U.S. at 645, 655 (citing *Hillsborough County v. Automated Med. Labs., Inc.*, 471 U.S. 707, 719 (1985)).

On the other hand, one can argue that the earlier cases stated that the presumption required a "direct and positive" conflict between a state and a federal law that regulated in the same field before the federal law would preempt the state law. *Reid*, 187 U.S. at 148. This raises two points. First, the manner in which the Court states the presumption might determine whether a particular state law is preempted. Second, since the presumption is a Court-made rule of statutory construction, the Court can use the presumption to engage in an equitable construction of a federal law that in fact could amount to judicial lawmaking to fill a gap between the language of a federal statute and its preemptive effects on a particular state law. In other words, the Court can use the "startling presumption" to narrow the preemptive effects of ERISA's broad preemption clause. That is, if the meaning of the phrase "relate to" is so broad that ERISA's preemption would never run its course, as Justice Souter stated in *Travelers*, then why did the Court not find that ERISA preempted New York's surcharges? If "relate to" and its "connection with" prong have infinite relations and connections, then the scope of these phrases is broad enough to encompass New York's surcharges and therefore lead to a preemption of the surcharges. However, through an equitable construction of ERISA's preemption clause, and "relate to," the Court effectively engaged in judicial lawmaking and found that ERISA's preemption clause should not be interpreted as broad as it could be. The Court stated that to give "relate to" its broadest interpretation "would be to read Congress's words of limitation as mere sham, and to read the presumption against preemption out of the law whenever Congress speaks to the matter with generality." *Travelers*, 514 U.S. at 655. One could argue that it seems ironic that to protect its own Court-created presumption, the Court would intimate that it would narrowly interpret ERISA's preemption clause to save the presumption against the preemption of state laws. One could also argue that when the Court does not interpret a federal law's preemption clause as broadly as possible, the Court is engaging in judicial lawmaking, despite the fact that the Court might couch its lawmaking in the guise of enforcing congressional intent through the ascertainment of the federal statute's object and purpose. However, it seems reasonable to conclude that Congress envisioned the use of judicial lawmaking to establish the parameters of ERISA's preemption. See *infra* note 88 and accompanying text. For a general statement of how the Second Circuit performs an analysis by using the presumption against the preemption of state laws, see *infra* note 285. See generally Marcin, *supra* note 30.

87. See *Dillingham Constr.*, 519 U.S. at 324-25. Importantly, even in light of the trilogy, it appears that the "startling presumption" against the preemption of state police power regulations will save a state law from preemption only when there is no conflict between the state law and ERISA's preemption clause purposes. See *id.* at 330. The Court stated:

That the States traditionally regulated these areas would not alone immunize their efforts; ERISA certainly contemplated the preemption of substantial areas of traditional state regulation. The wages to be paid on public works projects and the substantive

standards to be applied to apprenticeship training programs are, however, quite remote from the areas with which ERISA is expressly concerned—"reporting, disclosure, fiduciary responsibility, and the like." . . . A reading of § 514 (a) resulting in the preemption of traditionally state-regulated substantive law in those areas where ERISA has nothing to say would be "unsettling."

Id. (internal citations omitted).

That state regulations, even in traditional police power areas, may be preempted in the ERISA arena if such laws "interfere[] or [are] contrary to federal law" is consistent with general federal preemption doctrine. *Philip Morris, Inc. v. Harshbarger*, 122 F.3d 58, 67 (1st Cir. 1997). However, like *Travelers, Dillingham Construction* leaves several issues unresolved. First, the scope of the "unsettling" nature of preempting state laws in areas that ERISA does not specifically regulate needs clarification. At best, the Court's use of the word "unsettling" should lead to more scrutiny of preemption arguments that affect state laws in areas where there is no specific ERISA regulation. However, it is doubtful that the Court will reverse prior cases that have found preemption in such areas. Second, although critical of ERISA's "unhelpful text," the Court still attempts to apply a "connection with" analysis which raises doubts whether *Travelers* and *Dillingham Construction* really alters or improve the Court's prior attempts to interpret ERISA's preemption clause. Third, the Court implied that the preemption of "medical-care quality standards . . . that increase[] costs of providing certain benefits" would stretch ERISA preemption to an unreasonable limit. *Dillingham Constr.*, 519 U.S. at 329.

When considered in conjunction with the "unsettling" prospect of preempting state law in non-ERISA regulated areas, the presumption against the preemption of traditional state police power regulation, and the non-dispositive effect of an indirect economic influence on ERISA plan choices, could lead to a conclusion that one effect of the "medical-care quality standards" exception to ERISA preemption might be the non-preemption of state statutes and common law doctrines regulating the practice of medicine through medical malpractice lawsuits. Although the Court, on a case-by-case basis, will determine the impact of the presumption on ERISA preemption, the Court should establish and recognize, as a general proposition, that in close cases the use of the presumption against preemption should mean that ERISA will not preempt state laws unless the laws have a significant impact on ERISA plans.

One potential roadblock to the non-preemption of state malpractice lawsuits is the *Pilot Life* Court's statements that ERISA's six civil enforcement provisions are meant to be the only remedy for a claim alleging an improper processing of a claim for benefits. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52-57 (1987). See text accompanying *infra* notes 326-78.

Another hindrance might be the Court's inability to recognize that a claim for medical malpractice during an ERISA plan's utilization review process, that is premised on an ERISA plan's or managed care organization's violation of an independent state law obligation, is different in kind from a claim merely seeking denied benefits because of an alleged improper processing of a claim for benefits.

In addition to the above-discussed issues, Justice Scalia's concurring opinion, joined by Justice Ginsberg, emphasized that the Court's opinion in *Dillingham Construction* would not bring clarity to ERISA preemption issues, primarily because "it does obeisance to all our prior cases, instead of acknowledging that the criteria set forth in some of them have in effect been abandoned." *Dillingham Constr.*, 519 U.S. at 335 (Scalia, J., concurring). Their approach would be to deem "relate to" as being "irrelevant" as a guide to ERISA preemption, except that its only significance

A third implication from *Travelers* and its progeny is the Court's reaffirmation of the "too tenuous, remote, or peripheral" exception to ERISA's preemption.⁸⁸ Although one interpretation of the "presumption-objectives trilogy" is that the Court has adopted, or is moving toward the adoption of, a new

would be to identify the regulation of "employee benefits" as the field to be considered in applying ordinary federal field preemption. *See id.* Interestingly, Justice Scalia did not cite any legislative history to support his conclusion regarding Congress' intent to employ field preemption. *See id.* Similarly, Justice Scalia did not specifically identify those "criteria" employed in prior cases that have been abandoned. *See id.*

However, support for field preemption might be found in Senator Williams' legislative history statements, "with the narrow exceptions specified in the bill, the substantive and enforcement provisions . . . are intended to preempt the *field* for Federal regulation, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans." *Travelers*, 514 U.S. at 657 (quoting 120 CONG. REC. 29933 (1974) (statement of Sen. Williams) (emphasis added)). Although the Court in *Travelers* cited Senator Williams' above-referenced statement, it did not adopt field preemption as the proper method for ERISA's preemption; rather, it chose to disregard ERISA preemption clause's "unhelpful text" and "look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive" preemption, namely the objective of ERISA preemption clause. *Id.* at 656.

88. The Court stated that a broad interpretation of the preemption clause to preempt "all state laws affecting costs and charges" of an ERISA plan "could not be squared with our prior pronouncement that '[p]re-emption does not occur . . . if the state law has only a tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability.'" *Id.* at 661 (citing *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 130 n.1 (1992)).

The "too tenuous, remote, or peripheral" exception was first cited in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 n.21 (1983). For that proposition, the Court cited *AT&T v. Merry*, 592 F.2d 118, 121 (2d Cir. 1979), which allowed a "state garnishment of a spouse's pension income to enforce alimony and support orders." *Shaw*, 463 U.S. at 100 n.21. The equitable construction implication of the "too tenuous, remote, or peripheral" exception is that, to the extent that the exception prevents a broad application of ERISA's preemption clause by exempting from preemption those state laws having only a tenuous or insubstantial impact on ERISA plans, the Court's use of the exception is judicial lawmaking. It is judicial lawmaking because the Court has decided that it will not enforce the broad scope of ERISA's preemption clause when a state law has a "tenuous, remote, or peripheral" impact on an ERISA plan. If Congress really did, through the use of "relate to," intend that ERISA should preempt any state law that has a "connection with or a reference to" an ERISA plan, then by restricting the broadest application of these phrases, the Court, through judicial lawmaking, is disregarding congressional intent. However, Congress probably had no real idea or knowledge regarding the specific scope of "relate to." Rather, it seems logical that Congress intended that federal courts, through judicial lawmaking during a case-by-case interpretation of ERISA's preemption clause, would establish the legal parameters of "relate to." Therefore, courts' use of the "too tenuous, remote or peripheral" exception, and the presumption against the preemption of state laws in traditional areas of state regulation, is a legitimate interpretative device to fill gaps between ERISA's statutory language and its application to specific state laws and lawsuits. *See generally* Pittman, *supra* note 22.

method of ERISA preemption analysis, another interpretation might conclude that these cases are a second step in the Court's effort to establish the scope of the "too tenuous, remote, or peripheral" exception announced in *Shaw v. Delta Air Lines*.⁸⁹ Essentially, the Court in the trilogy concluded that the state laws' impact on the ERISA plans' financial well-being was too peripheral.⁹⁰ In doing so, the Court rejected the "trust fund doctrine" and a reduction in welfare benefit plans' funds as justifications for ERISA's preemption.⁹¹ Regardless of the indefinite scope of the "too tenuous, remote, or peripheral" exception to ERISA preemption, *Travelers* establishes that state laws and lawsuits with only an indirect economic impact on ERISA plans fall within the "too tenuous, remote or peripheral" exception; therefore, ERISA does not preempt such laws and lawsuits.

Clearly, the "too tenuous, remote, or peripheral" exception is a Court-made exception to ERISA preemption, given the absence of any legislative history showing congressional acknowledgment of the exception. Rather, the exception appears to have its origins in lower-level federal courts' decisions that ERISA did not preempt states' efforts to garnish employees' welfare benefits to enforce state child support and alimony decrees.⁹² Although the Supreme Court accepts the exception, it has not established any clear guidelines for when the exception will exempt state law from preemption. For example, the Court in *Shaw v. Delta Air Lines, Inc.*,⁹³ in dicta, referred to the exception in footnote twenty-one, but made no effort to define its boundaries.⁹⁴ *Mackey v. Lanier Collection Agency & Service, Inc.*,⁹⁵ without specifically citing the exception, made use of it when the Court held that ERISA did not preempt Georgia's generally applicable garnishment law despite a resulting increase in ERISA plans' costs when they are forced to bear the expense of processing state garnishment orders.⁹⁶ *District of*

89. See *Travelers*, 514 U.S. at 661-62. The Court in *Travelers* stated:

Indeed, to read the pre-emption provision as displacing all state laws affecting costs and charges on the theory that they indirectly relate to ERISA plans that purchase insurance policies or HMO memberships that would cover such services, would effectively read the limiting language in § 514(a) out of the statute, a conclusion that would violate basic principles of statutory interpretation and *could not be squared with our prior pronouncement that "[p]reemption does not occur . . . if the state law has only a tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability."*

Id. (emphasis added).

90. See *id.* at 668.

91. See *id.* (asserting that New York's surcharges "affect only indirectly the relative prices of insurance policies").

92. See *Shaw*, 463 U.S. at 100 n.21 (citing *AT&T*, 592 F.2d at 118).

93. See *id.*

94. See *id.*

95. 486 U.S. 825 (1988).

96. See *id.* at 842.

Columbia v. Greater Washington Board of Trade,⁹⁷ as a part of its general statement of ERISA's governing principles, also cited the exception in dicta, but did not delineate a test for applying it in future cases.⁹⁸

A fourth conceivable implication from *Travelers* is the Court's discounting (and possible rejection) of the "trust fund doctrine" whereby ERISA's preemption has sometimes been found when a state law reduces the funds available to ERISA plans for payment of employee benefits.⁹⁹ In *Travelers*, the Court specifically disregarded concerns that New York's surcharges might decrease the funds of those ERISA plans that purchased benefits from more expensive commercial insurers.¹⁰⁰ Some federal courts have adopted *Travelers'* reasoning and have refused to find preemption simply because the application of a state law might result in a reduction of an ERISA plan's benefits.¹⁰¹

The fifth and most promising impact of *Travelers* is its statements in support of states' authority to regulate the quality of health care. A reasonable interpretation of *Travelers* is that state quality of care regulations, including common law tort and medical malpractice causes of action, should in appropriate cases survive ERISA preemption. Implicit in such arguments is *Travelers'* reference to the non preemption of states' quality standards.¹⁰² Arguably, this means that, in many cases, medical malpractice lawsuits vindicating physicians' breaches of state medical malpractice laws and doctrines should escape preemption.¹⁰³ The non preemption of medical malpractice laws and lawsuits is

97. 506 U.S. 125 (1992).

98. See *id.* at 130 n.1.

99. See Pittman, *supra* note 22, at 427-30.

100. See *Travelers*, 514 U.S. at 661-62. Relying on *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988), the *Travelers* Court stated:

We took no issue with the argument of the Mackey plan's trustees that garnishment would impose administrative costs and burdens upon benefit plans If a law authorizing an indirect source of administrative cost is not preempted, it should follow that a law operating as an indirect source of merely economic influence on administrative decisions, as here, should not suffice to trigger pre-emption either.

Id. at 662 (citation omitted).

101. See *Lazorko v. Pa. Hosp.*, No. 96-4858, 1998 WL 405055, at *2 (E.D. Pa. June 30, 1998), *aff'd in part and vacated in part*, 237 F.3d 242 (3d Cir. 2000).

102. The *Travelers* Court stated:

Quality standards, for example, set by the State in one subject area of hospital services but not another would affect the relative cost of providing those services over others and, so, of providing different packages of health insurance benefits. Even basic regulation of employment conditions will invariably affect the cost and price of services.

Quality control and workplace regulation, to be sure, are presumably less likely to affect premium differentials among competing insurers, but that does not change the fact that such state regulation will indirectly affect what an ERISA or other plan can afford or get for its money.

Id. at 660-61.

103. See *infra* notes 127-48 and accompanying text.

especially appropriate given that the regulation of physicians' malpractice conduct has traditionally fallen within state law regulation of the medical profession.¹⁰⁴ Therefore, *Travelers'* presumption against the preemption of state police power regulations protects states' malpractice laws and lawsuits from preemption.¹⁰⁵

In sum, the future legal effect of the trilogy will evolve as courts apply it to new fact patterns while interpreting ERISA's preemption clause and civil enforcement provisions. However, to some extent, the Court's recent ERISA decision in *Pegram v. Herdrich*¹⁰⁶ shows *Travelers'* influence on states' medical malpractice lawsuits.

IV. PEGRAM V. HERDRICH AS AN EXTENSION OF TRAVELERS

In *Pegram*, the plaintiff, who was a beneficiary under her husband's ERISA benefit plan, alleged that she suffered a ruptured appendix and peritonitis when her treating HMO physician caused her to wait for eight days to have an ultrasound evaluation of her abdomen at an HMO-staffed facility approximately fifty miles away and not at a local hospital, despite the seriousness of her medical condition.¹⁰⁷ Arguably, the plaintiff, in part, contended that the delay in her treatment stemmed from the HMO's desire to save medical treatment expenses by having plaintiff treated at an affiliated medical facility instead of at the local hospital.¹⁰⁸ In addition to state medical malpractice theories, plaintiff alleged a theory under section 409 of ERISA, contending that the contract between the HMO and its affiliated physicians contained a clause that gave physicians a "year-end distribution" financial incentive to ration health care.¹⁰⁹ Apparently, the clause provided for a year-end payment to affiliated physicians based on their meeting established treatment goals.¹¹⁰ As the foundation of the section 409 theory, the plaintiff alleged that the HMO was an ERISA fiduciary, and that the financial incentive created "an inherent or anticipatory breach" of the HMO's

104. See *infra* notes 127-48 and accompanying text.

105. Like New York's hospital surcharge regulation, any indirect economic influence that state's medical malpractice lawsuits have on ERISA plans' selection of insurance companies and providers of employee benefits is not dispositive. The primary foreseeable influence of medical malpractice lawsuits is the probability that insurers and their independent utilization reviews will charge ERISA plans more premiums to offset any liability that the former will incur in defending against medical malpractice lawsuits. Such increases in premiums might represent the amount that the insurers and utilization reviews will incur in purchasing liability insurance as protection against such lawsuits. Many insurers and utilization reviews might already be paying for insurance coverage, and therefore, there might not be a substantial increase in employer's and ERISA plan's premiums.

106. 120 S. Ct. 2143 (2000).

107. See *id.* at 2146.

108. See *id.* at 2149.

109. *Id.* at 2150.

110. See *id.*

fiduciary duties under ERISA because it caused the HMO, through its treating physicians, to consider its own financial well-being while making medical treatment decisions for its member-subscribers, in contravention of the HMO's fiduciary duty to "act solely in the interest of beneficiaries."¹¹¹

The Court reversed the Seventh Circuit Court of Appeals' decision that the HMO was acting as an ERISA fiduciary when it treated the plaintiff and that the complained of act stated a claim for relief.¹¹² The Court held that the HMO's decisions were "mixed eligibility and treatment decisions."¹¹³ The Court further held that an HMO does not act in an ERISA fiduciary capacity while making such decisions; and therefore, a plaintiff cannot bring a breach of fiduciary duty claim under ERISA's civil enforcement provisions.¹¹⁴ In part, the Court found that allowing a breach of fiduciary duty claim would mostly be redundant of a state medical malpractice claim challenging the same type of financial incentive-induced, substandard medical treatment.¹¹⁵ Implicitly, the Court recognized that ERISA does not preempt a state medical malpractice claim against an HMO and its treating physicians when the challenged acts involve mixed eligibility and treatment decisions.¹¹⁶

111. *Id.* at 2153.

112. *See id.* at 2148. The Seventh Circuit stated:

Our decision does not stand for the proposition that the existence of incentives automatically gives rise to a breach of fiduciary duty. Rather, we hold that incentives can rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists (i.e., where physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses).

Id.

113. *Id.* at 2155.

114. *See id.* at 2158-59.

115. *See id.*

116. *See id.* The Court stated:

What would be the value to the plan participant of having this kind of ERISA fiduciary action? It would simply apply the law already available in state courts and federal diversity actions today, and the formulaic addition of an allegation of financial incentive would do nothing but bring the same claim into a federal court under federal-question jurisdiction. It is true that in States that do not allow malpractice actions against HMOs the fiduciary claim would offer a plaintiff a further defendant to be sued for direct liability, and in some cases the HMO might have a deeper pocket than the physician. But we have seen enough to know that ERISA was not enacted out of concern that physicians were too poor to be sued, or in order to federalize malpractice litigation in the name of fiduciary duty for any other reason. It is difficult, in fact, to find any advantage to participants across the board, except that allowing them to bring malpractice actions in the guise of federal fiduciary breach claims against HMOs would make them eligible for awards of attorney's fees if they won . . . But, again, we can be fairly sure that Congress did not create fiduciary obligations out of concern that state plaintiffs were not suing often enough, or were paying too much in legal fees. The

However, there is some uncertainty over *Pegram*'s full scope. Although the Court recognizes that a treating physician's decision that a patient does not need emergency care (or some other type of care) is a mixed eligibility and treatment decision,¹¹⁷ the Court deferred judgment on whether ERISA's preemption clause would preempt a state law claim challenging an HMO's denial of medical benefits when the decision is a mixed eligibility and treatment decision.¹¹⁸ However, the Court's extended discussion that the creation of a breach of ERISA fiduciary duty cause of action would be redundant of a state law medical malpractice cause of action is strong indication that ERISA would not preempt such a state law claim.¹¹⁹ At the very least, the Court has called into question the "standards governing such a claim" and its relationship to a claim for denied benefits under section 502(a) of ERISA's civil enforcement provisions. The Court's decision also raised questions regarding whether ERISA preempts state law claims challenging "a denial of benefits" in light of the Court's conclusion that mixed eligibility and treatment decisions are neither exercises of ERISA

mischief of Herdrich's position would, indeed, go further than mere replication of state malpractice actions with HMO defendants. For not only would an HMO be liable as a fiduciary in the first instance for its own breach of fiduciary duty committed through the acts of its physician employee, but the physician employee would also be subject to liability as a fiduciary on the same basic analysis that would charge the HMO. The physician who made the mixed administrative decision would be exercising authority in the way described by ERISA and would therefore be deemed to be a fiduciary . . . Hence the physician, too, would be subject to suit in federal court applying an ERISA standard of reasonable medical skill. This result, in turn, would raise a puzzling issue of preemption. On its face, federal fiduciary law applying a malpractice standard would seem to be a prescription for preemption of state malpractice law, since the new ERISA cause of action would cover the subject of a state-law malpractice claim . . . To be sure, [*Travelers*], throws some cold water on the preemption theory; there, we held that, in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose. But in that case the convergence of state and federal law was not so clear as in the situation we are positing; the state-law standard had not been subsumed by the standard to be applied under ERISA. We could struggle with this problem, but first it is well to ask, again, what would be gained by opening the federal courthouse doors for a fiduciary malpractice claim, save for possibly random fortuities such as more favorable scheduling, or the ancillary opportunity to seek attorney's fees. And again, we know that Congress had no such haphazard boons in prospect when it defined the ERISA fiduciary, nor such a risk to the efficiency of federal courts as a new fiduciary-malpractice jurisdiction would pose in welcoming such unheard-of fiduciary litigation.

Id. at 2158 (internal citations omitted).

117. *See id.* at 2154-55.

118. *See id.* at 2154. The Court stated "[N]or have we reason to discuss the interaction of such a claim with state law causes of the action." *Id.* at 2154 n.9.

119. *See id.* at 2158-59. For a further discussion of *Pegram*'s impact on an ERISA preemption clause analysis, see *infra* notes 316-20 and accompanying text.

fiduciary duties nor actionable breaches of fiduciary duties under ERISA's civil enforcement provisions.¹²⁰

Pegram is encouraging because it relied on *Travelers* for the proposition that in the field of health care, there is no ERISA preemption without a clear manifestation of congressional purpose. In the words of Justice Souter in *Pegram*, *Travelers* "throws some cold water on the preemption theory."¹²¹ A review of lower-level federal courts' decisions also leads to the conclusion that *Travelers* has weakened ERISA's preemption in the health care industry and has led to a better balance between state and federal regulation of medical services.

V. TRAVELERS AS A LIMITATION ON ERISA'S PREEMPTION OF STATE MEDICAL MALPRACTICE LAWS AND LAWSUITS

The Third Circuit's decision in *Dukes v. U.S. Healthcare, Inc.*,¹²² has been influential to the extent of its reliance on *Travelers* to limit the scope of ERISA's preemption clause.¹²³ Importantly, *Dukes* made a distinction between a state law claim seeking a remedy for the poor quality of provided medical benefits and a state claim seeking a remedy for denied benefits.¹²⁴ Since section 502 (a) of ERISA's civil enforcement provisions does not provide a remedy for the substandard quality of benefits that a health plan has provided to a beneficiary, the Third Circuit held that the defendants could not remove a state law vicarious liability claim to federal court under the complete preemption doctrine.¹²⁵ The

120. See *Pegram*, 120 S. Ct. at 2154.

121. *Id.* at 2158.

122. 57 F.3d 350 (3rd Cir. 1995). In *Dukes*, the decedent had ear surgery. See *id.* at 352. His surgeon ordered a blood test, but defendant hospital, for some reason, would not perform the test. Subsequently, the decedent died. Because his blood sugar was high at the time of death, an allegation was made that the high blood sugar level would have been diagnosed had the hospital performed the test. The plaintiff filed a direct medical malpractice lawsuit against certain of the decedent's treating physicians and treating hospital. Moreover, the plaintiff asserted a vicarious liability claim against the HMO from which the decedent received his medical treatment pursuant to an ERISA benefit plan, alleging that the HMO was responsible for the physicians' negligent actions because the HMO held the physicians out as its employees. See *id.* The plaintiff also alleged direct liability against the HMO on the grounds that it was negligent in its "selecting, retaining, screening, monitoring, and evaluating the personnel who actually provided the medical services." *Id.*

123. Despite *Dukes*' primary issue being whether the plaintiff's state law vicarious liability claims against an HMO should be removed from state court to federal court under the complete preemption doctrine, the court made statements supportive of an expansive application of *Travelers*. See *id.* at 356-58. The Third Circuit held that the state law claims were not completely preempted because they did not fall within the scope of section 502 (a)(1)(B) of ERISA's civil enforcement provisions in that they were not claims seeking denied benefits, nor did the claims seek either to enforce rights under the ERISA plan or to clarify rights under the plan. See *id.*

124. See *id.* at 356-57.

125. See *id.* The court held that the purpose of section 502(a) is to provide beneficiaries with

Dukes court strongly stated that the “[q]uality control of benefits . . . is a field traditionally occupied by state regulation” and that Congress’ silence on the issue meant that states should continue to govern the quality of health care.¹²⁶ Under the *Dukes* court’s reasoning, ERISA should not preempt either a direct liability claim against a treating physician or a vicarious liability claim against an HMO or other managed care organization, when the claims challenge negligent medical treatments, because such claims are traditionally part of the state’s regulation of the quality of medical care.

a cause of action in situations when an ERISA plan or administrator has failed to pay or will fail to pay benefits due under an ERISA welfare benefit plan. *See id.* at 357. First, the Court stated: “On its face, a suit ‘to recover benefits due . . . under the terms of [the] plan’ is concerned exclusively with whether or not the benefits due under the plan were actually provided. The statute simply says nothing about the quality of benefits received.” *Id.*

Second, section 502(a) does not provide a civil cause of action when an ERISA beneficiary receives benefits that are of a substandard quality, as the section’s purpose is to prevent denied benefits and remedy claims for denied benefits, and not claims for low quality benefits. *See id.* at 357. The court’s analysis is based on its interpretation of ERISA’s legislative history:

Nor does anything in the legislative history, structure, or purpose of ERISA suggest that Congress viewed § 502(a)(1)(B) as creating a remedy for a participant injured by medical malpractice. When Congress enacted ERISA it was concerned in large part with the various mechanisms and institutions involved in the funding and payment of plan benefits. That is, Congress was concerned that “owing to the inadequacy of current minimum [financial and administrative] standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered.” Thus, Congress sought to assure that promised benefits would be available when plan participants had need of them and § 502 was intended to provide each individual participant with a remedy in the event that promises made by the plan were not kept. We find nothing in the legislative history suggesting that § 502 was intended as a part of a federal scheme to control the quality of the benefits received by plan participants. Quality control of benefits, such as the health care benefits provided here, is a field traditionally occupied by state regulation and we interpret the silence of Congress as reflecting an intent that it remain such.

Id. (citation omitted).

• 126. *Id.* The court specifically cited *Travelers* as support for this conclusion, which shows the court’s interpretation of *Travelers*’ limitation on ERISA’s preemption. Although the Third Circuit’s opinion did not directly involve a decision regarding whether ERISA’s preemption clause preempted the state law ostensible agency and directly liability claims, given that complete preemption for removal purposes was the issue, it is reasonable to believe that the court would not find preemption in light of its strong statement that Congress’ silence on the issue of the quality of care of ERISA’s benefits shows an intent that this area of traditional state authority remain with the states. Such determination could not remain with the states if the court were to find preemption under ERISA. As a matter of fact, if ERISA preempts state law claims for vicarious liability and medical malpractice, quality of care controls of ERISA benefits would not lie anyplace given the absence of a remedy for substandard care under section 502(a) of ERISA’s civil enforcement provisions.

A. Low Quality Benefits Versus Denied Benefits—A Direct Liability Claim Against the Treating Physician

ERISA's preemption of state medical malpractice lawsuits depends on the identity of the defendant. It is reasonably clear that ERISA does not preempt a plaintiff's direct malpractice claim against a treating physician even if the plaintiff has chosen the physician from an HMO's list of preferred providers. For example, in *Lancaster v. Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.*,¹²⁷ the plaintiff, an eleven-year-old child who had medical coverage

127. 958 F. Supp. 1137 (E.D. Va. 1997). Plaintiff's treating physicians were members of a group of physicians who had a contract with Kaiser Foundation Health Plan, an HMO that provided medical services to an ERISA plan under which the plaintiff received medical treatment for severe headaches. *See id.* at 1139.

Plaintiff alleged that the treating physicians misdiagnosed her condition because Kaiser Foundation Health Plan, an HMO that provided medical services to plaintiff, and the treating physicians' medical group used bonuses to discourage the treating physicians from ordering medically necessary tests that would have diagnosed the tumor. *See id.* at 1140. The treating physicians had treated plaintiff with medication, but did not order either an EEG or an MRI until approximately four years after plaintiff first sought treatment. *See id.* Plaintiff alleged several acts of negligence:

(i) Count I (negligence) alleges that Campbell "deviated from the accepted standard of medical care" because, among other things, he "failed to create an appropriate and timely differential diagnosis; failed to timely and properly refer the [patient] to a neurologist; fail[ed] to properly and timely order an MRI, CT Scan, EEG and/or other diagnostic testing; . . . fail[ed] to timely respond to his patient['s] signs and symptoms of a growing brain tumor; and fail[ed] to prescribe and use appropriate drugs in the appropriate dosages of said drugs to treat his patient."

(ii) Count II (negligence) alleges that Pauls breached his duty to act as a reasonably prudent medical practitioner in the same manner and to the same extent as Campbell.

(iii) Count III (negligence) alleges that Kaiser "is [indirectly] liable [by virtue of] respondeat superior for the negligence of Campbell and Pauls" and directly liable "for the establishment of guidelines and cost standards which worked against the full and prompt diagnostic assessment [of Lancaster's brain tumor] within the accepted standard of care and for its failure to establish policies, protocols, guidelines and standards for an adequate diagnostic assessment and treatment of [Lancaster's] continuing headaches."

(iv) Count IV (negligence) alleges that the Medical Group "is liable for the negligence [of Campbell and Pauls by virtue of] respondeat superior" and "is further negligent for the establishment of guidelines and cost standards which work[ed] against [Lancaster] receiving a proper diagnosis and treatment assessment within the standard of care during the course of her treatment for her headaches and for the failure to establish policies, protocols, guidelines and standards for her diagnostic assessment during her hospitalization."

(v) Count V (actual and constructive fraud) alleges that each defendant . . . "made an

under an ERISA benefit plan, filed a medical malpractice claim against her treating physicians, alleging that the physicians negligently misdiagnosed a brain tumor.¹²⁸ Plaintiff also alleged a vicarious liability claim against the HMO that arranged her medical care and against the treating physicians' medical group, asserting that these entities were responsible for the treating physicians' malpractice.¹²⁹ The court rejected defendants' allegations that ERISA preempted plaintiff's claim,¹³⁰ relying on the *Travelers'* Court's pronouncement that ERISA's preemption clause is not limitless in its application. ERISA did not preempt the two counts alleging medical malpractice against plaintiff's treating physicians, because a malpractice claim is a generally applicable state law claim that does not have a sufficient impact on "the relations among traditional ERISA plan entities, including the principal, the plan, the plan fiduciaries, and the beneficiaries."¹³¹ The court concluded that "[c]ommon law medical malpractice is quintessentially the province of state authority."¹³² Consequently, because ERISA did not preempt the medical malpractice claims against the treating physicians, it did not preempt the vicarious liability claims against the HMO and

actual misrepresentation of a material fact knowingly and intentionally . . . with the intent to mislead . . . Barbara Lancaster. . . ." Specifically, defendants "represented that they would provide medical care within or exceeding the appropriate standard of care for reasonably prudent practitioners similarly situated . . . [and then, despite] that representation, each defendant herein knowingly and intentionally established policies and guidelines which would financially benefit [Campbell and Pauls] for not providing care as reasonably prudent practitioners similarly situated and that bonuses and/or profit incentives were paid to these physicians for not rendering full and adequate care as needed."

Id. at 1140-41.

128. *See id.* at 1139-40.

129. *See supra* note 127.

130. Before deciding the preemption issue, the court removed plaintiff's state law claim to federal court under the complete preemption doctrine. *See Lancaster*, 958 F. Supp. at 1145.

131. *Id.* at 1149. Several other courts have held that ERISA does not preempt a plaintiff's state law medical malpractice claim against a treating physician, even when the physician was a member of an HMO that administered plaintiff's ERISA plan; these cases primarily use the "too tenuous, remote, or peripheral" exception; the "run-of-the-mill state law" exception; the presumption against the preemption of traditional state laws exception; and the distinction between a state law claim challenging a denial of benefits and one challenging substandard medical treatment and/or the quality of medical benefits. *See Pacificare of Okla., Inc., v. Burrage*, 59 F.3d 151, 155 (10th Cir. 1995) ("Just as ERISA does not preempt the malpractice claim against the doctor, it should not preempt the vicarious liability claim against the HMO if the HMO has held out the doctor as its agent."); *Edelen v. Osterman*, 943 F. Supp. 75, 76 (D.C. 1996) (denying preemption of a state law medical malpractice claim against a treating physician, stating that the claim "is one of those 'run-of-the-mill' state claims that has too tenuous a relationship to an employee benefit plan to support a finding of preemption").

132. *Lancaster*, 958 F. Supp. at 1149.

the treating physicians' medical group as alleged in the complaint.¹³³

The court's decision in *Lancaster*, and its reliance on *Travelers*, is a reasonable recognition of federalism. States should be allowed to regulate, either through statutory provisions or medical malpractice lawsuits, the conduct of physicians who practice in their territorial boundaries. The *Lancaster* plaintiff's physicians could not practice medicine in the relevant state if they were not licensed to practice medicine there. Having submitted themselves to a state's medical licensure requirements and disciplinary jurisdiction, the treating physicians should hardly be heard to complain that they should not be subject to a medical malpractice lawsuit while treating patients in the state. This is especially true given that states, and not the federal government, regulate the quality of medical practice. Moreover, ERISA has no statutory provisions that either directly regulate the quality of medical care within a particular state or specifically limit a state's authority to regulate the quality of medical care.

Therefore, the lower-level federal cases that make a distinction between the *quality* of provided benefits and the *quantity* of benefits (with ERISA not providing a remedy for the former but providing one for the latter) support a

133. *See id.* at 1149-50. The court held that any reference to the plan language that would be required to establish the agency relationship between the HMO and the treating physicians was not sufficient to cause preemption because "such reference does not sufficiently implicate the underlying objectives of the ERISA statute." *Id.* at 1150. Further, the vicarious liability claim did not "purport to mandate or regulate an employee benefit plan." *Id.*

First, the court held that the complete preemption doctrine did not provide a basis for removal of plaintiff's state law medical malpractice claims (Count I and II) against the treating physicians, who denied allegations that they committed medical malpractice in their treatment of plaintiff by not ordering appropriate medical tests and by not referring plaintiff to a specialist. *See id.* The reason these claims were not preempted is that the medical malpractice claims attacked the quality of the physicians' medical treatments, and not the HMO's administrative decisions regarding whether to authorize payment for treatment the physicians might have recommended. Furthermore, the medical malpractice claim allegation against the treating physicians that the HMO's and medical group's bonus incentive plan caused the treating physicians to deviate from the acceptable medical standard of care was not sufficient enough to support complete preemption, given that to establish a state medical malpractice claim one must show only a deviation from the standard of care and not necessarily the motivation for the deviation. *See id.* at 1146. In sum, the court reasoned that the complete preemption doctrine was not applicable because the state law claim challenged the physicians' medical decision to not order certain tests and the quality of care of the medical decisions. *See id.* Similarly, and in reliance on *Dukes*' quantity/quality distinction, the court held that the vicarious liability claims against the HMO and the medical group, being based on the state medical malpractice claim against the physicians, was not a proper ground for complete preemption because it also involved the quality of medical decisions and the HMO's and medical group's legal responsibility for these decisions. *See id.* at 1145. Apparently the treating physicians did not ask the HMO for any authorization of the diagnostic tests the plaintiff contends that the treating physicians should have ordered. Therefore, there was no ERISA benefit plan administrative benefit denial decision to serve as the basis of the plaintiff's state law claim regarding the treating physicians' alleged medical malpractice. *See id.*

conclusion that ERISA should not preempt a state law medical malpractice claim against a treating physician because these cases leave the regulation of the quality of medical benefits to the states. The same conclusion is appropriate for vicarious liability claims against HMOs and other managed care organizations that provide treating physicians to patients.

B. Low Quality Benefits Versus Denied Benefits—Vicarious Liability Claims Against HMOs and Health Plans

A vicarious liability claim against an HMO or health plan seeks to hold such entities legally responsible for treating physicians' medical malpractice, normally because the HMO or health plan has mandated that the plaintiff-beneficiary select the treating physician from a restricted list of physicians.¹³⁴ To defend a vicarious liability claim, a HMO or health plan will frequently raise an ERISA preemption defense, alleging that the state law claim "relates to" the ERISA plan.¹³⁵ Some courts have cited *Travelers* to establish that ERISA does not preempt vicarious liability claims.¹³⁶

134. In other words, the HMO or health plan gives the beneficiary a preferred list of physicians from which the beneficiary typically must either choose a treating physician or suffer a reduction in the amount the HMO or health plan will pay. See Ryan L. Everhart, Comment, *New York Managed Care Legislature: A Substantive Response to Corporate Medicine or a Token Gesture to Ease Consumer Concerns?*, 46 BUFF. L. REV. 507, 516 (1998) ("Upon joining an HMO, the enrollee will usually receive a list of physicians from which he or she may seek treatment. If the enrollee seeks treatment from a different provider, the HMO will often refuse to pay for the services or charge a higher fee.").

135. See generally *Lazorko v. Pa. Hosp.*, No. 96-4858, 1998 WL 405055, at *2 (E.D. Pa. June 30, 1998), *aff'd in part and vacated in part*, 237 F.3d 242 (3d Cir. 2000).

136. Although the Fifth Circuit in *Giles v. NYLCare Health Plans, Inc.*, 172 F.3d 332 (5th Cir. 1999), did not determine whether ERISA preempted plaintiff's vicarious liability claim against an HMO for the medical malpractice of one of its preferred provider physicians, the court did hold that the district court had not abused its discretion in remanding the state law claim to state court. See *id.* at 339. The defendants had removed the lawsuit to federal court because plaintiff's lawsuit contained several state law claims that were completely preempted by section 502(a) of ERISA, therefore providing a basis for the district court's exercise of federal subject matter jurisdiction over the claims. See *id.* at 338-39. Once in federal court, the district court granted the defendants' motion to dismiss the completely preempted claims, but the court also granted the plaintiff's motion to remand the vicarious liability claim of the lawsuit to state court given the absence of the completely preempted claims. See *id.* at 335. The Fifth Circuit had jurisdiction to review the district court's remand because it was not a remand under section 1477(c), but was a remand based on the district court's discretionary decision not to exercise supplemental jurisdiction over state law claims that did not independently come within the court's subject matter jurisdiction. See *id.* at 336.

The Fifth Circuit asserted that comity for state court jurisdiction over the state law medical malpractice claim was one factor that supported the district court's decision to remand the lawsuit back to the state court. See *id.* at 339. The crucial consideration on the comity issue was the Fifth

In *Lazorko v. Pennsylvania Hospital*,¹³⁷ the plaintiff filed state law claims against U.S. Healthcare, an HMO that arranged for medical care under an ERISA health plan, when the treating physician did not request hospitalization for a wife whose subsequent suicide allegedly resulted from the absence of hospitalization treatment.¹³⁸ Although the district court held that ERISA preempted plaintiff's direct liability claim against the HMO,¹³⁹ it held that ERISA did not preempt the vicarious liability claim that alleged that the HMO was liable for the medical malpractice of the treating physicians.¹⁴⁰ The court stated:

Circuit's acknowledgment of *Travelers'* conclusion that ERISA should not preempt generally applicable state health law regulations "unless that was the clear and manifest purpose of Congress." *Id.* at 340 (citing *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995)). Although the Fifth Circuit did not express an opinion on whether ERISA preempted the plaintiff's state law vicarious liability and negligence claims, the court did recognize that these claims were a part of the state's common law regulation of the quality of health care, a matter traditionally left to state law regulation. *See Giles*, 172 F.3d at 339.

To reemphasize, although the Fifth Circuit recognized the comity of the state law regulation of the quality of health care, the court did not express an opinion on whether these comity principles were strong enough for the instant plaintiff's state law claims to escape ERISA's preemption. *See id.* at 339-40. That recognition would not necessarily prevent the Fifth Circuit from subsequently finding preemption; however, the court's acknowledgment of *Travelers'* and states' historical regulation of the quality of health care should cause the Fifth Circuit, and other courts, to engage in a more principled analysis of ERISA preemption issues with a goal towards giving more importance to evaluating the effects that state vicarious liability and medical malpractice lawsuits have on ERISA's preemption clause's objectives and purposes, and less importance on the vague and unhelpful meaning of "relate to."

137. No. 96-4858, 1998 WL 405055, at *2 (E.D. Pa. June 30, 1998), *aff'd in part and vacated in part*, 237 F.3d 242 (3d Cir. 2000).

138. *See id.* "The complaint recites four causes of action: trespass, intentional misrepresentation, fraud, and statutory violation." *Id.*

139. Therefore, in evaluating the HMO's preemption defense, the court emphasized that the plaintiff's complaint had a direct liability claim and a vicarious liability claim against the HMO. *See id.* at *9. The direct liability claim alleged that the HMO's "financial incentive system resulted in an economically motivated decision to refuse [the wife's] needed [hospitalization]," a refusal that caused the wife's suicide. *Id.* The court concluded that this allegation was really a claim for "a denial of plan benefits based upon U.S. Healthcare's administration of the insurance plan." *Id.* Therefore, the court held that the claim was preempted. *See id.* The court also held that plaintiff's claims

alleging intentional misrepresentation, fraud, and violations of Pennsylvania's Unfair Trade Practices and Consumer Protection Law—all focus on U.S. Healthcare's decisions in administering the relevant benefits plan. Because these counts seek damages under state law for the administration of an ERISA plan, they implicate the statutory objectives of ERISA in a meaningful way and are, therefore, preempted.

Id. (citing *Travelers*, 514 U.S. at 657).

140. *See id.*

In suing on vicarious liability principles, plaintiff seeks to vindicate rights under state tort law to recover alleged breaches of a physician's duty of care (to the extent that state-law agency principles will impute such a breach to the HMO). This is not a claim to recover damages for the denial of benefits. Nor is it one that otherwise implicates the administration of the plan in a meaningful way since it does not rest on a law that "mandate[s] employee benefit structures or their administration."¹⁴¹

Importantly, the court held that any indirect economic effect of the vicarious liability claim, to the extent that the claim would increase the HMO's operating expenses, falls within the "too tenuous, remote, or peripheral" exception to ERISA's preemption.¹⁴² The court also noted that state law medical malpractice claims fall within the presumption against the preemption of traditional state law.¹⁴³

Similarly, the court in *Dykema v. King*¹⁴⁴ held that ERISA did not preempt a plaintiff's vicarious liability and corporate negligence claims because these claims attacked the quality of the medical services that the treating physicians provided and not the quantity of the services.¹⁴⁵ Unlike a state law claim for denied benefits, the plaintiff's "suit rests solely on a failure to provide services

141. *Id.* (citing *Travelers*, 514 U.S. at 658).

142. *See id.* at *5.

143. *See id.* The court relied on *Travelers*' admonition against the preemption of states' regulation of health care. *Id.* (acknowledging an absence of proof that "Congress chose to displace general health care regulation, which historically has been a matter of local concern"). The court quoted from *Dillingham* that: "Indeed, if ERISA were concerned with any state action—such as medical-care quality standards or workplace regulation—that increased the costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we would scarcely see the end of ERISA's pre-emptive reach . . ." *Id.*

144. 959 F. Supp. 736 (D. S.C. 1997).

145. *See id.* at 741. Additionally, the claims did not seek either an enforcement of rights under an ERISA benefit plan or a clarification of rights to future benefits under the plan. *See id.* In *Dykema*, the plaintiff brought a vicarious liability claim and a corporate negligence claim against *Campion*, an HMO that administered a corporation's self-insured welfare benefit plan. *See id.* at 737. After entering into an administration agreement with plaintiff's decedent's husband, who allegedly died of a pulmonary embolism that his treating physicians did not diagnose, the HMO provided the decedent with a list of preferred providers, from which the decedent chose his treating primary care physicians. *See id.* at 738. After seeking treatment on several occasions, the decedent died. *See id.* at 739. The state law vicarious liability claim against the HMO alleged that, under state law, the HMO was vicariously liable for the negligence of the preferred treating physicians who misdiagnosed the decedent's medical condition. *See id.* at 737. The corporate negligence claim was that the HMO "negligently selected and credentialed" the preferred physicians. *Id.* at 739. In evaluating the HMO's motion to remove the state law claim to federal court under the complete preemption doctrine, the court denied removal on the grounds that ERISA did not preempt plaintiff's two state law claims. *See id.* at 741.

of acceptable quality.”¹⁴⁶ Therefore, the court denied removal under the complete preemption doctrine.¹⁴⁷

Lazorko and *Dykema* are consistent with cases holding that ERISA does not preempt a direct medical malpractice lawsuit against a treating physician. Like the direct malpractice claim, the vicarious liability claim is based on a state tort theory that exists independently of the terms and conditions of an ERISA plan. Similarly, vicarious liability claims regulate the quality of medical care to the extent that tort liability might encourage HMOs and other managed care organizations to provide patients with only qualified, non-negligent physicians. Or, the claims might give them an incentive to better monitor physicians’ treatment of patients. Being a regulation of the quality of physicians’ medical treatment, vicarious liability claims, like direct medical malpractice claims, should escape preemption under the rationale of *Travelers*, *Dukes*, and the above-referenced cases because they are a legitimate state regulation of the quality of medical care.¹⁴⁸

146. *Id.*

147. *See id.*

148. Furthermore, to the extent that one believes that enterprise liability is the best way to allocate medical malpractice liability, a vicarious liability claim against an HMO or other managed care organization is more consistent with principles of enterprise liability; and therefore, is another legitimate alternative for state regulation of the quality of medical care. *See generally* Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Choice of the Responsible Enterprise*, 20 AM. J.L. & MED. 29 (1994) (supporting enterprise liability in the medical profession); Clark C. Havighurst, *Making Health Plans Accountable for the Quality of Care*, 31 GA. L. REV. 587, 587 (1997) (“The thesis of this Article is that MCOs, as distinguished from indemnity-type health insurers, should bear exclusive legal responsibility for the negligence of physicians treating their subscribers or enrollees.”). Relying upon the “too tenuous, remote, or peripheral” exception, the insufficient nature of a “reference to” an ERISA plan to establish an agency relationship between HMOs and treating physicians, and the presumption against the preemption of traditional state laws, some cases find that ERISA does not preempt state vicarious liability claims (premised upon treating physicians’ medical malpractice) against HMOs and other managed care organizations. *Corporate Health Ins. v. Tex. Dep’t of Ins.*, 215 F.3d 526, 534 (5th Cir. 2000) (“Rather, the Act would allow suit for claims that a treating physician was negligent in delivering medical services, and it imposes vicarious liability on managed care entities for that negligence. This vicarious liability does not ‘relate to’ the managed care provider’s role as an ERISA plan administrator or affect the structure of the plans themselves so as to require preemption.”); *Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151, 155 (10th Cir. 1995) (“Just as ERISA does not preempt the malpractice claim against the doctor, it should not preempt the vicarious liability claim against the HMO if the HMO has held out the doctor as its agent.”).

At least one federal circuit court of appeals has found that ERISA preempts a vicarious liability claim against an HMO when the underlying claim against the treating physician alleges that the physician has been negligent in refusing to treat a plaintiff after an HMO has denied medical benefits (as opposed to the physician being negligent in rendering medical treatment that the HMO actually authorized). *See Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1494 (7th Cir. 1996) (distinguishing *Pacificare of Oklahoma, Inc.*, 59 F.3d at 151, the court stated: “In this case,

Despite strong arguments and good case law support that ERISA does not preempt direct liability and vicarious liability claims, these types of state law claims do not readily cover some negligent medical decisions that cause injuries. In other words, ERISA plan administrators, who make certain medical treatment decisions during the utilization review process, require special consideration under an ERISA preemption analysis.

*C. ERISA Administrators' Negligent Utilization Review Decisions
and Negligent Medical Treatment Decisions*

As with direct medical malpractice claims against treating physicians and vicarious liability claims against managed care organizations, the same reasoning should apply that some of the administrators' negligent decisions during the utilization review process should be subject to state law remedies without ERISA's preemption being a bar. However, state law claims against ERISA administrators run a greater risk of preemption because a limited number of ERISA claims and statutory provisions regulate administrators' conduct and provide a remedy for negligent decisions, albeit a very insubstantial, non-

however, Dr. Anderson's alleged negligence is intertwined with the benefits determination because the alleged negligence concerned a failure to treat where the Plan denied payment for the treatment."'). For cases distinguishing *Jass* on the grounds that it involves a physician's refusal to treat after an HMO denied requested medical benefits, although recognizing that the *Jass* court gave other reasons for preemption, including that the establishment of an agency relationship "would require an analysis of the underlying health care benefit plan and thus would 'relate to' the benefit plan," see *Corporate Health Insurance, Inc.*, 220 F.3d at 643 n.5 (stating the court's opinion that, under Texas' "quality of care" statute, "direct and vicarious liability claim[s] [against HMO] were not preempted when based on the actual negligent provision of medical services.'). See also *Hinterlong v. Baldwin*, 720 N.E.2d 313, 323 (Ill. 1999) (distinguishing *Jass* in part on the grounds that it did not involve an HMO's vicarious liability based upon a physician's negligence treatment, but also criticizing that "*Jass* suffers several infirmities [one of which is that it] completely ignores *Travelers* and engages in the purely textual analysis of [ERISA's preemption clause] called into question by *Travelers*").

For a listing of federal district court opinions that are for and against ERISA's preemption of vicarious liability claims against HMOs, and implicitly applicable to other managed care organizations, see generally *Pryzbowski v. U.S. Healthcare, Inc.*, 64 F. Supp. 2d 361 (D. N.J. 1999). At least one court has summed up the difference between the line of federal district court opinions against preemption and the line in favor of preemption, asserting that the majority of district court cases find no preemption on the grounds that "the medical malpractice claim against the HMO does not sufficiently relate to the plan so as to warrant preemption" and that "the doctor's negligence can be resolved without reference to the plan," while the opposing cases "reason[] that a vicarious liability malpractice claim concerns the delivery of benefits under the plan and the claim requires examination of the plan to determine obligations owed under the plan and the relationship between the plan and plan doctors." *Pacificare of Okla., Inc.*, 59 F.3d at 154-55 (finding that ERISA did not preempt the vicarious liability claim).

compensatory damage remedy.¹⁴⁹

Some courts have interpreted *Travelers* in a manner that distinguishes between an ERISA administrator's negligent utilization review decision and the administrator's negligent medical decision, with ERISA preempting the former but not the latter. In *Crum v. Health Alliance-Midwest, Inc.*,¹⁵⁰ although primarily involving a removal issue under the complete preemption doctrine, the court held that ERISA did not preempt a state law negligence claim against Health Alliance¹⁵¹ for its advisory nurses' alleged negligence during the utilization review process in misdiagnosing the decedent's medical condition when his wife spoke to the nurses on the phone regarding the decedent's complaints about chest pain and other symptoms.¹⁵² An advisory nurse, during a phone conversation, allegedly diagnosed the patient as suffering from "excess stomach acid" when he apparently showed symptoms of a heart attack; subsequently, the patient died without receiving any treatment.¹⁵³

The court held that ERISA did not completely preempt the state law claim because it alleged that the ERISA plan administrator was negligent in making a medical treatment decision, and not that the administrator was negligent in a

149. 29 U.S.C. § 1132(a) ; 29 U.S.C. § 1109(a) (1998).

150. 47 F. Supp. 2d 1013 (C.D. Ill. 1999).

151. *See id.* at 1021. The court's opinion did not specifically state whether Health Alliance was an HMO as opposed to another type of health plan. In any event, under the relevant ERISA plan, Health Alliance employed an advisory nurse who had some responsibility to make utilization review decisions regarding the type of treatments that the plaintiff's decedent needed. *See id.* at 1015.

152. *See id.* at 1015-16, 1017-18.

153. *Id.* at 1015. The major count of plaintiff's decedent's complaint alleged that:

Defendant, by and through its agents and/or employees, was guilty of one or more [of] the following acts and/or omissions:

- a. The advisory nurse or nurses undertook to render a medical diagnosis of [plaintiff's] condition, even though they were not trained, qualified nor licensed to practice medicine in the State of Illinois;
- b. The advisory nurse or nurses rendered medical diagnoses of [plaintiff's] condition, even though they were not trained, qualified nor licensed to practice medicine in the State of Illinois; and
- c. The advisory nurse or nurses failed to instruct [plaintiff] immediately to seek medical attention at a hospital emergency room.

Id. at 1016. The district court relied on three propositions from *Travelers* to support its decision against preemption of the state law claims. First, the court asserted that it "must look 'to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.'" *Id.* at 1017. Second, the court emphasized *Travelers*' conclusion against preemption "if the state law has only a tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability." *Id.* at 1017-18. Third, the district court stated *Travelers*' assertion that "nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Id.* at 1018.

utilization review decision to grant or deny medical treatment.¹⁵⁴ The district court's decision against preemption rested upon a difference between an ERISA administrator's utilization review decision to deny medical treatment and the administrator's negligent provision of either authorized benefits or medical opinions to beneficiaries.¹⁵⁵ ERISA completely preempts the former claims but not the latter claims under either a direct liability theory or a vicarious liability theory.¹⁵⁶

However, in some cases, the distinction between an administrator's negligent utilization review decisions and negligent medical treatment decisions is a vague and speculative standard to apply.¹⁵⁷ This might have been the reason why the

154. *See id.* at 1019.

155. *See id.* at 1020.

156. *See id.* The *Crum* court also held that the ERISA preemption clause did not preempt the claim based upon the nurses' alleged malpractice. *See id.* at 1017-18. This conclusion seems to be the import of the district court's reliance on *Moreno v. Health Partners Health Plan*, 4 F. Supp. 2d 88(D. Ariz. 1998), for the proposition that "[o]ther courts have similarly concluded that [ERISA's preemption clause] does not preempt claims based upon negligence in providing medical services." *Crum*, 47 F. Supp. 2d at 1018. The court in *Crum* also favorably cited cases that establish that "state law provisions making managed care entities liable for substandard health care treatment decisions [are] not preempted by [ERISA's preemption clause]." *Id.* (citing *Corporate Health Ins. Inc. v. Tex. Dep't of Ins.*, 12 F. Supp. 2d 597, 611-20 (S.D. Tex. 1998)). Moreover, the court stated that "ERISA 'does not oblige federal courts to take over the entire subject of medical care.'" *Id.* (citing *Cent. States v. Pathology Lab*, 71 F.3d 1251, 1254 (7th Cir. 1995)).

157. For example, the facts in *Crum* show that the patient's wife, after the patient experienced symptoms that were consistent with a heart attack, contacted the ERISA plan administrator's advisory nurse whose role was apparently that of a utilization reviewer of requested medical treatment. *See id.* at 1015-16. The district court does not clearly state whether the wife requested the authorization of emergency room treatment. *See id.* at 1015. The district court's statement of the relevant facts is as follows:

Plaintiff alleged that the advisory nurses were employees of Defendant or acted as Defendant's agents. Plaintiff alleged that, at approximately 10:50 p.m., she contacted an advisory nurse on Gary's behalf and informed the nurse of Gary's symptoms and the history of heart trouble in Gary's family. Plaintiff told the nurse she wanted to make sure Gary was not having a heart attack. The advisory nurse told Plaintiff that Gary's symptoms were probably due to excess stomach acids and that he should be fine. Plaintiff again telephoned an advisory nurse at approximately 11:34 p.m. Plaintiff informed the nurse of Gary's continued symptoms and also that he was experiencing pain in the middle of his chest. According to Plaintiff's Complaint:

The advisory nurse indicated that [plaintiff] should sit at a 40 degree angle, that he should drink some milk and that this would allow the stomach acids to recede and would help with the discomfort, and that he would be fine in the morning, and that he did not need to go to an emergency room.

At 11:55 p.m., Gary's symptoms had not ceased, and Plaintiff decided to drive Gary to a Medical Center. On the way, Gary became unresponsive. Cardiopulmonary resuscitation was performed when Gary arrived at the Medical Center at 12:05 a.m. The

district court in *Crum* stated that “the claims at issue here do not clearly involve ‘utilization review’ and instead are more accurately considered claims based on the ‘quality’ of medical care received and a ‘medical decision’ rather than an administrative decision.”¹⁵⁸

The problems stemming from *Crum* revolve around several issues. First, there is uncertainty over the types of claims that should fall within the quality of care exception to ERISA preemption, as discussed in *Crum*. The resolution of this issue might depend on the nature of a treating physician’s recommended treatment and on whether the ERISA administrator’s or ERISA utilization reviewer’s decision is (1) only a utilization review decision, (2) only a medical decision, or is (3) a “mixed medical and utilization review decision.”¹⁵⁹

efforts were not successful, and Gary was pronounced dead at 12:29 a.m. The cause of death was later determined to be acute myocardial infarction.

Id. at 1015-16. If the wife had requested treatment, then the advisory nurse’s statement that the patient was not suffering from a heart attack and therefore did not need medical treatment would have arguably been a negligent utilization review decision. ERISA’s preemption clause would have probably preempted plaintiff’s state law claims under the district court’s analysis in *Crum*. However, one could conclude that the wife’s purpose for telephoning the nurse was to obtain medical advice regarding what should be done in light of the husband’s symptoms. If such were the case, then plaintiff’s state law claims, being based on an alleged medical decision, would not have been preempted.

Of particular significance is the wife’s statement that she “told the nurse she wanted to make sure Gary was not having a heart attack.” *Id.* at 1015. The advisory nurse allegedly “told Plaintiff that Gary’s symptoms were probably due to excess stomach acids and that he should be fine.” *Id.* This appears to indicate that the wife was seeking medical advice and not making a request for an authorization of emergency room treatment.

158. *Id.* at 1020. Cases supportive of a state medical malpractice or vicarious liability claim against an ERISA health plan and/or against a plan’s agents and employees, including those involved in the plans’ utilization review, generally will not find preemption if the plaintiff’s complaint alleges negligence in the provision of benefits and not negligence in the plan’s decision to deny benefits. See *Huss v. Green Spring Health Servs., Inc.*, No. 98-6055, 1999 WL 225885, at *6 (E.D. Pa. Apr. 16, 1999) (holding that ERISA preempted a plaintiff’s state law malpractice claim based on a utilization reviewer’s alleged false statement that the plaintiff’s son was not covered under the plan because the claim “seeks redress for denial of benefits, caused by inadequate administration of an ERISA covered plan, . . . not quality, of benefit received”); *Phommyvong v. Muniz*, No. 3:98-CV-0070-L, 1999 WL 155714 (N.D. Tex. Mar. 11, 1999). In *Phommyvong*, ERISA did not preempt a plaintiff’s “negligence, breach of contract, and deceptive trade practices” claims against an employer who established an ERISA plan, nor plaintiff’s claim against the plan for “expenses for medical care and attention on behalf of their daughter,” nor plaintiff’s claim alleging that the plan “failed to select and retain competent personnel for the evaluation and treatment of plan members.” *Id.* at *1, *3. All claims were based on the death of plaintiff’s daughter after a nurse practitioner allegedly failed to diagnose lupus. See *id.* at *1. The court reasoned that the claim was “based upon the quality of care which the daughter received” and not on denied benefits. *Id.* at *3.

159. *Crum*, 47 F. Supp. 2d at 1018-19.

For example, if the treating physician requests a CAT scan and the ERISA plan administrator or utilization reviewer simply denies the request without any comments on the medical necessity of either the requested treatment or some alternative treatment, one could say that the denial of the treatment was "only a utilization review decision" to deny the treatment. Therefore, under some existing case law, ERISA would preempt a patient's state lawsuit against either an ERISA administrator or a utilization reviewer, alleging that a cancer went undiagnosed because the CAT scan was not authorized. Arguably, the administrator's or utilization reviewer's failure to authorize the CAT scan would be a utilization review decision that falls within ERISA's civil enforcement provisions; and ERISA's preemption clause would preempt a state law claim seeking to impose liability on either the administrator or the utilization reviewer pursuant to *Pilot Life's* preemption of state law claims seeking liability for an improper processing of a request for benefits.¹⁶⁰

On the other hand, an "only a medical decision" issue might exist if the administrator or utilization reviewer either authorizes a treating physician's treatment request or gives medical advice to a patient. In that event, under *Crum's* and *Dukes'* rationale, ERISA should not preempt a state law claim, against either the treating physician, the ERISA administrator, or the utilization reviewer, that asserts that the treatment was a negligent treatment. For example, if the treating physician requests and the ERISA administrator or utilization reviewer authorizes a CAT scan and the CAT scan is a negligent treatment, ERISA would not preempt a state law claim against the treating physician. There would be no preemption because the claim challenges the quality of provided medical benefits, as the treating physician would be liable under state medical malpractice laws for recommending and using a substandard procedure. In addition, a claim against the ERISA utilization reviewer or administrator could be based upon *Dukes'* distinction that allows state law regulation of utilization reviewer's and administrator's decisions during their role as the arrangers of medical treatment.¹⁶¹ Assuming the presence of an arranger or provider of medical treatment status, at least two possible state law malpractice claims could be filed against utilization reviewers and administrators. One claim would seek to hold these entities vicariously liable for the treating physician's malpractice.¹⁶² Another would impose corporate negligence liability for their negligence in selecting, monitoring, and supervising the treating physician.¹⁶³ The claim against the administrator and utilization reviewer could also be based upon *Crum's* holding that a utilization reviewer and an administrator can be liable for giving negligent medical advice without ERISA preempting such state law claims. These claims would assert direct liability against administrators and utilization reviewers for their decisions in authorizing negligent medical treatments, especially if they gave medical opinions or advice that either the

160. See *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49 (D. Mass. 1997).

161. See, e.g., *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 356-57 (3rd Cir. 1995).

162. See *id.*

163. See *id.*

patient's physician or the patient herself relied upon to the patient's detriment.¹⁶⁴

A "mixed medical and utilization review decision" would exist if, in addition to denying the requested CAT scan treatment, the administrator or utilization reviewer asserted that either the CAT scan was not medically necessary, that some other treatment was appropriate, or that no treatment at all was required. Furthermore, either the patient or the physician must have relied on the administrator's or utilization reviewer's medical advice to the patient's detriment. The resolution of an ERISA preemption issue in this type of situation appears more problematic than the two scenarios discussed above. The *Crum* court apparently would separate the administrator's or utilization reviewer's decision into a utilization review component (the denial of the medical treatment) and a medical decision component (opinions or advice regarding the medical necessity of the treatment). Under *Crum*, ERISA would not preempt a state law claim challenging only the quality of the medical decision, but a state lawsuit challenging a utilization review decision that denied medical treatment would likely be preempted.¹⁶⁵

However, some courts refuse to distinguish between negligent medical decisions and negligent utilization review decisions, opting instead to find preemption because the medical decision occurred during the processing of a claim for ERISA benefits. For example, in *Andrews-Clarke v. Travelers Insurance Co.*,¹⁶⁶ the plaintiff was the personal representative of Richard Clarke, an alcoholic who committed suicide when an ERISA plan's utilization reviewer would not authorize appropriate hospitalization for treatment of his alcoholism.¹⁶⁷ Despite an ERISA plan provision granting Clarke "at least one thirty day inpatient rehabilitation program per year," the utilization reviewer authorized only five days of hospitalization for Clarke's first treatment.¹⁶⁸ During a second hospitalization approximately thirty days later, the utilization reviewer authorized only eight days of care, despite Clarke's continued drunkenness and the benefit plan provision that would have allowed thirty days of care.¹⁶⁹ At the end of that hospitalization and "less than twenty-four hours later," Clarke again consumed a large quantity of alcohol and attempted suicide by locking himself in a garage with his car engine running.¹⁷⁰ After being rescued by his wife, Clarke was hospitalized and successfully treated for "carbon monoxide poisoning."¹⁷¹

Subsequently, a judge had Clarke involuntarily committed to prison for "his detoxification and rehabilitation" when the utilization reviewer, "despite the fact that enrollment in a thirty-day inpatient detoxification program is a defined benefit of the Travelers insurance policy, incredibly refused to authorize such a

164. See *Crum*, 47 F. Supp. 2d at 1019.

165. See *id.*

166. 984 F. Supp. 49 (D. Mass. 1997).

167. See *id.* at 50-52.

168. *Id.* at 51.

169. See *id.*

170. *Id.*

171. *Id.*

private admission.”¹⁷² Once in the prison, Clarke “was forcibly raped and sodomized by another inmate in his unit.”¹⁷³ Unfortunately, the prison did little to treat Clarke’s alcoholism condition.¹⁷⁴ Approximately one month later, Clarke was arrested for drunkenness and then admitted to another hospital which offered neither treatment for Clarke’s alcoholism nor a transfer to another facility for alcohol treatment.¹⁷⁵ After being released the next morning, Clarke “purchased a six-pack of Meisterbrau beer “and consumed it.”¹⁷⁶ Shortly thereafter, the police found his dead body in a parked car “with a garden hose extending from the tailpipe to the passenger compartment.”¹⁷⁷

Subsequently, the wife filed a lawsuit against Travelers, the administrator of the welfare benefit plan and against Greenspring, the utilization reviewers that allegedly denied Clarke sufficient hospitalizations on several occasions.¹⁷⁸ Alleging that Clarke’s death “was the direct and foreseeable result of the improper refusal of Travelers and its agent Greenspring to authorize appropriate medical and psychiatric treatment during Clarke’s repeated hospitalizations for alcoholism,” Clarke’s wife asserted theories of liability for “breach of contract, medical malpractice, wrongful death, loss of parental and spousal consortium, intentional and negligent infliction of emotional distress, and specific violations of the Massachusetts consumer protection laws.”¹⁷⁹

Although the federal district court showed righteous indignation against the harshness of ERISA preemption and acknowledged that ERISA should be amended to punish the type of improper denial of treatment that Clarke was forced to endure, the court held that ERISA preempted all of the wife’s claims.¹⁸⁰ First, the court, in part relying upon *Corcoran v. United Health Care, Inc.*,¹⁸¹ held that ERISA preempted the wife’s claim because it “[arose] out of the alleged improper processing of Clarke’s claim for benefits under an ERISA employee benefit plan.”¹⁸² The court used the same basic rationale as the Fifth Circuit in *Corcoran* by finding that *Pilot Life*, which held that ERISA preempts state law

172. *Id.*

173. *Id.*

174. *See id.*

175. *See id.* at 51-52.

176. *Id.* at 52.

177. *Id.*

178. *See id.*

179. *Id.*

180. *See id.* at 53. The court expressed its concern by stating:

ERISA is a “comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans.” . . . It is therefore deeply troubling that, in the health insurance context, ERISA has evolved into a shield of immunity which thwarts the legitimate claims of the very people it was designed to protect. What went wrong?

Id. at 56.

181. 965 F.2d 1321 (5th Cir. 1992).

182. *Andrews-Clarke*, 984 F. Supp. at 53-54.

claims for improper processing of ERISA welfare benefit claims, is broad enough to encompass a utilization reviewer's negligent decision during the processing of a claim even if the negligent act involves a medical decision that the recommended treatment is not medically necessary.¹⁸³ In other words, it appears that the *Andrews-Clarke* court believed that all decisions by a utilization reviewer that occur during the processing of a benefit claim warrant ERISA preemption of all state law claims challenging such decisions because the utilization reviewer's decision "relates directly to . . . [the] administration of benefits."¹⁸⁴

The court reached this conclusion despite its recognition of *Travelers'* admonition that ERISA's preemption clause's text is "unhelpful," and that courts must examine ERISA's objectives to clearly understand the scope of its preemption.¹⁸⁵ In an effort to reconcile its decision with *Travelers'* limitation on ERISA's preemption, the court stated that *Travelers* "made clear that [the Court's] prior ruling in *Pilot Life* remains good law."¹⁸⁶ Applying *Pilot Life* and *Corcoran*, the court held that "[un]like the hospital surcharge statute at issue in *Travelers*, which had only an indirect economic influence on plan administration, here [the wife's] claims go right to the heart of the benefit determination process."¹⁸⁷ Concentrating on *Corcoran's* rationale, the court reasoned that allowing this state law claim would create the type of disuniformity in the administration of ERISA benefit plans that ERISA's preemption clause sought to prevent.¹⁸⁸

183. *See id.* at 54 n.23.

184. *Id.* at 56 (quoting *Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc.*, 999 F.2d 298, 302-03 (8th Cir. 1993), *cert. denied*, 510 U.S. 1045 (1994)).

185. *Id.* at 57.

186. *Id.* at 58.

187. *Id.*

188. *See id.* The court stated:

This Court acknowledges that, in adopting ERISA's preemption provision, Congress intended to relieve employers and ERISA plans from the burdens of compliance with conflicting state laws not as an end in and of itself, but rather as a means to promote the principal object of ERISA as a whole—to protect plan participants and beneficiaries. At the time of its enactment, however, ERISA did provide an adequate remedy for the wrongful denial of health benefits. The present gap in remedies is therefore attributable not to an overbroad application of ERISA's preemption clause, but rather to the failure of Congress to amend ERISA's civil enforcement provision to keep pace with the changing realities of the health care system.

Id. at 58. The court seemed to believe that avoiding a disuniformity of regulation, ERISA's secondary goal, is "ancillary to the first" goal of protecting plan participants and administrators." *Id.* at 58 n.44. Although the court did not explain the full significance of this observation, it appears that the court believed that avoiding a disuniformity of regulation would reduce the cost of operating welfare benefits plans, and therefore, either would not discourage employers from establishing or maintaining benefit plans or would not cause employers to cut back on the level or amount of benefits to offset an increase in the cost of operating benefit plans that might result from a disuniformity of state law regulation. This appears to be the rationale that the Fifth Circuit used

Despite holding that ERISA preempts state causes of action for managed care organizations' negligent decisions during utilization review and that ERISA does not supply an appropriate remedy that provides suitable relief, the *Andrews-Clarke* court did not criticize the Supreme Court's expansive interpretation of ERISA's preemption clause. Instead, the court believed that the problem was Congress' failure to amend ERISA to accommodate negligent decisions made during prospective utilization review, a practice that was not common at the time Congress enacted ERISA.¹⁸⁹

Although the *Andrews-Clarke* court recognized that the "larger issue" was the changing nature of managed care from a retrospective payment system to a prospective payment system with "the incentives for undercare which now pervade American's health care system," the court thought it best to allow managed care organizations to continue to make utilization review decisions on a case-by-case basis, but to hold them "legally accountable for the consequences of their decisions."¹⁹⁰ In light of ERISA's preemption of state laws and lawsuits and the inadequacy of present ERISA civil enforcement remedies, the court believed that the proper solution was for Congress to amend ERISA to provide for a cause of action for negligent utilization review decisions.¹⁹¹ The court asserted that "[u]nder any criterion, however, the shield of near absolute immunity now provided by ERISA simply cannot be justified."¹⁹²

Given the adamant nature of Judge Young's opinion, one can conclude that he sincerely understood the injustice of ERISA's preemption of state law claims, especially the adverse incentives of prospective utilization review. Moreover, one can empathize with his efforts to maintain his judicial oath to follow U.S. Supreme Court precedent, which includes the Court's *Pilot Life* decision.¹⁹³

Judge Young addressed cases holding that managed care organizations can be vicariously liable under state law for the medical malpractice of their treating physicians without ERISA preemption.¹⁹⁴ However, he limited the application of these cases to a situation where the plaintiff alleges that a managed care organization is vicariously liable for the primary medical malpractice of an employee physician, as in a staff model HMO, or an independent contractor physician, as in a managed care organization's holding out of a treating physician as its agent.¹⁹⁵ In comparison, Judge Young noted that in *Andrews-Clarke* the plaintiff alleged that the plan administrator, and the utilization reviewer were directly liable "for negligent medical decisions made during the utilization

in *Corcoran*. See *Corcoran v. United Health Care, Inc.*, 965 F.2d. 1321, 1333 (1992).

189. See *Andrews-Clarke*, 984 F. Supp. at 58.

190. *Id.* at 62, 62-63.

191. See *id.*

192. *Id.* at 63.

193. See *id.* at 60. Judge Young stated: "This Court can neither simply disregard its sworn oath to comply with the opinions of the Supreme Court, nor can it 'legislate by judicial decree nor apply a statute, such as ERISA, other than as drafted by Congress.'" *Id.*

194. See *id.* at 56 n.27.

195. See *id.*

review process” and not that they were vicariously liable for physicians’ or hospitals’ negligent treatment decisions, a difference which apparently supported his conclusion in favor of preemption.¹⁹⁶

196. *Id.* at 52. Judge Young’s conclusion, that ERISA preempts state law claims seeking to impose liability on managed care organizations for negligent decisions during utilization review, is consistent with earlier legal opinions involving similarly state law claims. For example, in *Foster v. Blue Cross & Blue Shield of Michigan*, 969 F. Supp. 1020 (E.D. Mich. 1997), the plaintiff sued Blue Cross for its failure to pay for an autologous bone marrow transplant for his wife who had breast cancer. *See id.* at 1023. Blue Cross denied the treatment, allegedly because it was experimental. *See id.* The wife died after Blue Cross’ denial. *See id.* Despite the court’s recognition that *Travelers* held that ERISA’s preemption clause text is “unhelpful,” the court opined that the clause still has an expansive interpretation. *Id.* Applying the “connection with” and “reference to” definition of “relate to,” the court held that ERISA preempted plaintiff’s breach of contract, bad faith, infliction of emotional distress, negligent misrepresentation, fraud, and wrongful death claims which sought to hold Blue Cross liable for denying treatment. *See id.* at 1024. The court asserted that “[p]laintiff’s state common law claims all arose out of Defendant’s allegedly wrongful denial of benefits . . . [and therefore] are preempted by ERISA.” *Id.* at 1025. For its conclusion, the court primarily relied on *Kuhl v. Lincoln National Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th Cir. 1993). *Foster*, 969 F. Supp. at 1024-25. The court also found that preemption was proper because ERISA’s civil enforcement provisions provided a remedy, despite the fact that the provisions left plaintiff “without a meaningful remedy.” *Id.* at 1024 (quoting *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 943 (6th Cir. 1995)).

However, the court held that ERISA did not preempt the Michigan Blue Cross’ enabling law that mandated that “a health care corporation shall offer or include, in each group and non-group certificate, coverage for breast cancer diagnostic services, breast cancer outpatient treatment services, and breast cancer rehabilitative services.” *Id.* at 1026. Similarly, ERISA did not preempt another portion of the enabling law that mandated that nonprofit health corporations, like Blue Cross, provide “coverage for antineoplastic therapy” under certain circumstances. *Id.* The court held that, like the surcharges in *Travelers*, the enabling law neither regulated ERISA plans nor dictated the administration of those plans since ERISA plans were still free to choose plans other than Blue Cross plans, thereby avoiding any increase in cost because of Blue Cross’s compliance with Michigan’s enabling laws. *See id.* at 1027. Additionally, the court held that, even if the enabling laws fell within the scope of ERISA’s preemption clause, ERISA’s saving clause would have saved those laws from preemption. *See id.* at 1028.

However, the court held that ERISA preempted the portions of the enabling law that allowed a cause of action for misrepresentation of facts regarding a health plan and that provided a cause of action for a “[refusal] to pay claims without conducting reasonable investigation based upon the available information” because these provisions related to the ERISA plans apparently because ERISA’s civil enforcement provision provided a similar cause of action for “the wrongful’ denial of coverage.” *Id.* at 1028. Furthermore, ERISA’s saving clause did not exempt these provisions from preemption because they did not satisfy the relevant saving clause test. *See id.*

The distinction that Judge Young made in *Andrews-Clarke* about medical decisions during the utilization review process, as opposed to a claim that seeks to hold a managed care organization vicariously liable for the medical malpractice of a treating physician, can be used to distinguish other cases that have found that ERISA did not preempt a state law malpractice claim. For

Elsewhere this Author has argued that ERISA should not preempt all state law malpractice claims that challenge decisions that occur during the utilization review process.¹⁹⁷ Therefore, *Crum*, which separates negligent medical decisions from negligent utilization review decisions, finding no preemption when state lawsuits challenge a negligent medical decision, appears to be more in line with *Travelers'* criticism of ERISA's vague preemption clause. *Crum* recognizes *Travelers'* conclusion that the regulation of the quality of medical decisions falls within states' traditional police power regulation. As such, *Crum*, more than *Andrews-Clarke*, seems to give appropriate deference to the federalism concerns that *Travelers* promotes through its presumption against the preemption of traditional state law regulations.

However, *Crum* falls short because it fails to state whether ERISA should preempt a mixed eligibility and treatment decision. Given *Pegram's* conclusion that such mixed eligibility and treatment decisions are not a part of a managed care organization's fiduciary duties under ERISA, and that a beneficiary cannot bring a breach of fiduciary duty claim against such entities under ERISA's civil enforcement provisions, one should be able to bring a state law medical malpractice claim to challenge negligent mixed eligibility and treatment decisions, especially when either a managed care organization, its affiliated

example, one can look at *Ray v. Value Behavioral Health, Inc.*, 967 F. Supp. 417 (D. Nev. 1997), as a case involving the negligent rendition of medical treatment that had already been approved by the ERISA plan administrator, instead of any alleged negligence that occurred during the utilization review process of deciding whether or not to authorize treatment. *See id.* at 419. In *Ray*, the plaintiff alleged that a psychological counselor mistreated her by making oppressive sexual advances that worsened her psychological condition. *See id.* at 418-19. She filed a claim alleging theories of negligence by a professional counselor, breach of fiduciary duty, intentional infliction of emotional distress, negligent infliction of emotional distress and invasion of privacy. *See id.* at 419. The court held that ERISA did not preempt those claims because they did not have a reference to an ERISA plan since the counselor's alleged impermissible conduct would have happened whether or not there was an ERISA plan. *See id.* at 423. Similarly, plaintiff's state law claims did not have a connection with an ERISA plan because, given Congress' intent, these claims were "exactly the sort of generally applicable personal injury laws that [ERISA's preemption clause] does not preempt." *Id.* The court reasoned that "[s]tate tort laws of general applicability are matters of local concern which impose only indirect economic effects and costs on health plans." *Id.* Mindful of federalism, the court held that:

To hold that such claims are preempted by ERISA would federalize all tort claims on behalf of plaintiffs who obtain medical treatment through ERISA insurance plans. This Court will not impose such a sweeping federalization of basic personal injury claims in the absence of any language in the text of ERISA or in the absence of any evidence of Congressional intent.

Id. However, the court did assert that preemption might be proper if state law duties cannot be distinguished from ERISA imposed duties, or if the proof of such claims necessitated a reference to an ERISA plan or if the state law claims "are intertwined with an ERISA plan, or that the parties must refer to the plan, its language or coverage to prove or disprove" plaintiff's claim. *Id.* at 424.

197. *See Pittman, supra* note 22.

utilization reviewers, or its treating physicians have made the negligent decision. This is tantamount to recognizing that the medical decision portion of a mixed eligibility and treatment decision predominates over the eligibility decision. This is an appropriate conclusion because, in the absence of federal regulation of the quality of medical decisions, state law regulation in this area is not only appropriate but in furtherance of the presumption against the preemption of state law regulation in areas of traditional state concern.

D. States' Quality of Care Statutes

In addition to state regulation of managed care organizations, utilization reviewers, and ERISA benefit administrators through medical malpractice lawsuits and common law tort principles as discussed above, a state might enact a statute to govern the quality of medical care that managed care organizations give their patients. To defend against a lawsuit based on the failure to comply with such a state statute or to guard against other penalties for a violation of the statute, an ERISA administrator and an affiliated managed care organization might raise an ERISA preemption defense when an ERISA benefit plan provides the patient's treatment. At least one court has held that ERISA does not preempt a state statute that establishes the standard of care to which a managed care organization must adhere.

In *Corporate Health Insurance v. Texas Department of Insurance*,¹⁹⁸ the issue was whether ERISA preempts Texas' Health Care Liability Act ("Act"), which has several provisions dealing with two broad aspects of managed care. The "quality of care" provision sets an ordinary care standard to which "health insurance carriers, [HMOs and] other managed care entit[ies]" must adhere "when making health care treatment decisions."¹⁹⁹ In addition, it imposes civil liability for injuries flowing from a violation of the standard.²⁰⁰ The "benefit

198. 12 F. Supp. 2d 597 (S.D. Tex. 1998).

199. *Id.* at 603. The court cited relevant portions of the Act:

(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.

TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.002(a) and (b) (West 1998).

200. *See id.*

review” provisions establish an elaborate independent review system for review of a managed care organization’s negative benefit denial decisions.²⁰¹ The

201. See *Corporate Health Ins.*, 12 F. Supp. 2d at 622-24. The provisions provide:

(a) A person may not maintain a cause of action under this chapter against a health insurance carrier, health maintenance organization, or other managed care entity that is required to comply with the utilization review requirements of Article 21.58A, Insurance Code, or the Texas Health Maintenance Organization Act (Chapter 20A Vernon’s Insurance Code), unless the affected insured or enrollee or the insured’s or enrollee’s representative:

(1) has exhausted the appeals and review applicable under the utilization review requirements; or

(2) before instituting the action:

(A) gives written notice of the claim as provided by Subsection (b); and

(B) agrees to submit the claim to a review by an independent review organization under Article 21.58A, Insurance Code, as required by Subsection (c).

(b) the notice required by Subsection (a)(2)(A) must be delivered or mailed to the health insurance carrier, health maintenance organization, or other managed care entity against whom the action is made not later than the 30th day before the date the claim is filed.

(c) The insured or enrollee or the insured’s or enrollee’s representative must submit the claim to a review by an independent review organization if the health insurance carrier, health maintenance organization, or managed care entity against whom the claim is made requests the review not later than the 14th day after the date notice under Subsection (a)(2)(A) is received by the health insurance carrier, health maintenance organization, or other managed care entity. If the health insurance carrier, health maintenance organization, or other managed care entity does not request the review within the period specified by this subsection, the insured or enrollee or the insured’s or enrollee’s representative is not required to submit the claim to independent review before maintaining the action.

(d) Subject to Subsection (e), if the enrollee has not complied with Subsection (a), an action under this section shall not be dismissed by the court, but the court may, in its discretion, order the parties to submit to an independent review or mediation or other nonbinding alternative dispute resolution and may abate the action for a period of not to exceed 30 days for such purposes. Such orders of the court shall be the sole remedy available to a party complaining of an enrollee’s failure to comply with Subsection (a).

(e) The enrollee is not required to comply with Subsection (c) and no abatement or other order pursuant to Subsection (d) for failure to comply shall be imposed if the enrollee has filed a pleading alleging in substance that:

(1) harm to the enrollee has already occurred because of the conduct of the health insurance carrier, health maintenance organization, or managed care entity or because of an act or omission of an employee, agent, ostensible agent, or representative of such carrier, organization, or entity for whose conduct is liable under Section 88.002(b); and

(2) the review would not be beneficial to the enrollee, unless the court, upon motion by a defendant carrier, organization, or entity finds after that such pleading was not made in good faith, in which case the court may enter an order pursuant to Subsection (d).

(f) If the insured or enrollee or the insured’s or enrollee’s representative seeks to exhaust

federal district court held that ERISA did not preempt the quality of care provision.²⁰² The court found three reasons why the Act did not have a "reference to" ERISA plans. First, the conditions of the "quality of care" provisions apply to health insurers and managed care entities whether or not they were providing benefits under an ERISA plan.²⁰³ Second, unlike the case *District of Columbia v. Greater Washington Board of Trade*,²⁰⁴ the Act is not "premised on the existence of an ERISA plan."²⁰⁵ Third, "the existence of any ERISA plan [is] not essential to the operation of the Act."²⁰⁶

the appeals and review or provides notice, as required by Subsection (a), before the statute of limitations applicable to a claim against a managed care entity has expired, the limitations period is tolled until the later of:

(1) the 30th day after the date the insured or enrollee or the insured's or enrollee's representative has exhausted the process for appeals and review applicable under the utilization review requirements; or

(2) the 40th day after the date the insured or enrollee or the insured's or enrollee's representative gives notice under Subsection (a)(2)(A).

(g) This section does not prohibit an insured or enrollee from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for appeal and review places the insured's or enrollee's health in serious jeopardy.

TEX. CIV. PRAC. & REM. CODE ANN. § 88.003 (West 1998).

202. See *Corporate Health Ins.*, 12 F. Supp. 2d at 620.

203. See *id.* at 612. The court also emphasized that the Act, which "requires managed care entities to exercise ordinary care when making medical decisions[,] . . . excludes ERISA plans from the definition of a 'managed care entity.'" *Id.* However, some courts might interpret such a specific exclusion of ERISA plans as an impermissible protection of ERISA plans that would be sufficient to meet the requirement of a "reference to" to result in preemption under ERISA's preemption clause. See *Mackey v. Lanier Collecting Agency & Serv., Inc.*, 486 U.S. 825, 825 (1988) (holding that the garnishment statute, "which singles out ERISA employee welfare benefit plans for different treatment than non-ERISA welfare plans under state garnishment procedures, is pre-empted under § 514(a) of ERISA").

204. 506 U.S. 125 (1992).

205. *Corporate Health Ins.*, 12 F. Supp. 2d at 611 (quoting *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., Inc.*, 519 U.S. 316 (1997)). The court stated:

Contrary to Plaintiffs' contention, in *Greater Washington*, the Supreme Court did not conclude that the statute referred to ERISA plans simply because it contained certain terminology. Rather, as explained in [*Dillingham Construction*], the Court reasoned that the reference to ERISA plans resulted in preemption because the existence of ERISA plans was essential to the statute's operation. Unlike the statute in *Greater Washington*, the Act is not premised on the existence of an ERISA plan. It merely requires health insurance carriers, HMOs, and other managed care entities to exercise ordinary care when making medical decisions. The Act imposes this standard on these entities without any reference to or reliance on an ERISA plan.

Id. at 613 (internal citations omitted).

206. *Id.* at 614.

The district court also held that the "quality of care" provisions did not have an impermissible "connection with" an ERISA plan.²⁰⁷ First, a lawsuit under the Act would "relate to the quality of benefits received from a managed care entity when benefits are actually provided, not denied."²⁰⁸ Therefore, the district court used *Dukes*' distinction, between a lawsuit for denied benefits and one complaining about the quality of benefits that the administrator has already provided in her role as an arranger and provider of medical care, to hold that the quality of care provisions did not have a "connection with" ERISA plans.²⁰⁹

Additionally, the district court concluded that the Act's "quality of care" provisions fell within a "field traditionally occupied by state regulation" and that, as Congress has not specifically addressed the issue, Congress' silence indicates its desire to leave to states the regulation of the quality of provided benefits.²¹⁰

The district court also concluded that the "quality of care" provisions, and lawsuits premised thereon, did not establish an impermissible alternative enforcement procedure for obtaining denied ERISA benefits.²¹¹ This is true because a state lawsuit based upon a substandard quality of care under the Act would be based upon the provision of substandard benefits and not on the denial of benefits.²¹² Therefore, the lawsuit would not be seeking the same type of remedies allowable under ERISA's civil enforcement provisions, and would not result in a duplicate, and improper alternative means of obtaining denied benefits.²¹³

207. *Id.* at 620.

208. *Id.* at 617. The court distinguished *Corcoran v. United Health Care, Inc.*, 965 F.2d 1321 (1992), on the grounds that the plaintiff sought state law remedies for a medical decision that resulted in a denial of benefits. See *Corporate Health Ins.*, 12 F. Supp. 2d at 617. Therefore, *Corcoran* is not a case seeking damages for the provision of low quality or substandard benefits, but a decision "made in relation to the denial of certain plan benefits." *Id.*

209. See *Corporate Health Ins.*, 12 F. Supp. 2d at 618-19. The court stated:

Also in *Dukes*, the Court distinguished the *Corcoran* case based on the dual roles that may be assumed by an HMO. The Court emphasized that in *Corcoran*, United only performed an administrative function inherent in the utilization review whereas the defendant HMOs in *Dukes* played two roles—the utilization review role and the role as an arranger for the actual medical treatment for plan participants. [U]nlike *Corcoran*, [in *Dukes*] there . . . [was] no allegation . . . that the HMOs denied anyone any benefits that they were due under the plan. Instead, the plaintiffs [in *Dukes* were] . . . attempting to hold the HMOs liable for their role as the arrangers of their decedents' medical treatment. Likewise, a plaintiff bringing suit under the Act may seek to hold a HMO liable in its position as the arranger of poor quality medical treatment, thereby, avoiding any allegation that the HMO wrongfully denied benefits under the plan and therefore, any connection with ERISA.

Id. at 619 (internal citations omitted).

210. *Id.* at 620.

211. See *id.* at 628-29.

212. See *id.*

213. See *id.*

In reaching its decision, the court distinguished *Corcoran* on the ground that the Fifth Circuit had not taken into consideration *Travelers'* statements that there should be a presumption against the preemption of state laws in areas of traditional state regulation unless there is a clear and manifest intent of Congress that preemption should occur.²¹⁴ Also, in response to the Fifth Circuit's statement in *Corcoran* that the plaintiff's lawsuit would have caused an impermissible disuniformity in the regulation of ERISA plans' utilization review procedures, the court relied on *Travelers'* statements that "an 'indirect economic influence . . . does not bind a plan administrator to any particular choice and thus function as a regulation of an ERISA plan itself.'"²¹⁵ In other words, the court in *Corporate Health Insurance* held that despite the prospects of civil liability for negligent decisions under the Act's provisions, health plans were still free to choose the manner and means of providing their benefits to beneficiaries.²¹⁶

On appeal to the Fifth Circuit, the court of appeals, in part, affirmed the district court's opinion on different grounds. First, the Fifth Circuit asserted that the Supreme Court's "presumption-objectives trilogy" represents "the Court's [] returning to a traditional analysis of preemption, asking if a state regulation frustrated the federal interest in uniformity."²¹⁷ The court opined that "a broader reading of 'relate to' would sweep away common state action with indirect

214. *See id.* at 616-17.

215. *Id.* at 617 (quoting *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 659 (1995)).

216. *See id.* However, the court found that ERISA preempted the Act's "benefit review" provisions that established procedures for the review of an ERISA administrator's denial of benefits. *See id.* at 625. The primary feature of the benefit review procedure was a beneficiary's right to have an "independent review" of an administrator's negative benefit decision. *See id.* at 621-22. The court held that ERISA preempted the benefit review provisions because the procedures "improperly mandate the administration of employee benefits and therefore, have a connection with ERISA plans." *Id.* at 625. The apparent reason for preemption was that the review procedures impose certain administrative requirements on ERISA plans which mandated the manner in which the plans must administer themselves during the review of negative benefits decisions. *See id.*

Similarly, ERISA preempted another portion of the Act that mandated that managed care organizations could not enter into agreements with providers to obtain indemnification for any civil liability that the managed care organizations might suffer by being held liable under the Act's "quality of care" standards. *See id.* at 627. Another provision prevented a managed care organization from terminating a provider arrangement with any health care provider "for advocating on behalf of an enrollee for appropriate and medically necessary health care for the enrollee." *Id.* The court held that ERISA preempted both of these provisions because they bound ERISA administrators' choices in arranging the structure of ERISA plans. *See id.* In other words, they prevented administrators from structuring their plans in such a manner as to terminate providers and to obtain indemnification and hold harmless agreements from them; therefore, these provision had a impermissible connection with ERISA plans. *See id.*

217. *Corporate Health Ins., Inc. v. Tex. Dep't of Ins.*, 215 F.3d. 526, 533 (5th Cir. 2000), *petition for cert. filed*, 69 U.S.L.W. 3317 (U.S. Oct. 29, 2000) (No. 00-665).

economic effects on the costs of health care plans, such as quality standards which vary from state to state."²¹⁸ Second, in response to managed care organizations' arguments that the application of the law would "relate to" ERISA plans because questions regarding the quality of care would "inevitably question the provider's determinations of coverage under an ERISA plan,"²¹⁹ the court asserted two reasons why there should be no preemption of the "quality of care" provisions. First, the court interpreted the statute as being limited to claims challenging the quality of provided benefits, and not claims based upon a managed care organization's denial of benefits.²²⁰ Second, the court recognized a distinction between a managed care organization's role as an administrator of an ERISA plan and its role as "an arranger and provider of medical treatment."²²¹ The court asserted that "ERISA preempts malpractice suits against doctors

218. *Id.* at 533.

219. *Id.* at 534.

220. *See id.* The State of Oklahoma has adopted a statute that is very similar to Texas' Health Care Liability Act. *See* Managed Health Care Accountability Act ("MHCA"), OKLA. ST. ANN. tit. 36, § 6591 (West 2000). Section 6593 of MHCA provides:

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 shall be liable for damages for harm to an enrollee proximately caused by breach of the duty to exercise ordinary care if:

1. The failure to exercise ordinary care resulted in the *denial, significant delay, or modification of the health care service recommended for, or furnished to, an enrollee;* and
2. The enrollee suffered harm.

Id. § 6593 (emphasis added). One can make an argument that there is a substantial possibility that ERISA will preempt this Oklahoma statute because, unlike Texas' Health Care Liability Act, the Oklahoma statute's duty of care provision imposes the duty of care requirement on a "denial, significant delay, or modification" of health benefits that are "recommended for, or furnished to, an enrollee." *Id.*

In other words, whereas the Texas law governs the quality of benefits that a patient actually receives, the Oklahoma statute governs a managed care organization's negligence in denying, delaying and modifying benefits. Therefore, the Oklahoma law probably "relates to" an ERISA plan, and therefore ERISA's preemption clause probably preempts it because it imposes a standard of care on a managed care organization's denial of benefits. Similarly, a state law claim under the statute would probably be completely preempted by section 502(a) of ERISA's civil enforcement provisions because such a claim appears to be legally cognizable under section 502(a). However, at least one court has held that an Illinois statute that imposes similar requirements as the Texas' statute's independent review provision (that the Fifth Circuit Court of Appeals, in *Corporate Health Insurance*, 215 F.3d at 526, found to be preempted) was saved from ERISA's preemption because the Illinois statute fell within ERISA's saving clause's exemption from ERISA's preemption. *See Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959, 969 (7th Cir. 2000) (saved Illinois statute from ERISA preemption because it met both the "common sense understanding test" and saving Illinois statute "at least two of the McCarran-Ferguson factors").

221. *Corporate Health Ins.*, 216 F.3d at 534.

making coverage decisions in the administration of a plan, but it does not insulate physicians from accountability to their state licensing agency or association charged to enforce professional standards regarding medical decisions.”²²² The court concluded that ERISA did not preempt a state’s regulation of the quality of medicine when a managed care organization is acting as an arranger or provider of medical care.²²³ In light of these observations, the court also held that Texas’ “quality of care” statute did not “relate to” ERISA plans by “referring to” them since the provisions of the statute are “indifferent to whether the health care plan operates under ERISA and do not rely on the exercise of ERISA plans for their operation.”²²⁴

The court also found that ERISA did not preempt the anti-indemnification²²⁵ and anti-retaliation²²⁶ provisions of the statute because, similar to the quality of care provisions, these provisions were a legitimate state regulation of the quality of medical care in that they preserved “the physician’s independent judgment in the face of the managed care entity’s incentives for cost containment.”²²⁷ In other words, these provisions were a legitimate part of the state’s regulation of the quality of medical care that managed care organizations provide in their role as arrangers and providers of medical care.²²⁸

Similarly, the Fifth Circuit held that ERISA did not preempt the portion of the statute that required an independent review of claims that a plaintiff could bring under the “quality of care” portion of the Act because “[a]ny duty imposed on managed care entities by the independent review provisions extends no further than that imposed by the liability provision.”²²⁹ However, ERISA did preempt the portion of the Act that mandated an independent review of coverage denials in general (and not just of physicians’ negligent treatment decisions) because it “impose[s] a state administrative regime governing coverage determinations.”²³⁰

222. *Id.* at 535.

223. *See id.*

224. *Id.*

225. This portion of Texas’ law prevents managed care organizations from seeking indemnification from physicians in the event the organizations are held vicariously liable for the physicians’ negligence.

226. This portion of Texas’ law prevents managed care organizations from deselecting or refusing to contract with physicians who advocate treatment that is medically necessary.

227. *Id.* at 536. Regarding cost containment measures, the court stated: “Such a scheme is again[st] the kind of quality of care regulation that has been left to the states.” *Id.*

228. *See id.* at 536.

229. *Id.* at 537-38.

230. *Id.* at 538. The court further held that ERISA’s saving clause did not save the preempted independent review portion of the statute. Despite its meeting the “common sense” test and the McCarren-Ferguson three-factor analysis, that portion of the statute conflicted with ERISA’s civil enforcement provision because it provided an alternative enforcement mechanism for obtaining ERISA benefits. *See id.* As such, the Fifth Circuit reasoned that the *Pilot Life* statements regarding the exclusivity of ERISA’s civil enforcement provision warranted preemption of the independent review provision. *See id.* at 538-39. The independent review provision would have provided for

In sum, both the district court's decision and the Fifth Circuit's decision in *Corporate Health Insurance* establish that states can enact laws that regulate the quality of medical benefits that managed care organizations provide to employees under an ERISA plan without ERISA preempting such laws. These laws can even give injured beneficiaries a private state law cause of action for violations, and require an independent review of such claims before one can file a lawsuit based upon the violations. But, under the Fifth Circuit's opinion, a state law cannot provide for an independent review of a managed care organization's coverage denial decision when the organization has denied coverage during its role as an ERISA administrator of benefits.

Therefore, *Corporate Health Insurance* is an important decision that other states can use to substantially improve the quality of care that managed care organizations, and ultimately ERISA plans, give to health care beneficiaries. If other states follow Texas' lead by enacting statutes that control the standard of care that managed care organizations provide to beneficiaries, beneficiaries will have another level of needed protection against negligent medical treatment even when they obtain treatment under ERISA benefit plans.

E. Negligence in the Creation of Health Plans

Under certain situations, a managed care organization can be liable for medical malpractice because of the creation of a substandard health care plan. The relevant case law seems to make a distinction between health care plans that an ERISA plan itself establishes and health care plans that HMOs or other managed care organizations establish in carrying out their medical provider roles in conjunction with an ERISA plan. The reason for the difference is *Dukes'* distinction between a health plan's or managed care organization's role as an administrator of an ERISA plan and their role as an arranger or provider of medical care.²³¹

As discussed below, ERISA will probably preempt state lawsuits challenging either an ERISA plan's or its managed care organization's decisions that fall within the administration of an ERISA plan, but will not preempt state law claims challenging at least a managed care organization's negligent medical decision that the organization or its agent makes during their role as arrangers or providers of medical care. *Moreno v. Health Partners Health Plan*²³² is instructive. In that case, the plaintiff alleged that she suffered injuries because a managed care organization created and maintained a substandard health care plan.²³³ The court denied defendants' motion that ERISA preempted the state law medical

an independent review of a managed care organization's coverage denial decisions, and mandated that the managed care organization accept the medical necessity determination of the independent reviewer. *See id.* at 538.

231. *See Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 361 (1995).

232. 4 F. Supp. 2d 888 (D. Ariz. 1998).

233. *See id.* at 889.

malpractice claim.²³⁴ In *Moreno*, the court stated:

The allegations are nothing more nor less than recitations of traditional state law negligence claims. Each Defendant is alleged to be a *healthcare provider*. Each Defendant is alleged to have fallen below the applicable standard of care, either acting individually or through agents and employers. Each is alleged to have caused damage to the Plaintiff. Partners is alleged to be both directly liable for its own negligence (the creation of the substandard care plan by Aguilar) and vicariously liable for the negligence of the physicians who implemented that substandard care plan. Aguilar is alleged to be directly negligent for his role in creating the substandard plan.²³⁵

As did *Travelers*, the court bypassed the unhelpful text of "relate to" to "look instead to the objectives of ERISA" to determine whether ERISA preempted the state law claims.²³⁶ The court relied on ERISA's general "beneficiaries protection" purpose but did not refer to the preemption clause purpose of avoiding a nonuniformity of ERISA plan regulation.²³⁷ Then, the court analyzed defendants' preemption defense under several of *Travelers*' general purposes.²³⁸

First, the court outlined the three categories of state law that can be said to have a connection with ERISA plans: (1) "laws that mandate employee benefit structures or their administration," (2) "laws that bind employers or plan administrators to particular choices or preclude uniform administrative practice, thereby functioning as a regulation of an ERISA plan itself," and (3) "laws providing alternative enforcement mechanisms for employees to obtain ERISA plan benefits."²³⁹ The court stated that the state malpractice claims did not satisfy any of the tests because

the ability to sue on a medical malpractice claim does not mandate employee benefit structures or their administration, nor does it bind employers or plan administrators to particular choices or preclude uniform administrative practice, thereby functioning as a regulation of an ERISA plan itself, nor does it provide an alternative enforcement mechanism for employee to obtain ERISA plan benefits.²⁴⁰

The court reasoned that any tendency that a malpractice claim had to bind ERISA

234. *See id.* at 892-93.

235. *Id.* at 889. First, the court distinguished both *Corcoran v. United Health Care, Inc.*, 965 F.2d 1321 (5th Cir. 1992), and *Spain v. Aetna Life Insurance Co.*, 11 F.3d 129 (9th Cir. 1993), two cases holding that medical malpractice wrongful death claims alleging negligence by those involved in denying requested medical treatment, as not being persuasive in light of *Travelers*' attempt "to narrow" the expansiveness of ERISA's preemption clause. *See id.* at 891.

236. *Moreno*, 4 F. Supp. 2d at 891.

237. *See id.*

238. *See id.* at 891-92.

239. *Id.*

240. *Id.* at 892.

plans "to making choices that were not willfully or recklessly injurious" were "evaluative and not particular," and Congress has expressed no desire that ERISA be used to degrade the quality of healthcare."²⁴¹

Second, the court acknowledged the presumption that ERISA did not intend to preempt "the historic police powers of States,"²⁴² which "include the regulation of matters of health and safety."²⁴³ Importantly, the court stated that "[N]othing in the language of [ERISA] or the context of its passage indicates Congress chose to displace general health care regulation."²⁴⁴ The court hung its hat on *Dukes*' distinction between state law claims premised on the "quality of care" versus claims based on the "quantity of benefits."²⁴⁵ The court held that "plaintiff's malpractice claim goes to the quality of care received."²⁴⁶ Because of these reasons, ERISA did not preempt the malpractice claims.

The court further relied on the Ninth Circuit's mode of analysis of ERISA's preemption clause: "[W]here state law claims fall outside the three areas of concern identified in *Travelers*, arise from state laws of general application, do not depend on ERISA, and do not affect the relationships between the principal ERISA participants; the state law claims are not preempted."²⁴⁷ Applying the Ninth Circuit's test, the court stated:

Continuing with the analysis of the Ninth Circuit in *Geweke*, medical malpractice actions are grounded in state common law of general application to any practitioner of medicine whether or not arranged, paid for, or employed by an employer provided benefit plan. The possibility of medical malpractice actions do not affect the relationships between the principal ERISA participants.

Under the analysis adopted by the Ninth Circuit, medical malpractice actions are not preempted. This is reinforced by the Supreme Court

241. *Id.* at 893.

242. *Id.* at 892.

243. *Id.* (quoting *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995)).

244. *Id.* The court stated:

In addition, myriad state laws of general applicability may impose some burdens on the administration of ERISA plans and still not "relate to" them within the meaning of the ERISA statute. The Supreme Court gives the example of quality standards in a hospital which would effect the relative costs of a plan.

Id. at 892. (citing *Travelers*, 514 U.S. at 660 (internal citations omitted)).

245. *Id.*

246. *Id.*

247. *Id.* (citing *Geweke Ford v. St. Joseph's Omni Preferred Care Inc.*, 130 F.3d 1355, 1360 (9th Cir.1997) (quoting *Ariz. State Carpenters Pension Trust Fund v. Citibank*, 125 F.3d 715 (9th Cir.1997)).

referring to the general regulation of health and safety as examples of historic powers of the State which have not been superceded by Federal Act.²⁴⁸

In sum, the court found that ERISA did not preempt the state law medical malpractice claims under either *Dukes*' rationale or under the Ninth Circuit's formula.²⁴⁹ Although the court's decision involved a defendant's alleged negligence in the manner in which it created a health plan, the court's reference to *Travelers*' statement, that "the general regulation of health and safety [is an] example of historic powers of the State which have not been superceded by [ERISA]," is evidence that the *Moreno* court would not have found a preemption of other types of state lawsuits challenging the quality of care of provided medical benefits.

There is uncertainty about the scope of the *Moreno* decision as it relates to managed care organizations' and ERISA plans' ability to create substandard health plans. As stated above, the decision hinges on the distinction between a managed care organization's action as an arranger or provider of medical benefits and not as an administrator of benefits. When the organization is acting as an arranger or provider, one can make a strong argument that ERISA does not preempt state law medical malpractice claims alleging that the organization has created a substandard health plan. As the court stated in *Moreno*, such claims are "grounded in state common law of general application" and fall within *Travelers*' admonition that there is no evidence that Congress intended to preempt states' historic police power regulation of health and safety.²⁵⁰

On the other hand, when the state lawsuit challenges a managed care organization's decision to create a substandard health plan in its ERISA plan administration role, one can make a stronger argument that the lawsuit falls within Supreme Court precedent that arguably mandates preemption when a state law or lawsuit attempts to limit the manner in which an ERISA plan structures its operations.²⁵¹ One could allege that *Shaw* is applicable and that, like the New York law that prevented ERISA plans from structuring their operations to discriminate against pregnant women,²⁵² a state lawsuit that prevents an ERISA plan from structuring itself in a way to provide substandard care also impermissibly impinges on the plan's ability to structure its operations in a desired manner. This is especially true because ERISA does not specifically regulate the quality of benefits that an ERISA plan actually gives to beneficiaries

248. *Id.* at 893.

249. *See id.* at 892. Although *Moreno* is a complete preemption case, its statements about the nonpreemption of state medical malpractice lawsuits is relevant to a conflict preemption analysis under ERISA's preemption clause. The court left open the issue whether the defendants were practicing medicine for medical malpractice purposes and whether any malpractice was the proximate cause of plaintiff's injury. *See id.* at 893.

250. *Id.*

251. *See, e.g., Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983).

252. *See id.* at 97.

as opposed to the plan's decision to deny benefits.²⁵³ The only rebuttal against preemption under *Shaw's* rationale is the applicability of several influential principles from *Travelers*.

First, *Travelers* appears to be a refinement of *Shaw's* "too tenuous, remote, or peripheral" exception to preemption. It stands for the proposition that ERISA will not preempt a state law that has a "too tenuous, remote, or peripheral" impact on an ERISA plan, even though the law affects the ability of a managed care organization to structure its benefits.²⁵⁴ Second, *Travelers'* presumption against the preemption of state health care regulations (which encompasses state medical malpractice claims) and *Travelers'* assumption, that a state law that imposes only indirect economic cost on an ERISA plan is not sufficient to warrant preemption, can be used to argue against preemption despite the main holding in *Shaw* regarding the interference with an ERISA plan's ability to structure its operation. In other words, *Shaw* does not appear to have taken into consideration the implication of *Travelers'* presumption against the preemption of traditional state law regulation.

A review of three cases illustrates the confusion that courts can have in resolving preemption issues by using a distinction between a managed care organization's ERISA plan administrative role and the organization's medical provider role. The Third Circuit's²⁵⁵ decision in *In re U.S. Healthcare, Inc.*,²⁵⁶ the court's first case to consider its earlier decision in *Dukes*, reaffirms its belief that there is a difference between a managed care organization's decisions as an administrator of an ERISA plan and its decisions as an arranger or provider of medical care. The court held that the plaintiff's state law claims for direct liability and vicarious liability, alleging that an HMO had committed medical malpractice when it instituted a policy of discharging mothers twenty-four hours after their deliveries, did not fall within the complete preemption doctrine for removal from state court to federal court.²⁵⁷ Although the court did not decide the substantive issue of whether ERISA preempted the state law claims, the court's complete preemption analysis is instructive.

The gist of the court's opinion is that the plaintiff's state law claims alleged negligence against the HMO and its agents in their role as providers of medical care.²⁵⁸ For example, the plaintiff alleged that the HMO, the treating physician, and the hospital committed medical malpractice by discharging the mother under the twenty-four hour policy.²⁵⁹ The court held that such allegations attacked the

253. See Robert F. Rich & William D. White, *Federalism and Health Care Policy*, 1998 U. ILL. L. REV. 861, 875.

254. *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 646 (1995).

255. The Third Circuit has been one of, if not the, most proactive courts in developing new principles and analysis to determine the scope of ERISA's preemption of state law.

256. 193 F.3d 151 (3rd Cir. 1999).

257. See *id.* at 165.

258. See *id.* at 162-63.

259. See *id.*

quality of the medical care that the defendants provided, not negligence during the HMO's ERISA administrative role of denying or granting a beneficiary's request for medical benefits.²⁶⁰ Therefore, pursuant to *Dukes*' reasoning that

260. *See id.* In *Lazorko v. Pennsylvania Hospital*, 237 F.3d 242 (3rd Cir. 2000), the Third Circuit affirmed its conclusion that ERISA does not completely preempt a direct state law claim against an HMO or other managed care organizations whose financial incentives allegedly motivated a treating physician to render negligent medical care to obtain the financial benefits. *See id.* at 249-50. After wife committed suicide allegedly because treating physician did not order additional hospitalization, plaintiff alleged that treating physician, motivated by an HMO's financial incentives that penalized a decision to grant additional hospitalizations, made the medical decision not to readmit her to the hospital. *See id.* Importantly, the claim against the HMO appears to be a direct liability claim because it attacked the HMO's financial incentives on the grounds that they negligently motivate the treating physician to render negligent medical care. *See id.* Apparently, the Third Circuit's decision was based upon a conclusion that the state lawsuit challenged the quality of the HMO's medical decision to institute financial incentives that motivated treating physicians to give substandard medical care, and not a specific decision by an HMO to deny medical benefits. *See id.* Therefore, ERISA's civil enforcement provisions did not completely preempt the claims. *See id.* at 250.

Other courts have reached a similar conclusion that state lawsuits complaining about an HMO financial incentives are not preempted. *See Berger v. Livengrin Found.*, No. 00-CV-501, 2000 WL 325957, *3 (E.D. Pa. Mar. 27, 2000) ("The Court reads the Complaint's allegations regarding USHC's disincentive policy as challenging the quality of medical care provided."); *Stewart v. Berry Family Health Ctr.*, 105 F. Supp. 2d 807, 815 (S.D. Ohio 2000) (denying complete preemption because plaintiff alleged that "financial incentive program impacted the quality of care that she received from her physicians"); *Green v. Travis*, No. 00-C-2230, 2000 WL 1409828, *2 (N.D. Ill. July 21, 2000) (denying complete preemption, in part, by rejecting defendant's claim that plaintiffs' reliance on "'financial disincentives' imposed by [defendant] on its providers makes their claim one which arises under ERISA §502(a)"); *Delucia v. St. Luke's Hosp.*, No. 98-6446, 1999 WL 387211, *4 (E.D. Pa. May 24, 1999) (denying complete preemption where plaintiff's complaint alleged that "Aetna's disincentive policy had the effect of discouraging doctors from 'provid[ing] complete and proper care . . .,' because the claim "challeng[ed] the quality of medical care provided."); *Hinterlong v. Baldwin*, 720 N.E.2d 315, 325 (Ill. 1999) (denying defendant's contention that ERISA's preemption clause preempted plaintiff's vicarious liability claim against HMO even though the claim alleged that the HMO's financial incentives encouraged the treating physicians to render negligent medical care, thereby rejecting an argument that the claim was tantamount to one alleging "elements of a denial of benefits").

However, some courts might be influenced by whether the ERISA plan's documentation itself set forth the financial incentives, or whether the HMO's contract with affiliated treating physicians establishes the financial incentives. The inference is that, in the former situation, section 502(a) might completely preempt the state law claim for removal purposes, but that it will not do so in the latter situation because, unlike in the former situation, the latter situation does not require an examination of the ERISA plan to ascertain the nature, scope, and potential effects of the financial incentives. This avoids a potential conclusion that, if the incentives are set out in the ERISA plan itself, the litigation of the vicarious liability claim would require a "reference to" the ERISA plan which would satisfy the "relate to" requirement and cause ERISA's preemption. *See Green*, 2000

state claims challenging the quality of provided benefits do not fall within the complete preemption doctrine and to the distinction between a managed care organization's role as a medical provider and as an administrator who decides whether to grant or deny benefits, the court in *In re U.S. Healthcare* held that plaintiff's state law claims were not removal under the complete preemption doctrine.²⁶¹

However, given the dual role that managed care organizations play in providing medical care to beneficiaries under ERISA benefit plans, the court recognized that it would not always be easy to determine the exact role that a managed care organization was playing at the time of its alleged negligent conduct.²⁶² For example, in *In re U.S. Healthcare*, the court held that ERISA did not completely preempt the sixth count of the plaintiff's complaint. That count alleged that U.S. Healthcare was negligent because it did not provide plaintiff with a pediatric nurse even though the ERISA plan covered such treatment and plaintiff requested the treatment.²⁶³ Despite the district court's holding that plaintiff's claim was tantamount to a claim for denied benefits, the Third Circuit held that the count "raise[d] a claim regarding the adequacy of the care that [plaintiff] received and was therefore directed toward the HMO's action in its capacity as a medical provider, rather than as a benefits administrator."²⁶⁴ The Third Circuit asserted that plaintiff's allegation could be interpreted as alleging that "U.S. Healthcare failed to meet the standard of care required of health care providers by failing to arrange for a pediatric nurse," and therefore was "an ordinary state-law tort claim for medical malpractice."²⁶⁵

In contrast, the court in *Lancaster*²⁶⁶ would not rely on the medical provider versus ERISA administrator distinction to hold that a managed care organization's structuring of its utilization review and cost containment procedures occurred during the managed care organization's provider role. In *Lancaster*, a child suffered an alleged misdiagnosis of a brain tumor despite the

WL 1409828 at *2-*3. In other words, complete preemption for removal purposes, and maybe conflict or substantive preemption, would occur because resolution of the state law claim would require an "interpretation of the ERISA plan." See *id.* However, the mere "reference to" the plan during the lawsuit might fall within the "too tenuous, remote, or peripheral" exception to ERISA's preemption, which would not lead to preemption if the claim is based upon vicarious liability for the treating physician's alleged negligent treatment and not upon a denial of a specific request for medical benefits. *Hinterlong*, 720 N.E.2d at 325 (rejecting alleging that preemption should occur because of a "reference to" an ERISA plan to evaluate the financial incentives, asserting that "any reference to the plan documents would be necessary only for proving matters of agency, not for wrongful plan administration or for withholding of promised plan benefits").

261. *In re U.S. Healthcare*, 195 F. 3d at 162-63.

262. See *id.* at 162.

263. See *id.* at 164.

264. *Id.*

265. *Id.*

266. See generally *Lancaster v. Kaiser Found. Health Plan of Mid-Atl. States, Inc.*, 958 F. Supp. 1137 (E.D. Va. 1997).

fact that she had sought treatments from the same physicians over a four and a half year period with complaints of intense headaches and other symptoms.²⁶⁷ Eventually, the treating physicians ordered an MRI that showed that a tumor had infected approximately forty percent of the child's brain.²⁶⁸ In part, the plaintiff's state medical malpractice lawsuit alleged both direct liability and vicarious liability claims against Kaiser, the HMO involved in the arrangement of plaintiff's medical care under an ERISA plan.²⁶⁹ In Count III against Kaiser, plaintiff alleged that Kaiser

is directly liable for the establishment of guidelines and cost standards which worked against the full and prompt diagnostic assessment [of Lancaster's brain tumor] within the accepted standard of care and for its failure to establish policies, protocols, guidelines and standards for an adequate diagnostic assessment and treatment of [Lancaster's] continuing headaches.²⁷⁰

In Count V against Kaiser, the plaintiff alleged that Kaiser committed fraud when it told plaintiff that it would follow the applicable standard of medical care in providing for her treatment but instead instituted a financial incentive policy that provided a financial benefit to the treating physicians for not providing care in compliance with the standard of medical care.²⁷¹

Count IV, against the treating physicians' medical group, alleged that the group

is further negligent for the establishment of guidelines and cost standards which work[ed] against [Lancaster] receiving a proper diagnosis and treatment assessment within the standard of care during the course of her treatment for her headaches and for the failure to establish policies, protocols, guidelines and standards for her diagnostic assessment during her hospitalization.²⁷²

Count V against the medical group contained the same allegations of fraud as stated above against Kaiser.²⁷³

The court held that, under the complete preemption doctrine, the second section of Counts III and V against Kaiser, as discussed above, served as grounds for removal to federal court because they challenged the administration of the ERISA plan to the extent that they "focus[ed] on Kaiser's administrative decision to curb rising health care costs by employing a system of financial incentives that rewarded physicians for not ordering tests or treatments."²⁷⁴ The court further

267. *See id.* at 1139-40.

268. *See id.* at 1140.

269. *See id.* at 1140-41.

270. *Id.* at 1141.

271. *See id.*

272. *Id.*

273. *See id.*

274. *Id.* at 1147.

reasoned that the plaintiff's claims against Kaiser in effect alleged that the managed care organizations' financial incentives "had the effect of denying benefits to Lancaster as a plan participant because it inappropriately influenced" the treating physicians to take their own financial well-being into consideration in making decisions regarding the plaintiff's treatment.²⁷⁵ As such, the court held that the claims fell within section 502(a)(1)(B) of ERISA's civil enforcement provisions, thereby requiring complete preemption of the whole lawsuit, including Count IV and Count V against the medical group.²⁷⁶

The court proceeded to find that ERISA preempted the Count III and Count V claims against Kaiser. The court reasoned that the claims were preempted by ERISA's preemption clause, apparently because the claims, as reclassified by the court to be ones for denied benefits, "relate[d] to" the ERISA plan.²⁷⁷ Similarly, the court held that ERISA also preempted Counts IV and V against the medical group because "[l]ike the direct negligence and fraud claims against Kaiser, the direct negligence and fraud claims at issue here, at their core, assert that Lancaster was denied benefits by the administrative decision to establish and implement the Incentive Program, a policy that encouraged [the treating physicians] to limit health care costs."²⁷⁸ The court thought that a decision against preemption would create disuniformity in the regulation of ERISA plans. In addition, the court felt that there would be no claim against the medical group if there was no ERISA plan because "the terms and conditions of the plan are a critical factor in establishing defendants' liability under [the] claims."²⁷⁹

On the other hand, at least one court, consistent with *In re U.S. Healthcare* and in opposition to *Lancaster*, is more willing to hold that ERISA does not preempt an HMO's cost containment procedures when a plaintiff alleges that the procedures caused low quality medical treatment. In *Maltz v. Aetna Health Plans of New York, Inc.*,²⁸⁰ the Second Circuit considered whether an HMO's decision to change its preferred providers' compensation arrangement from fee-for-service to a capitation arrangement was in violation of ERISA's substantive provisions.²⁸¹ The plaintiff, who had chosen a primary care physician from the preferred provider list to treat her children, alleged that a capitated payment arrangement denied her family "reasonable and medically necessary" services.²⁸² However, the court found the allegation to be without merit.²⁸³ Relying on *Travelers* and *Dukes*, the court stated that "*Maltz* is essentially alleging a reduction in the quality of care that is properly brought under state law

275. *Id.*

276. *See id.* at 1147-48.

277. *Id.* at 1150.

278. *Id.* The court did not state whether the claims against the medical group were independently removable under the complete preemption doctrine.

279. *Id.*

280. No. 97-7942, 1998 WL 385830 (2d Cir. Apr. 20, 1998).

281. *See id.* at *1.

282. *Id.*

283. *See id.*

and is not preempted by ERISA.”²⁸⁴ In essence, the Second Circuit’s decision in *Maltz* is consistent with an interpretation of *Travelers* as being precedent that ERISA does not preempt lawsuits, such as medical malpractice lawsuits, alleging that a managed care organization provided substandard benefits.²⁸⁵

284. *Id.* at *2 (citing *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (1995)).

285. *See Maltz*, 1999 WL 385830, at *2. It is important to note that in *Maltz* there was no complaint that the health plan had denied requested benefits; rather, plaintiff had access to any physician that her family needed under the health plan. Her only complaint was that the quality of the care from a chosen physician either was or might be comprised and of a lower quality because of the capitation payment agreement. *See id.* at *1. Other Second Circuit cases are consistent with an expansive interpretation of *Travelers* that narrowly interprets ERISA’s preemption clause.

For instance, in *Devlin v. Transportation Communication International Union*, 173 F.3d 94 (1st Cir. 1999), the Second Circuit was asked to consider whether ERISA preempted the same New York human right law as at issue in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-100 (1995). *Devlin*, 173 F.3d at 99. Although the court acknowledged that *Travelers* “narrowed the parameters for determining when a state statute ‘relates to’ an ERISA plan,” it declined to reevaluate whether ERISA preempted the human rights law given that *Shaw*, a decision before *Travelers* that specifically addressed the same preemption issue, had held that the law was preempted. *Id.* The court’s refusal to reevaluate the preemption issue was based on its unwillingness to create a direct conflict with *Shaw*, a United States Supreme Court decision on the precise issue.

However, despite recognizing that *Travelers* has changed the focus of ERISA’s preemption analysis, the Second Circuit acknowledged that the text of a disputed statute is still the starting point of an ERISA analysis. *See Foxhall Realty Law Offices, Inc., v. Telecomm. Premium Servs., Ltd.*, 156 F.3d 432, 435 (2d Cir. 1998) (“In determining whether Congress intended to confer federal jurisdiction over private rights of action brought under the TCPA, our ‘analysis begins with the text of the provision in question.’”) (citing *Travelers*, 514 U.S. 645, 655 (1995)). Recognizing *Travelers*’s impact on an ERISA’s preemption clause analysis, the Second Circuit, in *Plumbing Industry Board, Plumbing Local Union No. 1 v. Howell Co.*, 126 F.3d 61 (2d Cir. 1997), outlined its steps in analyzing an ERISA preemption defense including the use of the presumption against the preemption of state laws:

In other words, the phrase “relate to” for purposes of legal analysis proved to be a verbal coat of too many colors. Instead, the Supreme Court has instructed that analysis under ERISA’s preemption clause must begin with the “starting presumption that Congress does not intend to supplant state law,” and admonished courts applying the preemption clause to “look to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.” That look should be guided by common sense. It should avoid a construction that theoretically is unending, which the Supreme Court warned against when it turned away from “relate to” as a guide. Hence, 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. The Supreme Court has identified several ways in which the anti-preemption presumption can be overcome. First, preemption will apply where a state law clearly “refers to” ERISA plans in the sense that the measure “acts immediately and exclusively

In comparison, *Maltz* is in conflict with *Lancaster* because, although in both cases the plaintiff complained about a cost containment method that allegedly led to low quality health care, the courts reached different conclusions on whether ERISA preempted the plaintiff's state law claims. The fact that in *Lancaster* the plaintiff's complaint was about financial incentive systems that gave treating physicians bonuses for "avoiding excessive treatments and tests," and in *Maltz* the plaintiff's complaint was about a capitated payment system,²⁸⁶ is irrelevant to the extent that both systems allegedly led (or had the potential of leading) to less care than required by the applicable standard of care. Given this conflict, the status of state law attempts to prevent managed care organizations and ERISA plans from establishing low quality plans is unclear. Following *In re U.S. Healthcare* and *Maltz*, some courts will not find preemption, while others will find preemption pursuant to *Lancaster's* rationale.

VI. THE FUTURE OF ERISA'S PREEMPTION

The above discussion shows that, following *Travelers'* lead, federal courts have limited ERISA's preemption of state law medical malpractice claims. Primarily, these courts have used the presumption against the preemption of traditional state health care regulations and the indirect economic effects of state

upon ERISA plans" or where "the existence of ERISA plans is essential to the law's operation." Second, a state law is preempted even though it does not refer to ERISA or ERISA plans if it has a clear "connection with" a plan in the sense that it "mandate[s] employee benefit structures or their administration" or "provid[es] alternative enforcement mechanisms." Outside these areas, the presumption against preemption is considerable—state laws of general application that merely impose some burdens on the administration of ERISA plans but are not "so acute" as to force an ERISA plan to adopt certain coverage or to restrict its choice of insurers should not be disturbed.

Id. at 66-67 (internal citations omitted). The above quote from the Second Circuit is one of the clearest statements regarding how courts should analyze a state law under the presumption against the preemption of state laws.

In the Second Circuit, to avoid preemption a state law must not interfere with ERISA's preemption clause purpose of "avoid[ing] a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Greenblatt v. Delta Plumbing & Heating Corp.*, 68 F.3d 561, 574 (2d Cir. 1995). Such interference occurs when the state laws "mandate[] employee benefit structures or their administration" or "provid[e] alternate enforcement mechanisms" to section 502(a). *Id.*

In *Demars v. CIGNA Corp.*, 173 F.3d 443, 446 (1st Cir. 1999), the court stated that "cost uniformity was almost certainly not an object of [ERISA] pre-emption." ERISA preemption was intended to guarantee regulatory uniformity, not intrastate or interstate cost uniformity. *Demars*, 173 F.3d at 446. *Demars'* distinction between regulatory uniformity and cost uniformity is important, and it should serve as a guide to other courts that interpret ERISA's preemption clause.

286. See *Lancaster v. Kaiser Found. Health Plan of Mid-Atl. States, Inc.*, 958 F. Supp. 1137, 1140 (E.D. Va. 1997); see also *supra* notes 281-82 and accompanying text.

medical malpractice lawsuits as their rationales.²⁸⁷ Using these rationales, some courts have held that ERISA does not preempt a direct liability medical malpractice claim against a treating physician because of states' traditional authority to regulate the quality of medical care.²⁸⁸ Other courts have held that ERISA does not preempt a state law vicarious liability claim against a managed care organization that has supplied a negligent treating physician because the claim involves the quality of medical care and is not a claim for denied medical benefits.²⁸⁹ Therefore, a direct liability claim against the treating physician and a vicarious liability claim against an HMO or other medical provider of the treating physician are the state law claims that are most likely to escape ERISA's preemption. Additionally, some courts are now more willing to hold that ERISA does not preempt direct liability claims against managed care organizations based upon their failure to comply with state statutes that establish the applicable quality of medical care and direct liability claims based upon negligent medical decisions that the managed care organizations themselves make.²⁹⁰

On the other hand, the most problematic claims are those that challenge an ERISA administrator's decisions during the utilization review process of deciding whether or not to award benefits. These claims fall into several categories. First, some courts hold that ERISA preempts a state law claim alleging that the ERISA administrator or other fiduciary made a negligent medical decision during utilization review, while other courts find the opposite.²⁹¹ Second, some courts hold that ERISA preempts state law claims challenging an ERISA plan's and its affiliated providers' financial incentives and other policies and procedures designed to control the cost of medical care, while other courts imply that ERISA does not preempt such claims.²⁹² These types of state law claims are more problematic than claims alleging either direct medical malpractice against a treating physician or vicarious liability against an HMO or other managed care organizations. The reason is that one can make an argument that such claims fall within *Pilot Life's* holding that ERISA preempts claims alleging an improper processing of a request for ERISA plan benefits during the utilization review process.

Therefore, given the continued validity of *Pilot Life*, there is a possibility that ERISA will continue to preempt a large number of medical malpractice lawsuits when the challenged medical decisions occur during an ERISA administrator's or managed care organization's utilization review process of granting or denying

287. See *Lancaster*, 958 F. Supp. at 1149.

288. See *id.*

289. See *Dykema v. King*, 959 F. Supp. 736 (D. S.C. 1997).

290. See *Corporate Health Ins. v. Tex. Dep't of Ins.*, 215 F.3d 526 (5th Cir. 2000); *Crum v. Health Alliance-Midwest, Inc.*, 47 F. Supp. 2d 1013 (C.D. Ill. 1999).

291. See *Crum*, 47 F. Supp. 2d at 1013; *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49 (D. Mass. 1997).

292. See *Maltz v. Aetna Health Plans of N.Y., Inc.*, No. 97-7942, 1998 WL 385830 (2d Cir. Apr. 20, 1998); *Lancaster*, 958 F. Supp. at 1150.

treatment.²⁹³ To avoid this result, federal courts should turn to their equity jurisdiction to prevent the injustice that results when ERISA plan administrators' and managed care organizations' negligent decisions go unpunished because there is not an adequate remedy to compensate beneficiaries for their injuries. The following sections of this Article proposes that federal courts use "equity preemption"²⁹⁴ to provide an otherwise unavailable remedy to negligently injured beneficiaries.

A. Equity Preemption

It is fairly clear that Congress intended that the law of trust govern ERISA welfare benefit plans.²⁹⁵ This observation leads to two conclusions. First, as the law of trust is within federal courts' equity jurisdiction,²⁹⁶ federal courts should use equity principles when interpreting ERISA's preemption clause, especially given their inherent and statutory equity power to interpret ERISA's statutory provisions.²⁹⁷ Court's equity analysis should include one of the well-established maxims of equity: "Equity will not suffer a wrong without a remedy." This Article will subsequently refer to the use of equity principles and maxims as

293. See *Andrews-Clarke*, 984 F. Supp. at 54 n.23 (holding that ERISA preempted state claim because alleged negligent decision occurred during the utilization review process of deciding whether or not to provide medical treatment).

294. See *infra* notes 295-378.

295. See *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 447 (1999) ("Although trust law may offer a 'starting point' for analysis in some situations, it must give way if it is inconsistent with 'the language of the statute, its structure, or its purposes.'"). In *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993), the Supreme Court stated:

Given ERISA's roots in the law of trusts, "equitable relief" could in theory mean all relief available for breach of trust in the common-law courts of equity, which would include the relief sought here. Since all relief available for breach of trust could be obtained from an equity court, however, that interpretation would render the modifier "equitable" superfluous; that reading would also deprive of all meaning the distinction Congress drew between "equitable relief" and "remedial" and "legal" relief throughout ERISA.

Mertens, 508 U.S. at 248-49. The Court also stated: "It is true that, at common law, the courts of equity had exclusive jurisdiction over virtually all actions by beneficiaries for breach of trust." *Id.* at 256. The Court asserted: "Finally, there can be no dispute that ERISA was grounded in this common-law experience and that we are [to be] guided by principles of trust law in construing the terms of the statute." *Id.* (White, J., dissenting) (citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111 (1989)). See also *Anthony v. Texaco, Inc.*, 803 F.2d 593, 599 (10th Cir. 1986) ("Accordingly, we hold that the district court did not err in exercising its equitable jurisdiction under ERISA to freeze the assets owing to the defendant corporations.").

296. See *supra* note 295 and accompanying text.

297. See *Cummings v. Briggs & Stratton Ret. Plan*, 797 F.2d 383, 390 (7th Cir. 1986) (refusing to create a claim for unjust enrichment, but asserting that federal courts have both inherent and statutory equitable power to interpret and enforce ERISA).

“equity preemption.”²⁹⁸

298. In a nutshell, equity preemption means that courts will use their equity jurisdiction and powers to ensure that ERISA will not preempt state law claims when ERISA does not supply a remedy, especially in those areas where congressional intent regarding ERISA's preemption of state law claims is not clearly expressed in either ERISA's statutory language or legislative history. Both federal and state courts can use the “equity preemption” concept. A state court can use it when a plaintiff has filed a state law claim in state court, and the defendant has not removed the claim to federal court. In that event, the state court will have to resolve any ERISA preemption defense that the defendant raises. A federal court can use “equity preemption” in those cases that a plaintiff either initially files in federal court or in the cases that a plaintiff files in state court and a defendant removes to federal court under the complete preemption doctrine. In those cases, the defendant, at some point, might raise an ERISA preemption defense. Whether a defendant raises the defense in federal or state court, “equity preemption” should become a part of the federal common law of ERISA preemption that should be obligatory on both federal and state courts as is the Black Law Dictionary's definition of “relate to.” There are several factors that weigh in favor of courts' use of “equity preemption.” First, as it relates to federal courts, they have both statutory and inherent powers to use equity principles when interpreting ERISA and ERISA's preemption clause. See *supra* notes 294-97 and accompanying text.

Second, Congress, as indicated in ERISA's legislative history, intended that federal courts (and state courts to the extent that they have an opportunity to interpret ERISA's preemption clause) develop a federal substantive common law of ERISA remedies and doctrines to fill gaps that ERISA's statutory provisions do not cover. See Pittman, *supra* note 22, at 436-40 (in part citing Senator Javits' legislative history statement regarding courts' abilities to create federal substantive common law and the Supreme Court's inconsistent use of his statement). At a minimum, the scope of a courts' powers to create federal substantive common law should include the use of “equity preemption,” which, in one sense, is tantamount to a rule of statutory interpretation that gives courts guidance on how they should resolve issues involving the application of ERISA's preemption to state laws.

In other words, courts' use of “equity preemption” becomes a part of ERISA's federal substantive common law, and therefore is a legitimate use of courts' powers as recognized by ERISA's legislative history and by the Supreme Court, which has acknowledged courts' authority to create federal substantive common law when interpreting ERISA and its preemption clause. The only open issue is whether the use of “equity preemption” falls within courts' powers to create a federal common law surrounding ERISA and its preemption clause. There are at least two responses to this issue. One, to the extent that the Supreme Court has the authority to define “relate to,” to create the “too tenuous, remote, or peripheral” exception to ERISA preemption, to create the presumption against the preemption of state laws in traditional areas of states' regulation, and to hold in *Travelers* that an indirect economic effect on an ERISA plan was not sufficient to warrant preemption, the use of “equity preemption” to avoid the preemption of state laws seems more than appropriate when there is no clear and manifest showing that Congress intended the preemption of a challenged state law. In such cases, “equity preemption” promotes the presumption against the preemption of traditional laws, and is therefore a proper recognition of federalism especially when the challenged state law is one that regulates the quality of medical care, a field that traditionally has fallen within states' legitimate police power regulation.

Third the use of “equity preemption” to avoid the preemption of state laws seems no more

drastic than the Supreme Court's use of equity principles to create federal causes of action from certain provisions of the United State Constitution. For example, in *Bivens v. Six Unknown Named Agents*, 403 U.S. 388 (1971), the Court held that an injured party can bring a private cause of action directly under the Fourth Amendment for compensatory damages stemming from a federal law enforcement agent's violation of the party's Fourth Amendments rights, even though the Amendment's language does not specifically provides for a compensatory damage remedy. See *Bivens*, 403 U.S. at 397. The Court stated: "Historically, damages have been regarded as the ordinary remedy for an invasion of personal interests in liberty. . . . 'The very essence of civil liberty certainly consists in the right of every individual to claim the protection of the laws, whenever he receives an injury.'" *Id.* at 395-97 (quoting *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 163 (1803)). If the Supreme Court can create a personal injury claim under the Fourth Amendment, because "the very essence of civil liberty" is that there should not be a wrong without a remedy, then certainly, through "equity preemption," courts (especially to effectuate the presumption against the preemption of states' traditional policy power protection of injured citizens) should be able to deny ERISA preemption of state law and lawsuits that remedy violations of independent state law obligations, especially when there is no clear and manifest showing of Congressional intent that preemption should occur.

Fourth, the use of "equity preemption" does not appear to be more drastic than state courts' use of equity principles to allow state law causes of actions and remedies for injuries that state citizens have suffered. For example, in a 1994 lawsuit, attorneys in Mississippi filed an equity restitution claim against tobacco manufactures alleging that they were unjustly enriched through the substantial profits that they made from selling cigarettes in Mississippi without paying the medical expenses stemming from the injuries that the cigarettes caused. See Doug Rendleman, *Common Law Restitution in the Mississippi Tobacco Settlement: Did the Smoke Get in Their Eyes?*, 38 GA. L. REV. 847, 848 (1999). The plaintiffs' attorneys and the tobacco defendants reached a settlement for \$3.3 billion. See *id.* The relevancy of the Mississippi tobacco litigation to this Article is that it shows a state court's acceptance of an equity cause of action to provide a remedy primarily by using the equity maxim that "equity will not suffer a wrong without a remedy." See *id.* at 865 ("The State seems to have sued in Chancery for two reasons. The first was to claim a maxim of equity. [] Equity will not suffer a wrong without a remedy. . . . This Honorable Court of equity should intervene and fashion a remedy to right this wrong."). Similarly, courts should accept "equity preemption" as a means of avoiding the preemption of state law claims vindicating violations of independent state law obligations by providing a compensatory damage remedy.

Finally, one can make an analogy to Rule 19 of the Federal Rules of Civil Procedure. That rule, particularly its indispensable party standards in Rule 19(b), has its origins in the maxim that "equity will not suffer a wrong without a remedy" and the court cases using that maxim to join necessary parties, against their will, to lawsuits if their presences were needed so that parties to the lawsuits could obtain a remedy or otherwise avoid any prejudice or inconsistent obligations flowing from the absence of necessary parties. See *Indep. Wireless Tele. Co., v. Radio Corp. of Am.*, 269 U.S. 459, 472 (1926) (asserting that "if there is no other way of securing justice to the exclusive licensee, the latter may make the owner without the jurisdiction a coplaintiff without his consent in the bill against the infringer. Equity will not suffer a wrong without a remedy") (citing 1 POMEROY'S EQUITY JURISPRUDENCE §§ 423, 424). See generally Geoffrey C. Hazard, Jr, *Indispensable Party: The Historical Origin of a Procedural Phantom*, 61 COLUM. L. REV. 1254 (1961) (discussing the equity origins of Rule 19). Importantly, Rule 19(b) mandates that a federal

B. First Step of an Equity Preemption Analysis

In applying “equity preemption,” a federal court does not have to engage in wholesale judicial lawmaking, but can continue to rely on *Travelers*’ principles that narrows ERISA’s preemption. Courts can apply equity preemption by using a two-step process. Under the first step of the analysis, *Travelers* and its progeny should be used, which might or might not lead to the preemption of state laws and lawsuits. Several general principles from *Travelers* are important to a first-step equity preemption analysis.

First, courts should not employ a literal application of either the “reference

district court dismiss a plaintiff’s federal lawsuit if there is an absent indispensable party over whom the court cannot assert federal subject matter or personal jurisdiction. See FED. R. CIV. P. 19. One factor that might lead to an absent party being an indispensable party is that, under Rule 19(a), if “in the person’s absence complete relief cannot be accorded among those already parties.” FED. R. CIV. P. 19(a). In such a case, if the federal district court cannot fashion a remedy that would avoid prejudice to a person who is already a party to the lawsuit, the court “shall determine whether in equity and good conscience” the lawsuit should be dismissed because the absent party is indispensable to the lawsuit. *Id.* Importantly, “equity and good conscience” determines whether the lawsuit should be dismissed. Therefore, Rule 19 allows federal courts to use equity principles and maxims to decide when a lawsuit should be dismissed because an absent party is an indispensable party.

Furthermore, in conjunction with their equity analysis, courts should also consider “whether the plaintiff will have an adequate remedy if the action is dismissed for nonjoinder.” FED. R. CIV. P. 19(b). Generally, a federal court should not dismiss a plaintiff’s lawsuit because of an inability to join an indispensable party unless the plaintiff can refile her lawsuit in a state court where she can obtain subject matter and personal jurisdiction over all indispensable parties. See JACK H. FRIEDENTHAL ET AL., CIVIL PROCEDURE 352 (3d ed. 1999).

The relevancy of this discussion to this Article is twofold. First, when a federal court dismiss a lawsuit under Rule 19(b), the plaintiff normally will refile the case in state court, a fact that the court anticipates because it is a part of the court’s consideration in deciding whether to dismiss the case. Second, the court loses jurisdiction to resolve the lawsuit if it cannot obtain subject matter or personal jurisdiction over an indispensable party and if “equity and good” conscious establish that a dismissal should occur. Therefore, Rule 19 is situation where the court gives up its jurisdiction over a case so that the appropriate state court can resolve the lawsuit after the joinder of all indispensable parties. The analogy to Rule 19 that impacts this Article, is that like a court that cannot obtain jurisdiction over an indispensable party, a federal court should use “equity preemption” to avoid the exercise of jurisdiction over some state law claims that have been removed to federal court along with section 502(a) claims (that are completely removal) by remanding the claims back to state court. Also, both federal courts and state courts, when they properly should retain jurisdiction of a state law claims, should use “equity preemption” to avoid the preemption of any state law claim when a plaintiff would not otherwise have a needed compensatory damage remedy. As such, both Rule 19 and ERISA preemption doctrines, including “equity preemption” would evidence courts use of their equity powers to provide necessary remedies to injured plaintiffs.

to" prong or the "connection with" prong of "relate to" since *Travelers* establishes that "the basic thrust of [ERISA's] pre-emption clause . . . [is] to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans."²⁹⁹ In other words, ERISA should preempt state laws and lawsuits only when they have a substantial impact on the structure or administration of an ERISA plan. Therefore, preemption should occur only when a state law or lawsuit substantially: (1) mandates employee benefit structures or their administration, (2) binds employers or plan administrators to particular choices or precludes uniform administrative practice, thereby functioning as a regulation of an ERISA plan itself, or (3) provides alternative enforcement mechanisms for employees to obtain ERISA plan benefits.³⁰⁰ These types of laws and lawsuits generally limit or control an ERISA plan's administrative choices, and therefore, might result in a disuniformity of ERISA plan regulation if different states enact different laws on the same subject.³⁰¹ As such, they are generally inconsistent with ERISA's preemption clause purpose of avoiding a multiplicity of state law regulation. This Article calls these types of laws "structural state laws" because they tend to have a substantial effect on the structure and administration of ERISA plans.

Second, there should be no preemption even when a state law or lawsuit is a "structural state law" if the law or lawsuit has a "too tenuous, remote, or peripheral" effect on an ERISA plan.³⁰² Falling within this exception are laws and lawsuits that have only an indirect economic effect on an ERISA plan, as did New York's surcharges in *Travelers*.³⁰³ An indirect economic effect primarily exists when a state law or lawsuit obligation might cause an ERISA plan to evaluate its administrative choices, but does not mandate that the plan choose one course of action over another.³⁰⁴

Third, given the presumption against the preemption of state law regulation in areas of traditional state authority, a court should not find preemption, even when a state law or lawsuit is a "structural state law" unless either ERISA's statutory language or legislative history clearly shows that Congress intended that the specific type of state law be preempted because the law interferes with ERISA's objectives and purposes.³⁰⁵

The above-referenced three principles stem from statements that the Supreme Court made in *Travelers* and they have evolved through some lower-level federal

299. N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 657 (1995).

300. See *id.* at 891-92. Generally, laws or lawsuits having the above-referenced substantial effects are thought of as having an impermissible "connection with" an ERISA plan, and therefore, ERISA preempts such claims. Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., Inc., 519 U.S. 316, 329 (1997).

301. See *Travelers*, 514 U.S. at 657-58.

302. Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 100 n.21 (1995).

303. *Travelers*, 514 U.S. at 659-60.

304. See *id.*

305. See *id.* at 654-55.

court decisions applying *Travelers* and ERISA's preemption clause on a case-by-case basis.³⁰⁶ Moreover, these principles represent a narrowing of the scope of ERISA's preemption clause.³⁰⁷

Applying the three principles under the first step of an "equity preemption" analysis to medical malpractice lawsuits, a court should find that ERISA does not preempt either a medical malpractice claim against a treating physician or a vicarious liability claim against an HMO or other managed care organization that provides treating physicians because such claims normally have only an indirect effect on ERISA plans; and therefore, they generally fall within the "too tenuous, remote, or peripheral" exception to ERISA's preemption.³⁰⁸ Importantly, these types of medical malpractice and vicarious liability claims are general state law regulation of the medical profession and the health care industry. Therefore, the presumption against preemption applies, and courts should find that ERISA does not preempt such claims because there is no clear expression from Congress that it intended to preempt state lawsuits that control the quality of health care,³⁰⁹ including state common law medical malpractice claims against treating physicians and managed care organizations acting in their role as providers of medical care and state statutory provisions that impose a medical standard of care on medical providers in their role as providers, as in the Texas statute at issue in *Corporate Health Insurance*.³¹⁰

306. See *supra* notes 122-286.

307. Mostly, step one is an application of the current analysis under *Travelers* and the more progressive cases that have applied its rationale. See *Travelers*, 514 U.S. at 654-55.

308. See generally *Lancaster v. Kaiser Found. Health Plan of Mid-Atl. States, Inc.*, 958 F. Supp. 1137 (E.D. Va 1997); *Lazorko v. Pa. Hosp.*, No. 96-4858, 1998 WL 405055 (E.D. Pa. June 30, 1998), *aff'd in part and vacated in part*, 237 F.3d 242 (3d Cir. 2000); *Dykema v. King*, 959 F. Supp. 738 (D. S.C. 1997). There should especially be no preemption when a plaintiff's claim is based on either a treating physician's, an ERISA plan's, or a managed care organization's violation of an independent state law obligation and the claim seeks compensatory or other damages that are not actionable under section 502(a) of ERISA's civil enforcement provisions.

309. See *Lancaster*, 958 F. Supp. at 1149.

310. This conclusion is consistent with *Dukes'* distinction between physicians and medical providers acting in their medical provider roles where no preemption is proper, and their acting as administrators of ERISA plans, where some courts have been more willing to find preemption. In addition to negligent decisions during utilization review, ERISA plans, their managed care organization administrators, and treating physicians might be guilty of other misconduct that does not fall within the confines of a traditional state law claim for medical malpractice or vicarious liability. Regardless of the nature of the alleged improper conduct or the nature of the state common law theory of liability or applicable statutory provision, courts should generally find no preemption of such common-law theories or statutory provisions if the alleged conduct occurred during the ERISA plan's, the managed care organization's, and the treating physician's role as a provider of medical care. At this point in the analysis, the distinction between *Pilot Life* and *Dukes* as interpreted in *In re U.S. Healthcare* comes into play. If the plaintiff is seeking denied benefits because the ERISA administrator was allegedly negligent or otherwise acted improperly in denying the benefits, then under *Pilot Life's* rationale the state-law claim should be preempted.

C. *The Second Step of an Equity Preemption Analysis*

The second step of an "equity preemption" analysis would come into play when, under the first step, the court reaches a conclusion that the disputed state law or lawsuit is a "structural state law," with an effect that is too substantial to fall within the "too tenuous, remote, or peripheral" exception to ERISA's preemption, but for which there is uncertainty as to whether Congress intended that ERISA preempt the law or lawsuit. The bottom line implication of an "equity preemption" analysis is that in situations where the scope of ERISA's preemption clause is uncertain, courts should not find a preemption of state laws if doing so means that beneficiaries will be left without an adequate compensatory damage remedy. Although other types of state laws and lawsuits might benefit from an analysis under the second step of an "equity preemption" analysis with its use of the maxim "equity will not suffer a wrong without a remedy," negligent utilization review decisions are ripe for this type of preemption analysis.

D. *Negligent Utilization Review Decisions*

At least three types of utilization review decisions are relevant to an "equity preemption" analysis: a pure eligibility decision, only a medication decision, and a "mixed eligibility and treatment decision." First, a pure eligibility decision is one where either the health plan or managed care organization makes a decision to deny or grant medical benefits without giving an opinion about the medical necessity of the treatment.³¹¹ Traditionally, ERISA's preemption clause has

However, if the plaintiff is seeking compensatory damages (and not denied benefits or other allowable equitable relief under section 502(a) of ERISA) because of a negligent medical decision or other acts of medical malpractice, then ERISA should not preempt the claim on *Dukes'* and *In re U.S. Healthcare's* rationale that ERISA does not preempt claims seeking to hold an ERISA administrator liable for the provision of low quality or substantial benefits, instead of denied benefits. This result should adhere even when an ERISA administrator gives only medical advice regarding how the plaintiff should seek treatment for her medical condition or regarding how plaintiff's treating physician should treat plaintiff's medical condition. In either situation, a plaintiff would not have a claim under section 502(a) of ERISA's civil enforcement provision because her claim would be about a medical decision-quality of care issue and for compensatory damages. Since there would be no remedy under section 502(a), a court, through the use of its equity powers and the maxim "equity will not suffer a wrong without a remedy," should be able to either create a remedy itself or to hold that ERISA does not preempt the state law claim so that state law can create the remedy. From a federalism standpoint, finding no preemption, instead of a court's use of its equity powers to create a common law remedy, appears to be more in line with *Travelers'* admonition that the regulation of health care is a matter that has traditionally been left to state law regulation. Therefore, the use of equity preemption is consistent with the presumption against the preemption of state law regulation in areas of tradition state concerns.

311. This might occur when the treating physician, totally independent of the health plan or managed care organization, recommends treatment and the plan or organization denies the treatment

preempted state lawsuits challenging these types of benefit determination decisions because arguably they fall within *Pilot Life's* preemption of state law claims that challenge "improper processing" of a request for benefits.³¹² Preemption of state law claims for specific denied benefits would probably be appropriate even under an "equity preemption" analysis because ERISA's preemption clause should preempt a state law claim that seeks only the specific denied benefits that a plaintiff could obtain through filing an ERISA claim under section 502(a), especially as the challenged decision would be a pure eligibility decision.³¹³

However, courts should be mindful of Justice Souter's admonition that *Travelers* "throws some cold water on the preemption theory."³¹⁴ Therefore, courts should not blindly follow *Pilot Life* to preempt all state law claims that arise during the utilization review process, but they should conduct a more rigorous analysis of state laws' impact on ERISA preemption clause purposes. In light of *Travelers* and *Pegram*, courts should make a distinction between state law claims that seek only the specific benefits that an ERISA plan or its affiliated managed care organization has denied, and state law claims that seek compensatory damages because of injuries that a plaintiff has suffered due to either the ERISA plan's or its managed care organization's violation of independent state law obligations during the process of denying benefits.³¹⁵ ERISA should not preempt a state law claim for compensatory damages that seeks to vindicate the violation of independent state law obligations when the plaintiff is complaining about "only a medical decision."³¹⁶ This conclusion is consistent with the court's conclusion in *Crum* and in *Moreno*. The primary

request without giving an opinion about whether the treatment is or is not medically necessary. See *Pegram v. Herdrich*, 120 S. Ct. 2143, 2144 (2000).

312. See generally *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

313. This result adheres through both conflict preemption and the *Pilot Life* rule that state law claims should not supplement the remedies provided by ERISA's civil enforcement provisions. See *id.* at 54.

314. *Pegram*, 120 S. Ct. at 2158.

315. The operative distinction should be whether the claim is based upon a violation of an independent state law obligation instead of a violation of either an ERISA's plan's terms and conditions or ERISA's statutory provisions. The distinction should not be based upon the type of damages that a plaintiff seeks, except that damages in the specific form allowable under section 502(a) of ERISA's civil enforcement provisions should not be allowed by means of a state law claim if the state law claim falls within the scope of the claims allowable under section 502(a). Therefore, other than claims for denied benefits, for enforcement of an ERISA's plan's terms and condition, or for resolution of dispute over rights to future benefits, one who brings a state law claim should be able to collect any state law remedies including compensatory damages, injunctions, and other applicable equitable relief.

316. ERISA should not preempt the claim unless the court can properly classify the claim as one for either a specific set of denied benefits or for other allowable equitable relief under ERISA's civil enforcement provisions, as opposed to a claim for compensatory damages for injuries flowing from negligence or other violations of independent state law obligations.

reason why there should be no preemption of these types of claims is that they challenge medical providers', managed care organizations', and ERISA plans' negligent decisions during their roles as medical providers and not solely their utilization review decisions. This same conclusion, that there should be no preemption of these types of claims, applies to what the *Pegram* Court called "mixed eligibility and treatment" decisions, which are not actionable as breaches of fiduciary duty claims under ERISA's civil enforcement provisions. They are not actionable because they involve a managed care organization's combined benefit eligibility decision and medical treatment decision.³¹⁷ Importantly, the Court in *Pegram* strongly implied that ERISA would not preempt state lawsuits challenging "mixed eligibility and treatment decisions," especially when the lawsuits involves an HMO's and its treating physicians' mixed decisions.³¹⁸ As a matter of fact, the Court relied on plaintiffs' apparent ability to bring state medical malpractice claims challenging "mixed eligibility and treatment decisions" as one reason supporting its decision in *Pegram* that managed care organizations are not acting in a fiduciary capacity when they make "mixed eligibility and treatment decisions."³¹⁹ Therefore, their decisions are not subject to challenge through an ERISA breach of fiduciary duty claim under either section 409(a) or section 502(a) of ERISA civil enforcement provisions.³²⁰

Implicit in *Pegram* is the Court's recognition that, at least as far as the medical treatment decision portion of a "mixed eligibility and treatment decision," state law obligations supply the quality control protection, and such protection falls within *Travelers'* presumption against the preemption of states' police power regulations.³²¹ Therefore, in furtherance of states' police power protection when the challenged act involves only a medical decision or a "mixed eligibility and treatment decision," "equity preemption" should apply and there should be no preemption of generally applicable state-law medical malpractice claims for compensatory damages, generally applicable state law claims vindicating relevant state law obligations, nor any generally applicable or specifically directed state statutory obligation.³²²

There are several reasons why the use of "equity preemption" should save state lawsuits based on the violation of independent state law obligations involving "only medical treatment decisions" and "mixed eligibility and

317. See *Pegram*, 120 S. Ct. at 2158 (asserting that a breach of fiduciary duty claim under ERISA's civil enforcement provisions "would simply apply the law already available in state courts and federal diversity actions today, and the formulaic addition of an allegation of financial incentive would do nothing but bring the same claim into a federal court under federal-question jurisdiction").

318. See *id.*

319. See *id.*

320. See *id.*

321. This conclusion applies to state common law theories, state statutory provisions, and state laws based on the violation of state statutory provisions.

322. There is no reason why the "equity preemption" concept should not apply to all types of state laws.

treatment decisions.” Most importantly, ERISA’s civil enforcement provisions do not presently provide a remedy for these types of claims.³²³ Beneficiaries are left without a meaningful compensatory damage remedy.³²⁴ By using “equity preemption,” especially regarding the “only medical decisions” and the “mixed eligibility and treatment decisions,” courts can avoid preemption if the preemption of state laws and lawsuits would leave a beneficiary without an adequate compensatory damage remedy.³²⁵ This result logically stems from the use of the maxim that “equity will not suffer a wrong without a remedy.” However, some observers might raise several objections to the use of “equity preemption” to avoid the preemption of state law claims challenging either an ERISA plan’s or affiliated managed care organization’s negligent acts during utilization review.

E. Responses to Potential Arguments Against the Use of Equity Preemption

First, one might argue that allowing a state law claim for compensatory damages, stemming from a violation of independent state law obligation, would be an impermissible alternative enforcement mechanism because it would provide a compensatory damage remedy when ERISA’s civil enforcement provisions provide only for denied benefits and non-monetary equitable relief.³²⁶ The short answer to this concern is that *Travelers*’ prohibition against state law claims that seek to establish an alternative enforcement mechanism speaks only against a claim for denied benefits.³²⁷ Because a state law claim for compensatory damages for a violation of state statutory provisions or common law doctrine is not for denied benefits, but for personal injuries flowing from an ERISA plan administrator’s or managed care organization’s negligent conduct or other improper actions during the utilization review process, the claim should not violate the rule against state laws providing an alternative enforcement mechanism.³²⁸

323. “Mixed eligibility” and treatment claims, pursuant to *Pegram*, are not actionable under either section 502(a) or section 409(a) because they do not fall within the fiduciary duty of a managed care organization. See *Pegram*, 120 S. Ct. at 2158.

324. See *Mertens*, 508 U.S. 240 (1993).

325. As the amount of denied benefits are the only monetary remedy under section 502(a), there is not adequate remedy under section 502(a) for compensatory damages based on a violation of independent state laws.

326. See *supra* note 20.

327. See *Corporate Health Ins., Inc. v. Tex. Dep’t of Ins.*, 12 F. Supp. 2d 597, 628-29 (S.D. Tex. 1998), *aff’d in part and rev’d in part*, 215 F.3d 526 (5th Cir. 2000).

328. The only limitation on the type of state laws and lawsuits that should escape ERISA’s preemption is that the above arguments should apply only to generally applicable state laws that are not specifically directed at the regulation of ERISA plans. Specifically directed laws are the ones that are in danger of running afoul of ERISA’s preemption. They are a direct regulation of ERISA plans and would be contrary to ERISA’s preemption clause purpose of avoiding a disuniformity of regulation of ERISA plans, as different states might enact different state laws that might place a

Second, some might assert that ERISA's civil enforcement provisions preempt the field of state law remedies such that one cannot use state law to obtain remedies that are not allowable under ERISA's civil enforcement provisions. This argument would be consistent with the assertions from some members of the Court that field preemption should be used to resolve ERISA's preemption issues.³²⁹ However, the Court's prior cases have not used field preemption to determine the scope of ERISA's express preemption.³³⁰

substantial burden on the operation of multi-state ERISA plans.

329. Justice Scalia's concurring opinion in *Dillingham Construction* asserts that the Court's ERISA preemption jurisprudence is essentially an application of the field preemption doctrine. *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., Inc.*, 519 U.S. 316, 334-35 (1997) (Scalia, J., concurring). Field preemption occurs when (1) there is a "scheme of federal regulation [that is] so pervasive as to make reasonable the inference that Congress left no room for the States to supplement it," and (2) when "an Act of Congress 'touch[es] 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.'" *English v. Gen. Elec. Co.*, 496 U.S. 72, 79 (1990) (citing *Rice v. Sante Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

330. *See Dillingham Constr.*, 518 U.S. at 333-34. At least one lower-level federal court has reasoned that ERISA's preemption is based on both express preemption and field preemption. *See Kanalos v. Graham*, 759 F. Supp. 374 (E.D. Mich. 1991). The *Kanalos* court stated "[i]t is by a combination of the first two of these circumstances, express preemption and field preemption, under which ERISA has been found to preempt state law." *Id.* at 376 However, the court's conclusion that ERISA did not preempt the employee's state law fraud, promissory estoppel, and breach of contract claims was based on express preemption doctrine and not field preemption. *See id.* at 378.

In any event, some of the Supreme Court's opinions do not lead to the conclusion that field preemption is applicable to an ERISA preemption analysis. For example, in *District of Columbia v. Greater Washington Board of Trade* 506 U.S. 125 (1992), the Court applied a literal interpretation of "relate to" to preempt a Washington workers' compensation law that merely had a "reference to" ERISA plans despite the fact that ERISA exempted state workers' compensation laws from ERISA regulation. *See id.* at 128-31. The workers' compensation law provided:

Any employer who provides health insurance coverage for an employee shall provide health insurance coverage equivalent to the existing health insurance coverage of the employee while the employee receives or is eligible to receive workers' compensation benefits under this chapter.

Id. at 128.

The Court held that ERISA preempted the law because of its "reference to" ERISA benefit plans that were the source of the existing health insurance referenced in the text of the workers' compensation law. The Court reasoned:

Section 2(c)(2) of the District's Equity Amendment Act specifically refers to welfare benefit plans regulated by ERISA and on that basis alone is pre-empted. The health insurance coverage that § 2(c)(2) requires employers to provide for eligible employees is measured by reference to "the existing health insurance coverage" provided by the employer and "shall be at the same benefit level." The employee's "existing health insurance coverage," in turn, is a welfare benefit plan under ERISA § 3(1), because it involves a fund or program maintained by an employer for the purpose of providing

Rather, the Court has used an express preemption analysis to interpret the effects of ERISA's civil enforcement provisions.³³¹ Furthermore, given the similarities between an ERISA express preemption analysis and a field preemption analysis, most cases would obtain the same preemption conclusion under a field preemption analysis as under ERISA's express preemption, especially since some of the same general principles apply to both types of preemption.³³²

For example, as with ERISA's express preemption, the Supreme Court appears hesitant to apply field preemption in areas of state law regulation "that

health benefits for the employee "through the purchase of insurance or otherwise." Such employer-sponsored health insurance programs are subject to ERISA regulation and any state law imposing requirements by reference to such covered programs must yield to ERISA.

Id. at 130-31 (citations omitted). In his argument against preemption of Washington's law, Justice Stevens' dissenting opinion implies that ERISA preemption clause implicates a field preemption analysis. However, Justice Stevens correctly asserts that some of the Court's prior opinions have established an interpretation of ERISA's preemption clause that is broader than field preemption. *See id.* at 136 (Stevens, J., dissenting). This is especially the case when the Court has found preemption when a state statute, although not directly regulating an ERISA plan, "make[s] it necessary for plan administrators to operate such plans differently." *Id.* Justice Stevens states:

In deciding where that line should be drawn, I would begin by emphasizing the fact that the so-called "pre-emption" provision in ERISA does not use the word "pre-empt." It provides that the provisions of the federal statute shall "supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title." Thus the federal statute displaces state regulation in the field that is regulated by ERISA; it expressly disavows an intent to supersede state regulation of exempt plans; and its text is silent about possible pre-emption of state regulation of subjects not regulated by the federal statute. Thus, if we were to decide this case on the basis of nothing more than the text of the statute itself, we would find no pre-emption (more precisely, no "supersession") of the District's regulation of health benefits for employees receiving workers' compensation because that subject is entirely unregulated by ERISA. I would not decide this case on that narrow ground, however, because both the legislative history of ERISA and prior holdings by this Court have given the supersession provision a broader reading. Thus, for example, in *Shaw* itself we held that the New York Human Rights Law, which prohibited employers from structuring their employee benefit plans in a manner that discriminated on the basis of pregnancy, was pre-empted even though ERISA did not contain any superseding regulatory provisions. State laws that directly regulate ERISA plans, or that make it necessary for plan administrators to operate such plans differently, "relate to" such plans in the sense intended by Congress.

Id. at 136-37. His contentions were based on the fact that ERISA exempts the regulation of workers' compensation plans from ERISA's preemption, and that the preempted workers' compensation law did not regulate ERISA plans. *Id.* (citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983)).

331. *See supra* note 330.

332. *See infra* notes 333-35.

have 'been traditionally occupied by the State.'"³³³ Second, the "too tenuous, remote, or peripheral" exception to ERISA's express preemption has a counterpart in the field preemption arena to the extent that laws with such an impact would also not be preempted under a field preemption analysis.³³⁴

333. See also *Medtronic, Inc. v. Lohr*, 518 U.S. 470 (1996). In *Medtronic*, the Court held that the express preemption clause of the Medical Device Amendments of 1976 (MDA), which imposed requirements on the sale and marketing of medical devices, did not preempt state law negligence claims and strict product liability claims based on the improper design, manufacturing and labeling of a Medtronic's pacemaker lead. See *id.* at 502-03. The MDA's expressed preemption clause provided for preemption only when a state requirement is different from, or in addition to, any requirement imposed by the MDA or the regulating agency. *Id.* at 481 (citing 21 U.S.C. § 360k(a)). Further, the Court held that the preemption clause covered only specific, conflicting state legislative enactments directed at a specific medical device and not a state's generally applicable common law causes of action. See *id.* at 486-91. Therefore, the Court, pursuant to its interpretation of the express preemption clause, and the MDA's implementing regulations, found that the state law claims were not preempted. See *id.* at 501. In his concurring opinion, Justice Breyer, responded to Justice O'Connor's dissenting opinion's reference to the "'comprehensive' and 'extensive'" nature of the MDA's regulations of the manufacturing and labeling of medical devices. *Id.* at 513-14 (O'Connor, J., dissenting). He asserted: "[T]his Court has previously said that it would 'seldom infer, solely from the comprehensiveness of federal regulations, an intent to pre-empt in its entirety a field related to health and safety.'" *Id.* at 507 (Breyer, J., concurring) (citing *Hillsborough County v. Automated Med. Labs., Inc.*, 471 U.S. 707, 718 (1985)). Although Justice O'Connor did not specifically mention field preemption, given that she spoke only of the extensive nature of the regulation as a ground for preemption, without identifying any particular conflict between the respondent's state common-law claim and the MDA statute and regulations, Justice Breyer's references to field preemption appear well-grounded. See *id.* at 513-14 (O'Connor, J., dissenting).

Medtronic, especially Justice Breyer's references to field preemption, might have implications for ERISA's preemption, especially if the Court accepts field preemption as the controlling doctrinal approach to preemption in this area. The major argument would be that simply because ERISA's section 502(a) civil enforcement provisions are arguably comprehensive and complete does not necessarily mean that one cannot bring a state common law cause of action unless there is some other indication that Congress intended to preempt the field for federal regulation. Justice Breyer states:

I can find no actual conflict between any federal requirement and any of the liability-creating-premises of the plaintiffs' state law tort suit; nor, for the reasons discussed above, can I find any indication that either Congress or the FDA intended the relevant FDA regulation to occupy entirely any relevant field.

Id. at 508 (Breyer, J., concurring).

334. See *N.W. Cent. Pipeline Corp. v. State Corp. Comm'n of Kan.*, 489 U.S. 493 (1989). In *Northwest Pipeline*, the State Corporation Commission of Kansas (KCC) issued an order "to provide for the permanent cancellation of underages" that an interstate gas pipeline accrued in withdrawing gas for common gas pools. *Id.* at 503. Northwest Pipeline contended that the National Gas Policy Act of 1978 (NGPA) preempted the Kansas order because in canceling underages the order affected the price that pipelines could charge for gas that they transported through interstate commerce. See *id.* at 510. Importantly, the NGPA provided that states could regulate the

Third, consistent with express preemption, to support an inference that field preemption trumps a state law, Congress' intent to employ field preemption must be "clear and manifest" as expressed in either a federal statute, supporting legislative history, or a regulatory agency's enforcement rules.³³⁵ These principles lead to the conclusion that, in comparison to ERISA's express preemption, the use of field preemption to resolve ERISA's preemption issues would not be a substantial improvement over the Court's current express preemption analysis.

In any event, section 502(a) of ERISA's civil enforcement provisions does not clearly and manifestly show that Congress' intent is that ERISA's civil enforcement provisions preempt state law remedies that are based upon violations of independent state law obligations. This observation leads to the

"production or gathering of natural gas." *Id.* at 507. On the other hand, the federal government had the exclusive authority "to regulate the wholesale pricing of natural gas in the flow of interstate commerce from wellhead to delivery to consumers." *Id.* The Court rejected the field preemption argument because Kansas' order fell within states' authority to control the production of natural gas within their boundaries. *See id.* at 511-12. In *Northwest Pipeline*, despite the fact that the state order indirectly increased the price of natural gas that pipelines transported in interstate commerce, the Court found that such an indirect effect on the price of gas did not intrude on the federal government's exclusive authority to regulate the interstate price of natural gas. *See id.* The Court reasoned that any exercise of a state's authority to regulate the production of natural gas would have some effect on the price of interstate gas. *See id.* at 512-13. The only way that the Kansas order would result in preemption was if Kansas, in issuing the order, had the purpose of regulating the price of interstate gas instead of regulating the production of gas within its local boundaries. *See id.* at 518. Such an ulterior purpose would have probably resulted in both field preemption and conflict preemption. Therefore, in *Northwest Pipeline*, the field preemption doctrine did not preempt a Kansas order canceling "underage" despite the order's indirect effect on interstate gas prices, even though the regulation of interstate gas prices was within the federal government's exclusive authority. *See id.* at 526.

335. *See* P.R. Dep't of Consumer Affairs v. Isla Petroleum Corp., 485 U.S. 495, 503 (1988). In one respect, ERISA's statutory scheme does not show a "clear and manifest" congressional intent that states have no regulatory role in the employment benefit field. The presence of ERISA's saving clause is clear evidence that Congress did envision a state role in regulating the business of insurance since the saving clause exempts state insurance laws from ERISA's preemption. *See* 29 U.S.C. § 1144 (b)(2)(A) (1988). Under the saving clause, numerous state laws have been saved from preemption. *See generally* Larry J. Pittman, "Any Willing Provider" Laws and ERISA's Saving Clause: A New Solution for an Old Problem, 64 TENN. L. REV. 409 (1997). This is significant because when Congress has wanted to, it has delineated those portions of the employee benefit field that should be subject to exclusive federal regulation. For example, the "deemer clause" makes the saving clause's exemption inapplicable to self-funded or self-insured welfare benefit plans. *See* 29 U.S.C. § 1144 (b)(2)(B) (1988). Given the distinction between insured plans that states can regulate, and self-insured plans that states cannot regulate, ERISA's legislative history statements, that ERISA's preemption clause provides for exclusive federal regulation of employee benefit plans, cannot be taken literally. 120 CONG. REC. 15737, 15742 (statement of Sen. Williams).

logical conclusion that the Court has misinterpreted congressional intent regarding the preemptive effects of ERISA's civil enforcement provisions. For example, in *Pilot Life*, the issue before the Court was whether ERISA preempted a Mississippi bad faith claim for an improper processing of a claim for disability benefits.³³⁶ To support its conclusion in favor of preemption, the Court made several broad statements regarding ERISA's section 502(a) being an expression of Congress' intent regarding the preemption of state laws. First, the Court stated: "The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive."³³⁷ One could argue that this statement means that one who has a claim against an ERISA welfare benefit plan for any type of injury must limit her remedies to those allowable under section 502(a).³³⁸

However, to support a field preemption of state laws, Congress' intent regarding the preempted field must be "clear and manifest" from either ERISA's expressed statutory language or from its relevant legislative history.³³⁹ Therefore, it is significant that the language of section 502(a) is clear and manifest only regarding the civil enforcement remedies for a breach of an ERISA plan's contractual language³⁴⁰ and for a breach of ERISA's substantive provisions.³⁴¹ It clearly and manifestly provides for a claim to recover denied benefits, enforce rights under the terms of the plan, or to clarify rights to future benefits under the terms of the plan.³⁴² The language does not speak either positively or negatively about state law claims based upon violations of independent state law obligations that seek compensatory damages. Therefore, from a strict interpretation of section 502(a)'s language, the only field that ERISA's civil enforcement provisions preempt is state laws that impose liability for a violation of the terms of an ERISA plan or for a violation of ERISA's substantive provisions and which seek the specific remedies allowable under section 502(a).³⁴³ The legislative history that the Court cited in *Pilot Life* does not alter this conclusion.

First, the *Pilot Life* Court emphasized ERISA's legislative history that "civil actions may be brought by a participant or beneficiary to recover benefits due under the plan, to clarify rights to receive future benefits under the plan, and for relief from breach of fiduciary responsibility."³⁴⁴ Those lawsuits shall be deemed "arising under the laws of the United States in similar fashion to those brought

336. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 43-44 (1987).

337. *Id.* at 54.

338. See *id.*

339. See *P.R. Dep't of Consumer Affairs*, 485 U.S. at 503.

340. See *Pilot Life*, 481 U.S. at 55.

341. See 29 U.S.C. § 1132 (a) (1988).

342. See *id.*

343. See *id.*

344. *Pilot Life*, 481 U.S. at 55.

under section 301 of the Labor-Management Relations Act of 1947 (LMRA).³⁴⁵ The Court proceeded to note that, under section 301 of the LMRA, all state law claims “for violation of contracts between an employer and a labor organization,” even when the state action purported to authorize a remedy unavailable under the federal provision, are preempted.³⁴⁶ Importantly, the Court then stated that “[i]n *Lucas Flour* the Court found that ‘[t]he dimensions of § 301 require the conclusion that substantive principles of federal labor law must be paramount in the area covered by the statute.’”³⁴⁷ The area covered by the statute was the violation of contractual terms between employers and employees.³⁴⁸

Applying the Court’s observation about the preemptive effects of the LMRA to the preemptive effects of section 502(a) of ERISA’s civil enforcement provisions, one should conclude that the relevant area of federal preemption is the area covered by the language of section 502(a). That area is lawsuits by participants and beneficiaries challenging an ERISA plan’s violation of either the terms of an ERISA welfare benefit plan or the substantive provisions of ERISA itself, and not lawsuits alleging a violation of an independent state law obligation. This conclusion is not altered by ERISA’s legislative history. For example, the Court in *Pilot Life* concluded that, “Congress’ specific reference to § 301 of the LMRA to describe the civil enforcement scheme of ERISA, makes clear its intention that all suits brought by beneficiaries or participants *asserting improper processing of claims* under ERISA-regulated plans be treated as federal questions governed by § 502(a)” because they in essence allege that an ERISA plan has violated the *contractual terms* of an ERISA plan by improperly denying *benefits*.³⁴⁹ A strict reading of the Court’s statements is that the Court’s interpretation of ERISA’s legislative history’s reference to section 301 of the LMRA means only that state law claims seeking remedies for an “improper processing” of claims for plan benefits, and alleging a breach of contractual terms, are preempted by section 502(a) through field preemption. Therefore, field preemption should not preempt state law claims that are not based upon “an improper processing” of claims for denied benefits, but are premised on the violation of an independent state law obligations and not on a violation of the terms and condition of an ERISA plan. There is no “clear and manifest” expression of Congress’ intent to preempt such claims.

One might allege that despite the absence of any language in section 502(a) explicitly preempting state claims alleging theories other than a violation of either an ERISA plan’s terms, an ERISA statutory provision, or “an improper processing of claims,” the comprehensiveness of federal regulation of the welfare benefit field means that there is no room left for states to regulate in the welfare benefit field.³⁵⁰ However, other than section 409(a), section 502(a), and the

345. *Id.*

346. *Id.*

347. *Id.* (emphasis added).

348. *See id.* at 56.

349. *Id.*

350. The comprehensiveness of federal regulation is one factor that could, in an appropriate

portion of the statute establishing fiduciary standards of conduct, there is no extensive and comprehensive federal regulation of employee welfare benefit plans, especially as to the quality of medical care that an ERISA plan and affiliated managed care organization provide to ERISA beneficiaries.³⁵¹ One is left with asserting that section 502(a)'s civil enforcement provisions are the relevant source for measuring the comprehensiveness of Congress' regulation of remedies flowing from either a breach of a welfare benefit plan or a breach of ERISA's statutory provisions. However, the language of section 502(a) does not clearly and manifestly show a congressional intent that ERISA's civil enforcement provisions should preempt state law claims alleging theories (other than one based on an improper processing of a specific benefit request) that are premised on independent state law obligations. Contrary to the *Pilot Life* Court's assertion, there is no persuasive evidence that Congress, as far as independent state law obligation is concerned, considered and rejected other theories of liability and remedies. Given the presumption against the preemption of state's historical police power regulations (including the regulation of the quality of medical care), any uncertainty about congressional intent to preempt state law theories should be resolved against preemption of those theories.³⁵²

Furthermore, the general legislative history statements about the scope of ERISA's preemption do not clearly and manifestly establish that field preemption proscribes all state law tort claims and remedies against those affiliated with or those managing ERISA welfare benefit plans. A common theme throughout ERISA's legislative history is that Congress was primarily concerned about state laws that attempted to "regulate" how private pension plans and welfare benefits plans operated within the states. The operative term is "regulate." For example, Senator Williams, one of ERISA's sponsors, stated:

It 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 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.³⁵³

case, lead to field preemption. See *English v. Gen. Elec. Co.*, 496 U.S. 72, 79 (1990).

351. See 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, 50 (1999).

352. The presumption applies even when field preemption is used. See *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 507 (1996).

353. 120 CONG. REC. 15737, 15742 (statement of Sen. Williams) (emphasis added). Senator Williams further asserted that:

This principle is 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. Consistent with this principle, State professional associations acting under the guise of

Similarly, Senator Javits, another ERISA sponsor, asserted:

Although the desirability of further *regulation*—at either the State or Federal level—undoubtedly warrant further attention, on balance, the emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required-but for certain exceptions-the displacement of State action in the field of private employee benefit programs. The conferees-recognizing the dimensions of such a policy-also agreed to assign the Congressional Pension Task Force the responsibility of studying and evaluating preemption in connection with State authorities and reporting its findings to the Congress. If it is determined that the preemption policy devised has the effect of precluding *essential legislation* at either the State or Federal level, appropriate modifications can be made.

In view of Federal preemption, *State laws compelling disclosure from private welfare or pension plans, imposing fiduciary requirements on such plans, imposing criminal penalties on failure to contribute to plans-unless a criminal statute of general application-establishing State termination insurance programs, et cetera, will be superseded.* It is also intended that a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans.³⁵⁴

Both Senator Williams' and Javits' statements seem to be primarily concerned with states passing statutes to directly regulate ERISA employee benefit plans. As such, the Supreme Court arguably misinterpreted Senator Javits' statement in *Shaw v. Delta Air Lines, Inc.*,³⁵⁵ when the Court stated:

In fact, however, Congress used the words "relate to" in § 514(a) in their broad sense. To interpret § 514(a) to preempt only state laws specifically designed to affect employee benefit plans would be to ignore the remainder of § 514(a). It would have been unnecessary to exempt generally applicable state criminal statutes from pre-emption in § 514(b), for example, if § 514(a) applied only to state laws dealing specifically with ERISA plans.³⁵⁶

State-enforced professional regulation, should not be able to prevent unions and employers from maintaining the types of employee benefit programs which Congress has authorized—for example, prepaid legal services programs—whether closed or open panel—authorized by Public Law 93-95.

Id.

354. 120 CONG. REC. 15737, 15751 (statement of Sen. Javits) (emphasis added).

355. 463 U.S. 85 (1983).

356. *Id.* at 98. To the contrary, the distinction could have been simply for the purpose of emphasizing the different types of state laws that might be preempted, and to make clear that generally applicable state criminal laws escape ERISA preemption.

Contrary to the Court's interpretation, Senator Javits' statement is more susceptible to an interpretation that Congress was primarily concerned about states passing criminal laws, and other types of laws, for the direct purpose of regulating ERISA benefit plans. This is shown by a portion of Senator Javits' above-quoted statement: "In view of Federal preemption, State laws compelling disclosure from private welfare or pension plans, imposing fiduciary requirements on such plans, *imposing criminal penalties on failure to contribute to plans-unless a criminal statute of general application*-establishing State termination insurance programs, et cetera, will be superseded."³⁵⁷

The gist of Senator Javits' statement seems to express a congressional intent to preempt state statutes designed specifically to regulate employee welfare benefit plans. The portion of his statement regarding the exemption of state criminal laws of general applicability, that the Court in *Pilot Life* interpreted to mean that ERISA's preemption clause reaches general state laws that were not specifically enacted to regulate employee benefit plans, seems specifically for the purpose of showing that when states specifically pass criminal laws to regulate employee benefit plans that those laws are preempted. This is shown by Senator Javits' statement's emphasis on the preemption of state laws "*imposing criminal penalties on failure to contribute to plans-unless a criminal statute of general application*."³⁵⁸ Obviously, the congressional concern was about states that pass laws specifically to regulate ERISA plans. If that were not the case, there would have been no need for Senator Javits and Congress to make a distinction between criminal laws specifically directed towards ERISA plans and those of general applicability.³⁵⁹ Senator Javits' statement regarding generally applicable criminal laws appear to be Congress' effort to recognize states' general authority to proscribe criminal activity. One could infer that congressional respect for states' criminal law authority was so strong that, despite a congressional intent to create a uniformity of regulation for ERISA plans, Congress intended that ERISA's preemption clause not supersede state generally applicable criminal laws.

However, because neither ERISA's statutory language nor its legislative history specifically refers to non-criminal state laws of general applicability,

357. 120 CONG. REC. 15737, 15751 (statements of Sen. Javits) (emphasis added).

358. *Id.* (emphasis added).

359. ERISA's preemption clause preempted the former while the latter was not preempted. Apparently, the generally applicable criminal laws were not preempted out of a congressional concern to respect states' authority to proscribe criminal activity through generally applicable statutes. In any event, it seems a dubious proposition for the U.S. Supreme Court to base a substantial portion of its ERISA jurisprudence on a tenuous conclusion from Senator Javits' statements and from the ERISA preemption clause. The Court found that the congressional intent was that ERISA preempts all generally applicable laws simply because Senator Javits' statement and the preemption clause itself exclude generally applicable criminal laws from ERISA's preemption. 29 U.S.C. § 1144(b)(4) (1994). In light of *Travelers*, any uncertainty regarding ERISA's preemption of generally applicable state laws should be resolved against the preemption of these laws.

under either express or field preemption doctrines there is no clear and manifest expression of congressional intent regarding the preemption of generally applicable tort laws not designed to specifically regulate employee benefit plans. Therefore, the nutshell response to an allegation that ERISA's civil enforcement provisions preempt state law remedies based on independent state law obligations is that such contentions have no merit when a state law claim does not fall within the specific scope of the claims allowable under section 502(a) of the civil enforcement provisions.

Additionally, an analysis of section 301 of the LMRA shows that there are several principles that caution against a use of section 502(a) of ERISA's civil enforcement provisions to preempt independent state law obligations that are not premised on either the terms of an ERISA plan or on a violation of ERISA's substantive provisions. For example, section 301 will preempt a state law claim only if it is based directly on either rights created by a collective bargaining agreement or if it is "substantially dependent on an interpretation of a collective bargaining agreement."³⁶⁰ One court has stated:

A court's determination of whether a state law claim is preempted by § 301 "must focus . . . on whether [the state law claim] confers nonnegotiable state-law rights on employers or employees independent of any right established by contract, or, instead, whether evaluation of the [state law] claim is inextricably intertwined with consideration of the terms of the labor contract."³⁶¹

Furthermore, if the terms of a collective bargaining agreement are not in dispute, a mere examination of, or review of, the agreement is not sufficient to cause the preemption of a state law.³⁶²

The court's decision in *Roessert v. Health Net*³⁶³ is instructive. In that case, the plaintiff was a member of an ERISA employee benefit plan.³⁶⁴ The ERISA plan had a contract with an HMO that required the HMO to provide medical care to plaintiff.³⁶⁵ In turn, the HMO had a contract with several medical groups that supplied primary care physicians who treated the plaintiff.³⁶⁶ On several occasions, the plaintiff requested but did not receive sufficient medical treatment from the primary care physicians.³⁶⁷ At some point, the HMO, without plaintiff's consent, allegedly contacted one of its primary care physician groups and allegedly instructed a physician to assist the plaintiff's husband in obtaining a

360. *Aguilera v. Pierelli Armstrong Tire Corp.*, 223 F.3d 1010, 1014 (9th Cir. 2000).

361. *Firestone v. S. Cal. Gas Co.*, 219 F.3d 1063, 1065 (9th Cir. 2000).

362. *See Aguilera*, 223 F.3d at 1014; *Firestone*, 219 F.3d at 1065 ("When the meaning of particular contract terms is not disputed, the fact that a collective bargaining agreement must be consulted for information will not result in § 301 preemption.").

363. 929 F. Supp. 343 (N.D. Cal. 1996).

364. *See id.* at 346.

365. *See id.*

366. *See id.*

367. *See id.* at 346-47.

confinement of plaintiff to a psychiatric institution because of her alleged suicidal tendencies.³⁶⁸ Plaintiff brought a medical malpractice suit alleging that the HMO and the primary care physician were negligent in recommending plaintiff's confinement.³⁶⁹ Defendants removed the lawsuit to federal court, alleging that ERISA preempted plaintiff's claims because she complained of defendants' conduct during the administration of benefits under an ERISA plan.³⁷⁰

The federal district court remanded the case to state court, finding that complete preemption was not proper because plaintiff's lawsuit did not fall within the scope of section 502(a) of ERISA's civil enforcement provisions.³⁷¹ The plaintiff was not seeking denied benefits but was complaining about the quality of defendants' alleged medical decision to recommend plaintiff's confinement to a psychiatric institution.³⁷² In other words, the lawsuit challenged defendants' conduct as medical providers, not as administrators of ERISA benefits, because defendants' actions allegedly were not in response to a specific request by plaintiff for medical benefits. Rather, defendants' actions allegedly were pursuant to their own efforts to recommend a certain course of treatment for plaintiff. In regards to the connection between section 301 of the LMRA and section 502(a) of ERISA's civil enforcement provisions, the court acknowledged that the Supreme Court has used section 301 "to interpret the preemptive scope of section 502(a)" and that "the appropriate inquiry is whether the claim 'rests upon the terms of the plan' or requires construction of plan language."³⁷³ The court concluded that "the question of whether [defendant's] alleged recommendation of specific treatment for [plaintiff] was negligent can surely be decided apart from the terms of the plan."³⁷⁴ As such, section 502(a) of ERISA's civil enforcement provisions did not completely preempt plaintiff's malpractice claims.³⁷⁵ Although *Roessert* primarily involves a complete preemption issue, it supports the conclusion that, like section 301 of the LMRA, section 502(a) of ERISA's civil enforcement provisions does not preempt state lawsuits that are based upon independent state law obligations that do not allege a violation of either ERISA's statutory provision or the terms and conditions of an ERISA plan, nor seek the specific type of damages allowable under section 502(a).

368. *See id.* at 347.

369. *See id.*

370. *See id.*

371. *See id.* at 350-51.

372. *See id.*

373. *Id.* at 351.

374. *Id.*

375. The court left open the issue whether ERISA's preemption clause preempted the claim. *See id.* at 353.

CONCLUSION

The bottom line of the above-stated "equity preemption" analysis is that, generally, unless the plaintiff's state law claim falls within section 502(a) and seeks the types of remedies allowable under that section, ERISA should not preempt the claim. More specifically, ERISA's preemption clause should not preempt state law claims that seek compensatory damages based on an ERISA plan's or its affiliated managed care organization's violation of independent state law obligations. Through the use of "equity preemption" and the maxim "equity will not suffer a wrong without a remedy," federal courts should prevent the preemption of these types of claims, as more specifically discussed above. This conclusion is proper despite the federal court cases that have held that the absence of an ERISA remedy does not prevent ERISA from preempting a state law claim that "relates to" an ERISA plan.³⁷⁶ The best interpretation of these

376. See *Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1009-10 (3d Cir. 1998) (holding that the absence of an ERISA remedy did not prevent the preemption of state law claims complaining of a bad faith denial of autologous bone marrow transplant procedure (ABMT) benefits, a claim that was cognizable under ERISA's civil enforcement provision); *Cannon v. Group Health Serv. of Okla., Inc.*, 77 F.3d 1270, 1272 (10th Cir. 1996) (holding that the absence of ERISA remedy did not prevent preemption of state law claim for negligence and bad faith denial of ABMT when claim was cognizable under ERISA's civil enforcement provision); *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 943 (6th Cir. 1995) (distinguishing instant case on the grounds that the preempted state-law claims fell within the type of claim that could have been brought under ERISA's civil enforcement provision, and thereby recognizing a distinction between the non-preemption of a state law claim when it could not have been brought under ERISA's civil enforcement provision and the preemption of a state law claim that could have been brought under ERISA's civil enforcement provision); *Corcoran v. United Health Care, Inc.*, 965 F.2d 1321, 1333 (5th Cir. 1992) (holding that ERISA preempted a state wrongful death claim based on an ERISA administrator's denial of requested medical treatment despite the fact that ERISA did not provide a remedy when the preempted claim was cognizable under ERISA's civil enforcement provision, which would not have granted a compensatory damage remedy).

Dependhal v. Falstaff Brewing Corp., 653 F.2d 1208 (8th Cir. 1981), appears to be the first case where a court implied that ERISA would not preempt a state law claim when ERISA did not provide a remedy for the alleged wrongful conduct. See *id.* at 1215-16. However, the court held that preemption was appropriate because ERISA did provide a remedy. See *id.* at 1216. Subsequently, the Sixth Circuit in *Perry v. P*I*E Nationwide, Inc.*, 872 F.2d 157 (6th Cir. 1989), interpreted *Dependhal* as holding "that preemption should apply to a state law claim only if Congress has provided a remedy for the wrong or wrongs asserted." *Id.* at 162. In *Perry*, the court sustained the lower court's opinion (as to plaintiffs' fraud, misrepresentation, and promissory estoppel claims) that ERISA did not preempt plaintiffs' state law claims, which, instead of seeking denied benefits under an ERISA plan, sought a holding that plaintiffs not be considered as participants in an ERISA plan that their employer allegedly, through fraud, induced them to participate in by using misrepresentation. See *id.* The gist of the Sixth Circuit's opinion appears to be the court's acceptance of the lower court's conclusion that plaintiffs' state law claims were not cognizable under ERISA's civil enforcement provision; and therefore, ERISA should not

cases is that if plaintiff's state law claim is cognizable under section 502(a), the absence of an ERISA remedy (or a sufficient ERISA remedy) is not a bar to ERISA's preemption of the state law claim.³⁷⁷ However, if the state law claim is premised on a theory and seeks remedies that are not actionable under section 502(a), the absence of an ERISA remedy (especially a compensatory damage remedy) and cause of action should mean that ERISA does not preempt the state law claim. This conclusion is all the more appropriate when courts, even in the face of criticism against the use of equity principles to interpret statutes,³⁷⁸ consider and use "equity preemption" and the equity maxim that "equity will not suffer a wrong without a remedy."

preempt the claims because plaintiffs would not otherwise have a remedy. *See id.* Thereafter, the Sixth Circuit in *Tolton v. American Biodyne, Inc.*, 48 F.3d 937, 943 (6th Cir. 1995), a case involving an alleged denial of medical benefits during utilization review, distinguished *Perry* on the grounds that it did not hold that, in the absence of a remedy under ERISA, ERISA would not preempt a state law claim that was cognizable under ERISA's civil enforcement provision. *See id.* at 943 n.5.

From the above discussion, a logical conclusion is that if plaintiff's state law claim is not cognizable under ERISA's civil enforcement provisions, then ERISA should not preempt the claim if the plaintiff would be left without a remedy for an ERISA administrator's alleged wrongful conduct.

377. *See Tolton*, 48 F.3d at 943 n.5.

378. The general argument against the unfettered use of equitable construction, is that judges, in the guise of statutory interpretation, will engage in judicial lawmaking and therefore apply a statute in such a way as to carry out their own view of what the law should be despite the fact that Congress, if it had thought of the matter, possibly would have had a different intent regarding the statute's application. However, it seems that equitable interpretation is appropriate when a statute's language leaves a gap between its general application and its application in the particular case before the judge. *See Marcin, supra* note 30. If the answer can be obtained by looking at legislative history and other aids of statutory interpretation, then courts should rely on such aids and interpret statutes consistently with legislative or congressional intent. When the gap cannot be filled, because interpretative aids are not helpful, then courts should engage in equitable construction by using any means necessary to aid it in determining whether the particular facts of the cases fall within the scope of the statute, especially when there is legislative or other authority supporting judicial lawmaking and equitable construction. Therefore, it is important that Congress has given federal courts the authority to engage in judicial lawmaking through the creation of federal common-law causes of action to fill in the gaps that exist in ERISA's statutory scheme. *See Pittman, supra* note 22. However, in respect for federalism and the presumption against the preemption of states' historical regulation of the quality of medical care, courts should defer to state law regulation by avoiding preemption of state law claims through the use of equity preemption when there is otherwise no adequate remedy under ERISA's civil enforcement provisions.

