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Distinguishing Between Coverage and Treatment Decisions Under ERISA Health Plans: What’s Left of ERISA Preemption?

PHYLLIS C. BORZI†

INTRODUCTION

In recent years, policymakers at every level of government have grappled with the difficult question of how to assure every American access to affordable health insurance. Amid much fanfare and passion the great Congressional debate occurred in 1993-1994 concerning the Clinton Health Plan, centering on whether a national solution or something less sweeping was necessary to correct the weaknesses in our current health care delivery system.1 The inability of Congress and the Clinton

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1. The Clinton Health Plan was introduced in Congress in 1993 as the Health Security Act. H.R. 3600, 103d Cong. (1993). Under the Clinton plan, employers would be required to offer and contribute to the cost of coverage for all employees and their families, unemployed individuals would be covered through state-organized but privately run health alliances, and early retirees would be covered under the expanded Medicare program. One alternative approach was a single-payer proposal introduced by Representative James McDermott, the American Health Security Act of 1993. H.R. 1200, 103d Cong. (1993). Under H.R. 1200, all Americans would be covered under a single health plan and employer coverage would be eliminated. Another alternative was the Health Equity and Access Reform Today Act of 1993, introduced by the late Senator John Chafee. S. 1770, 103d Cong. (1993). Under S. 1770, all individuals would have to purchase insurance, and employers would have to make health
Administration to reach a consensus resulted in the collapse of this major public policy effort. When the rhetoric died down and the dust settled, the American people continued to receive their health care in ways similar to those of the past—largely through workplace-based group health plans.

One of the most potent weapons to inflame public opinion used by those who opposed the Clinton plan was the threat that it would force millions of Americans into managed care organizations (primarily health maintenance organizations or HMOs), whose reputation for ruthless bottom-line-driven decisionmaking was a cause for concern for ordinary citizens all across the country.\(^2\) Denied the flexibility to choose their health care providers and health plans,\(^3\) the argument went, individuals would be left to the mercy of a government-run bureaucracy in which health care decisions would be made by green eye-shade types or, worse yet, faceless folk manning toll-free telephone numbers thousands of miles away from where care would be delivered.\(^4\)

Ironically, despite the spectacular failure of the Clinton Health Plan, since 1994 millions of Americans have been forced into managed care organizations by dint of the marketplace itself and, in particular, the rising cost of health care for employers.\(^5\) Faced with this reality, coverage available to employees but would not be required to contribute to that coverage.


3. The percentage of workers with the unlimited right to choose their medical providers under their employer-sponsored health plans has fallen from 90% in 1988 to 21% in 2000. The Henry J. Kaiser Family Found. and Health Research & Educ. Trust, Employer Health Benefits 2000 Annual Survey 55 Ex. 5.1 (2000) [hereinafter Kaiser Survey]. The percentage of employers providing their workers with a choice of health plans varies by firm size. For instance, currently in 91% of all firms with 3-199 workers, only one health plan is offered. Id. at 56 Ex. 5.3. Only 6% of those firms offer employees the choice of two plans and only 3% a choice of three or more plans. Id. In contrast, only 16% of all firms with 5000 or more employees offer only one health plan; 17% of those firms offer two plans and 67% offer three or more plans. Id.

4. See Lawrence R. Jacobs & Robert Y. Shapiro, Politicians Don’t Pander 130, 137-38 (2000); Skocpol, supra note 2, at 137-38.

5. In 1988, 16% of all workers with health insurance were in HMOs. Kaiser Survey, supra note 3, at 67 Ex. 6.1. In 1993, that number had risen to 21%. Id. In 2000, 29% of workers are in HMOs. Id. Health care premiums increased at a rate of 12% in 1988. Id. at 15 Ex. 2.2. Interestingly, in the mid-1990s, the rate
consumers have become increasingly concerned about the way that managed care plans decide to provide or withhold care.\textsuperscript{3}

Traditionally, regulation of the business of insurance and the delivery of health care has been within the purview of the states, with the McCarran-Ferguson Act\textsuperscript{7} providing the statutory authority for states to enact strong consumer protection laws and to deploy an arsenal of weapons to enforce those laws. With the enactment of the Employee Retirement Income Security Act of 1974 (ERISA),\textsuperscript{8} however, many state consumer protections have been struck down as they apply to employer-sponsored group health plans.\textsuperscript{9} The legal basis for nullification of these protections is § 514 of ERISA. With a few narrow exceptions, § 514 preempts all state laws that "relate to" an employee benefit plan.\textsuperscript{10}

Initially courts interpreted ERISA broadly, holding most state laws preempted.\textsuperscript{11} In recent decisions, however, the Supreme Court has taken a closer look at challenged state laws and pointed the way to a more balanced evaluation of whether a state has overstepped its bounds in trying to protect consumers.\textsuperscript{12} At the same time that the courts have restricted state consumer protection activity, judicial interpretations have limited the scope of ERISA's

\begin{itemize}
\item of increase dropped, resulting in an 8.5% increase in 1993 and a mere 0.8% increase in 1996. \textit{Id.} At the time, there was speculation that this drop reflected an artificial depression of costs during the Congressional debate on health care reform in order to forestall legislation, rather than a true decrease in costs. Since 1996, costs have skyrocketed with monthly premiums in 2000 showing an 8.3% increase. \textit{Id.} at 15 Ex. 2.2. In 2000, the average monthly premium is $202 for single coverage and $529 for family coverage. \textit{Id.} at 2. The increase in premiums (8.3% between spring 1999 and summer 2000) was more than five percentage points higher than the rate of inflation. \textit{Id.}
\item 11. See generally John H. Langbein & Bruce A. Wolk, \textit{PENSION AND EMPLOYEE BENEFIT LAW} 506-10 (3d ed. 2000) (discussing Supreme Court's initial preemption jurisprudence).
\end{itemize}
In particular, the Supreme Court has narrowly construed the remedies available for injuries caused by the negligence or unreasonableness of plans in their decisions about whether a particular service or treatment is covered by the plan.\textsuperscript{14}

This article chronicles that change, and describes how the courts have sought to keep pace with developments in the health care industry in spite of the constraints of a statute written for an entirely different health care delivery system. The article also addresses the implications of recent judicial trends for participants who seek to hold ERISA-covered group health plans accountable for their decision-making activities.

I. BACKGROUND

More than 158 million individuals were covered under employer-sponsored group health plans in America in 1999.\textsuperscript{15} This represents 73.3\% of the workforce, or about two-thirds of the entire non-elderly population.\textsuperscript{16} The great majority of those workers and their families are covered under group health plans subject to ERISA.\textsuperscript{17}

ERISA covers all types of employer-sponsored employee benefit plans.\textsuperscript{18} Section 3(1) of ERISA defines these plans as “any plan, fund, or program” established or maintained by an employer, an employee organization, or both, to provide

\textsuperscript{13} See, e.g., Mertens v. Hewitt Assocs., 508 U.S. 248 (1993) (holding that only traditional equitable relief, such as injunctive remedies, disgorgement, and restitution, is available under ERISA § 502(a)(3), not money damages); Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134 (1985) (holding that extra-contractual compensatory or punitive damages are not available under ERISA § 502(a)(2)).


\textsuperscript{15} PAUL FRONSTIN, SOURCES OF HEALTH INSURANCE AND CHARACTERISTICS OF THE UNINSURED 4 tbl.1 (Employee Benefits Research Institute, Issue Brief No. 228, 2000).

\textsuperscript{16} Id. at 6 chart 4.

\textsuperscript{17} In 1999, 163.8 million individuals received coverage under private sector ERISA health plans out of a total 240.7 million Americans with health insurance. Paul Fronstin, Job-Based Health Benefits Continue to Rise While Uninsured Rate Declines, EBRI NOTES, Nov. 2000, at 4 tbl.4.

\textsuperscript{18} The “employee welfare benefit plan,” ERISA § 3(1), 29 U.S.C. § 1002(1) (1994), and the “employee pension benefit plan,” id. § 3(2), 29 U.S.C. § 1002(2), are the two main categories of employee benefit plan.
participants and beneficiaries with certain specified benefits. Employee welfare benefit plans provide:

through the purchase of insurance or otherwise, (A) 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, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

ERISA-covered health plans, which may be insured or self-insured, comprise the largest group of welfare plans. In terms of substantive requirements for group health plans, ERISA mandates certain reporting, disclosure, fiduciary, claims dispute, and health insurance continuation requirements. ERISA also limits preexisting condition exclusions and mandates certain other aspects of plan design. These rules are designed to ensure that participants in those plans are fairly treated. In addition, ERISA § 502 generally provides for civil enforcement mechanisms, including authorizing private rights of action and, under some circumstances, actions brought by the U.S. Secretary of Labor.

When Congress enacted ERISA, it intended to retain broad federal regulatory authority over all employee benefit plans covered under the Act. The sweeping language of ERISA's preemption clause reflects this intention. Section 514(a) of ERISA preempts any state law that "relates to" an employee benefit plan, unless the state law falls within the "savings" clause. State laws that escape preemption by virtue of the savings clause include state insurance,
banking, and securities laws, as well as generally applicable criminal laws. Under the so-called “deemer” clause, however, states cannot define employee benefit plans to be insurance companies in order to use the state insurance law exception to circumvent the general prohibition on state regulation of plans.

As a result, ERISA-covered employee benefit plans, whether insured or self-insured, are subject to federal regulation and are immune from direct state regulation. However, as discussed later in this article, ERISA-covered plans may be affected indirectly by state insurance regulation.

When Congress enacted ERISA in 1974, most employees were covered by fee-for-service plans. Firms generally covered their employees through insured health plans, such as the traditional Blue Cross/Blue Shield major medical and outpatient coverage. Only the largest employers self-insured health benefits. Self-insured health plans were also generally administered in-house. Some staff model HMOs existed (particularly in California where Kaiser was popular), but there was not the wide variety of managed care organizations that are available today in the marketplace.

In the 1980s, escalating costs led many employers to move away from a traditional fee-for-service or indemnity system and toward various types of managed care

29. Id., 29 U.S.C. § 1144(b)(2)(A) (“nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities”).
33. See Bogan, supra note 9, at 997-98.
34. See id. at 998-99.
35. “Self-insurance” means that the plan sponsor bears the insurance risk itself instead of transferring the risk to another entity, such as an insurer or HMO, and simply paying that entity a premium or a capitation fee for providing employee coverage. For example, if claims experience is worse than anticipated, the plan sponsor in a self-insured plan has to absorb the loss. Self-insured plans may be either “funded” (the money to pay claims is set aside in a separate trust or other arrangement) or “unfunded” (the money to pay claims comes out of the general assets of the plan sponsor).
36. See Bogan, supra note 9, at 998-99.
arrangements. Employers were attracted to managed care because it held the promise of delivering better and more comprehensive medical care in a more cost-effective manner. Although some employers have completely abandoned their former indemnity plans and moved their employees into closed panel health maintenance organizations (HMOs) or preferred provider organizations (PPOs), most moved slowly to introduce managed care features. More recently, employers have shifted away from the more tightly managed arrangements to accommodate employee complaints that a greater degree of flexibility in choosing health care providers is needed.

Managed care organizations (MCOs) operate through a series of interlocking and overlapping legal relationships—primarily those between the employer and the MCO and the MCO and its providers. These relationships are circumscribed by agreements and contracts. Although a few contract provisions may be required to comply with state law, the specific language of the contract and the respective allocation of rights and responsibilities is generally left to the parties to negotiate.

The shift from fee-for-service to managed care has given rise to new arrangements for financing and delivering health care that were not contemplated by the framers of ERISA. Although managed care organizations may not be called “insurance companies,” many do perform the same risk-bearing functions that have long characterized the business of insurance. The types of risk to be borne and

37. See id. at 998; Sara L. Broyhill, Comment, Death of a Remedy: The Supreme Court’s Ill-Fated Decision to Foreclose an Avenue of Liability Against Managed Care Organizations Under ERISA in Pegram v. Herdrich, 79 Neb. L. Rev. 762, 763-65 (2000).
39. Id. at 239-40.
40. The percentage of workers covered under point-of-service health plans (i.e., those permitting them to choose to receive treatment from non-network providers) more than doubled between 1988 and 2000 (from 21% to 44%). Kaiser Survey, supra note 3, at 55 Ex. 5.1.
42. See id.
43. The National Association of Insurance Commissioners (NAIC) issued a bulletin in 1995 on insurance licensure for risk-bearing entities, which include, for example, various forms of provider-sponsored organizations. See, e.g., NAIC
the degree to which risk is shifted under the structure of these new entities are evolving as the marketplace changes.

Yet despite this change in the health insurance marketplace and the emergence of a wide variety of risk-bearing entities that are not traditional insurance companies, ERISA’s original statutory preemption language remains largely intact. As states have sought to assert their traditional role as regulators of insurers and protectors of consumers of health insurance, ERISA preemption provided a virtually impenetrable shield for these new entities. Indeed, until 1995, judicial precedent supported the view of many ERISA experts that the reach of ERISA preemption was virtually limitless and that state statutes that even indirectly impacted ERISA plans would be invalidated.44

Since 1995, however, several important Supreme Court preemption decisions have signaled a potential change in the Court’s thinking,45 and now most legal experts have concluded that ERISA’s preemptive sweep is not as broad as they once thought, particularly when it comes to state regulation of health plans.46

II. THE SCOPE OF ERISA PREEMPTION

A. General Framework for Analysis

The starting point for analysis of whether ERISA preempts state law is, of course, the statutory language of ERISA itself. The analytic framework set forth in ERISA § 514 must be applied to the language of the state law. The lesson of the ERISA preemption cases (particularly the recent Supreme Court cases) is that the state’s choice of words is important. Both legal and factual analyses are


45. See ABA SECTION OF LABOR & EMPLOYMENT LAW, EMPLOYEE BENEFITS LAW 793-95 (2d ed. 2000) [hereinafter EMPLOYEE BENEFITS LAW].

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critical in determining whether a challenged state law will be preempted.

B. The "Relate to" Clause

Section 514(a) of ERISA provides that ERISA will "[s]upersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in [ERISA] section 4(a) [29 U.S.C. § 1003 (a)] and not exempt under [ERISA] section 4(b) [29 U.S.C. § 1003(b)]." A state includes "[a] State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter." State laws include "[a]ll laws, decisions, rules, regulations, or other State action having the effect of law, of any State."

C. The "Savings" Clause

The savings clause is an exception to the general rule preempting state laws that relate to an employee benefit plan. As noted above, the statute saves from preemption state laws that regulate insurance, banking, or securities. Insurance laws continue to be the most significant of the three, both in terms of their substantive reach and the number of ERISA preemption challenges that have been raised. As states have broadened access to health insurance for the uninsured and responded to consumer

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47. ERISA § 514(a), 29 U.S.C. § 1144(a) (1994).
48. Id. § 514(c)(2), 29 U.S.C. § 1144(c)(2).
49. Id. § 514(c)(1), 29 U.S.C. § 1144(c)(1). Additionally, ERISA § 514 provides that "[a] law of the United States, applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States." Id., 29 U.S.C. § 1144(c)(1).
50. Id. § 514 (b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) ("nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities").
51. See EMPLOYEE BENEFITS LAW, supra note 45, at 799-804.
backlash against managed care, state insurance regulation has become a lightning rod for legal challenges based on preemption.

D. The "Deemer" Clause

The deemer clause is a limitation on the savings clause. It is designed to prevent states from circumventing the general prohibition on state regulation of employee benefit plans by preventing states from regulating employee benefit plans under the guise of regulating insurance. The clause provides that:

[N]either an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust, company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

E. Conventional Preemption Principles Apply to ERISA Cases

1. Conflict Preemption. Quite apart from ERISA's own preemptive effect, ordinary preemption jurisprudence recognizes an independent basis for preemption if a state law conflicts with the federal regulatory scheme. In Boggs v. Boggs, for example, the Supreme Court found it unnecessary to determine if Louisiana community property law "related to" employee benefit plans because applying the state law would conflict with specific ERISA provisions.

Boggs involved a challenge to the right of the surviving second wife (Sandra) to a deceased participant's pension

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56. Id. at 844 ("In the face of this direct clash between state law and the provisions and objectives of ERISA, the state law cannot stand.").
benefits. The challenge was brought by the sons from the participant’s first marriage, whose deceased mother (Dorothy) had made a purported testamentary transfer of her interest in their father’s pension benefits. At issue was the validity of Louisiana’s community property law, which allowed a non-participant spouse to transfer an interest in undistributed pension benefits by testamentary instrument.

Although state law has traditionally governed the disposition of community property, the Court concluded that the clear intent of Congress in passing the Retirement Equity Act of 1984 (REA) was to preempt state laws that purported to divide a participant’s pension in a manner that conflicted with federal law. Writing for the majority, Justice Kennedy stated that Boggs was a simple case of conflict preemption. Absent a valid waiver, REA provided that the surviving spouse was entitled to the qualified joint and survivor annuity (QJSA). Because no one, not even the participant spouse during his lifetime, could deprive Sandra of her right to the QJSA without her consent, Dorothy had no interest in the undistributed pension benefits to pass on to her sons. Louisiana’s community property law was, therefore, preempted by ERISA.

As the Court explained, there was no need to apply the “relates to” language in § 514:

In the face of this direct clash between state law and the provisions and objectives of ERISA, the state law cannot stand. Conventional conflict preemption principles require preemption “where compliance with both federal and state regulations is a physical impossibility, . . . or where state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.” In part, it would undermine the purpose of ERISA’s mandated survivor’s annuity to allow Dorothy, the predeceasing spouse, by her testamentary transfer to defeat Sandra’s entitlement to the annuity § 1055 guarantees her as the surviving spouse. This cannot be. States are not free to change ERISA’s structure and balance.

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58. See 520 U.S. at 843.
59. Id. at 843.
60. Id. at 841.
61. Id. at 844 (quoting Gade v. Nat’l Solid Wastes Mgmt. Ass’n, 505 U.S. 88, 98 (1992)).
It is more problematic to apply conflict preemption principles when state law is specifically saved from ERISA preemption. The savings clause, by its terms, applies to all of Title I of ERISA, not just to the express preemption provision in § 514. Nonetheless, when the requirements of ERISA specifically conflict with state insurance law, federal rules prevail. For example, in *John Hancock Mutual Life v. Harris Trust*, the Supreme Court held that ERISA's fiduciary provisions superseded state regulation of an insurance company's general account, where the general account was comprised, in part, of employee benefit plan assets.

We are satisfied that Congress did not order the unqualified deferral to state law that Hancock advocates and attributes to the federal lawmakers. Instead, we hold, ERISA leaves room for complementary or dual federal and state regulation, and calls for federal supremacy when the two regimes cannot be harmonized or accommodated.

The most controversial use of conflict preemption to supersede state insurance law is the Supreme Court's decision in *Pilot Life Insurance Co. v. Dedeaux*. In *Pilot Life*, the Court preempted a common law cause of action for the bad faith processing of an insurance claim. The Court performed a conventional savings clause analysis to conclude that the state law before it was not a "law regulating insurance" within the meaning of the savings clause. The Court then bolstered its holding by stating in *dicta* that Congress clearly intended to make exclusive ERISA's civil enforcement scheme. That intent, the Court believed, was inconsistent with any state law granting participants and beneficiaries additional remedies, even laws used to enforce insurance contract terms that could be applied indirectly to ERISA-covered employee benefit plans under ERISA § 514(b)(2)(A) (the savings clause):

The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in

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62. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (1994) ("[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.").
64. *Id.* at 98.
its choice of remedies argue strongly for the conclusion that
ERISA's civil enforcement remedies were intended to be exclusive.
This conclusion is fully confirmed by the legislative history of the
civil enforcement provision. The legislative history demonstrates
that the pre-emptive force of § 502(a) was modeled after § 301 of
the [Labor-Management Relations Act of 1947].

The reasoning reflected in the dicta of Pilot Life has
been used to invalidate bad faith claims that were clearly
based on state insurance law. More recently, Pilot Life was
relied on in Corporate Health Insurance, Inc. v. Texas
Department of Insurance to invalidate a state mandated
administrative system of external review of health claims
denials by health insurers covering ERISA plan
participants and beneficiaries.

Although conflict preemption seems safely ensconced in
ERISA jurisprudence, the express savings clause in §
514(b)(2)(A) provides a means for attacking the validity and
scope of Pilot Life's sweeping conclusions about the
exclusive nature of ERISA's remedies. In UNUM Life
Insurance Co. of America v. Ward, the Supreme Court
noted, but did not reach, the Solicitor General's suggestion
that this aspect of Pilot Life should be revisited. Several
federal appellate courts, however, have addressed the issue.
The Second Circuit has flatly stated that "it would be
quixotic to rule that a claim under a state statute that is
saved from ERISA preemption, with the result that the
claim may not be removed to federal court, may nonetheless
be enforced only via ERISA provisions and remedies." Furthermore, the Fifth Circuit panel that denied rehearing
in the Corporate Health case suggested that a state
substantive right to coverage of "medically necessary"
conditions as defined by state insurance law rather than
contract might be enforced through a state procedure

66. Id. at 54.
Cir. 1989).
68. 215 F.3d 526, 538-39, reh'g and reh'g en banc denied, 220 F.3d 641 (5th
Cir. 2000).
69. But see Moran v. Rush Prudential, 230 F.3d 959 (7th Cir. 2000)
(upholding a state's external review procedure).
71. Id. at 376 n.7.
72. Franklin H. Williams Ins. Trust v. Travelers Ins. Co., 50 F.3d 144, 151
(2d Cir. 1995).
(implicitly offering state remedies) without running afoul of ERISA preemption. 73 No area of ERISA preemption doctrine bears closer watching than this one.

2. Complete Preemption. During the same term as Pilot Life, the Supreme Court decided Metropolitan Life Insurance Co. v. Taylor. 74 In Taylor, the Court relied on the reasoning of Pilot Life and upheld removal jurisdiction of a suit challenging the denial of disability benefits by an insurer—including damages and remedies unavailable under ERISA—based on Congress's clearly expressed intent that benefits claims under ERISA be found to arise under federal law in the same manner as contract claims under § 301 of the Labor Management Relations Act (LMRA). 76 As in Pilot Life, the Court found the state law in question to be outside the scope of ERISA's savings clause. The Court seemed to suggest that this conclusion was not as critical to its holding as the intent of Congress that ERISA § 502(a)(1)(B) should be the exclusive means for challenging a benefit decision. 78 If the Court were, in effect, to overrule the position it expressed in dicta in Pilot Life—that ERISA's remedial provisions were exclusive—and conclude that enforcement mechanisms associated with a saved state law are not preempted by ERISA, this would require a reevaluation as well of the the scope of ERISA's removal jurisdiction, because the state laws containing those enforcement tools would no longer be completely preempted and claims under those laws removable to federal court.

Federal courts commonly face ERISA preemption questions as questions of removal jurisdiction. While there is some confusion among the lower courts, the question whether a participant's claim is completely preempted is analytically distinct from the question of whether a claim is preempted by ERISA § 514, or even whether a claim conflicts with ERISA, as in Boggs. 77 Only claims that Congress clearly intends to fall exclusively within ERISA's remedial provisions will be found to be completely preempted. Accordingly, a court should make a

73. Corporate Health Ins., Inc. v. Tex. Dep't of Ins., 220 F.3d 641, 644-45 (5th Cir. 2000).
75. Id. at 65.
76. Id. at 64-66.
77. See infra text accompanying notes 55-61 (discussing Boggs).
III. THE SUPREME COURT'S VIEW OF WHEN STATE LAWS "RELATE TO" EMPLOYEE BENEFIT PLANS

A. State Laws Having a "Connection with or Reference to" an ERISA Plan "Relate to" a Plan

In *Shaw v. Delta Airlines, Inc.*, the Supreme Court held that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, *if it has a connection with or reference to such a plan.*" *Shaw* involved a challenge to a section of the New York Human Rights Law that prohibited discrimination in employee benefit plans on the basis of pregnancy. Before Congress passed the Pregnancy Discrimination Act of 1978 (PDA), Delta had maintained a welfare benefit plan that did not provide benefits to employees disabled by pregnancy, although it did cover other types of disabilities. The New York law made it unlawful for an employer to "discriminate against [an]
individual in compensation or in terms, conditions or privileges of employment" on the basis of sex. Federal law defined sex-based discrimination to include discrimination "[b]ecause of or on the basis of pregnancy, childbirth or related medical conditions" and required that women affected by these conditions "be treated the same for all employment-related purposes, including receipt of benefits under fringe benefit programs, as other persons not so affected but similar in their ability or inability to work."

Because the New York law directly referred to and implicated benefit plans (including ERISA-covered plans), the Court held that the state law "related to" an employee benefit plan. Although the state argued that its law was saved from preemption because ERISA does not preempt other federal laws (the PDA had subsequently been enacted by Congress and it explicitly preserved certain state laws), the Court held that to the extent that the New York law went further than the federal PDA, it was preempted.

The Supreme Court reached a similar conclusion in *FMC Corp. v. Holliday.* There, FMC challenged provisions of the Pennsylvania Motor Vehicle Financial Responsibility Law that precluded reimbursement from a claimant's tort recovery for benefit payments by "'[a]ny program, group contract or other arrangement for payment of benefits.'" FMC's self-insured medical plan had a subrogation clause that required participants to reimburse the plan for benefits if they recovered on a liability claim against a third party. Mr. Holliday brought a successful negligence action against another driver for injuries suffered by his daughter. FMC notified Mr. Holliday that the plan must be reimbursed. The Hollidays refused, citing the Pennsylvania law.

The Court held that the state law "related to" ERISA plans because it had both a "reference to" benefit plans governed by ERISA and a "connection with" these plans:

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85. N.Y. Exec. Law § 296.1(a).
86. 42 U.S.C. § 2000e(k) (1994) (§ 701 of the Civil Rights Act of 1964, added by § 1 of the PDA)).
87. *Id.*
88. 463 U.S. at 96-100.
89. *Id.* at 100-06.
91. *Id.* at 59 (quoting 75 PA. CONS. STAT. § 1719 (1987)).
92. *Id.* at 54.
93. *Id.* at 59. ("The statute states that '[i]n actions arising out of the
Pennsylvania's antisubrogation law prohibits plans from being structured in a manner requiring reimbursement in the event of recovery from a third party. It requires plan providers to calculate benefit levels in Pennsylvania based on expected liability conditions that differ from those in States that have not enacted similar antisubrogation legislation. Application of differing state subrogation laws to plans would therefore frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide.  

Although the Court also found that the Pennsylvania law fell within the scope of ERISA's insurance savings clause, the deemer clause prevented the savings clause from being applied to FMC's self-insured plan.

B. State Laws Premised on the Existence of a Plan “Relate to” a Plan

The Supreme Court has held that even state laws which indirectly affect employee plans may be preempted. In Alessi v. Raybestos-Manhattan, Inc.,97 the Court found that the New Jersey Workers' Compensation Act, which expressly prohibited the offset of workers' compensation benefits by pension benefits, was preempted.98 The New Jersey law stated that "'[t]he right of compensation granted by this chapter may be set off against disability pension benefits or payments, but shall not be set off against employees' retirement pension benefits or payments."99 The Raybestos-Manhattan plan offset an employee's retirement benefits by the amount of workers' compensation benefits received. Two former employees sued in state court to prohibit this reduction in benefits.

Overturning the district court's determination that the offset caused a forfeiture of pension benefits forbidden by

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94. Id.
95. Id. at 60.
96. Id. at 60-61.
98. Id. at 524-25.
ERISA, the Third Circuit held the state law to be preempted.\textsuperscript{100} The Supreme Court affirmed the Third Circuit's decision, even though the state argued that it was only trying to protect workers' compensation benefits, not regulate plans.\textsuperscript{101} The New Jersey law "related to" ERISA-covered plans, the Supreme Court held, because it eliminated a method of calculating pension benefits that was permitted by federal law.\textsuperscript{102} Despite its intentions, then, New Jersey was "intrud[ing] indirectly, through a workers' compensation law, rather than directly, through a statute called 'pension regulation.'\textsuperscript{103}

C. State Laws Specifically Exempting ERISA Plans "Relate to" a Plan

State laws may "relate to" an employee benefit plan even when they exempt such a plan from otherwise applicable rules. In \textit{Mackey v. Lanier Collection Agency & Service, Inc.,}\textsuperscript{104} a Georgia garnishment statute singled out ERISA-covered welfare plans for special treatment not accorded to non-ERISA plans.\textsuperscript{105} The Georgia law prevented creditors, such as Lanier Collection Agency, from enforcing a money judgment by garnishing a debtor's benefits under an ERISA-covered plan. The Georgia law provided that "'[f]unds or benefits of a pension, retirement, or employee benefit plan or program subject to the provisions of the federal Employee Retirement Income Security Act of 1974, as amended, shall not be subject to the process of garnishment, unless . . . such garnishment is based upon a judgment for alimony or child support.'\textsuperscript{106} The Supreme

\textsuperscript{101} See Alessi, 451 U.S. at 523-24.
\textsuperscript{102} Id. at 505.
\textsuperscript{103} Id.; see also Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 139-40 (1990) (holding that Texas wrongful discharge law may be preempted, even though it is not specifically designed to affect such plans or the effect is indirect, because the cause of action is premised on the existence of a plan); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) (holding that, although Mississippi common-law breach of contract and tort claims action for bad faith processing of claims was not directed at employee benefit plans, it was nevertheless preempted because it purported to expand ERISA's exclusive remedies).
\textsuperscript{104} 486 U.S. 825 (1988).
\textsuperscript{105} Id. at 829.
\textsuperscript{106} Id. at 828 n.2 (quoting GA. CODE ANN. § 18-4-22.1 (1982)).
Court held that, although the Georgia law was designed to shield ERISA-covered plans from otherwise applicable state law, the express reference to ERISA plans caused the law to be preempted because it "related to" plans. As the Court noted, "legislative 'good intentions' do not save a state law within the broad pre-emptive scope of § 514(a)."

D. Limits on the Reach of the "Relates to" Clause

Notwithstanding the breadth of ERISA's preemption clause, the Supreme Court has set some limits on it. In Shaw v. Delta Airlines, Inc., the Court stated that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." Since Shaw, the courts have struggled to determine when a state action is too remote or too tenuous to "relate to" an ERISA plan.

Although the Court struck down the provision of the Georgia garnishment statute that singled out ERISA-covered pension plans for protection in Mackey, it held that the general garnishment provisions were not preempted as they applied to employee welfare benefit plans. More recently, in New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., the Court held that a New York statute that imposed hospital surcharges on commercial insurers and HMOs, but not on Blue Cross/Blue Shield, did not "relate to" ERISA-covered employee benefit plans and was not preempted. The Court found that the state statute involved an area of traditional state regulation and had only an indirect economic effect on choices made by plans. Additionally, the state law did not bind plan administrators to any particular choice or preclude uniform administrative practices.

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107. Id. at 829-30.
108. Id. at 830.
110. 486 U.S. at 831-32.
112. N.Y. PUB. HEALTH LAW § 2807-c (McKinney 1993).
113. Travelers, 514 U.S. at 668.
114. Id. at 660-62.
115. Id. at 659-62.
IV. Travelers: A New Direction for the Supreme Court?

Despite the sweeping language of ERISA § 514 and the Supreme Court’s own decisions involving the reach of the “relates to” clause, the Court has recognized some limits on federal preemption as an outgrowth of Shaw’s admonition that if a state law’s impact on ERISA plans is “too tenuous, remote, or peripheral” the state law could survive a preemption challenge.

In Travelers, the Court reconsidered the issue of limits on ERISA preemption. Travelers involved several challenges to a New York statute that imposed hospital surcharges on hospital bills paid by third-party payers (including commercial insurers and HMOs) but not on bills paid by Blue Cross/Blue Shield (“the Blues”). The surcharges were primarily used to compensate hospitals for uncompensated care expenses. One surcharge of 13% was imposed on hospital patients covered by any form of health insurance other than the Blues, a health maintenance organization, or a government plan (such as Medicare). Another 11% surcharge applied to payments made by commercial insurers. A third surcharge only applied to HMOs. It varied based on the number of Medicaid enrollees in an HMO and could be as high as 9% of the HMO’s aggregate payments for in-patient monthly hospital charges.

The plaintiffs (which included commercial insurers, HMOs, and trade associations representing these groups) argued that to the extent that the New York hospital surcharges were paid in connection with ERISA-covered plans, they “related to” employee benefit plans and thus were preempted by ERISA. After consolidating the various actions that had been filed, the district court found that the surcharges were preempted by ERISA because of their indirect effect on ERISA-covered plans (i.e., increasing the costs of health insurance provided by issuers other than the

118. See id. at 649 (citing N.Y. PUB. HEALTH LAW § 2807-c (McKinney 1993)).
119. See id., 514 U.S. at 650.
120. See id.
ERISA PREEMPTION

In addition, the district court found that the surcharges were not saved from preemption under ERISA § 514(b) as laws regulating insurance. Therefore, the district court enjoined the state from enforcing the surcharges against commercial insurers or HMOs in connection with their coverage of patients in ERISA plans.

On appeal, the Second Circuit rejected the defendants’ arguments that the surcharges were laws of general application and that their indirect economic effect was not substantial enough to affect the structure or administration of the plans. Relying on the Supreme Court’s recent decision in District of Columbia v. Greater Washington Board of Trade, the appellate court affirmed the district court’s decision. In doing so, the Second Circuit expressly rejected its holding in Rebaldo v. Cuomo. The circuit court found that Rebaldo, which held that ERISA does not preempt New York hospital rate-setting regulations governing the right of self-insured ERISA plans to negotiate discounts with hospitals, was superseded by the Supreme Court’s holding in Ingersoll-Rand Co. v. McClendon that a state law may “relate to” an employee benefit plan, even if the law “is not specifically designed to affect such plans or the effect is only indirect.” Finally, the circuit court agreed with the district court that the surcharges were not saved from preemption by the exception for state insurance law, holding that the surcharges did not regulate any aspect of the insurer-insured relationship, but rather were designed to encourage plans to purchase coverage through the Blues.

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122. Id. at 1007.
123. Id. at 1013-14.
125. 506 U.S. 125, 129-30 (1992) (“Under § 514(a), ERISA pre-empts any state law that refers to or has a connection with covered benefit plans (and that does not fall within a § 514(b) exception) even if the law is not specifically designed to affect such plans, or the effect is only indirect . . . .”) (citation and internal quotation omitted).
127. Id. at 719; Rebaldo v. Cuomo, 749 F.2d 113 (2d Cir. 1984), cert. denied, 471 U.S. 1008 (1985).
129. Travelers Ins. Co. v. Cuomo, 14 F.3d at 718 (quoting Ingersoll-Rand, 498 U.S. at 139).
130. Id. at 721-23.
Several months earlier, the Third Circuit had reached the opposite result in *United Wire v. Morristown Memorial Hospital*. In *United Wire*, the Third Circuit held that a New Jersey law that allowed hospitals to impose a surcharge on hospital bills to cover uncompensated care losses was not preempted, even though the law imposed an economic burden on ERISA plans. In upholding the state law, the Third Circuit noted that it was a law of general application and did not "relate to" an employee benefit plan.132

The Supreme Court granted review of the Second Circuit's decision in *Travelers* to resolve this dispute between the circuits. The Court's unanimous decision, delivered by Justice Souter, reversed and remanded the Second Circuit's decision, finding that the surcharges were not preempted because they did not "relate to" employee benefit plans.133

After first restating the Court's presumption under the Supremacy Clause that Congress generally does not intend to supplant state law, Justice Souter reviewed the Court's previous interpretations of the phrase "relates to." Finding the "connection with or reference to" language from *Shaw* no more helpful than ERISA's original text in defining the reach of preemption,134 Justice Souter focused on the objective of Congress in enacting ERISA § 514: to eliminate the threat of conflicting and inconsistent state regulation in order to permit nationally uniform plan administration.135

In that context, the Court examined the surcharges. The surcharges applied to all hospital bills, regardless of whether paid by commercial insurers, employers, individuals, other non-ERISA groups, such as churches or HMOs. ERISA plans were not singled out or expressly referred to.136

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132. Id. at 1191-95.
133. Travelers, 514 U.S. at 662.
134. Id. at 654-55.
135. Id. at 656.
136. Id. at 656-57.
137. Id. at 656.
Unquestionably, one purpose of the surcharges was to make coverage by the Blues more economically attractive. But Justice Souter reasoned that the effect of the New York law was distinguishable from the effect of the state laws in the Court's previous decisions finding preemption, because the indirect economic effect of imposing additional costs on payers was different from state laws that mandated benefits, affected the administration or operation of plans or provided alternative remedies. The Court noted:

An indirect economic influence ... does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself; commercial insurers and HMO's may still offer more attractive packages than the Blues. Nor does the indirect influence of the surcharges preclude uniform administrative practice or the provision of a uniform interstate benefit package if a plan wishes to provide one. It simply bears on the costs of benefits and the relative costs of competing insurance to provide them. 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.

In addition, the Court noted that state laws have long affected hospital charges and costs, in part, through state regulation of employment conditions and quality standards which affect the cost and price of services. Finally, Justice Souter observed that Congress could not have intended ERISA to preempt state laws that affect hospital costs, because shortly after it passed ERISA it enacted other laws designed to encourage states to adopt laws that provided for differences in rates to various classes of purchasers of health care.

In Travelers, the Court was careful to note that by holding that the New York law did not "relate to" an employee benefit plan because it imposed only indirect economic costs, the Court did not mean that only direct

138. Id. at 659.
139. Id. at 657-658.
140. Id. at 659-60.
141. Id. at 660.
regulation of ERISA plans was preempted. Instead, the Court held open the possibility that:

[A] state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and that such a state law might indeed be preempted under § 514.¹⁴³

In addition, the Court limited its holding to the application of the surcharges to commercial insurers and HMOs, noting that because the issue of whether the surcharges were valid as applied to self-insured ERISA plans had not been addressed by the courts below, the factual record was insufficient to decide that preemption issue.¹⁴⁴

The Court's more recent decision in California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.¹⁴⁵ reinforces several key aspects of the analysis in Travelers. Dillingham involved a challenge to California's prevailing wage law. The California law permitted employers to pay a lower wage on public works projects to apprentices who participated in a state-approved apprenticeship program, but required employers to pay prevailing wages to apprentices who were not participating in such a program.¹⁴⁶ While Dillingham Construction was the general contractor of a public works project, one of its subcontractors paid a lower wage to apprentices who were not participating in an approved program at the time the work was performed. Although the program was later approved, the approval was not retroactive.¹⁴⁷

Although the facts of the case were complicated, the Court drew several analogies between Travelers and Dillingham. Like the New York statute in Travelers, the apprenticeship portion of the California prevailing wage law in Dillingham did not bind ERISA plans to anything.¹⁴⁸

¹⁴³. Travelers, 514 U.S. at 668.
¹⁴⁴. Id. at 652 n.4. In the remand proceeding subsequent to the Supreme Court's decision in Travelers, the Second Circuit, in a per curiam opinion, held that ERISA does not preempt the New York hospital surcharge statute with respect to self-insured plans. Travelers Ins. Co. v. Pataki, 63 F.3d 89 (2d Cir. 1995).
¹⁴⁶. Id. at 319-20.
¹⁴⁷. Id. at 321-22.
¹⁴⁸. Id. at 332.
Apprenticeship programs were not required to be state-approved. Public works contractors were not required to hire apprentices. Even if these contractors did hire apprentices, the apprentices were not required to be part of an approved program. However, to take advantage of the exemption from payment of the prevailing wage (i.e., to pay apprentices a lower wage), the California law required contractors to use apprentices from state-approved programs. Thus, like the New York surcharges at issue in Travelers, the California law "alter[ed] the incentives, but did not dictate the choices, facing ERISA plans."

Both Travelers and Dillingham were unanimous decisions. Clearly, those who hoped that Travelers' more limited view of ERISA preemption was an aberration, rather than a sign of shifting views on the high court, could take little comfort in the Dillingham decision. And, in fact, the Court reinforced the Travelers' principles in another case decided in 1997, DeBuono v. NYSA-ILA Medical and Clinical Services Fund. This case involved a challenge to a New York gross receipts tax, the Health Facility Assessment (HFA). The state legislature adopted the tax in 1990 to raise funds necessary to avoid a shortfall in the state medicaid program. The assessment was general in application, falling on all hospitals operating in the state. The HFA defined the term "hospital" broadly and included facilities that provided health care services under the supervision of a physician or dentist. The law also applied to diagnostic and treatment centers.

The NYSA-ILA Medical and Clinical Services Fund (the "Fund") was a self-insured, jointly-trusteed multiemployer health and welfare fund established by the New York Shipping Association and the International Longshoremen's Association. The Fund provided medical, dental and other health services on an outpatient basis through three medical centers that it owned and operated. Two of them were in New York and were licensed as diagnostic and

149. Id.
150. Id. at 320.
151. Id. at 334.
152. 520 U.S. 806 (1997).
154. See DeBuono, 520 U.S. at 815-16.
155. Id. at 809-810.
156. Id. at 810.
treatment centers. These centers principally treated ILA workers, retirees, and their families covered by the Fund. 157

Initially, the centers complied with the New York law by paying the applicable 0.6% surcharge and filing the required reports. After about a year, however, the centers discontinued payments and ceased filing reports. The Fund brought an action to obtain a refund of its HFA tax paid in 1991, and to enjoin the state from future assessments on the grounds that HFA was preempted by ERISA. 158 However, the district court held that because the HFA was a law of general application, not directed at ERISA plans but applicable to all health facilities, and had an insubstantial financial impact on plans, it was not preempted. 159 The Second Circuit reversed and held the HFA preempted. 160 The Supreme Court granted New York’s petition for certiorari, vacated the judgment of the Second Circuit, and remanded the case for further proceedings consistent with the Travelers decision. 161 The Second Circuit reaffirmed its prior decision on remand, 162 and New York again successfully sought review from the Supreme Court. The Court reversed the Second Circuit. Applying the Travelers principles, the Court held that the New York law did not “relate to” ERISA plans. 163

The Supreme Court’s final preemption case of 1997 was Boggs v. Boggs. 164 Although state domestic relations law was ultimately preempted in Boggs, the Court’s analysis is entirely consistent with the rationale used in Travelers, Dillingham, and DeBuono to uphold state laws. 165 The inescapable conclusion in the aftermath of Travelers and the cases decided in 1997 is that the Court has abandoned its pattern of broadly construing ERISA’s “relates to” test so

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157. Id.
159. Id. at *4.
165. See infra text accompanying notes 55-61 for discussion of Boggs.
as to invalidate nearly all state laws that were presented to it.

Travelers changed the inquiry courts undertake when they address preemption questions under ERISA. Before Travelers, courts seldom focused on the impact of the challenged state law on ERISA plans themselves because the threshold for finding that a state law "relates to" an ERISA plan was relatively low. In fact, taken together, the pre-Travelers precedents might easily lead one to conclude that when courts approached preemption cases, they generally began with a presumption of preemption that the state (or the plaintiff seeking to enforce state law) had to overcome by proving that the challenged state law was not preempted. Clearly, Travelers and later cases have changed that paradigm. Except in cases raising a clear conflict with ERISA, state laws addressing areas of traditional state regulation that do not single out ERISA plans are likely presumed to be valid. Moreover, the Supreme Court has sent strong signals that in evaluating questions of preemption, the necessary analysis involves not only legal principles but factual determinations.

166. Of course, even if a court were to find that the challenged state law "related to" an ERISA plan, that would not necessarily be dispositive. The court would then determine whether the law was "saved" and if so, whether the "deemer" clause would apply. This article does not discuss these cases in detail. However, the most important savings clause cases decided by the Supreme Court are Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985) (holding that a state law that mandated mental health benefits in insurance contracts sold in-state was not preempted because the state law met the McCarran-Ferguson Act's requirements for regulating "the business of insurance"), Pilot Life v. Dedeaux, 481 U.S. 41 (1987) (holding that Mississippi's law of bad faith was not a law directed at the insurance industry exclusively and therefore could not be considered to regulate it), and UNUM Life Ins. Co. of America v. Ward, 526 U.S. 358 (1999) (holding that a state law can be saved as a law that regulates insurance even if all three McCarran-Ferguson criteria are not met). The leading "deemer" clause case is FMC Corp. v. Holliday, 498 U.S. 52 (1990) (holding that a state anti-subrogation law was clearly a law regulating insurance, but by precluding subrogation under any ERISA-covered plan, the law was deeming the plan to be the insurer and thus was preempted).

167. See, e.g., Hewlett-Packard Co. v. Diringer, 42 F. Supp. 2d 1038 (D. Co. 1999) (holding that ERISA does not preempt the Colorado Workers' Compensation Act requiring employers to include the value of benefits provided through an ERISA plan in calculating employee's average weekly wage because the Act only has indirect economic impact on plans and thus does not "relate to" ERISA plans).
V. After Travelers: Defining New Limits of State Action

A. The Promise of Travelers

For many years courts construed plaintiffs' allegations of medical malpractice and negligence against MCOs as benefit claims cases so as to find these state law claims completely preempted. Recently, however, some courts have instead looked more closely at the nature of the allegations, not simply assuming that claims involving allegations of malpractice are benefit claims in disguise. These courts have distinguished between allegations of negligence involving improper coverage decisions and allegations that the care provided was substandard (i.e., traditional malpractice allegations). In simple terms, courts have distinguished between cases involving denial of care and cases challenging quality of care. In general, courts agree that a claim that relates to the processing or administration of a claim for reimbursement (or a pre-certification of treatment or reimbursement) is completely preempted by ERISA. In a growing number of jurisdictions, however, courts have held that claims against an MCO relating to the delivery of medical services are neither completely preempted as in Metropolitan Life v. Taylor nor preempted under the express preemption provision in ERISA § 514(a).

168. See, e.g., Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992), cert. denied, 506 U.S. 1033 (1992). In Corcoran, the plaintiff's obstetrician sought pre-certification for a hospital stay during plaintiff's high-risk pregnancy. Id. at 1324. Under the employer's previous insured health plan, she had been hospitalized in an earlier pregnancy for similar problems. Id. at 1323 n.1. In performing utilization review for the employer's self-funded medical plan, the defendant determined that hospitalization was not necessary and instead, authorized ten hours per day of home nursing care. Id. at 1324. During a period when no nurse was on duty, the fetus went into distress and died. Id. The Fifth Circuit affirmed the district court's decision that ERISA preempted the plaintiff's state law tort claim for wrongful death (allegedly resulting from defendant's erroneous medical decision). Although the defendant made medical decisions and gave medical advice, the court determined that it did so in the context of determining the availability of benefits under an ERISA plan and therefore, its decision to deny hospitalization was a benefit decision. Id. at 1331. Accordingly, the court held that plaintiff's malpractice claims related to the plan and were completely preempted by ERISA. Id.

169. 481 U.S. 58 (1987); see supra Part II.E.2. for discussion of Taylor.

There is an apparent split of authority in the courts about whether traditional medical malpractice claims may be filed against an MCO. The cases involve a variety of agency theories, although the most successful theory involves claims that an MCO is vicariously liable for the actions of its providers. Only a handful of circuit courts have addressed this issue, but the majority have permitted state malpractice actions to go forward. In 1995, three circuit courts (the Third, Seventh, and Tenth) addressed the issue of whether ERISA preempts claims against MCOs that are based on allegations that the MCO is vicariously liable for negligently provided medical services, holding that state causes of action for negligent delivery of care are not completely preempted by ERISA because challenging the quality of care received is not the same as challenging a benefit denial. In 1999, the Eighth Circuit rejected the vicarious liability theory, holding that determining a course of treatment for a plan participant is simply an aspect of determining benefit coverage. These decisions are described below.

The seminal vicarious liability case is Dukes v. U.S. Healthcare, Inc.\(^{170}\) The case is significant not only for the standards the court sets out, but also because it marked the first time that the Department of Labor, as amicus curie, weighed in to support the argument that state law medical malpractice claims were not preempted.\(^{171}\) This case was actually a consolidation of two cases filed in state courts, alleging medical malpractice against U.S. Healthcare. The first involves care provided to Darryl Dukes; the second involves care provided to Linda Visconti while she was pregnant with Serena Visconti.

Mr. Dukes had been suffering from a variety of medical problems. After he had surgery for an ear ailment, his treating physician ordered some additional blood tests. For unexplained reasons, the hospital laboratory refused to perform the tests.\(^{172}\) The next day, Mr. Dukes sought

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172. Dukes, 57 F.3d at 352.
treatment for another ailment at a different facility; this treating physician ordered blood tests that were performed. However, Mr. Dukes's condition continued to deteriorate and he died shortly thereafter. All of the treatment Mr. Dukes sought was from U.S. Healthcare's HMOs, network facilities, and their providers.

After his death, Mr. Dukes's wife brought suit in state court against U.S. Healthcare and a number of entities in the network (including the hospital, the second facility, and the two doctors), seeking damages under various state law theories for injuries arising from the medical malpractice of the HMOs' hospitals and medical providers. The HMO removed the case to federal court, arguing that removal was proper because treatment had been provided as a benefit under an ERISA plan. Plaintiff's claims, the HMO argued, were completely preempted under Taylor and expressly preempted by § 514(a). The district court agreed and dismissed the claims.

The Viscontis made similar allegations of malpractice. During the third trimester of her pregnancy, Linda Visconti developed symptoms typical of preeclampsia. The condition was not diagnosed or treated and, as a result, Serena Visconti was stillborn. Mrs. Visconti was treated by a network obstetrician at an HMO owned by U.S. Healthcare. The Viscontis sued both U.S. Healthcare and Linda Visconti's obstetrician under state law, alleging that the provider's negligence caused Serena's death. They also claimed that U.S. Healthcare was vicariously liable for the doctor's malpractice under various ostensible and actual agency theories. They also sued under a direct negligence theory, alleging that U.S. Healthcare was negligent both in selecting the doctor for the network and in overseeing the performance of its doctors.

The HMO removed the case to federal court, arguing that the Viscontis' claims were completely preempted by ERISA. The district court agreed, dismissing the Viscontis' appeal of the removal and granting the HMO's motion to

173. Id.
174. See id.
175. See id. at 352-53.
177. See Dukes, 57 F.3d at 353.
178. Id.
The Dukes and Visconti cases were consolidated on appeal. The Third Circuit first considered the procedural question of whether it was proper to remove the cases to federal court. To resolve this question, the court had to decide whether the case was one that arose under federal law. If it did, the case was removable. If it did not, the case could only be heard in state court because federal courts only have the jurisdiction to hear cases “arising under” federal law. The determination of whether a case arises under federal law is made by carefully examining the plaintiff's complaint. The Third Circuit described the procedure as follows:

Under the well-pleaded complaint rule, a cause of action “arises under” federal law, and removal is proper, only if a federal question is presented on the face of the plaintiff's properly pleaded complaint. ... A federal defense [such as preemption] to a plaintiff's state law cause of action ordinarily does not appear on the face of the well-pleaded complaint, and, therefore, usually is insufficient to warrant removal to Federal court. ...

The Supreme Court has recognized an exception to the well-pleaded complaint rule—the “complete pre-emption” exception—under which “Congress may so completely preempt a particular area that any civil complaint raising this select group of claims is necessarily federal in character.” ...

The Supreme Court has determined that Congress intended the complete-preemption doctrine to apply to state law causes of action which fit within the scope of ERISA's civil-enforcement provisions.

To determine whether the plaintiffs' claims fell within ERISA's enforcement structure and were therefore completely preempted, the Third Circuit examined the nature of the allegations. Finding that the plaintiffs' claims involved the quality of care they received, rather than claims to recover benefits due under the plan, the court

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180. Dukes, 57 F.3d at 353.
181. Id. at 353-54 (citations omitted) (quoting Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 63-64 (1987)).
concluded that removal was improper because the cause of action was not completely preempted by ERISA. The Third Circuit then remanded the cases to district court with instructions to send them back to state court for trial on the issue of vicarious liability of the MCO for the actions of its providers. Interestingly, in sending the cases back to state court, the Third Circuit assumed for the sake of its procedural instruction to the district court that the HMO was a plan and ignored the threshold question integral to an ERISA § 514 preemption analysis: whether the HMO itself was an ERISA plan entitled to claim preemption (if not, the state law malpractice claims would not be preempted because they did not relate to an ERISA plan).

In 1999, the Third Circuit revisited and expanded upon the principles it articulated in Dukes when it decided In re U.S. Healthcare, Inc. In this case, the plaintiffs (the Baumans) sued in New Jersey state court for damages arising from the death of their newborn daughter. Mrs. Bauman gave birth to her daughter and, in accordance with the pre-certification provided by the HMO prior to her admittance, both mother and child were discharged from the hospital after twenty-four hours. The day after the baby was discharged (two days after she was born), the baby became ill. The Baumans made numerous calls to the pediatrician, but were never advised to bring the baby back to the hospital. At the same time, they contacted the HMO and requested an in-home visit by a pediatric nurse, a service that was covered under the plan’s “L’il Appleseed Program.” The nursing visit was not provided. Thus, a strep infection that the baby had contracted in the hospital was undiagnosed and untreated. The infant rapidly developed meningitis, and died that same day.

The Baumans alleged that U.S. Healthcare’s policy required participating physicians to discharge mothers and newborns after twenty-four hours, and discouraged them from readmitting infants to the hospital when health

182. Id. at 356-57.
183. Id. at 361.
185. In re U.S. Healthcare, 193 F.3d at 156.
186. Id.
187. Id.
problems arose after discharge. The Baumans sued the pediatrician responsible for their daughter's care, the hospital where the child was born, and the HMO (a subsidiary of U.S. Healthcare) to which the Baumans belonged. The complaint alleged various tort violations (including negligence for not providing medically appropriate care and for failure to diagnose and treat the infection) against all defendants and direct negligence and vicarious liability against the hospital and the HMO.

The defendants removed the case to federal court, alleging complete preemption under ERISA. In the district court, the defendants moved for dismissal or, alternatively, for summary judgment. The plaintiffs moved to remand, arguing that their claims could not be completely preempted, because they did not fall within any of ERISA's civil enforcement provisions and therefore there could be no basis for federal jurisdiction. However, the district court disagreed, holding that the count challenging the failure of the HMO to provide a nurse's visit was completely preempted under ERISA § 502, as well as expressly preempted under ERISA § 514(a). The court therefore dismissed that count. But the other five counts were remanded to state court for further examination. U.S. Healthcare appealed the district court's order and filed a mandamus motion. The Baumans appealed the dismissal of the single count and the refusal of the court to remand it to state court.

The district court amended its original order to state that the dismissal of the single count was with respect to U.S. Healthcare only, and affirmed its remand of the other counts. U.S. Healthcare then appealed and filed a writ of mandamus, which was referred by the Third Circuit to a panel to rule on the merits of the allegations. A complicated series of motions by the defendants and cross-motions by the Baumans were filed.

The issue before the Third Circuit was a procedural one: whether the plaintiff's claims arose under ERISA as benefit claims and were therefore completely preempted by

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188. Id. at 157.
189. See id. at 155-57.
190. See id. at 156.
ERISA § 502(a)(1)(B) or whether they were state negligence and malpractice claims outside the scope of ERISA. In essence, however, the circuit court focused on the role U.S. Healthcare was playing when it performed the acts that caused the death of the infant: was it the processor of a claim for benefits or the overseer of a system for delivering medical care?

As in Dukes, the Third Circuit examined the facts of the case and concluded that the Baumans were not complaining about a benefit denial, but rather that the behavior of the defendants in establishing and implementing the policies regarding discharge and readmission was negligent and inconsistent with quality health care. The circuit court concluded that the Baumanns’ claims involved the quality of medical decisionmaking and medical care, not coverage, and therefore were not completely preempted by ERISA. For this reason, the Third Circuit directed that the claims be remanded to state court.

Similarly, in Pacificare of Oklahoma v. Burrage, the Tenth Circuit held that the district court properly remanded state law malpractice and vicarious liability claims brought against a physician and an HMO because they were not preempted by ERISA. The action had originally been filed in state court. The defendants removed it to federal court, but the district court concluded that only one of the plaintiff’s three claims was preempted. It dismissed that claim and remanded the other two. The defendants then filed a writ of mandamus to force the district court to rescind the remand. The Tenth Circuit denied the mandamus request, finding that the district court correctly concluded that the claims were saved from preemption under ERISA § 514 because they did not relate to an ERISA plan. The Tenth Circuit agreed with the district court that the negligence claim against the physician could be resolved without reference to the plan.

193. See id. at 162.
194. Id. at 163-64.
195. Id. at 163.
196. See id. at 163-64.
197. 59 F.3d 151 (10th Cir. 1995).
198. See id. at 155.
199. Id. at 152.
200. See id. at 154.
201. Id.
In addition, the court said that the question whether an agency relationship existed between the doctor and the HMO did not involve either plan benefits or administration. Therefore, neither of these claims was sufficiently related to a plan so as to be preempted by ERISA § 514.

The Seventh Circuit's conclusion in Rice v. Panchal was the same as the Tenth Circuit's in Pacificare. David Rice filed claims alleging medical malpractice against two providers and vicarious liability for malpractice against the plan administrator (Prudential). The claim against Prudential was based on a respondeat superior theory. Prudential removed to federal court, arguing that ERISA completely preempted Mr. Rice's claims. The district court then dismissed Mr. Rice's action against Prudential because there was no remedy under ERISA for malpractice. On appeal, Rice argued that the case was improperly removed because his claims were not completely preempted. The Secretary of Labor, as amicus curie, agreed. The Seventh Circuit, like the Third Circuit in Dukes, discussed the differences between "complete preemption" under ERISA § 502(a) and "preemption" as a defense under ERISA § 514(a). Because Mr. Rice's malpractice claims did not rest on the terms of the plan and could be resolved without interpreting the plan, the court held they were not completely preempted by ERISA. Therefore, removal was improper and the case was remanded to state court to resolve the issue of whether there was an agency relationship between the doctor and Prudential, acting as plan administrator.

A contrary result was reached by the Eighth Circuit in Hull v. Fallon, where the court refused to recognize a cause of action against an MCO for medical malpractice.
Mr. Hull, a participant in a health insurance plan issued by Prudential Health Care Plan, Inc., visited his primary care physician claiming shortness of breath, chest pain, and arm pain. His physician twice requested authorization to give Mr. Hull a stress test, but both requests were denied by Dr. Fallon (the administrator of Prudential's ERISA plan), although Dr. Fallon did authorize a treadmill stress test. Unfortunately, Mr. Hull suffered a heart attack and additional serious complications allegedly as a result of the delay in diagnosis and treatment of his heart condition.

Mr. Hull brought a medical malpractice action in state court against both Dr. Fallon, the medical doctor who administered the insured health plan, and the health insurance issuer itself, claiming that the issuer was vicariously liable for the medical malpractice of Dr. Fallon. After the case was removed to federal court, the district court held that the state claims were completely preempted and dismissed the action, concluding that Dr. Fallon was acting as a plan administrator, rather than as a treating physician, in denying the services sought by Mr. Hull.

The Eighth Circuit affirmed the district court's decision that the state malpractice claim against the HMO and Dr. Fallon were preempted by ERISA. Even though Mr. Hull argued that his was a quality of care case involving the negligent diagnosis and treatment of his illness, the defendants were successful in convincing both the district and circuit courts that Dr. Fallon was operating as the plan administrator.

and Rice, the analysis used by the Eighth Circuit in reaching its conclusion that a medical malpractice action did not lie is actually consistent with those cases, because the Hull court concluded that the complaint involved a benefit denial decision (i.e., denial of a thallium stress test) made by the plan's administrator, Dr. Fallon, not a treatment decision. Id. at 942. Thus, the Eighth Circuit never reached the question of whether, had a treatment decision been involved, the MCO could be held vicariously liable for medical negligence. Arguably the case that could be viewed as conflicting with Hull is In re U.S. Healthcare, where the Third Circuit concluded that the HMO's failure to provide an in-home visit by a pediatric nurse as part of the plan's Li'l Appleseed program was a question of adequacy of care, not denial of benefits. In re U.S. Healthcare, 193 F.3d 151, 164 (3d Cir. 1999).

212. 188 F.3d at 941.
213. Id.
214. Id. at 941-42.
administering a coverage decision, rather than a physician making a medical decision:

The district court found that Dr. Fallon... denied the thallium test as part of a determination of benefits owed by the Plan. We agree with the district court's reasoning and conclude that Hull's claims... are preempted by ERISA. In short, although Hull's characterization of his claims sound in medical malpractice, the essence of his claim rests on the denial of benefits. As a Plan participant, he could have brought an action under section 502(a). Because his claims relate to the administration of benefits, they fall squarely within the scope of section 502(a). Therefore, Hull's claims are completely preempted by ERISA. Plan administrators necessarily exercise medical judgment in determining benefits due under the plan. To find that Hull's claims are not preempted would be to expose plan administrators to varying state causes of actions for claims within the scope of section 502(a). This "would pose an obstacle to the purposes and objectives of Congress."

Although many courts have applied the coverage-treatment distinction developed in Dukes, Rice, and Burrage and elaborated in Bauman, the results have not always been consistent. Nonetheless, most courts

215. Id. at 943 (emphasis added) (quoting Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 52 (1987)).

216. See, e.g., Shea v. Esensten, 208 F.3d 712 (8th Cir. 2000) (finding that negligent misrepresentation claims against physicians are not preempted); Maio v. Aetna Inc., 221 F.3d 472 (3d Cir. 2000) (holding that health care provider's failure to reveal financial incentive arrangement it had with physicians did not address the quality of health care services); Corporate Health Ins., Inc., v. Tex. Dep't of Ins., 215 F.3d 526 (5th Cir. 2000) (holding that a state statute requiring HMOs and other health insurers to establish a system of independent external review for disputed claims and establish other administrative mechanisms effectively created an alternate enforcement mechanism to ERISA's benefit claims procedures and was thus preempted); Giles v. Nylcare, 172 F.3d 332 (5th Cir. 1999) (holding that claims for vicarious liability and negligence against health care provider were properly remanded to state court); Danca v. Private Healthcare Sys., Inc., 185 F.3d 1 (1st Cir. 1999) (holding that negligent decision making and consultation practices were deemed part of the administrative process used to assess claim for benefit payments and therefore were preempted); Maltz v. Aetna Health Plans, 1998 U.S. App. LEXIS 12675 (2d Cir. 1998) (holding that an action seeking to enjoin a health care provider from changing its method of compensation to physicians is not a violation of ERISA; the claim is essentially alleging a reduction in quality of care that is properly brought in state court); Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482 (7th Cir. 1996) (holding that claims against nurse for her refusal to authorize non-medically necessary rehabilitation treatment are really a claim for benefits preempted by ERISA); Prudential Health Care Plan, Inc. v. Lewis, 1996 U.S. App. LEXIS 2595 (10th Cir. 2001)
generally have distinguished claims about the quality of medical care from claims about the quantity of care, that is, claims asserting that benefits were wrongfully withheld. "Quality" claims arise from an HMO's actions as a health care provider—that is, as an arranger or provider of medical treatment, either directly or through contracts with hospitals, doctors, or nurses. They are not actionable under § 502(a)(1)(B) and do not arise under federal law. Accordingly, a plaintiff may pursue such claims under state law, even though the relevant state law may ultimately be preempted by ERISA § 514. 217 "Quantity" claims challenging plan administration decisions, even when the decisions involve the exercise of medical judgment, are considered actionable under ERISA § 502(a)(1)(B) and, thus, are completely preempted. 218


218. See, e.g., Hull v. Fallon, 188 F.3d at 943; see also Corcoran v. United Healthcare Inc., 965 F.2d 1321, 1331-34 (5th Cir. 1992).
C. Pegram v. Herdrich—Beyond Dukes?

Although the lower courts have developed a consensus of sorts concerning the coverage-treatment distinction, this analytical framework is not without its problems. Most importantly, coverage and treatment issues are often so intertwined that it seems arbitrary or subjective to classify a decision as either a choice about coverage (quantity) or a choice about treatment (quality). In *Nascimento v. Harvard Community Health Plan*, the court described the dilemma as follows:

"[I]t may be . . . that HCHP physicians who provided plaintiff with treatment functioned both as health care providers and as utilization review administrators. . . . Even if HCHP physicians actually functioned, at least in part, as plan administrators, however, I am of the opinion that the result would not change. When a physician makes a decision both as a plan administrator and as a health care provider, only a metaphysician can separate the components of the treatment decision rooted in plan considerations from those rooted in pure medical judgments, particularly when the plan covers all medically necessary treatment."

In *Pegram v. Herdrich*, the Supreme Court abruptly called into question the developing consensus concerning the coverage-treatment distinction and offered a new and perhaps clearer framework for distinguishing between decisions that involve the core of a health plan's operations and decisions that are medically based. *Pegram* itself did not involve ERISA preemption at all. The issue before the Court was quite different: Is it a breach of fiduciary duty under ERISA for an HMO to use financial incentives to ration care? Not surprisingly, the Court said no. In the process of answering that simple question, however, the Court broke significant new ground as well as reaffirmed some old principles and clarified some current ambiguities.

*Pegram* involved claims against the Carle Clinic Association, an HMO that was owned by the doctors who provided treatment and made eligibility decisions. Carle provided financial incentives that directly linked year-end

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220. Id. at *26 n.12.
221. 530 U.S. 211 (2000).
222. See id. at 214.
profit distributions to the physician-owners' ability to limit care, whether through limiting the cost of treatment or through claims determinations based in part on medical judgment. The case arose out of treatment provided to Cynthia Herdrich by Dr. Lori Pegram, one of the physician-owners of Carle. Dr. Pegram found a large, inflamed mass in Mrs. Herdrich's abdomen and concluded that it was an inflamed appendix. Dr. Pegram ordered a diagnostic ultrasound for Mrs. Herdrich, with the procedure to take place eight days later in a Carle-owned facility more than fifty miles away, rather than at a local hospital. In the interim, Mrs. Herdrich's appendix ruptured.

Mrs. Herdrich brought medical malpractice and fraud claims in state court against Dr. Pegram and Carle Clinic. Although Mrs. Herdrich's malpractice claim against Dr. Pegram was successful, Carle and Pegram removed the fraud claims to federal court. The district court dismissed the fraud claims on the basis of ERISA preemption. Mrs. Herdrich amended her complaint and alleged that the financial incentives Carle gave to its physicians breached fiduciary duties under ERISA. The district court dismissed Mrs. Herdrich's claim after concluding "that Carle was 'not involved [in these events] as' an ERISA fiduciary." On appeal, the Seventh Circuit reversed, holding that Carle was acting as a fiduciary when its physicians made treatment decisions and that the decisions themselves were fiduciary acts.

The Supreme Court perceived Pegram as a frontal assault on the core principle of managed care. In the traditional fee-for-service system, there are clear distinctions between treatment and payment decisions. Managed care is a system of risk and rewards that is designed to balance the financial risks of assuming responsibility for the care of a patient with the costs associated with providing essential and efficient treatment when the patient needs it. Thus, managed care necessarily blurs the lines between treatment and payment decisions.

223. Id. at 215.
224. Id.
225. Id. at 216.
226. Id. at 217.
Writing for a unanimous court, Justice Souter in *Pegram*
used the provocative term “rationing” to describe what an MCO does when it pays doctors more if they reduce utilization of medical care. He stated candidly that “[n]o HMO could survive without some incentive connecting physician reward with treatment rationing.” Through its encouragement of HMOs, Congress had long sanctioned such rationing. The notion of applying ERISA’s strict fiduciary standards to such rationing decisions was impossible to fathom. If fiduciary standards were applied, any decision based on cost rather than the best interests of the participants and beneficiaries would be a violation of ERISA. The Court concluded that there was no reason to suppose that Congress had intended such a result. Accordingly, rationing decisions could not be subject to ERISA’s fiduciary rules.

The next portion of the decision was devoted to an interesting but not particularly groundbreaking discussion of several well-established but often overlooked ERISA principles. The Court concluded that an HMO is not an ERISA plan, but rather a service provider for ERISA plans. In reaching this conclusion, the Court started with the basics: the definition of a “plan” as the term is used in ERISA. Justice Souter concluded that a “plan” is a scheme decided on in advance: “a set of rules that define the rights of a beneficiary and provide for their enforcement.”

[But] when employers contract with an HMO to provide benefits to employees subject to ERISA, the provisions of documents that set up the HMO are not, as such, the ERISA plan, but the agreement between an HMO and an employer who pays the premiums may, as here, provide elements of a plan by setting out rules under which beneficiaries will be entitled to care.

229. *Id.* at 220-21.
230. *Id.* at 220.
231. *Id.* at 222.
232. *See id.*
233. *Id.* at 222.
236. *Id.*
This is a key distinction that has often been disregarded by the courts. Two other well-established principles that the Court reiterated on the way to its conclusion that Carle was not engaged in fiduciary conduct when it created financial incentives for providers were (1) that fiduciary status must be determined under a functional test, and (2) that, unlike at common law where trustees can wear only one hat, under ERISA, trustees can wear more than one, although only one at a time. Perhaps the most significant reaffirmation of prior Supreme Court principles was the Court's lengthy discussion of how the decision of the HMO to include financial incentives for its doctors is analogous to a plan sponsor's decision about the content or design of a plan. When a plan sponsor decides to include financial incentives for providers in its health care plan, it acts as a settlor, rather than as a fiduciary. Justice Souter stated that the same principle applies to an HMO. An HMO may be a fiduciary when it performs plan administration functions for an ERISA-covered group health plan, but when it carries out its own business operations, it is not subject to ERISA's fiduciary standards any more than an

237. In Dukes, for example, the Third Circuit never addressed this question, although it noted that the U.S. Department of Labor, as amicus curie, had argued strenuously that the HMO was not the ERISA plan. See 57 F.3d 350, 356 (3d Cir. 1995). For purposes of its preemption analysis, the court simply assumed that U.S. Healthcare was a fiduciary performing acts of plan administration with respect to an ERISA plan, concluding that it was unnecessary to resolve the issue. See id. That assessment is clearly correct. The Third Circuit had already concluded that Mr. Dukes's claim was not completely preempted; the question of whether or not the HMO is an ERISA plan (or is performing acts of plan administration) is most relevant to determining whether the state law is preempted under ERISA § 514, the precise issue before the state court on remand. Determining which entity is the ERISA plan is critical to determining whether a state law is preempted under ERISA § 514. ERISA § 514(a) only protects ERISA plans from state regulation; ERISA does not insulate vendors or service providers to ERISA plans from state regulation as they otherwise carry out their own business activities simply because of their connection to ERISA plans. Thus, distinguishing between acts of plan administration and acts that relate to the internal business decisions of the HMO or MCO is quite important in evaluating the merits of an ERISA preemption defense to a state law claim.

238. See Pegram, 530 U.S. at 225.
239. Id. at 226-27.
240. Id.
employer is when the employer carries out settlor functions.\textsuperscript{241}

Moreover, even though the Carle Clinic was a fiduciary with respect to Mrs. Herdrich’s plan because it administered the plan, the decision to include financial incentives in Carle’s physician compensation structure preceded Carle’s contract with State Farm. On that ground alone, the Court could have concluded that adoption of the financial incentives was not a fiduciary act with respect to Mrs. Herdrich’s plan.\textsuperscript{242}

As previously noted, the Court believed that applying ERISA’s fiduciary standards to treatment decisions would undermine the very foundation of managed care.\textsuperscript{243} At the same time, however, the Court struggled to understand the precise nature of the issue it confronted in \textit{Pegram}. Justice Souter acknowledged that it was difficult to determine exactly which of the acts Mrs. Herdrich was alleging constituted a fiduciary breach.\textsuperscript{244} Having concluded that the decision to include financial incentives for providers in its compensation structure could not be a fiduciary act on the part of Carle, the Court turned to the question of whether, in the course of administering the plan, certain actions of the physician/owners acting on behalf of the HMO were fiduciary in nature and, if so, whether these actions were improperly influenced by the presence of the bonus pool arrangement.

In analyzing this question, Justice Souter focused on two types of administrative acts that the physician/owners undertook:

What we will call pure “eligibility decisions” turn on the plan’s coverage of a particular condition or medical procedure for its treatment. “Treatment decisions,” by contrast, are the choices about how to go about diagnosing and treating a patient’s condition: given a patient’s constellation of symptoms, what is the appropriate medical response?\textsuperscript{245}

\textsuperscript{241} See id. at 226-27.
\textsuperscript{242} See id. at 227 n.7.
\textsuperscript{243} See id. at 235 (“The Court of Appeals did not purport to entertain quite the broadside attack that Herdrich’s ERISA claim ... entails . . . ”).
\textsuperscript{244} Id. at 227-28.
\textsuperscript{245} Id. at 228.
Noting that "[t]hese decisions are often practically inextricable," Justice Souter explained that the problem arises for a variety of reasons:

This is so not merely because, under a scheme like Carle's, treatment and eligibility decisions are made by the same person, the treating physician. It is so because a great many and possibly most coverage questions are not simple yes-or-no questions, like whether appendicitis is a covered condition (when there is no dispute that the patient has appendicitis), or whether acupuncture is a covered procedure for pain relief (when the claim of pain is unchallenged). The more common coverage question is the when-and-how question. Although coverage for many conditions will be clear and various treatment options will be indisputably compensable, physicians must still decide what to do in particular cases.

For example, the Court noted that the government's amicus brief provides an example of an HMO's refusal to pay for emergency care because the HMO concluded that, under the circumstances, no emergency existed. In that situation, said Justice Souter, "these eligibility decisions cannot be untangled from physicians' judgments about reasonable medical treatment." The decisions involved in Mrs. Herdrich's treatment, the Court concluded, were mixed eligibility and treatment decisions. Still struggling to define the parameters of Mrs. Herdrich's fiduciary breach claims, however, the Court concluded that she did not mean to allege a breach of fiduciary duty regarding "pure eligibility determinations"—those that can be made without reference to the individual patient's condition (e.g., does the plan cover an undisputed case of appendicitis) or those administrative decisions not involving medical judgment.

Turning once again to an examination of congressional intent, Justice Souter stated that Congress could not have intended that an HMO should be treated as a fiduciary "to the extent that it makes mixed eligibility decisions acting

246. Id.
247. Id.
248. Id. at 229.
249. Id.
250. See id. ("The eligibility decision and the treatment decision were inextricably mixed, as they are in countless medical administrative decisions every day.").
251. Id. at 230.
through its physicians, because these decisions bear little resemblance to the traditional fiduciary functions undertaken by plan trustees regarding plan assets. In contrast to the typical financial decisions made by pension plan trustees involved in plan administration, the types of decisions made by HMOs involve whether or not to provide medical care—a decision that is not fundamentally financial in nature.

Thus the Court concluded that neither pure treatment decisions, nor mixed treatment and eligibility decisions made by physicians, are acts of plan administration, and, therefore, ERISA's fiduciary rules do not apply to these decisions. Only "pure eligibility decisions" will be considered acts of plan administration under ERISA.

Since Pegram carefully limited acts of plan administration undertaken by HMOs to pure eligibility decisions, most typical HMO activities appear to be beyond the reach of ERISA fiduciary responsibility rules. Although HMOs and their treating physicians exercise broad discretion regarding the provision of medical services to participants in ERISA plans, these types of decisions are likely to fall within the non-fiduciary realm and thus subject to accountability under state law, not ERISA. Two possible exceptions are cases involving misrepresentations and disclosure. On this latter point, in dicta, the Court left the door open to the possibility that even though the existence of financial incentives for HMO physicians was not a fiduciary violation under ERISA, failure to disclose them by the HMO might be.

In the final paragraphs of the decision, the Court engaged in a curious discussion of ERISA preemption. The Court assumed that providing a fiduciary action under ERISA for mixed eligibility decisions would be of little value to participants, since that would simply federalize under ERISA the type of action already available under state

252. Id. at 231.
253. Id. at 231-32.
254. See id. at 231-37.
255. Id. at 227-28 n.8. ("Although we are not presented with the issue here, it could be argued that Carle is a fiduciary insofar as it has discretionary authority to administer the plan, and so is obligated to disclose characteristics of the plan and of those who provide services to the plan, if that information affects beneficiaries' material interests.").
malpractice laws. In its discussion, the Court assumes the validity of such state laws: "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."

This statement should give comfort to the growing number of states that have enacted HMO liability laws, since the Court's observation would likely be meaningless unless it assumed that those laws were valid.

Although Pegram was about the scope of ERISA's fiduciary duties, considerable speculation has been raised about whether its rationale will be applied to future ERISA preemption cases involving participants' benefit claims. This speculation has been fueled by some puzzling aspects of the Pegram decision itself. In a footnote in the middle of its discussion of mixed eligibility decisions, the Court noted the existence of a separate cause of action under ERISA for suits for benefits and then ducked the question of whether the same conclusion about the applicability of state law to mixed eligibility decisions would be drawn if the suit had involved claims for benefits under § 502(a)(1)(B). After raising the issue, the Court simply remarked that it had no reason to discuss this question.

In its preemption discussion at the end of the opinion, the Court referred to Travelers and emphasized the presumption against preemption of state medical regulation unless there is a clear manifestation of Congress's intent to

256. See id. at 235.
257. Id. at 235-36.
259. Pegram, 530 U.S. at 229 n.9.
260. Id.
preempt.\footnote{261} In the footnote described above, the Court mysteriously cross-referenced the discussion of preemption at the end of its opinion.\footnote{262} Yet the Court neither discussed nor alluded to the doctrines of conflict preemption or complete preemption. These doctrines have consistently been used by the lower courts to preempt state law in actions challenging coverage decisions.

D. Post-Pegram Cases

Confusing the picture further, one week after it decided Pegram, the Supreme Court denied certiorari in the Bauman case (\textit{In re U.S. Healthcare}).\footnote{263} In addition, also on the same day, the Court granted certiorari and vacated the decision of the Supreme Court of Pennsylvania in \textit{Pappas v. Asbel}\footnote{264} and then remanded \textit{Pappas} for further consideration in light of Pegram.

In \textit{Pappas I}, the Supreme Court of Pennsylvania held that claims against an HMO based on a delay in approving the transport of a patient with a back injury that led to his paralysis were not preempted under ERISA § 514 because they did not “relate to” a plan.\footnote{265} The court analyzed the challenged conduct as a malpractice claim because the HMO’s decision concerned the interrelated questions of coverage and safe medical practice. The court concluded that Congress did not intend to preempt state laws regarding medical care.\footnote{266}

On remand from the U.S. Supreme Court, the Supreme Court of Pennsylvania again held in \textit{Pappas II} that the state claims were not preempted by ERISA.\footnote{267} The court first described two guiding principles that the Supreme Court had articulated in Pegram: (1) HMO physicians occupy dual roles—plan administrators when they make coverage decisions and health care providers when they decide what medical treatment the participant will receive;

\begin{itemize}
  \item \footnote{261} See id. at 236-37.
  \item \footnote{262} Id. at 229 n.9.
  \item \footnote{265} 724 A.2d at 893 (\textit{Pappas I}).
  \item \footnote{266} Id. (citing N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995)).
  \item \footnote{267} Pappas v. Asbel, 768 A.2d 1089 (Pa. 2001) (\textit{Pappas II}).
\end{itemize}
and (2) there are three types of decisions an HMO physician may make: "pure eligibility decisions," "treatment decisions," and "mixed eligibility and treatment decisions." 

Rejecting the HMO's argument that the decision not to permit the referral of Mr. Pappas to a non-network hospital "constituted a quintessential 'coverage' determination," the court concluded that U.S. Healthcare's decision was a mixed treatment and eligibility decision as described in Pegram. The court found it clear that Mr. Pappas's injury had occurred when the HMO (1) rejected the medical judgment of the emergency room physician that immediate transfer was necessary because Mr. Pappas's condition was a medical emergency and (2) did not refuse Mr. Pappas's request for a transfer, but rather offered three alternative treatment facilities to which Mr. Pappas could be transferred to handle his medical problem." The court noted that these types of decisions were not the "simple yes or no" decisions as to whether a condition is covered, cited in Pegram as pure eligibility questions, but rather reflected the medical judgments of where and under what circumstances Mr. Pappas's condition would be treated (i.e., mixed treatment and eligibility decisions) and therefore the plaintiff's state claims were not completely preempted by ERISA.

Most courts have read Pegram narrowly and have not altered their preemption analysis based on its dicta. In Schusteric v. United Healthcare Insurance Co., the Northern District of Illinois became the first district court to consider the impact of Pegram in deciding whether to remand a claim against an HMO for a benefits decision based on medical judgment. The district court held that Pegram had no impact at all on the question whether a negligence claim of the type alleged by Schusteric is completely preempted by ERISA § 502(a). The district court employed the familiar coverage-treatment distinction to find that Schusteric's claim, challenging an HMO's delay in agreeing to pay for physical therapy following dental

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268. Id. at 1093-94.
269. Id. at 1096.
270. Id. at 1091, 1095-96.
271. Id. at 1096.
273. Id. at "2.
surgery because it was not medically necessary, was completely preempted. Restricting its discussion of Pegram to the Court's holding regarding the scope of ERISA's fiduciary duties, the district court rejected Schusteric's argument that Pegram required a different result.274

Similarly, the district court for the Southern District of New York, in Rubin-Schneiderman v. Merit Behavioral Care Corp.,275 concluded that a decision to deny inpatient treatment made by Merit Behavioral Care Corp. (a utilization review organization under contract to Empire Blue Cross and Blue Shield) was a coverage decision, not a treatment decision. The court distinguished Pegram in two ways: (1) the decision was made by an independent utilization review entity, not an HMO's own doctors or administrators, and (2) the health plan at issue was not an HMO, but rather a preferred provider organization (PPO), an entity more like the traditional fee-for-service plan.276

Recently, the defendant in Lazorko v. Pennsylvania Hospital277 unsuccessfully tried to invoke Pegram to argue that imposing state liability on an HMO accused of denying treatment based on financial incentives was improper because, by recognizing that financial incentives were an integral feature of HMOs, Pegram insulated HMOs from liability—even state liability—attributable to the existence of financial incentives.278 The Third Circuit concluded that the vicarious liability claims against an HMO alleging that the HMO's financial disincentives discouraged the treating physician from recommending additional treatment involved medical judgments and therefore were not completely preempted by ERISA.279

VI. COVERAGE V. TREATMENT DECISIONS: A NEW DIRECTION?

After twenty years of broadly interpreting the sweep of ERISA's preemption provision, since 1995 the Supreme Court has switched gears and appears to be narrowing the
reach of ERISA § 514, at least as applied to employee welfare benefit plans. In the aftermath of Travelers and the trio of preemption cases decided in 1997 that fleshed out the Travelers framework for preemption analysis, a new paradigm for ERISA preemption seems to have emerged. State laws involving traditional areas of state regulation, such as medical decisionmaking, are presumed valid, unless a specific intent to preempt by Congress can be shown. State laws that conflict with ERISA must give way, but to the extent that state laws do not single out ERISA plans, nor interfere with their administration, those state laws are likely to survive ERISA preemption challenges. State laws providing alternate enforcement mechanisms for ERISA claims are also preempted, but it is possible that the Supreme Court may revisit that issue in the future, at least when the enforcement procedures in question are integral to state laws saved under ERISA's insurance savings clause.

The Supreme Court's decision in Pegram suggests, however, that the methodology for examining preemption of state law claims involving medical decisionmaking that has emerged since Travelers may itself be changing.

In Dukes, the Third Circuit faced a series of claims by Mr. Dukes's survivors that Mr. Dukes's injury occurred because the medical providers and the HMO under which he was covered failed to diagnose his ultimately fatal condition through a timely blood test. The Third Circuit could have looked at those facts and concluded the actions complained of simply involved a denial of benefits (i.e., failure to provide the blood test). If so, that was a coverage decision and state law claims concerning that decision should have been preempted. Other courts, most notably the Fifth Circuit in Corcoran v. United Healthcare Inc., had done exactly that. But instead, the Third Circuit concluded that the essence of the Dukes family’s claim was

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not simply that Mr. Dukes was not given the blood test that clearly was covered under the plan, but that the care he got under the plan was substandard. The court concluded that the claims were actually medical malpractice claims, not benefit claims in disguise. Thus, the state law claims could go forward and were not preempted. At the time, Dukes was considered quite controversial and cutting edge.

The Fifth Circuit's analysis in Corcoran was, and probably still is, the mainstream view of how courts approach coverage questions. The claims before the Fifth Circuit were analogous to those in Dukes. Mrs. Corcoran's treating physician recommended hospitalization for the remaining time of her high-risk pregnancy. But the utilization review firm (United Healthcare) substituted its medical judgment for that of the treating physician and ordered instead home nursing care for ten hours a day. During a time that the nurse was not on duty, the fetus went into distress and died. Mrs. Corcoran argued that her case was not about denial of hospitalization but about the decision of the utilization review firm to substitute treatment—a medical decision, not solely a coverage decision. Nonetheless, while acknowledging that the utilization firm was giving medical advice when it rejected the recommendation of the treating physician and substituted alternative care, the Fifth Circuit said that it was doing so in the course of handling a benefit claim, an act of plan administration. Thus, the state law negligence and wrongful death claims were preempted.

In Dukes, the Third Circuit explicitly rejected Corcoran, distinguishing it because although United Healthcare was making medical decisions (at least in part) when it was involved in utilization review activities, those activities did not involve the actual provision of medical care or the supervision of those who provided medical treatment for plan provisions.

But what would happen if one were to apply the Pegram analysis to preemption cases like Dukes and Corcoran? Recall that the facts at issue in Pegram involved decisions that treating physicians made on behalf of the HMO. Those facts were similar to the situation in Dukes, since the alleged negligence related to actions of the

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285. See supra note 167 for a discussion of Corcoran.
286. See Corcoran, 965 F.2d at 1331-32.
treating physician and the HMO. Those acts would be either pure treatment decisions or mixed eligibility decisions under the Pegram analysis. In either case, they would not be fiduciary acts, therefore, state law would govern. Thus, although the result would be the same (i.e., state law would not be preempted), the Third Circuit would not have to conclude that the issue involved quality of care to reach that result. Even if the decisions were in part coverage decisions, state law would still be applied. This is in contrast to the general rule, embodied in Corcoran and Hull, in which challenges to so-called mixed eligibility decisions would result in preemption of state law.

The result of applying a Pegram-type analysis in preemption cases like Corcoran is not as clear. Unlike Pegram or Dukes, Corcoran did not involve a challenge to the decisions of a treating physician. Indeed, in Corcoran, the treating physician's recommendation was overruled. So the question would be whether the decisions of a utilization review entity, acting on behalf of the HMO, would be fiduciary acts? Arguably, although it was not performing hands-on medical treatment, the activities of the utilization review entity were not purely administrative in nature, but rather required medical judgment.

The distinction that Justice Souter seemed to be drawing in Pegram was between pure coverage or eligibility decisions (which could be made by looking at the plain language of the plan itself) as distinguished from a mixed eligibility decision (which required the application of the plan's language to the particular circumstances presented by the individual seeking treatment to determine coverage). In other words, "Whether hospitalization during pregnancy was covered under the plan?" would be a pure eligibility or coverage decision. In contrast, "Whether, given the high-risk nature of Mrs. Corcoran's pregnancy and other medical factors specific to her, was hospitalization during pregnancy medically necessary or appropriate and therefore covered under the plan?" would be a mixed eligibility decision or treatment decision.287 Viewed in that context, it would be hard to argue that even though the medical judgment was being exercised by the utilization review entity on behalf of the plan, not the treating physician, the principles

287. For Justice Souter's explanation of the difference between the two types of decisions, see Pegram v. Herdrich, 530 U.S. 211, 228 (2000).
articulated by the Court in Pegram should not apply. At its core, what the Court was saying in Pegram was that decisionmaking by ERISA-covered health plans that is premised in part on medical judgment cannot be considered purely administrative in nature. Thus state law principles applicable to medical decisionmaking should apply.

This result would be consistent with Travelers and a natural progression in preemption jurisprudence flowing from the application of Pegram principles, even though the case itself involved the scope of ERISA's fiduciary duties, not preemption. Whether the Supreme Court ultimately moves in that direction is an open question, but given the current Court's clear preference for protecting state prerogatives at the expense of curbing the reach of Federal power, the seeds for such a further limitation on ERISA preemption of state law with respect to ERISA health plans have clearly been sown in Pegram.
