

THE FAILED JURISPRUDENCE OF MANAGED CARE, AND HOW TO FIX IT: REINTERPRETING ERISA PREEMPTION

Russell Korobkin^{*}

Most Americans receive their healthcare from a managed care organization (MCO), which makes state regulation of MCOs a significant policy issue. Most Americans also obtain their MCO membership through an employer-sponsored benefits plan subject to federal regulation. Consequently, courts must determine whether and to what extent federal law preempts state MCO regulation.

Over the last quarter-century, two questions have been particularly troublesome for the courts: (1) may patients sue their MCOs for negligence and related state law claims? and (2) may states regulate the benefits provided by MCOs to employment groups? Judicial attempts to address these issues have resulted in a confusing and doctrinally inconsistent jurisprudence of managed healthcare, in which like cases are treated differently and congressional intent is all but forgotten. In three recent decisions concerning managed care, *Pegram v. Herdrich*, *Rush Prudential HMO v. Moran*, and *Kentucky Ass'n of Health Plans v. Miller*, the U.S. Supreme Court missed opportunities to rationalize this body of law, further entrenching a failed jurisprudence of managed care.

This Article contends that the flaws in the Court's jurisprudence stem from a single mistake of statutory construction; specifically, the failure to recognize that medical benefits promised to patients by MCOs are not employment benefits, even when paid for by an employer. Were the Supreme Court to recognize and reverse this simple mistake, a new jurisprudence of managed care would emerge that eliminates confusion, avoids doctrinal conflict and inconsistency, and effectuates congressional intent. The new jurisprudence would also obviate much of the perceived need for federal "Patients' Bill of Rights" legislation.

INTRODUCTION.....	458
I. MANAGED CARE AND THE LAW OF EMPLOYER-PROVIDED BENEFITS.....	462
A. The Rise of Managed Care	462
B. The Federal Regulation of Employee Benefits	464
C. Statutory Structure	466
1. "Conflict Preemption": Section 514	466
a. The Relates-to Clause	466

^{*} Professor, UCLA School of Law. Advice and comments from Jill Horwitz, Gillian Lester, Peter Jacobson, John Jacobi, Bill Sage, and Jeff Stempel are gratefully acknowledged, as well as comments from the faculty of the Seton Hall Law School, where I was the Merck Visiting Health Care Law Scholar in the Spring of 2003. This Article could not have been completed without the excellent research assistance of Frank Dworak and Dan Lucas.

b. The Savings Clause	467
c. The Deemer Clause	467
d. The Effect of Conflict Preemption	468
2. "Complete Preemption": Section 502(a)	469
D. The Lynchpin of Managed Care Regulation: What Constitutes an ERISA Plan Benefit?	470
II. THE PRIVATE REGULATION OF MANAGED CARE: SUING MCOS	474
A. The Die Is Cast	476
1. <i>Pilot Life</i> and the Early Law of Managed Care	476
2. Inconsistent Implications for the Jurisprudence of Managed Care	478
3. The Conflict With ERISA's Purposes	483
4. The Road Not Taken: A Simple Solution	485
5. The Problem of Self-Insured Employers	486
B. The Mid-1990s: Less Preemption, More Confusion	488
1. <i>Travelers</i> and the Rollback of Conflict Preemption	488
2. Confronting the Elephant in the Room: The Remedies Problem	490
3. What About Utilization Review?	494
a. Negligence and Related Tort Claims	495
b. The Fiduciary Duty Claim	498
III. THE PUBLIC REGULATION OF MANAGED CARE: STATUTORY MANDATES	501
A. The Prevailing Approach: Preempted but Saved	502
B. The Problems With the Savings Clause Path	507
1. External Review Statutes and the Remedies Problem Revisited	507
2. The MCO-Physician Relationship: Any Willing Provider Laws	509
IV. OPPORTUNITIES MISSED: MANAGED CARE JURISPRUDENCE IN THE TWENTY-FIRST CENTURY	513
A. <i>Pegram v. Herdrich</i>	514
1. Fiduciary Duties	514
2. Challenges to Utilization Review Decisions	519
B. <i>Rush Prudential HMO v. Moran</i>	524
C. <i>Kentucky Ass'n of Health Plans v. Miller</i>	529
CONCLUSION	534

INTRODUCTION

If a primary care physician negligently provides treatment and thus causes injury to the patient, the patient has a valid claim against the doctor for malpractice. If the patient pre-purchased healthcare directly from a managed

care organization (MCO),¹ and the MCO employed the physician, the patient would have a vicarious liability claim against the MCO. If the negligent treatment decisions were made by a physician serving as a “utilization reviewer” for the MCO rather than by the primary physician, the patient would have a direct liability claim against the MCO. If, in an attempt to prevent injuries caused by negligent medical decisions, the state legislature enacted a statute requiring the MCO to submit its medical decisions to an independent oversight panel and the MCO refused to do so, the patient could sue the MCO for damages caused by its failure to heed the law.²

Should any of these results be different if the patient’s membership in the MCO was purchased for a fixed sum by his employer and provided as a fringe benefit of employment? Logic suggests that whether the patient is a third-party beneficiary of a contract between the MCO and his employer—as opposed to having contracted directly with the MCO or received his coverage through a public healthcare program—should be a distinction without a difference when it comes to ensuring that the patient receives the quality of care for which the MCO accepted payment.

Since MCOs appeared on the American healthcare scene in the 1970s, however, most federal courts, attempting to follow the U.S. Supreme Court’s opaque reasoning on related questions, have held that the legal rights of patients are affected, at least in some circumstances, by whether an employer purchases their MCO membership. Between 2000 and 2003, the Supreme Court decided two lawsuits against MCOs brought by patients who received their coverage as a fringe benefit of employment, and one dispute between MCOs and a state that was premised on the fact that healthcare coverage is often an employment benefit, thus giving the Court a historic opportunity to clarify and rationalize the jurisprudence of managed care. In

1. The term “managed care organization” encompasses a variety of somewhat different organizational arrangements, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point of service (POS) plans. Unlike traditional indemnity insurance, under which the insurer pays for healthcare benefits but has no role in procuring or providing the benefits, MCOs combine a risk-bearing function with a provision of care function, accepting premiums from patients or their employers and then contracting with physicians and other providers to provide care if the patient becomes ill during the policy period. See generally Patricia Danzon & Frank Sloan, *Comments on “The Assault on Managed Care: Vicarious Liability, ERISA Preemption, and Class Actions,”* 30 J. LEGAL STUD. 661, 662–63 (2001) (discussing the general characteristics of MCOs).

2. Cf. Wendy K. Mariner, *Slouching Toward Managed Care Liability: Reflections on Doctrinal Boundaries, Paradigm Shifts, and Incremental Reform*, 29 J.L. MED. & ETHICS 253, 260 (2001) (“Without ERISA preemption, it is fair to say that all managed care organizations would be subject to state common law liability to their patients, as are other insurers and corporations.”).

these cases, *Pegram v. Herdrich*,³ *Rush Prudential HMO v. Moran*,⁴ and *Kentucky Ass'n of Health Plans v. Miller*,⁵ the Court's decisions ultimately permitted patients to exercise the same rights under state law that they would have had if their MCO coverage had not been employment related. To reach these results, however, the Court engaged in a stunning array of doctrinal contortions, repeating mistakes of earlier employee benefits decisions and creating more jurisprudential problems and issues than it resolved.⁶

One but-for cause of the resulting, utterly confusing, body of law is the Employee Retirement Income Security Act of 1974 (ERISA)⁷ enacted by Congress. ERISA's primary purpose was to guarantee that employers would be able to honor pension commitments made to their employees,⁸ but the statute was written so as to apply to other employment benefits, such as health insurance, as well.⁹ As the courts have mentioned time and again, ERISA is far from being a model of clear drafting.¹⁰

But it is the Supreme Court, in interpreting ERISA, rather than Congress in drafting it, that is most responsible for the current confused and illogical state of managed care law. In fact, the confusing, internally contradictory, and sometimes nonsensical law of managed care attributable to ERISA can be traced to a single, simple interpretive failure: ERISA, meant to govern relationships between employers and employees, should never have been interpreted to govern the relationships between employees and third parties, such as MCOs, that contract with employers to provide services for

3. 530 U.S. 211 (2000).

4. 536 U.S. 355 (2002).

5. 123 S. Ct. 1471 (2003).

6. For a thorough analysis of the *Pegram*, *Rush Prudential*, and *Kentucky Ass'n* decisions, see *infra* Part IV.

7. Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended at 29 U.S.C. §§ 1001-1461 (2000)).

8. On January 3, 1973, Representative Dent introduced H.R. 2 and H.R. 462 to the ninety-third Congress, by stating "I am pleased to submit . . . two bills that I consider a 'first step' toward our goal of securing retirement benefits earned during working years." STAFF OF U.S. S. SUBCOMM. ON LABOR OF THE COMM. ON LABOR AND PUBLIC WELFARE, 930 CONG., 1 LEGIS. HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, PUB. L. NO. 93-406 1 (Comm. Print 1973) [hereinafter ERISA HISTORY]; see also H.R. 2, 93d Cong. (1973) (enacted) ("It is hereby further declared to be the policy of this Act to protect . . . the interests of participants in private pension plans . . ."); H.R. 462, 93d Cong. (1973) ("It is the declared policy of this Act to protect . . . the equitable interests of participants in private pension plans and their beneficiaries . . ."); Statement on the Employee Retirement Income Security Act of 1974, 46 PUB. PAPERS 78 (Sept. 2, 1974) ("Today, with great pleasure, I am signing into law a landmark measure that may finally give the American worker solid protection in his pension plan.").

9. 29 U.S.C. § 1002(1) (2000).

10. See, e.g., *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995); *John Hancock Mut. Life Ins. Co. v. Harris Trust and Sav. Bank*, 510 U.S. 86, 99 (1993); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987); *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985).

employees. By correcting this single error, the Supreme Court could rationalize the law of managed care immediately.¹¹ Unfortunately, the Court consistently has failed to do so throughout a quarter-century of ERISA-related decisions, up to and including its last term.

This Article explains and defends this argument in the following steps: Part I briefly describes the rise of managed care as the nation's dominant paradigm of healthcare insurance and delivery, and it reviews the legislative purposes underlying ERISA and its statutory provisions relevant to the regulation of managed care. In sum, this part explains the background conditions and forces from which the Supreme Court has embarked on its errant path and highlights that the text of ERISA did not render the Court's managed care jurisprudence inevitable.

Parts II and III critique how, prior to the year 2000, the federal courts dealt with the two most significant legal issues concerning managed care: the ability of patients to assert state law tort claims against MCOs (Part II), and the ability of states to regulate benefits provided by MCOs (Part III). These parts explain how early Supreme Court interpretations of ERISA created a dysfunctional and contradictory body of managed care law, how the Court's ill-fated attempt in the mid-1990s to revisit its flawed ERISA interpretation set the federal courts on a different, yet still illogical and inconsistent, path of managed care jurisprudence, and how the Supreme Court could have avoided a myriad of problems if not for its single underlying interpretive mistake.

Part IV describes how the twenty-first century Supreme Court, in deciding *Pegram*, *Rush Prudential*, and *Kentucky Ass'n*, further entrenched a confused doctrine, and again missed opportunities to interpret ERISA in a way that rationalizes the jurisprudence of managed care.

Part V concludes by explaining how reinterpreting what constitutes an ERISA plan benefit would not only rationalize and simplify judicial doctrine, but also would reduce substantially the perceived need for a federal "Patients' Bill of Rights"—legislation that is extremely popular but that has been mired in congressional conflict for a decade.

11. This Article takes the existence of ERISA as a given. Its goal is judicial reform of the doctrine of managed care regulation to better serve the principles of internal logic and coherence, horizontal equity, and fidelity to statutory language and intent. For this reason, I consciously avoid taking a position here on the distinct policy debate concerning whether, how, and by whom MCOs should be regulated. For purposes of full disclosure, I note that I have addressed aspects of this policy debate elsewhere. See Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1 (1999).

I. MANAGED CARE AND THE LAW OF EMPLOYER-PROVIDED BENEFITS

A. The Rise of Managed Care

When ERISA was enacted in 1974, nearly all employees who received healthcare benefits through their employer enjoyed insurance that paid for “fee-for-service” medicine, according to which patients selected their physicians, physicians and patients decided what treatments were appropriate, and the insurer reimbursed patients for the full cost of each treatment (perhaps less copayments and deductibles).¹² As a consequence of significant inflation in the healthcare industry in the 1970s and early 1980s, however, employers began to look for healthcare options that could rein in expenses.¹³ The result was the rise to dominance of “managed care,” an institutional arrangement in which one company provides an insurance function and provides (or arranges with subcontractors for the provision of) healthcare services.¹⁴ Today, most Americans with private health coverage are enrolled in some type of managed care program,¹⁵ and the large majority of these Americans—although, importantly, not all—receive their health coverage through an employee benefit plan.¹⁶

Fee-for-service medicine often was criticized for encouraging the overprovision of healthcare service because insurers had little control over healthcare expenditures and neither physicians nor patients had an incentive to limit them.¹⁷ Managed care provides the opposite set of incentives.

12. See, e.g., MARK A. HALL ET AL., *HEALTH CARE LAW AND ETHICS IN A NUTSHELL* 11–12 (1990); Korobkin, *supra* note 11, at 10–11.

13. See, e.g., Cathie Jo Martin, *Markets, Medicare, and Making Do: Business Strategies After National Health Care Reform*, 22 J. HEALTH POL. POL'Y & L. 557, 564 (1997).

14. See, e.g., BARRY R. FURROW ET AL., *HEALTH LAW* § 8.1 at 505–11 (2d ed. 2001). The concept of managed care is operationalized in a variety of institutional forms, such as HMOs, PPOs, IPAs, and POSs. For a description of the differences between these forms, see Jonathan P. Weiner & Gregory de Lissovoy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. HEALTH POL. POL'Y & L. 75 (1993).

15. In 2001, approximately 150 million Americans with private health coverage were enrolled in some type of managed care program. MANAGED CARE FACT SHEETS: MANAGED CARE NATIONAL STATISTICS, at <http://www.mcareol.com/factshts/factnati.htm>.

16. See, e.g., Timothy S. Jost, *Pegram v. Herdrich: The Supreme Court Confronts Managed Care*, 1 YALE J. HEALTH POL'Y L. & ETHICS 187, 187 (2001) (estimating that 88 percent of Americans with private health insurance have employment-based coverage); FAMILIES USA FOUNDATION, *HIT AND MISS: STATE MANAGED CARE LAWS* 12 (1998) (reporting that 83 percent of insured Americans are ERISA preempted), available at <http://www.familiesusa.org/site/DocServer/hitmiss.pdf?docID=753>.

17. See generally CLARK C. HAVIGHURST, *HEALTH CARE CHOICES* 93 (1995) (noting concerns raised by the divorce of consumption decisions from obligations to pay). One study estimated that a significant percentage of all healthcare spending could be attributed to the moral hazard problems of traditional health insurance. Roger Feldman & Bryan Dowd, *A New Estimate*

MCOs receive a fixed per capita payment from their customers or their customers' employers, and their profits depend on minimizing the costs of providing care.¹⁸ Thus, a financial incentive exists to underprovide rather than overprovide care.

MCOs can reduce the amount of care provided, and thus increase their profit margin, either by contracting *ex ante* to provide a smaller package of services, or by controlling the cost of care through treatment decisions. As examples of the first strategy, an MCO may use contractual language to exclude coverage for preexisting conditions,¹⁹ for types of service (such as chiropractic care), or for specific products (such as oral contraceptives). MCOs pursue the second strategy by drafting contracts with customers limiting coverage to "medically necessary" treatments and excluding "experimental" treatments, and then attempting to limit care by narrowly interpreting these terms. Such *ex post* enforcement of vague contract terms is achieved either by controlling the provision of care directly or by incentivizing physicians to do the same.²⁰ To achieve the former, many MCOs conduct "utilization review," in which their employees review treatments recommended by patients' physicians in advance of their provision and either approve or disapprove such treatments based on the MCO's position of what is "medically necessary" or "experimental."²¹ Alternatively, or in concert with utilization review, many MCOs provide financial incentives to their physicians to limit resource use in the form of capitation payments, bonuses, and/or fee withholds. This technique encourages the physicians to conduct

of the Welfare Loss of Excess Health Insurance, *AM. ECON. REV.*, Mar. 1991, at 297. In the era of fee-for-service medicine, insurance companies occasionally did deny claims, but only in egregious circumstances. Also, such refusals to pay took place after services were provided. This meant that a patient would not be reimbursed or a physician would not be paid directly, but the insurer's denial of the claim did not result in the patient not receiving the services at issue. See Karen A. Jordan, *Coverage Denials in ERISA Plans: Assessing the Federal Legislative Solution*, 65 *MO. L. REV.* 405, 411-12 (2000).

18. See Richard A. Epstein & Alan O. Sykes, *The Assault on Managed Care: Vicarious Liability, ERISA Preemption, and Class Actions*, 30 *J. LEGAL STUD.* 625 (2001).

19. A federal law, the Health Insurance Portability and Accountability Act of 1996, now places important limits on the ability of insurers to exclude coverage for preexisting conditions. Pub. L. No. 104-191, 110 Stat. 1936 (codified in scattered sections of 29, 42 U.S.C.).

20. See E. Haavi Morreim, *Another ERISA Twist: The Mysterious Case of Pegram and the Missing Fiduciary*, 63 *U. PITT. L. REV.* 235, 236 (2002) (claiming that health plans achieved cost control in the 1990s through "two basic approaches: control and incentives"); Sharon Reece, *The Circuitous Journey to the Patients' Bill of Rights: Winners and Losers*, 65 *ALB. L. REV.* 17, 31 (2001) ("The main strategies MCOs employ to control costs are financial incentive programs for physicians and utilization review of physicians.").

21. See, e.g., Patricia M. Danzon, *Tort Liability: A Minefield for Managed Care?* 26 *J. LEGAL STUD.* 491, 498 (1997); Jordan, *supra* note 17, at 413-14; Arnold Milstein, *Managing Utilization Management: A Purchaser's View*, *HEALTH AFF.*, May-June 1997, at 87.

their own careful utilization review before providing or authorizing costly services.²²

Two types of legal responses to MCO efforts to place limits on the provision of healthcare arguably have created conflicts between state law and ERISA. First, in response to MCOs' ex post efforts to limit care, such as utilization review, patients who receive their managed care coverage through an employee benefit plan and who are unhappy with the quality or quantity of benefits received sue the MCO under a state law cause of action. The cause of action usually (but not always) is negligence, and it may be based on either a theory of direct liability or vicarious liability for the negligence of others. Second, in response to MCOs' ex ante efforts to limit the scope of coverage provided, state governments have enacted statutes requiring MCOs operating in their state to provide minimum levels of benefits and services. The managed care industry has sought judicial determinations that ERISA preempts such private lawsuits and public legislation. The remainder of this part describes the textual background for these claims.

B. The Federal Regulation of Employee Benefits

ERISA was drafted in the early 1970s as a response to the mismanagement and subsequent failure of a number of employer-sponsored pension funds,²³ which resulted in employees receiving either a small percentage of their promised benefits or none at all.²⁴ The primary purpose of the statute was to regulate private-sector pension plans at the federal level and thus guarantee the solvency and integrity of such plans for the benefit of employ-

22. See, e.g., Edward B. Hirshfield & Gail H. Thomason, *Medical Necessity Determinations: The Need for a New Legal Structure*, 6 HEALTH MATRIX 3, 28–29 (1996). MCO's risk-sharing arrangements with their physicians are both complicated and varied. In many, perhaps most, utilization of expensive services impacts the earnings of both the MCO and its physicians. See *id.* at 29–30 (noting that financial arrangements between MCOs and providers vary); Carol J. Simon & David W. Emmons, *Physician Earnings at Risk: An Examination of Capitated Contracts*, HEALTH AFF., May–June 1997, at 120, 124–25.

23. See, e.g., *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 264 (1993) (White, J., dissenting); see generally JOHN H. LANGBEIN & BRUCE A. WOLK, *PENSION AND EMPLOYEE BENEFIT LAW* 68–84 (3d ed. 2000).

24. The legislative history of the statute is replete with such anecdotes. See, e.g., ERISA HISTORY, *supra* note 8, at 208 (comments of Senator Ribicoff regarding workers who had lost their pension rights). Perhaps the single most significant precipitating event of ERISA's enactment was the default of the Studebaker pension fund in 1963, which caused 11,000 employees to lose promised pension benefits. See generally LANGBEIN & WOLK, *supra* note 23, at 68–71; James A. Wooten, "The Most Glorious Story of Failure in the Business": *The Studebaker-Packard Corporation and the Origins of ERISA*, 49 BUFF. L. REV. 683 (2001).

ees.²⁵ In the drafting process, however, the scope of ERISA was expanded to provide federal oversight of all employer-sponsored fringe benefit plans,²⁶ including plans that provide for the medical care of employees.²⁷ Importantly, however, Congress gave very little explicit consideration to the implications of this expansion,²⁸ which occurred in the conference committee charged with reconciling competing House- and Senate-approved bills that were both more limited in scope.²⁹

Despite its broad scope, ERISA carefully avoids requiring employers to provide any particular set of fringe benefits, or any benefits at all, to their employees.³⁰ By federalizing employee benefits law, however, ERISA's drafters sought to provide legal uniformity for employers that administrate benefits plans.³¹ Uniformity was intended to reduce the administrative cost and inconvenience to multistate employers³² of offering employee benefits

25. See H.R. REP. NO. 93-533, at 1 (1973) ("The primary purpose of the bill is the protection of individual pension rights . . .").

26. See 120 CONG. REC. 29,933 (1974) (Senator Williams noting that ERISA will "reach any rule, regulation, practice or decision of any State . . . which would affect any 'employee benefit plan'" (emphasis added)).

27. *Id.* at 31,065.

28. See Catherine L. Fisk, *Lochner Redux: The Renaissance of Laissez-Faire Contract in the Federal Common Law of Employee Health Benefits*, 56 OHIO ST. L.J. 153, 165-66 (1995) (observing that in drafting ERISA, Congress gave "relatively little thought to the problem of health benefits"). It has been noted:

At the time of the law's passage, there appeared to be no reported news articles or abstracts of any detail discussing ERISA as having any significant impact on the delivery of group employee fringe benefits such as health care or insurance. The media focus on ERISA was one that treated the law as a pension law and not an all-consuming regulation. Jeffrey W. Stempel & Nadia von Magdenko, *Doctors, HMOs, ERISA, and the Public Interest After Pegram v. Herdrich*, 36 TORT & INS. L.J. 687, 688 n.6 (2001).

29. See Donald T. Bogan, *ERISA: The Savings Clause, § 502 Implied Preemption, Complete Preemption, and State Law Remedies*, 42 SANTA CLARA L. REV. 105, 118-19 (2001).

30. See, e.g., 120 CONG. REC. 4440 (1974) (Representative Archer noting that ERISA would not change the voluntary nature of benefit plans and cautioning the House that increasing the cost of such plans might cause employers to withdraw them).

31. See *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657 (1995); 120 CONG. REC. 29,942 (1974) (Senator Javits commenting that "the emergence of a comprehensive and pervasive Federal interest and the interests in uniformity . . . [required] the displacement of State action in the field of private employee benefit programs").

32. 120 CONG. REC. 29,933 (Senator Williams noting that ERISA preemption eliminates "the threat of conflicting or inconsistent regulation of employee benefit plans"); 120 CONG. REC. 29, 197 (Representative Dent stating that a purpose of ERISA is to "eliminat[e] the threat of conflicting and inconsistent state and local regulation"). See generally Howard Shapiro et al., *ERISA Preemption: To Infinity and Beyond and Back Again? (A Historical Review of Supreme Court Jurisprudence)*, 58 LA. L. REV. 997, 999 (1998) (asserting that ERISA's authors believed that without a uniform federal system, multistate employer plans "might be required to keep records in some states but not in others; to make certain benefits available in some states but not in others . . . and to comply with certain fiduciary standards in some states and not others").

plans and, indirectly, to make the voluntary provision of fringe benefits more attractive to them.³³

C. Statutory Structure

ERISA's purpose of federalizing employee benefits law is embodied in two different portions of the statute. Section 514³⁴ outlines the preemptive effect of ERISA on state laws. Section 502(a),³⁵ ERISA's remedy provision, both provides federal courts with jurisdiction over employee lawsuits against ERISA plans and limits the scope of available remedies, thus having the effect of preempting any broader remedies that might otherwise be provided under state law.

1. "Conflict Preemption": Section 514

Labeled "conflict preemption" by courts,³⁶ section 514 of ERISA seeks to define the range of state laws that conflict with the federal statute and thus are preempted by it. Understanding the statutory scheme requires an analysis of the interaction of three separate elements of this section.

a. The Relates-to Clause

Section 514's "relates-to" clause³⁷ (sometimes also called the "preemption clause"³⁸) explicitly proclaims ERISA's relationship vis-à-vis state laws. This clause provides that any state laws that "relate to" an employee benefits plan

33. See *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987). In the words of the Court: A patchwork scheme of regulation would introduce considerable inefficiencies . . . which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Pre-emption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations.

Id.

34. 29 U.S.C. § 1144(a) (2000).

35. *Id.* § 1132(a).

36. See, e.g., *Darcangelo v. Verizon Communications, Inc.*, 292 F.3d 181, 186–87 (4th Cir. 2002); *Funkhouser v. Wells Fargo Bank*, 289 F.3d 1137, 1141 (9th Cir. 2002); *Moran v. Rush Prudential HMO*, 230 F.3d 959, 966 (7th Cir. 2000); *Heimann v. Nat'l Elevator Indus. Pension Fund*, 187 F.3d 493, 499 n.1 (5th Cir. 1999); *Prudential Ins. Co. of Am. v. Nat'l Park Med. Ctr.* 154 F.3d 812, 818 n.4 (8th Cir. 1998).

37. See, e.g., *Egelhoff v. Egelhoff*, 532 U.S. 141, 153 (2001); *Cal. Div. of Labor Stds. Enforcement v. Dillingham Constr.*, 519 U.S. 316, 336 (1997).

38. See, e.g., *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 363 (1999); *Humana Inc. v. Forsyth*, 525 U.S. 299, 310 (1999); *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 653 (1995); *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99 (1993).

are “superseded” by the federal statute.³⁹ While the relates-to clause makes clear that the statute has a preemptive intent, it is unclear as to the extent of the preemption. Any law can be said, with some plausibility, to bear some “relation” to any other law. The question, unanswered by the statutory text, is what type, and how close, of a relationship, is required for ERISA to invalidate a state law.

b. The Savings Clause

The “savings” clause of section 514 limits the preemptive expanse of ERISA, as proclaimed by the relates-to clause, by carving out a safe harbor for state laws that “regulate insurance.”⁴⁰ The clear intent of this provision is to prevent the relates-to clause from being read so broadly as to supercede the myriad, complicated, and historically rooted regulation of the business of insurance by state legislators and regulators.⁴¹ An unstated implication of the savings clause is that ERISA does not seek to provide regulatory uniformity to insurance companies that operate in multiple states in the way that it seeks to provide regulatory uniformity to multistate employers: The savings clause protects the ability of the fifty states to enact different and inconsistent insurance regulations.

c. The Deemer Clause

Finally, the “deemer” clause limits the safe harbor provided to state legislators by the savings clause by clarifying that self-insured employee benefits plans cannot be “deemed” insurance companies by the states in order to ensure that “saved” insurance regulations apply to them.⁴² In other words, if

39. 29 U.S.C. § 1144(a) (“Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan . . .”) (emphasis added).

40. 29 U.S.C. § 1144(b)(2)(A) (“Except as provided in subparagraph (B), 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.*” (emphasis added)).

41. See *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985) (“We . . . must presume that Congress did not intend to pre-empt areas of traditional state regulation.”); *Chamblin v. Reliance Standard Life Ins. Co.*, 168 F. Supp. 2d 1168, 1176 (N.D. Cal. 2001) (“When Congress enacted ERISA in 1974, it made clear that it did not intend to encroach on the power of the states to regulate the insurance industry.”).

42. 29 U.S.C. § 1144(b)(2)(B). The deemer clause provides:

Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), 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

an employer acts like an insurance company in the process of providing a set of benefits to its employees—for example, by promising to pay all the medical expenses incurred by its employees in the future⁴³—state insurance regulations cannot apply in that circumstance.⁴⁴ For purposes of the savings clause, insurance regulations may only regulate companies in the business of selling insurance, not companies in the business of providing some other good and/or service that happens to insure their employees as a fringe benefit.

d. The Effect of Conflict Preemption

To summarize, the relates-to clause describes the preemptive scope of ERISA in relation to state laws, but its expanse is limited by the savings clause, the expanse of which is, in turn, limited by the deemer clause. When these three clauses, read together, suggest that a state law is preempted, a defendant that is sued by an employee-plaintiff under state law can invoke preemption as a defense and succeed in having the state law claim dismissed.⁴⁵ The employee plaintiff then can maintain only a claim brought under ERISA and limited by the remedies ERISA provides.⁴⁶ Because, as discussed below, ERISA's remedies are circumscribed, an employee's claims brought under ERISA often will be less valuable than a claim brought under a relevant state law.

any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

Id.

43. "Self-insured" or "self-funded" employers may either set aside funds to pay employee benefit claims or pay those claims out of their general funds. Either way, the employer bears the risk of loss rather than paying a third party to bear that risk. See Troy Paredes, *Stop-Loss Insurance, State Regulation, and ERISA: Defining the Scope of Federal Preemption*, 34 HARV. J. ON LEGIS. 233, 234 (1997).

44. See *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) ("State laws that directly regulate insurance are 'saved' but do not reach self-funded employee benefit plans . . .").

45. See *Stewart v. U.S. Bancorp*, 297 F.3d 953, 958 (9th Cir. 2002) (holding that the dismissal of a state law claim for failure to state a claim because it was preempted by ERISA was a dismissal on the merits); see also *Caffey v. UNUM Life Ins. Co.*, 302 F.3d 576, 582 (6th Cir. 2002); *Ceccanecchio v. Cont'l Cas. Co.*, 50 Fed. Appx. 66, 69 (3d Cir. 2002); *Cox v. Reliance Standard Life Ins. Co.*, 43 Fed. Appx. 606, 608 (4th Cir. 2002).

46. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). The Court reasoned:

The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. "The six carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted . . . provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly."

Id. (quoting *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)).

2. "Complete Preemption": Section 502(a)

ERISA's section 502(a) authorizes a beneficiary of an ERISA plan to file a civil suit "to recover benefits due to him under the terms of his plan" or "to enforce his rights under the terms of the plan."⁴⁷ Sometimes called the "complete preemption" clause,⁴⁸ section 502(a) provides federal court jurisdiction for lawsuits brought by ERISA plan beneficiaries and limits the range of remedies permitted to them.⁴⁹ The first consequence of this section is that a defendant may remove a lawsuit seeking ERISA benefits filed in state court to federal court even if the plaintiff does not plead a federal law violation.⁵⁰ The second consequence is that the remedies available for a claim that a defendant has failed to provide an obligatory employee benefit are limited to the benefit due,⁵¹ plus costs and attorneys fees.⁵² This means that under ERISA, an employee who fails to receive a fringe benefit promised by his employer can sue to recover that benefit, but he can recover neither punitive damages⁵³ nor, under the Supreme Court's interpretation of the statute, consequential damages that resulted from the employer's failure to provide the benefit.⁵⁴

47. 29 U.S.C. § 1132(a).

48. See, e.g., *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1487 (7th Cir. 1996) (noting "a claim brought 'under ERISA, [section] 502(a) provides the basis for complete preemption'" (quoting *Rice v. Panchal*, 65 F.3d 637, 639 (7th Cir. 1993))).

49. See *Rice*, 65 F.3d at 640 (noting that complete preemption under section 502(a) creates federal question jurisdiction and that a claim within the scope of section 502(a) limits a litigant's ability to recover damages).

50. The "well-pleaded complaint" rule generally requires that a plaintiff raise issues of federal law in her complaint in order to invoke federal subject matter jurisdiction. See *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987). However, if federal law so thoroughly occupies a field such that facts pled by the plaintiff are "necessarily federal in character," the complete preemption doctrine allows the defendant to remove the case to federal court. *Id.* at 63–64. In *Metropolitan Life*, the Supreme Court interpreted section 502(a) to completely preempt state law claims to recover ERISA benefits. *Id.* at 66.

51. 29 U.S.C. § 1132(a)(1)(B).

52. *Id.* § 1132(g)(1) ("[T]he court in its discretion may allow a reasonable attorney's fee and costs of action to either party.").

53. See, e.g., *Rush Prudential HMO v. Moran*, 536 U.S. 355, 377 (2002) (damages for emotional distress and punitive damages unavailable under ERISA); *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985) (noting that detailed ERISA enforcement provisions provide strong evidence that Congress did not intend to authorize non-enumerated remedies); *Medina v. Anthem Life Ins. Co.*, 983 F.2d 29, 32 (5th Cir. 1993) (ERISA provides no right to recover punitive or extracontractual damages).

54. See *Mertens v. Hewett Assocs.*, 508 U.S. 248, 255–62 (1993) (finding that section 502(a)(3)'s provision for "other appropriate equitable relief" does not include consequential damages); see also *Russell*, 473 U.S. at 144 (finding nothing in the text of section 502(a) "to support . . . a private right of action for compensatory or punitive relief"); cf. *Cicio v. Does*, 321 F.3d 83, 106–10 (2d Cir. 2003) (Calabresi, J., dissenting) (arguing that section 502(a) should be interpreted to allow consequential damages).

Both aspects of section 502(a) are consistent with the policy goals that underlie ERISA generally. Federal court jurisdiction is consistent not only with ERISA's main purpose of protecting employees who do not receive promised benefits, but also with its goal of providing legal uniformity to multistate employers. Federal jurisdiction of benefits claims can allow for the development of a uniform federal common law rather than fifty different sets of state common law. Limitations on remedies are consistent with the statute's purposes of ensuring the solvency of employee benefits plans and encouraging employers to provide fringe benefits. The possibility of large judgments against a plan could discourage employers from offering fringe benefits in the first instance, and an actual large award potentially could render a plan insolvent and thus unable to provide promised benefits to other employees.

D. The Lynchpin of Managed Care Regulation: What Constitutes an ERISA Plan Benefit?

Both sections 514 and 502(a), of course, seek to shelter from the effects of state law only ERISA-qualified employee welfare benefits plans (ERISA plans), not every action that an employer might take or all controversies involving the employment relationship. Neither of these two sections would apply, for example, if a state enacted a law prohibiting sexual harassment in the workplace, or if an employee sued an employer for sexual harassment. In such circumstances, the state law at issue clearly would not "relate to" an ERISA plan, nor would the employee be seeking to recover ERISA plan benefits.

Unfortunately, ERISA provides scant textual guidance concerning the precise extent of the statute's scope. In a provision that the Supreme Court has called "ultimately circular,"⁵⁵ ERISA defines an "employee welfare benefit plan" as "any plan, fund, or program . . . established or maintained by an employer or by an employee organization"⁵⁶ . . . for the purpose of providing . . . through the purchase of insurance or otherwise . . . (A) medical, surgical, or hospital care, or benefits . . ."⁵⁷ The statute is completely silent as to what precisely constitutes an "employee welfare benefit plan benefit" or an "ERISA plan benefit."

The statutory definition of an "employee welfare benefit plan" includes an employer-maintained "program . . . for the purpose of providing . . . medi-

55. Pegram v. Herdrich, 530 U.S. 211, 222 (2000).

56. An "employee organization" is defined as a labor union or other association of employees formed in whole or in part to deal with employers on behalf of employees. See 29 U.S.C. § 1002(4).

57. *Id.* § 1002(1).

cal . . . benefits,”⁵⁸ thus clearly implying that an employer’s promise to directly provide particular healthcare services would fall within the boundaries of the statute. Thus, if an employer promised to provide employees with a series of vaccinations, this vaccination program would constitute an employee welfare benefit plan and, by inference, the vaccinations would constitute ERISA plan benefits. If the employer failed to provide the vaccinations, aggrieved employees would be limited to the federal remedies provided by section 502(a) of ERISA. If the employer did not include the polio vaccine among its group of promised vaccinations and the state enacted a statute requiring all employers to provide a polio vaccine, the employer could claim that the statute relates to an ERISA plan and is preempted under section 514 (unless saved by the savings clause) because it specifies benefits ERISA plans are obligated to provide.

The statement that a qualifying ERISA plan might “purchase . . . insurance”⁵⁹ suggests that an ERISA plan need not provide services to employees directly, but rather might contract with third parties to provide benefits such as medical services. Thus, if an ERISA plan promises to purchase a health insurance policy for employees as a fringe benefit and then fails to do so, the implication would seem identical to that of the ERISA plan that promises to provide vaccinations but fails to do so. Any subsequent lawsuit brought by an employee against the employer for failing to provide the insurance policy would both relate to an ERISA plan and seek the provision of an ERISA plan benefit (and thus be limited to ERISA’s statutory remedies). A state law requiring an employer to purchase insurance for its employees, or specifying what insurance it must purchase, would seem to relate to ERISA plans as well by creating obligations for them, and thus would be subject to preemption.

What is not clear from the statutory language is whether the same analysis applies if the employer purchases a set of benefits for the employee from a third-party contractor that fails to live up to its contractual obligations to the employee; or, alternatively, if the state attempts to regulate the third party in ways that affect what it can or cannot provide for employees pursuant to a contract with an employer. For example, consider the following not-so-hypothetical situations:

Case 1. Firm purchases an MCO membership for Employee as a fringe benefit. MCO promises to provide all “medically necessary” care to

58. *Id.*

59. *Id.*

Employee. Employee believes MCO fails to provide "medically necessary" care and files suit against MCO.⁶⁰

Case 2. Firm purchases an MCO membership for Employee as a fringe benefit. MCO promises to provide all "medically necessary" care to Employee. State enacts a law defining the term "medically necessary" as used by MCOs in their contracts.⁶¹ MCO files suit against State.

In Case 1, Employee is suing for a "benefit," in the sense that Employee is a third-party beneficiary of a contract between Firm and MCO. But is Employee suing for an ERISA plan benefit, thus invoking the remedial provisions of section 502(a), or is the ERISA plan benefit only the insurance contract that was promised (and provided) by the employer? In Case 2, the law enacted by State clearly relates to an MCO's benefit plan because it regulates the terms of that plan. But does the law relate to Firm's ERISA plan, thus raising the possibility of section 514 conflict preemption because it affects the ERISA plan's purchase options, or does it not relate to Firm's ERISA plan because it imposes no obligations on Firm?

The Supreme Court and the lower federal courts uniformly have assumed that the specific services promised by an employer's third-party contractor are, in fact, ERISA plan benefits,⁶² although the Court never has analyzed this issue in detail. This determination—almost always made implicitly rather than explicitly⁶³—is neither clearly consistent nor clearly inconsistent with

60. See, e.g., *Hull v. Fallon*, 188 F.3d 939, 941 (8th Cir. 1999) (denial of thallium stress test); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1485 (7th Cir. 1996) (denial of physical therapy following knee replacement surgery); *Kuhl v. Lincoln Nat'l Health Plan, Inc.*, 999 F.2d 298, 299–300 (8th Cir. 1993) (denial of heart surgery); *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1322–24 (5th Cir. 1992) (denial of hospitalization for a high-risk pregnancy).

61. See, e.g., *Corporate Health Ins., Inc. v. Tex. Dep't of Ins.*, 220 F.3d 641 (5th Cir. 2000) (involving health plans and insurers that sought declaration that ERISA preempts the Texas Health Care Liability Act); see also Texas Health Care Liability Act, 1997 Tex. Sess. Law. Serv. ch. 163 (Vernon) (codified as amended in scattered sections of TEX. CODE ANN.).

62. Cf. Sharon J. Arkin, *Tort Actions Against Health Maintenance Organizations and Their Doctors*, 23 WHITTIER L. REV. 609, 612 (2002) ("[A]s a practical matter, any time the benefit is provided through employment it should be presumed . . . that the benefit is part of an ERISA plan." (citation omitted)).

63. The only statements made by the Court directly on point came in *Pegram v. Herdrich*, decided twenty-six years after ERISA's enactment. See *Pegram v. Herdrich*, 530 U.S. 211, 223 (2000) (determining that benefits provided by an HMO paid for by an employer are part of the ERISA plan). In two cases in the 1980s, the Court focused its attention on the definition of a plan in deciding whether a one-time benefit could constitute an ERISA plan, see *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 7–8 (1987) (finding that a one-time severance payment is not a "plan"), and focused its attention on the definition of a welfare benefit plan in deciding whether vacation pay constitutes such an ERISA plan, see *Massachusetts v. Morash*, 490 U.S. 107, 115 (1989) (holding that vacation pay is similar to salary and thus not an ERISA plan). These inquiries,

ERISA's text, because the statute never describes what constitutes an ERISA plan benefit. The courts' determination that services promised by third-party MCOs are ERISA plan benefits, however, has had far-reaching consequences. This subtle interpretive decision, is, in fact, the primary foundation of a body of law concerning the regulation of managed care that is illogical, internally inconsistent, and at odds with the underlying goals of ERISA.

The better reading of ERISA is that the benefits due to employees as a result of third-party beneficiary contracts are not *ERISA plan* benefits at all—only the insurance contract or the MCO membership is a plan benefit. To better understand the logic of this distinction, consider the following metaphor: Suppose that an employer promises to provide an employee a holiday gift basket at the end of the calendar year as a fringe benefit of employment. Come December, the employer purchases a gift basket filled with candies, nuts, and cheeses and wrapped in festive cellophane and ribbons from a well-known retailer of foods and gifts and has the retailer deliver the basket to the employee. The employee takes home and unwraps the basket, only to find that one of the food items supposed to be inside is defective or missing. At this point, the disappointed employee would have a valid complaint against the retailer for failing to provide all the food items for which the employer paid. But the failure of the retailer to provide the benefits it promised the employer (specific foods) does not suggest that the employer failed to provide the benefit it promised the employee (a gift basket). The employee is unlikely to believe that the employer failed to satisfy its obligation; his ire or disappointment likely, and properly, would be directed toward the retailer. In the same way, the failure of an MCO to fulfill a specific obligation to employees that it promised to the employer (say, to provide care nonnegligently) does not suggest that the employer failed to provide the benefit (the MCO membership) that it promised the employee,⁶⁴ and few employees are likely to blame their employer for the failures of their MCO.

To extend the metaphor, now suppose that the state enacts a statute that requires all commercial sellers of gift baskets to include a certain number of cheese products in each gift basket sold. Obviously the law relates to gift baskets because it places restrictions on their content. But it does not relate

however, are distinct from the issue raised in this Article; namely, what benefits should constitute *ERISA plan* benefits as opposed to benefits arising from a non-ERISA source or plan.

64. In an extreme case, so many items might be defective or missing that the employee could contend that the employer did not in fact provide a gift basket, under any reasonable definition of that concept—for example, if there were a lone piece of fruit inside the cellophane wrapping. Similarly, if an employer promised healthcare coverage and then provided an employee membership in an MCO that had no physicians or hospitals, the employee might fairly argue that the employer had failed to provide the promised ERISA plan benefit. But this is a rare, if not nonexistent, complaint in the context of litigation concerning ERISA.

to employers or their ERISA plans, even if some ERISA plans purchase commercial gift baskets, because ERISA plans can choose not to provide gift baskets at all or to make gift baskets for their employees themselves. To the extent that any employer purchases gift baskets for its employees, it would be plausible linguistically to argue that the new statute has an extremely attenuated relationship to ERISA plans because the statute affects the range of market options that the plan may select. To make this argument, however, would be to claim that a very broad range of state laws (perhaps most) relate to ERISA plans and are preempted.

Differentiating between the ERISA plan benefits promised by an employer to its employees and the specific medical benefits promised by an MCO to its members logically leads to the following two conclusions:

- (1) Patient lawsuits against MCOs brought under state law are not claims for ERISA plan benefits preempted by section 502(a), nor are they subject to section 514 conflict preemption because the state common law underlying such lawsuits has no relationship to ERISA plans themselves.
- (2) State statutes governing MCOs do not suffer conflict preemption because they too have no relation to ERISA plans, and patients seeking to vindicate their statutory rights under state law do not face complete preemption under section 502(a) because the benefits they seek are not ERISA plan benefits.

If the Supreme Court recognized a distinction between an ERISA plan benefit and an MCO medical benefit, it could rectify the troubling consequences of its managed care jurisprudence, and the resulting body of law would be consistent with both ERISA's text and its underlying intent. The following parts of this Article describe the doctrinal problems created by the courts' critical interpretive failure, and the benefits that can be attained with a single, small doctrinal adjustment.

II. THE PRIVATE REGULATION OF MANAGED CARE: SUING MCOs

When a physician provides treatment that fails to meet the customary standard of care and that failure causes an injury to the patient, the patient has a cause of action against the physician for malpractice.⁶⁵ In such circumstances, courts also have found that organizations in which physicians operate, such as hospitals, can be sued for their negligence in operating the facility and

65. See, e.g., FURROW ET AL., *supra* note 14, § 6.2 at 264.

screening⁶⁶ or supervising⁶⁷ personnel, as well as for the negligence of employees and subcontractors under theories of vicarious liability.⁶⁸ Health insurance providers who fail to provide promised benefits are subject to breach of contract claims that can include recovery for consequential damages suffered⁶⁹ and potentially for punitive damages if the breach was committed in "bad faith."⁷⁰ Courts have found MCOs subject to state law actions on each of these bases as well when the claims are brought by patients who did not receive their health coverage through an employer.⁷¹

When a patient receives her MCO benefits as a fringe benefit of employment, however, the federal courts have held that the patient's legal rights are severely limited. Prior to 1995, most federal courts held that ERISA preempted any and all state law claims against MCOs if the patient received her MCO membership through an employer, thus limiting patients to a federal law ERISA action and its associated limited remedies. A landmark Supreme Court decision in 1995 somewhat reduced the extent of ERISA preemption but failed to rationalize the law of managed care or make it consistent with ERISA's underlying purposes.

66. See, e.g., *In re U.S. Healthcare, Inc.*, 193 F.3d 151, 161 (3d Cir. 1999); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 352 (3d Cir. 1995); *Bell v. Sharp Cabrillo Hosp.*, 260 Cal. Rptr. 886, 886-87 (Ct. App. 1989); *Humana Med. Plan, Inc. v. Erdely*, 785 So. 2d 714 (Fla. Dist. Ct. App. 2001); *Appalachian Regional Health Care, Inc. v. Johnson*, 862 S.W.2d 868, 869 (Ky. 1993); *Ruacho v. Aetna U.S. Healthcare, Inc.*, No. 3:00-CV-1861-L, 2001 U.S. Dist. LEXIS 16053 at *22 (N.D. Tex. Oct. 4, 2001).

67. See, e.g., *In re U.S. Healthcare*, 193 F.3d at 161; *Cahill v. HCA Mgmt. Co.*, 812 F.2d 170, 171 (4th Cir. 1987); *Herrera v. Lovelace Health Sys.*, 35 F. Supp. 2d 1327, 1331 (D.N.M. 1999); *Fritts v. Khoury*, 933 F. Supp. 668, 670-72 (E.D. Mich. 1996); *Elsesser v. Hosp. of the Phil. Coll. of Osteopathic Med.*, 802 F. Supp. 1286, 1290-91 (E.D. Pa. 1992).

68. See, e.g., *Gilbert v. Sycamore Muni. Hosp.*, 622 N.E.2d 788, 794 (Ill. 1993); *Hardy v. Brantley*, 471 So. 2d 358, 371 (Miss. 1985); *Johnson v. LeBonheur Children's Med. Ctr.*, 74 S.W.3d 338, 347 (Tenn. 2002).

69. See, e.g., *Washington v. Group Hospitalization, Inc.*, 585 F. Supp. 517 (D.D.C. 1984); *Aetna Health Plans, Inc. v. Yucaipa-Calimesa Joint Unified Sch. Dist.*, 85 Cal. Rptr. 2d 672, 677 n.5 (Ct. App. 1999); *Collier v. MD-Individual Practice Ass'n, Inc.*, 607 A.2d 537, 542-43 (Md. 1992); *Batas v. Prudential Ins. Co. of Am.*, 724 N.Y.S.2d 3, 11-12 (App. Div. 2001).

70. See, e.g., *Group Hospitalization*, 585 F. Supp. at 520-21; *Aetna Health Plans*, 85 Cal. Rptr. 2d at 677 n.5; *Valerio v. HMO Colo., Inc.*, 957 P.2d 1057 (Colo. Ct. App. 1998); *McEvoy v. Group Health Coop.*, 570 N.W.2d 397, 405 (Wis. 1997); see *Epstein & Sykes*, *supra* note 18, at 632 ("[M]any states now allow punitive damages against insurers who deny coverage without a reasonable basis for doing so (denial of coverage in 'bad faith').").

71. See, e.g., *Jones v. Chicago HMO Ltd.*, 730 N.E.2d 1119, 1135 (Ill. 2000) (finding an MCO directly liable for negligence in a non-ERISA case); *Petrovich v. Share Health Plan, Inc.*, 719 N.E.2d 756, 775 (Ill. 1999) (finding an MCO vicariously liable for physician negligence in a non-ERISA case); *McEvoy*, 570 N.W.2d at 405 n.6 (noting that a tort claim for bad faith breach was permissible against an MCO in a non-ERISA case).

A. The Die Is Cast

1. *Pilot Life* and the Early Law of Managed Care

In the 1980s and early 1990s, the federal courts consistently ruled that ERISA preempted state law causes of action against MCOs brought by patients who received their healthcare coverage as an employer-provided benefit.⁷² The primary Supreme Court precedent for this rule of near-blanket preemption was *Pilot Life Insurance Co. v. Dedeaux*,⁷³ a case involving a state law tort suit against a disability insurance company for allegedly breaching its contractual obligations in bad faith.⁷⁴ In holding that the plaintiff, who received a disability insurance policy as an employer-sponsored fringe benefit, could not maintain his state law claim against the insurer, the Court analyzed ERISA's sections 514 and 502(a).⁷⁵

Citing the relates-to clause test laid down in *Shaw v. Delta Airlines*,⁷⁶ the Court determined that section 514 should be read broadly, so as to preempt any state law that makes "reference to" or has a "connection with" an ERISA plan.⁷⁷ The Court found that the state common law at issue "undoubtedly" ran afoul of the relates-to clause and thus fell within the ambit of preemption under section 514 because *Dedeaux* sought relief for "improper processing of a claim for benefits under an employee benefit plan."⁷⁸

An analysis of the limitations that the savings clause places on the relates-to clause also was required before concluding that lawsuits against MCOs

72. The leading case was *Corcoran v. United HealthCare*, 965 F.2d 1321, 1331 (5th Cir. 1992) (holding that all claims against an MCO arising out of a decision not to provide extended hospitalization following a high-risk pregnancy are preempted because it was a decision made "in the context of making a determination about the availability of benefits under the plan"); see also *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 133 (9th Cir. 1993); *Kuhl v. Lincoln Nat'l Health Plan, Inc.*, 999 F.2d 298, 303-04 (8th Cir. 1993); *Pomeroy v. Johns Hopkins Med. Servs., Inc.*, 868 F. Supp. 110, 111-16 (D. Md. 1994); *Visconti ex rel Visconti v. U.S. Health Care*, 857 F. Supp. 1097, 1105 (E.D. Pa. 1994), *rev'd by Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 361 (3d Cir. 1995); *Ricci v. Gooberman*, 840 F. Supp. 316, 318 (D.N.J. 1993).

Some federal district courts (but no circuit courts) allowed state law claims against MCOs if the patient's cause of action against the MCO was derivative of a primary claim against a physician for malpractice—that is, when the patient alleged vicarious liability rather than direct liability based on the MCO's conduct. See *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544, 549 (S.D. Ill. 1994); *Stroker v. Rubin*, Civ. A. No. 94-5563, 1994 WL 719694, at *10 (E.D. Pa. 1994); *Dearmas v. Av-Med, Inc.*, 865 F. Supp. 816, 818 (S.D. Fla. 1994); *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182, 188 (E.D. Pa. 1994); *Smith v. HMO Great Lakes*, 852 F. Supp. 669, 673 (N.D. Ill. 1994).

73. 481 U.S. 41 (1987).

74. *Id.* at 43-48.

75. *Id.* at 44-57.

76. 463 U.S. 85 (1983).

77. *Pilot Life*, 481 U.S. at 47-48; *Shaw*, 463 U.S. at 96-97.

78. *Pilot Life*, 481 U.S. at 48.

are preempted. In its first case analyzing the savings clause, *Metropolitan Life Insurance v. Massachusetts*,⁷⁹ the Court held that a state law “regulates insurance” and thus that the savings clause was invoked, if (a) the state law in question had a “common sense” relationship to the business of insurance and (b) the law also satisfied the McCarran-Ferguson Act’s three-pronged test for whether a law constitutes an insurance regulation, including whether the law affects the spread of insurance risk and is limited to entities in the insurance industry.⁸⁰ Applying this test in *Pilot Life*, the Court found that Mississippi’s law permitting lawsuits for bad faith breach of contract was not saved, primarily because its application was not limited to insurance providers but rather, theoretically, could be employed in lawsuits against noninsurers.⁸¹

The Court explained that its savings clause analysis also relied on its understanding of ERISA as a whole, and particularly the statute’s remedial provisions.⁸² Section 502(a), the court explained, provided an exclusive list of remedies for claims, like the plaintiff’s, that seek “benefits under an ERISA-regulated plan,” thus requiring that the plaintiff’s suit should be preempted.⁸³ Thus, although the opinion concludes with the statement that the plaintiff’s claims are preempted by section 514,⁸⁴ the Court’s analysis of section 502(a) was integral to that determination suggesting that the latter section could have served as an independent basis for finding preemption.

Relying on *Pilot Life*, lower federal courts subsequently found—almost without exception—that ERISA preempted state lawsuits by patients concerning MCO benefits, such as claims of malpractice, other forms of negligence, or bad faith breach of contract, if the patient received her MCO membership through an employer. Depending on the court, the statutory

79. 471 U.S. 724 (1985).

80. *Id.* at 740–43. The McCarran-Ferguson Act test has three components: (1) whether the regulation has the effect of transferring or spreading a policyholder’s risk; (2) whether the regulation is integral to the policy relationship between the insurer and the insured; and (3) whether the regulation is limited to entities within the insurance industry. *Id.* at 743 (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)). In *Kentucky Ass’n of Health Plans v. Miller, Inc.*, 123 S. Ct. 1471 (2003), the Supreme Court jettisoned its use of the McCarran-Ferguson test in the ERISA savings clause context. See *infra* Part IV.C.

81. *Pilot Life*, 481 U.S. at 50.

82. *Id.* at 51.

83. *Id.* at 52.

84. *Id.* at 57.

source of this preemption could be section 514,⁸⁵ section 502(a),⁸⁶ or both.⁸⁷ Since remedies available under a federal law ERISA claim do not include pain and suffering damages,⁸⁸ much less the possibility of punitive damages,⁸⁹ in many instances preemption left patients without a useful remedy against the MCOs—a point routinely acknowledged by judges who felt that, nonetheless, their hands were tied by Congress and/or the Supreme Court.⁹⁰

2. Inconsistent Implications for the Jurisprudence of Managed Care

Whatever the policy merits of a rule precluding most state lawsuits against MCOs, the Court's decision in *Pilot Life* is troubling because of the logical inconsistencies in the law of managed care that it created. The first such inconsistency is that the majority of patients who receive their MCO membership through an ERISA plan lack legal rights available to other patients enrolled in the same MCO. MCO members whose claims would not be subject to preemption include not only the relatively few individuals who purchase individual memberships directly from the MCO, but also the large group of patients who receive coverage through the government, includ-

85. See *Corcoran v. United Health Care, Inc.*, 965 F.2d 1321, 1334 (5th Cir. 1992) (holding that a tort action for wrongful death did not constitute a state regulation of insurance for purposes of the savings clause); see also *Rodriguez v. Pacificare, Inc.*, 980 F.2d 1014, 1017 (5th Cir. 1993); *Ramirez v. Inter-Cont'l Hotels*, 890 F.2d 760, 762–63 (5th Cir. 1989); *Dearmas v. Av-Med, Inc.*, 865 F. Supp. 816, 817–18 (S.D. Fla. 1994); *Butler v. Wu*, 853 F. Supp. 125, 129 (D.N.J. 1994); *Ricci v. Gooberman*, 840 F. Supp. 316, 317 (D.N.J. 1993); *Diaz v. Tex. Health Enters.*, 822 F. Supp. 1258, 1261 (W.D. Tex. 1993).

86. See, e.g., *Lafoy v. HMO Colo.*, 988 F.2d 97, 99–100 (10th Cir. 1993); *Kanne v. Conn. Life Ins. Co.*, 867 F.2d 489, 494 (9th Cir. 1988); *Jones v. Tex. Health Choice, L.C.*, No. 4:02-CV-388, 2003 WL 302217, at *7 (E.D. Tex. Feb. 7, 2003); *Masucci v. Chiu*, No. Civ. A. 02-10949-RWZ, 2003 WL 192165, at *1 (D. Mass. Jan. 28, 2003); *Healey v. Thompson*, 186 F. Supp. 2d 105, 118 (D. Conn. 2001); *Klover v. Antero Healthplans*, 64 F. Supp. 2d 1003, 1009 (D. Colo. 1999); *Stroker v. Rubin*, No. Civ. A. 94-5563, 1994 WL 719694, at *5–*7 (E.D. Pa. Dec. 22, 1994).

87. See, e.g., *Cicio v. Does*, 321 F.3d 83, 92–97 (2d Cir. 2003); *Haynes v. Prudential Health Care*, 313 F.3d 330, 333–34 (5th Cir. 2002); *Roark v. Humana, Inc.*, 307 F.3d 298, 305 (5th Cir. 2002); *Bell v. UNUM Provident Corp.*, 222 F. Supp. 2d 692, 696 (E.D. Pa. 2002); *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966, 970–74 (S.D.N.Y. 1994); *Craft v. Northbrook Life Ins. Co.*, 813 F. Supp. 464, 469 (S.D. Miss. 1993).

88. See *Hemelt v. U.S.*, 122 F.3d 204, 208 (4th Cir. 1997) (“ERISA actions are not designed to compensate for these intangible injuries . . .”).

89. See *Rush Prudential HMO v. Moran*, 536 U.S. 355, 377 (2002) (citing *Mass. Mut. Life Ins. Co. v. Russel*, 473 U.S. 134, 148 (1985)).

90. Cf. *Corcoran*, 965 F.2d at 1338 (noting that ERISA preemption of a state malpractice claim “means that the [plaintiffs] have no remedy, state or federal, for what may have been a serious mistake”).

ing government employees (whose employment benefits are not subject to ERISA)⁹¹ and participants in Medicare⁹² or Medicaid.⁹³

A second inconsistency created by *Pilot Life* is that in most circumstances ERISA shields MCOs, but not physicians and hospitals, from tort liability. Consider a common institutional arrangement for the provision of medical care: Employer contracts with MCO to provide healthcare for its employees, including Patient; MCO then contracts with Hospital to provide emergency medical care to Patient and with Physician to provide primary care to Patient. If Patient sues MCO, this action has an attenuated affect on Employer, because Employer purchases services from MCO. But if Patient sues Hospital or Physician, this also has an attenuated affect on Employer, because MCO purchases services from Hospital and Physician, packages them, and then resells them to Employer. In either case, litigation and liability costs can increase Employer's expenses in the following year. Yet no court has ever ruled that ERISA preempts malpractice actions against physicians brought by patients whose health insurance or MCO membership is paid for by his employer.⁹⁴

A third inconsistency is that *Pilot Life* suggests that the rights of identically situated patients to sue their MCOs depend on whether their states explicitly specify that insurers are proper defendants in tort or contract suits. The Mississippi bad faith breach of contract statute at issue in *Pilot Life* was a law of general applicability, but most states recognize a specific tort for bad faith breach of an insurance contract.⁹⁵ *Pilot Life* implies that patients in those states could sue their MCOs under state law. It also implies that patients in Mississippi could sue their MCOs under state law if Mississippi simply enacted a separate bad faith statute limited to the insurance

91. See *McEvoy v. Group Health Coop.*, 570 N.W.2d 397, 405 n.6 (Wis. 1997).

92. See *Ardary v. Aetna Health Plans, Inc.* 98 F.3d 496 (9th Cir. 1996) (finding that a state law claim against a Medicare provider for its failure to provide treatment was not preempted by ERISA or the Medicare Act); see also *Hofler v. Aetna US Healthcare, Inc.*, 296 F.3d 764, 768–70 (9th Cir. 2002); *Kelly v. Advantage Health, Inc.*, No. Civ A 99-0362, 1999 WL 294796, at *1 (E.D. La. May 11, 1999); *Plocica v. Nylcare, Inc.*, 43 F. Supp. 2d 658 (N.D. Tex. 1999); *Wartenberg v. Aetna U.S. Healthcare, Inc.*, 2 F. Supp. 2d 273 (E.D.N.Y. 1998); *Caputo v. U.S. Health Care Sys.*, No. Civ A 97-5542, 1998 WL 808611, at *1 (E.D. Pa. Nov. 23, 1998); *Berman v. Abington Radiology Assocs., Inc.*, No. Civ A 97-3208, 1997 WL 534804, at *3 (E.D. Pa. 1997).

93. See *Wickline v. California*, 239 Cal. Rptr. 2d 810 (Ct. App. 1986) (finding no preemption issue for a state law claim against a Medicaid provider for its negligent denial of treatment).

94. Cf. *Lancaster ex rel. Lancaster v. Kaiser Found. Health Plan*, 958 F. Supp. 1137, 1149 (E.D. Va. 1997) (finding that ERISA does not apply to medical actions by treating physicians); *Dearmas v. Av-Med, Inc.*, 865 F. Supp. 816, 818 (S.D. Fla. 1994) (finding ERISA preemption of a negligence claim against an HMO, but sustaining a malpractice action against the physician defendants).

95. See Richard J. Kohlman, *Bad Faith Tort Remedy for Breach of Contract*, 34 AM. JUR. TRIALS 343, 394 (1987).

industry, even though doing so would not otherwise expand insurers' liability.⁹⁶ Similarly, although *Pilot Life* strongly suggests that ERISA preempts a common law negligence suit brought against an MCO that sells coverage to employer groups (and has been interpreted by lower courts as doing just this), its reasoning implies that preemption would be improper if a state simply enacted a specific tort of "negligent provision of health insurance" to complement its common law of torts.

The illogic of these implications can be attributed to the difference in interpretive approach the Court employed to explicate the relates-to clause and the savings clause of ERISA's section 514. The *Pilot Life* Court and the lower courts that followed read both prongs of the *Shaw* relates-to clause test extremely broadly. A state law that makes "reference to" ERISA plans in order to regulate them clearly conflicts with ERISA.⁹⁷ But this prong of the *Shaw* preemption test was interpreted extremely formalistically to mean also that any state law that so much as mentioned the topic of ERISA plans was preempted.⁹⁸ The "connection with" portion of the test was read even more

96. To avoid this absurd implication of *Pilot Life*, some courts have found that tort suits in other states for bad faith breach of insurance contract are not saved because those state laws fail to satisfy the *Metropolitan Life* Court's three-part test borrowed from the McCarran-Ferguson Act. See, e.g., *Anschultz v. Conn. Gen. Life Ins. Co.*, 850 F.2d 1467, 1468-69 (11th Cir. 1988); cf. Bogan, *supra* note 29, at 135 (concluding that *Anschultz* and its genre . . . def[y] common sense"). Alternatively, courts have held that such statutes, although facially targeted at insurance companies, have their roots in broader common law torts and thus fail the "common sense" test of being directed at the insurance industry. See *Gilbert v. Alta Health & Life Ins. Co.*, 276 F.3d 1292, 1297 n.7 (11th Cir. 2001). The Supreme Court's opinion in *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999) seems to foreclose those arguments squarely. The *UNUM* Court determined, for the purposes of savings clause analysis, that the McCarran-Ferguson factors are merely guideposts for courts to consider, and that all three factors need not be satisfied for a state law to be saved. *Id.* at 373-74. It also found that a state statute applying only to insurance contracts is saved from ERISA preemption despite the fact that the specific law is an embodiment of a broader principal embodied in the state's common law—"the law abhors a forfeiture"—and not applicable only to the insurance industry. *Id.* at 370-71; see also *Elliot v. Fortis Benefits Ins. Co.*, 337 F.3d 1138, 1145-47 (2003).

97. See, e.g., *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 129 (1992) (finding that a District of Columbia statute requiring employers that provided health insurance coverage to their employees to provide equivalent coverage to their employees while the employees were receiving or were eligible to receive workers' compensation benefits is preempted by ERISA); *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) (finding that a state statute precluding employers from providing less health insurance to employees who receive worker's compensation insurance than to other employees is preempted by ERISA).

98. See, e.g., *Greater Washington*, 506 U.S. at 130 (holding that a local statute "specifically refers to welfare benefit plans regulated by ERISA and on that basis alone is preempted"). The Court's formalistic approach to interpreting this prong of the *Shaw* test led it to the bizarre holding that a statute that explicitly exempted ERISA plans from the burdens of a generally applicable law (in order to avoid the risk of preemption) was preempted because it referred to ERISA plans in order to express the exemption. *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 829 (1988) (holding that a Georgia statute that singled out ERISA plan benefits for exemption from state garnishment procedures, thereby expressly referencing ERISA, was preempted by ERISA).

broadly to preempt any state law that has an effect, even indirectly, on an ERISA plan.⁹⁹ The *Pilot Life* Court expanded the breadth of the relates-to clause even further by concluding that state laws of general applicability, which can apply to ERISA plans as well as to countless other entities, “relate to” ERISA plans by virtue of having a “connection with” them. In stark contrast, however, the Court interpreted the savings clause narrowly in the same respect, finding that laws of general applicability do not “regulate” insurance because they are not exclusively applied to the business of insurance.¹⁰⁰

Because the inconsistencies in the regulation of managed care created by *Pilot Life* resulted from the juxtaposition of a broad relates-to clause and a narrower savings clause, the blame theoretically could lie with Congress rather than the Court. Congress has the power to draft a broad relates-to clause and a narrow savings clause if it so desires. Similarly, Congress has the power to create a separate set of rules for people who receive their medical care through an employer-purchased plan than for people who receive their medical care through a self-purchased or a government plan.¹⁰¹ It probably even has the power to create separate rules for people whose states have or have not enacted tort statutes directed specifically at providers of insurance, although this distinction might be more susceptible to an equal protection challenge under rational basis review. If Congress makes such choices, it is, of course, the courts’ duty to enforce the will of the elected branch without second guessing the soundness of the resulting policy implications.

The problem with this explanation of early managed care jurisprudence is that there is no evidence that Congress intended that the relates-to clause be read more broadly than the savings cause. The Supreme Court

99. See *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990) (finding that state law may relate to an employee benefit plan even if “the effect is only indirect”); see also *Anderson v. Humana, Inc.*, 24 F.3d 889, 891–92 (7th Cir. 1994) (“doom[ing]” a claim brought against an HMO under the Illinois Consumer Fraud and Deceptive Practices Act because fraudulent statements “relate to” medical benefits packages, which are regulated under ERISA); *Kuhl v. Lincoln Nat’l Health Plan, Inc.*, 999 F.2d 298, 302 (8th Cir. 1993) (holding that a negligence claim brought against an HMO for delay in medical services affected the administration of an ERISA plan and was thus preempted); *Rodriguez v. PacifiCare, Inc.*, 980 F.2d 1014, 1017 (5th Cir. 1993) (holding that state law negligence claims against an HMO have a connection with an ERISA plan and are thus preempted under section 514(a)); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1333–34 (5th Cir. 1992) (holding that a tort action for the wrongful death of an unborn child was preempted because the claim arose out of actions taken in connection with an ERISA plan).

100. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987) (finding the savings clause not satisfied merely because a state law has an “impact on the insurance industry”).

101. Such a distinction does not implicate a suspect classification and would thus be subject only to rational basis review under the Equal Protection Clause. See *Frontiero v. Richardson*, 411 U.S. 677, 686–88 (1973) (noting that only “immutable” characteristics, such as sex or race, form the basis for a suspect class).

justified its expansive reading of the relates-to clause by referring to some specific items drawn from ERISA's voluminous legislative history.¹⁰² Assuming *arguendo* that such a broad reading of the relates-to clause was justified,¹⁰³ however, there is no ERISA legislative history even hinting that courts should read the savings clause more narrowly than the relates-to clause.¹⁰⁴ This point, in fact, was recognized by the Court in *Metropolitan Life*,¹⁰⁵ a case in which it rejected the contention that the savings clause should be read narrowly.¹⁰⁶ In the absence of such direction from Congress and in light of the

102. See *Ingersoll-Rand Co.*, 498 U.S. at 138 ("Congress used [the] words ['relate to'] in their broad sense, rejecting more limited preemption language that would have made the clause 'applicable only to state laws relating to the specific subjects covered by ERISA.'") (quoting *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 98 (1983)). Senator Harrison Williams, Jr. (D-NJ), Chair of the Labor and Public Welfare Committee, and one of the key legislators behind ERISA, stated:

It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent state and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.

120 CONG. REC. 29,933 (1974).

103. Ten years after *Pilot Life*, the Court actually would narrow its interpretation of the relates-to clause. See *infra* Part II.B.1.

104. There is no discussion in the legislative history of the relationship between the relates-to clause and the savings clause, and indeed very little discussion of the savings clause at all. The Conference Committee Report merely observed that "[t]he preemption provisions of title I are not to exempt any person from any State law that regulates insurance." H.R. CONF. REP. NO. 93-1280, at 383 (1974). There is a complete absence of evidence that Congress intended a narrow reading of the savings clause. There are a few passing references in the record of the floor debate to the "narrow" exceptions to the preemption clause. See 120 CONG. REC. 29,197 (remarks of Representative Dent) ("narrow exceptions specifically enumerated"); *id.* at 29,933 (remarks of Senator Williams) ("narrow exceptions specified in the bill . . . eliminating the threat of conflicting or inconsistent State and local regulation"); *id.* at 29,942 (remarks of Senator Javits) (avoiding the danger of "potentially conflicting State laws hastily contrived"). But, as the Supreme Court noted, these references are "far too frail a support on which to rest [a narrow reading of the savings clause]." *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 746 (1984).

The savings clause appeared in its present form in bills introduced in 1970 leading up to ERISA. See S. 3589, 91st Cong., § 14, 116 CONG. REC. 7284 (1970). In the early versions of ERISA, the preemption clause sought to preempt only those state laws dealing with subjects regulated by ERISA. That clause was broadened significantly shortly before ERISA was enacted—and long after the savings clause existed in its present form—to preclude all state laws that "relate to" benefit plans. The preemption clause apparently was broadened out of a fear that "state professional associations" otherwise would hinder the development of such employee-benefit programs as "pre-paid legal service programs." See 120 CONG. REC. 29,197 (1974) (remarks of Representative Dent); *id.* at 29,933 (remarks of Senator Williams); *id.* at 29,949 (remarks of Senator Javits). There is no suggestion that the preemption provision was broadened out of any concern about state regulation of insurance contracts.

105. *Metropolitan Life*, 471 U.S. at 745 (noting that ERISA's legislative history is silent on the relationship between the relates-to clause and the savings clause and has little to say about the savings clause at all).

106. *Id.* at 746.

established history of state regulation of the insurance industry,¹⁰⁷ the Court probably should have interpreted the savings clause just as broadly as it interpreted the relates-to clause.¹⁰⁸ The slight difference in connotation between the terms “relates to” and “regulates” (in the savings clause), if one exists at all, hardly seems to justify the consequent difference in legal status afforded to otherwise similarly situated MCO patients.¹⁰⁹

Had the *Pilot Life* Court determined either that the relates-to and savings clauses both could be implicated by state laws of general applicability, or that both were triggered only by specifically targeted state laws (in other words, targeted at ERISA plans in the case of the relates-to clause and insurers in the case of the savings clause), those two clauses considered apart from the rest of ERISA would have suggested that Dedeaux’s state law claim would not have been preempted. But even this analysis would not have avoided the doctrinal inconsistencies that stemmed from *Pilot Life* because it would have failed to take into account the preemptive implications of section 502(a). Dedeaux’s suit sought to recover benefits due under and/or enforce rights provided under his disability insurance policy. If his rights under the policy constituted ERISA plan benefits, it is difficult to see how he could have been permitted to pursue these rights through means other than a federal law ERISA cause of action under section 502(a), notwithstanding the inconsistent implications for managed care jurisprudence that flow from this conclusion.

3. The Conflict With ERISA’s Purposes

The broad preemption doctrine created by the Supreme Court in *Pilot Life* was objectionable not only because of its inconsistent doctrinal implications, but also because it created a body of law that did not effectuate ERISA’s underlying purposes. Recall that the primary purposes of preempting the state law of employee benefits were the protection of employees’ reasonable expectations and the minimization of the administrative burdens to employers associated with providing pensions and other fringe

107. See *id.* at 744 n.21 (finding that the savings clause was enacted “to preserve the McCarran-Ferguson Act’s reservation of the business of insurance to the States”).

108. It bears mentioning that in recent years the Court has relaxed its test for when the savings clause is triggered. See *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358, 373–74 (1999) (holding the McCarran-Ferguson test’s three factors are only “guideposts” and state law need not satisfy all three prongs to be saved from section 514 preemption); *Kentucky Ass’n of Health Plans, Inc. v. Miller*, 123 S. Ct. 1471, 1479 (2003) (replacing the McCarran-Ferguson test with a simpler two-part inquiry). However, the Court has never questioned its conclusion in *Pilot Life* that state common law claims against insurance providers are not saved.

109. Cf. *UNUM*, 526 U.S. at 363 (observing that the relates-to clause and the savings clause are “phrased with similar breadth”).

benefit plans in order to encourage them to sponsor more plans.¹¹⁰ In *Alessi v. Raybestos-Manhattan Inc.*,¹¹¹ the Supreme Court's first ERISA preemption case, the Court found a New Jersey law prohibiting employers from subtracting the value of workers' compensation benefits from employees' pensions was preempted by ERISA because the law would force multistate employers to adopt different methods of calculating benefits for its employees in New Jersey than for its employees in other states.¹¹² As the Court recognized, the *Alessi* decision was consistent with ERISA's goal of minimizing administrative burdens on employers that operate in more than one state. In contrast, permitting lawsuits against MCOs that contract with employers would protect the expectations of employees while creating no additional administrative burdens for employers—only for MCOs.¹¹³ The savings clause,¹¹⁴ which explicitly protects the rights of the states to promulgate inconsistent insurance regulations, clearly indicates that Congress had no intent to ease any administrative burdens caused by inconsistent state regulation of insurance providers.

MCO liability under state law might increase the price MCOs charge employers, and this might, in turn, reduce the attractiveness to employers of providing healthcare benefits. But the same could be said of an infinite number of state health and safety regulations that have the effect of increasing the costs of operating an MCO or the costs of operating any other type of business with which an employee benefit plan might wish to contract. Interpreting ERISA to preempt any state law that indirectly could increase the cost to employers of purchasing fringe benefits for their employees could threaten nearly every state law, and there clearly is nothing in ERISA's text or legislative history that suggests a congressional intent to give ERISA a preemptive scope that broad. The inclusion of the savings clause in ERISA's text in fact demonstrates that Congress specifically was not troubled with the notion that employers might face differential costs of employee health insurance across states.

110. See *supra* text accompanying notes 23–33.

111. 451 U.S. 504 (1981).

112. *Id.* at 524–25; see also *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 (1983) (finding that ERISA preempted a New York law requiring employers to provide sick leave benefits to pregnant employees).

113. This point largely seems to have been lost on courts, some of which specifically cite the purpose of federal uniformity as a justification for the preemption of claims against MCOs. See, e.g., *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1333 (5th Cir. 1992); Stempel & von Magdenko, *supra* note 28, at 707 (“The concern [in *Corcoran*] was that the national uniformity sought by ERISA would be gutted by application of the tort law of the fifty states.”).

114. 29 U.S.C. § 1144(b)(2)(A) (2000).

4. The Road Not Taken: A Simple Solution

The legacy of *Pilot Life* was the inconsistent treatment of similarly situated healthcare recipients and the lack of fit between ERISA's purposes and its results. It was a legacy that could have been avoided quite easily. The Supreme Court need only have recognized a fundamental difference between what the employer promises to an employee and what a third-party contractor promises to an employee, and then determined that only the former is an ERISA plan benefit.¹¹⁵ In *Pilot Life*, this would have meant that, rather than assuming Dedeaux's complaint against a third-party disability insurance company was a claim for improper processing of an ERISA benefit,¹¹⁶ the Court would have found that Dedeaux's ERISA benefit was the group disability insurance policy. The specific promises enumerated in the text of that insurance policy—made by Pilot Life Insurance Company, not by Dedeaux's employer—would be disability insurance benefits, but not ERISA plan benefits.

By analogy, an MCO membership paid for by an employer would be considered an ERISA plan benefit, whereas the specific medical benefits that the MCO promises to provide to its members would not be ERISA plan benefits. Such a distinction would lead logically to the following analysis under ERISA: (1) Lawsuits against MCOs do not relate to ERISA plans because they neither act upon nor have any connection with the employer and, accordingly, such lawsuits are not preempted; (2) complaints concerning benefits provided or not provided by third-party MCOs are not claims for ERISA plan benefits and, therefore, are not subject to preemption under section 502(a).

The analysis that flows logically from the distinction between benefits promised by the employer and benefits promised by a third-party contractor would have avoided all three doctrinal inconsistencies created by *Pilot Life*: All members of any particular MCO would enjoy the same rights regardless of who paid for the membership; the law would treat MCOs the same as other institutions that arrange for medical care, such as hospitals; and patients' rights would not appear to depend on substantively inconsequential differences in the language of state statutes. Other benefits of such an analysis include: that the results would have been faithful to the congressional

115. Cf. Edward A. Zelinsky, *Travelers, Reasoned Textualism, and the New Jurisprudence of ERISA Preemption*, 21 CARDOZO L. REV. 807, 848–49 (1998) (arguing that ERISA should not be interpreted to preempt lawsuits against “service providers” to employers such as the insurer in *Pilot Life*).

116. Cf. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987) (finding section 502(a) relevant because it governs all suits brought by ERISA plan “beneficiaries or participants asserting improper processing of claims under ERISA-regulated plans”).

purpose of providing uniformity of regulation for multistate employers but not for multistate insurance providers; that the Court would have avoided the interpretive problems created by the juxtaposition of the relates-to clause and the savings clauses; and that state tort and contract law would have been applicable to all MCOs and their patients, regardless of who paid a patient's membership fee.

5. The Problem of Self-Insured Employers

The interpretation of ERISA proposed here, that benefits promised to employees by third parties that contract with employers fall outside of ERISA's scope, would create one inconsistency of its own. Patients who receive their MCO membership through an insured ERISA plan—that is, through an employer that purchased the membership in an MCO and thus shifted the insurance risk of the patient to the MCO in exchange for a monthly fee¹¹⁷—could bring state law tort claims against their MCO without fear of preemption. However, patients who receive identical medical care through a “self-insured” or “self-funded” ERISA plan—one in which the employer promises to provide specific healthcare services to the employee and retains the risk of loss should the employee require expensive medical care¹¹⁸—would find their identical state law tort claims subject to scrutiny under and possibly preempted by section 514's relates-to clause.¹¹⁹

In an insured plan, the “ERISA benefit” is a contract with a third-party MCO, and subsequent disputes between the employee and the MCO do not concern ERISA. In a self-insured plan, in contrast, the employer promises the employee specific healthcare services and, therefore, these specific services, not a contract with a third party, are the ERISA plan benefits.¹²⁰

117. See Jordan, *supra* note 17, at 442–45 (distinguishing “insured” from “self-funded” ERISA plans).

118. See *id.*

119. Between one-third and one-half of Americans with employer-sponsored health insurance are covered by self-insured plans, depending on who is making the estimate, so this distinction is quite significant. See, e.g., Ann H. Nevers, *ERISA Right to Sue: An RX for Health Care That Places Forum Over Substantive Consumer Rights*, 31 N.M. L. REV. 493, 494 (2001); Paredes, *supra* note 43, at 234.

120. Employers operating self-insured health benefit plans usually hire a third party to administer those plans, and these third-party administrators often are the same companies that operate the third-party MCO plans purchased by insured ERISA plans for their employees. See, e.g., *Mich. United Food & Commercial Workers Unions v. Baerwaldt*, 767 F.2d 308, 308–10 (6th Cir. 1985) (involving a self-insured plan that hired an insurance company to administer plan benefits). Thus, many employees do not even know if they are part of an insured or self-insured plan. The distinction between self-insured and insured plans is critical, however, because in a self-insured plan the third party acts merely as an agent for the employer, and the employer maintains the contractual obligation to provide care and to cover the risk of financial loss should that care prove costly.

Accordingly, any state common law that would form the basis for a lawsuit concerning those benefits at least arguably relates to the ERISA plan, and such lawsuits would be subject to preemption under *Pilot Life's* broad reading of the relates-to clause.¹²¹ Even a broader reading of the savings clause than *Pilot Life* provides would not protect private lawsuits brought under state common law from preemption, because ERISA's deemer clause explicitly prevents the savings clause from protecting state laws that regulate employers providing an insurance function.¹²² In addition, a state lawsuit concerning a benefit promised by the employer directly to the employee would be subject to section 502(a) preemption.

To many, this outcome might seem logically untenable because it appears to mean that similarly situated individuals will be treated differently for no good reason.¹²³ But differential treatment of employees in self-insured and insured ERISA plans was contemplated explicitly by Congress, as demonstrated by ERISA's deemer clause,¹²⁴ and therefore is rooted in specific congressional intent. Further, the difference in treatment is consistent with ERISA's goal of minimizing the administrative burdens of multistate employers. If a multistate employer purchases health coverage for its employees from an MCO (in other words, the employer is insured), any differences in state law that essentially require MCOs in one state to provide different services or benefits than MCOs in another will not increase administrative burdens on the employer (although it might mean that the employer must

121. Even under a narrower reading of the relates-to clause, such as the one the Supreme Court adopted in 1995 in *Travelers*, see *infra* Part II.B., state law actions against self-insured employee healthcare benefits plans arguably would be preempted because they would directly affect the administration of ERISA plans. See, e.g., *Miner v. Empire Blue Cross/Blue Shield*, No. 97 Civ. 6490 (LAP), 2001 WL 96524, at *1 (S.D.N.Y. Feb. 5, 2001); *Duckett v. Blue Cross & Blue Shield*, 123 F. Supp. 2d 1286 (M.D. Ala. 2000); *Harvey v. Machigonne Benefits Adm'rs*, 122 F. Supp. 2d 179 (D. Me. 2000); *Guilbeaux v. 3927 Found., Inc.*, 177 F.R.D. 387, 393 (E.D. Tex. 1998); *Mein v. Pool Co. Disabled Int'l Employee Long Term Disability Benefits Plan*, 989 F. Supp. 1337, 1341 (D. Colo. 1998); *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 58 (D. Mass. 1997); *Livingston v. Cent. States, S.E. & S.W. Areas Health & Welfare Fund*, 900 F. Supp. 108, 112–13 (E.D. Mich. 1995).

122. 29 U.S.C. § 1144(b)(2)(B) (2000). See also *FMC Corp. v. Holliday*, 498 U.S. 52, 64–65 (1990), which holds that a state law prohibiting the deduction of a claimant's tort recovery from insurance benefits is saved but cannot be applied to a self-insured medical benefits plan due to the deemer clause. "[I]f a plan is insured, a State may regulate it indirectly through regulation of its insurer . . . if the plan is uninsured, the State may not regulate it." *Id.*

123. See, e.g., *FMC*, 498 U.S. at 65–66 (Stevens, J., dissenting) (stating that there is no rational reason to allow uninsured plans to enforce a subrogation clause against employees while state law prevents insured plans from doing the same). Today, the majority of self-insured ERISA plans purchase stop-loss insurance from insurance companies in order to limit their exposure to risk, see *Paredes*, *supra* note 43, at 249, thus further reducing the actual differences in circumstances between insured and self-insured plans.

124. 29 U.S.C. § 1144(b)(2)(B); cf. *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985) (distinguishing "between insured and uninsured plans . . . merely give[s] life to a distinction created by Congress in the 'deemer clause'").

pay a different price for its employees' MCO memberships in different states). On the other hand, differences in state laws could increase the administrative burden on self-insured multistate employers, who essentially would be required to provide different services or levels of services to employees residing in different states.¹²⁵ Thus, the differential treatment of employees in self-insured and insured ERISA plans, while inconsistent from one perspective, in fact would be consistent with one of ERISA's primary purposes and with Congress's implicit determination that self-insured and insured employers are not similarly situated in all relevant ways.

B. The Mid-1990s: Less Preemption, More Confusion

1. *Travelers* and the Rollback of Conflict Preemption

In 1995, after years of criticism of its broad preemption doctrine, the Supreme Court scaled back ERISA's preemptive effect in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*¹²⁶ by proclaiming that its prior relates-to clause jurisprudence had given ERISA preemption too broad a scope, and that the clause should be interpreted more narrowly than the Court's previous opinions had suggested. The *Travelers* opinion, however, offered no guidance to lower courts as to whether its reasoning extended to state lawsuits against MCOs and thus constituted an implicit disavowal of *Pilot Life*. Thus, *Travelers* did little to help clarify the legal status of private suits against MCOs under state law.

In *Travelers*, the State of New York imposed a hospital cost surcharge on some but not all health insurers and MCOs,¹²⁷ thus making healthcare benefits more expensive for employers to provide and providing an incentive for employers to switch their coverage to the Blue Cross plans exempt from the surcharge. Reversing a Second Circuit decision that ERISA preempted the state law, the Court held that section 514's relates-to clause did not preempt the surcharge,¹²⁸ essentially repudiating its prior view that any indirect effect of a state law on ERISA plans triggered preemption.¹²⁹ The

125. Of course, even employers with self-insured ERISA plans usually hire third parties to actually administrate their health benefits program. See, e.g., Jordan, *supra* note 17, at 443. But the critical difference between self-insured and insured ERISA plans is that the former are ultimately responsible for conforming with state laws concerning healthcare coverage (assuming no preemption) and would suffer any financial repercussions of those laws (assuming no deemer clause), whereas the latter have no financial or legal risk if their employees sue their MCOs.

126. 514 U.S. 645 (1995).

127. *Id.* at 645.

128. *Id.* at 649.

129. In *Travelers*, the Court invoked the language used to qualify its broad reading of the relates-to clause in *Shaw* that laws that are "too tenuous, remote or peripheral" do not "relate[] to"

Court observed that, at some level, everything relates to everything else, and that Congress did not intend for ERISA to preempt all state laws.¹³⁰ It then concluded that a line must be drawn between state laws that closely relate to ERISA plans and those that relate distantly, and it admitted that its earlier opinions did “not give us much help drawing the line.”¹³¹

The Court announced that a congressional intent to preempt must be “clear and manifest”¹³² in order to be found, apparently shifting the prevailing presumption in favor of preemption to a baseline presumption against preemption. And the holdings of *Travelers* and two subsequent decisions,¹³³ all of which found ERISA did not preempt state laws that altered the financial incentives of offering certain benefits to ERISA plans,¹³⁴ made clear that ERISA does not preempt state laws that merely increase the costs that employers would have to pay to purchase certain fringe benefits in the marketplace. *Travelers* failed to make the precise location of the preemption line at all clear. It ultimately replaced its prior extremely broad reading of the relates-to clause with an amorphous inquiry into whether the effect of the state law at issue on ERISA plans was of the type that Congress intended to preempt.¹³⁵

Travelers’ clear statement that ERISA’s preemptive effect should be read more narrowly, coupled with its ambiguity as to exactly how narrowly, led a few courts to interpret that decision as implicitly reversing *Pilot Life* and thus permitting state lawsuits against MCOs by patients with employer-purchased managed care.¹³⁶ The Court’s opinion, however, cannot support

employee benefit plans. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 n.21 (1983). In the process, the Court distanced itself not only from its application of the *Shaw* test in *Pilot Life*, but also from its statement in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990), that laws that have only an indirect effect on ERISA plans can be preempted, without explicitly overruling any of those cases.

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

131. *Id.*

132. *Id.*

133. *DeBuono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 816 (1997); *Cal. Div. of Labor and Standards Enforcement v. Dillingham Constr. N.A., Inc.*, 519 U.S. 316, 334 (1997).

134. *Travelers*, 514 U.S. at 668; see *DeBuono*, 520 U.S. at 815 (concluding that tax on health-care providers “is one of ‘myriad state laws’ of general applicability that impose some burdens on the administration of ERISA plans but nevertheless do not ‘relate to’ them”); *Dillingham*, 519 U.S. at 329 (“[I]f ERISA were concerned with any state action . . . that increased costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we could scarcely see the end of ERISA’s pre-emptive reach . . .”).

135. *Travelers*, 514 U.S. at 656; *DeBuono*, 520 U.S. at 813–14.

136. See *Pappas v. Asbel*, 724 A.2d 889, 893–94 (Pa. 1998) (holding that a state law negligence suit against an MCO was not preempted because negligence laws have only a “remote” connection with ERISA plans), *vacated*, *U.S. Healthcare Sys., Inc. v. Pa. Hosp. Ins. Co.*, 530 U.S. 1241 (2000); see also *Cent. States, S.E. & S.W. Areas Health & Welfare Fund v.*

such an expansive reading. The Court's findings of preemption in *Pilot Life* and in *Ingersoll-Rand Co. v. McClendon*¹³⁷ five years later, relied heavily on the implication of section 502(a) that lawsuits brought by ERISA plan beneficiaries could be maintained only under that section.¹³⁸ Because *Travelers* concerned a challenge to a state statute, rather than a private lawsuit concerning benefits, section 502(a) was not implicated in its particular context. This significant contextual difference suggests that *Travelers'* general teaching—that the Court would construe the scope of preemption more narrowly than in past cases—cannot fairly be read to call into question *Pilot Life's* specific holding that state lawsuits for ERISA benefits are preempted.

Travelers would have implied the reversal of *Pilot Life* if the Court were to have determined that section 502(a) was not relevant to state lawsuits against MCOs—most obviously, by determining that MCO-promised benefits are not ERISA plan benefits and thus cannot be recovered through a federal ERISA lawsuit brought under that section. But the Court most certainly did not do this.

2. Confronting the Elephant in the Room: The Remedies Problem

Just months after the *Travelers* decision was issued, the Third Circuit broke new doctrinal ground in *Dukes v. U.S. Healthcare Inc.*¹³⁹ by holding that section 502(a) did not lead to the preemption of tort claims against an MCO arising from the negligence of one of its physicians.¹⁴⁰ Although the *Dukes* court could have reached this decision by finding that the medical services provided by the third-party MCO were not ERISA plan benefits subject to section 502(a) limitations, it pursued a different analytical path. The court did not reason that the medical services at issue were not ERISA

Pathology Labs., P.A., 71 F.3d 1251, 1254 (7th Cir. 1995) (stating that ERISA “does not oblige federal courts to take over the entire subject of medical care”); *Pacificare, Inc. v. Burrage*, 59 F.3d 151, 154–55 (10th Cir. 1995); *Crum v. Health Alliance-Midwest, Inc.*, 47 F. Supp. 2d 1013, 1018 (C.D. Ill. 1999); *Moreno v. Health Partners Health Plan*, 4 F. Supp. 2d 888, 892–93 (D. Ariz. 1998) (“Congress has expressed no desire that ERISA be used to degrade the quality of healthcare.”); *Edelen v. Osterman*, 943 F. Supp. 75, 77 (D.D.C. 1996); *Miller v. HealthAmerica Pa. Inc.*, No. GD 99-910, 2000 WL 33364207, at *19–*20 (Pa. Com. Pl. Dec. 12, 2000).

137. 498 U.S. 133 (1990).

138. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987) (finding that Congress made “clear its intention that all suits brought by beneficiaries or participants asserting improper processing of claims under ERISA-regulated plans be treated as federal questions governed by [section] 502(a)”; *Ingersoll-Rand*, 498 U.S. at 144–45 (holding that when a plaintiff can bring a claim against his employer under section 502(a), that section provides an exclusive remedy).

139. 57 F.3d 350 (3rd Cir. 1995).

140. Specifically at issue were a vicarious liability claim for the physician's negligence and a direct claim for negligent selection of the negligent physician. *Id.* at 351–52.

plan benefits;¹⁴¹ rather, it held that because the benefits had been provided (albeit badly), the plaintiffs were not suing to recover the benefits as would be permitted under section 502(a) of ERISA. That is, section 502(a) did not preempt the state law tort suit because the plaintiffs' claims were based on the negligent provision of benefits, rather than on the failure to provide benefits.¹⁴²

The *Dukes* opinion is famous for basing its ruling on the distinction between state law claims based on the quantity of medical care provided (preempted by ERISA's remedy provisions), and claims based on the quality of medical care provided (not preempted), or alternatively, on the distinction between an MCO's "benefits determinations" (preempted) and "treatment determinations" (not preempted).¹⁴³ This distinction, adopted and still followed by all the federal circuit courts that have addressed the issue directly,¹⁴⁴ appears to classify lawsuits against MCOs into two easily identifiable categories, and thus promises to rationalize ERISA law. If a plaintiff complains that she did not receive a service promised under her employer-sponsored MCO membership, she has a claim for benefits that must be brought in federal court and limited by ERISA's section 502(a) remedies. If a plaintiff complains that a medical benefit was negligently provided, however, she is not seeking the provision of an unprovided ERISA benefit, and thus she may sue under state law and seek state law remedies.

The *Dukes* decision removed the protection from garden-variety negligence claims that MCOs had previously enjoyed, thus providing MCOs with the same incentive to exercise caution in the selection and monitoring of their member physicians that the common law provides other organizers

141. *Id.* at 356. The Court assumed without deciding that the medical care provided by the MCO was an ERISA plan benefit. *Id.*

142. *Id.* at 357.

143. *Id.*; see also *In re U.S. Healthcare, Inc.*, 193 F.3d 151, 162 (3d Cir. 1999) (describing *Dukes* as recognizing "a distinction between claims pertaining to the quality of the medical benefits provided to a plan participant and claims that the plan participant was entitled to, but did not receive, a certain quantum of benefits").

144. The Fourth, Fifth, Seventh, and Tenth circuits have implicitly followed the quality/quantity distinction. See *Corporate Health Ins. Inc. v. Tex. Dept. of Ins.*, 215 F.3d 526, 534 (5th Cir. 2000); *Giles v. NYLCARE Health Plans, Inc.*, 172 F.3d 332, 335-37 (5th Cir. 1999); *Coyne & Delany Co. v. Selman*, 98 F.3d 1457, 1471 (4th Cir. 1996); *Rice v. Panchal*, 65 F.3d 637, 646 (7th Cir. 1995); *Pacificare, Inc. v. Burrage*, 59 F.3d 151, 155 (10th Cir. 1995). Although some circuits have continued to find preemption of negligence claims against MCOs, those cases have arisen in the context of "mixed" treatment and eligibility determinations by an MCO (in which medical determinations are intertwined with benefits eligibility determinations) and should not be read as rejecting the quality/quantity framework. See, e.g., *Danca v. Private Health Care Sys., Inc.*, 185 F.3d 1, 3 (1st Cir. 1999); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1489 (7th Cir. 1996); see also the discussion *infra* Part II.B.3.

of healthcare services, such as hospitals.¹⁴⁵ It also provided patients with employer-provider coverage the same legal rights that other MCO patients enjoyed. Finally, it seemed to resolve the pre-*Travelers* doubt as to whether ERISA preempted vicarious liability claims against MCOs that are derivative of a malpractice claim against a physician.¹⁴⁶ Because it opened the door for some liability claims previously in doubt or clearly prohibited, *Dukes* has received acclaim from commentators frustrated with the policy implications of the Supreme Court's broad pre-*Travelers* preemption doctrine.¹⁴⁷ But the *Dukes* framework is unsatisfactory as an attempt to rationalize the law of managed care because the distinction it offers, like the Supreme Court's decision in *Pilot Life*, cannot be justified by reference to ERISA's language or underlying goals, and ultimately it fails to treat similarly situated individuals the same.

The *Dukes* court relied heavily on the observation that claims arising from malpractice are not claims to "recover benefits due . . . under the terms

145. See *supra* notes 139–143 and accompanying text.

146. Cf. Epstein & Sykes, *supra* note 18, at 630 ("[I]t is probably fair to say that in most jurisdictions, MCOs covered by ERISA preemption can nevertheless be reached for physician malpractice to the extent that they would otherwise be held liable under the conventional rules of vicarious liability."). Gail B. Agrawal & Mark A. Hall, *What if You Could Sue Your HMO? Managed Care Liability Beyond the ERISA Shield*, 47 ST. LOUIS L.J. 235, 236 (2003) ("At least since [*Dukes*], theories of vicarious liability for the negligence of treating physicians have not been preempted in most jurisdictions.") For a discussion of the pre-*Dukes* split in authority as to whether vicarious liability lawsuits were preempted, see *supra* note 72.

147. See, e.g., James F. Henry, Comment, *Liability of Managed Care Organizations After Dukes v. U.S. Healthcare: An Elemental Analysis*, 27 CUMB. L. REV. 681 (1996); Sylvia L. Wenger, Comment, New York State Conference of Blue Cross & Blue Shield Plans, et al. v. *Travelers Insurance Company*, et al.: *Medical Malpractice and Enabling Regulation in States Again*, 51 U. MIAMI L. REV. 131 (1996); see also Darryl Van Duch, *Courts Peel HMO Shield in Medical Malpractice Cases*, NAT'L L.J., Sept. 4, 1995, at B1; Mike McKee, *A Chink in HMOs' Armor*, RECORDER (San Francisco), Nov. 20, 1996, at 1; Martin Paskind, *Two Suits Open Question of HMO Liability*, ALBUQUERQUE J., June 17, 1996, Business Outlook, at 10; Berkeley Rice, *Look Who's on The Malpractice Hot Seat Now*, MED. ECON. Aug. 12, 1996, at 192. It is questionable, however, how valuable the protection for state law actions provided by *Dukes* ever was for patients. Physicians are usually well insured, so plaintiffs have little to gain, even in theory, from the ability to bring vicarious liability suits against MCOs based on a physician's negligence. See Epstein & Sykes, *supra* note 18, at 631. In practice, it appears that most plaintiffs' attorneys prefer to bring malpractice claims arising from a physician's negligence only against the physician rather than complicating the case by adding a vicarious liability claim against the MCO (except perhaps in the unusual case of staff-model HMOs, in which the HMO employs its physicians rather than contracting with them for services). See Agrawal & Hall, *supra* note 146, at 246–48 (drawing conclusions about HMO "law in action" from interviews with healthcare lawyers). There is disagreement over whether vicarious liability for MCOs provides any greater incentive for MCOs to exercise care than they would otherwise have. Compare Clark C. Havighurst, *Vicarious Liability: Relocating Responsibility for the Quality of Medical Care*, 26 AM. J.L. & MED. 7, 17–20 (2000) with Epstein & Sykes, *supra* note 18, at 638–41. Regardless, however, the incentive effects of direct liability are almost certainly more significant than the incentive effects of vicarious liability.

of the [the] plan,” which would require a federal law action under ERISA, because there is no claim that the plan “withheld benefits due.”¹⁴⁸ In other words, quality claims fall outside of section 502(a)’s scope according to its text. But this analysis ignores that section 502(a) specifies remedies not only for lawsuits to “recover benefits due” but also for lawsuits to “enforce . . . rights under the terms of the plan.”¹⁴⁹ If a patient’s contractual right to receive medical care from the MCO includes an implicit qualification that such care will be provided nonnegligently (as the *Dukes* court claims),¹⁵⁰ and if such medical care is an ERISA plan benefit (as the *Dukes* court assumes),¹⁵¹ then it follows that a claim that care was provided negligently is one to “enforce . . . rights under the terms of the plan.” Thus, the statutory language does not support the distinction between quantity claims and quality claims.

Attempts to anchor the quantity/quality distinction in ERISA’s underlying purposes similarly prove unsuccessful. ERISA’s purpose of reducing employers’ administrative burdens by providing a single federal law of employee benefits is not compromised by tort suits against third-party MCOs (who are not employers) for failure to provide either a particular quality of benefits or a promised quantity of benefits. Therefore, the distinction between quantity and quality cannot be justified on this ground. Tort suits against MCOs based on claims that the MCOs failed to provide a promised *quantity* of benefits could increase the cost to employers of providing healthcare benefits and might be viewed as contrary to the spirit of ERISA for this reason, but the same reasoning would apply to tort suits that assert *quality* claims. Successful lawsuits against MCOs (and even against physicians, for that matter) based on either quality or quantity theories will lead to higher costs to employers of providing healthcare benefits. Thus, the goal of encouraging employers to provide healthcare benefits is not served by distinguishing between claims based on the quality and quantity of services provided.

Perhaps the most serious failing of the *Dukes* quality/quantity distinction, however, is that, as it turns out, the distinction is not as clear as it first appears. In fact, it fails to help determine whether state law actions against MCOs arising from MCO utilization review decisions, whether based on the law of tort or contract, are preempted. This failure, which continues to this day to create substantial conceptual problems for the jurisprudence of managed care, is addressed separately in the next subpart.

148. *Dukes*, 57 F.3d at 356–57.

149. 29 U.S.C. § 1132(a) (2000).

150. See *Dukes*, 57 F.3d at 358 (claiming that the plaintiffs’ malpractice claims are not efforts to define new rights but rather to enforce rights that exist as a result of state agency and tort law).

151. *Id.* at 356.

3. What About Utilization Review?

One hallmark of managed care, and the feature that perhaps has raised the most ire among patients and the media,¹⁵² is the process of utilization review. Because appropriate medical treatment depends on the patient's precise combination of symptoms and other health issues, as well as the current state of constantly evolving medical knowledge and innovation, MCOs cannot realistically offer their customers an obligationally complete contract that specifies all the medical services that the MCO promises to provide under all possible circumstances.¹⁵³ Instead, MCO contracts almost universally promise—subject to some specific limitations and exclusions—to provide care that is “medically necessary.”¹⁵⁴ In order to limit the treatment provided to that which is medically necessary, many MCOs practice utilization review, according to which an expensive procedure or service recommended by a treating physician must be approved by MCO management prior to its provision.¹⁵⁵ Services that require utilization review and are not approved through that process are not covered by the MCO contract.¹⁵⁶

Although the frequency with which MCO utilization reviewers deny treatments recommended by a patient's physician is relatively low,¹⁵⁷ such decisions often result in lawsuits when the patient's condition subsequently worsens or the patient dies. An MCO's negative decision in the course of utilization review to deny a requested treatment does not, in theory, prevent the patient from receiving the desired treatment, because the patient

152. See, e.g., Bob Herbert, *Mugged in the Hospital*, N.Y. TIMES, Aug. 9, 1996, at A27.

153. Korobkin, *supra* note 11, at 29–31; Mariner, *supra* note 2, at 256–57 (noting the necessity of professional judgment means MCOs “can almost never specify in advance what treatment the plan will pay for when the patient gets sick”).

154. Korobkin, *supra* note 11, at 30.

155. See, e.g., *Pegram v. Herdrich*, 530 U.S. 211, 219 (2000).

156. Such a denial often is referred to by state statute as an “adverse determination.” See, e.g., FLA. STAT. ANN. § 641.47 (West 2003); 215 ILL. COMP. STAT. 134/10 (2000); KY. REV. STAT. ANN. § 304.17A-600 (Michie 2000); MO. ANN. STAT. § 376.1350 (West 2003).

157. A 1995 survey of over two thousand physicians found that approximately 6 percent of physician-recommended services were denied initially by utilization reviewers. However, many of these initial decisions were reversed by MCOs, so the rate of final denials was no more than 3 percent. MCOs initially denied 3.4 percent of physicians' requests to hospitalize patients, but two-thirds of these were reversed on appeal. For other procedures studied, the ultimate denial rates were also low, the highest being for requests for a mental-health referral, which were eventually denied 3 percent of the time. Dahlia K. Remler et al., *What Do Managed Care Plans Do to Affect Care? Results From a Survey of Physicians*, 34 INQUIRY 196, 200 (1997). These results are roughly consistent with those of a study conducted during 1998 and 1999 of 28,000 utilization reviews for a single hospital, which found a denial rate of less than 1 percent. Mary Ellen Murray, *Outcomes of Concurrent Utilization Review*, 19 NURSING ECON. 17 (2001); see also Agrawal & Hall, *supra* note 146, at 277–78 (judging from interviews that MCOs' “clinically based coverage determinations may be much less intrusive on the course of treatment than is commonly believed”).

is always entitled to pay for that treatment if the MCO will not. Given the high cost of complicated medical treatments, however, an adverse utilization review decision often effectively forecloses the patient's access to care.

a. Negligence and Related Tort Claims

Prior to 1995, courts followed the Supreme Court's broad interpretation of the relates-to clause and held that suits against MCOs for negligent utilization review were preempted under section 514.¹⁵⁸ The *Travelers* and *Dukes* decisions established a more narrow view of ERISA preemption, but they failed to resolve the question of whether lawsuits claiming negligent utilization review (and related claims concerning utilization review such as bad faith breach of contract) are preempted. The analytical problem is that a utilization reviewer's decision to deny a requested treatment is a decision that concerns both the quantity of care and quality of care, because the usual contractual standard ("medical necessity") requires a medical judgment.¹⁵⁹ Although the *Dukes* court recognized that distinguishing between quantity and quality claims would be difficult in some cases,¹⁶⁰ it offered no method of resolving this problem.¹⁶¹

Assume that a patient's physician recommends surgery for the patient's condition. The MCO's utilization reviewer then must determine prospectively whether to approve payment or deny it on the ground that surgery is not medically necessary in light of the potential for using drug therapy instead. To make the decision, the utilization reviewer must determine

158. See, e.g., *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1332 (5th Cir. 1992) (holding that state law tort claims for medical negligence were preempted by ERISA's broad relates-to language contained in section 514(a)); *Kuhl v. Lincoln Nat'l Health Plan, Inc.*, 999 F.2d 298, 302 (8th Cir. 1993), cert. denied, 510 U.S. 1045 (1994) (construing broadly ERISA preemption under section 514(a)); *Rodriguez v. Pacificare, Inc.*, 980 F.2d 1014, 1017 (5th Cir. 1993) (finding preemption under section 514(a) for an HMO's arguably negligent denial of coverage for an orthopedic specialist following an auto accident).

159. Cf. *Murphy v. Bd. of Med. Exam'rs*, 949 P.2d 530, 535-36 (Ariz. Ct. App. 1997) (finding that utilization reviewers are engaged in the practice of medicine). In some MCO contracts, the MCO tries to define the term "medical necessity" with more specificity, but the ultimate determination of whether the standard is met in a particular case always requires some degree of medical judgment. See, e.g., *Jordan*, *supra* note 17, at 417-18 (analyzing policy language attempting to define "medical necessity").

160. See *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 358 (3d Cir. 1995).

161. The *Dukes* court decided it did not need to draw a clearer line between quality and quantity because the facts of the case before it did not require such further clarification; the court concluded that the physician's negligence definitely fell into the quality category. *Id.* at 358. The court cast some doubt on whether claims based on medical negligence by a treating physician would always elude ERISA preemption, however, by suggesting the possibility that the quality of benefits could be so low as to not constitute "medical benefits" at all, in which case a lawsuit might be characterized as a quantity claim. *Id.*

whether the standard of care requires surgery or permits the MCO to administer drug therapy instead, a medical decision that appears to go to the quality of care according to the *Dukes* dichotomy. If the utilization reviewer denies payment, and the patient sues the MCO for negligence, that lawsuit would seem to implicate traditional concerns of state law (and thus not be preempted under the *Travelers* interpretation of section 514) rather than seeking to recover benefits (and thus not running afoul of section 502(a)). At the same time, the utilization reviewer's decision determines whether or not the surgery is a benefit covered under the patient's MCO contract, because the MCO contractually promises to provide only medically necessary services. From this perspective, the decision appears to be an administrative one concerning the quantity of benefits due, of the type that section 502(a) envisions being cognizable only under ERISA.

After the *Travelers* and *Dukes* opinions and before the Supreme Court's recent decision in *Pegram*, the federal courts were nearly unanimous in holding that ERISA did preempt state law challenges of utilization review denials. Along with holding that a vicarious liability claim against an MCO arising from a physician's malpractice was not preempted, the *Dukes* court opined that ERISA would preempt challenges to utilization review decisions.¹⁶² Other circuits followed this dictum, determining that utilization review challenges were claims for benefits (quantity) that could be challenged only under ERISA and in accordance with its limited remedies.¹⁶³ For example, in *Jass v. Prudential Health Care Plan*,¹⁶⁴ the Seventh Circuit held that an HMO nurse's determination that therapy following knee surgery was not medically necessary was a benefits determination preempted under section 502(a).¹⁶⁵ In *Danca v. Private Health Care Systems*,¹⁶⁶ the First Circuit held

162. *Dukes*, 57 F.3d at 359–61 (distinguishing the Fifth Circuit's *Corcoran* decision on the ground that *Corcoran* involved utilization review, and claiming that the "difference between the 'utilization review' and the 'arranging for medical treatment' roles [of MCOs] is crucial for the purposes of [section] 502(a)"). In a later case, *In re U.S. Healthcare*, the Third Circuit found that a patient's suit against an MCO for requiring mothers and newborns to be discharged from the hospital twenty-four hours after birth was not preempted. *In re U.S. Healthcare*, 193 F.3d 151, 161–62 (1999). Arguably, the plaintiff's claim could have been construed as a charge of negligent utilization review or its equivalent, given that in setting a twenty-four-hour discharge policy the MCO implicitly must have determined that longer hospital stays were not medically necessary. The plaintiff's complaint is far from clear however, see *id.* at 156–57, and it seems that the patient never requested a longer hospital stay, *id.* at 162–63. Thus, in finding no preemption, the court distinguished the facts from a utilization review challenge, implicitly affirming the *Dukes* dicta that such challenges are preempted. *Id.* at 163–64.

163. See *Jordan*, *supra* note 17, at 420 (claiming that as of the year 2000, "most courts steadfastly continue" to hold that ERISA preempts state law claims arising from the negligent exercise of medical judgment in coverage determinations).

164. 88 F.3d 1482 (7th Cir. 1996).

165. *Id.* at 1489.

166. 185 F.3d 1 (1st Cir. 1999).

that a claim against an MCO for negligent utilization review based on the MCO's denial of a mental health patient's request for hospitalization followed by the patient's suicide was also preempted on the ground that the suit sought ERISA benefits.¹⁶⁷ In *Hull v. Fallon*,¹⁶⁸ the Eighth Circuit found a plaintiff's claim against an MCO administrator who denied authorization for a thallium stress test preempted under section 502(a) on the grounds that the administrator made a coverage decision,¹⁶⁹ despite the fact that the plaintiff attempted to label the claim as one based on vicarious liability for the primary physician's negligence.¹⁷⁰

These opinions correctly observe that the utilization review decisions at issue were *benefits* determinations, but they provide no convincing explanation of why they should not also be considered *quality of care* determinations, subject to state tort law or, alternatively, why the benefits-determination nature of utilization review decisions should outweigh their quality-of-care nature. Ultimately, any attempt to rationalize ERISA jurisprudence by differentiating between quantity claims (preempted) and quality claims (not preempted) is doomed to failure because utilization review decisions made pursuant to a medical necessity standard necessarily include elements of both. The doctrinal categories provided by *Dukes* simply offer no assistance in logically determining the fate of state law utilization review challenges.

Given the inscrutability of *Travelers* on the issue of state law actions against MCOs and the substantial uncertainty about the proper application of the *Dukes* quality/quantity distinction, it comes as no surprise that in subsequent years some lower courts held that ERISA does permit state law causes of action against MCOs¹⁷¹ while others continued to find such actions to be preempted,¹⁷² with the precise type of claim appearing to be only loosely correlated with the outcome.¹⁷³

167. *Id.* at 7.

168. 188 F.3d 939 (8th Cir. 1999).

169. *Id.* at 943.

170. *Id.* at 941.

171. See, e.g., *Dukes*, 57 F.3d at 356; *In re U.S. Healthcare*, 193 F.3d at 164; *Coyne & Delany Co. v. Selman*, 98 F.3d 1457, 1471 (4th Cir. 1996); *Giles v. NYLCARE Health Plans, Inc.*, 172 F.3d 332, 335–37 (5th Cir. 1999).

172. See, e.g., *Hull*, 188 F.3d at 941; *Danca*, 185 F.3d at 7.

173. An extensive statistical study of managed care litigation from 1975 to 1999 found that plaintiffs were significantly more likely to prevail in lawsuits against MCOs post-*Travelers* than pre-*Travelers*, but that defendants continued to prevail in roughly half of all managed care cases post-*Travelers*. Peter D. Jacobson et al., *The Role of the Courts in Shaping Health Policy: An Empirical Analysis*, 29 J.L. MED. & ETHICS 278, 284–85 (2001). The authors found that defendants prevailed in 61.6 percent of litigated cases pre-*Travelers* and 50 percent post-*Travelers*. *Id.* at 283 tbl.3. The shift is likely the result not only of *Travelers*, but also of the Third Circuit's important decision the same year in *Dukes*, discussed *infra* Part II.B.2.

b. The Fiduciary Duty Claim

When Dr. Lori Pegram failed to order a timely ultrasound test, which resulted in Cynthia Herdrich's appendix bursting,¹⁷⁴ Herdrich sued Pegram for malpractice under state law—and won a \$35,000 award.¹⁷⁵ Herdrich also sued her MCO, physician-owned Carle HMO, from which she received care through her husband's employer-sponsored benefit plan.¹⁷⁶ Plaintiffs attempting to sue their MCOs routinely argue that their claims are outside the ambit of ERISA and seek to invoke state law causes of action. Herdrich, however, embraced ERISA, arguing that her MCO benefits were ERISA benefits and that Carle breached a fiduciary duty that it owed to her under ERISA.¹⁷⁷ Presumably, Herdrich adopted this strategy because she believed success would have provided broader remedies than would have been available under section 502(a) for a benefits claim, as a separate section of ERISA specifies the appropriate remedies for breach of fiduciary duty, including disgorgement of any benefits improperly appropriated by the fiduciary.¹⁷⁸

Herdrich's ERISA-based fiduciary duty claim rested on two contentions. The first was that Carle owed a fiduciary duty to Herdrich.¹⁷⁹ This contention relied on ERISA's definition that "a person is a fiduciary with respect to a plan to the extent [that] . . . he exercises any discretionary authority or discretionary control respecting management of such plan or . . . he has any discretionary authority or discretionary responsibility in the administration of such plan."¹⁸⁰ The second contention was that Carle breached that fiduciary duty by establishing a compensation structure for its physicians that provided a financial incentive to limit resource use, thus pitting the interests of physicians against the interests of patients.¹⁸¹ Variations on this structure are, of course, among the most common features of MCOs.¹⁸²

174. Herdrich v. Pegram, 154 F.3d 362, 365–67 (7th Cir. 1998).

175. *Id.* at 367.

176. *Id.* at 365.

177. See generally 29 U.S.C. §§ 1104(a)(1), 1109(a) (2000).

178. ERISA provides that remedies for breach of fiduciary duty include the disgorgement of any benefits improperly appropriated by the fiduciary. 29 U.S.C. § 1109(a). But what motivated Herdrich's claim is unclear, as the Supreme Court previously had ruled that recoveries for a breach of fiduciary duty belong to the ERISA plan, not to the individual plaintiff claiming harm. *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140–44 (1985).

179. Herdrich, 154 F.3d at 371.

180. 29 U.S.C. § 1002(21)(A).

181. Herdrich, 154 F.3d at 372–73.

182. See, e.g., Jack Hadley et al., *Perceived Financial Incentives, HMO Market Penetration, and Physicians' Practice Styles and Satisfaction*, 34 HEALTH SERV. RES. 307, 308 (1999); F.J. Hellinger, *The Impact of Financial Incentives on Physician Behavior in Managed Care Plans*, 53 MED. CARE RES. & REV. 294, 294–314 (1996).

The district court dismissed Herdrich's fiduciary duty claim.¹⁸³ In *Herdrich v. Pegram*, however, a divided panel of the Seventh Circuit reversed and reinstated the claim, finding that Carle did owe a fiduciary duty to Herdrich due to its power to determine her care, and that it was a question of fact as to whether its physician compensation program constituted a breach of that duty.¹⁸⁴

The Seventh Circuit's decision in *Herdrich* highlights another doctrinal problem that stems directly from the Supreme Court's consistent failure to distinguish the benefits promised by an employer to an employee (membership in an MCO) from benefits promised by a third party to an employee as a consequence of a third-party beneficiary contract (a certain quality of care or quantity of services). By statute, the administrator of an ERISA plan has a fiduciary duty to plan members,¹⁸⁵ which prohibits the administrator from acting "in any transaction . . . on behalf of a party . . . whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries."¹⁸⁶ But it is the fundamental nature of managed care that MCOs increase earnings by reducing the cost of care provided to patients. Thus, the concept of managed care is fundamentally inconsistent with an MCO, or its employees who act on its behalf, owing fiduciary duties to the MCO's patients.¹⁸⁷ If an MCO attempts to manage care, its interests are adverse to those of individual patients who desire services; if an MCO acts in the undivided interest of each individual patient, the costs of care cannot be "managed."

In other contexts, courts have determined that ERISA fiduciaries may face some conflicts of interest without being found to have breached their duties.¹⁸⁸ But if a fiduciary could occupy a position in which its financial interests are diametrically opposed to those of the beneficiary and not be found to be in breach of its duties when it makes a discretionary decision that favors itself at the beneficiary's expense, such as MCOs do in the utilization

183. *Herdrich*, 154 F.3d at 367.

184. *Id.* at 380.

185. 29 U.S.C. § 1109(a).

186. *Id.* § 1106(b)(2).

187. Cf. *Mariner*, *supra* note 2, at 263 ("The traditional concept of a fiduciary is one whose entire loyalty is to his beneficiary Managed care organizations have no such loyalty to patients, nor does anyone expect them to.")

188. See, e.g., *Ehlmann v. Kaiser Found. Health Plan*, 198 F.3d 552, 555 (5th Cir. 2000) (holding that "[i]t is for Congress to determine whether to impose [a fiduciary duty for HMOs to disclose physician compensation schemes] under ERISA and this court will not encroach on that authority by imposing a duty which Congress has not chosen to impose"); *Friend v. Sanwa Bank*, 35 F.3d 466, 469 (9th Cir. 1994) ("ERISA does not expressly prohibit a trustee from having dual loyalties . . ."); see also 29 U.S.C. § 1108(c)(3) (permitting ERISA plan fiduciaries to be officers or employees of the plan sponsor).

review process, the concept of a fiduciary duty would have little meaning.¹⁸⁹ Thus, it seems that the Seventh Circuit's decision in *Herdrich*, if it stood, essentially would render the operation of a for-profit MCO impossible.

Not only would this conclusion have potentially disastrous public policy implications in an era in which nearly all private healthcare exhibits elements of managed care, it could not possibly be consistent with congressional intent in enacting ERISA. In 1973, Congress passed the federal HMO Act, which gave legal recognition to the institutional structure of managed care.¹⁹⁰ Presumably, had Congress intended to overturn the HMO Act with the enactment of ERISA one year later in 1974, there would be some affirmative indication of such an intent.

This interpretive problem could be solved entirely, however, simply by recognizing that third-party MCO benefits are not ERISA plan benefits. From this premise, it logically would follow that MCO utilization reviewers are not administrators of an ERISA plan with fiduciary duties to plan members. In the usual case, MCOs contract with ERISA plans, managed by employers, to provide services to employees. The "administrator" of the ERISA plan is the employer's representative who enters into contractual obligations with the MCO. The MCO personnel, in contrast, administer a set of contractual benefits promised in return for an annual fee. This relationship between the MCO and the employee is an arms-length one, lacking the element of trust involved when an employer promises to provide for the employee in her retirement by managing the investment of pension plan assets—the type of relationship that Congress had in mind when enacting ERISA's fiduciary duty provisions.

In dissent to the Seventh Circuit's denial of a motion for rehearing en banc in *Herdrich*, Judge Frank Easterbrook contended that MCOs do not meet the definition of a fiduciary because, although they "administer" their businesses, they do not "administer" ERISA plans.¹⁹¹ It is logically possible for MCO benefits to constitute ERISA plan benefits while, at the same time, MCO administrators are not ERISA fiduciaries. For example, managed care contracts theoretically could be so specific that MCO personnel would enjoy no discretion at all over what benefits are provided to employee enrollees. As a practical matter, however, covered healthcare benefits cannot

189. Cf. *Herdrich*, 154 F.3d at 373 ("Our point is not that a fiduciary may not have dual loyalties; it is that the tolerance of dual loyalties does not extend to . . . situation[s] . . . where a fiduciary jettisons his responsibility to the physical well-being of beneficiaries in favor of 'loyalty' to his own financial interests.").

190. 42 U.S.C. §§ 300e–300e-17 (2000).

191. *Herdrich v. Pegram*, 170 F.3d 683, 685 (7th Cir. 1999) (Easterbrook, J., dissenting from the denial of a petition for rehearing en banc).

fully be specified by contract *ex ante*. There are too many possible treatments for too many possible medical conditions, and medical science changes too quickly. The prepaid healthcare industry has little choice but to offer a product in which it articulates only a vague standard *ex ante* that will govern what services it actually will provide to patients *ex post*, such as services that are medically necessary, and to retain at least some case-by-case discretion over what services actually will be provided to particular patients.¹⁹² Thus, it is but a short step from Easterbrook's conclusion that MCOs are not ERISA plan fiduciaries to the broader argument, offered in this Article, that MCO benefits are not ERISA plan benefits at all—a step that Easterbrook appears to support implicitly when he advocates “treating the Carle HMO as the [employee] benefit.”¹⁹³

Only three of Judge Easterbrook's colleagues joined his opinion;¹⁹⁴ not enough to grant an *en banc* rehearing. By granting *certiorari* in *Herdrich*,¹⁹⁵ however, the Supreme Court would have another opportunity to establish the distinction between MCO benefits and ERISA plan benefits, hinted at—although not clearly articulated—by Judge Easterbrook.¹⁹⁶ What the Court made of that opportunity is discussed in Part IV.

III. THE PUBLIC REGULATION OF MANAGED CARE: STATUTORY MANDATES

The second way that ERISA preemption issues arise in the regulation of managed care—in addition to private plaintiffs attempting to assert state law tort claims against MCOs—is when state governments enact legislation or regulations that restrict the operations of MCOs. Again, these conflicts could be resolved, consistent with the statutory language, the purposes of ERISA, and the requirements of rational and consistent public policy, by interpreting such regulation of third parties as being beyond the scope of ERISA preemption. Instead, the courts have attempted to deal with such conflicts with more complicated interpretations of limitations within sections 514 and 502(a). The result has been logical inconsistency and doctrinal confusion.

192. See sources cited *supra* note 20.

193. *Herdrich*, 170 F.3d at 686.

194. Judge Easterbrook was joined by Chief Judge Posner, Judge Wood, and Judge Flaum (who dissented from the panel decision). *Id.* at 683.

195. 527 U.S. 1068 (1999).

196. For an analysis of the Supreme Court's decision, see *infra* Part III.A.

A. The Prevailing Approach: Preempted but Saved

In 1985, the Court in *Metropolitan Life* upheld a Massachusetts requirement that health benefits packages sold by MCOs and traditional health insurers include mental health benefits.¹⁹⁷ In the 1990s, the popular backlash against perceived excesses of MCO attempts to control costs by limiting benefits was so great, it is likely that more mandated benefits bills were enacted by state legislatures than any other single type of law.¹⁹⁸ Thus, the Supreme Court's conclusion that ERISA does not preempt mandated benefits laws has had a considerable practical effect on the nation's healthcare system.¹⁹⁹ Since *Metropolitan Life*, the lower courts have upheld a variety of such state mandated benefits statutes, ranging in the content of their mandates from alternative medicine to infertility treatments.²⁰⁰

The basis for the Court's *Metropolitan Life* decision was that the Massachusetts benefits mandate regulates the provision of insurance, and thus it is saved from preemption by ERISA's savings clause.²⁰¹ To examine whether the state law was saved, the Court introduced a two-part analytical doctrine. First, the Court asked whether the state law regulates insurance under a commonsense understanding of that concept.²⁰² Second, in order to check its intuition on the first question, the Court asked whether the state law satisfied a three-part test that it had created for cases brought under the McCarran-Ferguson Act,²⁰³ which grants to states the authority to regulate the "business of insurance."²⁰⁴ The McCarran-Ferguson Act test for the business of insurance asks: "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and insured; and

197. *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 758 (1985).

198. See Korobkin, *supra* note 11, at 2.

199. Under the *Metropolitan Life* reasoning, ERISA's deemer clause protects self-funded ERISA plans that bear the insurance risk of employee healthcare expenses from the effect of "saved" mandated benefits laws, thus reducing their scope. *Metropolitan Life*, 471 U.S. at 747; see also *FMC Corp. v. Holliday*, 498 U.S. 52, 64 (1990).

200. See, e.g., *Wash. Physicians Serv. Assoc. v. Gregoire*, 147 F.3d 1039, 1047 (9th Cir. 1998) (holding that a statute requiring MCOs to cover various alternative medical treatments was saved from preemption); *Macro v. Indep. Health Ass'n, Inc.*, 180 F. Supp. 2d 427, 436-38 (W.D.N.Y. 2001) (holding that statutes requiring enumerated infertility treatments were not preempted); *Sluiter v. Blue Cross & Blue Shield*, 979 F. Supp. 1131, 1136-38 (E.D. Mich. 1997) (holding that statutes requiring treatment for breast cancer patients were not preempted); *Denette v. Life of Ind. Ins. Co.*, 693 F. Supp. 959, 966 (D. Colo. 1988) (holding that a statute limiting exclusion for preexisting conditions was not preempted).

201. See *Metropolitan Life*, 471 U.S. at 744.

202. *Id.* at 740-42.

203. 15 U.S.C. § 1012 (2000).

204. *Metropolitan Life*, 471 U.S. at 742-43.

third, whether the practice is limited to entities within the insurance industry."²⁰⁵ Applying this framework, the Court determined that the Massachusetts mandate met the commonsense definition of an insurance regulation, and that it satisfied all three prongs of the McCarran-Ferguson Act test because it determined whether the insurer or the insured bore the risk of mental health expenses, affected the responsibility of the insurer to the insured, and applied only to entities engaged in the business of providing health insurance.²⁰⁶

The Court needed to reach the question of whether the statute was saved, however, only because it first determined that the state law relates to ERISA plans and therefore would be subject to conflict preemption if not saved. The analysis to support this conclusion was brief and nonspecific. In one short paragraph, the Court concluded that the mental health mandate "clearly 'relates to' welfare plans governed by ERISA," noting that the relates-to clause was given "broad scope" under *Shaw* and that even the Commonwealth of Massachusetts did not challenge this conclusion.²⁰⁷ At the time, the Court's conclusion was unremarkable, coming as it did against the backdrop presumption that a law that had any indirect effect on ERISA plans related to ERISA plans. After *Travelers* narrowed the scope of conflict preemption, however, whether mandated benefits statutes relate to ERISA plans became a more complicated question.

To the extent that *Travelers* offered any guidance as to how to determine whether a state law relates to ERISA plans, beyond the Court's general injunction to look to the intent of Congress, its message appeared to be that section 514 preempts laws that create administrative burdens or interfere with the provision of uniform interstate benefits packages, but that it does not preempt laws that affect the costs of providing benefits. According to the *Travelers* Court, *Shaw* found preemption because the state law at issue "require[d] employers to pay employees specific benefits,"²⁰⁸ and *FMC v. Holliday*²⁰⁹ found preemption because the state law at issue would frustrate ERISA plan administrators who wished to provide uniform benefits.²¹⁰ The New York hospital tax at issue in *Travelers*, in contrast, did not affect the administrative practices or burdens of ERISA plans but only the costs of procuring services.²¹¹ And, as the Court pointed out, finding that ERISA preempts "all state laws

205. *Id.* at 743 (citing *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)).

206. *See id.* at 743–44.

207. *See id.* at 739.

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

209. 498 U.S. 52 (1990).

210. *Id.* at 657–58.

211. *Id.* at 660.

affecting costs and charges on the theory that they indirectly relate to ERISA plans that purchase insurance policies or HMO memberships that would cover such services would effectively read the limiting language in § 514(a) out of the statute.”²¹²

Under the *Travelers* reasoning concerning the preemptive scope of the relates-to clause, it would seem that mandated benefits statutes do in fact relate to ERISA plans if no distinction is made between the specific medical benefits promised by MCOs and ERISA plan benefits. A state law requiring MCOs to provide mental health benefits to all of their members clearly imposes specific content and administrative requirements on MCOs, rather than merely affecting the cost of operating an MCO. Thus, if MCO benefits and ERISA plan benefits are understood to be one and the same, it follows logically from *Travelers* that such a state law imposes content requirements on ERISA plans.

If courts were to recognize a distinction between benefits promised by third-party contractors such as MCOs and ERISA plan benefits, however, such that the “ERISA plan benefit” was understood to be the MCO membership rather than the specific contractual obligations the MCO undertakes vis-à-vis employees, then the *Travelers* reasoning would imply the opposite result: that mandated benefits statutes do not relate to ERISA plans and are not subject to conflict preemption.²¹³ Under this understanding of what constitutes an ERISA plan benefit, a state law requiring MCOs to provide mental health benefits would affect neither the content nor the administration of ERISA plans. ERISA plans could contract with third-party MCOs to provide health-care to their employees, or not—exactly as would be the case in the absence of the state law.

A mental health mandate would have an indirect financial effect on ERISA plans, of course, because it presumably would make MCO memberships more expensive and limit the range of MCO products that ERISA plans could purchase. One might contend that, on this basis alone, mandated benefits laws relate to ERISA plans and are thus susceptible to section 514 conflict preemption, but this is exactly the type of linguistically possible yet logically unsustainable interpretation of the relates-to clause that the Supreme Court renounced in *Travelers* because it effectively would render the relates-to clause limitless.²¹⁴ If MCO benefits are not ERISA plan

212. *Id.* at 661.

213. At least one court has recognized this argument, although the Supreme Court has not. See *Wash. Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039, 1043–45 (9th Cir. 1998), discussed *infra* text accompanying notes 221–224. Cf. *Zelinsky*, *supra* note 115, at 857–58 (contending that ERISA’s text does not support finding that the relates-to clause preempts regulations of “service providers”).

214. See *Travelers*, 514 U.S. at 663–64.

benefits, mandated benefits statutes could be said to affect ERISA plans, but no more so than do state health and safety restrictions concerning food, which affect ERISA plans to the extent that some employers offer lunch as a fringe benefit.²¹⁵ Under this understanding of ERISA plan benefits, mandated benefits statutes could not be preempted as “state laws that mandate employee benefit structures”—explicitly preempted under *Travelers*²¹⁶ and clearly contrary to the intent of ERISA—because no employer is required to purchase health insurance as an employee benefit.

In the post-*Travelers* era, most lower courts have continued to follow the *Metropolitan Life* analysis, finding that mandated benefits statutes relate to ERISA plans but are saved from preemption because they regulate insurance.²¹⁷ This hardly is surprising, and is perhaps the prudent course for lower courts to take, in light of the facts that (1) the Supreme Court had strongly implied in *Pilot Life* that benefits promised by third-party contractors are ERISA plan benefits, (2) the Court cited its *Metropolitan Life* analysis with approval in *Travelers*,²¹⁸ and (3) the Court never suggested that *Travelers* cast doubt on its analysis in *Metropolitan Life*. In its 1999 opinion in *UNUM Life Ins. Co. v. Ward*,²¹⁹ the Court seemed to reinforce the *Metropolitan Life* approach to mandated benefits cases when it upheld on savings clause grounds a state law that imposed specific terms on a life insurance contract purchased by an ERISA plan for an employee based on an analysis of the savings clause, thus implying that the law did in fact relate to ERISA plans.²²⁰

The most notable exception to this pattern of lower court decisions was issued by the Ninth Circuit in *Washington Physician's Service Ass'n v. Gregoire*.²²¹ In *Gregoire*, the State of Washington had enacted an “Alternative Provider”

215. Cf. *id.* at 668 (finding hospital surcharges “no different from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate”).

216. *Id.* at 646.

217. See, e.g., *Express Scripts, Inc. v. Wenzel*, 262 F.3d 829, 836–38 (8th Cir. 2001) (determining that a state law regulating MCO prescription drug rules was saved and thus the court need not determine whether the law relates to an ERISA plan); *United of Omaha v. Bus. Men's Assurance Co. of Am.*, 104 F.3d 1034, 1042 (8th Cir. 1997); *Macro v. Indep. Health Ass'n, Inc.*, 180 F. Supp. 2d 427, 436 (W.D.N.Y. 2001); *Sluiter v. Blue Cross & Blue Shield*, 979 F. Supp. 1131, 1137–38 (E.D. Mich. 1997); *Foster v. Blue Cross & Blue Shield*, 969 F. Supp. 1020, 1027–28 (E.D. Mich. 1997). But see *Selby v. Principal Mut. Life Ins. Co.*, No. 98-Civ. 5283, 2000 WL 178191, at *3 n.6 (S.D.N.Y. Feb. 16, 2000) (holding state law saved as an insurance regulation but speculating that the law also “may not ‘relate to’ employee benefit plans within the meaning of ERISA’s preemption clause”).

218. *Travelers*, 514 U.S. at 663.

219. 526 U.S. 358 (1999).

220. This implication is not completely clear, as the Court’s opinion notes that the parties agreed that the law in question relates to an ERISA plan but does not evaluate the merits of that claim. See *id.* at 367.

221. 147 F.3d 1039 (9th Cir. 1998).

statute, requiring every "health plan" to permit all categories of healthcare providers, such as acupuncturists and massage therapists, to provide care under the plan.²²² Recognizing the distinction between an employer's ERISA plan and health plans marketed by MCOs and traditional health insurers, the *Gregoire* court found that the Washington statute did not relate to ERISA plans. "In the end," the court wrote, "what saves the [statute] from ERISA preemption is that it does not have anything to do with employee benefit plans in particular. It is merely one of many state laws that regulates one of many products that an employee benefit plan might choose to buy."²²³ The *Gregoire* court no doubt realized that its reasoning was in tension with the Supreme Court's prior ERISA jurisprudence, because it followed its relates-to clause analysis with an "alternative" holding that the savings clause would protect the Washington law from preemption even if the relates-to clause did not.²²⁴

Whether state mental healthcare and alternative medicine mandates do not relate to ERISA plans, or whether they do relate to ERISA plans but are saved, the substantive outcome is, of course, the same. Under either line of reasoning, the mandates are upheld, and ERISA's purposes of guaranteeing administrative uniformity for multistate employers (but not for sellers of health insurance) and not requiring employers to provide any fringe benefits at all are served. But the choice of the courts to uphold mandated benefits statutes on savings clause grounds rather than on relates-to clause grounds is not an issue of merely academic interest. In fact, it has significant practical consequences for the jurisprudence of managed care.

By failing to establish a distinction between MCO benefits and ERISA plan benefits, and therefore resting its mandated benefits doctrine on the savings clause, the Supreme Court created a conflict between section 514's savings clause and section 502(a)'s remedies provision in the context of utilization review, as well as uncertainty about the legal status of state attempts to regulate MCO-physician relationships. In both cases, the result was an avoidable circuit split that the Court would have to resolve but would be unable to resolve satisfactorily. The conflicts created by the Court's mandated benefits jurisprudence are described in the next subpart. The Court's subsequent attempts to resolve these conflicts are dealt with in Part IV.

222. *Id.* at 1042.

223. *Id.* at 1044-45.

224. *See id.* at 1045-47.

B. The Problems With the Savings Clause Path

1. External Review Statutes and the Remedies Problem Revisited

As was true with the federal courts' approach to state law tort suits against MCOs, the Supreme Court's approach to dealing with mandated benefits laws is most problematic in the context of utilization review. In response to the public backlash against managed care generally and utilization review specifically, and perhaps partly due to the prevailing opinion of the federal courts that ERISA preempts state tort claims for negligent utilization review, at least forty-one states and the District of Columbia have enacted "external review" mandates.²²⁵ Varying slightly from state to state in their particulars,²²⁶ these laws establish oversight of MCOs' utilization review processes. Typically, external review statutes guarantee MCO patients who have received adverse utilization review decisions the right to appeal those decisions to a medical expert independent of the MCO.²²⁷ If the independent expert determines that the requested treatment is medically necessary, the statutes then obligate the MCO to provide the treatment.²²⁸

The Supreme Court's savings clause approach to mandated benefits statutes, as described in *Metropolitan Life*, seems to preclude claims that section 514 preempts external review requirements, just like other benefits mandates. The reasoning is as follows: (1) State external review statutes substantially affect benefits provided by MCOs; (2) because MCO benefits are understood to be ERISA plan benefits when contracted for by an employer, external review statutes relate to ERISA plans, even post-*Travelers*,²²⁹ because they directly curtail the potential content of those plans; (3) however, because external review laws allocate risk between insurers and insureds and were enacted specifically to regulate MCOs, they are protected from preemption by the savings clause.

225. Mark C. Nielsen, *Piercing the Preemptive Veil: Rush Prudential HMO v. Moran Opens the Door for Additional State Regulation of Managed Care Organizations*, 14 HEALTH LAW. 15, 15 (2002) (discussing external review statutes enacted by forty-one states and the District of Columbia); see, e.g., ALASKA STAT. § 21.07.050 (Lexis 2002); ARIZ. REV. STAT. ANN. § 20-2537 (West 2002); CAL. HEALTH. & SAFETY CODE ANN. § 1370.4 (West 2003); COLO. REV. STAT. § 10-16-113.5 (2002); 215 ILL. COMP. STAT. ANN. 125/4-10 (West 2000); N.Y. INS. LAW § 4914 (McKinney 2000); TEX. INS. CODE ANN. art. 20A.12 (Vernon Supp. 2003) (repealed 2001).

226. For an introduction to the similarities and differences between external review statutes from state to state, see Arkin, *supra* note 62, at 622-41 (describing the California external review law in detail and contrasting it to others, most notably the Texas law).

227. See, e.g., COLO. REV. STAT. § 10-16-113.5(1) (2002); TEX. CIV. PRAC. & REM. CODE ANN. § 88.003(c) (Vernon Supp. 2003).

228. See, e.g., ARIZ. REV. STAT. ANN. § 20-2537(N) (West 2002).

229. *Metropolitan Life*, decided in 1985, preceded *Travelers* by ten years.

This line of reasoning, however, does not take into account the Court's teaching in *Pilot Life* that section 514 cannot be interpreted in a vacuum, completely removed from the requirements of section 502(a). If MCO benefits are ERISA plan benefits, and negative utilization review decisions by an MCO constitute benefits determinations, as most of *Dukes'* successors have assumed,²³⁰ external review mandates arguably are preempted by ERISA because they provide patients with an alternative remedy for adverse benefits determinations—namely, binding external review of MCO decisions—to those afforded by section 502(a).

The first circuit court opinion to address external review mandates was the Fifth Circuit's decision in *Corporate Health Insurance v. Texas Department of Insurance*.²³¹ That opinion held that a Texas external review mandate was preempted because it violated section 502(a)'s requirement that remedies for a failure to provide ERISA benefits were limited to federal court injunctions.²³² In *Moran v. Rush Prudential HMO*,²³³ the Seventh Circuit hewed more closely to the Supreme Court's reasoning in *Metropolitan Life* than to its reasoning in *Pilot Life*, holding that ERISA does not preempt an Illinois external review statute (similar in language to the Texas statute) because the state law merely adds a mandatory term to managed care contracts, just as any mandated benefit law does, rather than providing an alternative remedy for the denial of ERISA benefits.²³⁴

Both circuits' opinions, and therefore the resulting circuit split, were understandable in light of the conflicting guidance emanating from the Supreme Court's unnecessarily complex preemption jurisprudence, which seems to simultaneously counsel for and against preemption of external review statutes. ERISA clearly did not preordain this conflict over external review statutes. It could have been avoided entirely had the Court simply found, at any point, that state laws regulating third parties that market benefits plans to employers (as opposed to state laws regulating employers) do not relate to ERISA plans and therefore are not subject to ERISA pre-

230. See, e.g., *Stewart v. Berry Family Health Ctr.*, 105 F. Supp. 2d 807, 812 (S.D. Ohio 2000); *Tiemann v. U.S. Healthcare Inc.*, 93 F. Supp. 2d 585, 590 (E.D. Pa. 2000); *McDonald v. Damian*, 56 F. Supp. 2d 574, 576 (E.D. Pa. 1999); *Herrera v. Lovelace Health Sys., Inc.*, 35 F. Supp. 2d 1327, 1330 (D.N.M. 1999); *Moscovitch v. Danbury Hosp.*, 25 F. Supp. 2d 74, 80 (D. Conn. 1998); *Newton v. Tavani*, 962 F. Supp. 45, 46–47 (D.N.J. 1997); *Fritts v. Khoury*, 933 F. Supp. 668, 671 (E.D. Mich. 1996); *Roessert v. Health Net*, 929 F. Supp. 343, 349 (N.D. Cal. 1996).

231. 215 F.3d 526 (5th Cir. 2000).

232. *Id.* at 539.

233. 230 F.3d 959 (7th Cir. 2000).

234. *Id.* at 972.

emption. By granting certiorari in *Rush Prudential v. Moran*,²³⁵ the Supreme Court provided itself with the opportunity to make this doctrinal adjustment.

2. The MCO-Physician Relationship: Any Willing Provider Laws

By upholding the legality of mandated benefits laws via the savings clause rather than the relates-to clause, the Supreme Court's decision in *Metropolitan Life* also had the effect of creating complicated preemption issues when state laws regulate the relationship between MCOs and medical professionals who provide services as part of MCOs' networks—a category of laws that is even further afield from ERISA's primary concern with the employee-employer relationship than mandated benefits statutes. The most heavily litigated of this category of statutes are known as "any willing provider" (AWP) laws.

AWP statutes, enacted in some form in roughly half of the states,²³⁶ require MCOs offering healthcare coverage in that jurisdiction to permit any physician (or, in some cases, other healthcare providers such as pharmacists²³⁷ or chiropractors²³⁸) to be part of its provider network if the physician is licensed in the jurisdiction and agrees to accept the MCO's terms and conditions of network membership.²³⁹ In other words, AWP statutes prevent MCOs from keeping providers out of their networks.

The merits of AWP statutes from a policy perspective are complicated and controversial. AWP laws allow patients who receive healthcare through MCOs a broader initial choice of service providers than patients might otherwise have.²⁴⁰ Such laws also help patients to maintain physician-patient relationships over time, which often is not possible if networks regularly add and delete providers, or if patients change employers and become enrolled

235. 533 U.S. 948 (2001).

236. See Larry J. Pittman, "Any Willing Provider" Laws and ERISA's Saving Clause: A New Solution for an Old Problem, 64 TENN. L. REV. 409, 428–29 (1997); Leonard A. Hagen, Comment, *Physician Credentialing: Economic Criteria Compete With the Hippocratic Oath*, 31 GONZ. L. REV. 427, 461 (1995) (counting twenty-seven states).

237. See, e.g., *Tex. Pharmacy Ass'n v. Prudential Ins. Co. of Am.*, 105 F.3d 1035 (5th Cir. 1997) (holding that a statute contains AWP requirements for pharmacists).

238. See, e.g., *Ky. Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d 352, 354 (6th Cir. 2000) (holding that a statute contains AWP requirement for chiropractors).

239. For general discussions of what constitutes an AWP statute and how such statutes can vary, see Jill A. Marsteller et al., *The Resurgence of Selective Contracting Restrictions*, 22 J. HEALTH POL. POL'Y & L. 1133, 1138–39 (1997) (discussing how AWP laws can be less or more restrictive regarding the types and numbers of providers they require MCOs to accept); Pittman, *supra* note 236, at 428–29.

240. See, e.g., Alice T. Armstrong, Comment, *ERISA Preemption of "Any Willing Provider": Why the Eighth Circuit Got It Right*, 7 GEO. MASON L. REV. 753, 760 (1999).

in different closed-network plans.²⁴¹ AWP laws also prevent MCOs from using an implicit threat of removing a provider from the network—often called “deselection”²⁴²—in order to coerce providers into providing insufficient care in order to minimize costs.²⁴³

Along with these benefits, however, come costs. AWP laws prevent MCOs from bargaining for price discounts from providers in return for committing to keeping the network small.²⁴⁴ As the theory goes, MCOs prevented from limiting network size will be unable to win large price concessions from providers for two reasons: First, without guarantees of high patient volume, providers will not be willing to offer large price concessions;²⁴⁵ second, providers will not compete to cut prices out of fear that they might otherwise be shut out of the network.²⁴⁶ AWP statutes also prevent MCOs from using the threat of deselection to assure high quality care²⁴⁷ and enforce reasonable cost containment policies among their providers.²⁴⁸ Forcing MCOs to contract limitlessly with providers suboptimally

241. See, e.g., Ezekiel J. Emanuel & Nancy N. Dubler, *Preserving the Physician-Patient Relationship in the Era of Managed Care*, 273 JAMA 323, 327 (1995); James W. Childs, Jr., Comment, *You May Be Willing, but Are You Able? A Critical Analysis of “Any Willing Provider” Legislation*, 27 CUMB. L. REV. 199, 216–18 (1996); Richard S. Liner, Comment, *Physician Deselection: The Dynamics of a New Threat to the Physician-Patient Relationship*, 23 AM. J.L. & MED. 511, 528 (1997).

242. See Mark A. Kadzielski, *Provider Deselection and Decapitation in a Changing Healthcare Environment*, 41 ST. LOUIS L.J. 891, 897 (1997).

243. See Emanuel & Dubler, *supra* note 241, at 328; Barry R. Furrow, *Incentivizing Medical Practice: What (if Anything) Happens to Professionalism*, 1 WIDENER L. SYMP. J. 1, 4 (1996); Jerome P. Kassirer, *Managed Care and the Morality of the Marketplace*, 333 NEW ENG. J. MED. 50, 50 (1995); Bryan A. Liang, *Deselection Under Harper v. Healthsource: A Blow for Maintaining Patient-Physician Relationships in the Era of Managed Care?*, 72 NOTRE DAME L. REV. 799, 802–04 (1997); Pittman, *supra* note 236, at 432; Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J.L. & MED. 241, 250–53 (1995); cf. Clark C. Havighurst, *Prospective Self-Denial: Can Consumers Contract Today to Accept Health Care Rationing Tomorrow?*, 140 U. PA. L. REV. 1755, 1781 (1992) (claiming that physicians in closed networks typically provide fewer services than others).

244. See Bruce W. Karh, *Health Care Reform in the United States*, 13 DEL. LAW. 17, 20 (1995); David L. Meyer & Charles F. Rule, *Health Care Collaboration Does Not Require Substantive Antitrust Reform*, 29 WAKE FOREST L. REV. 169, 179–81 (1994); Pittman, *supra* note 236, at 429; Hagen, *supra* note 236, at 462.

245. See, e.g., Jordan, *supra* note 17, at 917; Meyer & Rule, *supra*, note 244, at 179; Armstrong, *supra* note 240, at 760.

246. See, e.g., Jordan, *supra* note 17, at 917; Pittman, *supra* note 236, at 429; Childs, *supra* note 241, at 207.

247. See, e.g., Linda H. Aiken & William M. Sage, *Staffing National Health Care Reform: A Role for Advanced Practice Nurses*, 26 AKRON L. REV. 187, 208 (1992); Arnold Celnick, *A Competitive Analysis of Most Favored Nations Clauses in Contracts Between Health Care Providers and Insurers*, 69 N.C. L. REV. 863, 882 n.125 (1991); Pittman, *supra* note 236, at 429–30; Childs, *supra* note 241, at 212–13.

248. See Thomas L. Greaney, *Managed Competition, Integrated Delivery Systems and Antitrust*, 79 CORNELL L. REV. 1507, 1539–40 (1994) (arguing that selective contracting encourages cost effectiveness).

utilizes providers,²⁴⁹ which decreases quality of care by denying providers opportunities to perfect their skills²⁵⁰ and increases the inefficient allocation of funds. Theoretically, AWP laws could increase the administrative costs of operating an MCO as well, because they force MCOs to deal with more providers.²⁵¹ These potential negative effects have caused some commentators to argue that AWP statutes constitute special interest legislation for physicians or other providers rather than consumer protection measures.²⁵²

What seems hard to dispute, however, is that the relationship between MCOs and physicians is quite distant from ERISA's core concern with the employer-employee relationship. Unlike patient lawsuits against MCOs or mandated benefits statutes, both of which directly concern employees (although not employers), AWP statutes do not directly affect either the employers that purchase healthcare coverage for their workforce or the employees who actually receive medical care as a fringe benefit of employment. Quite easily, and consistently with ERISA's purposes, courts could have determined that AWP laws do not relate to ERISA plans based on the same reasoning the Ninth Circuit offered in *Gregoire*: If specific medical benefits are not assumed to be ERISA plan benefits, AWP laws have nothing at all to do with ERISA plans. By prohibiting one MCO cost-control method, AWP statutes might increase costs for ERISA plans that wish to purchase MCO memberships, and by prohibiting closed-network MCOs, AWP statutes limit the range of products that might otherwise be available in the marketplace for purchase by ERISA plans. But, again, as *Travelers* correctly points out, this cannot be a sufficient nexus for ERISA preemption or else the expanse of preemption would know no bounds.

The logic of this position notwithstanding, every circuit court to review an AWP statute has concluded that the statute relates to ERISA plans, most relying on the reasoning of *Metropolitan Life* and subsequent mandated-benefits cases.²⁵³ This conclusion is plausible if specific MCO-promised

249. See Karen A. Jordan, *Managed Competition and Limited Choice of Providers: Countering Negative Perceptions Through a Responsibility to Select Quality Network Physicians*, 27 ARIZ. ST. L.J. 875, 918 (1995); Pittman, *supra* note 236, at 429.

250. See Jordan, *supra* note 249, at 918; Pittman, *supra* note 236, at 431.

251. See, e.g., Vickie Yates Brown & Barbara Reid Hartung, *Managed Care at the Crossroads*, 7 ANNALS HEALTH L. 25, 37 (1998); Pittman, *supra* note 236, at 431; Childs, *supra* note 241, at 210; Hagen, *supra* note 236, at 462 ("A 1991 Wyatt Company survey showed that allowing any willing provider to join a PPO network would increase administrative costs by 34%.").

252. See, e.g., Childs, *supra* note 241, at 200.

253. See *Ky. Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d 352 (6th Cir. 2000); *Prudential Ins. Co. of Am. v. Nat'l Park Med. Ctr., Inc.*, 154 F.3d 812 (8th Cir. 1998); *Tex. Pharmacy Ass'n v. Prudential Ins. Co. of Am.*, 105 F.3d 1035 (5th Cir. 1997); *Cigna Healthplan v. Louisiana*, 82 F.3d 642 (5th Cir. 1996); *Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500 (4th

medical benefits are ERISA plan benefits. Under this understanding, AWP statutes directly regulate the content of ERISA plans.²⁵⁴ As one commentator urging preemption of AWP statutes noted in support of her argument, "it simply is not possible for a *managed care plan* to opt out of the AWP scheme. Therefore, to argue that AWP does not 'relate to' ERISA plans is disingenuous."²⁵⁵ Note, however, that this logic requires that managed care plan benefits be ERISA plan benefits.

As is the case with mandated benefits statutes, judicial conclusions that AWP statutes relate to ERISA plans would have little practical relevance were it clear that such statutes regulate insurance, because the statutes would be saved. But it is far less clear that AWP laws constitute insurance regulations than that mandated benefits constitute insurance regulations. This issue created a circuit split, with the Fourth Circuit²⁵⁶ and most recently the Sixth Circuit²⁵⁷ holding AWP statutes are saved, the Eighth Circuit²⁵⁸ holding that they are not saved, and the Fifth Circuit holding that they may or may not be saved depending on their wording.²⁵⁹

Some dispute about the validity of AWP laws has concerned whether or not certain statutes were drafted too broadly to be confined solely to the insurance industry. For example, some AWP laws apply to third-party administrators that manage claims for insurance entities but do not themselves provide a risk-spreading function.²⁶⁰ But even if AWP statutes are drafted carefully to apply only to insurance providers, they do not obviously constitute the "regulation of insurance" under the savings clause. AWP statutes inherently present a far less compelling case for savings clause pro-

Cir. 1993). *But see* Am. Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc., 973 F. Supp. 60 (D. Mass. 1997) (finding that an AWP law does not relate to ERISA plans).

254. In some cases, courts have relied on far less plausible justifications for their conclusions that AWP statutes relate to ERISA plans. The Arkansas AWP statute described the law's requirements and then concluded with the disclaimer that the law does not apply to self-funded plans that are exempt from state regulation under ERISA. The Eighth Circuit found that the statute "refers to" ERISA plans, and thus relates to ERISA plans, by virtue of this disclaimer. *Prudential Ins. Co.*, 154 F.3d at 823. In other words, the court ruled that the state statute is preempted by federal law because it goes out of its way to avoid any conflict with the federal law, thus turning the concept of preemption on its head.

255. *Armstrong*, *supra* note 240, at 785 (emphasis added).

256. *See Stuart Circle*, 995 F.2d at 500.

257. *See Kentucky Ass'n*, 227 F.3d at 352.

258. *See Prudential Ins. Co.*, 154 F.3d at 812.

259. *See Tex. Pharmacy Ass'n v. Prudential Ins. Co. of Am.*, 105 F.3d 1035 (5th Cir. 1997) (finding one version of an AWP statute saved and another not saved).

260. *Compare Kentucky Ass'n*, 227 F.3d at 366 (statutes directed toward "insurers"), *with id.* at 376 (Kennedy, J., dissenting) (Kentucky laws "attempt to regulate entities outside the insurance industry."). *See also* Cigna Healthplan v. Louisiana, 82 F.3d 642, 650 (5th Cir. 1996) (finding an AWP law not saved because it applies to entities outside the insurance industry, including "third party administrators").

tection than do mandated benefits statutes because AWP laws neither directly expand patients' rights to benefits or services nor directly regulate the MCO-patient relationship. The most obvious consequence of AWP statutes is that they require MCOs to do business with certain vendors. But if a state required MCOs to purchase paper clips from a particular store, this hardly would constitute the "regulation of insurance." Arguably, AWP laws shift the risk from the patient to the MCO of a patient receiving services from a provider who otherwise would be excluded from the MCO's network. But this is only true if the provider in question agrees to abide by the MCO's terms and conditions and to treat the patient. That is, any additional rights that patients *might* gain vis-à-vis insurance providers under an AWP statute are contingent on providers' independent actions. An AWP statute alone does not expand the rights of any patients or the responsibilities of any insurers to their patients.

By addressing the mandated benefits issue through the savings clause rather than through the relates-to clause, the Supreme Court unintentionally laid the foundation for the subsequent circuit split over whether AWP statutes are preempted. The difficult savings clause issues that arise concerning AWP laws could have been avoided, of course, had the Court held that state statutes regulating MCOs, but not employers, do not relate to ERISA plans and, therefore, are not subject to conflict preemption.

In *Kentucky Ass'n of Health Plans v. Nichols*,²⁶¹ decided in 2000, a Sixth Circuit panel upheld two Kentucky AWP laws against an ERISA preemption challenge over a vigorous dissent that argued that the AWP statute was not an insurance regulation protected by the savings clause.²⁶² By granting certiorari in the case,²⁶³ the Supreme Court gave itself yet another opportunity to rule that state regulations of third parties that sell services to employers do not relate to ERISA plans and, therefore, that such statutes are valid without need to resort to a difficult savings clause analysis.

IV. OPPORTUNITIES MISSED: MANAGED CARE JURISPRUDENCE IN THE TWENTY-FIRST CENTURY

In its last four terms, the Supreme Court decided three cases concerning the intersection of state regulation of managed care and ERISA preemption: *Pegram v. Herdrich*, *Rush Prudential HMO v. Moran*, and *Kentucky Ass'n of Health Plans v. Miller*. In all three, the Court's rulings effectively

261. 227 F.3d at 352.

262. See *id.* at 372–84 (Kennedy, J., dissenting).

263. 536 U.S. 956 (2002).

limited the scope of ERISA preemption of state law and, in so doing, achieved results consistent with the underlying purposes of ERISA. Yet the three cases were missed opportunities nonetheless. Each provided the Court the opportunity to recognize the fundamental difference between ERISA plan benefits provided by an employer and medical benefits provided by a third-party MCO, and thus to rationalize its ERISA jurisprudence. Instead of seizing one or all of these chances to right the jurisprudential ship, however, the Court chose to build on its existing, faulty doctrinal foundation. In the process, the Court's decisions have raised more questions than they have resolved and have left the jurisprudence of managed care even more problematic than it was at the turn of the century.

A. *Pegram v. Herdrich*

1. Fiduciary Duties

The Seventh Circuit's decision in *Pegram* threatened the existence of managed care, an institutional structure that dominates the healthcare industry, which in turn comprises over 14 percent of the United States' economy.²⁶⁴ The enormity of this fact made most commentators confident that the Court would decisively reverse the Seventh Circuit's finding that the existence of financial incentives to ration healthcare made out a claim for a violation of fiduciary duties under ERISA.²⁶⁵ The basis for the Court's decision, however, was very much in doubt.

Pegram provided a clear opportunity for the Court to revisit its implicit but consistent assumption that MCO contractual obligations to patients constitute ERISA plan benefits if the patient received his MCO membership through an employer. Reversing that implicit position logically would have led to the conclusion that an MCO's employees are not ERISA plan administrators and thus have no ERISA-based fiduciary duties to patients.

264. In 2000, healthcare spending in the United States totaled \$1.3 trillion, 13.2 percent of the country's Gross Domestic Product (GDP). John K. Iglehart, *Medicare's Declining Payments to Physicians*, 346 N. ENG. J. MED. 1924, 1924 (2002). In 2001, spending increased 8.7 percent to \$1.4 trillion, representing 14.1 percent of the GDP. Lee Bowman, *Health Costs Grow Fastest, Reach Over \$5,000 a Person*, PITTSBURGH POST-GAZETTE, Jan. 8, 2003, at A8.

265. See, e.g., Ross Runkel, *Supreme Court Examines HMO Physician Incentives*, EMPLOYEE BENEFIT NEWS, Apr. 1, 2000 ("Most observers expect Herdrich to lose, essentially because ERISA was not designed to regulate the way health care is actually provided."); Judy Greenwald, *Rate Hikes, Improved Results Fuel HMO Optimism*, BUS. INS., Mar. 20, 2000, at 33 ("It is . . . 'pretty clear' that the Pegram case will be overturned in the industry's favor by the Supreme Court."). Cf. Phyllis C. Borzi, *Pegram v. Herdrich: A Victory for HMOs or the Beginning of the End for ERISA Preemption?*, 1 YALE J. HEALTH POL'Y L. & ETHICS 161, 162 (2001) ("[T]he Court's ultimate conclusion was hardly a bombshell.").

Such a holding simultaneously would have established that lawsuits against MCOs under state tort law are not preempted by ERISA, thus mooted the troubling but prevailing distinction between lawsuits concerning the quality of benefits and those concerning the quantity of benefits, as established by the Third Circuit in *Dukes* and followed eagerly elsewhere.

In June 2000, the High Court did reverse the Seventh Circuit as expected, and the opinion was unanimous. Rather than determining that MCO contractual promises are not themselves ERISA plan benefits and thus MCO employees cannot be ERISA fiduciaries, however, the Court interpreted ERISA in a way that protected the viability of MCOs but rendered the law of managed care regulation more complicated, more internally inconsistent, and more inconsistent with the purposes underlying ERISA.

The *Pegram* Court first found that, although an MCO itself is not an ERISA plan,²⁶⁶ the benefits and services promised to patients by an MCO that contracts with an employer do constitute "elements of" an ERISA plan.²⁶⁷ This statement made explicit what past rulings had implied and was the source of numerous doctrinal problems: If the employer or employer-sponsored group purchases the MCO membership, benefits promised by the MCO to employees do constitute ERISA plan benefits. Because an ERISA fiduciary is defined as anyone who makes discretionary decisions concerning the administration of plan benefits,²⁶⁸ it would seem that the Court's conclusion that MCO benefits are ERISA plan benefits would require a determination that MCO personnel who exercise discretion over the dispensation of MCO services, such as utilization reviewers or physicians, are ERISA plan fiduciaries.²⁶⁹

The *Pegram* Court attempted to avoid this seemingly unavoidable conclusion²⁷⁰ by claiming that an MCO's establishment of an internal financial structure, such as the Carle HMO method of compensating its physicians, is

266. *Pegram v. Herdrich*, 530 U.S. 211, 226 (2000).

267. *Id.* at 223.

268. 29 U.S.C. § 1002(21)(A) (2000).

269. *Cf. Morreim, supra* note 20, at 259–60 (concluding that a "physician [who] is empowered to decide which tests and treatments are medically necessary . . . satisf[ies] ERISA's definition of a fiduciary"). If the employer were self-insured but hired an MCO as a third-party administrator, such that the MCO acted only as an agent for the employer and the MCO's benefits determinations did not affect its own profits, presumably the employer rather than the MCO would be the fiduciary.

270. *Cf. Kathryn E. Diaz, There Is No Plain Meaning: The Jurisprudence of ERISA and the "Exclusive Benefit" Rule*, 4 U. PA. J. LAB. & EMP. L. 71, 73 (2001) (calling the Supreme Court's decision in *Pegram* that MCOs are not fiduciaries "arguably extralegal . . . in the face of unambiguous statutory language").

not a fiduciary act.²⁷¹ But this point really is not responsive to Herdrich's complaint: The most logical reading of her claim is that the alleged breach of fiduciary duty occurs not when an MCO establishes its internal payment rules, but when it contracts with an employer to make discretionary decisions in which its interests are in direct conflict with the interests of the ERISA plan's beneficiaries.

The Court also attempted to avoid the conclusion that utilization reviewers are fiduciaries by expressing its "doubt" that Congress intended for an MCO to "be treated as a fiduciary" when it makes provision-of-care determinations through its physicians that combine medical and eligibility determinations (what the Court called "mixed eligibility decisions"),²⁷² such as decisions concerning whether a treatment is medically necessary.²⁷³ The justification offered for the Court's doubt was that medical necessity decisions bear only a "limited resemblance" to the characteristic duties of fiduciaries under the law of trusts, which usually include managing assets, distributing property to beneficiaries, and paying money in the interest of beneficiaries.²⁷⁴ Indeed, the Court noted, when Congress debated ERISA fiduciary duties, it "concentrated on fiduciaries' financial decisions, focusing on pension plans."²⁷⁵

In furtherance of its congressional intent argument, the Court also claimed that if MCOs were in fact fiduciaries for the purpose of making utilization review decisions, Herdrich would need to show only that a "profit incentive to ration care would generally affect" such decisions in order to prove a breach of the fiduciary duty, as reflected in both the common law and ERISA itself,²⁷⁶ to "act solely in the interest of the patient."²⁷⁷ Consequently, a finding of fiduciary status would make a finding that MCOs breach their fiduciary duties a foregone conclusion, which in turn would mean the "elimination of the for-profit HMO."²⁷⁸ This result, according to the Court, would be inconsistent with the fact that Congress enacted ERISA one year after the HMO Act with no apparent intent to outlaw HMOs and has also amended the HMO Act on a number of occasions since.²⁷⁹

The Court's determination that MCO benefits are ERISA plan benefits but that utilization review decisions are not fiduciary acts is troublesome for

271. See *Pegram*, 530 U.S. at 226–27.

272. *Id.* at 228–29, 231 (distinguishing pure eligibility decisions, treatment decisions, and mixed decisions).

273. See *id.* at 230–31.

274. *Id.*

275. *Id.* at 232.

276. See 29 U.S.C. § 1104(a)(1) (2000).

277. *Pegram*, 530 U.S. at 233.

278. *Id.* at 233–34.

279. See *id.*

two reasons. First, by reinforcing its implicit conclusion of nearly thirty years that MCO benefits are ERISA plan benefits, the Court created a conflict between its holding and the plain language of ERISA's fiduciary definition, which provides that a person who exercises discretion over the administration of plan benefits is a fiduciary.²⁸⁰ Although the Court correctly noted that ERISA provides for the possibility that an individual may be a fiduciary for the purposes of some actions but not for others,²⁸¹ making a decision about whether a patient will or will not receive contingent ERISA plan benefits is the precise type of discretionary authority that defines an ERISA fiduciary. The Court's assumption that MCO benefits are ERISA plan benefits created a choice between honoring the statute's plain language (that individuals with discretion over plan benefits are fiduciaries) and honoring the almost-certain intent of Congress (that standard MCO cost containment efforts are not per se illegal). It chose the latter.

Given the Hobson's choice it faced, the Supreme Court arguably chose the result that was the lesser of two evils. What warrants criticism is that the Court allowed itself to face such a choice. Basic principles of statutory construction suggest that the Court should interpret ambiguous provisions of ERISA so as to avoid a conflict between clear statutory language and underlying congressional intent.²⁸² The Court itself has recognized this principle frequently in the context of preemption analysis.²⁸³ In *Pegram*, this principle pointed toward a finding that MCO benefits are not ERISA plan benefits.²⁸⁴ ERISA's definition of "employee welfare benefit plans," recall, is at a minimum ambiguous as to whether specific MCO benefits—as opposed to the MCO membership—are themselves ERISA plan benefits.²⁸⁵

The second problem with the Court's reasoning in *Pegram* is that it suggests an unsupportable distinction between the fiduciary nature of medical necessity decisions and "eligibility" determinations. Recall that the Court

280. 29 U.S.C. § 1002(21)(A).

281. *Pegram*, 530 U.S. at 225–26 (noting that ERISA defines an administrator as a fiduciary "only 'to the extent' that he acts in such a capacity in relation to a plan"); see also 29 U.S.C. § 1002(21)(A); *Varity Corp. v. Howe*, 516 U.S. 489, 527 (1996) (Thomas, J., dissenting) (noting that ERISA defines "fiduciary" in "functional terms of control and authority over the plan" (quoting *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262 (1993))).

282. A basic canon of construction counsels that statutes should be construed in light of the harm the legislature meant to remedy. See, e.g., 2A NORMAN J. SINGER, STATUTES AND STATUTORY CONSTRUCTION § 48:3 (5th ed. 1992).

283. See *Cal. Fed. Sav. & Loan Ass'n v. Guerra*, 479 U.S. 272, 284 (1987) (noting that, in determining questions of preemption, a court must "examine the [Act's] language against the background of its legislative history and historical context"); see also *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 516 (1992) (calling the intent of Congress the "ultimate touchstone" of preemption analysis).

284. This conclusion is shared by Stempel and von Magdenko, who conclude that "HMOs are in essence simply vendors for ERISA plans." Stempel & von Magdenko, *supra* note 28, at 725.

285. See *infra* Part I.D.

determined that (1) MCOs administrate ERISA plan benefits, (2) some but not all administrative decisions are fiduciary acts, and (3) decisions concerning necessary treatment (such as utilization review determinations made under a medical necessity standard) are not fiduciary acts. In determining that decisions concerning treatment are not fiduciary acts, the Court identified two types of "arguably administrative" MCO acts: "eligibility decisions" and "treatment decisions."²⁸⁶ The strong implication of these findings, taken together, is that eligibility decisions—that is, an MCO's determination of whether a patient is eligible to receive a particular benefit or service—are fiduciary in nature. Quite logically, some commentators have interpreted *Pegram* as standing for precisely this proposition.²⁸⁷

This proposition is problematic because eligibility decisions, like decisions concerning appropriate treatment, pit the interests of the MCO against the interests of its patients. According to the Court²⁸⁸ and to the text of ERISA,²⁸⁹ it is improper for fiduciaries to make decisions in such contexts. If MCOs could not act as fiduciaries for the purpose of making treatment decisions without breaching their duties to patients, as the Court concluded,²⁹⁰ it is difficult to see how MCOs can act as fiduciaries for the purpose of making eligibility decisions without also breaching their duties. An argument could be made that eligibility determinations bear a somewhat closer resemblance to traditional fiduciary-type decisions than do medical necessity determinations, but this distinction seems thin, especially because neither bears much of a resemblance to the duties of the prototypical "trustee" who manages assets for the benefit of trust beneficiaries. Both MCO eligibility decisions and treatment decisions bear a far closer resemblance to decisions made by any other service provider that contractually agrees to provide specified services contingent on certain events, and against whom breaches of duty can be addressed satisfactorily under state contract or tort law.

The *Pegram* Court's resolution of Herdrich's fiduciary duty challenge illustrates the continued doctrinal difficulties that stem from the ill-fated determination that MCO benefits are ERISA plan benefits. The Court's decisions to protect the viability of managed care forced it to hold that Dr. Pegram's treatment decision was not fiduciary in nature. Because ERISA

286. *Pegram*, 530 U.S. at 228.

287. See, e.g., Stempel & von Magdenko, *supra* note 28, at 714 ("When the HMO makes a pure eligibility decision, the [*Pegram*] Court suggested that it may then be acting in the role of plan administrator subject to the fiduciary duty and liability sections of ERISA.").

288. See *Pegram*, 530 U.S. at 233 ("[f]iduciary standard to act solely in the interest of the patient without possibility of conflict"); *id.* at 234 ("The fiduciary is, of course, obliged to act exclusively in the interest of the beneficiary . . .").

289. See 29 U.S.C. § 1104(a)(1) (2000).

290. See *Pegram*, 530 U.S. at 233.

contemplates that at least some administrative acts are fiduciary in nature, the Court distinguished the type of decision at issue in *Pegram* from other MCO decisions. But this distinction makes little sense in the context of the historical understanding of what it means to be a fiduciary, which the Court embraces in order to understand ERISA's fiduciary duty provisions.

Had the Court simply determined that third-party MCO benefits are not ERISA plan benefits, none of the tortured logic that followed would have been necessary. If MCO benefits are not ERISA plan benefits, MCO employees making any benefit determinations, whether or not the decisions require the exercise of discretion, clearly would not be ERISA plan fiduciaries. The analysis would end there. No implausible interpretations of ERISA's definition of fiduciaries would have been necessary in order to avoid the conclusion, which would have been clearly contrary to congressional intent, that operating an MCO that provides coverage to employer groups contravenes federal law.

2. Challenges to Utilization Review Decisions

In the last few pages of the *Pegram* decision, and almost in passing, the Court issued what appeared to be a major statement concerning attempts to use state tort law to regulate MCO utilization review.²⁹¹ As a secondary justification for its holding that MCOs are not fiduciaries for the purpose of making "mixed eligibility and treatment decisions," the Court claimed that recognizing a right to sue for a violation of fiduciary duties under ERISA would be duplicative of the right to challenge mixed treatment and eligibility

291. The Department of Labor appears to have read the *Pegram* opinion as an important statement about the extent of ERISA preemption, although the opinion putatively concerns only the scope of ERISA fiduciary duties. The Department of Labor argued in a subsequently filed amicus brief before the Pennsylvania Supreme Court that "*Pegram* holds that treatment decisions and mixed eligibility decisions by physician employees of an HMO are governed by state malpractice standards." Brief of Amicus Curiae Dept. of Labor at 10–11, *Pappas v. Asbel*, 768 A.2d 1089 (Pa. 2001) (No. 0098 EAP 1996), available at 2000 WL 34016555. A number of commentators have argued that *Pegram*'s statement about state malpractice law, although not dealing at all with the question accepted for certiorari, is extremely significant. See, e.g., Borzi, *supra* note 265, at 166 ("[A]pplying the *Pegram* rationale, the Court would presumably . . . uphold the application of state law [in cases of] 'mixed eligibility decisions.'"); Timothy S. Jost, *Pegram v. Herdrich: The Supreme Court Confronts Managed Care*, 1 YALE J. HEALTH POL'Y L. & ETHICS 187, 191 (2001) (concluding that in *Pegram* proponents of MCO liability "lost a small battle, but advanced significantly in a much larger war"); William M. Sage, *UR Here: The Supreme Court's Guide for Managed Care*, 19 HEALTH AFF. 219, 220 (Sept./Oct. 2000) (concluding that *Pegram* "seems to place" claims against utilization review in the category of cases not preempted by ERISA); Stempel & von Magdenko, *supra* note 28, at 721 ("After *Pegram*, the *Corcoran* line of cases granting nearly carte blanche ERISA preemption and immunity to HMOs can no longer be good law . . .").

decisions under state law, which *Herdrich* already enjoyed.²⁹² The casual way in which the Court asserted this positive claim about the extent of Herdrich's ability to seek redress under state law was surprising, to say the least, for two reasons. First, the Supreme Court had never before addressed the question of whether ERISA preempted state tort suits challenging mixed eligibility and treatment determinations, such as those commonly made in the utilization review process. In fact, having never before decided a case concerning a patient's lawsuit against an MCO, the Court never even had endorsed the Third Circuit's landmark decision in *Dukes* that pure treatment decisions are not preempted. Second, most courts that previously had addressed the issue of state law challenges to "mixed" determinations such as utilization review had held that such decisions are fundamentally benefits determinations, and thus that tort suits challenging them are preempted by section 502(a).²⁹³

In light of the controversy over managed care utilization review practices and the confusion over the extent of ERISA preemption, the Court's statement about mixed determinations was extremely important, suggesting as it did that the range of suits against MCOs that are not preempted by ERISA is much larger than even the Third Circuit established in *Dukes* and most of the circuit courts apparently believed.²⁹⁴ But the Court's apparent resolution of that issue still leaves a doctrinal landscape that is illogical and inconsistent with ERISA's purposes.

To begin, *Pegram* suffers from precisely the same problem that plagues *Dukes*. Both opinions distinguish between challenges to treatment decisions (not preempted) and eligibility decisions (preempted) but fail to offer a compelling justification for why decisions that necessarily combine both a medical evaluation and a benefits determination should be placed in one category rather than the other. Whereas *Dukes* opined that challenges to utilization review decisions were preempted,²⁹⁵ *Pegram* determined just the opposite, but its reasoning is no more compelling.

In addition, the *Pegram* distinction would appear to lead to the perverse result of discouraging MCOs from making utilization review decisions promptly. If the MCO denies a requested treatment that is medically necessary, under the *Pegram* reasoning the patient may bring a state law negligence claim seeking full compensatory damages and perhaps punitive damages. If

292. *Pegram*, 530 U.S. at 235 (emphasis added).

293. See *supra* notes 162–170 and accompanying text.

294. *Id.*

295. See *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 359–61 (3d Cir. 1995).

rather than denying the request, however, the MCO considers it indefinitely, to the point in time at which the requested treatment loses its value, there arguably is no action that can be challenged under state law because no medical judgment is at issue. In *Pryzbowski v. U.S. Healthcare*,²⁹⁶ the Third Circuit considered a plaintiff's state law claims against her MCO for delaying for months before approving her physician's request to perform surgery, thus reducing the effectiveness of the surgery and leaving her in "persisten[t]" and "excruciating pain."²⁹⁷ Relying in part on *Pegram*, the *Pryzbowski* court decided that the plaintiff's claim of delay went "squarely" to an administrative rather than medical function of the MCO and therefore was preempted by ERISA.²⁹⁸

The *Pegram* Court's distinction between mixed decisions and pure-eligibility decisions cannot be justified on the basis of ERISA's purposes either. Holding that MCOs' "pure eligibility" decisions remain subject to ERISA preemption promotes national uniformity of the law governing MCO eligibility determinations, which reduces administrative burdens on multistate MCOs. But such uniformity will not affect the administrative burdens on multistate employers that operate insured ERISA plans. Recall that ERISA intends the opposite result: It seeks to limit the administrative burden on employers, but not the administrative burden on MCOs, which the statute's savings clause explicitly exposes to the burden of potentially conflicting state regulations.

Finally, *Pegram*'s distinction between mixed decisions and pure eligibility decisions can be criticized on the ground that it has created rather than resolved confusion among lower courts. Immediately following *Pegram*, the Pennsylvania Supreme Court read the decision to "instruct[] that an HMO's mixed eligibility and treatment decision implicates a state law claim for medical malpractice, not an ERISA cause of action," and it accordingly held that a state lawsuit alleging negligent utilization review is not preempted.²⁹⁹ Recently, a split panel of the Second Circuit agreed, explaining that *Pegram* implicitly overruled earlier circuit court decisions finding that

296. 245 F.3d 266 (3d Cir. 2001).

297. *Id.* at 269–70.

298. *Id.*; see also *Hotz v. Blue Cross & Blue Shield, Inc.*, 292 F.3d 57, 60–61 (1st Cir. 2002) (finding that ERISA preempts a state lawsuit alleging undue delay in an insurer's processing of a referral).

299. *Pappas v. Asbel*, 768 A.2d 1089 (Pa. 2001). In an amicus brief, the Department of Labor urged the Pennsylvania Supreme Court to adopt this reading of *Pegram*. Brief of Amicus Curiae Dept. of Labor at 10–11, *Pappas v. Asbel*, 724 A.2d 889 (Pa. 1998) (No. 0098).

state law claims for negligent utilization review are preempted.³⁰⁰ The Eleventh Circuit appears to have agreed as well.³⁰¹

Other courts have declined to interpret *Pegram*'s dicta as permitting state law challenges to utilization review decisions. Some, most notably the Third Circuit, have dismissed *Pegram* as relevant only to cases involving breach of fiduciary duty claims³⁰²—a position endorsed, albeit in a footnote, by the dissenting Supreme Court Justices in *Rush Prudential* two terms after *Pegram*.³⁰³ Some district courts have recognized *Pegram*'s relevance but avoided its implications by interpreting lawsuits concerning utilization review decisions (that were clearly based in medical judgments) as challenging pure eligibility decisions and therefore still subject to preemption.³⁰⁴

300. *Cicio v. Does*, 321 F.3d 83, 99–106 (2d Cir. 2003). In dissent Judge Calabresi interpreted *Pegram* to permit state lawsuits challenging mixed treatment and eligibility decisions only when the allegedly negligent coverage decision “also plausibly constitutes medical maltreatment by a party who can be deemed to be a treating physician.” *Id.* at 109 (Calabresi, J., dissenting).

301. *Land v. CIGNA Healthcare*, 339 F.3d 1286, 1292–94 (11th Cir. 2003) (calling a nurse's utilization review decision a “mixed-eligibility” decision not subject to section 502(a) preemption and remanding the case to state court). Although the tone of the *Land* opinion suggests that the court believed there was no ERISA preemption of the claim at issue, the court did not explicitly consider the question of whether it could be subject to section 514 preemption. Thus, it is not entirely clear that the Eleventh Circuit would follow the reasoning of the Second Circuit in *Cicio* rather than the reasoning of the Fifth Circuit in *Roark*, discussed *infra* text accompanying notes 305–309.

302. *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 450 (3d Cir. 2003); see also *Howard v. Coventry Health Care Iowa*, 158 F. Supp. 2d 937, 943 (S.D. Iowa 2001); *Tran v. Kaiser Found. Health Plan*, 2001 WL 1082418, at *6 (N.D. Tex. 2001); *Cicio v. Vytra Healthcare*, 208 F. Supp. 2d 288, 292–93 (E.D.N.Y. 2001), *rev'd*, *Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003).

303. *Rush Prudential HMO v. Moran*, 536 U.S. 355, 376 n.7 (2002) (Thomas, J., dissenting) (reading *Pegram* to decide the “limited question” of whether HMO medical decisions were subject to an ERISA fiduciary claim and not suggesting that the decision implies coverage decisions that rely on medical judgment are exempt from ERISA preemption).

304. See *Rubin-Schneiderman v. Merit Behavioral Care Corp.*, 2003 WL 22019833 (S.D.N.Y. 2003); *Calad v. CIGNA Healthcare, Inc.* 2001 WL 705776 (N.D. Tex. 2001), *rev'd*, *Roark v. Humana*, 307 F.3d 298 (5th Cir. 2002), *cert granted*, 72 U.S.L.W. 3105 (U.S. Nov. 3, 2003) (No. 03-83).

In a petition for certiorari that was recently granted by the Supreme Court, see *Cigna Healthcare of Tex., Inc. v. Calad*, 2003 WL 21693650, petitioner Cigna argued that the Fourth, Eighth, and Tenth Circuits have held, even after *Pegram*, that ERISA preempts state tort suits “that are indistinguishable in substance” from mixed eligibility and treatment decisions made by MCOs conducting utilization review. See Petition for a Writ of Certiorari, *Cigna Healthcare, Inc. v. Davila*, at 14–19, available at 2003 WL 22428549; Petition for a Writ of Certiorari, *Aetna Health, Inc. v. Davila*, at 19–28, available at 2003 WL 22428332 (companion petition, also granted by the Supreme Court, making similar claims). In fact, none of the cases cited by Cigna in support of this claim squarely address the issue—the Third Circuit's decision in *DiFelice* is the only circuit court opinion that clearly interprets *Pegram* as not permitting state law attacks on mixed eligibility and treatment decisions. *DiFelice*, 346 F.3d at 448–50 (holding the plaintiff's state law claim preempted, notwithstanding *Pegram*, even when determining that the requested treatment was not medically necessary and the MCO “necessarily had to exercise some medical judgment”).

In *Marks v. Watters*, 322 F.3d 316 (4th Cir. 2003), the Fourth Circuit denied the plaintiffs' claim that *Pegram* permitted them to maintain a state law negligence suit against a utilization reviewer,

The Fifth Circuit interpreted *Pegram* as governing authority in utilization review cases for purposes of section 502(a) analysis but not for section 514 analysis. Reviewing four district court decisions on plaintiffs' motions to have their negligent utilization review lawsuits remanded to state court, that circuit concluded that, under *Pegram*, the claims were not preempted by section 502(a), and that therefore plaintiffs could bring such claims in state court.³⁰⁵ It then held, however, that the claim of one plaintiff that was properly in federal court on the basis of supplemental jurisdiction was preempted under section 514.³⁰⁶ Although the court conceded that the "dictum of *Pegram* gives [] reason to doubt" that ERISA preempts the plaintiff's state law suit against its MCO for "[failing] to use ordinary care when [making] its medical necessity decisions,"³⁰⁷ it declined to hold that *Pegram* overruled its own decision in *Corcoran*³⁰⁸ that state law negligent utilization review claims are preempted because they relate to ERISA plans.³⁰⁹

Pegram established that cost containment, the core institutional characteristic of managed care, is not a per se violation of federal law. But it neither has rationalized the law of preemption at a conceptual level nor

id. at 318–19, but there was no allegation in that case that the utilization reviewer made any determination that required medical judgment, such as whether a treatment was medically necessary. See *id.* at 321 (describing the plaintiff's allegations); *id.* at 325 (noting that "[t]he case manager . . . had no authority to decline approval for payment"). Thus, no mixed eligibility and treatment determination was at issue.

The Tenth Circuit's decision in *Conover v. Aetna US Health Care, Inc.*, 320 F.3d 1076 (10th Cir. 2003), did not involve an MCO decision concerning the appropriateness of any treatment; that case concerned a disability insurer's judgment concerning whether a claimant was capable of working. Thus, the opinion does not address whether an MCO determination that implicitly or explicitly rests on a judgment about whether a particular treatment is indicated can be challenged under state tort law.

The Eighth Circuit's decision in *Thompson v. Gencare Health Systems, Inc.*, 202 F.3d 1072 (8th Cir. 2000), does hold that a challenge to a mixed eligibility and treatment decision is preempted (the MCO declined coverage for a bone marrow transplant it determined was not medically necessary), but the case was decided prior to *Pegram*. In *Howard v. Coventry Health Care, Inc.*, 293 F.3d 442 (8th Cir. 2002) (cited by Aetna in its cert petition but not by Cigna), the court states that "*Pegram* did not hold that all quality of care claims exist outside the scope of ERISA." *Id.* at 445. It is difficult to know what to make of this statement, however, because it is unclear from the facts as described by the court whether the plaintiff alleged that the MCO decision at issue involved any medical judgment at all. The MCO declined coverage for surgery by an out-of-network provider located "closer to [the plaintiff's] home" but approved coverage for the same surgery provided by a different out-of-network provider, *id.* at 444, suggesting that the MCO probably did not determine that the requested treatment was not medically necessary. See also *Howard v. Coventry Health Care Iowa*, 158 F. Supp. 2d 937 (S.D. Iowa 2001) (equally unclear as to the nature of the plaintiff's allegations).

305. *Roark*, 307 F.3d at 311.

306. *Id.* at 313–15.

307. *Id.* at 304.

308. See *supra* note 72.

309. *Roark*, 307 F.3d at 313–15.

produced clear practical guidance for lower courts. At the conceptual level, MCOs continue to enjoy substantial, although far from absolute, protection from state laws, even though they are not the intended beneficiaries of ERISA and favored treatment has no effect on administrative burdens suffered by employers. At the practical level, even the viability of tort lawsuits against MCOs for negligent medical decisions in the course of utilization review remains much in doubt and subject to different opinions across jurisdictions.

B. *Rush Prudential HMO v. Moran*

Recall that the split between the Seventh and Fifth Circuits, leading to the Supreme Court's grant of certiorari in *Rush Prudential* concerned whether state external review statutes are preempted by section 502(a) because they provide plaintiffs with an alternative remedy for obtaining ERISA plan benefits.³¹⁰ As was the case in *Pegram*, the most logical way for the Court to address this issue would have been to hold that state laws affecting third-parties that contract with employers, such as MCOs, are not subject to ERISA preemption because the third-party MCO's contractual obligations to their patients are not ERISA plan benefits. If the benefits sought by patients through the external review process were not considered ERISA plan benefits, whether external review laws create remedies that are inconsistent with those provided by section 502(a) would be irrelevant because ERISA would be inapplicable.

Such a ruling would have been perfectly consistent with ERISA's purpose of minimizing the administrative burdens to which employers are subject. There is no doubt that an external review requirement creates administrative burdens for MCOs, which must institute the procedures. But the requirement poses no administrative burden to employers that contract with MCOs, even to multistate employers that must contract with different MCOs that are in turn subject to different state-enacted external review requirements. Ironically, the *Rush Prudential* Court did make precisely this observation,³¹¹ but it failed to recognize that the logical implications of this observation are that external review statutes do not relate to ERISA plans and that claims for MCO benefits under external review statutes are not claims for ERISA plan benefits.

In addition to mootng the disagreement between the Fifth and Seventh Circuits and promoting the underlying purposes of ERISA, by finally ruling

310. See *supra* Part III.B.

311. See *Rush Prudential HMO v. Moran*, 536 U.S. 355, 381 n.11 (2002).

that state laws regulating MCOs do not fall within ERISA's preemptive ambit, the Court also could have reduced the need for plaintiffs to attempt to employ state tort law to challenge negligent utilization review decisions, thus raising the doctrinal problems that the Court failed to resolve in *Pegram*.

In the particular case of *Rush Prudential*, this reasoning would have required the Court to remand Debra Moran's lawsuit against her MCO for failing to follow the requirements of the Illinois external review statute to state court, which is where the case began before *Rush Prudential* removed it to federal court under section 502(a) and there argued that ERISA preempts the Illinois statute.³¹² Neither the Court's five-justice majority³¹³ nor its four-justice dissent³¹⁴ adopted this approach.

The *Rush Prudential* majority began by finding that the Illinois external review mandate relates to ERISA plans by "requiring them to submit to an extra layer of review . . . if they purchase medical coverage from [an MCO]."³¹⁵ Thus, the Court adhered to the determination explicitly made in *Pegram* that MCO benefits are ERISA plan benefits and, therefore, that restrictions and burdens placed on MCOs by state law concomitantly affect the ERISA plan.³¹⁶ Following *Metropolitan Life*, the Court then concluded that the state statute was saved from preemption as a regulation of insurance.³¹⁷

Relying on *Pilot Life* and following the Fifth Circuit's decision in *Corporate Health*, the four *Rush Prudential* dissenters countered that state insurance regulations that are otherwise viable under the savings clause of section 514 still can face preemption under section 502(a) if they provide a means of recovering ERISA benefits that is alternative to an injunction in federal court.³¹⁸ The dissenters characterized the state-mandated external review mechanism as an arbitration regime designed to ensure that MCOs provide promised ERISA plan benefits,³¹⁹ and they then concluded that this arbitral mechanism was inconsistent with section 502(a).³²⁰

The Court's majority did not take issue with the dissent's reading of *Pilot Life* that section 502(a) can preempt a state law that otherwise would be saved from conflict preemption if the law provides remedies not permitted

312. See *id.* at 362 (describing the procedural history of the case).

313. The majority opinion, authored by Justice Souter, was joined by Justices Stevens, Breyer, Ginsburg, and O'Connor.

314. Justice Thomas authored the dissent, which was joined by Chief Justice Rehnquist and Justices Scalia and Kennedy.

315. *Rush Prudential*, 536 U.S. at 365.

316. See *Pegram v. Herdrich*, 530 U.S. 211, 223 (2000).

317. See *Rush Prudential*, 536 U.S. at 370–76.

318. See *id.* at 388–89 (Thomas, J., dissenting).

319. See *id.* at 394–95 (Thomas, J., dissenting).

320. See *id.* at 399 (Thomas, J., dissenting).

under section 502(a).³²¹ But the majority parted paths with the dissent on the question of whether the Illinois external review statute was in fact inconsistent with ERISA's remedies. On behalf of its position, the Court argued³²² that the state external review statute neither provides patients with access to more expansive remedies than they could obtain under ERISA nor creates a "new cause of action under state law."³²³ The Court pointed out that to receive her desired benefit from a recalcitrant MCO, Moran would have to pursue a federal court action under section 502(a),³²⁴ a point the dissent considered irrelevant given that the external review decision presumably would render the outcome of such a lawsuit preordained.³²⁵

The majority seems to have a stronger argument than the dissent with respect to whether external review statutes are inconsistent with ERISA's remedy provisions. Congress intended section 502(a) to serve as the sole means for employees to secure promised ERISA plan benefits, but that section provides no substantive standard by which federal courts determine whether benefits are in fact due. To resolve this substantive question, courts acting under section 502(a) might have to review the terms of contracts between MCOs and patients or state statutes that supplement or supercede such terms. An external review statute instructs the federal court adjudicating a patient's section 502(a) claim to recover medically necessary treatments from an MCO to look to a fact-specific decision by a neutral external reviewer, rather than to a specific statutory provision, in order to determine whether or not the desired benefit is in fact due. In a lawsuit arising in Illinois, the federal court's resolution of a plaintiff's claim for benefits when medical necessity is in dispute likely will turn on the external reviewer's determination. But in a dispute arising in Massachusetts, a federal court's resolution of a plaintiff's claim for mental health benefits will turn on the state statute requiring MCOs to provide such benefits. The *Metropolitan*

321. See *id.* at 377–80. The dissent's assertion that section 502(a) trumps the savings clause, while suggested by *Pilot Life*, was never before explicitly stated by the Court and, in fact, was deferred explicitly. See *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 376–77 n.7 (1999).

322. The majority also took issue with the dissent's categorization of external review as an arbitration system, on the ground that Illinois' external review procedure lacks many of the accoutrements of traditional arbitration processes. See *Rush Prudential*, 536 U.S. at 381–84. This distinction seems beside the point, because the potential flaw with external review statutes is not that they provide for "arbitration" per se, but because they provide a means of securing benefits *other than* the federal courts according to the means specified in section 502(a).

323. *Id.* at 379.

324. See *id.* at 380; accord *UNUM*, 526 U.S. at 376–77 (finding no conflict between a state law and section 502(a) when the state law effectively determined whether the plaintiff had a valid claim for benefits but the plaintiff sued for the benefits under section 502(a)).

325. See *Rush Prudential*, 536 U.S. at 395–96 (Thomas, J., dissenting).

Life Court did not see the latter case as a threat to ERISA's remedial scheme, and the former case provides no greater threat.

Beyond its superior internal logic, the majority's holding creates a result broadly consistent with ERISA's underlying purposes. *Rush Prudential* unambiguously establishes that states may enact laws that provide oversight of utilization review decisions, which protects the expectations of employees—of particular importance because MCOs have a profit incentive to deny treatments, especially if their worst possible litigation outcome is having to provide the requested benefits under section 502(a)—without creating any administrative burdens for multistate employers in the process.

This said, the Court's decision reinforces the past failures of its managed care jurisprudence by losing sight of the forest, even as it treads successfully through the trees. Congress enacted ERISA to govern the employer-employee relationship, not to referee contract disputes between MCOs and their patients. Moreover, the goal of establishing a uniform federal law for benefits claims, which the dissent sees as the principle motivating its vigorous defense of section 502(a),³²⁶ exists primarily to limit the administrative burdens on multistate employers that would arise if they were forced to comply with fifty different sets of state law and, in turn, to limit disincentives to providing their employees with fringe benefits. None of these issues were at stake in *Rush Prudential*, because the administrative burdens created by external review statutes fall on MCOs, not employers.³²⁷ The existence of the savings clause demonstrates that Congress was not concerned when it enacted ERISA that multistate health insurers might be subject to different rules in different jurisdictions. External review requirements, like any other mandated benefit, might, of course, raise the costs to employers and therefore discourage the purchase of MCO memberships. But if Congress's overriding goal in enacting ERISA was to minimize the cost of fringe benefits, it would not have "saved" state insurance regulations, and the relates-to clause would have no discernable limits.

Thus, to fully effectuate the underlying intent of Congress, the Court should have held that an MCO's promise to provide medically necessary care to its patients does not relate to ERISA plans, and lawsuits to obtain such care are not suits for ERISA plan benefits. In other words, the state statute at issue in *Rush Prudential* did not need to be "saved," because it is beyond ERISA's proper scope. And the majority did not need to maintain, over a vigorous dissent, that the Illinois statute was consistent with section

326. See *id.* at 392–93 (Thomas, J., dissenting).

327. As the Court points out, the Illinois statute by its terms is unenforceable against self-funded ERISA plans, and ERISA's deemer clause would make it unenforceable against self-funded plans in any event. See *id.* at 371–72 n.6.

502(a)'s remedies, because those remedies are not relevant to a lawsuit against a third-party MCO.

In addition to failing to effectuate Congress's intent in enacting ERISA, the *Rush Prudential* decision promises to further confuse rather than rationalize the broader body of managed care law. The most troubling doctrinal consequence of the *Rush Prudential* reasoning is that it implicitly contradicts the Court's statement in *Pegram* concerning the reach of ERISA. Recall that in *Pegram* the Court signaled that challenges to MCO utilization review decisions based on medical necessity may be brought under state law without fear of ERISA preemption.³²⁸ External review mechanisms, such as the Illinois statute at issue in *Rush Prudential*, exist primarily to provide patients with a way to challenge the medical necessity analysis underlying utilization review decisions.³²⁹ The Court upheld these mechanisms, however, only because it found that they do not create a state law cause of action, which it claimed would be anathema to ERISA.³³⁰ On this reasoning, a state cause of action for negligent utilization review resulting in the failure to provide medically necessary treatment, seemingly approved in *Pegram*, would appear to be preempted under *Rush Prudential*.

This contradiction between *Rush Prudential* and *Pegram* creates a related problem as well. If an MCO refuses to abide by an external review requirement, is the patient limited to an ERISA claim with limited section 502(a) remedies for the MCO's failure to provide an ERISA benefit (an external review), or may the patient elect to bring a state tort suit against the MCO for negligently making the underlying utilization review decision that gave rise to the patient's request for external review? *Rush Prudential* suggests the former, because it holds that when a state mandates external review, external review becomes an ERISA plan benefit.³³¹ *Pegram* strongly suggests the latter, however, because if a state may entertain a tort suit against an MCO for negligent utilization review without fearing ERISA preemption, it would make little sense that a state would forfeit its sovereignty by enacting an external review statute.

The Court's opinion in *Rush Prudential*, then—much like its previous ERISA preemption decisions dating back as far as *Pilot Life*—not only fails

328. See *supra* Part III.A.2.

329. The Court, in fact, points out that the sole job of the external reviewer is to review the MCO's medical necessity determination. See *Rush Prudential*, 536 U.S. at 383.

330. See *id.* at 379–80.

331. In *Rush Prudential*, the Court observed that a suit seeking to compel an MCO to abide by a state external review mandate might be an ERISA claim for a benefit rather than a state law claim. *Id.* at 362 n.2. This is a related but somewhat different question than whether a patient can sue on the underlying tort rather than suing to enforce the external review requirement. In any event, the Court declined to resolve this issue. *Id.*

to comport with the congressional purposes underlying ERISA, but also creates doctrinal inconsistencies: in this case, a direct conflict between the implications of its only two cases dealing directly with managed care utilization review. The one bright spot is that this conflict almost certainly foreshadows new petitions for certiorari calling on the Court for clarification, which will result in further opportunities for the Court to recognize the MCO benefits/ERISA plan benefits distinction and thus rationalize its jurisprudence of managed care.

C. *Kentucky Ass'n of Health Plans v. Miller*

The Court decided *Kentucky Ass'n of Health Plans v. Miller*,³³² its third case involving managed care in four years, in the term immediately following its decision in *Rush Prudential*. Although *Kentucky Ass'n* concerned state AWP statutes rather than benefits mandates, the case offered yet another opportunity for the Court to differentiate between ERISA plan benefits and third-party medical benefits, and thus to wall off public and private attempts to regulate MCOs from ERISA preemption.

This time, the Court not only missed the opportunity, it declined even to address whether the state law at issue in the case relates to ERISA plans and thus is the proper subject of conflict preemption. The Court's unanimous opinion, authored by Justice Scalia, noted that the district court initially determined that the state statute relates to an ERISA plan before finding that the statute was saved.³³³ Other than this reference, however, the Court's opinion failed to mention, much less analyze, the relates-to clause, even though, logically, the Court needed to reach the savings clause issue only if it first found that necessary relationship between the state statute and ERISA plans. The Court's failure to address the relates-to clause was not entirely surprising given that all of the circuits to rule on AWP statutes³³⁴ and all three judges on the Sixth Circuit panel that split in *Kentucky Ass'n*³³⁵ agreed that AWP statutes do relate to ERISA plans. But the Court obviously could have revisited the lower courts' relates-to clause analysis, and, given that the savings clause is implicated only by statutes that relate to ERISA plans, its failure to do so implies approval. The Court's description of its grant of certiorari reinforces this implication. The

332. 123 S. Ct. 1471 (2003).

333. *Id.* at 1474.

334. See the cases cited *supra* note 253.

335. Compare *Kentucky Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d 352 (6th Cir. 2000) (statutes relate to ERISA plans but are saved), with *id.* at 372 (Kennedy, J., dissenting) (statutes relate to ERISA plans but are not saved).

Court's opinion states that the justices "granted certiorari to decide whether [ERISA] pre-empts either, or both, of [Kentucky's] 'Any Willing Provider' (AWP) statutes," without suggesting in any way that its analysis only assumes arguendo satisfaction of the relates to test.³³⁶

The *Kentucky Ass'n* Court held that AWP statutes are saved from preemption.³³⁷ Thus, the decision, like *Rush Prudential*, has the same practical effect as would have a decision that the statutes at issue did not relate to ERISA plans and therefore were not subject to conflict preemption. Either way, Kentucky's statutes are enforceable. Also like *Rush Prudential*, given the premise that the state statute at issue does relate to ERISA plans, the Court's ruling in *Kentucky Ass'n* that Kentucky's AWP laws are saved is a more defensible interpretation of ERISA than the opposing conclusion would have been. That is, although the savings clause issue in the case is a close one, the Court's resolution of that issue was sound. AWP laws are not laws of general applicability but have meaning only in the context of the insurance business. This suggests that they are among the class of laws that, under ERISA's savings clause, states are privileged to enact.

The primary positive contribution of *Kentucky Ass'n* to the jurisprudence of managed care is the Court's decision to jettison for the purposes of savings clause analysis the three-factor test for what constitutes the "business of insurance," which the Court created in a different context to interpret the McCarran-Ferguson Act and had employed in the savings clause arena ever since *Metropolitan Life*.³³⁸ The use of the three-factor test made the doctrinal question of whether a state law is an insurance regulation confusing and complicated, not merely because it is somewhat cumbersome, but because the test never was appropriate to the savings clause context. The federal McCarran-Ferguson Act grants to states the right to regulate the "business of insurance,"³³⁹ but whether a statute regulates the business of insurance is not necessarily the same question as whether a statute "regulates insurance," which is the operative question for savings clause purposes.³⁴⁰ More importantly, the three-factor test originally was developed in an antitrust case to analyze whether a particular business relationship between private parties constituted the business of insurance.³⁴¹ Thus, the test calls for the court to ask questions about "the practice": whether it reallocates a "policyholder's risk"; whether it is a "part" of the policy relationship; whether it is "limited" to entities in the

336. *Kentucky Ass'n*, 123 S. Ct. at 1471.

337. *See id.*

338. *Id.* at 1479; *see also supra* notes 201–206.

339. 15 U.S.C. § 1012(a) (2000).

340. *See Kentucky Ass'n*, 123 S. Ct. at 1478 (noting the difference in wording).

341. *See id.* (citing *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 126 (1982)).

insurance industry.³⁴² The practice at issue in the case for which the test was developed, *Union Labor Life Ins. Co. v. Pireno*,³⁴³ was a business practice. If the business practice was the business of insurance, the state could regulate it.³⁴⁴

When the *Metropolitan Life* Court applied the test to the savings clause context, the practice implicitly at issue was a state regulation.³⁴⁵ But it does not make sense to ask whether a statute has the effect of “spreading” a policyholder’s risk, “is an integral part of the policy relationship,” or “is limited to entities in the insurance industry.” So the *Metropolitan Life* Court subtly reworded the test without making clear that it was doing so, asking whether the statute “regulates the spreading of risk,” “regulates an integral part” of the policyholder relationship, and “imposes requirements only on insurers.”³⁴⁶ The legacy was nearly two decades of judicial attempts to apply a test developed to analyze business transactions to the subject of state statutes. As if trying to stuff a square peg into a round hole, a generation of federal judges, including Supreme Court justices, clumsily attempted to resolve savings clause cases using questions that were linguistically inappropriate and confusing.

Finally recognizing that the McCarran-Ferguson test as applied to savings clause cases shed more heat than light, the *Kentucky Ass’n* Court renounced the test, substituting for it the simpler and more appropriate test of whether the state law at issue is “specifically directed toward entities engaged in insurance” and whether it “substantially affect[s] the risk pooling arrangement between the insurer and the insured.”³⁴⁷

Despite this positive development in savings clause jurisprudence, by upholding AWP statutes on the basis of the savings clause rather than the relates-to clause, *Kentucky Ass’n* failed to help resolve the implicit contradiction between *Rush Prudential* and *Pegram*, as it might have done. In addition, its savings clause analysis of AWP laws is far from compelling. As discussed in Part III, there are two strong arguments for why AWP laws are not insurance regulations. In *Kentucky Ass’n*, the Court failed to provide a satisfactory response to either.

First, AWP statutes routinely are drafted to apply to a range of businesses, not all of which are traditional insurance companies or MCOs. For

342. *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743 (1984) (quoting *Pireno*, 458 U.S. at 129).

343. *Pireno*, 458 U.S. at 129.

344. *Id.* at 133.

345. See *Metropolitan Life*, 471 U.S. at 743 (finding that the Massachusetts statute regulates risk spreading, the policyholder relationship, and insurers).

346. *Id.* at 743 (emphasis added).

347. *Kentucky Ass’n of Health Plans, Inc. v. Miller*, 123 S. Ct. 1471, 1479 (2003).

example, some AWP statutes—including, arguably Kentucky's³⁴⁸—can be read to not only prohibit insurance companies themselves from discriminating against licensed providers, but also to prohibit third-party administrators who process claims for insurance companies but bear no insurance risk from doing so.³⁴⁹ In addition, the Kentucky AWP laws clearly apply not only to insurance companies and MCOs, but also to self-insured plans that are not protected by ERISA's deemer clause,³⁵⁰ such as self-insured government and church plans.³⁵¹ The Supreme Court might have explained that these features do not suggest that the state statutes are not "specifically directed toward entities engaged in insurance," because: (a) Prohibitions against discrimination by claims administrators ultimately are meant to prevent the insurer from discriminating—claims administrators have no particular reason to prefer closed networks to open ones, nor do they decide the requirements of network membership; and (b) self-insured employers clearly are "engaged in insurance" (hence the label "*self-insured*"), even if insurance is not their primary business, and even though ERISA's deemer clause prevents states from regulating many self-insured plans.

Instead of refuting the colorable argument against AWP statutes made by, among others, the dissenting judge in the Sixth Circuit's *Kentucky Ass'n* opinion,³⁵² the Supreme Court attacked a straw man. Its decision confronts only the claim that AWP statutes are not directed specifically at insurance because they prevent *providers* from joining closed networks in addition to preventing *insurers* from operating such networks.³⁵³ As the Court correctly points out, the fact that a state law has an effect on an entity outside the insurance industry cannot alone exclude the law from being labeled an

348. Compare *Kentucky Ass'n of Health Plans v. Nichols*, 227 F.3d 352, 366 (6th Cir. 2000) (statute could not be enforced against a party acting solely as a plan administrator), with *id.* at 374–75 (Kennedy, J., dissenting) (finding statutes would "clearly apply" to MCO or insurance companies providing plan administration services—perhaps for a self-insured employer—but retaining no insurance risk).

349. See, e.g., *Prudential Ins. Co. v. Nat'l Park Med. Ctr.*, 154 F.3d 812, 829 (8th Cir. 1998) (finding that an AWP statute places restrictions on "employers and administrators of self-insured plans"); *Tex. Pharmacy Ass'n v. Prudential Ins. Co.*, 105 F.3d 1035, 1039 (5th Cir. 1997) ("[I]f [a self-insured] employer signed up with an HMO or PPO, these organizations would be subject to the statute . . ."); *Cigna Healthplan v. Louisiana*, 82 F.3d 643, 650 (5th Cir. 1996) (finding that an AWP statute regulates third-party administrators).

350. KY. REV. STAT. ANN. §§ 304.17A-160, 304.17A-100(4)(a) (Banks-Baldwin 1995) (repealed).

351. See *Kentucky Ass'n*, 227 F.3d at 374 (Kennedy, J., dissenting); see also *Blue Cross & Blue Shield v. Nielsen*, 917 F. Supp. 1532, 1538–39 (finding that an AWP law is not an insurance regulation because it applies to self-funded plans and thus is not directed exclusively toward the insurance industry).

352. See *supra* notes 260–263.

353. See *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 123 S. Ct. 1471, 1476–78.

insurance regulation, because regulations directed toward one entity almost always will prevent other entities from doing what the regulations forbid.³⁵⁴

The second, and stronger, argument against saving AWP statutes as insurance regulations is that they do not affect the allocation of risk between insurers and insureds because they do not alter what benefits and services the insurer must pay for or provide.³⁵⁵ In response, the Court says only that AWP statutes constitute insurance regulations because they “substantially affect[] the type of risk pooling arrangements that insurers may offer” and “alter the scope of permissible bargains between insurers and insureds in a manner similar to [mandated benefits laws].”

This proposition insufficiently responds to the analytical problem, which is that AWP statutes do not actually alter any contractual rights of particular insureds in the way that benefits mandates do. In *Metropolitan Life*, the Court pointed out that the complete language of ERISA’s deemer clause prevents self-insured employers from being deemed insurers for purposes of any state law regulating insurance companies or “insurance contracts.”³⁵⁶ The Court reasoned that this language suggests that state regulations of insurance contracts must otherwise be protected by the savings clause, or else the language in the deemer clause would be unnecessary.³⁵⁷ AWP laws prevent insurers and patients from contracting for a closed-network managed care plan. But whether a network is open or closed is a technical point that arguably has no effect on the insured’s substantive contractual rights. First, whether the network is open or closed has no effect on the substantive benefits and services to which the insured is entitled. Second, even if the right to receive treatment from a specific provider would constitute a benefit itself, AWP statutes do not provide any insured with the right to receive treatment from any specific physician. The insured can only avail herself of a provider’s services if the provider agrees to the MCO’s terms and agrees to treat the insured.³⁵⁸ MCOs contract to provide or pay for benefits and services, but seldom (if ever) guarantee that the benefits will be administered by any particular provider, and AWP laws do not change this situation.

In order to justify its conclusion that AWP laws are saved, the Court might have explained that a state law regulates insurance even without affecting the allocation of risk between any particular insureds and insurers

354. See *id.* at 1478–79.

355. See, e.g., *Kentucky Ass’n*, 227 F.3d at 378, 380 (Kennedy, J., dissenting); *Prudential Ins. Co. v. Nat’l Park Med. Ctr.*, 154 F.3d 812, 830 (an AWP statute defines the terms of the relationship between insurer and provider but not between insurer and insured).

356. *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740–41 (1984).

357. *Id.* at 741.

358. Cf. *Kentucky Ass’n*, 227 F.3d at 373 (Kennedy, J., dissenting) (noting that AWP laws do not provide patients with a right to see the provider of their choice).

so long as it affects the ability of insurers to use any tools they otherwise might use to manage or limit risk, even if this does not necessarily affect the rights of any particular insured. An insurer can manage the costs of patient illness, and thus manage its overall risk, by selectively contracting only with providers who meet the insurer's high quality standard and agree to favorable reimbursement rates. When a statute interferes with an insurer's management of its overall risk in this way, it "regulates insurance." The Court's opinion, however, does not offer this explanation.

CONCLUSION

The Supreme Court's recent decisions in *Pegram v. Herdrich*, *Rush Prudential HMO v. Moran*, and *Kentucky Ass'n of Health Plans v. Miller* have reinforced the doctrinal confusion and inconsistency created by its managed care jurisprudence of the last quarter of the twentieth century. The lower courts, charged with applying this doctrine, are often at wit's end. In a recent opinion, a frustrated Third Circuit judge likened resolving ERISA preemption claims in the healthcare context to a "descent into a Serbonian bog wherein judges are forced to don logical blinders and split the linguistic atom to decide even the most routine cases."³⁵⁹ He complained that "our caselaw grows massively inconsistent due to the sheer complexities of the subject and lack of any meaningful guidance. There must be a better way."³⁶⁰

There is. By reinterpreting ERISA to recognize that specific medical benefits promised to patients by third-party MCOs *do not* fall within the purview of the federal law designed to regulate the employee-employer relationship, the Supreme Court could rationalize an area of jurisprudence of importance to the 170–180 million Americans who enjoy employment-based health insurance.³⁶¹ Although it has repeatedly failed to seize this opportunity in the past, the Court will have yet another chance to do so in 2004: It recently granted certiorari in *Aetna Health v. Davila*³⁶² and *Cigna HealthCare of Texas v. Calad*,³⁶³ two of the cases decided by the Fifth Circuit in *Roark v.*

359. *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 454 (2003) (Becker, J., concurring). "A Serbonian bog is a mess from which there is no way of extricating oneself." *Id.* at n.1.

360. *Id.* at 467 (Becker, J., concurring).

361. See Paul Fronstein, *Uninsured up in 2001, Number With Job-Based Health Benefits Decline*, 23 EBRI NOTES, Nov. 2002, at 1, 1 (reporting that in 2001, 176.6 million Americans—62.6 percent of the population—had employment-based health insurance); Agrawal & Hall, *supra* note 146, at 250 n.49 (attributing a slightly lower figure to the U.S. Census Bureau). Most, but not all, of these employees' insurance is provided by private sector plans subject to ERISA. See *id.*

362. *Aetna Health, Inc. v. Davila*, 2003 WL 21489912.

363. *Cigna Healthcare, Inc. v. Calad*, 2003 WL 21693650. The Fifth Circuit's attempt in *Roark* to interpret the Supreme Court's guidance in *Pegram* is discussed *supra* Part IV.A.2. Interestingly, although the Fifth Circuit's decision in *Roark* seemed to provide only a pyrrhic

*Humana*³⁶⁴ concerning the relationship of ERISA to state tort suits alleging negligent utilization review on the part of MCOs.

In the Alice-in-Wonderland world of current ERISA jurisprudence, patient rights depend on who purchases the MCO membership; the validity of state law claims against non-employer entities is undermined by a statute designed to regulate employers; preemption is invoked in the name of national uniformity to protect the same health insurers that ERISA's savings clause explicitly recognizes are properly subject to state regulation; the validity of state law claims for negligent utilization review apparently are undermined if the state attempts to mandate a utilization review process and an MCO ignores that process; and the Supreme Court's most recent decision in theory, if not in practice, expands federal employment law to presumptively regulate the contractual relationships between MCOs and physicians.

The statutory reinterpretation proposed here, in contrast, would result in decisions that would be consistent with ERISA's underlying purposes of protecting the expectations of employees, subjecting employers (but not MCOs or insurance companies) to a single law of employee benefits for the purpose of minimizing administrative costs to multistate employers of providing welfare benefits, and refraining from mandating that employers provide any particular welfare benefits. In so doing, such a reinterpretation would not violate any clear statutory language of ERISA, which does not explicitly address the issue of whether services promised by third-party MCOs are or are not ERISA plan benefits.

The proposed reinterpretation also would have the indirect benefit of satisfying much of the perceived need for federal "Patients' Bill of Rights" legislation, which has failed to emerge from Congress despite widespread support for such legislation among members of both political parties.³⁶⁵

victory for aggrieved patients—by permitting them to maintain tort suits challenging utilization review decisions in state court but then establishing that such claims are preempted—it was the MCOs that sought certiorari.

364. 307 F.3d 298 (5th Cir. 2002).

365. See, e.g., Frank Bruni, *Bush Strikes a Positive Tone on a Patients' Bill of Rights*, N.Y. TIMES, July 10, 2001, at A14; Foster, *A Patients' Bill of Rights?*, MILWAUKEE J. SENTINEL, June 21, 2001, at 16A (citing Health and Human Services Secretary Tommy Thompson as saying that "Democrats and Republicans have agreed on 85% to 90% of the ingredients in a reform measure"); Karen Hosler, *Disagreements Few, but Big Over Patients' Bill of Rights*, PITT. POST-GAZETTE, June 26, 2001, at A-9 ("[M]ost senators seem to have accepted the premise of legal accountability as a last resort for patients denied care their doctors say they need."). Members of the two parties regularly compete to prove that their party is the more dedicated to the cause of patients' rights. Compare Rob Hotakainen & Greg Gordon, *Patients' Testimony Helped Bill in Senate*, MINNEAPOLIS STAR TRIB., July 2, 2001, at 1A ("Too many people have died," said Democratic Majority Leader Tom Daschle. "Too many families . . . have been destroyed in so many ways as a result of the inaction of the Congress. We cannot allow this to go on."); William M. Welch, *Compromises Give Push to Patients' Bill of Rights*, USA TODAY, June 29, 2001, at 10A ("We keep knocking down

During Congress's last term, both the Republican-controlled House of Representatives and the Democrat-controlled Senate passed patient protection legislation,³⁶⁶ although neither bill became law after negotiations between the Senate and the White House to reconcile the two bills collapsed.³⁶⁷ Although there were important differences between the House and Senate bills—particularly with the level of damages injured parties could recover in lawsuits against MCOs³⁶⁸—these were far overshadowed by their similarities. Both bills would require MCOs to provide patients with a lengthy list of benefits;³⁶⁹ both bills would mandate a neutral, external review

obstacles to getting patient protections, and it looks like by tomorrow we will get it passed," said Senator John Edwards, D-N.C.) with Edwin Chen & Greg Miller, *Patients' Rights Bill in President's Sights*, L.A. TIMES, June 21, 2001, at A10 ("This issue is reaching an hour of decision, and before this year is out, I want to sign into law a patients' bill of rights," President Bush said.); Matt Kelley, *Despite Bush Request, Ganske Rolls out Patients' Bill of Rights*, OMAHA WORLD-HERALD, Feb. 7, 2001, at 6 ("I think it's time to put patient-protection legislation on the president's desk," said U.S. Representative Greg Ganske, R-Iowa).

366. S. 1052, 107th Cong. (2001); H.R. 2563, 107th Cong. (2001).

367. The White House, which was intimately involved in fashioning the bill passed by the House, agreed in September 2001 to try to mediate the differences with the Democrat-controlled Senate rather than send the bills to a congressional conference committee, where previous patients' rights bills had died. See Amy Goldstein, *Patients' Rights Talks Hit Impasse*, WASH. POST, Aug. 2, 2002, at A4. This effort failed. See, e.g., Janet Hook, *Negotiations Fail on Bill of Rights for HMO Patients*, L.A. TIMES, Aug. 2, 2002, at 20; John A. MacDonald, *Right-to-Sue Bill Stalled on Hill; Patients' Bill of Rights Negotiations Break Down as Congress Recesses*, HARTFORD COURANT, Aug. 3, 2002, at A2 ("Just before they left on a month long summer recess, Senate Democratic leaders announced they had ended talks with the White House aimed at bridging differences over the legislation, which was designed to give patients greater rights in dealing with health maintenance organizations and other forms of managed care.").

368. The Senate bill provided that, in state courts, patients could collect whatever damages awards state law allowed, while patients could collect unlimited non-economic damages and punitive damages of up to \$5 million in federal court. S. 1052, 107th Cong. § 402 (2001). In contrast, the House bill limited damages awards in either state or federal court to \$1.5 million in non-economic damages, with patients eligible for punitive damages of up to \$1.5 million only if a health plan refused to provide care ordered by an external appeals board. H.R. 2563, 107th Cong. § 402 (2001). The House bill would have preempted state laws allowing higher damage awards, but states with lower damage limits could keep their own caps.

369. See H.R. 2563, 107th Cong. § 111 (consumer choice option), § 112 (choice of health-care professional), § 113 (access to emergency care), § 114 (timely access to specialists), § 115 (access to obstetrical and gynecological care), § 116 (access to pediatric care), § 117 (continuity of care), § 118 (access to needed prescription drugs), § 119 (coverage for individuals participating in approved clinical trials), and § 120 (coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations); S. 1052, 107th Cong. § 111 (consumer choice option), § 112 (choice of healthcare professional), § 113 (access to emergency care), § 114 (timely access to specialists), § 115 (access to obstetrical and gynecological care), § 116 (access to pediatric care), § 117 (continuity of care), § 118 (access to needed prescription drugs), § 119 (coverage for participation in approved clinical trials), and § 120 (coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer, and coverage for secondary consultations).

procedure of medical necessity determinations;³⁷⁰ and both bills would permit aggrieved patients to sue MCOs for non-economic damages (the House bill would cap these) and, in specified instances, punitive damages.

For proponents of more stringent regulation of MCOs through both government regulation and private tort law, federal patients' rights legislation could offer some benefits that judicial reinterpretation of ERISA preemption would not. Federalizing patients' rights would provide a healthcare benefits floor, at least for Americans with private healthcare coverage. And if a federal Patients' Bill of Rights were to preempt all related state statutes, thus providing a rights ceiling as well as a floor, federalization could reduce the costs to multistate MCOs of complying with the law.³⁷¹

The primary substantive benefits of a federal Patients' Bill of Rights, however, would be rendered superfluous if the courts repair their flawed jurisprudence of managed care by reinterpreting ERISA's ambiguous text to exclude from its preemptive scope services provided by third parties that contract with employers. State mandated benefits laws would apply to Americans who receive healthcare through an employer-sponsored plan that purchases coverage from a third party on the grounds that such statutes do not pertain to ERISA plans, as they do under current Court jurisprudence on the grounds that they are protected by the savings clause. The threat of section 502(a) preemption of state mandated procedures for making health benefits decisions would be eliminated because such procedures would not seek to vindicate ERISA benefits. Unless prohibited by state law, injured patients could maintain tort suits against MCOs based on theories of vicarious liability for physician malpractice, direct liability for negligent screening or supervision of MCO physicians, negligent mixed eligibility and treatment decisions (as are common in utilization review), or negligent or bad faith benefits denial. None of these causes of action would be subject to section 514 conflict preemption, since all such claims would be viewed as affecting only third parties that contract with ERISA plans, rather than relating to ERISA plans themselves. And none of these claims would suffer section 502(a) complete preemption, because none would be claims for ERISA benefits.³⁷²

370. See H.R. 2563, 107th Cong. § 503C (requiring access to an independent external review for any denial of a benefits claim); S. 1052, 107th Cong. § 104 (same).

371. Both bills passed by the 107th Congress would have provided only a floor and, thus would not have provided this benefit. See S. 1052, 107th Cong. § 152 (preemption, state flexibility, and construction); H.R. 2563, 107th Cong. § 152 (same).

372. Whatever their flaws, the Supreme Court's recent decisions in *Pegram*, *Rush Prudential*, and *Kentucky Ass'n*, by cutting back on ERISA's preemptive scope, have already reduced the impact that a federal Patients' Bill of Rights would have on the substance of the law of managed care. See, e.g., Edward A. Zelinsky, *Against a Federal Patients' Bill of Rights*, 21 YALE L. & POL'Y REV. 443, 443 (2003) (arguing that, due to recent Supreme Court decisions, "there is no longer a regulatory gap" for a Patients' Bill of Rights to fill). The statutory reinterpretation proposed in this Article, however, would make a federal Patients' Bill of Rights more clearly superfluous.
