

BENEFIT DENIALS AND ERISA PREEMPTION: THE ONGOING STORY

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ABSTRACT

Recent Supreme Court decisions involving ERISA (1) have increased the scope of power that state legislatures can exercise to regulate the decision-making procedures of health care providers, particularly HMOs, that lead to granting or denying benefits; but also (2) have made it increasingly difficult for patients and their families to recover meaningful damages under state or federal law for wrongful denials of treatment. Language in individual justices' opinions reveal a potential sharp split over the remedies courts may provide for benefit denials under the language of section 502 of ERISA authorizing "other appropriate equitable relief."

The United States Supreme Court decided a major Employee Retirement Income Security Act (ERISA) [1] preemption case in each of three recent terms: *Rush Prudential HMO, Inc. v. Moran* in 2002 [2]; *Kentucky Association of Health Plans, Inc. v. Miller* in 2003 [2]; and *Aetna Health, Inc. v. Davila* in 2004 [4]. The three decisions confirm trends that had been visible in earlier cases, but also break new ground, by uncoupling ERISA analysis from that under the McCarran-Ferguson Act [5] and adopting a test when common-law actions are preempted that implies that the Court continues to take a broad view of the range of claims that can be made under section 502(a) of ERISA.

The result has been to expand the areas in which state legislatures may enact programs of administrative supervision that apply to providers of health care, but at the same time to maintain strict limits on the areas in which states may provide traditional or nontraditional contract and tort remedies to employees harmed by

decisions made by those same providers of care. This outcome is arguably consistent with the Court’s hesitant approach to making recovery available to injured workers under the Federal Employer’s Liability Act (FELA) [6] and also under principles of maritime law.

THE STATUTORY LANGUAGE

The so-called “preemption clause” of ERISA [1, §1144(2)] does not in fact use that term, but speaks of “supersedure.” This broadly written provision, section 514(a) of the original statute, states:

Except as provided in subsection (b) . . . the provisions of this [statute] . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . Not exempt under section 1003(b)...[1, §1144(2)].

Subsection (b)(2)(A) is the “saving” clause, so called because it “saves” the effectiveness of state law:

Except as provided in [the “deemer” clause] . . . Nothing in this [statute] . . . shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities [1, §1144(b)(2)(A)].

Subsection (b)(2)(B) is the “deemer” clause:

Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or to be engaged in the business of insurance or banking for the purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies [1, §1144(b)(2)(B)].

Section 1003(b) referred to in the supersedure clause, exempts from ERISA coverage several categories of plans, including those “maintained solely for the purpose of complying with applicable workers compensation laws or unemployment compensation or disability insurance laws” [1, §1003(b)].

Section 502 (codified in Title 29 of United States Code as §1132) is the principal section governing civil enforcement. The language important to the issues involved in this discussion is:

- (a) . . . A civil action may be brought - . . . (1) by a participant or beneficiary – . . . (2) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan; . . .
- (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or

(ii) to enforce any provisions of this subchapter or the terms of the plan; . . . [1, §1132].

As any number of commentators, including the justices of the Court, have said, the language of section 514 is not particularly helpful in reaching decisions in specific cases. The “relate to” language elicited a comment from Justice Scalia in *Dillingham*: “[A]s many a curbstone philosopher has observed, everything is related to everything else” [7, at 335]. The Court’s first attempt to give more substance to the phrase was in *Shaw v. Delta Airlines*, where the opinion said a law would relate to a plan if it makes “reference to” or “has a connection with” a regulated plan [8, at 97]. “Connection with,” however, does not spell out what sort of connection and so did little to assist the lower courts, where the volume of preemption cases has been high [9].

PRIOR DECISIONS

The Supremacy Clause of the U.S. Constitution provides:

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding [10].

Under this language, the courts have recognized three different varieties of federal preemption of state law:

1. *Explicit preemption*. A statute states that it does or does not displace state law.
2. *Conflict preemption*. The clearest case is one in which “it is impossible for a private party to comply with both state and federal requirements” [11, at 79]. This would be the situation if a state law commands what federal law prohibits, for instance. Less clear-cut is the situation in which state law prohibits what federal law permits. In such a case, the issue is whether the “permission” reflects a conscious decision by the Congress that the activity should be allowed to go forward [12].
3. *Field preemption*. The congress often enacts a statute that occupies a field broadly, such as the National Labor Relations Act (NLRA) [13], so that for the purposes of attaining national uniformity, ease of administration, or the like, it seems sensible to displace state law [14]. When asked to preempt state law in such cases, a court seeks to determine whether the Congress intended to “occupy the field” by looking to the pervasiveness of the federal regulation and the extent to which federal interests are dominant [15]. In the case of field preemption, it makes a difference whether the area is one in which state law has traditionally played a major role. If that is true, those

Table 1. Pre-2000 ERISA Preemption Cases Involving Statutory Regulation

Case Style	Nature of "regulation"	"Relate to" a "plan"?	"Savings clause" applicable?	Plan excluded under Section 1003(b)?
<i>Alessi v. Raybestos-Manhattan, Inc.</i> , 451 U.S. 504 (1981)	Statute forbids integration of workers' compensation benefits and pension benefits	Yes	No	No, since regulated plan not maintained "solely" for workers compensation purposes
<i>Shaw v. Delta Air Lines, Inc.</i> , 463 U.S. 85 (1983)	State disability benefits law requires payment of sick leave benefits to pregnant employees	Perhaps, if there is "reference to" or "connection with" a plan	No	Depends on whether sick leave benefits are provided under general plan subject to ERISA or under plan adopted solely to provide mandated disability benefits.
<i>Metropolitan Life Insurance Company v. Massachusetts</i> , 471 U.S. 724 (1985)	Insurance code mandates including mental health benefits in coverage of health insurance policies	Yes	Yes	No

<p><i>Fort Halifax Packing Company v. Coyne</i>, 482 U.S. 1 (1987)</p>	<p>Statute requires one-time severance payment to longer-term employees not covered by severance plan provision in contract</p>	<p>No, no "plan" involved.</p>	<p>No</p>	<p>No</p>
<p><i>Mackey v. Lanier Collection Agency & Service, Inc.</i>, 486 U.S. 825 (1988)</p>	<p>Garnishment law excludes ERISA plans from garnishment</p>	<p>Yes, makes "reference to" ERISA plans</p>	<p>No</p>	<p>No</p>
<p><i>Massachusetts v. Morash</i>, 490 U.S. 107 (1989)</p>	<p>Statute requires payment "of all wages" due at time of discharge including vacation benefits</p>	<p>Depends on whether a vacation "plan" includes certain vested accumulation provisions</p>	<p>No</p>	<p>No</p>
<p><i>FMC Corp. V. Holliday</i>, 498 U.S. 52 (1990)</p>	<p>Financial responsibility law bans provisions in health plans that would permit reimbursement of plan from ultimate tort recovery</p>	<p>Yes</p>	<p>Yes, but "deemer clause" prevents applying it to health plan operated as self-funded entity</p>	<p>No</p>

Table 1. Cont'd.

Case Style	Nature of "regulation"	"Relate to" a "plan"?	"Savings clause" applicable?	Plan excluded under Section 1003(b)?
<i>District of Columbia v. Greater Washington Board of Trade</i> , 506 U.S. 125 (1992)	Workers compensation ordinance requires benefit-liable employer to maintain health insurance for worker during disability	Yes	No	No (over vigorous dissent urging a broader purpose-driven interpretation of Section 1003(b))
<i>New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co.</i> , 514 U.S. 645 (1995)	Statute imposing surcharge on health-care bills paid by commercial insurers, but not on those paid by Blues	No "reference to" plans; no "connection with" since effect is indirect in area of traditional state regulation	Not reached, but arguable	No

<p><i>California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.</i>, 519 U.S. 316 (1997)</p>	<p>Contractors on public works projects may pay below "prevailing wage" rates to participants in approved apprenticeship plans</p>	<p>No "reference to" since some apprenticeship plans may not be ERISA governed; no "connection with" since law does not require plan to do anything</p>	<p>Not reached (would be no)</p>	<p>No</p>
<p><i>DeBuono v. NYSA-ILA Medical and Clinical Services Fund</i>, 520 U.S. 806 (1997)</p>	<p>Tax imposed on gross receipts for patient treatment at hospitals, treatment centers, and other medical facilities, including those directly operated by a plan</p>	<p>No "reference to" plan, only to possible providers; no "connection with" even though there is direct impact on a particular plan, in area of traditional state regulation</p>	<p>Not reached (would probably be no, although such a tax on HMOs and other PPOs might be considered a type of insurance regulation, depending on how it was structured</p>	

Table 2. Pre-2000 ERISA Preemption Cases Involving Individual Nonregulatory Claims

Case Style	State law claim	"Relate to" a "plan"?	"Savings clause" applicable?	Plan excluded under Section 1003(b)?
<i>Pilot Life Insurance Company v. Dedeaux</i> , 481 U.S. 41 (1987)	Action for bad faith refusal to pay benefits under group disability insurance policy	Yes	No, largely because Congress intended ERISA's own remedies to be exclusive	No
<i>Metropolitan Life Insurance Company v. Taylor</i> , 481 U.S. 58 (1987)	Action for breach of promise to pay benefits; defendant seeks removal to federal court	Yes	No, citing <i>Dedeaux</i> and its reasoning; case therefore removable	No
<i>Ingersoll-Rand Company v. McClendon</i> , 498 U.S. 133 (1990)	Common law cause of action for wrongful discharge in order to evade pension obligations	Yes	No, since ERISA provides a remedy under Section 510	No

<p><i>Unum Life Insurance Co. of America v. Ward</i>, 526 U.S. 358 (1999)</p>	<p>1. "Notice prejudice" rule (lack of timely notice to insurer does not bar claim unless insurer prejudiced by lateness);</p> <p>2. Notice to employer is notice to insurer under group policy</p>	<p>1. Stipulated by parties</p>	<p>1. Yes</p>	<p>No</p>
<p><i>Egelhoff v. Egelhoff</i>, 532 U.S. 141(2001)</p>	<p>Statute provides that beneficiary designations of "non-probate assets" are automatically revoked at time of divorce;" non-probate assets" defined to include employee benefit plans</p>	<p>Yes</p>	<p>No</p>	

seeking preemption must convince the court that there is more than a mere possibility that the state law may in some way frustrate the federal purpose [16].

The three are not mutually exclusive, but shade into one another. In the case of the NLRA, for instance, union-management relations and the enforcement of collective bargaining agreements are broadly regulated by federal law, and much state law is preempted [16]. On the other hand, the enforcement of individual employment contracts has remained largely a matter of state law, with the important exception that interpreting the scope of an arbitration clause in an employment agreement is largely a matter of federal law, although the validity of the contract itself is a state law question [17]. Therefore, the state law claims of replacement workers that their individual employment contracts had been breached by the terms of a strike-settlement agreement reached by their employer were found by the Court not to be preempted under the NLRA [18].

In its early ERISA cases, the Court treated section 514 as an instance of “explicit” preemption. Over time, however, it has become increasingly clear to many of the justices that the language is so nonspecific that it is more appropriate to apply approaches used in “conflict” and “field” preemption [19]. Table 1 sets out the results in one set of cases.

There is another sort of state law, of course, which is not explicitly “regulation” as such—the law of torts and contracts and property—much of it court-made common law. Table 2 sets out the results in the few cases the Court has decided.

RECENT DECISIONS

Rush Prudential HMO, Inc. v. Moran [2]

Rush Prudential HMO was decided by a 5-4 vote. The majority opinion by Justice Souter drew the support of justices Breyer, Ginsburg, O’Connor, and Stevens. Justice Thomas wrote a separate dissent for himself, the chief justice and justices Scalia and Kennedy. The close vote reflects the fact that the case fell very near the dividing line between the “claim for wrongful denial of benefits” cases, in which state law had regularly been found not available to claimants, and the “regulation of benefit provider” cases, in which the results had been more mixed.

Debra Moran, the claimant, was married to an employee of a firm whose benefit plan provided health care to employees and their families through a contract with Rush Prudential. Rush in turn had contracts with a number of physicians and hospitals, and persons enrolled in the plan were required to choose their primary care physician from among those who had agreements with Rush. Under the terms of its contract with employers, Rush would pay the cost of a nonaffiliated physician’s services only if those services were authorized by both the primary

care physician and Rush’s own medical director. When numbness and pain in her shoulder did not respond to the conservative treatment provided by her primary care physician, that physician recommended surgery to be performed by an unaffiliated physician. The proposed surgery involved some nonstandard procedures. Rush’s medical director did not approve the surgery. Moran then demanded an independent medical review of her request, a review provided for by an Illinois HMO statute. Rush refused, and Moran sued in state court to compel compliance with the Illinois statute. The state court ordered the review, and the reviewing physician found the procedure medically necessary. Rush still refused to provide the procedure, offering a more standard surgery instead. Moran had the nonstandard procedure and amended her state court complaint to seek reimbursement for its cost. Rush moved to remove the case to federal court.

The majority justices found that although the Illinois HMO statute clearly “related to” a plan, it fit within the “saving clause” and also would not be preempted as an attempt to provide remedies beyond those provided by ERISA itself. The first point occupies much of the opinion. Justice Souter began the majority opinion by noting that as early as 1973 the Congress had treated HMOs as a specialized type of insurer [2, at 367-368]. The opinion then followed a pattern of earlier cases by applying to the Illinois statute the three-factor test used to determine whether a party is doing an “insurance business” subject to state regulation under the McCarran-Ferguson Act [20]. Clearly, at least two of the three factors would be met, the opinion concluded, and a “common sense” view of the way an HMO operates indicates that it is a type of insurance. Therefore, Moran was entitled to assert her rights under the Illinois law, and the lower court was wrong when it dismissed her reimbursement claim.

It is the second point—that the Illinois statute provides no additional remedy to that provided for by ERISA—with which the dissent disagreed strongly. The dissent argued that the review procedure called for by the statute is the equivalent of “arbitration” and therefore the statute gives plan beneficiaries a remedy in addition to those the Congress established under section 502(a) of ERISA. That is serious, the dissent argued, because this lessens the ability of parties such as Rush to control the costs of health care, and is thus a disincentive for employers to establish health-care plans [2, at 401]. The majority found that the nature of the review procedure simply does not resemble traditional adjudication enough to constitute either an alternative forum or an alternative remedy to those available under section 502(a). Rather, they found this similar to the statute the Court had found not preempted in *Metropolitan Life Ins. Co. v. Massachusetts*, requiring health insurance policies to provide mental health benefits.

Kentucky Association of Health Plans, Inc. v. Miller [3]

The other two recent cases were decided by a unanimous Court. The opinion in *Kentucky Association of Health Plans, Inc. v. Miller* was written by Justice Scalia,

who was in dissent in *Rush Prudential*. The statutes in question are provisions of the “any willing provider” law in force in Kentucky. One forbids discrimination “against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky state Medicaid program and Medicaid partnerships” [3, at 331]. The other similar provision applies to chiropractors.

The plaintiffs, operators of several health-care plans, sued the state insurance commissioner, asking that she be forbidden to enforce the statute. They argued that the statutes were preempted by virtue of section 514. They lost in the Sixth Circuit, and the Supreme Court affirmed that decision. Plaintiffs’ principal arguments focused on two of the McCarran-Ferguson factors: They argued that the scope of the provisions was not “specifically directed toward” entities within the insurance industry, and that the statutes had to do with the relationship between provider organizations and beneficiaries, but rather with the relationship between provider organizations and third parties [3, at 334-335]. In an earlier decision, *Group Life & Health Ins. Co. v. Royal Drug*, the Court had found that arrangements between insurers and pharmacies did not constitute the “business of insurance” under McCarran-Ferguson [22, at 214].

Justice Scalia’s opinion dealt with the first argument by saying that the fact that a statute affects other entities as well as insuring organizations does not mean that the law is not “focused on” insurers. Some effects on third parties must be inevitable, he noted. For example, the Pennsylvania statute “we held saved from preemption in *FMC Corp.* . . . prohibiting insurers from exercising subrogation rights against an insured’s tort recovery . . . also prevented insureds from entering into enforceable contracts with insurers allowing subrogation” [3, at 335]. The argument based on *Royal Drug* was also rejected. The saving clause applies to laws that regulate insurance, not necessarily insurers, just as McCarran-Ferguson preserves the “business of insurance” to state control, not insurers. What is important, Justice Scalia wrote, is that the state law affects the risk pooling that is characteristic of insurance. In this case, the statute does so, because, “No longer may Kentucky insureds seek insurance from a closed network of health-care providers in exchange for a lower premium. The AWP prohibition substantially affects the type of risk pooling arrangements that insurers may offer” [3, at 339].

The opinion up to this point read as if the Court had still viewed it as important to apply not only the “common sense” approach to whether a state law regulates insurance, but also to check this by using the traditional McCarran-Ferguson factors. In section III of the opinion, however, Justice Scalia announced that the Court had decided “that our use of the McCarran-Ferguson case law in the ERISA context has misdirected attention, failed to provide clear guidance to lower federal courts, and, as this case demonstrates, added little to the relevant analysis” [3, at 339-340]. Instead, in the future, courts are to apply a two-factor test: “First, the state law must be specifically directed toward entities engaged in

insurance . . . [citing *Pilot Life* [28], *UNUM* [29], and *Rush Prudential* [2]]. Second, . . . the state law must substantially affect the risk pooling arrangement between the insurer and the insured” [3, at 342].

Clearly, this two-factor test will make application of the saving clause more straightforward. Problems are likely to persist, however, as witness the difficulty the courts had with deciding how to apply the new test to a “collateral source” rule in a New Jersey statute. The statute provided:

In any civil action brought for personal injury or death, . . . if a plaintiff receives or is entitled to receive benefits for the injuries allegedly incurred from any other source . . . the benefits . . . shall be disclosed to the court and the amount thereof which duplicates any benefit contained in the award shall be deducted from any award recovered by the plaintiff, less any premium paid to an insurer . . . by the plaintiff . . . for the policy period during which the benefits are payable [23].

Many readers will recognize that this is a total reversal of the older common law rule that required a person liable for a plaintiff’s injury to pay damages for that wrong without regard to whether the plaintiff had received benefits from any other source. In a 2001 decision, *Perreira v. Rediger*, the New Jersey Supreme Court held that this statute invalidated a regulation issued by the New Jersey Department of Insurance [24]. The regulation permitted group health insurers to include in their policies subrogation provisions that would allow the insurers to recoup benefits they had paid to their insureds from damage recoveries those insureds obtained later, provided the damage award clearly represented the cost of medical care the insurer had provided. In *Levine v. United Healthcare Corp.*, a panel of the Third Circuit, reversing a lower court decision, held 2-1 that this statute was not saved from preemption by the saving clause of section 514, because it failed the first prong of the new two-factor test [25]. Ms. Levine had been injured by a third party, and required medical care as a result. This care was paid for in part by an insurer. Later, Ms. Levine sued the party who injured her and negotiated a settlement of her claim. Her insurer then asked for reimbursement of what it had paid for her medical care, as called for under the policy. Ms. Levine paid part of her settlement over to the insurer in response. Soon after, the state supreme court decided *Perreira*. When she learned of this, Ms. Levine filed an action seeking to get her money back from the insurer. (The claim she made was in the form of a class action, seeking to vindicate not only her rights but those of other similarly situated parties.) The statute was not, the majority reasoned, “specifically directed toward the insurance industry,” since by its terms the statute “is not limited to regulating either health insurance or liability insurance providers” [25, at 165]. The majority also noted that the statute was placed not in the insurance section of the New Jersey Code, but in the portion of the statutes dealing with civil actions in general. Judge Garth, dissenting, agreed with the majority that the statute did not appear on its face to be an insurance regulation, but insisted that the federal court

must consider the interpretation placed on the statute's purposes by the state supreme court, which had said in *Perreira* that "a secondary goal was clearly the containment of spiraling insurance costs" [25] and that the legislature had spent substantial time in its consideration of the statute debating about what segments of the insurance industry should have the benefit of the statute [25, at 169]. Both opinions clearly have merit, and can find support in the opinions of the U.S. Supreme Court.

Aetna Health, Inc. v. Davia [4]

Aetna Health, Inc. v. Davila was also a unanimous decision, but there is a tension between the descriptions of ERISA's remedial scheme in the majority and concurring opinions that indicates the Court is likely to be divided when it next considers the proper interpretation of section 502(a). The claimants in *Davila* sued under the Texas Health Care Liability Act, which imposes a "duty to exercise ordinary care when making health care treatment decisions" on any "health insurance carrier, health maintenance organization, or other managed care entity for a health care plan" [26]. One claimant's provider had refused to provide a medication recommended by his physician. The claimant then took an alternative, over-the-counter medication to which he had a severe reaction that required hospitalization. The second claimant's physician had recommended extra time in the hospital following her surgery. The provider organization refused, and she experienced complications that required her to return to the hospital for further treatment. Both brought actions in state court. The defendants sought to remove the case to federal district court. The defendants' motions were granted and the district court dismissed the claims because the state law was preempted by ERISA.

The U.S. Court of Appeals for the Fifth Circuit reversed. First, the Fifth Circuit reasoned that the claims were not claims for benefits, but tort claims for consequential harm. Speaking for the Court, Justice Thomas wrote that in fact the claimants "complain only about denials of coverage promised under the terms of ERISA-regulated employee benefit plans" [4, at 211]. He points out that under section 502(a) the claimants had more than one course of action available to them: Seek a preliminary injunction or pay for the desired treatment and then seek reimbursement [4]. The claimants' actions were not the sort of *Pegram* malpractice claim for which ERISA provides no remedy [27]. Second, the Fifth Circuit held that the saving clause of section 514 applied. The Court disagreed with this also, emphasizing the similarity between the claim in this case and that in *Pilot Life* [28]. "Under ordinary principles of conflict preemption . . . even a state law that can be arguably characterized as 'regulating insurance' will be preempted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme" [4, at 217-218]. That language obviously reflects the concern expressed earlier by Justice Thomas, in his *Rush Prudential* dissent, which said that states must not be permitted to create additional

“claims” against ERISA plans beyond those provided by the federal statute itself [2]. The breadth of this language has already begun to trouble lower courts as they seek to reconcile *Davila* [4] with the other two decisions discussed here. In *Hawaii Management Alliance Association v. Insurance Commissioner*, the Hawaii Supreme Court held that under conflict preemption principles (but not under section 514), federal law preempted a state statute that provided for external review by the state insurance commissioner of benefit denials [30]. The court distinguished this statute from that in *Rush Prudential* by finding that by creating a right to external review, the Hawaii statute created a claim different from that provided for by plan documents, rather than simply requiring that entities providing care include a second review of their decision as part of their procedures. As the court phrased it:

Reading *Rush Prudential* and *Aetna Health* together, we believe that the Supreme Court intended to distinguish between state laws that (1) create a state law claim for relief against an employee benefit plan and (2) require insurers to provide certain procedural protections to insureds (even if the insurance is provided as part of an ERISA-covered employee benefit plan [30, at 33].

Justice Ginsburg concurred in *Davila*, in an opinion joined by Justice Breyer. The concurrence acknowledged that the majority opinion is a fair application of existing ERISA precedent, but goes on to say that the broad reach the Court has given section 514 must be viewed not in isolation but together with “a cramped construction of the ‘equitable relief’ available under § 502(a)(3)” [4, at 222]. The net result, Justice Ginsburg said, is that “a ‘regulatory vacuum’ exists: ‘Virtually all state remedies are preempted but very few federal substitutes are provided’ [31, and 4, at 222]. Her opinion at this point refers to a series of decisions in which the Court denied “make whole” relief to ERISA beneficiaries. *Massachusetts Mutual Life Ins. Co. v. Russell* held that a plan beneficiary could not recover extracontractual damages from a plan administrator for a wrongful denial of benefits that the administrator did not correct for more than four months [32]. The Court acknowledged that interference with state law was not a reason for refusing to imply such a cause of action, since any state law claim would be preempted. *Mertens v. Hewitt Associates* decided that monetary damages are not available against a nonfiduciary as “other appropriate equitable relief” under section 502(a)(3) [33]. *Great-West Life & Annuity Ins. Co. v. Knudson* held that an insurer could not bring an action under 502(a)(3) against a plan beneficiary seeking damages for breach of contract, since that would constitute “legal” rather than “equitable” relief [34].

Justice Ginsburg’s “cramped construction” language contrasts markedly with Justice Thomas’s description of ERISA remedies, quoted from *Pilot Life*:

The detailed provisions of §502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt

and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. 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 [4, at 2495].

CONCLUSION

The three recent cases interpreting ERISA's supersedure clause continue a pattern that had emerged in the prior decade. The Court is willing to modify its approach to allow greater room for state law to operate in the administrative oversight of benefit providers. The justices are not, however, ready to reduce the scope of ERISA preemption to allow states to provide broader damage remedies to the victims of allegedly wrong denials of treatment by HMOs and other providers. Only if a person injured by the denial can cast his or her claim as a malpractice claim under *Pegram* [27] will state law be available.

The remaining question is whether the Court will modify what Justice Ginsburg characterized as a "cramped construction" of section 502(a). This seems possible, but dubious. First, the most recent decision of this sort, *Great-West*, was a 5-4 decision and was reached by the same justices who currently sit on the Court [34]. Second, it seems fair to say that the Court includes a substantial number of justices who are not eager to broaden the scope of remedies under federal law for personal injury. In the case of injured workers, for example, one thinks of *Miles v. Apex Marine Corp.* limiting damages recoverable by the survivors of sailors killed while in the service of a vessel by analogizing to limits imposed under the Death on the High Seas Act [35]. During the last dozen years the Court also decided FELA cases in which the opinion has either limited the scope of liability or the scope of damages that can be recovered. In *Consolidated Railroad Corp. v. Gottshall*, the Court adopted a stringent version of the "zone-of-danger" test to limit the category of persons who can seek recovery for the infliction of mental distress [36]. In *Metro-North Commuter R.R. Co. v. Buckley* the majority applied *Gottshall* in a recovery-restricting fashion, and set a high threshold for plaintiffs to meet to justify an award of medical monitoring costs as an element of damages for wrongful exposure to harmful substances [37].

Finally, there are the punitive-damage cases, culminating in *State Farm Mutual Automobile Ins. Co. v. Campbell* in which the Court has begun to subject these awards to Constitutional limits [38]. This leads one to believe that persons injured by wrongful denials of benefits are unlikely to find substantial legal redress available unless there is congressional action or a change in the Court's personnel.

Congressional action is also a bit of a long shot. Proposals to modify ERISA's preemption structure have been before the Congress during each of the last several sessions [39]. Managed-care organizations and the health insurance community

have significant lobbying power and have convinced many that allowing state tort actions would undo the cost savings associated with the move to managed care. Those who reject this cost-based argument divide sharply over whether state tort law or a new federal remedy would be the better solution. Such divisions will probably continue to prevent a consensus solution.

ENDNOTES

1. Employee Retirement Income Security Act, 29 U.S.C. §§1001-1461.
2. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002).
3. *Kentucky Association of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003).
4. *Aetna Health, Inc. v. Davila*, 542 U.S. 200 (2004).
5. McCarran-Ferguson Act, see 15 U.S.C. § 1012(b).
6. Federal Employer's Liability Act, 45 U.S.C. §§ 51-60.
7. *California Division of Labor Standards Enforcement v. Dillingham Constructions, N.A., Inc.*, 519 U.S. 316 (1997).
8. *Shaw v. Delta Airlines*, 463 U.S. §85 (1983).
9. Following the lead of Justice Stevens in an earlier case, I performed a quick LEXIS search and found that more than 3,000 federal court opinions have at least mentioned section 514.
10. U.S. Const. Article. VI. Para. 2.
11. *English v. General Electric Co.*, 496 U.S. 72, 79 (1990) (state law claim for intentional infliction of mental distress not preempted by Energy Reorganization Act).
12. See, e.g. *Bronco Wine Co. v. Jolly*, 2004 Cal. Lexis 7082, reversing *Bronco Wine Co. v. Espinoza*, 104 Cal. App. 4th 598; 128 Cal. Rptr. 2d 320 (2002).
13. National Labor Relations Act, 29 U.S.C. §§ 151-169.
14. See *Garmon v. San Diego Building Trades Council (Garmon II)*, 359 U.S. 236 (1959).
15. *Rice v. Santa Fe Elevator Co.*, 331 U.S. 218 (1947).
16. *Jones v. Roth Packing Co.*, 430 U.S. 519 (1977).
17. See *First Options of Chicago v. Kaplan*, 514 U.S. 938 (1995); *Gibson v. Neighborhood Health Clinics*, 121 F.3d 1126, 1130 (7th Cir. 1997); *Penn v. Ryan's Family Steak Houses*, 269 F.3d 753 (7th Cir. 2001).
18. *Belknap, Inc. v. Hale*, 463 U.S. 491 (1983).
19. See, e.g., the concurring opinion of Justice Scalia, joined by Justice O'Connor, in *Dillingham*, 519 U.S. at 334-336.
20. "A law regulating insurance for McCarran-Ferguson purposes targets practices or provisions that 'have the effect of transferring or spreading a policyholder's risk; . . . [that are] an integral part of the policy relationship between the insurer and the insured; and [are] limited to entities within the insurance industry.'" [2, at 373].
21. Ky. Rev. Stat. Ann. §304.17A-270 (West 2001).
22. *Group Life & Health Ins. Co. v. Royal Drug*, 440 U.S. 205 (1979).
23. N.J. Stat. Ann. §2A:15-97.
24. *Perreira v. Rediger*, 169 N.J. 399, 778 A.2d 429 (2001).
25. *Levine v. United Healthcare Corp.*, 402 F.3d 156 (3d Cir. 2005).
26. Texas Health Care Liabilities Act, Tex. Civ. Prac. & Rem. Code § 88.002 (2004).

27. See *Pegram v. Herdrich*, 530 U.S. 211 (2000) (action alleging physician owners of HMO delayed plaintiff's treatment to increase their bonuses does not constitute claim for breach of fiduciary duty under ERISA but a malpractice claim to be decided under state law).
28. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).
29. *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358 (1999).
30. *Hawaii Management Alliance Association v. Insurance Commissioner*, 106 Haw.21, 100 P.3d 952 (2004), opinion amended, 2004 Haw. LEXIS 801, cert. denied sub nom. *Baldado v. Hawaii Management Alliance Association*, 544 U.S. 1061 (May 31, 2005).
31. [4, at 2503], quoting from *DiFelice v. Aetna U.S. Healthcare, Inc.*, 346 F.3d 442, 456 (3d Cir. 2003). She also cited an article highly critical of the Court's 502(a)(3) jurisprudence: J. Langbein, What ERISA Means by "Equitable": The Supreme Court's Trail of Error in Russell, Mertens and Great West (eds.), 103 Columbia Law Review. 1317 (2003). For an earlier critique focusing on the *Mertens* decision, see Dana Muir, ERISA Remedies: Chimera or Congressional Compromise? 81 Iowa Law Review 1 (1995).
32. *Massachusetts Mutual Life Ins. Co. v. Russell* 473 U.S. 134 (1985).
33. *Mertens v. Hewitt Associate*, 508 U.S. 248 (1993).
34. *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002).
35. *Miles v. Apex Marine Corp.*, 498 U.S. 19 (1990).
36. *Consolidated Railroad Corp. v. Gottshall*, 512 U.S. 532 (1994).
37. *Metro-North Commuter R.R. Co. v. Buckley*, 521 U.S. 424 (1997).
38. *State Farm Mutual Automobile Ins. Co. v. Campbell*, 538 U.S. 408 (2003).
39. For accounts of early efforts, see Karen Jordan, Coverage Denials in ERISA Plans: Assessing the Federal Legislative Solution, 65 Missouri Law Review 405 (2000); Julia Anastasio, Legislative Developments in the Regulation of Insurance Coverage, 7 *American University Journal of Gender, Social Policy & Law*, 55 (1998/1999). Providing tort remedies as a counter to the incentives for a managed-care organization to provide insufficient care has been criticized by some, however, as inefficient. See Jeffrey O'Connell and James Neale, HMOs, Cost Containment, and Early Offers: New Malpractice Threats and a Proposed Reform, 14 *Journal of Contemporary Health Law & Policy*, 287 (1998). Another alternative, a federal "statutory tort" remedy has also been proposed. See, e.g., Jeffrey Shuren, Legal Accountability for Utilization Reviews in ERISA Health Plans, 77 *North Carolina Law Review*, 731 (1999).

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