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ERISA: STATE REGULATION OF INSURED PLANS AFTER DAVILA

DONALD T. BOGAN*

Consumers who receive their health care benefits or disability benefits through their employment often endure significant legal obstacles in enforcing benefit claims, in addition to suffering the medical hardships which may underlie those claims. ERISA, enacted by Congress in 1974 to reform the private pension industry, also impacts non-pension employee fringe benefit programs, including health care benefit plans and disability benefit plans. Federal courts have interpreted ERISA to preempt traditional state law consequential and punitive damage remedies in claims arising from employment-provided fringe benefit plans, without substituting any comparable federal remedies. Additionally, under the guise of deferential review, federal courts have created a system of summary adjudication in employee benefit claims that routinely denies consumers the right to examine witnesses and to cross-examine opposition witnesses in order to resolve factual disputes in ERISA claims litigation, denies the right to a jury trial, denies the right to conduct discovery as provided in the Federal Rules of Civil Procedure, and denies consumers the opportunity to conduct a de novo trial before a neutral fact-finder when challenging an insurance company's claim denial.

The recent United States Supreme Court decision, Aetna Health, Inc. v. Davila, establishes that ERISA prohibits plan participants from pursuing extra-contractual damages under state law in actions arising from abusive claims settlement practices committed by ERISA plan insurers. However, Davila does not totally void state bad faith insurance laws in ERISA claims litigation; the decision only nullifies the plan participant's individual remedy against an ERISA plan insurer for extra-contractual damages. The Davila case offers the opportunity to re-examine the ongoing influence of state bad faith insurance laws in the ERISA context. This Article suggests that state bad faith insurance laws continue to set standards of behavior that insurers, even ERISA plan insurers, must abide by in their claims settlement practices. The remaining impact of state bad faith laws on individual plan participant claims after

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Davila may be to help plan participants recover at least their contract damages under ERISA section 502(a)(1)(B) when courts apply an arbitrary and capricious standard of review to ERISA plan insurer claim denials. An insurer's violation of state bad faith standards when evaluating claims may define the insurer's actions as arbitrary and capricious, per se, in ERISA cases applying the deferential review standard. Despite Davila, recent Supreme Court ERISA cases confirm that the states can still have a significant role to play in regulating ERISA plan insurers and in enforcing state insurance laws. In particular, now that the Supreme Court has nullified individual plan participant state law remedies, consumers should urge their state Insurance Commissioners to enforce unfair insurance practices laws in order to curb insurance bad faith arising in the ERISA context. Additionally, states that act to prohibit grants of discretionary powers in insurance contracts may restore an equal legal footing to consumers who contest ERISA benefit claim denials by assuring plan participants a de novo hearing when they challenge their ERISA plan insurers.

I. PREFACE

The Employee Retirement Income Security Act of 1974 ("ERISA")¹ regulates employment-provided fringe benefit plans, including both pension benefit plans and non-pension or "welfare" benefit plans.² Among the most prominent welfare benefit plans subject to ERISA regulation are health care benefit plans and disability benefit plans.³

1. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended at 29 U.S.C. §§ 1001-1461 (Supp. III 1997) and in scattered sections of the Internal Revenue Code, 26 U.S.C.) [hereinafter ERISA]. A selected history of ERISA, beginning in January 1973 with the introduction of House Bill 2, H.R. 2, 93d Cong. (1973), and Senate Bill 4, S. 4, 93d Cong. (1973), the bills which ultimately formed the basis of the final legislation, are compiled in a three volume committee print. See 1-3 SUBCOMM. ON LABOR OF THE SENATE COMM. ON LABOR & PUB. WELFARE, 94TH CONG., LEGISLATIVE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (Comm. Print 1976) [hereinafter LEGISLATIVE HISTORY].

2. Employee benefit plans are fringe benefit programs provided or available to workers and their beneficiaries through the worker's employment, either from the worker's employer, or union, or from both. ERISA §§ 3(1)-(2), 29 U.S.C. §§ 1002(1)-(2) (2000). Welfare benefit plans are any non-pension fringe benefit programs, whether self-funded by the plan sponsor or funded through the purchase of insurance, including health care benefit plans, accident and death benefit plans, disability benefit plans, and severance benefit plans. ERISA § 3(1), 29 U.S.C. § 1002(1). The most significant exceptions to ERISA's regulation of employee benefit plans are for government provided plans and for church plans. See ERISA § 4(b), 29 U.S.C. § 1003(b).

3. See Jon Gabel, *Job-Based Health Insurance, 1977-1998: The Accidental System Under Scrutiny*, HEALTH AFFAIRS, Nov./Dec. 1999, at 63, available at <http://content.healthaffairs.org/cgi/reprint/18/6/62> (reporting that 152 million

ERISA plan sponsors often fund health care plans and disability plans through the purchase of insurance.⁴ The states have historically regulated insurance, consequently, ERISA's enactment created the potential for overlap and conflict between the states' regulation of insurance and ERISA's regulation of employee benefit plans. Congress addressed the relationship between state and federal law in ERISA by including an express preemption provision in the statute.⁵

ERISA's preemption language dealing with state law contains three inter-related subparts, commonly known as the *preemption clause*, the *savings clause*, and the *deemer clause*.⁶ The preemption clause recites that ERISA shall supersede any and all state laws

Americans receive health care benefits through their employment, including ninety-three percent of privately insured Americans). *See also* HEALTH, EDUC., & HUMAN SERVS. DIV., U.S. GEN. ACCOUNTING OFFICE, EMPLOYER-BASED HEALTH PLANS: ISSUES, TRENDS, AND CHALLENGES POSED BY ERISA 44-48 (1995), available at <http://www.gao.gov/cgi-bin/getrpt?HEHS-95-167> (reporting, based upon a 1993 survey, that approximately 114 million Americans received their health care benefits from employer- or union-sponsored health plans).

4. Many large employers, and an increasing number of smaller employers, now self-insure their health care benefit plans; however, "self-insure" is somewhat of a misnomer, because the large majority of small firms, in particular, that self-insure, obtain re-insurance protection by purchasing stop-loss insurance. *See* Gregory Acs et al., *Self-Insured Employer Health Plans: Prevalence, Profile, Provisions, and Premiums*, HEALTH AFFAIRS, Summer 1996, at 269-70, available at <http://content.healthaffairs.org/cgi/reprint/15/2/266>.

5. ERISA § 514, 29 U.S.C. § 1144. The statute provides in relevant part:

Other laws

(a) Supersedure; . . .

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 hereinafter relate to any employee benefit plan described in section 4(a) [29 U.S.C. § 1003(a)] and not exempt under section 4(b) [29 U.S.C. § 1003(b)] of this title . . .

(b) Construction and application

. . . .

(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.

(B) Neither an employee benefit plan described in section 4(a) of this title [29 U.S.C. § 1003(a)], which is not exempt under section 4(b) of this title [29 U.S.C. § 1003(b)] (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 any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

6. *See id.* ERISA's express preemption language also recites that ERISA shall not be construed to supersede any other federal laws. *See* ERISA § 514(d), 29 U.S.C. § 1144(d).

that relate to any employee benefit plan.⁷ The savings clause then exempts state laws that regulate insurance from ERISA preemption.⁸ Finally, the deemer clause prohibits the states from treating self-funded employee benefit plans as insurers for purposes of ERISA's savings clause exception to preemption.⁹

In addition to ERISA's express preemption language, the statute contains a civil enforcement provision which provides the foundation for even further preemption of state law, according the United States Supreme Court. ERISA's civil enforcement provision, found at section 502 of the statute, details specific remedies authorized by Congress to serve ERISA plan participants and beneficiaries, ERISA fiduciaries, and the United States Secretary of Labor.¹⁰ Despite the lack of standing for other potential ag-

7. ERISA § 514(a), 29 U.S.C. § 1144(a). ERISA section 514(c), 29 U.S.C. § 1144(c), defines state law to include state decisional law, in addition to statutes and regulations.

8. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). ERISA's legislative history discloses that the insurance savings clause was contemplated long before the Conference Committee significantly broadened the scope of the preemption clause. Compare H.R. REP. NO. 93-1280, at 82-83 (1974), reprinted in 3 LEGISLATIVE HISTORY, *supra* note 1, at 4357-58, with S. 4, 93d Cong. § 609 (1973), reprinted in 1 LEGISLATIVE HISTORY, *supra* note 1, at 186-87. See Donald T. Bogan, *Protecting Patient Rights Despite ERISA: Will the Supreme Court Allow States to Regulate Managed Care?*, 74 TUL. L. REV. 951, 977-85 (2000) [hereinafter Bogan, *Protecting Patient Rights*]. ERISA's savings clause appears to have been a non-controversial provision when included in the early versions of ERISA; however, after the Conference Committee expanded the reach of the preemption clause, the savings clause exception to preemption grew significantly in importance. See *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 745-46 & n.23 (1985). See generally Donald T. Bogan, *ERISA: The Savings Clause, § 502 Implied Preemption, Complete Preemption, and State Law Remedies*, 42 SANTA CLARA L. REV. 105, 118-20 (2001) [hereinafter Bogan, *Savings Clause*].

9. ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B). See *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990).

10. Employee fringe benefit programs often offer insurance coverage or other benefits for both the worker (plan participant) and for the worker's family members or other designated persons entitled to receive a benefit (plan beneficiary). See ERISA § 3(7)-(8), 29 U.S.C. § 1002(7)-(8). For ease of reference, throughout this Article I will use the term participant to include any person who may be entitled to receive a benefit under an ERISA plan. ERISA's civil enforcement provision, 29 U.S.C. § 1132, provides:

(a) Persons empowered to bring a civil action. A civil action may be brought –

(1) by a participant or beneficiary –

(A) for the relief provided in subsection (c) of this section [concerning requests to the administrator for information], or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409 [§ 1109] [breach of fiduciary duty];

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or

grieved parties not expressly authorized to bring suit under ERISA section 502, the Supreme Court has characterized ERISA's civil enforcement scheme as comprehensive.¹¹ Based upon that characterization, the Supreme Court suggests that Congress intended ERISA to provide the exclusive remedies available for plan participants in claims arising from their employee benefit plans.¹²

ERISA's savings clause allows the states to indirectly regulate employee benefit plans by regulating ERISA plan insurers.¹³ As part of their historic role in regulating insurance, most states

practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provision of this title or the terms of the plan;

(4) by the secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 105(c) [1025(c)] [information to be furnished to participants];

(5) except as otherwise provided in subsection (b), by the Secretary (A) to enjoin any act or practice which violates any provision of this title, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), or (6) of subsection (c) or under subsection (i) or (l);

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 609(a)(2)(A) [§ 1169(a)(2)(A)];

(8) by the Secretary, or by an employer or other person referred to in section 101(f) (1) [§ 1021(f)(1)], to enjoin any act or practice which violates subsection (f) of section 101 [§ 1021(f)], or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(a) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title [subtitle] or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

Paragraphs seven and eight were added to section 502 by amendment in 1993, while paragraph nine was added the following year.

11. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 53-54 (1987); *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146-47 (1985).

12. See *Pilot Life*, 481 U.S. at 54. ("The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive."). But see *Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 25 (1983) (explaining ERISA's savings clause "makes clear that Congress did not intend to preempt entirely every state cause of action relating to [ERISA employee benefit plans]").

13. See *FMC Corp. v. Holliday*, 498 U.S. at 64-65; *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. at 747.

require that insurers treat their customers in accordance with a standard of good faith and fair dealing.¹⁴ Additionally, many states allow consumers to recover extra-contractual damages, including punitive damages or treble damages, from insurers who violate the standard of good faith and fair dealing in their interactions with insurance consumers.¹⁵ States developed the law of insurance bad faith remedies because history had shown that, absent exposure to an extra-contractual remedy, insurance companies often failed to treat their insured's fairly, particularly in the claims evaluation process.¹⁶

ERISA's civil enforcement scheme only allows plan participants to obtain contract-based monetary damages from plans that wrongfully deny employee benefit claims.¹⁷ Because ERISA's civil

14. See generally STEPHEN S. ASHLEY, *BAD FAITH ACTIONS: LIABILITY AND DAMAGES* (2d ed. 1997).

15. See, e.g., *Christian v. Am. Home Assurance Co.*, 577 P.2d 899, 904 (Okla. 1977); *Fletcher v. W. Nat'l Life Ins. Co.*, 10 Cal. App. 3d 376, 401-02 (1970). See generally ASHLEY, *supra* note 14. There is some debate in various jurisdictions concerning the level of scienter an insured must prove to recover in a bad faith action, with a minority of states allowing recovery against an insurer "if a person of ordinary prudence, in the exercise of that degree of care which such a person would use in the management of his affairs" would pay a claim or settle a claim. See *id.* § 2:04 (citing cases). For my purposes in this Article suggesting that proof of an insurer's bad faith should be viewed as a per se abuse of discretion in an ERISA action where a court reviews an insured plan's claim denial under a deferential standard of review, I limit my analysis to those circumstances where bad faith is established under a level of scienter greater than mere negligence. See, e.g., *Badillo v. Mid Century Ins. Co.*, 2004 OK 42, 2004 Okla. LEXIS 49, at *33 (Okla. June 8, 2004) ("bad faith must involve dishonest intentions, unconscientious advantage, or action taken that is unreasonable and unfounded."). See generally ASHLEY, *supra* note 14, §§ 2:04-2:06 (comparing different scienter standards).

16. See generally *id.* The duty of good faith and fair dealing as applied to insurance contracts recognizes the separate promise, of economic and emotional security, that insurers make to their insureds that the insurer will be there for the insured in times of crisis. See, e.g., *Christian v. Am. Home Assurance Co.*, 577 P.2d at 904 ("[W]e consider the duty of an insurer to act in good faith and fairly when handling the claim of an insured, namely a duty not to withhold unreasonably payments due under a policy That responsibility is not the requirement mandated by the terms of the policy itself—to defend, settle, or pay. It is the obligation, deemed to be imposed by the law, under which the insurer must act fairly and in good faith in discharging its contractual responsibilities.") (quoting *Gruenberg v. Aetna Ins. Co.*, 510 P.2d 1032, 1037 (Cal. 1973)); *Fletcher v. W. Nat'l Life Ins. Co.*, 10 Cal. App. 3d at 404 ("[T]he special relationship and duties [imposing a duty of good faith and fair dealing upon insurers] of the insurer exist in recognition of the fact that the insured does not contract . . . 'to obtain a commercial advantage but to protect [himself] against the risks of accidental losses, including mental distress which might follow from the losses. Among the considerations in purchasing . . . insurance, as insurers are well aware, is the peace of mind and security it will provide in the event of an accidental loss'" (quoting *Crisci v. Sec. Ins. Co.*, 426 P.2d 173, 179 (Cal. 1967)). See generally ASHLEY, *supra* note 14.

17. See *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. at 147 (characterizing

enforcement provision does not specifically authorize plan participants who have been mistreated by their ERISA plan insurers to obtain consequential damages or punitive damages for bad faith breach of an insurance contract, plan insurers have urged courts to limit plan participants to the monetary remedy for contract damages available under ERISA section 502(a)(1)(B).¹⁸

State laws that provide consumer remedies aimed solely at the insurance industry present a unique ERISA preemption puzzle. The statute's express preemption language instructs that ERISA does not preempt state insurance laws. However, the Supreme Court says that ERISA impliedly preempts state law remedies arising in connection with plan participant employee benefit claims. When an ERISA plan participant sues an ERISA plan insurer under a state insurance law that provides a specific consumer remedy aimed solely at the insurance industry, implied preemption of state law remedies under ERISA section 502 directly confronts ERISA's express savings clause exception to preemption located in ERISA section 514(b)(2)(A). Is the state insurance law remedy expressly saved from preemption under ERISA section 514, thereby allowing the consumer to seek extra-contractual damages against the plan insurer, or does ERISA shield the plan insurer from claims for extra-contractual damages by impliedly preempting the state law bad faith remedy under ERISA section 502?¹⁹

The question of ERISA's preemptive impact on state bad faith insurance claims has caused lower court confusion, particularly in recent years as the Supreme Court has more prominently emphasized the maxim that federal law should not be interpreted to su-

an ERISA section 502(a)(1)(B) claim as authorizing contractual damages). Plan participants can also obtain injunctive or declaratory relief. See ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) (participant can sue "to clarify his rights to future benefits"); ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3) (civil action may be brought "to enjoin any act or practice which violates any provision of this title or the terms of the plan"). ERISA section 502(a)(3), 29 U.S.C. § 1132(a)(3) also allows plan participants to recover "other appropriate equitable relief," though the Supreme Court has not yet defined the parameters of such equitable relief. See *Aetna Health, Inc. v. Davila*, 124 S. Ct. 2488, 2502 n.7 (2004); *id.* at 2503-04 (Ginsburg, J., concurring). See also *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 453-67 (3d Cir. 2003) (Becker, J., concurring). See generally John H. Langbein, *What ERISA Means by "Equitable": The Supreme Court's Trail of Error in Russell, Mertens, and Great-West*, 103 COLUM. L. REV. 1317 (2003).

18. 29 U.S.C. § 1132(a)(1)(B). See, e.g., *Pilot Life*, 481 U.S. at 41.

19. See generally Bogan, *Savings Clause*, *supra* note 8, at 153-55 (characterizing implied preemption versus the savings clause exception to preemption as a different form of statutory construction problem than the classic federal law versus state law preemption question, and suggesting that the question of ERISA's preemption of state law bad faith remedies instead presents an internal battle within ERISA, pitting ERISA section 514 versus ERISA section 502).

persede state law in areas of historic state regulatory authority, unless Congress clearly manifests an intention to preempt.²⁰ In a 2004 decision, *Aetna Health, Inc. v. Davila*,²¹ the Supreme Court firmly established that implied preemption under ERISA's remedies provision trumps the statute's express savings clause exception to preemption for state laws that regulate insurance.²²

While the question of a plan participant's access to state law remedies is now resolved (and resolved against consumers), further questions concerning the scope of ERISA's preemption of state bad faith laws, and of other state insurance laws, remain. Bad faith laws do more than just authorize an extra-contractual remedy; bad faith laws define standards of conduct that insurance companies must adhere to in their interactions with insurance consumers. The *Davila* ruling eliminates plan participants' bad faith insurance remedies; however, it remains uncertain how courts will apply ERISA's savings clause when plan participants urge courts to hold ERISA plan insurers to the specific standards of behavior required under state unfair insurance practices laws. Additionally, many states empower their state Insurance Commissioner to seek injunctive relief, or penalties, or both against insurance companies that violate state insurance law standards of good faith and fair dealing.²³ Does ERISA section 502 preempt state insurance law remedies in favor of state governmental officials who lack standing to sue under ERISA section 502?

Part II below briefly summarizes the history of state bad faith insurance claims under ERISA up to the *Davila* ruling. Part III explores *Davila*. Part IV suggests that, even after *Davila*, state law bad faith standards are saved from ERISA preemption and

20. See N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 654-55 (1995).

21. 124 S. Ct. 2488.

22. See *id.* at 2500 ("As this Court has recognized in both *Rush Prudential* and *Pilot Life*, ERISA § 514(b)(2)(A) must be interpreted in light of the congressional intent to create an exclusive federal remedy in ERISA § 502(a). Under ordinary principles of conflict pre-emption, then, even a state law that can arguably be characterized as 'regulating insurance' will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme."). Prior to *Davila*, I examined this issue of implied preemption versus the savings clause exception to preemption and concluded that ERISA's express language saving state insurance laws from preemption should defeat the inference of preemption of state law remedies arising under ERISA section 502. See generally Bogan, *Savings Clause*, *supra* note 8.

23. See, e.g., N.C. GEN. STAT. § 58-63-15; OKLA. STAT. tit. 36, §§ 1250.1-1250.16 (2000). See also *Farlow v. Union Cent. Life Ins. Co.*, 874 F.2d 791, 795 (11th Cir. 1989) (describing Alabama's unfair insurance practices law). See generally ASHLEY, *supra* note 14, § 9:03, and apps. I-VI, which reprint the Model Unfair Insurance Practices Laws, promulgated by the National Association of Insurance Commissioners ("Model Acts"), including the Unfair Claims Settlement Practices Act (app. III).

may impact the outcome of section 502(a)(1)(B) claims for benefits due by defining certain unfair insurance claims settlement practices as arbitrary and capricious. Part V examines state statutes that authorize state Insurance Commissioners to enforce state unfair insurance practices laws and concludes that such enforcement actions do not fall within the scope of ERISA section 502's implied preemption. Finally, Part VI comments briefly on a model insurance regulation recently adopted by the National Association of Insurance Commissioners ("NAIC"), which aims to restore de novo review of plan participant insured benefit claims by utilizing ERISA's savings clause exception to preemption.

II. ERISA'S PREEMPTIVE IMPACT ON BAD FAITH REMEDIES PRIOR TO *DAVILA*

A. Pilot Life: *The Savings Clause, Implied Preemption, and State Bad Faith Laws*

In a 1987 case from Mississippi, *Pilot Life Insurance Co. v. Dedeaux*,²⁴ the United States Supreme Court first examined whether ERISA preempts state law claims for bad faith breach of an insurance contract.²⁵ The employer and plan sponsor in *Pilot Life*, Entex, Inc., offered its workers disability coverage as an employee fringe benefit. Entex, Inc. funded the employee disability benefits plan by purchasing insurance from Pilot Life Insurance Company ("Pilot Life").²⁶ After a frustrating series of stops and starts, ultimately resulting in the denial of his disability claim, Mr. Dedeaux sued Pilot Life under state law seeking disability benefits pursuant to the insurance contract, plus consequential damages and punitive damages under Mississippi's common law

24. 481 U.S. 41 (1987).

26. See *id.* at 52-57. See also *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. at 147-48 (concluding that a plan participant cannot recover extra-contractual damages under ERISA section 502(a)(2) for a fiduciary's breach of duty in violation of ERISA section 409).

26. ERISA requires that plan sponsors fund employee pension plans through the establishment of a trust or through the purchase of insurance. See ERISA § 403, 29 U.S.C. § 1103. However, ERISA's funding rules do not apply to welfare benefit plans. See ERISA § 301(a)(1), 29 U.S.C. § 1081(a)(1). Consequently, while welfare plan sponsors that choose to fund plan promises must either establish a trust for that purpose or purchase insurance to fund the promise, welfare plan sponsors can choose not to fund their employee benefit plans. When a welfare benefit plan sponsor chooses not to fund a plan, so that no trust is established and no insurance policy exists, benefits must be paid out of the plan sponsor's operating capital. See *Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1050-51 (7th Cir. 1987). See generally Donald T. Bogan, *ERISA: Rethinking Firestone in Light of Great-West—Implications for Standard of Review and the Right to a Jury Trial in Welfare Benefit Claims*, 37 J. MARSHALL L. REV. 629, 670-72 (2004).

tort action for bad faith breach of contract.²⁷ Pilot Life defended the action by asserting ERISA preemption as an affirmative defense to the state law claims.²⁸

To defeat the insurance company's argument that ERISA preempted his state law claims for punitive damages, Mr. Dedeaux asserted that ERISA expressly saved his bad faith breach of contract remedy from preemption because the remedies law regulated insurance. Pilot Life responded that Mississippi's common law bad faith remedy was not aimed solely at the insurance industry, and therefore, that it was not a law that regulates insurance within ERISA's savings clause.²⁹ Additionally, the Solicitor

27. Dedeaux sought contract damages in the form of benefits due under the insurance policy, consequential tort damages for infliction of mental and emotional distress, and punitive damages for bad faith breach of contract. See *Pilot Life*, 481 U.S. at 43.

28. Mr. Dedeaux filed his action in federal district court based upon diversity jurisdiction; consequently, the question of federal court removal jurisdiction under the complete preemption doctrine did not arise in *Pilot Life*. Further, the *Pilot Life* opinion does not discuss whether the federal district court should have converted Dedeaux's state law insurance claim to a claim under ERISA section 502(a)(1)(B) for benefits due under a plan. On the same day the Supreme Court decided *Pilot Life*, the Court also issued its opinion in *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987), which did address federal court removal jurisdiction in claims arising from an ERISA plan originally filed in state court. In *Taylor*, the Court first held that the complete preemption doctrine applies to ERISA, and that ERISA completely preempts all state law claims that fall within the scope of ERISA section 502. Cf. *Franchise Tax Bd.*, 463 U.S. at 27-28 (discussing applicability of complete preemption doctrine to ERISA, but holding that ERISA does not completely preempt state tax agency's garnishment action against an ERISA trust). See discussion *infra* in text accompanying notes 70-114.

29. In *Metropolitan Life Insurance Co. v. Massachusetts*, the Supreme Court crafted a two-part savings clause test, where part two of the test included a three-pronged analysis. 471 U.S. at 740-44. When the Supreme Court applied that test in *Pilot Life*, the Court asked first whether the state law in question regulated insurance under a common sense understanding of that phrase. See *Pilot Life*, 481 U.S. at 48. Then the Court applied the three-pronged test the Court had utilized in deciding whether an insurer could avoid federal anti-trust regulation under the McCarran-Ferguson Act. *Id.* The McCarran-Ferguson Act factors ask whether the state law at issue affects an integral part of the insured-insurer relationship; whether the state law transfers policyholder risk; and whether the regulated practice is limited to entities within the insurance industry. *Id.* at 48-49. Subsequently, in *Kentucky Ass'n of Health Plans, Inc. v. Miller* ("KAHP"), the Supreme Court abandoned the McCarran-Ferguson Act-based test and substituted a new two-factor savings clause test for evaluating whether a state law regulates insurance within the meaning of ERISA's savings clause. 538 U.S. 329, 341-42 (2003). The KAHP test now instructs courts to determine first, whether a state law is "specifically directed toward entities engaged in insurance," and second, whether the law "substantially affect[s] the risk pooling arrangement between the insurer and the insured." *Id.* at 342. See generally Matthew G. Vansuch, Note, *Not Just Old Wine in New Bottles: Kentucky Ass'n of Health Plans, Inc. v. Miller Bottles a New Test for State Regulation of Insurance*, 38 AKRON L. REV. 253 (2005).

General, appearing as amicus curiae in *Pilot Life*, suggested that ERISA impliedly preempted Mr. Dedeaux's state law claims because Congress intended ERISA's civil enforcement provision (section 502) to provide the exclusive remedies for all plan participant complaints arising from the alleged mishandling of an employee benefit claim.³⁰

The United States Supreme Court found that, under Mississippi law, the bad faith breach of contract remedy for extra-contractual damages could arise from the breach of any contract, not just an insurance contract.³¹ Consequently, said the Court, the Mississippi bad faith remedies law did not fit within ERISA's savings clause exception to preemption as a law that regulates insurance. Further, in dicta that would ultimately become the most far reaching component of the opinion,³² the *Pilot Life* Court suggested that the comprehensiveness of ERISA's civil enforcement scheme indicated that Congress intended to preempt all state law remedies arising from a plan participant's challenge to an adverse benefits determination.³³

Following *Pilot Life*, and for more than a decade, lower courts uniformly held that ERISA preempted all plan participant state law bad faith claims, even statutory claims that expressly applied only against the insurance industry, either because the state laws did not regulate insurance within the meaning of ERISA's express savings clause,³⁴ or because ERISA impliedly preempted the bad

30. See *Pilot Life*, 481 U.S. at 52. See also Brief for the United States as Amicus Curiae at 10-11, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (No 85-1043), available at LEXIS at 1985 U.S. Briefs 1043.

31. See *Pilot Life*, 481 U.S. at 49-50.

32. See *Davila*, 124 S. Ct. at 2500 (relying on *Pilot Life* to hold that implied preemption of state law remedies under section 502 trumps ERISA's express savings clause exception to preemption for state laws that regulate insurance).

33. See *Pilot Life*, 481 U.S. at 52 ("The conclusion that § 502(a) was intended to be exclusive is supported, first, by the language and structure of the civil enforcement provisions, and second, by legislative history in which Congress declared that the pre-emptive force of § 502 was modeled on the exclusive remedy provided by § 301 of the Labor Management Relations Act, 1947 (LMRA), 61 Stat. 156, 29 U.S.C. § 185."). But see Brief for the United States as Amicus Curiae Supporting Petitioner in Part and Supporting Respondent in Part at 25, *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999) (No. 97-1868), available at LEXIS at 1997 U.S. Briefs 1868 (distinguishing the LMRA analogy from ERISA section 502 claims by noting that preemption of state law remedies under LMRA section 301 is not limited by an express savings clause exception to preemption as in ERISA).

34. See *Anschultz v. Conn. Gen. Life Ins. Co.*, 850 F.2d 1467, 1468-69 (11th Cir. 1988) (remarking that an action under Florida's unfair insurance practices statute is preempted by ERISA, even though the state law applies only against the insurance industry, because the unfair insurance practices law does not transfer risk or affect an integral part of the insurer-insured relationship). See also *In re Life Ins. Co. of N. Am.*, 857 F.2d 1190, 1194-95 (8th Cir. 1988) (citing cases).

faith remedy,³⁶ or for both reasons.³⁶ Then in the mid-to-late 1990's, the Supreme Court issued a series of ERISA preemption decisions that appeared to signal a retreat from the expansive view of ERISA preemption developed by the Court in its early ERISA cases, as exemplified by *Pilot Life*.³⁷

B. *Travelers, the Ward Footnote, and the Moran Dicta*

In 1995, the United States Supreme Court announced what appeared to be a major shift in its ERISA preemption analysis. The Court chose a case involving state law taxes, *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*,³⁸ to herald the Court's new direction for analyzing ERISA's preemption language. Prior to *Travelers*, the Supreme Court had applied ERISA preemption very broadly under its "plain meaning" interpretation of the "relates to" language in ERISA's preemption clause.³⁹ In *Travelers*, the Court re-examined its approach and determined that the plain meaning model of statutory construction failed to clarify the law of ERISA preemption because "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course for 'really, universally, relations stop nowhere.'"⁴⁰

Abandoning the plain meaning interpretative method,⁴¹ the Court returned to one of the bedrock principles of Supremacy Clause jurisprudence by emphasizing that "[we] have addressed claims of pre-emption with the starting presumption that Congress does not intend to supplant state law [Additionally,] we

35. See *Kanne v. Conn. Gen. Life Ins. Co.*, 867 F.2d 489, 492 (9th Cir. 1988) (stating that ERISA impliedly preempts state unfair insurance practices claim under ERISA section 502, even if state remedies law only applied against insurance industry).

36. See *Juckett v. Beecham Home Improvement Prods., Inc.*, 684 F. Supp. 448-50 (N.D. Tex. 1988). See generally *Bogan, Savings Clause*, *supra* note 8, at 150.

37. See *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813 (1997); *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 324 (1997); *Travelers*, 514 U.S. at 654-55.

38. 514 U.S. at 645.

39. See, e.g., *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983) ("We must give effect to this plain language unless there is good reason to believe Congress intended the language to have some more restrictive meaning.")

40. *Travelers*, 514 U.S. at 655 (quoting HENRY JAMES, RODERICK HUDSON (New York ed., World Classics 1980) (1875)). See also *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. at 335 (Scalia, J., concurring) ("[A]pplying the 'relate to' provision according to its terms was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else.")

41. See *Travelers*, 514 U.S. at 656 ("We simply must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.")

have worked on the 'assumption that the historic police powers of the States were not to be superseded by [a] Federal Act unless that was the clear and manifest purpose of Congress.'⁴²

The new *Travelers* shift in emphasis caused some lower courts to re-examine the question of ERISA's preemption of state law bad faith claims, particularly after the 1999 decision in *UNUM Life Insurance Co. v. Ward*.⁴³ In *Ward*, the Supreme Court re-kindled plan participants' hopes that the Court may narrow the application of *Pilot Life* implied preemption of state law remedies, primarily through a footnote referencing the conflict between implied preemption under ERISA section 502 and the savings clause exception to preemption.⁴⁴

Ward involved a claim for disability benefits against an ERISA plan insurer. Mr. Ward had previously obtained state and social security disability benefits, but was apparently unaware that he was also covered under a group disability insurance policy provided through his employment. Almost two years after he stopped working, Mr. Ward discovered the insurance policy, issued by UNUM Life Insurance Company of America ("UNUM"), while cleaning out a safety deposit box.⁴⁵ Mr. Ward filed a claim with UNUM, however, the UNUM policy required plan participants to submit a proof of loss within eighteen months of the onset of a claimed disability. Since Mr. Ward failed to meet the policy deadline, UNUM rejected the claim.⁴⁶

California, where Mr. Ward lived and worked, however, applied a state common law insurance regulation, known as the "notice-prejudice" rule, which offered Mr. Ward some relief. Under the notice-prejudice rule, in order for an insurer to enforce a policy-imposed notice deadline, it had to show that the delay in presenting a claim actually prejudiced the insurer's ability to defend the action.⁴⁷ After UNUM refused to consider Mr. Ward's disability claim, Mr. Ward sued UNUM under ERISA section 502(a)(1)(B) to recover benefits due from the plan, invoking the California notice-

42. *Id.* at 654-55 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). This rule suggests that the presumption against preemption applies with extra vigor where the state law at issue regulates in a subject area that the states have historically dominated. See generally Bogan, *Protecting Patient Rights*, *supra* note 8, at 1012-18; Karen A. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption*, 13 YALE J. ON REG. 255, 257 (1996).

43. 526 U.S. 358 (1999).

44. See *id.* at 377 n.7.

45. See *id.* at 365. See also Brief for the United States as Amicus Curiae Supporting Petitioner in Part and Supporting Respondent in Part at 2, *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999) (No. 97-1868).

46. Mr. Ward filed his lawsuit within the applicable statute of limitations. The UNUM policy imposed time limits to provide notice of claims that were shorter than the statute of limitations.

47. See *Ward*, 526 U.S. at 368-73.

prejudice rule to overcome the policy deadline.

UNUM advanced two arguments in defense of Mr. Ward's pleas: first, that Mr. Ward could not avoid the notice provision in the insurance contract because ERISA expressly preempted the California notice-prejudice rule;⁴⁸ and second, that ERISA impliedly preempted California's notice-prejudice rule because application of the rule would allow a state law to interfere with ERISA's civil enforcement provision.⁴⁹ Because UNUM urged both express preemption under ERISA section 514 and implied preemption under ERISA section 502 as defenses to Mr. Ward's claim, the United States Solicitor General, appearing as amicus curiae, addressed the interaction between implied preemption under ERISA section 502 and the express savings clause exception to preemption found in ERISA section 514.⁵⁰

Previously in *Pilot Life*, the Solicitor General had urged the view, then adopted by the Supreme Court, that Congress intended ERISA's civil enforcement provision to impliedly preempt all plan participant state law claims arising in connection with the denial of an employee benefit claim.⁵¹ In *Ward*, the Solicitor General modified the position his office had advanced as amicus curiae in *Pilot Life* concerning the scope of implied preemption under ERISA section 502.

In *Ward*, the Solicitor General pointed out that the state law claim at issue in *Pilot Life* was a law of general application, and not a law that specifically regulated insurance; consequently, *Pilot Life* did not present a conflict between implied preemption and ERISA's express savings clause.⁵² The preemption question in *Ward* was more complicated than in *Pilot Life*, said the Solicitor General, because the California notice-prejudice rule at issue in *Ward* was a law that regulates insurance.⁵³ If the Court determined that the California notice-prejudice rule fit within the scope of ERISA section 502 implied preemption, as asserted by UNUM, the Solicitor General in *Ward* argued that implied preemption under ERISA section 502 conflicted with ERISA's express savings clause exception to preemption for state laws that regulate insurance. The Solicitor General in *Ward* concluded that if a state law provides a remedy that can be pursued only against the insurance industry, and therefore fits within ERISA's savings clause, the

48. See Brief for Petitioner at 22-32, *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999) (No. 97-1868), available at LEXIS at 1997 U.S. Briefs 1868.

49. See *id.* at 32-36.

50. See *Ward*, 526 U.S. at 377 n.7.

51. See *Pilot Life*, 481 U.S. at 52; Brief for the United States as Amicus Curiae at 10-11, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (No 85-1043).

52. See Brief for the United States as Amicus Curiae Supporting Petitioner in Part and Supporting Respondent in Part at 21-22, *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999) (No. 97-1868).

53. See *id.* at 22-25 & n.14.

savings clause express exception to preemption must trump the implied preemption of state law remedies.⁵⁴

Ultimately, the *Ward* Court did not reach the question of implied preemption under ERISA section 502 versus the savings clause because the Court found that California's notice-prejudice rule did not provide an alternative state law remedy in conflict with ERISA section 502.⁵⁵ In a footnote reference, however, the *Ward* Court recognized the friction between implied preemption under ERISA section 502 and ERISA section 514's express savings clause. In the footnote, the *Ward* Court remarked on how the Solicitor General had refined its implied preemption analysis since *Pilot Life*, but the Court did not specifically agree or disagree with the Solicitor General's conclusion that ERISA's express exception to preemption trumps implied preemption arising under the statute's civil enforcement provision.⁵⁶

Following *Ward*, a number of plan participant lawyers read the Supreme Court's trend to limit the scope of ERISA preemption following *Travelers* in conjunction with the *Ward* footnote and therein found instructions to press courts to revisit the issue of ERISA's preemption of state law insurance bad faith claims in states (unlike Mississippi) where the remedy only applied against the insurance industry. While the majority of lower courts continued to reject plan participant state law bad faith claims,⁵⁷ a handful of federal district judges found room to distinguish *Pilot Life*, based upon the *Ward* footnote, and allowed plan participants' to pursue bad faith claims arising from state law in states where the claim was only available against the insurance industry.⁵⁸

Four years after *Ward*, the Supreme Court added another

54. See *Ward*, 526 U.S. at 377 n.7. See Brief for the United States as Amicus Curiae Supporting Petitioner in Part and Supporting Respondent in Part at 22-25 & n.14, *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999) (No. 97-1868).

55. *Ward* held that the state notice-prejudice rule is saved from preemption under ERISA section 514 as a law that regulates insurance. Acknowledging that the state law notice-prejudice rule would control the outcome of the benefits claim, the Court nonetheless found that the state law did not provide a separate state law remedy because the plan participant was still required to sue under ERISA section 502 to recover his benefits. See *Ward*, 526 U.S. at 376-77.

56. See *id.* at 377 n.7.

57. See, e.g., *Coffman v. Metro. Life Ins. Co.*, 138 F. Supp. 2d 764, 766-68 (S.D. W. Va. 2001); *Love v. Fortis Benefits Ins. Co.*, 120 F. Supp. 2d 997, 1001-05 (M.D. Ala. 2000).

58. See, e.g., *Hill v. Blue Cross & Blue Shield*, 117 F. Supp. 2d 1209 (N.D. Ala. 2000), *overruled by* *Gilbert v. ALTA Health & Life Ins. Co.*, No. 01-10829, 2001 U.S. App. LEXIS 27200 (11th Cir. Dec. 27, 2001); *Lewis v. Aetna U.S. Healthcare, Inc.*, 78 F. Supp. 2d 1202 (N.D. Okla. 1999). Each of these cases relies on express preemption under ERISA section 514, and most prominently, the savings clause exception to preemption; they do not address the issue of implied preemption under ERISA section 502.

helpful ingredient to the recipe of reasons plan participants urged to limit the *Pilot Life* holding in state bad faith insurance claims. In *Kentucky Ass'n of Health Plans, Inc. v. Miller* ("KAHP"),⁵⁹ the Supreme Court abandoned the three-factor savings clause test which it had created in *Metropolitan Life Insurance Co. v. Massachusetts*,⁶⁰ and relied upon in *Pilot Life*,⁶¹ to determine whether a challenged state law regulates insurance.⁶² The new, broader savings clause test announced in *KAHP* further advanced the rationale for lower courts to conclude that *Pilot Life* should be narrowly construed, and that ERISA does not preempt state law bad faith insurance claims.⁶³ In evaluating a state law to ascertain whether the law regulates insurance under ERISA's savings clause, the *KHAP* test now instructs courts to determine first, whether a state law is "specifically directed toward entities engaged in insurance,"⁶⁴ and second, whether the law "substantially affect[s] the

59. 538 U.S. 329 (2003).

60. 471 U.S. 724, 740-44 (1985).

61. See *Pilot Life*, 481 U.S. at 48-51.

62. See *KAHP*, 538 U.S. at 341-42.

[W]e make a clear break from the McCarran-Ferguson factors and hold that for a state law to be deemed a 'law . . . which regulates insurance' under § 1144 (b)(2)(A) [the savings clause], it must satisfy two requirements. First, the state law must be specifically directed toward entities engaged in insurance [citing *Pilot Life*, *UNUM*, and *Rush Prudential*]. Second, as explained above, the state law must substantially affect the risk pooling arrangement between the insurer and the insured. Kentucky's [AWP] law satisfies each of these requirements.

Id.

63. See *Elliot v. Fortis Benefits Ins. Co.*, 337 F.3d 1138, 1147-48 (9th Cir. 2003), *cert. denied*, 540 U.S. 1090 (2003) (holding the state unfair insurance practices act is a law that regulates insurance under *KAHP*, however, state law claim for extra-contractual damages is still impliedly preempted by ERISA section 502); *Kidneigh v. UNUM Life Ins. Co.*, 345 F.3d 1182 (10th Cir. 2003) (Henry, J., concurring in part and dissenting in part) (agreeing that ERISA impliedly preempts state law bad faith claims under section 502, but dissenting from the majority opinion's analysis of the savings clause because he believed that Colorado's unfair insurance practices law regulates insurance under the new *KAHP* two-factor test). *But see* *Ellis v. Liberty Life Assurance Co.*, 394 F.3d 262, 276-77 (5th Cir. 2004) (common law bad faith claim is not directed toward entities engaged in insurance under *KAHP* test); *Barber v. UNUM Life Ins. Co.*, 383 F.3d 134, 142-44 (3d Cir. 2004) (Pennsylvania bad faith claim does not substantially affect the risk pooling arrangement between insurer and insured under *KAHP* test); *Allison v. UNUM Life Ins. Co.*, 381 F.3d 1015 (10th Cir. 2004) (Oklahoma common law bad faith claim not saved under *KAHP* test). See generally Donald T. Bogan, *Saving State Law Bad-Faith Claims from Preemption*, TRIAL, Apr. 2003, at 52 (enumerating reasons why ERISA should not be interpreted to preempt state law bad faith claims).

64. *KAHP* confirms that a state law which is "specifically directed toward entities engaged in insurance" does not have to be limited in its scope *exclusively* to entities solely engaged in insurance. See 538 U.S. at 336 n.1. The *KAHP* Court stated:

[W]e think petitioners' argument [that a law does not fall within the savings clause if it is directed at entities engaged in insurance and some

risk pooling arrangement between the insurer and the insured.”⁶⁵

The final Supreme Court wrinkle preceding *Davila* then came with *Rush Prudential HMO, Inc. v. Moran*.⁶⁶ In *Moran*, the Supreme Court ruled that ERISA does not preempt a state external review law which required insurers that refused to approve medical treatment recommended by a plan participant’s physician to submit to binding review of the claim denial by an independent panel. Rush Prudential HMO argued that ERISA preempted Illinois’ external review law because it provided an alternative remedy to the remedies provided in ERISA section 502. The Supreme Court rejected Rush Prudential HMO’s argument that the external review law created an alternate remedy to ERISA section 502 under the same reasoning it had applied in *Ward*. The Supreme Court held that, even though the state external review law dictated the result of the claims dispute, to enforce the claim for benefits the plan participant still had to sue under ERISA section 502 (a)(1)(B) to recover the benefit.⁶⁷

Despite the Court’s conclusion that section 502 implied preemption did not apply in *Moran*, the Court nonetheless offered its opinion on the implied preemption versus the savings clause exception to preemption controversy. In a gratuitous aside that would subsequently be relied upon in *Davila* to shut the door on plan participant state law claims for extra-contractual damages,⁶⁸ the *Moran* Court declared that the inference of preemption of state law remedies arising from ERISA’s civil enforcement scheme was

that are not] is foreclosed by *Rush Prudential*, 536 U.S. at 372, where we noted that Illinois’ independent-review laws contained “some overbreadth in the application of [the Illinois statute] beyond orthodox HMO’s,” yet held that “there is no reason to think Congress would have meant such minimal application to noninsurers to remove a state law entirely from the category of insurance regulation saved from preemption.”

Id.

65. See *id.* at 342. *KAHP* makes clear that the savings clause does not apply only to state laws that regulate insurance companies that deal in risk. The savings clause applies to state laws that regulate any “entity engaged in insurance” including, for example, an entity that performs insurance claims processing services, such as an HMO, and arguably, an insurance company or Blue Cross/Blue Shield that just provides administrative services to a self-insured plan (often identified as a Third Party Administrator or “TPA”), even if the entity does not sell products that spread risk. See *id.* at 336 n.1 (“[N]oninsuring HMOs [that do not act as insurer’s but instead provide administrative services] would be administering self-insured plans, which we think suffices to bring them within the activity of insurance for purposes of § 1144(b)(2)(A) [the savings clause].”). See generally Vansuch, *supra* note 29.

66. 536 U.S. 355 (2002).

67. See *id.* at 380. Cf. *Haw. Mgt. Alliance Ass’n v. Ins. Comm’r*, 100 P.3d 952 (Haw. 2004) (holding ERISA preempts Hawaii external review law to the extent the state law creates a state law remedy to enforce an independent reviewer’s decision).

68. See *Davila*, 124 S. Ct. at 2500.

so strong that it trumped even the express language of the statute that would have otherwise saved the state insurance law remedies from preemption.⁶⁹

III. *DAVILA* ESTABLISHES THAT ERISA PREEMPTS PLAN PARTICIPANT STATE LAW REMEDIES

In *Aetna Health Inc. v. Davila*,⁷⁰ ERISA's express exception to preemption for state laws that regulate insurance actually collided with implied preemption under ERISA section 502 for the first time.⁷¹ The Texas statute at issue in *Davila* provided a negligence remedy aimed at the insurance industry, not a bad faith law, but the *Davila* result clearly encompasses bad faith claims asserted against ERISA plan insurers.

The advent of managed care in our health care delivery system has brought a blurring of the lines that had historically separated the providers of health care to consumers from the payors of health care provider bills—typically Blue Cross & Blue Shield entities or private health insurance companies for non-elderly consumers. In particular, Health Maintenance Organizations (“HMOs”) now often serve as both health care providers and health care benefits insurers.⁷² As part of its efforts to regulate the health care industry and the insurance industry in response to the newer models of health care delivery systems, Texas enacted an HMO reform law known as the Texas Health Care Liability Act (“THCLA”).⁷³ The THCLA creates a remedy for individuals against health care insurers, HMOs, and other managed care entities who fail to exercise ordinary care in refusing to pay for recommended

69. *Moran*, 536 U.S. at 375-77.

70. 124 S. Ct. 2488.

71. See *Moran*, 536 U.S. at 359 (applying savings clause, but holding that state external review law does not implicate implied preemption under ERISA section 502 because state law does not provide an alternate remedy); *Ward*, 526 U.S. at 364 (applying savings clause, but holding state notice-prejudice law does not implicate implied preemption under ERISA section 502 because state law does not provide an alternate remedy); *Pilot Life*, 481 U.S. at 43-44 (discussing implied preemption under ERISA section 502, but holding state bad faith breach of contract remedies law at issue does not regulate insurance); *Metro. Life Ins. Co. v. Taylor*, 481 U.S. at 66 (discussing implied preemption under ERISA section 502, but holding state tort remedy for infliction of emotional distress does not regulate insurance); *Franchise Tax Bd.*, 463 U.S. at 28 (discussing complete preemption doctrine based upon implied preemption of state law remedies under ERISA section 502, and suggesting that implied preemption under section 502 is limited by the savings clause, but remanding back to state court because ERISA does not completely preempt state tax collection agency's garnishment remedy where state agency does not have standing to sue under ERISA section 502).

72. See *Pegram v. Herdrich*, 530 U.S. 211, 218-20 (2000) (noting that HMO's assume risk and act as insurers when they make coverage decisions).

73. TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-88.003 (Vernon Supp. 2004).

medical treatment because the insurer determines the treatment is not medically necessary.⁷⁴ The targets of the Texas statute are entities that make medical judgments in the context of insurance coverage determinations.⁷⁵

In *Davila*, the Supreme Court found that ERISA nullified the plan participants' THCLA negligence claims against their HMOs or health insurers because the state law claims conflicted with the exclusive remedies provided in ERISA's civil enforcement provi-

74. *Id.* § 88.002(a). A primary battlefield in the managed care debate involves the standard exception to coverage in health insurance policies for treatment that is not "medically necessary." Under the traditional fee-for-service, prospective pay model of health insurance contracts, physicians, in consult with their patients, decided upon a treatment plan without regular involvement of the insurers who would ultimately bear the cost of the treatment decision. *Pegram v. Herdrich*, 530 U.S. at 218. One of the defining characteristics of managed care is the shift to pre-certification in health insurance regimens that allows an insurer to impose its judgment on what treatment is medically necessary for a covered patient before the treatment is rendered. *Id.* at 219. As a result of the shift in who makes the "medically necessary" determination, from treating physician (or other providers) to insurers, insurers now make medical judgments that substantially affect health care consumers. *See id.* at 228-31 (noting that when an HMO doctor decides what treatment is medically necessary for a patient, the HMO doctor makes a mixed eligibility decision). The THCLA illustrates one way in which the states have responded to problems that have arisen when health insurers, rather than treating medical providers, determine what amount or kind of medical service is proper or reasonable to treat a patient's medical condition. The THCLA response imposes a similar duty of care on insurers who exercise medical judgments in the context of coverage decisions that the state common law imposes on physicians making the same treatment decisions. *See Corporate Health Ins., Inc. v. Tex. Dep't of Ins.*, 215 F.3d 526, 531 (5th Cir. 2000). Another way states have responded to problems that have arisen when an insurance company or HMO decides what treatment is medically necessary (and which they must therefore reimburse or provide) is by enacting "external review" laws. *See, e.g.*, Illinois Health Maintenance Organization Act, 215 ILL. COMP. STAT. 125/4-10 (2000); TEX. INS. CODE ANN. arts. 20A.09, 20A.12A (Vernon 1997). If an insured challenges an insurer's decision refusing to pre-certify treatment recommended by a patient's physician, external review laws typically require the insurer to submit the question to an outside expert or panel to review whether the treatment is medically necessary. If the external reviewer decides the recommended treatment is medically necessary, the insurer must pay for the treatment. *See, e.g., Moran*, 536 U.S. at 361; *Corporate Health Ins., Inc. v. Tex. Dep't of Ins.*, 215 F.3d at 526. *See generally* J. S. Andresen, *Is Utilization Review the Practice of Medicine? Implications for Managed Care Administrators*, 19 J. LEGAL MED. 431 (1998); Patricia Butler & Karl Polzer, *Private Sector Health Coverage: Variation in Consumer Protection Under ERISA and State Law* (1996) (National Health Policy Forum, George Washington University) (discussing utilization review decisions).

75. The THCLA exempts insurers from liability for prescribed treatment that falls outside the insurance policy coverage. *See* TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(d). That is, if the insurance entity denies a claim for reasons that do not involve the exercise of some medical judgment, such as a statute of limitations violation, the THCLA does not apply.

sion.⁷⁶ The specific preemption issue presented in *Davila* involved the federal court's "complete preemption" removal jurisdiction to hear an action premised on state law and filed in state court.⁷⁷

Complete preemption operates as an exception to the well-pleaded complaint rule. The well-pleaded complaint rule provides that, for federal question jurisdiction purposes, federal courts only examine the plaintiff's complaint to determine whether it presents a federal claim for relief.⁷⁸ The plaintiff is considered the master of his or her lawsuit, and if only state law theories are pursued (in good faith),⁷⁹ the fact that federal preemption of state law may arise as an affirmative defense to the state law action does not allow a defendant to remove the state-filed action to federal court.⁸⁰

The Supreme Court has recognized an exception to the well-pleaded complaint rule, however. In the rare circumstances where federal courts determine that Congress intended a federal remedy to provide the exclusive means of enforcing rights in a federally regulated field, courts employ a legal fiction to convert state law claims into federal claims, thereby creating federal question jurisdiction and authorizing removal of state-filed actions to federal court.⁸¹ This exception to the well-pleaded complaint rule is known as the complete preemption doctrine,⁸² and the Supreme Court has

76. *Davila*, 124 S. Ct. at 2495-2500.

77. *Id.* at 2493.

78. *Franchise Tax Bd.*, 463 U.S. at 10 ("[Whether] a case is one arising under the Constitution or a law or treaty of the United States, in the sense of the jurisdictional statute, . . . must be determined from what necessarily appears in the plaintiff's statement of his own claim in the bill of declaration, unaided by anything alleged in anticipation of avoidance of defenses which it is thought the defendant may interpose.") (quoting *Taylor v. Anderson*, 234 U.S. 74, 75-76 (1914)).

79. *Fair v. Kohler Die & Specialty Co.*, 228 U.S. 22, 25 (1913) ("[T]he party who brings a suit is master to decide what law he will rely upon."). See also *Franchise Tax Bd.*, 463 U.S. at 22 ("[I]t is an independent corollary of the well-pleaded complaint rule that a plaintiff may not defeat removal by omitting to plead necessary federal questions in a complaint.").

80. See *Franchise Tax Bd.*, 463 U.S. at 14 ("[S]ince 1887 it has been settled law that a case may not be removed to federal court on the basis of a federal defense, including the defense of pre-emption, even if the defense is anticipated in the plaintiff's complaint, and even if both parties admit that the defense is the only question truly at issue in the case.").

81. See *id.* at 22-26; *Speciale v. Seybold*, 147 F.3d 612, 617 (7th Cir. 1998).

82. The Supreme Court first established the complete preemption exception to the well-pleaded complaint rule in *Avco Corp. v. Aero Lodge No. 735, Int'l Ass'n of Machinists & Aerospace Workers*, 390 U.S. 557, 561-62 (1968). Some courts have called complete preemption a misnomer because the doctrine really is a jurisdictional rule. See *McClelland v. Gronwaldt*, 155 F.3d 507, 515-16 (5th Cir. 1998); *Jass v. Prudential Health Care Plans, Inc.*, 88 F.3d 1482, 1487 (7th Cir. 1996). While it is true that the complete preemption doctrine only operates in the circumstance of a defendant's attempt to remove a state-filed action to federal court, the underlying basis for imposing federal question jurisdiction is the implied preemption of state law remedies.

ruled that the doctrine applies in ERISA actions.⁸³ While complete preemption arises in the context of removal jurisdiction, removal to federal court based upon a predominant federal remedy under the complete preemption doctrine necessarily requires that courts determine the scope of congressional intent to supersede state law.

The parameters of a federal law's preemption of state law can be expressly detailed in the federal statute or can arise by implication,⁸⁴ but in either case, preemption analysis, including complete preemption analysis, inherently seeks to determine congressional intent.⁸⁵ Whether express or implied, the scope of a federal statute's preemption of state law falls into one of two categories, according to the Supreme Court's traditional preemption formula, conflict preemption or field preemption.⁸⁶ Conflict preemption applies where Congress intends a federal law to supersede only state laws that directly conflict with the federal statute,⁸⁷ or where enforcement of a state law would operate as an obstacle to achieving the purposes of the federal act.⁸⁸ Under conflict preemption, state laws that regulate in the same field as a federal law, but which merely supplement or compliment the federal law, are enforceable.⁸⁹

Field preemption is much broader than conflict preemption. When Congress intends to occupy a particular field of regulation, the federal act preempts all state laws operating in the field, even state laws that merely supplement or compliment the purposes of

83. See *Metro. Life Ins. Co. v. Taylor*, 481 U.S. at 63-64. See also *Franchise Tax Bd.*, 463 U.S. at 22-26 (discussing the possible application of the complete preemption doctrine in ERISA cases, but holding that ERISA does not completely preempt claims by a party who does not have standing to sue under ERISA). See generally Karen A. Jordan, *The Complete Preemption Dilemma: A Legal Process Perspective*, 31 WAKE FOREST L. REV. 927, 928 (1996).

84. See *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977).

85. See *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. at 738 ("In deciding whether a federal law preempts a state statute, our task is to ascertain Congress' intent in enacting the federal statute at issue. Preemption may be either express or implied, and is compelled whether Congress' command is explicitly stated in the statute's language or implicitly contained in its structure and purpose.") (internal quotation and citation omitted). See also *Travelers*, 514 U.S. at 655.

86. See *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 516 (1992); *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984).

87. See *Fla. Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 142-43 (1963).

88. See *Hillsborough County v. Automated Med. Labs., Inc.*, 471 U.S. 707, 713 (1985) ("Even where Congress has not completely displaced state regulation in a specific area, state law is nullified to the extent that it actually conflicts with federal law. Such a conflict arises when compliance with both federal and state regulations is a physical impossibility or when state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.") (quoting *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941)) (internal quotations and citations omitted).

89. See *Rice v. Santa Fe Elevator Corp.*, 331 U.S. at 229-31.

the federal enactment.⁹⁰ Courts infer congressional intent to occupy the field of regulation in a particular subject area where the federal statute regulates the subject so comprehensively that it can reasonably be assumed that Congress intended to block the states from intervening in the subject area, or when the subject of the regulation is peculiarly within federal authority.⁹¹ In applying field preemption, whether by adherence to Congress' express instructions or by inference, courts must also identify the boundaries of the field Congress intended the federal law to occupy.⁹²

The Supreme Court's disagreement with the Fifth Circuit Court of Appeals in *Davila* illustrates the difference between application of conflict preemption and field preemption in the context of a defendant's removal of a state-filed lawsuit under the complete preemption doctrine. The Supreme Court had previously declared that all state-filed claims that fall "within the scope" of ERISA section 502 may be removed to federal court.⁹³ The *Roark/Davila* litigation, then, produced divergent views of what "within the scope" means.

In *Roark v. Humana, Inc.*,⁹⁴ the Fifth Circuit Court of Appeals utilized implied conflict preemption principles to analyze an insurer's suggestion that Congress intended ERISA to preempt all state law remedies that fall within the scope of ERISA section 502.⁹⁵ Based upon specific language in prior Supreme Court opinions, the Court of Appeals found that ERISA only preempts state law remedies that "duplicate the causes of action listed in ERISA § 502(a)."⁹⁶ Since the tort remedy provided under the THCLA did not duplicate any of the remedies available under ERISA section 502, the Fifth Circuit ruled that ERISA did not completely preempt the plan participants' state law claims arising from an

90. See *id.* at 230. See generally S. Candace Hoke, *Preemption, Pathologies and Civic Republican Values*, 71 B.U. L. REV. 685 (1991).

91. See *Rice v. Santa Fe Elevator Corp.*, 331 U.S. at 230.

92. See *Cipollone v. Liggett Group, Inc.*, 505 U.S. at 517. See also Bogan, *Protecting Patient Rights*, *supra* note 8, at 960-63.

93. See *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990) (holding the Texas wrongful discharge tort conflicts with ERISA's enforcement provision because state law remedy duplicates elements of a claim under ERISA); *Metro. Life Ins. Co. v. Taylor*, 481 U.S. at 64. See also *Avco Corp. v. Aero Lodge No. 735*, 390 U.S. at 559-60 (LMRA section 301 completely preempts any state law cause of action that comes within the scope of the federal claim and necessarily arises under federal law).

94. 307 F.3d 298 (5th Cir. 2002), *rev'd sub nom.* *Aetna Health, Inc. v. Davila*, 124 S. Ct. 2488 (2004). *Roark* is the lower court case name for several actions presenting similar ERISA preemption questions involving THCLA claims that were consolidated for hearing in the Fifth Circuit. Only Juan Davila's case versus Aetna Health, Inc. and Ruby Calad's claim versus Cigna Healthcare of Texas, Inc. proceeded on to resolution in the Supreme Court.

95. *Id.* at 305.

96. See *id.* at 310-11 (citing *Moran*, 536 U.S. at 379). See also *Ingersoll-Rand Co. v. McClendon*, 498 U.S. at 142-44.

ERISA-governed employee benefit plan.⁹⁷ Essentially, the Fifth Circuit held that the phrase “within the scope” means “duplicate.”⁹⁸

In *Davila*, however, the Supreme Court ruled that ERISA’s civil enforcement provision supersedes more state law remedies than just those that duplicate the relief afforded in section 502. The *Davila* opinion proceeds at length to describe complete preemption and to explore the intended scope of implied preemption under ERISA section 502. In contrast to the Court of Appeals, however, Justice Thomas’ opinion concludes that Congress intended ERISA to occupy the field of all plan participant remedies arising in connection with an employee benefit plan.⁹⁹ Justice Thomas reasoned that ERISA nullified the plan participants’ THCLA claims because ERISA section 502 preempts “any state law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy”¹⁰⁰ Contrary to the Fifth Circuit, the Supreme Court ruled that the phrase “within the scope” means something broader than to “duplicate,” but the *Davila* Court put no boundaries on how much broader the scope of ERISA section 502 might be.¹⁰¹

Consistent with traditional conflict preemption analysis, the

97. *Roark*, 307 F.3d at 305, 309-11.

98. *See id.* at 310-11 (“States may not duplicate the causes of action listed in ERISA § 502(a). This is, essentially, the test employed for ‘complete preemption.’”).

99. *See Davila*, 124 S. Ct. at 2498-2500.

100. *Id.* at 2495. Interestingly, Justice Thomas defined the Court’s approach as applying implied conflict preemption rules, however, Justice Thomas’ opinion clearly employed field preemption rules (comprehensiveness) and reached a field preemption conclusion (ERISA section 502 preempts all state law remedies that “duplicate, supplement, or supplant” ERISA’s remedies). *Id.*

101. Arguably, in the Supreme Court’s first discussion of complete preemption jurisdiction under ERISA, the Court did establish at least two boundaries to the field of state law claims completely preempted by ERISA. In *Franchise Tax Board*, the Court held that a state taxing authority’s suit against an ERISA plan was not completely preempted by ERISA because the state agency prosecuting the claim was not one of the entities (plan participant or beneficiary, plan fiduciary, or the Secretary of Labor) that had standing to bring a suit under ERISA section 502. 463 U.S. at 25. Additionally, the Court remarked that the field of state law claims impliedly preempted by ERISA section 502 was also limited by ERISA’s savings clause:

The phrasing of § 502(a) is instructive. Section 502(a) specifies which persons—participants, beneficiaries, fiduciaries, or the Secretary of Labor—may bring actions for particular kinds of relief It does not purport to reach every question relating to plans covered by ERISA. Furthermore, § 514(b)(2)(A) of ERISA, 29 U.S.C. § 1132(b)(2)(A) [the savings clause], makes clear that Congress did not intend to pre-empt entirely every state cause of action relating to such plans. With important, but express limitations, it states that “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.”

Id.

Fifth Circuit in *Roark* would have allowed state law remedies to supplement ERISA's express civil remedies, so long as such remedies were not directly duplicative of ERISA section 502. The Supreme Court overruled the Fifth Circuit, and incorporating language familiar from field preemption jargon, held that ERISA preempts even supplementary and complementary state law remedies that do not directly conflict with section 502 remedies, and which arguably advance Congress' overarching purpose in enacting ERISA to protect workers rights to receive promised benefits.¹⁰²

A number of questions arise from Justice Thomas' application of implied preemption principles to conclude that ERISA completely preempts the Texas statutory tort remedy against ERISA plan insurers.¹⁰³ The most intriguing question, which Justice Thomas largely ignored, is the contribution ERISA's express preemption language should have on the complete preemption analysis.

In ERISA, where Congress included an express provision to signal its preemptive intentions, one might expect that a court would trust the statute's specific preemption language to influence its analysis of congressional intent to supersede state law remedies. The Supreme Court, however, has applied a version of statutory construction in ERISA cases that puts the cart before the horse. Beginning with *Pilot Life*, and then thoughtlessly repeated in *Davila*, the Court has determined that the comprehensiveness of ERISA's civil enforcement scheme should "inform" the Court's interpretation of ERISA's express preemption language, rather than applying the statute's express preemption language to inform the Court's interpretation of the scope of implied preemption arising from ERISA section 502.¹⁰⁴

In *Pilot Life*, the Court examined two arguments presented in support of preemption: first, that ERISA expressly preempted the subject state remedies law (under section 514) because the law "related to" an ERISA plan and was not saved from preemption as a law that regulates insurance; and second, that ERISA impliedly

102. See *Davila*, 124 S. Ct. at 2495.

103. For example, Justice Thomas' opinion ignores the rule, re-invigorated in *Travelers*, that courts should presume that Congress did not intend to supersede state law, particularly in areas of traditional state predominance, such as insurance law. See *Travelers*, 514 U.S. at 654-55. Additionally, the express language of ERISA section 514 recites that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . ." ERISA's remedies provision, found at section 502, is within "this subchapter," consequently, the unambiguous, plain meaning of ERISA section 514 instructs that ERISA section 502 "shall [not] be construed" to trump the savings clause. Brief for the United States as Amicus Curiae Supporting Petitioner in Part and Supporting Respondent in Part at 23, *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999) (No. 97-1868). See generally Bogan, *supra* note 63.

104. See *Davila*, 124 S. Ct. at 2500 (quoting *Pilot Life*, 481 U.S. at 52).

preempted the state law remedy (under section 502) because the federal statute included its own comprehensive enforcement provision.¹⁰⁵ In construing a statute, it is elementary that courts should first look to the language of the act to glean Congress' intent.¹⁰⁶ In analyzing the scope of a federal statute's possible preemption of state law, it is equally elementary that a court should look first to the statute's express preemption provision, if it contains one, to determine the scope of Congress' preemptive intentions.¹⁰⁷ When a court examines a statute which contains express preemption language, but also senses further preemptive intentions based on some other, non-preemption, statutory provision,¹⁰⁸ it also seems elementary that a court should examine the suggestion of preemption arising from the non-preemption language in concert with the express preemption provision in an attempt to harmonize the inference of preemption with Congress' express preemption instructions.¹⁰⁹ In such a circumstance, where a court seeks to determine the scope of implied preemption arising from a statute that also contains express preemption language, I suggest that a court should consult the express preemption language to "inform" its interpretation of the scope of implied preemption—it should not be the other way around.

In *Davila*, the Supreme Court blundered when it parroted *Pilot Life* and decided that its perception of a broad intent to preempt arising by inference from the comprehensiveness of ERISA's remedies provision trumps ERISA's express savings clause.¹¹⁰ Instead, the Court should have consulted the statute's express pre-

105. See Brief for Petitioner at 1, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (No 85-1043), available at LEXIS at 1985 U.S. Briefs 1043.

106. See *Park 'N Fly, Inc. v. Dollar Park and Fly, Inc.*, 469 U.S. 189, 194 (1985) (observing that when interpreting statutes, a court "begin[s] with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose").

107. See *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. at 740 (quoting *Park 'N Fly, Inc. v. Dollar Park and Fly, Inc.*, 469 U.S. at 194).

108. In *Boggs v. Boggs*, 520 U.S. 833 (1997), the Supreme Court ruled that implied preemption principles, notably conflict or field preemption analysis, apply in ERISA actions as tools to examine congressional intent to preempt, in addition to Congress' express preemption instructions. See also *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99-101 (1993).

109. See *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. at 98 (stating that while ERISA's savings clause "leaves room for complementary or dual federal and state regulation," ERISA "calls for federal supremacy when the two regimes cannot be harmonized or accommodated").

110. See *Davila*, 124 S. Ct. at 2500 ("As this Court stated in *Pilot Life*, 'our understanding of [§ 514(b)(2)(A)] [the savings clause] must be informed by the legislative intent concerning the civil enforcement provisions provided by ERISA § 502(a), 29 U.S.C. § 1132(a).'" (quoting *Pilot Life*, 481 U.S. at 52). Recall that the *Pilot Life* Court ruled that the state law at issue in that case was not a law that regulates insurance; consequently, the *Davila* Court's heavy reliance on *Pilot Life* is particularly misplaced.

emption provision, and in particular the savings clause since the issue in *Davila* involved a state insurance law remedy, and it should have attempted to harmonize the scope of implied preemption under section 502 with ERISA's express preemption language. In *Pilot Life*, the Court's emphasis was wrong because the Court allowed the inference of preemption arising from a non-preemption provision to direct its construction of express preemption language on the specific question of the statute's preemption of state law. In *Davila*, the Court went even further astray because Justice Thomas' opinion did not even pretend to incorporate ERISA's express preemption language into the mix when it ruled that ERISA impliedly preempted a state insurance law.¹¹¹

In *Davila*, if the Court had attempted to harmonize implied preemption under section 502 with the section 514(b)(2)(A) exception to preemption for state laws that regulate insurance, instead of merely dismissing the express provision as inferior to section 502 implied preemption, an easy solution would have been apparent. If we assume that the comprehensiveness of section 502 indicates a congressional intent to occupy the field of civil remedies arising in connection with an employee benefit plan, the question still remains: What are the boundaries to the field Congress intended ERISA to occupy? The Court continues to assert that Congress intended ERISA remedies to be exclusive,¹¹² but that tells us very little. If a plan rents office space, did Congress intend section 502 to preempt state landlord-tenant law?

When a court invokes field preemption analysis, it must somehow define or limit the scope of the preempted field. If the *Davila* Court had recognized that there must be some boundaries

111. See *id.* at 2500 (chastising the plan participants for suggesting that the THCLA regulates insurance within ERISA's savings clause "for the first time in their brief to this Court" and then perfunctorily dismissing the savings clause argument). Lower courts have generally examined complete preemption removal jurisdiction solely according to section 502 implied preemption analysis. By ignoring ERISA's express preemption language when evaluating a motion to remand, federal courts put themselves in a box if the state law remedy under consideration is a law that regulates insurance. By failing to consider how the savings clause might limit implied preemption under section 502, courts routinely deny the motion to remand, tacitly agreeing that ERISA preempts the claim without ever taking the opportunity to consider ERISA's exception to preemption for state laws that regulate insurance. The better procedure is for courts to examine both implied preemption under section 502, and the express preemption instructions of section 514 at the motion to remand stage. At that point a court would best be in position to avoid needlessly hearing non-diverse, state-filed, and state law-controlled insurance disputes. See *Franklin H. Williams Ins. Trust v. Travelers Ins. Co.*, 50 F.3d 144, 151 (2d Cir. 1995). See also *Hamilton v. United Healthcare of La., Inc.*, No. 01-585 c/w 01-650 Section: "J"(4), 2001 U.S. Dist. LEXIS 6791, at *18 (E.D. La. May 17, 2001); *Selby v. Principal Mut. Life Ins. Co.*, 98 Civ. 9283 (RLC), 2000 U.S. Dist. LEXIS 1495, at *11 (S.D.N.Y. Feb. 16, 2000).

112. See *Davila*, 124 S. Ct. at 2495.

to the exclusive field of remedies occupied by ERISA, the Court could have harmonized its interpretation of section 502 with section 514 by applying the savings clause to define at least one of the boundaries of the field occupied by section 502—that is, the Court could have, and should have, held that the field of remedies occupied by ERISA section 502 does not include state insurance law remedies.¹¹³

In *Davila*, the Court's failure to consult ERISA's express preemption language to at least determine the boundaries of the field Congress intended ERISA to preempt caused the Supreme Court to incongruously rule that the inference of preemption arising from ERISA's civil enforcement provision was a better indicator of Congress' preemptive intentions than the express preemption provision Congress included within the statute.¹¹⁴

Davila is wrongly decided. That said, following *Davila*, at least there is no longer any ambiguity about one long-contested ERISA preemption issue—ERISA nullifies state insurance bad faith laws to the extent ERISA plan participants rely upon such laws to seek extra-contractual damages from an insured ERISA plan.¹¹⁵ However, because insurance bad faith laws do more than offer individual consumers a tort remedy, we must now proceed to examine what remaining impact state insurance bad faith laws may have in the ERISA claims process after *Davila*.

IV. BAD FAITH LAWS IN PLAN PARTICIPANT CLAIMS AFTER DAVILA

A. Bad Faith Laws Define Standards of Conduct

Bad faith insurance laws come in many sizes and shapes. Some states enforce their insurance bad faith laws entirely through the common law.¹¹⁶ The majority of states have enacted

113. See *Franchise Tax Bd.*, 463 U.S. at 25.

114. See *Davila*, 124 S. Ct. at 2500 (“The existence of a comprehensive remedial scheme demonstrates an ‘overpowering federal policy’ that determines the interpretation of a statutory provision designed to save state law from being pre-empted.”); *id.* (“Under ordinary principles of conflict pre-emption, thus, even a state law that can be arguably characterized as ‘regulating insurance’ will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA’s remedial scheme.”). But see *Franchise Tax Bd.*, 463 U.S. at 25.

115. By this I mean there is no ambiguity under the arguments as presented, unless, of course, the Supreme Court fixes the mistakes it has made in this area. Further, it must be noted that the *Davila* plan participants abandoned the issue of whether the ERISA plan sponsor's promise was to pay health care costs or merely to pay for membership in the HMO. See *Davila*, 124 S. Ct. at 2497 n.2.

116. See, e.g., *Moradi-Shalal v. Fireman's Fund Ins. Cos.*, 758 P.2d 58 (1988) (noting that individual remedy not available under California unfair insurance practices act, though the state Insurance Commissioner can pursue administrative remedies and individuals can pursue common law bad faith

some version of the Model Unfair Claims Settlement Practices Act.¹¹⁷ Some states hold insurance companies to their duty of good faith and fair dealing through a combination of statutory standards and common law claims.¹¹⁸ Many states authorize individual insurance consumers to enforce bad faith standards through civil actions for extra-contractual damages, including punitive damages.¹¹⁹ Other states grant statutory treble damage remedies to insurance consumers.¹²⁰ Some states only allow the state Commissioner of Insurance or Attorney General to enforce the state's insurance law standards established in statutory unfair insurance practices laws.¹²¹

While the states vary in the remedies they authorize in response to insurer bad faith, one thing that all bad faith laws have in common is that they establish standards of conduct insurers must adhere to in their interactions with their insurance customers. In sum, insurance bad faith laws do two things: 1) they establish standards of behavior required of insurers; and 2) they provide some type of remedy against insurers who violate the standards of behavior.

Davila establishes that ERISA impliedly preempts plan participant state law bad faith remedies because such state law remedies, whether common law or statutory, "conflict" with ERISA's civil enforcement provision.¹²² However, because state bad faith insurance law standards of conduct have effect standing alone—that is, absent the remedy, they still regulate insurance—state laws that establish standards of conduct for insurers do not always implicate implied preemption under ERISA section 502. Further, since bad faith laws that impose standards of insurer conduct fit within ERISA's savings clause,¹²³ such laws should avoid express preemption under ERISA section 514. The question then arises: What impact do state laws that impose standards of

claims). *But cf.* *Spencer v. Aetna Life & Cas. Ins. Co.*, 611 P.2d 146 (Kan. 1980) (in first party claim, Kansas unfair insurance practices remedies preempt common law bad faith actions).

117. See UNFAIR CLAIMS SETTLEMENT PRACTICES ACT (NAIC 1991), reprinted in *ASHLEY*, *supra* note 14, app. III, at appx-25.

118. See *Moradi-Shalal v. Fireman's Fund Ins. Cos.*, 758 P.2d at 66 (discussing administrative remedies under state unfair insurance practices act and common law claims available to individual insureds).

119. See, e.g., *Badillo v. Mid Century Ins. Co.*, 2004 Okla. LEXIS 49, at *10.

120. North Carolina authorizes either an individual common law action seeking punitive damages for bad faith breach of an insurance contract, or a statutory action for treble damages by enforcing the unfair insurance practices statute through an individual action under the state's general unfair trade practices statute. See *Vazquez v. Allstate Ins. Co.*, 529 S.E.2d 480 (N.C. App. 2000).

121. See *infra* text accompanying notes 193-206.

122. See *Davila*, 124 S. Ct. at 2495.

123. See *Elliot v. Fortis Benefits Ins. Co.*, 337 F.3d at 1147-48. See also discussion of *KAHP* savings clause test in text accompanying notes 59-65, *supra*.

conduct on insurance companies have on ERISA plan participant benefit claims, if the bad faith laws cannot be enforced through individual state law remedies?

I suggest that state bad faith laws that establish standards of insurer conduct should assist plan participants in overcoming ERISA plan insurer claim denials in the common circumstance where courts defer to insurer actions under an arbitrary or capricious standard of review. Before we examine how state bad faith laws may establish an insurer's arbitrary and capricious behavior, we should first recall the deferential standard of review process common in ERISA plan participant benefit claims.

B. The Deferential Standard of Review in ERISA Benefit Claims

The application of a deferential standard of review in ERISA claims litigation, along with the preemption of state consumer protection laws and remedies, make ERISA a frequent target for consumer-protection advocates' legislative reform efforts.¹²⁴ Additionally, preemption of state laws and application of a deferential review standard engender much hand-wringing by judges¹²⁵ (and an occasional justice¹²⁶) who bemoan the unfairness of the benefit claim processes developed under ERISA. While the implementation of deferential review in ERISA claims litigation lacks a sound legal foundation,¹²⁷ every federal circuit adheres to the practice, with some variation in the details,¹²⁸ due to a dicta pronouncement in the 1989 Supreme Court opinion, *Firestone Tire & Rubber Co. v. Bruch*.¹²⁹

In *Firestone*, a number of former employees challenged Firestone Tire & Rubber Co.'s ("Firestone") interpretation of a clause in an employee termination pay plan, which Firestone sponsored for its workers. The severance plan promised benefits to any workers who lost their jobs at Firestone due to a "reduction in work

124. See, e.g., Health Security Act of 1993, H.R. 3600, 103d Cong. (1993); Bipartisan Consensus Managed Care Improvement Act of 1999, H.R. 2723, 106th Cong. (1999) (Patient Bill of Rights).

125. See *DeFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 453 (3d Cir. 2003) (Becker, J., concurring); *Cicio v. Vytra Healthcare*, 321 F.3d 83, 106-10 (2d Cir. 2003) (Calabresi, J., dissenting); *Cannon v. Group Health Serv. of Okla., Inc.*, 77 F.3d 1270, 1271 (10th Cir. 1996); *Graham v. L & B Realty Advisor, Inc.*, No. 3:02-CV-0293-N, 2003 U.S. Dist. LEXIS 17272, at *12-14 (N.D. Tex. Sept. 30, 2003); *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 52-53 (D. Mass. 1997); *Jordon v. Reliable Life Ins. Co.*, 694 F. Supp. 822, 827 (N.D. Ala. 1988).

126. See *Davila*, 124 S. Ct. at 2503-04 (Ginsburg, J., concurring).

127. See Bogan, *supra* note 26. See also Mark D. DeBofsky, *The Paradox of the Misuse of Administrative Law in ERISA Benefit Claims*, 37 J. MARSHALL L. REV. 727 (2004).

128. See generally, Kathryn J. Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 AM. U. L. REV. 1083, 1084 (2001).

129. 489 U.S. 101 (1989).

force.”¹³⁰ When Firestone sold its Plastics Division to Occidental Petroleum Company (“Occidental”), workers within the Plastics Division who lost their jobs with Firestone sought benefits under the severance plan, even though Occidental immediately hired many of the workers to perform substantially the same jobs they had been performing for Firestone.¹³¹ Firestone felt that the contract phrase “reduction in work force” did not include workers who transferred to a new employer as part of a corporate restructuring, but who never actually missed a day of work.¹³²

Firestone’s interpretation of the “reduction in work force” phrase resulted in the denial of severance benefits; however, an equally reasonable interpretation of the phrase would have allowed the former employees to obtain the benefits. Ultimately, the legally significant question in *Firestone* was not finding the correct interpretation of the contested contract language, but deciding who had the power to make the interpretation. Rather than just urging its construction as correct, Firestone argued that it had the sole right to interpret the plan contract because it was acting in the capacity of ERISA plan administrator when it construed the plan language contrary to the workers’ interests.

Firestone’s assertion of exclusive authority to interpret plan provisions must have seemed audacious to the former Firestone workers, since the plan itself merely identified Firestone as a party to the employment contract—it was not judge, jury, arbitrator, or administrative law judge, and there was no language in the plan contract granting discretionary powers to Firestone.¹³³ The workers should be excused for their lack of ERISA sophistication, however, since Firestone itself apparently did not understand that ERISA governed the severance benefit plan.¹³⁴ Consequently, the written termination pay plan did not reference ERISA and it did not identify anyone as an ERISA plan administrator. Firestone only served in the capacity of plan administrator because ERISA’s default rule appoints the plan sponsor to act as plan administrator when an employee benefit plan fails to identify a plan administrator.¹³⁵ Regardless of how it became the plan administrator, Firestone argued that as plan administrator, the court could only interfere with its construction of plan provisions if Firestone acted

130. See *id.* at 105-06.

131. See *id.* at 105. But see Brief for Respondents, at 2 n.1, *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989) (No. 87-1054), available at LEXIS at 1987 U.S. Briefs 1054 (asserting that Occidental did not hire all the former Firestone employees and suggesting losses in benefits resulted to those who were retained).

132. See *Firestone*, 489 U.S. at 106.

133. See *id.* at 112.

134. Firestone conceded that it did not know ERISA governed its severance benefits plan. *Firestone*, 489 U.S. at 105.

135. ERISA § 3(16)(A)(ii), 29 U.S.C. § 1002(16)(A)(ii).

arbitrarily or capriciously.¹³⁶

Firestone urged the Supreme Court to apply the deferential “arbitrary and capricious” standard of review to its decisions as plan administrator by analogizing ERISA benefit claims to individual worker claims filed under section 302(c) of the Labor Management Relations Act (“LMRA”).¹³⁷ Several courts had previously interpreted LMRA section 302(c) to authorize an individual union worker’s breach of trust lawsuit against the trustees of a collectively-bargained benefits plan.¹³⁸ Courts that recognized this implied LMRA remedy limited their review of the trustees’ discretionary actions because trust law dictates that courts examine trustee discretionary acts only to assure that discretionary decisions are free from arbitrary and capricious actions.¹³⁹ Since LMRA section 302(c) claims sound in trust law, and because Congress incorporated much of LMRA trust law principles into ERISA, Firestone contended that a trust law-based deferential standard of review applied in ERISA benefit claims, just like in LMRA section 302(c) actions.¹⁴⁰

The Supreme Court rejected Firestone’s argument that a deferential standard of review applied because the Firestone severance plan did not grant discretionary powers to the plan administrator.¹⁴¹ However, the *Firestone* opinion offered a road map to plan sponsors who wanted to prevent courts from meddling into their employee benefits business. Despite the Court’s rejection of the LMRA section 302(c) trust law analogy, the Supreme Court instructed, nevertheless, that trust law did generally govern ERISA plan administration (even though the Firestone severance plan was not funded through a trust).¹⁴² Further, the *Firestone* Court opined that under trust law, courts should defer to an ERISA plan

136. See *Firestone*, 489 U.S. at 109-12 (arguing that the interpretation of the terms of a trust is an inherently discretionary function). See also Brief for Petitioner at 5-20, *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989) (No. 87-1054), available at LEXIS at 1987 U.S. Briefs 1054.

137. See LMRA § 302(c), 29 U.S.C. § 186(c).

138. LMRA section 301 provides a breach of contract remedy, but individual workers are not granted standing to sue under LMRA section 301, which only authorizes unions and employers to enforce collective bargaining agreements. LMRA § 301, 29 U.S.C. § 185.

139. See RESTATEMENT (SECOND) OF TRUSTS § 187 (1959).

140. *Firestone*, 489 U.S. at 109. Firestone did not separately fund its severance plan—that is, it did not set aside assets in a trust to pay the promised benefits, nor did it purchase insurance to fund the severance plan. Additionally, because the severance benefits were paid out of Firestone’s operating capital, every decision Firestone made as plan administrator to deny benefits resulted in a dollar-for-dollar gain for Firestone, the plan sponsor. See *Bruch v. Firestone Tire & Rubber Co.*, 828 F.2d 134, 144 (3d Cir. 1987), *aff’d in part and rev’d in part*, 489 U.S. 101 (1989).

141. See *Firestone*, 489 U.S. at 112, 115.

142. Interestingly, the Court first observed that Congress did not intend to wholly incorporate LMRA trust law into ERISA. See *id.* at 109.

administrator's discretionary decision-making if an ERISA plan specifically empowers the plan administrator with discretionary authority.¹⁴³ Since the Firestone plan failed to expressly grant discretionary powers to the plan administrator, the Court held that a *de novo* standard of review applied, but the legacy of *Firestone* is the rule that courts must defer to ERISA plan administrators in their exercise of specifically assigned discretionary authority.¹⁴⁴

Predictably, a great many ERISA plan sponsors added grants of discretion to their plan administrators after *Firestone*,¹⁴⁵ and following the Supreme Court's suggestion in *Firestone*, lower courts now defer to an ERISA plan administrator's discretionary acts in interpreting plan language and in deciding benefit claims, so long as the necessary grant of discretionary powers is included in the plan, and so long as the plan administrator does not abuse its discretion.¹⁴⁶ Applying this deferential review standard to ERISA claims, courts limit the judicial role to evaluating whether the plan administrator's "interpretation was made rationally and in good faith—not whether it was right."¹⁴⁷

Further complicating the ERISA standard of review issue is the fact that in their application of the deferential standard in ERISA claims, courts talk trust law, but actually apply an administrative law-style of deferential review.¹⁴⁸ Under the ERISA model

143. See *id.* at 115 (noting also the exception that courts must account for any trustee conflict of interest as a factor when it decides whether the trustee's actions were arbitrary and capricious). See also RESTATEMENT (SECOND) OF TRUSTS § 187.

144. See *Firestone*, 489 U.S. at 115. See generally Kennedy, *supra* note 128, at 1114-16.

145. See *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 383 n.2 (3d Cir. 2000) (citing John H. Langbein, *The Supreme Court Flunks Trusts*, 1990 SUP. CT. REV. 207).

146. Most courts equate the "abuse of discretion" standard of review with the "arbitrary and capricious" standard of review. See, e.g., *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1558 n.1 (11th Cir. 1990). But see *Morton v. Smith*, 91 F.3d 867, 870 (7th Cir. 1996).

147. See *Brown v. Ret. Comm. of Briggs & Stratton Ret. Plan*, 797 F.2d 521, 529 (7th Cir. 1986) (quoting *Riley v. MEBA Pension Trust*, 570 F.2d 406, 410 (2d Cir. 1977)). See also *Morton v. Smith*, 91 F.3d at 870 ("A decision constitutes an abuse of discretion when it is 'not just clearly incorrect, but downright unreasonable.'") (quoting *Fuller v. CBT Corp.*, 905 F.2d 1055, 1058 (7th Cir. 1990)); *Rehmar v. Smith*, 555 F.2d 1362, 1371 (9th Cir. 1977) (courts defer to the discretionary actions of a trustee so long as its conduct is not "arbitrary, capricious, or made in bad faith, not supported by substantial evidence, or [is] erroneous on a question of law").

148. See *Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 978 (7th Cir. 1999) ("[W]e have held that courts may treat welfare benefit plans just like administrative law judges implementing the Social Security disability-benefit program."). But see *Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 332 (7th Cir. 2000) ("What may have misled courts in some cases is the analogy between judicial review of an ERISA plan administrator's decision to deny disability benefits and judicial review of the denial of such

as applied by the courts, which actually equates the ERISA plan administrator with an administrative law judge, not a trustee, courts typically examine only the plan administrator's claim file to determine whether, at the time the plan administrator denied a claim, the "administrative record" contained evidence to support the plan administrator's exercise of discretion.¹⁴⁹ Courts usually do not allow plan participants to offer further evidence in support of his or her claim,¹⁵⁰ and courts usually do not hear live witness testimony in an ERISA benefit claim, even when courts conduct a bench trial.¹⁵¹ Additionally, courts do not allow plan participants to conduct discovery, unless there is a question whether the plan administrator was operating under a conflict of interest.¹⁵² Finally, courts usually deny plan participants the right to a jury trial in plan participant benefits claims, ostensibly because trust law permeates ERISA, and trust law is governed under equitable principles.¹⁵³

Court deference to an insurance company's claim denial as if

benefits by the Social Security Administration."); *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d at 1564 ("We express caution, however, at the wholesale importation of administrative agency concepts into the review of ERISA fiduciary decisions. Use of the administrative agency analogy may, ironically, give too much deference to ERISA fiduciaries."). See also DeBofsky, *supra* note 127.

149. See, e.g., *Perry v. Simplicity Eng'g*, 900 F.2d 963, 967 (6th Cir. 1990). But see *Herzberger v. Standard Ins. Co.*, 205 F.3d at 332. In reality, no "administrative record" is created when a plan administrator/insurer investigates a claim. DeBofsky, *supra* note 127, at 739. There are seldom sworn affidavits, or deposition transcripts in the claims file, which should concern courts that enter "summary judgment" under the summary adjudication process developed by federal courts to deal with the glut of ERISA benefits claims. See *id.* at 746-47; Donald T. Bogan, *The Unsupported Delegation of Conflict Adjudication in ERISA Claims Under the Guise of Judicial Deference*, 57 OKLA. L. REV. 21 (2004).

150. The plan participant can submit documents, including medical records, affidavits, and expert witness reports to the plan administrator for its consideration, but once the plan administrator makes its final decision to deny benefits, its file is closed and courts do not usually allow the plan participant or the plan administrator to offer new evidence in court. Michael A. de Freitas, Annotation, *Judicial Review of Denial of Health Care Benefits Under Employee Benefit Plan Governed by Employee Retirement Income Security Act (ERISA)* (29 U.S.C.A. 1132(a)(1)(B)—*Post Firestone Cases*, 128 A.L.R. FED. 1, § 48 (Supp. 2003).

151. See *Hess v. Hartford Life & Accident Ins. Co.*, 274 F.3d 456, 461 (7th Cir. 2001) (stating that a "judge decides cases as a trial on the papers when the parties agree to stipulated facts").

152. See generally Kennedy, *supra* note 128, at 1083.

153. See generally Annotation, *Plaintiff's Right to Jury Trial in Civil Action Under 502(a)(1)(B) of Employee Retirement Income Security Act*, 29 U.S.C. 1132(a)(1)(B), 56 A.L.R. FED. 880 (Supp. 2001). But see Bogan, *supra* note 26, at 685-93. See also *Bona v. Barasch*, 01 Civ. 2289 (MBM), 2003 U.S. Dist. LEXIS 4186 (S.D.N.Y. Mar. 20, 2003) (jury trial awarded in ERISA claim because claimant sought legal relief).

the insurer was an administrative law judge, coupled with a court's refusal to enforce the rules of civil procedure in allowing discovery and in conducting a trial, as if the plan participant had previously enjoyed the due process of law in an administrative trial, often render an ERISA plan participant's section 502(a)(1)(B) suit to recover benefits due under an insured plan an illusory remedy.

C. ERISA Plan Insurers Abuse Their Discretion when They Violate State Insurance Law Standards of Conduct

State unfair insurance practices statutes typically define many unfair practices in such broad terms that it is difficult to define specific behaviors that are always objectionable.¹⁵⁴ However, where the plan participant can establish that a plan insurer violated a state bad faith law in the process of denying a claim for benefits, for example, by interpreting ambiguous policy language in its own favor¹⁵⁵ or by failing to conduct an adequate investiga-

154. State unfair insurance practices laws, patterned on the Unfair Claims Settlement Practices Model Regulation (NAIC 1981), reprinted in ASHLEY, *supra* note 14, app. II, at appx-17, typically define the following generally stated practices as unfair (or, in common law parlance, in violation of an insurer's duty of good faith and fair dealing):

- unreasonable withholding of payments due under an insurance policy;
- failing to act in good faith in discharging the insurer's contractual responsibilities;
- refusing, without proper cause, to compensate its insured for a loss covered by the policy;
- unreasonable delay in paying claims where there is no honest doubt about the insurer's liability.

See, e.g., OKLA. STAT. tit. 36, § 1250.5 (2000). *See also* Richardson v. Employers Liab. Assurance Corp., 25 Cal. App. 3d 232 (1972) (requiring insured to bear the expense of proving facts which are not reasonably in dispute). The difficulty in applying state bad faith insurance law standards when the facts are not obvious arises from the common practice of denying plan participants the right to conduct discovery in ERISA claims litigation, and the practice of denying plan participants an evidentiary hearing. *See generally* Kennedy, *supra* note 128, at 1102 (stating absent an opportunity to discover bad faith violations and to present evidence of such bad faith in court when questions of fact predominate, it may be only in the limited circumstances that would support a summary judgment that a plan participant will be able to press a court to overturn an ERISA claim denial because the insurer's bad faith established an arbitrary and capricious violation). *See generally* Kennedy, *supra* note 128, at 1102.

155. *See, e.g.,* Harrell v. Old Am. Ins. Co., 829 P.2d 75, 79 (Okla. Ct. App. 1991) (finding that an insurer acted in bad faith when it interpreted an ambiguous pre-existing condition clause in insurance policy in its own favor in order to deny coverage); Sparks v. Republic Nat'l Life Ins. Co., 647 P.2d 1127, 1137 (Ariz. 1982) (patently ambiguous policy provision), *cert. denied*, 459 U.S. 1070 (1982). *See also* Fletcher v. W. Nat'l Life Ins. Co., 10 Cal. App. 3d at 388 (insurer acted in bad faith when it deliberately misinterpreted medical records to avoid coverage). *See generally*, ASHLEY, *supra* note 14, § 5.11 n.32.

tion,¹⁵⁶ courts should accept the bad faith violation as a per se abuse of discretion.¹⁵⁷

Despite the difficulty a plan participant may have in proving bad faith in ERISA cases that prohibit discovery, ban evidence, and discount the right to cross-examine adverse witnesses, even when a statute defines standards very broadly, many states have interpretive case law that does define explicit behaviors as violative of state law.¹⁵⁸ In such circumstances, a plan participant may be able to establish some bad faith violations as a matter of law based upon facts admitted in the plan administrator's claims file.¹⁵⁹ For purposes of this analysis, I will focus on one common practice that does lend itself to a summary adjudication of bad faith as a matter of law. The claims settlement practice that I suggest violates most state insurance law bad faith standards is the insurance company practice of interpreting ambiguous policy provisions in their own favor to deny claims.¹⁶⁰

156. See ASHLEY, *supra* note 14, § 5:08 (gathering cases).

157. This is not really a novel suggestion because federal courts have consistently defined arbitrary and capricious behavior or abuses of discretion in ERISA cases in language that incorporates or mirrors the catch-all "bad-faith" term which the states have utilized to describe unreasonable insurance company conduct. Additionally, the description of unfair practices contained in state unfair insurance practices laws often is couched in terms of behavior that is unreasonable. See *supra* text accompanying note 154. My analysis here merely frees federal courts to examine historic state court bad faith precedents to find concrete examples of specific behaviors that are "unreasonable," or "unfair," or "arbitrary and capricious." See, e.g., *Brown v. Ret. Comm. of Briggs & Stratton Ret. Plan*, 797 F.2d at 529 (stating ERISA courts applying deferential standard of review only care that the plan insurer's "interpretation was made rationally and in good faith—not whether it was right") (quoting *Riley v. MEBA Pension Trust*, 570 F.2d at 410); *Rehmar v. Smith*, 555 F.2d at 1371 (courts defer to the discretionary actions of a trustee so long as its conduct is not "arbitrary, capricious, or made in bad faith, not supported by substantial evidence, or [is] erroneous on a question of law").

158. See ASHLEY, *supra* note 14.

159. This sounds like a summary judgment standard, assuming the file contains sworn affidavits, sworn answers to interrogatories, admissions in pleadings, and deposition transcripts, but most courts disregard the niceties of summary judgment in ERISA cases. See DeBofsky, *supra* note 127, at 743-46. Courts routinely enter summary judgment in ERISA claims based upon the "administrative record," but the administrative record is rarely, if ever, compiled under the rules of evidence—witnesses are not sworn, no evidentiary foundation is established to assure that documents contained in the file would be admissible, and there is seldom deposition testimony. At most, the file occasionally contains some sworn affidavits. While the parties may stipulate that the file submitted to the court contains all of the materials reviewed by the plan administrator, there is typically no stipulation as to the admissibility of the contents of the file. See generally Kennedy, *supra* note 128.

160. See *Wolf v. Prudential Ins. Co. of Am.*, 50 F.3d 793 (10th Cir. 1995); *Employees' Benefit Ass'n v. Grissett*, 732 So. 2d 968 (Ala. 1998); *Sanders v. Home Indem. Ins. Co.*, 594 So. 2d 1345 (La. Ct. App. 1991); *Harrell v. Old Am. Ins. Co.*, 829 P.2d 75 (Okla. Ct. App. 1991); *Sparks v. Republic Nat'l Life Ins.*

In the ERISA context, state bad faith laws that impose standards of conduct on insurers should apply to plan insurers in similar fashion to the notice-prejudice rule in *Ward*, and to the external review law at issue in *Moran*, as previously discussed.¹⁶¹ State insurance bad faith laws that proscribe standards of conduct, and particularly standards of conduct targeting the claims settlement process, reasonably fit within the *KHAP* two-factor savings clause test.¹⁶² First, bad faith standards of behavior, whether defined by statute or developed under the common law of most states, only apply to the insurance industry.¹⁶³ Second, state insurance laws defining an insurer's standards of conduct substantially impact the risk pooling arrangement between the insurer and the insured because such laws add policy terms to the insurance contract.¹⁶⁴

Recall here that the insurance rule of bad faith interpretation of an insurance contract is different than the general rule of contract interpretation known as *contra proferentum*. The rule of *contra proferentum* requires courts, in de novo trials, to construe ambiguous contract language against the interpretation, even a reasonable interpretation, offered by the drafter of the ambiguous language, and in favor of a reasonable interpretation offered by the non-drafter of the ambiguous language.¹⁶⁵ *Contra proferentum*

Co., 647 P.2d 1127 (Ariz. 1982), cert. denied, 459 U.S. 1070 (1982). See also *Fletcher v. W. Nat'l Life Ins. Co.*, 10 Cal. App. 3d at 376 (deliberate misinterpretation of medical records to avoid coverage). See generally, ASHLEY, *supra* note 14, § 5.11 n.32.

161. See discussion in text accompanying notes 43-58 and 66-69, *supra*.

162. See *KAHP*, 538 U.S. at 341-42 (holding state laws regulate insurance if they are specifically directed toward "entities engaged in insurance" and if they "substantially affect the risk pooling arrangement between the insurer and the insured"). See discussion in text accompanying notes 59-65, *supra*.

163. See *Elliot v. Fortis Benefits Ins. Co.*, 337 F.3d at 1147-48 (holding the Montana unfair insurance practices statute is a law that regulates insurance under *KAHP* two-factor test). Compare *Pilot Life*, 481 U.S. at 41 (holding that Mississippi's bad faith remedy is available for any breach of contract, not just the tortious breach of an insurance contract), with *Lewis v. Aetna U.S. Healthcare, Inc.*, 78 F. Supp. 2d 1202 (N.D. Okla. 1999) (declaring that Oklahoma common law bad faith remedy is available only in claims against the insurance industry).

164. *KAHP* establishes that the savings clause does not apply only to state insurance laws that transfer risk, as most courts had interpreted the old three-factor McCarran-Ferguson Act test, which *KAHP* overruled. See *KAHP*, 538 U.S. at 342. See also discussion in text accompanying notes 59-65, *supra*.

165. See JOHN EDWARD MURRAY, JR., MURRAY ON CONTRACTS § 88G (3d ed. 1990) ("The common sense basis for the rule [of *contra proferentum*] is that, where language may be reasonably interpreted in a way that favors the drafter or in a way that favors the non-drafter, the latter interpretation will be preferred since the drafter had control over the language and may even have left the language less than clear so as not to alert the other party to certain troublesome possibilities of which the drafter now seeks a favorable interpretation. Since the drafter is responsible for the unclear language, it should be interpreted against him even if he intended no advantage to himself in drafting it."). See also RESTATEMENT (SECOND) OF CONTRACTS § 206 (1979).

is a common law rule that *courts* apply in a lawsuit between two parties to a contract where each party has the right to advocate for its favored interpretation. The purpose behind the *contra proferentum* rule is to encourage drafters of contracts to write clear contract language so that disputes, leading to lawsuits, can be avoided.¹⁶⁶

While some courts apply the *contra proferentum* rule in ERISA benefit claims as a matter of ERISA common law, particularly where the court reviews the matter de novo,¹⁶⁷ the rule must be distinguished from the insurance bad faith standard involving interpretations of insurance contracts. The insurance bad faith standard provides that when an insured submits an insurance coverage claim to his or her insurer, prior to any lawsuit, the insurer acts in bad faith if it interprets ambiguous policy language in its own favor and against the insured in order to deny coverage.¹⁶⁸ The insurance law duty of good faith and fair dealing requires one party to an insurance contract—the insurance company—to interpret the contract in favor of the other party to the contract—the insured—before any lawsuit has been initiated. The insurance bad faith rule, therefore, prohibits the insurance company from advocating for its own interests, but rather requires the insurer to respect the insured's reasonable expectations and to credit those reasonable expectations in the interpretation of ambiguous insurance policy language.

To the extent that state law enforces the insurance rule that an insurer acts in bad faith if it interprets ambiguous insurance policy language against the insured, that state insurance rule is a law that regulates insurance which falls within ERISA's savings clause exception to preemption. As we have seen in *Ward* and *Moran*, state laws that regulate insurer conduct can be enforced

166. The common parental response to children who fight over who gets the bigger piece of pie presents a good parallel here. As we all know, the child that does not cut the pie gets to choose which piece of pie to eat—this rule tends to provide an incentive to the child that cuts the pie to be careful that each piece is the same size. Similarly, where ambiguous language in a contract will be construed against the drafter, the drafter has an incentive to be clear.

167. See *Phillips v. Lincoln Nat'l Life Ins. Co.*, 978 F.2d 302 (7th Cir. 1992) (en banc); *Masella v. Blue Cross & Blue Shield, Inc.*, 936 F.2d 98 (2d Cir. 1991); *Olson v. Troike*, 959 F. Supp. 847 (N.D. Ill. 1997). Some courts also apply the *contra proferentum* rule in ERISA cases applying a deferential standard of review. See *Doe v. Group Hospitalization & Med. Servs.*, 3 F.3d 80 (4th Cir. 1993); *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534 (9th Cir. 1990); *Bucci v. Blue Cross-Blue Shield, Inc.*, 764 F. Supp. 728 (D. Conn. 1991); *Kekis v. Blue Cross & Blue Shield, Inc.*, 815 F. Supp. 571 (N.D.N.Y. 1993). Cf. *Finley v. Special Agents Mut. Ben. Ass'n*, 957 F.2d 617 (8th Cir. 1992) (*contra proferentum* rule does not apply); *Allen v. Adage, Inc.*, 967 F.2d 695 (1st Cir. 1992) (*contra proferentum* rule does not apply).

168. See, e.g., *Harrell v. Old Am. Ins. Co.*, 829 P.2d 75 (Okla. Ct. App. 1991) (holding that an insurer acted in bad faith when it misinterpreted a pre-existing condition clause in an insurance policy in order to defeat coverage).

by ERISA plan participants only through the remedies available under ERISA section 502.¹⁶⁹ When an ERISA plan grants discretionary powers to a plan administrator, triggering a deferential standard of review, an insurer's violation of state unfair insurance practice laws establishes the insurer's abuse of discretion, per se, because courts equate "arbitrary and capricious" and "abuse of discretion" with "bad faith."¹⁷⁰

For example, assume that a state interprets an unfair claims settlement practices statute to prohibit an insurance company from construing ambiguous policy language in its own favor. Assume also that the challenged plan language in *Firestone*, "reduction in work force," was contained in an insured ERISA severance plan. Finally, assume that this hypothetical plan named the hypothetical insurer as plan administrator and that the plan grants the insurer/plan administrator discretion to interpret policy language and sole discretion to decide benefit claims.

A plan participant's challenge the hypothetical insurer/plan administrator's interpretation of the "reduction in work force" phrase in its own favor would likely be denied if a court applied an arbitrary and capricious standard of review, as suggested in *Firestone*, absent a contribution from ERISA's savings clause. While the insurer/plan administrator's construction of the policy language, finding that the termination of the workers due to the sale of a part of the employer's business does not trigger benefits under the "reduction in work force" language, may be incorrect, a deferring court does not care whether the plan administrator reached the right conclusion; it only cares that the insurer's interpretation is not arbitrary.¹⁷¹ However, if a court employed the state insurance bad faith rule prohibiting an insurer from construing ambiguous policy language against the insured, I suggest that a court should reach a contrary result.

Because the plan participant invokes the insurance bad faith law in an action to recover benefits due under ERISA section 502 (a)(1)(B), implied preemption of state law remedies does not apply.

169. See discussion in text accompanying notes 43-58 and 66-69, *supra*.

170. See, e.g., *Brown v. Ret. Comm. of Briggs & Stratton Ret. Plan*, 797 F.2d at 529 (stating ERISA courts applying deferential standard of review only care that the plan insurer's "interpretation was made rationally and in good faith—not whether it was right") (quoting *Riley v. MEBA Pension Trust*, 570 F.2d at 410); *Rehmar v. Smith*, 555 F.2d at 1371 (equating "arbitrary [or] capricious" with "bad faith"). See also de Freitas, *supra* note 150, §§ 32-34.

171. See, e.g., *Glista v. UNUM Life Ins. Co.*, No. 01-10202-GAO, 2003 U.S. Dist. LEXIS 17457 (D. Mass. Sept. 30, 2003), *rev'd and remanded*, 378 F.3d 113 (1st Cir. 2004). See also discussion in text accompanying notes 124-153, *supra*. In *Firestone*, the Supreme Court declared that de novo review applied, but the Court did not decide the contract interpretation question on the merits. The Supreme Court remanded the matter back to the Third Circuit and then to the district court to make that interpretation. See *Firestone*, 489 U.S. at 107-08.

Rather, like the notice-prejudice rule in *Ward* and the external review law in *Moran*, the state statute merely adds a term to the insured plan contract, even though the added term may direct the outcome of the section 502(a)(1)(B) benefits claim.¹⁷² A court evaluating this hypothetical claim under an arbitrary and capricious standard of review, taking into account ERISA's savings clause, should decide that the hypothetical insurer abused its discretion in denying the claim because the insurer's violation of the state insurance law standards of behavior defines the insurer's practice of favoring itself over its insured's when construing ambiguous contract terms as arbitrary and capricious, per se. In this hypothetical, the savings clause would dictate that the insurer construe the "reduction in work force" language in favor of the workers (as required under most states' insurance laws) and the insurer's failure to do so would violate the plan insurance policy, and would amount to an abuse of discretion.¹⁷³

A recent Tenth Circuit case, *Fought v. UNUM Life Insurance Co.*,¹⁷⁴ presents a good, complicated, and real fact pattern to further consider how a state insurance bad faith standard may impact a plan participant's claim for benefits due under ERISA section 502(a)(1)(B). In *Fought*, UNUM Life Insurance Company ("UNUM") issued an insurance policy to fund an ERISA-governed group disability benefits plan. The insurance policy contained a pre-existing condition exclusion which provided that: "Your plan does not cover any disabilities caused by, contributed to by, or resulting from your . . . pre-existing condition."¹⁷⁵ Additionally, the policy defined a pre-existing condition as any medical condition for which the insured received medical treatment, consultation, care or services in the three months just preceding the effective date of the disability policy, or for which the insured had symptoms that an ordinarily prudent person would have consulted a health care provider.¹⁷⁶

Ms. Fought suffered from pre-existing coronary disease. Several months after the effective date of her UNUM disability coverage, Ms. Fought underwent first, angioplasty, and then elective

172. See 2 LEE R. RUSS & THOMAS F. SEGALLA, COUCH ON INSURANCE § 19:1, at 19:2 to 19-4 (3d ed. 1995) ("Existing and valid statutory provisions enter into and form a part of all contracts of insurance to which they are applicable.").

173. Federal courts could reach the same result by further developing ERISA common law, and particularly, a federal common law of contracts and insurance law, where state law should serve as a predictive model. However, it appears that courts are reluctant to apply a common law of contracts and insurance law to implement ERISA, due primarily to the Supreme Court's overbroad application of trust law in ERISA. See Bogan, *supra* note 26, at 636-37 n.30.

174. 379 F.3d 997 (10th Cir. 2004), *cert. denied*, 125 S. Ct. 1972 (2005).

175. See *Fought*, 379 F.3d at 999 (quoting the UNUM policy).

176. *Id.*

coronary artery revascularization surgery to treat her heart condition. During surgery the doctors discovered that Ms. Fought suffered from a deformity in her sternum which required the surgeon to employ a special procedure to close the surgical wound. Ms. Fought's doctors anticipated that the post-operative course would be "quite challenging" due to concern about the surgical wound.¹⁷⁷

Ms. Fought was discharged with her wounds healing well and with no evidence of infection. Subsequently the wound split open, causing a second hospitalization. After the doctors administered antibiotics, they again discharged Ms. Fought with dramatic improvement in the healing of the surgical wound. Within a month, Ms. Fought was again admitted to the hospital, now suffering a persistent staph infection that proved to be immune to antibiotic treatment. As a result of the staph infection, Ms. Fought then underwent intensive-care treatment, numerous surgical procedures, and was placed on a ventilator.

Ms. Fought submitted a claim under the UNUM insurance policy for disability benefits arising from the persistent staph infection. UNUM denied the claim. UNUM interpreted the pre-existing condition exclusion to cover disability resulting from the staph infection, despite several treating physician reports which declared that the staph infection and resulting disability were separate and unrelated to the pre-existing coronary condition.¹⁷⁸ UNUM concluded that, while "the staph infection itself was not present during the pre-existing condition period . . . , it was the result of surgery that was performed for a cardiac condition that was present, diagnosed and treated during [the pre-existing condition] time period."¹⁷⁹ An alternate construction of the pre-existing condition language, which appears equally reasonable, if not more reasonable, than the interpretation advanced by UNUM suggests that, since Ms. Fought did not suffer from a staph infection within three months prior to the effective date of the disability policy, she was entitled to the disability benefits.

The district judge in *Fought* applied an arbitrary and capricious standard of review because the plan sponsor granted the administrator discretionary powers, though the district judge did modify the deferential review standard to reflect UNUM's admitted conflict of interest while serving as both plan administrator and payor of plan benefits. Given the deferential standard of review, the district court determined that UNUM's denial of benefits, based upon its interpretation of the pre-existing condition exclusion to include the attenuated causation of Ms. Fought's staph

177. *Id.*

178. One of the several doctor reports confusingly stated that Ms. Fought was "totally disabled due to her heart condition. The staph infection was not a pre-existing condition." *Id.* at 1000.

179. *See id.* at 1001.

infection, was not unreasonable.¹⁸⁰

The Tenth Circuit Court of Appeals, sitting en banc in *Fought*, examined the confusing state of the law on how a “sliding scale” deferential standard of review should be applied in ERISA benefit cases when the plan administrator suffers a conflict of interest.¹⁸¹ The Tenth Circuit Court of Appeals ultimately reversed the district court. In the process the Tenth Circuit created a new two-factor test that may, or may not, help lower courts and parties understand how to apply this confusing review standard in conflict of interest cases.¹⁸² I suggest the Tenth Circuit could have followed a much easier path to reach its conclusion that UNUM’s claim denial was arbitrary and capricious. By applying state insurance bad faith standards to UNUM’s behavior, the Tenth Circuit could have easily concluded that UNUM abused its discretion in denying Ms. Fought’s claim for benefits.

UNUM is an insurance company subject to state insurance laws, including state law insurance bad faith standards.¹⁸³ An insurer acts in bad faith when it interprets ambiguous policy language in its own favor and against an insured in order to deny coverage. Under state insurance law, insurer standards of conduct, whether described by the common law or detailed in an Unfair Insurance Practices law, are incorporated into every insurance contract.¹⁸⁴ When an insurer acts in bad faith under state law by interpreting ambiguous policy provisions in its own favor to deny coverage, it also abuses its discretion under a deferential standard of review because it has violated the terms of the contract and because courts define abuse of discretion as acting in bad faith.

Once the *Fought* trial court found that the pre-existing condition provision in the policy was ambiguous, because the definition of “pre-existing condition” did not clearly define all of the parameters of what is included within the definition of pre-existing condition, the court merely had to look and see that UNUM denied the claim based upon its interpretation of the policy language in its own favor. Even if UNUM’s interpretation of the policy language was reasonable, if the plain language of the policy did not declare the winner, then the insurer had to apply the insured’s reasonable interpretation of the contract; UNUM’s failure to comply with

180. The District Judge apparently did not discuss the rule of *contra proferentum* in *Fought*.

181. See *id.* at 1003-04 (“To say that there is a sliding scale of deference, however, begs the question: *how much* less deference ought a reviewing court afford?”). See also Kennedy, *supra* note 128.

182. See *id.* at 1005-07.

183. The savings clause allows the states to indirectly regulate employee benefits plans by regulating insurance companies that fund the plans. See *FMC Corp. v. Holliday*, 498 U.S. 52 (1990); *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

184. See note 172, *supra*.

state insurance law standards of good faith and fair dealing rendered its claim denial arbitrary and capricious.

One further question arises when a court finds that a plan insurer abused its discretion in denying an ERISA benefits claim because the insurer acted in bad faith. What is the remedy? It appears that a court has three options: 1) the court, applying a summary judgment standard, could find that the plan participant is entitled to the benefits as a matter of law; or 2) where questions of fact need to be resolved, the court could conduct a de novo trial on the merits, applying the insurance law standards, which are saved from preemption, to decide anew whether the insurer's decision to deny the claim was correct given the evidence and the controlling law; or 3) according to many ERISA opinions, the court could "remand" the matter to the plan administrator, directing the plan administrator to reconsider the claim, taking into account the state bad faith standards of behavior.¹⁸⁵

Where, upon cross motions for summary judgment, the application of the state insurance law upon admitted facts directs that the plan participant wins, clearly the court should enter judgment in favor of the plan participant, as in the hypothetical above. Where questions of fact prevent a diligent court from finding for either party as a matter of law, I suggest that courts should conduct a de novo trial to determine the correct outcome, rather than remanding to the plan administrator for re-consideration.¹⁸⁶ Where questions of fact prevent a diligent court from finding for either party as a matter of law, I suggest that courts should conduct a de novo trial to determine the correct outcome, rather than remanding to the plan administrator for re-consideration. The option of remand to a plan administrator is procedurally deficient.¹⁸⁷ Additionally, the fear stated by one district judge that a trial court should not try ERISA benefit cases because it would turn the court into "a substitute plan administrator" is absurd.¹⁸⁸ The stated fear that courts may become "substitute plan administrators" displays a fundamental misunderstanding of ERISA—ERISA plan administrators are not administrative law judges and a plan administrator's internal claims evaluation process is not a substitute for a governmental agency conducting an administrative trial. Federal district courts are trial courts, empowered and uniquely situated to hear evidence and decide facts. When federal district courts refuse to try ERISA cases, they refuse to do their job.

185. See *Banuelos v. Constr. Laborers Trust Funds*, 382 F.3d 897 (9th Cir. 2004) (holding that an order for remand to plan administrator is subject to appeal).

186. See *Perlman v. Swiss Bank Corp.*, 195 F.3d at 977-80 (discussing that it is doubtful a federal district court can remand actions to a plan administrator as if to administrative agencies).

187. See *id.* See generally DeBofsky, *supra* note 127.

188. See *Perry v. Simplicity Eng'g*, 900 F.2d at 966.

As suggested above, courts remand ERISA benefits cases back to the plan administrator when a court finds that the plan administrator abused its discretion because courts have treated ERISA claims as if the plan participant is appealing from an adverse ruling by an administrative law judge, equating the plan administrator to an original, neutral, fact-finder in a trial below.¹⁸⁹ However, ERISA plan administrators are not neutral, and they do not conduct any type of hearing where plan participants can examine and cross-examine witnesses to expose facts.¹⁹⁰ ERISA expressly provides plan participants a direct federal (or state) court remedy,¹⁹¹ and importantly, the statute nowhere implies that Congress intended plan participants who sue under ERISA section 502(a)(1)(B) to obtain benefits due under an ERISA plan should not have all the process afforded by the rules of civil procedure and guaranteed by the United States Constitution.¹⁹²

V. ERISA DOES NOT BAR STATE INSURANCE LAW ENFORCEMENT
ACTIONS URGED BY STATE GOVERNMENTAL OFFICIALS
VERSUS ERISA PLAN INSURERS

A. *ERISA Does Not Completely Preempt State Insurance
Commissioner Enforcement Actions*

The Model Unfair Claims Settlement Practices Act,¹⁹³ as adopted in most states,¹⁹⁴ grants state Insurance Commissioners express authority to pursue unfair insurance practice actions against insurance companies operating within their states, including ERISA plan insurers. Typically, the Insurance Commissioner can obtain injunctive relief under the state insurance law, and recover fines and penalties.¹⁹⁵

The question of whether ERISA completely preempts enforcement lawsuits brought by state Insurance Commissioners against ERISA plan insurers was effectively resolved in the first United States Supreme Court cases to discuss complete preemption in the ERISA context. In *Franchise Tax Board v. Construction*

189. See, e.g., *Perlman v. Swiss Bank Corp.*, 195 F.3d at 975. See also discussion in text accompanying notes 148-149, *supra*.

190. See DeBofsky, *supra* note 127, at 738.

191. ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(1)(a)(B).

192. See DeBofsky, *supra* note 127, at 727-28. ERISA's legislative history shows that Congress considered, and rejected, the idea of establishing an administrative apparatus to hear ERISA benefit claims. See Bogan, *supra* note 149, at 24 n.14. Congress also rejected a proposal to require arbitration of ERISA benefit claims. See *id.*

193. See UNFAIR CLAIMS SETTLEMENT PRACTICES ACT, reprinted in ASHLEY, *supra* note 14, app. III, at appx-25.

194. See ASHLEY, *supra* note 14, § 9:02.

195. See *id.* § 5-7.

Laborers Vacation Trust,¹⁹⁶ the California state agency charged with responsibility for collecting state taxes issued an order of levy to obtain assets of delinquent California taxpayers by accessing the taxpayers' property in the possession of the Construction Laborers Vacation Trust for Southern California ("CLVT"), an ERISA plan fiduciary.¹⁹⁷ The CLVT obtained an advisory opinion from the United States Secretary of Labor which declared that ERISA preempted the California garnishment statute at issue.¹⁹⁸

After the CLVT, armed with the advisory opinion, refused to comply with the garnishment order, the Franchise Tax Board sued the CLVT in state court to enforce the garnishment order. The CLVT removed the action to federal court asserting ERISA preemption as a basis for federal court jurisdiction. The Supreme Court ruled that ERISA did not completely preempt the tax agency's lawsuit against the ERISA Trust because the action did not fall within the scope of ERISA section 502.¹⁹⁹ Specifically, the Supreme Court held that ERISA section 502 did not completely preempt the Franchise Tax Board's action because the Franchise Tax Board lacked standing to sue under ERISA's civil enforcement provision.²⁰⁰ Since the Franchise Tax Board was not an entity that could sue under section 502, the Tax Board's suit did not fall within the scope of ERISA section 502, and therefore, the federal courts did not have removal jurisdiction to address the merits of the Tax Board's assertions, or the CLVT's affirmative defense of express preemption under ERISA section 514.²⁰¹ The Court held that the action must be remanded to state court, where the state court then had to decide whether ERISA preempted the Tax Board's enforcement of the state garnishment law under ERISA section 514.²⁰² The Supreme Court expressed no opinion on how the state courts should resolve the section 514 question.

196. 463 U.S. 1 (1983).

197. *See id.* at 3-5. Because union tradesmen constantly move from job to job, the state's usual process of garnishing a delinquent taxpayer's wages to collect past due state taxes did not provide the tax authority with a viable option to collect taxes against individual union workers. *See id.* at 5 n.2.

198. *See id.* at 7 n.4.

199. *See id.* at 25-26. The federal district court had ruled that it had jurisdiction to decide the matter, but then ruled that ERISA did not preempt the state law enforcement action. *See id.* at 7.

200. *Id.* at 25. Only plan participants and beneficiaries, plan fiduciaries, and the Secretary of Labor are authorized to sue under ERISA section 502. *See* ERISA § 502, 29 U.S.C. § 1132.

201. *Franchise Tax Bd.*, 463 U.S. at 26-28.

202. In subsequent action in the state court, the state court ruled that the state garnishment law did not relate to ERISA within the meaning of ERISA section 514(a), and therefore the tax agency could collect the delinquent taxes from the Trust. *Franchise Tax Bd. v. Constr. Vacation Laborers Trust*, 204 Cal. App. 3d 955, 965-66 (1988) (citing *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 830-31 (1988) (explaining that ERISA does not preempt state general garnishment law)).

The Supreme Court's holding in *Franchise Tax Board* appears to resolve the question of whether ERISA completely preempts a state Insurance Commissioner's action to enforce state insurance laws against an ERISA plan insurer. Because a state Insurance Commissioner lacks standing to sue under ERISA section 502, an unfair insurance practices enforcement action brought by a state Insurance Commissioner does not fall within the scope of ERISA section 502, and is not completely preempted by ERISA.

B. State Laws Authorizing State Insurance Commissioner Claims Versus ERISA Plan Insurers Are Saved from ERISA Preemption

While implementing *Franchise Tax Board*'s holding as applied to an Insurance Commissioner's state-filed unfair insurance practices action against an ERISA plan insurer, state courts must still address the insurer's affirmative defense of express preemption, under ERISA section 514. To avoid the state law enforcement action under ERISA's express preemption provision, an ERISA plan insurer must establish that the state unfair insurance practices law authorizing an Insurance Commissioner's enforcement action against an ERISA plan insurer "relates to" an ERISA plan and does not regulate insurance. While the Supreme Court's *Travelers* opinion in 1995 significantly narrowed the express "relates to" test for preemption under ERISA section 514, a state court might very well hold that a state's unfair insurance practices statute, as applied against an ERISA plan insurer in an Insurance Commissioner enforcement action, relates to an ERISA plan because enforcement of the state law will substantially impact the ERISA plan's benefit claims settlement practices. However, even if the state unfair insurance practices statute relates to an insured plan under ERISA section 514, an Insurance Commissioner's enforcement action under the state law should be saved from ERISA preemption under ERISA section 514(b)(2)(A) because the state remedy law regulates insurance.

Applying the *KHAP* test to state laws that authorize the state Commissioner of Insurance to enforce state insurance laws against ERISA plan insurers, it seems unquestionable that such state laws target the insurance industry, and that they substantially affect the risk pooling arrangement between the insurer and the insured. The first prong of the test is obvious—state laws that expressly apply only to insurance companies target the insurance industry. Additionally, under the second prong of the *KAHP* test, Insurance Commissioner enforcement actions under state unfair insurance practices statutes affect the risk pooling arrangement between the insurer and the insured because the laws dictate the standards of behavior insurers must comply with in their benefit

claims practices involving insured ERISA plan participants.²⁰³

C. ERISA Section 502 Does Not Impliedly Preempt State Insurance Commissioner Claims Versus ERISA Plan Insurers

The final question that a state court must resolve in an Insurance Commissioner's suit for injunctive relief, plus fines and penalties against an ERISA plan insurer is whether ERISA impliedly preempts the state insurance law remedy sought by the Insurance Commissioner under ERISA section 502. As we have seen in *Davila*, the Supreme Court has held that ERISA impliedly preempts an individual plan participant's state law remedies that fall within the scope of ERISA section 502, even if the remedies law would otherwise be saved from preemption under ERISA section 514. Further, Justice Thomas' opinion in *Davila* indicates that ERISA preempts all state law remedies within the field of state laws remedies that fall within the scope of ERISA section 502, not just remedies that directly conflict with or duplicate the ERISA section 502 remedies.²⁰⁴ However, we have also seen that in 1983, the Supreme Court specifically held that actions by a state agency to enforce state laws against an ERISA plan are not impliedly preempted under ERISA section 502, at least for purposes of complete preemption jurisdiction analysis, because the state agent lacks standing to sue under ERISA section 502. Is the test for assessing implied preemption under ERISA section 502 the same when a plan or plan administrator asserts implied preemption of state law remedies as an affirmative defense, as it is when utilized to assess complete preemption jurisdiction?

In the complete preemption context, an Insurance Commissioner's enforcement action does fall within the scope of ERISA section 502 because the state agent lacks standing; however, in the *Franchise Tax Board* litigation, on remand to state court, the Franchise Tax Board's standing and jurisdiction were no longer at issue. In an Insurance Commissioner's state unfair insurance practices action, the plan insurer will likely assert that ERISA impliedly preempts the Insurance Commissioner's claim due to the contention that Congress intended ERISA to supply the exclusive remedies arising from ERISA plan. Unfortunately, in *Davila*, the Supreme Court failed to define the boundaries of the field wherein ERISA's remedies act exclusively. Is it the field of all state law remedies that "relate to" an ERISA plan, as suggested in ERISA section 514(a) (the preemption clause)? If so, are not state law remedies that regulate insurance expressly excluded from that field under ERISA section 514(b)(2)(A) (the savings clause)? Is it the field of all state law remedies that fall within the scope of

203. See discussion in text accompanying notes 59-65, *supra*.

204. See discussion in text accompanying notes 93-114, *supra*.

ERISA section 502? If so, presumably, a state agency's enforcement action under state law against an ERISA plan insurer is not preempted because *Franchise Tax Board* teaches that actions by parties who lack standing to sue under ERISA section 502 do not fall within the scope of ERISA section 502.²⁰⁵

Absent some clear authority overruling *Franchise Tax Board*, that opinion provides the best directive on how to assess implied preemption of an Insurance Commissioner's state law enforcement action under ERISA section 502. *Franchise Tax Board* held that a state agency's enforcement action against an ERISA plan does not fall within the scope of ERISA section 502. Further, in *Franchise Tax Board*, the Supreme Court found that Congress did not intend ERISA's remedies provision to provide the exclusive remedies arising from an ERISA plan, because ERISA's savings clause works to limit the field of state laws impliedly preempted under ERISA section 502.²⁰⁶ *Franchise Tax Board* instructs that an Insurance Commissioner's state law action against an ERISA plan insurer to enforce a state's unfair insurance practices act is not impliedly preempted by ERISA section 502.

VI. STATE LAWS THAT PROHIBIT GRANTS OF DISCRETIONARY POWERS IN INSURANCE CONTRACTS WILL RESTORE DE NOVO REVIEW IN PLAN PARTICIPANT INSURANCE CLAIMS

Along with the preemption of state consumer protection laws, consumer advocates condemn the application of a deferential standard of review in ERISA insurance claims litigation as the most destructive processes resulting from ERISA's intrusion into the traditionally state-regulated fields of health law and insurance law.²⁰⁷ As suggested above, state government action may be required to curb unfair insurer claims practices, because the *Davila* decision indicates that ERISA preempts individual plan participant common law bad faith and statutory unfair insurance practices claims. Similarly, it appears that official state action will be necessary to limit application of the abusive deferential review

205. See *supra* text accompanying notes 196-202 (discussing standing to sue under ERISA).

206. See *Franchise Tax Bd.*, 463 U.S. at 25; Bogan, *Savings Clause*, *supra* note 8, at 110-11. See generally Karen A. Jordan, *Coverage Denials in ERISA Plans: Assessing the Federal Legislative Solution*, 65 MO. L. REV. 405, 435-43 (2000).

207. See, e.g., *Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1052 (7th Cir. 1987) ("[P]ension rights are too important these days for most employees to want to place them at the mercy of a biased tribunal subject only to a narrow form of 'arbitrary and capricious' review, relying on the company's interest in its reputation to prevent it from acting on its bias."). See generally Bogan, *Protecting Patient Rights*, *supra* note 8, at 952-53; DeBofsky, *supra* note 127, at 728-29.

standard to self-funded ERISA plans.²⁰⁸ While at least one state Insurance Commissioner has already attempted to prohibit grants of discretionary powers in their insurance policies,²⁰⁹ the NAIC²¹⁰ recently took action that will likely encourage more states to pursue similar consumer protections.

In 2002, the NAIC began efforts to propose a model insurance law that would prohibit insurance companies from including grants of discretion authorizing the insurer to interpret the terms of insurance policies or to alter historic state law standards for courts reviewing claims arising from the denial of insurance benefits. After a two-year period of soliciting comments and weighing testimony, the NAIC recently approved the Model Act for distribution and recommendation to the fifty states, the District of Columbia, and several U.S. Territories.²¹¹

States that decide to enact this NAIC Model Act #42, known as the Discretionary Clause Prohibition Act, will significantly assist ERISA plan participants in gaining an equal legal footing with ERISA plan insurers in disputes arising from insured ERISA benefit plans. ERISA courts should find that the Discretionary Clause Prohibition Act is saved from ERISA preemption as a law that regulates insurance. Under the first factor of the *KAHP* savings clause test, the NAIC Act regulates insurance because the Model Act only applies to health insurers and health insurance policies, and to disability insurers and disability insurance policies.²¹² Additionally, applying the second *KAHP* factor, the Discretionary Clause Prohibition Act will substantially affect the risk pooling arrangement between the insurer and the insured by adding a mandatory contract term to health and disability insurance policies contained in ERISA plan insurance policies.²¹³

VII. CONCLUSION

The Supreme Court's application of express preemption, implied preemption, and complete preemption in ERISA benefit claims prevents ERISA plan participants from pursuing individual

208. See *FMC Corp. v. Holliday*, 498 U.S. at 61 (explaining that state laws that regulate insurance within the meaning of ERISA savings clause do not apply to self-funded employee benefit plans because states cannot deem self-funded plans to be insurance companies).

209. See *Firestone v. Acuson Corp.* Long Term Disability Plan, 326 F. Supp. 2d 1040, 1049-51 (N.D. Cal. 2004).

210. The NAIC, formed in 1871, is a voluntary organization of the states (plus Washington, D.C. and various U.S. territories) chief insurance regulatory officials. For more information on the NAIC, see its website, at <http://www.naic.org> (last visited Mar. 23, 2005).

211. See PROHIBITION ON THE USE OF DISCRETIONARY CLAUSES MODEL ACT (NAIC 2002).

212. See *id.* § 4.

213. See discussion in text accompanying notes 59-65, *supra*.

state law extra-contractual remedies in damage claims arising from ERISA employee benefit plans. Additionally, the summary adjudication process applied in ERISA claims litigation under the pretext of trust law and the trust law-based deferential standard of review has also served to emasculate plan participants in their attempts to recover even their contract damages arising from ERISA benefit plans. While historically our justice system has encouraged individuals to protect themselves from wrongdoing by offering individuals the opportunity to present their own claims in courts and before juries, ERISA has put a heavy thumb on the scales of justice in favor of ERISA plans, plan insurers and plan sponsors. Absent individual rights, consumers must turn to their state officials to seek justice on their behalf. Consumers will now look to their state Insurance Commissioners to hold insurers accountable for abusive claims settlement practices, as authorized under most states insurance laws. It is unlikely that such state officials will have sufficient staff to pursue each claim of allegation of wrongdoing leveled against ERISA plan insurers, however, recent concerted government action against the UNUM/Provident companies suggests that governmental officials will respond when complaints become voluminous.²¹⁴ Similarly, consumers will now look to their state governments to implement a new state insurance law, as proposed by the NAIC, that will prohibit insurers from including discretionary clauses in health and disability insurance policies. It appears that state government regulation will be the best consumer protection against abusive practices arising from insured ERISA employee benefit plans. Following *Davila*, official government action appears to be the most likely avenue to restore equilibrium in the ERISA benefit claim process.

214. See Report of the Targeted Multistate Market Conduct Examination of UNUM Life Insurance Company, *available at* http://www.state.me.us/pfr/ins/Unum_Multistate_ExamReport.htm (last updated Nov. 17, 2004).

