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ERISA Preemption: A Product Rule and the Neglected Workhorse

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ERISA PREEMPTION: A PRODUCT RULE AND THE NEGLECTED WORKHORSE

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The Supreme Court often resolves ERISA preemption of state law issues, particularly in cases relating to welfare benefit plans, the most common welfare benefit plans being employer sponsored group health plans.¹ Supreme Court justices have echoed the frustrations employers, 
employees, plan administrators, states, and practicing attorneys feel in determining when, or even
the proper analytical approach to determine if, ERISA preempts a state law. Each Supreme
Court opinion offers more guidelines.

(1990); Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1990); Firestone Tire and Rubber Co.
(1985); Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724 (1985); Shaw v. Delta

Justice Scalia, joined by Justice Ginsburg, vented as follows:

Since ERISA was enacted in 1974, this Court has accepted certiorari in, and decided, no less than
14 cases to resolve conflicts in the Courts of Appeals regarding ERISA pre-emption of various
sorts of state law. The rate of acceptance, moreover, has not diminished (we have taken two more
ERISA pre-emption cases so far this Term), suggesting that our prior decisions have not
succeeded in bringing clarity to the law.

I join the Court's opinion today because it is a fair description of our prior case law, and a fair
application of the more recent of that case law. Today's opinion is no more likely than our earlier
ones, however, to bring clarity to this field--precisely because it does obeisance to all our prior
cases, instead of acknowledging that the criteria set forth in some of them have in effect been

abandoned. Our earlier cases sought to apply faithfully the statutory prescription that state laws are pre-empted "insofar as they ... relate to any employee benefit plan." Hence the many statements, repeated today, to the effect that the ERISA pre-emption provision has a "broad scope," an "expansive sweep," is "broadly worded," "deliberately expansive," and "conspicuous for its breadth." But applying 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. The statutory text provides an illusory test, unless the Court is willing to decree a degree of pre-emption that no sensible person could have intended--which it is not.

I think it would greatly assist our function of clarifying the law if we simply acknowledged that our first take on this statute was wrong; that the "relate to" clause of the pre-emption provision is meant, not to set forth a test for pre-emption, but rather to identify the field in which ordinary field pre-emption applies--namely, the field of laws regulating "employee benefit plan[s] described in section 1003(a) of this title and not exempt under section 1003(b) of this title," 29 U.S.C. §§ 1144(a). Our new approach to ERISA pre-emption is set forth in John Hancock Mut. Life Ins. Co. v. Harris Trust and Sav. Bank, 510 U.S. 86, 99, 114 S.Ct. 517, 526, 126 L.Ed.2d 524 (1993): "[W]e discern no solid basis for believing that Congress, when it designed ERISA, intended fundamentally to alter traditional pre-emption analysis." I think it accurately describes our current ERISA jurisprudence to say that we apply ordinary field pre-emption, and, of course, ordinary conflict pre-emption. Nothing more mysterious than that; and except as establishing that, "relates to" is irrelevant.

In an earlier dissenting opinion, Justice Stevens wrote:

Given the open-ended implications of today's holding and the burgeoning volume of litigation involving ERISA pre-emption claims, I think it is time to take a fresh look at the intended scope of the pre-emption provision that Congress enacted.


Most recently, Justice Ginsburg joined by Justice Breyer wrote in a concurring opinion:

I therefore join in the Court’s opinion. But, with greater enthusiasm, . . . I also join ‘the rising judicial chorus urging that Congress and [this] Court revisit what is an unjust and increasingly tangled ERISA regime.’

ERISA preemption is not a singular theory. In fact, the two main preemption clauses, the conflict preemption clause\(^3\) and the complete preemption clause,\(^4\) derive from separate code sections. The proper analytical framework depends on which parties are involved and what ERISA provisions are involved.

One set of rules applies when a state regulates. ERISA does not preempt many state laws as long as the state does not regulate ERISA plans directly, including benefits and the relationships among the key parties to an ERISA plan -- the sponsor, the fiduciaries, the participants, and the beneficiaries.\(^5\) ERISA preempts all state laws directly regulating ERISA plans and the relationships of the parties in it. With that in mind, Part I introduces the Product Rule, a concept based on the exceptions to ERISA § 514's Conflict Preemption Clause. The Product Rule recognizes that states can regulate health care and insurance services and products marketed in the state.

A different analytical approach prevails when an ERISA plan participant or beneficiary brings a claim. Here the issue is not whether ERISA preempts state law but whether an ERISA plan participant or beneficiary can seek a remedy at all under state law or under ERISA. This issue

\(^3\) 29 U.S.C.A. § 1144(a) (West 1997).

\(^4\) 29 U.S.C.A. § 1132(a) (West 1997)

\(^5\) *See infra* text accompanying notes __.
dominates the ERISA preemption landscape currently. The Supreme Court has consistently required ERISA plan participants and beneficiaries to bring benefit claims and benefit determinations pursuant to ERISA § 502. ERISA plan participants and beneficiaries who bring claims against plan sponsors and fiduciaries under state law rather than pursuant to ERISA § 502 generally see the Supreme Court dismiss the claim whereas plaintiffs who fit their state law claims under § 502 generally can pursue their claims on the merits. Part II inquires into ERISA § 502's Complete Preemption Clause with a particular emphasis on § 502(a)(1)(B), the workhorse of ERISA claims by plan participants and beneficiaries. The ERISA § 502's Complete Preemption Clause analysis is separate from the ERISA § 514 Conflict Preemption Clause developed in Part I. Finally, Part III critiques the Supreme Court’s latest ERISA preemption case, Aetna Health Inc. v. Davila applying the analysis developed in parts I and II.

I. THE PRODUCT RULE

A. THE PROPOSED PRODUCT RULE

The Product Rule is an umbrella term derived from the categories of state laws the United States Supreme Court has identified that are not preempted by ERISA:

\begin{footnotesize}
\footnote{6 See, e.g., Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 56 (1987).}
\footnote{7 See, e.g., UNUM Life Ins. Co. v. Ward, 526 U.S. 358, 377 (1999).}
\end{footnotesize}
(a) Those protected by ERISA’s Savings Clause;\(^8\)
(b) Those “too tenuous, remote or peripheral;”\(^9\)
(c) Those of “general applicability;”\(^10\)
(d) Those falling under an area of “traditional state regulation” like health care.\(^11\)

The Product Rule addresses the power of a state to regulate products and services marketed in the state. While a state cannot regulate ERISA plans directly or the relationships among ERISA plan parties – sponsors, administrators, fiduciaries, participants and beneficiaries – including what benefits and procedures a plan incorporates, the state may regulate the products and services marketed in the state. An ERISA plan choosing to utilize products and services take them subject to state law.

The Product Rule recognizes that state laws in the area of health care survives ERISA preemption as long as a state law merely regulates products or services available to employee benefit plans.

and not the ERISA plans themselves. The legal rationale is that state regulation of products and services does not relate to employee benefit plans, is a health concern historically regulated by states, or is saved as an insurance regulation. A consequence of such regulation may be to limit the products and services available to ERISA plans, who must choose between using products and services permitted in the state or to perform them internally.

12 See infra text accompanying notes __.

13 See infra text accompanying notes __.

14 See infra text accompanying notes __. In addition, with the number of federal laws working in conjunction with state laws, a court can uphold a state law under another ERISA Preemption Clause exception, 42 U.S.C. § 1144, which provides that nothing in ERISA shall be construed to “alter, amend, modify, invalidate, impair, or supersede” any law, rule or regulation of the United States. When a federal statute anticipates or looks to state law or a state agency for the enforcement of the federal law, the state law is protected against ERISA preemption by § 1144(d)’s protection of federal laws.

The employee welfare benefit plan, the ERISA plan, composes the contractual and fiduciary relationships among the sponsor, administrator, fiduciaries, participants, and beneficiaries. ERISA preempts state laws pertaining to these plan relationships. States can regulate all service and product suppliers outside the plan relationships. Thus states can regulate which persons can practice medicine, offer utilization review services, and market insurance in the state. States also can set standards for the products and services offered in the state.
While states can set the standard for products and services marketed in the state, they cannot mandate directly the relationship rules within the welfare benefit plan among sponsors, administrators, fiduciaries, participants and beneficiaries. Likewise, while states can regulate the products and services offered to ERISA plans, ERISA preempts any state mandate that an ERISA plan must use a certain service or product. Thus, for example, a state can mandate benefits offered by insurance companies and by health maintenance organizations (HMO), even though these are the only products available to the plans; but a state could not require an ERISA plan offer participants at least one HMO option and at least one traditional indemnity insurance option, require all health care plans to provide health care coverage through HMOs or indemnity insurance, or require the ERISA plans to offer certain benefits.

The welfare plan sponsor or administrator can implement the plan “through the purchase of insurance or otherwise.”\(^\text{16}\) If an employee group health plan purchases a group health insurance policy, under the Savings Clause and the Product Rule, a state can limit the insurance products available to be purchased by the ERISA plan, and can dictate the terms of the insurance policies including benefits, charges, and utilization review procedures.\(^\text{17}\)


\(^\text{17}\) Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S.724, 744 & n.21.
In addition, states can regulate HMOs. HMOs are insurance companies for purposes of the Savings Clause. Until Rush Prudential HMO v. Moran, the power of states to regulate HMOs that serviced employee benefit plans was in doubt. No more. States can set minimum standards for HMO products marketed in the state. ERISA plans offering an HMO option are limited to the HMO products available in the state.

Under the Product Rule, employee benefit plans can contract for products and services from insurance companies, HMOs, PPOs, IPAs, hospitals, physicians, pharmacies, nursing homes, ambulatory clinics, home health agencies, and other products and service providers. States

18 See Rush Prudential HMO, 542 U.S. at 373 (right to independent medical review of denials of service by HMO based on HMO’s determining the service is not ‘medically necessary’).

19 Id.


21 See note__ infra.


23 Preferred provider organizations (PPO) are organizations through which providers, generally hospitals and physicians, offer services at a discounted rate. The providers are paid a fee for each service rendered. Independent practice associations (IPA) are organizations of providers
actively regulate these products, services, and providers. States, for example, license physicians and facilities, control expansion of medical facilities and services through certificates of need, and regulate insurance, HMO, PPO, and utilization review organizations. An ERISA plan that purchases one of the regulated products or services incorporates the terms of the regulation into the plans, the terms enforceable by participants and beneficiaries under ERISA § 502 (a)(1)(B).

that contract to be paid on a capitation basis, a prepaid care concept where the employee welfare benefit plan (or an HMO or insurer) pays the IPA a fixed fee per enrollee per month for all services to be offered during the capitation period, notwithstanding the actual services provided.

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26 See, e.g., Ala Code § 22-21-261 et seq (Michie 1996).

27 See, e.g.,


29 See, e.g.,

30 See, e.g., N.Y. Ins. Law § 4900 (McKinney 1997).

31 29 U.S.C.A. § 1132(a)(1)(B) (West 1997). ERISA plan participant and beneficiary rights to bring a civil action to enforce these rights are discussed in part II infra.
This Part I-A summarized the Product Rule. The legislative and judicial background leading to the development of the Product Rule is set out in Parts I-B to I-D, which develop along the three steps in the Preemption Clause. Part I-E illustrates the Product Rule in the context of HMOs. Part I-F applies the Product Rule to Utilization Review Organizations.

B. ERISA § 514’s CONFLICT PREEMPTION CLAUSE

Congress enacted the Employee Retirement Income Security Act of 1974 (ERISA) mainly to safeguard employees’ pension plans. The House Conference Report describes in elaborate detail how ERISA would protect workers’ retirement benefits, including participation, vesting, coverage, exemptions, recordkeeping, funding, fiduciary responsibilities, excise taxes, actions by Secretary of Labor and the Internal Revenue Service, contributions by self-employed individuals and shareholders, individual retirement accounts, distributions, plan termination insurance, and plan terminations.33 Very little of ERISA addresses welfare benefit plans specifically. Likewise, the legislative history adds little to the workings of the ERISA preemption clause.34


34 See id. at ____, 1974 U.S.C.C.A.N. at 5162:
The provisions of title I are to supersede all State laws that relate to any employee benefit plan that is established by an employer engaged in or affecting interstate commerce or by an employee organization that represents employees engaged in or affecting interstate commerce. (However, following title I generally, preemption will not apply to government plans, church plans not electing under the vesting, etc., provisions, workmen's compensation plans, non-U.S. plans primarily for nonresident aliens, and so-called 'excess benefit plans.')

The preemption provisions of title I are not to exempt any person from any State law that regulates insurance, banking or securities. However, the substitute generally provides that an employee benefit plan is not to be considered as an insurance company, bank, trust company, or investment company (and is not to be considered as engaged in the business of insurance or banking) for purposes of any State law that regulates insurance companies, insurance contracts, banks, trust companies, or investment companies.

The ERISA preemption clause\textsuperscript{35} is open to various interpretations. With little guidance from the legislative history, the Supreme Court developed, and is developing, the reach of the three major components of the complete preemption clause, its results ranging from a broad preemption of state law to the current view of almost equally broad exceptions to the preemption clause.

The first of the tripartite preemption factors is § 514 (a)’s Conflict Preemption Clause.\textsuperscript{36} The Conflict Preemption Clause provides that ERISA “supersedes” “any and all State Laws insofar as they may now or hereafter relate to any employee benefit plan” with certain exceptions not relevant here. The Preemption Clause never mentions the word ‘preemption,’ and falls under the bland title of “Other Laws” of § 514, and the equally nondescript § 514(a) title, “Supersedure; effective date.”\textsuperscript{38} Although the clause never mentions the word ‘preemption,’ the legislative history specifically calls it the preemption provision.\textsuperscript{39} The enacted Preemption Clause is broader than the initial ones proposed by the House and Senate, which preempted only state laws that

\begin{footnotesize}
\begin{enumerate}
\item[35] 29 U.S.C.A. § 1144(a) (West 1997).
\item[36] Id.
\item[37] 29 U.S.C.A. § 1144(a) (West 1999).
\item[38] Id.
\end{enumerate}
\end{footnotesize}
regulated matters covered by ERISA. Unfortunately, the legislative history gives no official reason for the change, for the scope of the clause, or for the meaning of the words “relate to.”

Senator Harrison Williams, Chair of the Senate Committee on Labor and Public Welfare, said the provision was intended to eliminate “the threat of conflicting or inconsistent State and local regulations of employee benefit plans.” As developed more fully, this rationale suits ERISA’s pension plan regulations, which dictate substantive provision concerning vesting, funding, and participation, more so than ERISA’s welfare benefit plans regulations, which are limited to reporting and fiduciary requirements. Pension plan benefits, moreover, accrue over many years or decades and perhaps in several states. Calculating benefits owed at retirement could be an administrative nightmare if all state law and changes in state law had to be recreated and reconciled with federal law. ERISA itself dealt with pension issues in a comprehensive manner and no further state law regulation was deemed necessary. Health care benefits, on the other hand, are not accrued over time but are given and used in the same time period.

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42 See infra text accompanying notes __.
Senator Williams said the preemption provision was “intended to apply in its broadest sense to all actions of a State or local government, or any instrumentality thereof, which have the force or effect of law.”43 His concern here was not that the provision should be interpreted broadly to reach all manner of laws, but that the provision reached all sources of state law. To explain what he meant Sen Williams continued, “Consistent with this principle [that the preemption clause applies in its broadest sense to all actions of State or local government or instrumentality thereof], State professional associations acting under the guise of State-enforced professional regulation should not be able to prevent unions and employers from maintaining the types of employee benefit programs which Congress has authorized – for example, prepaid legal services programs – whether closed or open panel – authorized by Public Law 93-95.”44

Senator Williams’ mentioning prepaid legal plans apparently was not accidentally. Bar associations were lobbying states to adopt rules of professional conduct that would have stifled


44 Id. (bracketed phrase added)
the development of prepaid legal plans, or at least restrict them in ways the AFL-CIO disfavored.\footnote{See Daniel C. Schaeffer & Daniel M. Fox, Semi-Preemption in ERISA: Legislative Process and Health Policy, 1988 Am. J. Tax Pol. 47, 49 (1988).}

Lawyers were not the only professionals lobbying states against new service vehicles. Medical societies lobbied state legislatures and licensing authorities to ensure HMOs would not operate outside physician control, and insurance companies lobbied to ensure HMOs would not gain a competitive advantage as to them. A few months before passing ERISA, Congress enacted the Health Maintenance Organization Act (HMOA)\footnote{S.R. 93-129, 93rd Cong., 1st Sess., 87 Stat. 914 (1973)} encouraging the formation of health maintenance organizations. As part of the HMOA legislation, HMOs that satisfied all the requirements of the federal statute were not subject to state laws that required as a condition to doing business in the state that a medical society approve the HMO; that required physicians constitute all or a percentage of the governing body; that required all physicians or a percentage of physicians in the locale be permitted to participate as providers in the HMO; that required HMOs to meet the same financial standards as insurers respecting initial capitalization and establishment of financial reserves against insolvency.\footnote{See 42 U.S.C.A. § 300e-10 (West 1997).}
Combating the influence of professional associations was not the only purpose of the preemption provision, however. Unions, for example, did not want state regulation of ERISA plans. They wanted the flexibility to negotiate the best deal for their members, even if that meant giving up some benefits for other benefits.\textsuperscript{48} State-mandated benefits for employees, including union members, negated that flexibility.

Very few persons, if any, considered the effect the preemption provision would have on health care. The main concern was pension plans, not health care benefits. No legislator, for example, consulted with members of the health care subcommittees.\textsuperscript{49} Similarly, major insurers and health care providers gave the preemption provision no thought at the time.\textsuperscript{50}

With so little legislative or statutory guidance on the preemption provision and virtually no mentioning of health care plans or the welfare benefit plans in the legislative history, the Supreme Court initially interpreted the general Preemption Clause broadly. The Supreme Court latched onto the words ‘relate to’ as the touchstone to identify state laws that ERISA supersedes.\textsuperscript{51}

\begin{footnotesize}
\begin{enumerate}
\item See Schaefer & Fox, \textit{supra} note 8, at 51.
\item \textit{Id.} at 52.
\item \textit{Id.} at 51.
\end{enumerate}
\end{footnotesize}
Quoting Black’s Dictionary for the definition of ‘relate,’ the Court concluded, “A law ‘relates to’ an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan.” Citing legislative history, the Court held the Preemption Clause was to be interpreted in the broadest sense to preempt all state laws that related to an ERISA plan. Early on, the Court said ERISA even could preempt state laws that were not specifically designed to affect employee benefit plans. Under that approach ERISA preempts all state laws that have a

52 _Id._ at 97 n16. “Relate. To stand in some relation; to have bearing or concern; to pertain; refer; to bring into association with or connection with.” Black’s Law Dictionary 1158 (5th ed. 1979) (quoted in _Shaw_, 463 U.S. at 97 n.6.

53 _Shaw_, 463 U.S. at 96-97.

54 _Id._ at 98 and nn.18, 19, & 20.

55 _Id._ at 99.

56 FMC Corp. Holliday, 498 U.S. 52, 58 (1990) (“[Congress] did not mean to preempt only state laws specifically designed to affect employee benefit plans.”)

State laws include “all laws, decisions, rules, regulations, or other State actions having the effect of law, of any State.” 29 U.S.C. § 1144(c)(1)(19–). “State” includes a State, any political subdivision thereof, or any agency or instrumentality that purports to regulate, directly or indirectly, the term and conditions of employee benefit plans. _Id._ § 1144(c)(1).
connection with an employee benefit plan, unless an exception applies, even if the state law is consistent with ERISA and even if it feels a gap in the ERISA scheme.\textsuperscript{57}

The Supreme Court subsequently retreated from the truly expansive application of ‘relate to.’ In \textit{Shaw v. Delta Air Lines, Inc.}, for example, the Court noted in footnote that some “state actions may affect plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law ‘relates to’ the plan.”\textsuperscript{58}

\begin{flushright}
\textsuperscript{57} Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724, 739 (1985). The Court has backed off from this assertion about the reach of the Preemption Clause, at least as it applies to the Savings Clause’s regulation of insurance. In UNUM Life Insurance Co. v. Ward, 526 U.S. 358, 375, the Court upheld a California notice-prejudice law over the objection the state law conflicted with ERISA’s substantive notice provision, 29 U.S.C. § 1133, concluding, “By allowing a longer period to file than the minimum filing terms mandated by federal law, the notice-prejudice rule complements rather than contradicts ERISA and the regulations.” \textit{Id.} at 377.

\textsuperscript{58} Shaw, 463 U.S. at 100 n.21.
\end{flushright}
The Court’s current view is that while the Conflict Preemption Clause’s literal language is “clearly expansive,”\textsuperscript{59} the clause should not extend to its furtherest reach.\textsuperscript{60} Instead, the Court, gleaning insight from ERISA’s congressional sponsors that they wished to “eliminat[e] that threat of conflicting and inconsistent State and local regulation,”\textsuperscript{61} concluded Congress meant for the Conflict Preemption Clause to ensure employees and plan sponsors would avoid a “multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.”\textsuperscript{62}

The ERISA preemption clause reaches three categories of state laws: Those state laws that require ERISA plans provide certain benefits or methods of calculating benefits, those laws that

\begin{itemize}
  \item \textsuperscript{60} Id. The Court in both Travelers, 514 U.S. at 655, and De Buono, 520 U.S. at 813, quoted H. James Roderick Hudson xli (New York ed. World’s Classics 1980) in recognizing that “If ‘relate to’ were taken to extend to the furthest stretch of indeterminacy, then for all practical purposes pre-emption would never run its course, for ‘[r]eally, universally, relations stop nowhere.’” 514 U.S. at 655. See also Justice Scalia’s comments supra note 2.
  \item \textsuperscript{61} Travelers, 514 U.S. at 657 (quoting Rep. Dent and Sen. Williams). See also Fort Halifax Packing Co. v. Coyne, 482 U.S. 1,11 (1987).
  \item \textsuperscript{62} Id.
\end{itemize}
add or modify ERISA plan participants’ and beneficiaries’ rights and remedies, and those laws that expressly refer to employee benefit plans or the existence of the plan is critical to the state law’s cause of action.\textsuperscript{63} State laws mandating employee group health plans provide certain benefits, for example, relate to employee benefit plans in a very direct sense, and are preempted.\textsuperscript{64}

At the other extreme, the Supreme Court has concluded other categories of state laws, such as those “myriad state laws of general applicability,” do not relate to employee benefit plans for purposes of ERISA preemption, even if they directly or indirectly affect some cost or function of the plans.\textsuperscript{65} In a pendulum swing from earlier cases, the Court in 1995 announced it will not find ERISA preempts a state law unless the Court concludes Congress clearly and manifestly intended the state law be preempted.\textsuperscript{66} Courts quickly and consistently recognized and enforced state law malpractice actions against negligent providers, for example.\textsuperscript{67} As another example, the Supreme

\textsuperscript{63} See De Buono, 520 U.S. at 814-15.

\textsuperscript{64} Shaw, 463 U.S. at 655. As discussed more fully in the next section, states can affect plan coverage, however, by mandating all insurance policies marketed in the state provide certain benefits and rights.

\textsuperscript{65} Id. at 815.

\textsuperscript{66} Travelers, 514 U.S. at 655.

Court concluded a state law that requires hospitals to collect surcharges from patients, some patients in ERISA plans and others not, escapes preemption since the surcharges are only indirect economic influences and do not bind plan administrators to any particular choice of benefits or remedies.\(^68\) Hence ERISA does not preempt the fee surcharge. Even a state tax on a health care facility operated by an employee benefit plan does not relate to the plan for ERISA purposes since the law mandating the tax is a rule of general applicability that happens to affect the plan because of its circumstances.\(^69\)

The state laws the Supreme Court easily conclude relate to an ERISA plan are those that directly refer to or rely on the existence of an employee benefit plan for the law’s implementation.\(^70\) The

\(^{68}\) Travelers, 514 U.S. at 659.

\(^{69}\) De Buono, 520 U.S. at 815. In an ERISA preemption case unrelated to health care benefits, the Court held a state’s prevailing wage law specifically aimed at apprentice or other training program does not relate to an ERISA plan even though apprentice or training programs are specifically listed as ERISA welfare benefit plans since the minimum wage requirement” alters the incentive, but does not dictate the choices.” California Division of Labor Standards Enforcement v. Dillingham, 519 U.S. 316, 334 (1997).

\(^{70}\) See, e.g., Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 140 (1990) (common law exception to the employment-at-will doctrine when employer terminates an employee so the
most informative case in this area may be *Mackey v. Lanier Collection Agency & Service, Inc.*

The Georgia legislature, apparently in an effort not to run afoul of the Conflict Preemption Clause, enacted a garnishment law that provided in part, “Funds or benefits of a pension, retirement, or employee benefit plan or program subject to the provisions of the federal Employee Retirement Income Security Act of 1974, as amended, shall not be subject to the process of garnishment ....” The Supreme Court, instead of welcoming the state’s endorsement of the hands-off policy to ERISA plans, ruled that the provision singled out ERISA welfare benefit plans and thus was preempted.

The Court next analyzed the Georgia garnishment statute to decide whether the statute without the offending provision ‘related to’ an ERISA plan. The garnishment statute clearly affected a plan since in the case in hand a collection agency was attempting to garnish benefits owing to 23 of the employer can avoid contributing to or paying benefits from an ERISA plan preempted because relies on existence of an ERISA plan for implementation).

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72 *Id.* at 828 n.2 (*reprinting* Ga. Code Ann. § 18-4-22.1(1982)).

73 *Id.* at 830. In retrospect, ERISA should not preempt state laws that exempt a state law’s application to ERISA plans since such provisions promote a sponsor’s uniform national administration of its ERISA plan.
plan participants. The Court held the garnishment law was a means to collect judgments under state substantive laws. The garnishment law, a law of general applicability, was not one that relates to any employee benefit plan for purposes of ERISA, concluded the Court even though it affects a plan participant’s rights against the participant’s creditors. The collection agency was entitled to garnish the plan assets held for the 23 plan beneficiaries.

C. THE SAVINGS CLAUSE

The ERISA Conflict Preemption Clause by its own terms does not supersede or preempt all state laws that relate to employee benefit plans. The most notable statutory exception to conflict

74 Id. at 827-28.

75 Id. at 835 & n.10. Four dissenting justices felt the garnishment procedure potentially subjected plan administrators to significant burdens and costs, and should have been preempted for that reason. Id. at 842.

76 29 U.S.C. § 1144(a). The key exception developed in this article is the Savings Clause, but § 1144(b) also exempts from preemption any cause of action arising before January 1, 1975, id. §1144(b)(1); use by the Secretary of Labor of services or facilities of a State agency as permitted under 29 U.S.C. § 1136, id. § 1144(b)(3); any generally applicable state criminal law, id. § 1144(b)(4); the Hawaii Prepaid Health Care Act as in effect on September 2, 1974, id. § 1144(b)(5); some laws applicable to Multiple Employer Welfare Arrangements (MEWA), id. §
preemption is found in the Savings or Saving Clause that shields all state laws that regulate insurance, banking, or securities. For group health insurance plans, the most important of these, and the one receiving the most attention, is insurance regulation. State laws that regulate insurance or insurance companies will be enforced even though ‘relate to’ employee benefit plans.

The Savings Clause is worded as broadly as the Conflict Preemption Clause: “[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which

1144 (b)(6); qualified domestic relations orders and qualified medical child support orders, id. § 1144(b)(7); state’s rights under certain federal laws related to Medicaid, id. § 1144(b)(8).

Although subsection 1144(a) does not subject the preemption clause to subsection 1144(d), subsection 1144(d) limits the reach of the Preemption Clause. Section 1144(d) provides, “Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States . . . , or any rule or regulation issued under such law.” The Supreme Court relied on § 1144(d) to uphold the state law in Rush Prudential HMO, Inc. v. Moran, –U.S. –, 122 S. Ct. 2151 (2000), discussed infra at text accompanying notes --.

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. 29 U.S.C. § 1144(b)(2)(A) (2000). Subparagraph (B) contains the ‘Deemer Clause,’ the third of the relevant preemption clauses, to be discussed infra –.
regulates insurance, banking, or securities.” What little references are made to the Savings Clause in the legislative history reinforces the expansive reading of the Savings Clause. The House Report expressly stated “state laws regulating banking, insurance, or securities remain unimpaired.” The Joint Conference Report explained that the preemption provisions “are not to exempt any person from any State law that regulates insurance, banking or securities.”

The meaning of insurance is critical as regards employee welfare benefit plans providing health care benefits. The legislative history indicates the “regulation of insurance” was to be interpreted broadly. Neither the statute nor the legislative history discussion of the preemption provision define insurance. In the legislative history on fiduciary rules, however, the Senate-House conferees wrote, “The conferees understand that some companies that provide, e.g., health insurance, are not technically considered as ‘insurance companies.’ It is intended that these companies are to be included within the terms ‘insurance service or insurance organization.’”


81 Id. at __, 1974 U.S.C.C.A.N. at 5077.
The conferees did not expound on what they meant by saying some companies are not technically insurance companies but will be included as insurance companies for ERISA. Presumably the conferees had in mind Blue Cross & Blue Shield, who had argued successfully they were not insurance companies for many purposes. Possibly the distinction was between insurance companies that indemnified beneficiaries for certain amounts, leaving the responsibility to pay the physician or hospital, and services companies that paid the providers directly. It may have been a recognition of the small but emerging health maintenance organization vehicle that combined risk spreading aspects of insurance with the provision of services on a prepaid basis through the same organization. It may have been a recognition that insurance providers were expanding and developing new products and approaches, and the conferees were expressing their intention that a company not lose benefits or protection under ERISA nor escape responsibilities under ERISA by a narrow definition of insurance companies. A common sense view of insurance and insurance companies, and one the Supreme Court accepts, reaches indemnity companies, Blue Cross & Blue Shield, health maintenance organizations (HMOs), and other variations of health insurers.

Combinations and expansions of services by insurers should be relatively easy to classify as insurance companies. A company that provides insurance will still offer “insurance” even if it

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combines the insurance function with other functions, such as an HMO becoming the health care service provider. Transferring or spreading risk for health care costs is a familiar indicator of insurance, as is whether the matter is of the type expected to be in a contract between an insurer and the insured as is adoption of any insurance-related vehicle by members of the health insurance community.

The Supreme Court slowly recognized the broad sweep of the Savings Clause. Savings Clause issues in early Supreme Court cases involved whether the regulation of insurance under ERISA was limited to the “traditional” regulation of insurance companies’ financial revenue and marketing activities. The Supreme Court broadly construed the Savings Clause to safeguard state-mandated benefits be included in insurance policies marketed in the state.

To determine whether a state law regulates insurance, the Supreme Court turned to the meaning of insurance under the McCarran-Ferguson Act to define ‘insurance’ for purposes of the ERISA

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85 Id.


87 Id. at 736.

Savings Clause.\textsuperscript{89} The Court subsequently broadened the reach of the Savings Clause by clarifying that the McCarran-Ferguson factors are relevant but not required in determining whether a state law regulates insurance,\textsuperscript{90} and then four years later making a “clean break from the McCarran-Ferguson factors.”\textsuperscript{91} Under current Supreme Court guidelines, a state law regulates

\begin{quote}
No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance.

\end{quote}

\textsuperscript{89} See Metropolitan Life Ins. Co., 471 U.S. at 742-43.

\textsuperscript{90} UNUM Life Ins. Co., 526 U.S. at 373. A court using the McCarran-Ferguson factors would decide first under a common-sense approach whether a state law regulated insurance. \textit{Id.} At 374. If necessary, a court could engage in a more particularized analysis, considering the following three factors: (1) whether the rule at issue “has the effect of transferring or spreading a policyholder’s risk;” (2) whether the rule is an “integral part of the policy relationship between the insurer and the insured;” and (3) whether the rule is limited to entities within the insurance industry. \textit{Id.} at 374-75.

\textsuperscript{91} Kentucky Ass’n of Health Plans, Inc. v. Miller, 538 U.S. 329, 341 (2003).
insurance when the law is specifically directed toward entities in insurance and the law affects the risk pooling arrangement between the insurer and the insureds.\textsuperscript{92}

The Court to date has refused to impose any limitation on what constitutes insurance regulation under the Savings Clause.\textsuperscript{93} The Court, for example, in one case upheld a California notice-prejudice law under which an insurer remains liability on a policy even if the claimant files outside the time for filing claims unless the insurer is prejudiced by the delay.\textsuperscript{94} Against claims California’s notice-prejudice rule was akin to Mississippi’s bad faith claim rule preempted in \textit{Pilot Life},\textsuperscript{95} the Court said the California notice-prejudice rule, while certainly a special application of a common-law maxim, was a “special order, a rule mandatory for insurance contracts, not a principle a court may pliably employ when circumstances so warrant.”\textsuperscript{96}

\textsuperscript{92} Id.

\textsuperscript{93} Metropolitan Life Ins. Co., 471 U.S. at 736.


\textsuperscript{96} 526 U.S. at 371. While the Supreme Court did not limit insurance regulations protected by the Savings Clause to statutory or administrative rulings, it appears the Court will review judicially created laws more strictly than legislative acts under the Savings Clause.
In *Rush Prudential HMO, Inc. v. Moran*, the Supreme Court held state HMO regulation fell under the auspices of insurance regulation and was not preempted. Specifically, the Court upheld section 4–10 of the Illinois’ Health Maintenance Organization Act, which granted recipients of HMO services a right to independent medical review of certain denials of benefits. The Court concluded the Illinois provision provided no new cause of action under state law and authorized no new forms of ultimate relief.

The Court in *Rush Prudential HMO* observed it had yet to consider a forced choice between the congressional policies of exclusively federal remedies and the reservation of insurance regulation to the states, but dicta in *Pilot Life* suggested state insurance regulation would lose out if the state law allowed participants to obtain remedies that are not included in ERISA. The state law in *Rush Prudential HMO* – the right of a member in an HMO to seek an independent review of an HMO’s denial of coverage when the HMO and the physician recommending a treatment disagree

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98 *Id.* at 372-73.

99 *Id.* at 361.

100 *Id.* at 379.

101 *Id.* at 381.
whether the treatment is medically necessary – was not such a conflict with ERISA remedies to invoke the *Pilot Life* categorical preemption.\footnote{\textit{Id.} Many ERISA preemption cases involve state regulation of HMOs, since many self-insured plans contract with HMOs to furnish health-care services to beneficiaries and participants. Until the Supreme Court released *Rush Prudential HMO, Inc. v. Moran* in June 2002, lively debate ensued over whether ERISA preempted state regulation of HMOs to the extent HMOs contracted with employer-sponsored group health plans.

On one side, a good argument, ultimately rejected by the Supreme Court, was fervently made the HMO regulation related to employee benefit plans. One goal of ERISA assures employers they can offer one employee benefit plan for all employees located in all United States jurisdictions without adjusting to differing and changing laws in the several states. \textit{See} Travelers, 514 U.S. at 657 (\textit{quoting} Ingersoll-Rand, 498 U.S. at 142). Since state HMO regulations could impose heavy administrative burdens on benefit plan administration, ERISA should preempt much HMO regulation under this first argument.

Under a second theory in favor of preempting HMO regulation, HMO regulation should not be saved as an insurance regulation since HMOs are not insurance companies. Insurance companies indemnify beneficiaries for services received, and bear risk associated with the indemnification obligation. HMOs, on the other hand, offer services on a prepaid basis, and an HMO’s risk is the
same as any other company offering prepaid services. The risk is the same any other business agreeing to provide services for a fixed price assumes.

Finally, argued those in favor of a preemption of state laws regulating HMOs, even if the state could regulate HMOs as insurance providers outside their contracts with employer-sponsored plans, the Deemer Clause prohibited states from extending the consequences of HMO regulation to ERISA plans. Given that sponsors of employee benefit plans establish group health plan benefits, procedures, and remedies, notwithstanding individual state laws, went the argument, the states should not force these plans to change their plan structure when they contract with hospitals, physicians, pharmacies, HMOs, and other providers to carry out of terms of the ERISA plans.

On the other side, the ultimately prevailing argument contended that HMOs and other providers are not part of the employee benefit plans. An employer-sponsored plan details the internal workings of the plan and the benefits, procedures, financing mechanisms, and so on. The HMO is one of many products the plan can purchase, but it is a product or service existing outside the plan itself. The state is free to regulate products available to ERISA plans, either because the law is one of general applicability that does not relate to ERISA plans, see, e.g., De Buono, 520 U.S. at 815 (tax on hospital operated by ERISA fund not preempted), or is a “general health-care regulation, which historically has been a matter of local concern,” Travelers, 514 U.S. at 661, and which the Supreme Court feels Congress did not choose to preempt. Id.
Moreover, according to this view, even if HMOs relate to an ERISA plan, state HMO regulation should be saved under the Savings Clause as an insurance regulation. Despite the technical differences that insurance companies charge premiums in return for indemnifying beneficiaries for health care whereas HMOs collect capitation payments in return for supplying health care over the coverage period, the similarities between the two are so great that states’ regulation of HMO should be considered a subset of or a natural extension of insurance regulation.

State HMO regulation often specifies minimum benefits, financial reserve requirements, marketing restrictions, insolvency provisions, and licensing of agents. See, e.g., Virginia Health Maintenance Organization (HMO) Act, Va. Code Ann. § 38.2-4000 et seq (Michie 1996). Moreover, individuals enrolled with both HMOs and with the insurance companies view the payment of the premiums or capitation as the monthly payment to guarantee the enrollees and beneficiaries will receive health care. To a large extent, individuals have access to the same hospitals, physicians, pharmacies, and other providers whether they have an insurance policy or belong to an HMO. It would be incongruous to uphold state regulation of insurance policies, see Metropolitan Life Ins. Co., 471 U.S. at 744, but not to enforce the same regulation of HMOs and other managed care organizations.

On this side, the Deemer Clause poses no hurdle. The state regulates HMOs, insurance companies, hospitals, physicians, and other products and services available to employee plans. The state laws regulate products available to the ERISA plans, not the plans themselves.
The Supreme Court in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), sided with those arguing ERISA does not preempt state regulation of HMOs. *Id.* at 372-73. The Court concluded HMOs are both health-care providers and insurers. *Id.* HMOs’ risk assumption is greater than that of a typical business or contract, wrote the Court. HMOs actually underwrite and spread the actuarial risk among its members and participants, much like an insurance company. The Court bolstered its conclusion by reviewing the Health Maintenance Act of 1973 (HMO Act), 87 Stat. 916, codified as amended in 42 U.S.C. § 300e (1994), enacted one year prior to the Employee Retirement Income Security Act of 1974, in which Congress viewed HMOs as a novel form of insurers. *Rush Prudential HMO*, 542 U.S. at 368. The HMO Act and its legislative history, moreover, were premised to a large extent on state insurance laws, or their equivalent state regulation, applying to HMOs. *Id.* at 368. Since Congress enacted ERISA one year after it enacted the 1973 HMO ACT, the Court gathered Congress considered HMOs and other managed care entities to be insurers for purposes of ERISA’s Savings Clause. *Id.* The Court found more support for its ruling in the wording of commentators who considered HMOs to be insurers. *Id.* Finally, the state law at issue qualified as insurance regulation under the three McCarron-Ferguson factors. *Id.* at 373-75. For more on the McCarran- Ferguson factors, see *supra* note __. The state law at issue in *Rush Prudential HMO* authorized independent review of an HMO’s coverage denial if the HMO and the beneficiary’s physician disagreed whether the service was ‘medically necessary.’
The Court in Moran, moreover, saw “nothing standing in the way of applying the saving clause” to a contractor that provided only administrative services for a self-funded plan. In other words, insurance regulation is not limited to risk-bearing organizations but extends to organizations such as third party administrators and utilization review organizations. The Moran Court further was “convinced” it would find no “further limitations on insurance regulation” to deserve judicial recognition beyond those found in Pilot Life and Ingersoll-Rand. A year later the Court reiterated that the Savings Clause saved state laws regulating non-insuring third-party entities administering self-insured plans from ERISA preemption.

Drawing from the preceding analysis, the Product rule recognizes that states have broad authority to regulate insurance products marketed in the state. Insurance includes but is not limited to traditional indemnity plans, service plans, HMOs, third party administrators, utilization review organizations, independent practice associations, and preferred provider organizations.

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103 Moran, 536 U.S. at 371.

104 See id n.6 (Illinois’ Act would not be ‘saved’ as an insurance law to the extent it applied to self-funded plans. This fact, however, does not bear on Rush’s challenge to the law as one that is targeted toward non-risk-bearing organizations.”)

105 Id. at 381. See infra text accompanying notes for a discussion of Pilot Life and text accompanying notes ___ for a discussion of Ingersoll-Rand.

D. THE DEEMER CLAUSE

The expanded role of the Savings Clause will force courts to grapple with the reach of the third significant clause, the Deemer Clause, which states in relevant part,

“This neither an employee benefit plan described in section 1003(a) of this title,... nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer,... or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulating insurance companies, insurance contracts,...”

107 29 U.S.C. § 1144(b)(2)(B) (2000). Congress’ rationale for the Deemer Clause may not have been to deter states from regulating employee benefit plans by statutorily defining employee benefit plans as insurance companies. Rather, Congress may have wanted to keep employers and other sponsors of pension plans from avoiding ERISA preemption by claiming trusts formed under the pension plan were in fact insurance companies, banks, or investment companies. See David Gregory, The Scope of ERISA Preemption of State Law: A Study in Effective Federalism, 48 U. Pitt. L. Rev. 427, 451 (1987). ERISA in giving employees greater protection concurrently imposed greater financial, administrative, and fiduciary responsibilities on employers than state laws mandated. See Indemnification of Fiduciary and Employee Litigation Costs Under ERISA, 25 B.C. L. Rev. 1 (1983). Whatever Congress’ meaning, the
The Supreme Court has not plumbed the reaches of the Deemer Clause. The Court has noted, in two footnotes, that ERISA preempted state laws that required self-insured plans to provide benefits and review procedures.\(^{108}\) In its only interpretation of the Deemer Clause, the Court explained that self-funded ERISA plans are exempted from state laws that ‘relate to’ the plans under the Preemption Clause.\(^{109}\) State laws relating to self-insured plans cannot be saved as an insurance regulation, either.\(^{110}\) State laws that regulate insurance are still valid but the state laws cannot apply directly to self-funded employee benefit plans.\(^{111}\) On the other hand, wrote the Court, state insurance laws do apply to insurance companies.\(^{112}\) An ERISA plan that buys Deemer Clause is a two-edged sword: It prevents employers and sponsors trying to avoid ERISA mandates from labeling a part or all of its benefit plan as an insurance, banking or securities firm; and it prevents states from defining employee benefit plans as insurance, banking or securities companies.


\(^{110}\) Id.

\(^{111}\) Id.

\(^{112}\) Id. at 59.
insurance coverage from an insurance company consequently is bound indirectly by the state insurance law. The Court acknowledged its decision resulted in a distinction between insured and uninsured plans, but left to Congress the option of remedying the situation should it so desire.

While the Deemer Clause keeps states from regulating self-insured ERISA plans, the Deemer Clause does not prohibit states from regulating products and services marketed to self-insured plans. The existence of a self-insured plan, in other words, does not shield any third party contracting with an ERISA plan from state law. The judicial pronouncement that states cannot regulate self-insured plans derives from the Deemer Clause’s prohibition against a state’s deeming an ERISA plan to be an insurer. A self-insured plan that ventures into the marketplace to purchase products or services is limited to and must accept products and services as regulated by state law.

E. THE PRODUCT RULE APPLIED TO HMO’S

\[\text{Id.} \]

\[\text{Id. The Supreme Court in Rush Prudential HMO, Inc v. Moran concluded HMOs are a form of insurance provider and thus states may regulate HMOs pursuant to the savings clause. 536 U.S. 355 (2002).}\]
The health care product generating the most litigation in ERISA preemption cases has been the HMO. The Supreme Court in *Rush Prudential HMO, Inc. v. Moran* concluded HMOs are insurance providers and thus states may regulate HMOs pursuant to the Savings Clause.\(^{115}\)

State HMO regulations to date have emphasized minimum health-care services, financial reserves and other protections against insolvency including ‘hold harmless clauses,’ standards governing the management of HMOs, licensing of HMOs, marketing of HMOs, mandatory complaint review systems, any-willing-provider laws, and utilization review statutes.\(^{116}\) All these state laws regulating HMOs should escape ERISA preemption. The HMO in this instance is the product or service an ERISA plan purchases to provide the benefits to beneficiaries provided for in the plan. The HMO is not the employee benefit plan. The ERISA plan contracts with an HMO, but that link to an ERISA plan does not save the HMO from state regulation.

The result is a good one. HMOs must comply with the state laws, whether or not they serve ERISA plans.\(^{117}\) The biggest downside on ERISA plans is that a state’s laws regulating HMOs

\(^{115}\) 536 U.S. at 372-73. *See supra* note __.


\(^{117}\) The result fosters a statutory construction consistency. For example, interpreting the McCarran-Ferguson Act proviso that no act of Congress shall be construed to “invalidate,
including mandating minimum benefits that must be offered could vary from state to state.\textsuperscript{118} This is the same conflict plans that purchase traditional group health insurance policies face, however. Under the Product Rule, states regulate physicians, hospitals, HMOs, PPOs, IPAs, and other providers that may contract with ERISA plans, and the providers must adhere to the state laws notwithstanding any affiliation with the ERISA plans.

impact or supercede” any state insurance law, the Supreme Court, in upholding RICO action against an insurance company, concluded that no federal law is precluded from effect as long as the federal law does not directly conflict with state law and application of the federal law would not frustrate any declared state policy or interfere with a state’s administrative regime. Humana Inc. v. Forsyth, 525 U.S. 299, 310 (1999) (using Shaw to illustrate the standard) (emphasis added). The use of ‘supersede’ in the ERISA general Preemption Clause coupled with the broadly worded Savings Clause supports enforcing state laws that do not invalidate, impair or supersede federal law.

\textsuperscript{118} In contrast to pension plans, the administration of a group health plan related to an employee’s moving from one jurisdiction to another and changing health care plans are minimal. An employee’s health care benefits, moreover, apply to a time certain, and if a policy changes, the former policy ends. In stark contrast, an employee’s retirement benefits accrue over time. Calculating an employee’s retirement benefits accrued over time when state rules within a jurisdiction changed over time and when laws in different states where an employee may have worked during his or her employment differ from each other and over time creates the administrative nightmare ERISA sought to alleviate. Health coverage calculation is simpler.
While a state may require health insurance companies or HMOs to include certain benefits or providers in their coverage, the Deemer Clause prevents the states from regulating employee benefit plans as insurers. Hence, the sponsor of an employee benefit plan can establish benefits, procedures, and remedies without regard to state law. No state law can force its dictates directly onto the plan. Thus, a state’s otherwise available remedies and causes of action are preempted except as made part of the ERISA plan itself. To illustrate, a state could not require a self-insured plan to provide any particular benefit.119 Further, no state common-law cause of action arises for a fiduciary’s acting with malice or wanton indifference to the rights of a participant or beneficiary.120 But a state could limit the type of insurance and HMO products marketed in the

119 Shaw, 463 U.S. at 97 (ERISA preempts state law mandating pregnancy benefits). The state law in Shaw was related to an ERISA plan and preempted at that stage of the analysis. The state law in Shaw was not an insurance regulation. The same ultimate conclusion should result, however, if the state had passed the same provision as an insurance regulation, including as insurers all organizations that provide health benefits, including employee welfare benefit plans, since the Deemer Clause prohibits states from deeming self-insured employee benefit plans to be insurers. See also Metropolitan Life Ins. Co., 471 U.S. at 740 (ERISA does not preempt state laws that mandate minimum benefits in insurance policies, even if employee benefit plans purchase the insurance policies, but the Deemer Clause prevents the same state law from applying directly to the plan itself).

120 Russell, 473 U.S. at 138.
state. A sponsor of an employee welfare benefit plan that wanted to purchase insurance or an HMO product would be limited to the legally available products in the state. If the plans want to offer a mix of benefits different from those available in state approved products, the plan sponsor must self-fund and contract directly with individual providers.

F. THE PRODUCT RULE APPLIED TO UTILIZATION REVIEW ORGANIZATIONS

Under the Product Rule and the Savings Clause, states can regulate utilization review products and services by stipulating what utilization review services or third party administrative services can be marketed in the state. State laws regulating utilization review organizations escape ERISA preemption under the Savings Clause even though they are non-risk-bearing entities. Thus, an “independent review requirement” not preempted by ERISA as applied to HMOs would survive ERISA preemption applied to utilization review organizations and other third party

\[121\] See Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 371-72 & n.6 (2002) (independent review requirement not preempted; applies even to those non-risk-bearing organizations that provide only administrative services); Kentucky Ass’n of health Plans, Inc. v. Miller, 538 U.S. 329, 336 n.1 (2003) (non-insuring HMOs administering self-insured plans brought under Savings Clause).
In sum, a state can regulate third party administrators including utilization review organizations just as it can regulate HMOs and insurance companies.

ERISA’s Deemer Clause prohibits a state from regulating ERISA plans, but an ERISA plan that contracts with an utilization review organization incorporates the state laws into the ERISA plans, and beneficiaries and participants can enforce these rights against the utilization review organization. Such laws as the Illinois independent medical review approved by the Supreme Court in *Rush Prudential HMO Inc. v. Moran* would survive preemption if applied to utilization review organizations.

II. THE WORKHORSE: CIVIL ENFORCEMENT UNDER ERISA § 502

A. ERISA § 502(a) AS THE EXCLUSIVE VEHICLE FOR ENFORCEMENT ACTIONS

122 *See Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 371-72 & n.6 (2002)* (independent review requirement not preempted; applies even to those non-risk-bearing organizations that provide only administrative services).

123 *See infra* Part II on rights ERISA plan participants and beneficiaries enjoy under ERISA§ 502(a)(1)(B) to enforce state laws regulating products and services.

124 *Id.*
The second part of the ERISA Preemption puzzle, centered around the enigmatic *Pilot Life*, is the so-called Complete Preemption Clause of ERISA § 502.\textsuperscript{125} The label ‘complete preemption clause’ is a misnomer, however. ERISA § 502 is titled “Civil Enforcement” and nowhere mentions or even alludes to preemption. The Supreme Court in two 1987 companion cases crafted the two facets of the complete preemption clause.\textsuperscript{126}

In *Pilot Life*, a case in which the plaintiff sought damages under state law for an insurer’s wrongfully terminating the plaintiff’s disability payments, the Court decided ERISA § 502(a) was the exclusive vehicle for actions by ERISA plan participants asserting improper processing of a claim for benefits under an ERISA plan.\textsuperscript{127} Relying on ERISA legislative history referencing § 301 of the Labor-Management Relations Act of 1947, the Court reasoned Congress was “well aware that the powerful preemptive force of § 301 of the LMRA displaced all state actions for violation of contracts between an employer and a labor organization.”\textsuperscript{128} Therefore, concluded the Court, Congress intended all suits brought by ERISA participants and beneficiaries asserting

\textsuperscript{125} 29 U.S.C.A. § 1132(a) (West 1997).


\textsuperscript{127} *Pilot Life*, 481 U.S. at 52.

\textsuperscript{128} *Id.* at 55.
improper processing of claims under ERISA-regulated plans be treated as federal questions under ERISA § 502(a).\(^{129}\)

The Court has limited the reach of the complete preemption clause but steadfastly retains § 502(a) as ERISA’s exclusive enforcement vehicle. First came *UNUM Life Insurance Company v. Ward*\(^{130}\) approving a California Supreme Court decisional rule known as the notice-prejudice rule. The California Supreme Court by decision in previous cases established a rule that an insurer cannot avoid liability on a contract even if the insured files his proof of claim after the deadline for filing claims unless the insurer shows it was prejudiced by the delay.\(^{131}\) The United States Supreme Court determined California’s notice-prejudice rule was saved as an insurance regulation.\(^{132}\)

The defendant insurance company based two separate arguments on *Pilot Life*. In the first, the insurance company argued California’s notice-prejudice rule resembled Mississippi’s bad-faith rule that the Court decided was not saved in *Pilot Life*.\(^{133}\) The Supreme Court rejected the

\(^{129}\) *Id.* at 56.

\(^{130}\) 526 U.S. 358 (1999).

\(^{131}\) *Id.* at 366-67.

\(^{132}\) *Id.* at 368.

\(^{133}\) 526 U.S. at 368-69.
argument, reasoning that while both the California and the Mississippi judicial-decisional rules were outgrowths of legal maxims, California’s notice-prejudice rule was a rule mandatory for insurance contracts, “not a principle a court may pliably employ when the circumstances so warrant.” California’s notice-prejudice rule “firmly applied to insurance contracts” and was not a “general principle guiding a court’s discretion in a range of matters.” The Court in footnote observed California courts did not apply the maxim much outside the insurance context and then under a case’s peculiar situation. The Mississippi bad faith rule, on the other hand, was too vague and manipulative to be saved as an insurance regulation.

Putting this point in context under the Product Rule discussed in Part I of this Article, the California notice-prejudice rule was a judicially-imposed insurance contract term. All insurance policies sold in the state carry that provision. An ERISA plan purchases insurance policies with the notice-prejudice provision as part of the coverage and the notice-prejudice provision rights become part of the ERISA plan. ERISA plan participants and beneficiaries can enforce the provision under ERISA § 502(a)(1)(B).

134 Id. at 370-71 (damages for bad faith in contract or tort in Mississippi; “the law abhors a forfeiture” in California).
135 Id. at 371.
136 Id.
137 Id.
138 Id. at 370 n.3.
The insurer next argued ERISA § 502’s civil enforcement provision preempts any action for plan benefits under state law.\textsuperscript{139} The Court rebuffed the argument as irrelevant here since the plaintiff brought his action under ERISA § 502.\textsuperscript{140} The notice-prejudice provision was part of the participant’s rights under the ERISA plan’s contract with the insurer. Plaintiff sought to enforce his rights under the plan pursuant to ERISA § 502(a)(1)(B).\textsuperscript{141}

Next came Rush Prudential HMO, Inc. v. Moran,\textsuperscript{142} in which the Supreme Court held Illinois’ statutory law that an HMO’s treatment decision may be subject to independent medical review was saved as an insurance regulation.\textsuperscript{143} The HMO claimed that, even if the independent review requirement would normally be saved under the Savings Clause, such a benefit overrode congressional intent and should be preempted.\textsuperscript{144} The Court rejected that argument.\textsuperscript{145} The Mississippi state law in Pilot Life, wrote the Court, “provided a form of relief in a judicial forum

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\textsuperscript{139} & Id. at 376. \\
\textsuperscript{140} & Id. at 377. \\
\textsuperscript{141} & Id. \\
\textsuperscript{142} & 536 U.S. 355 (2002). \\
\textsuperscript{143} & Id. at 375. An issue under the insurance regulation part of the opinion was whether HMOs were insurers for purposes of ERISA. The Supreme Court said HMOs were insurers. Id. \\
\textsuperscript{144} & Id. at 375. \\
\textsuperscript{145} & Id. at 378.
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that added to the judicial remedies provided by ERISA.”\textsuperscript{146} ERISA’s policy is to induce employers to offer employee benefits by assuring a “predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards.”\textsuperscript{147} The Court did not explain what the quoted language meant in a concrete situation, but it concluded the rights of a participant or beneficiary to seek an independent medical review of an HMO’s denial of treatment based on a “medical necessity” determination did not involve “the sort of additional claim or remedy” ERISA preempted.\textsuperscript{148}

The Court re-enforced its decision by noting that Congress’ saving state insurance regulation from ERISA preemption inevitably leads to disuniformities in rights and obligations among the states.\textsuperscript{149} The ERISA plan, moreover, is not burdened. It is the HMO in \textit{Rush Prudential}, the product or service provider contracting with ERISA plans, and not the plans themselves, that are subject to state regulation.\textsuperscript{150} Every HMO operating in the state must conform to state law.\textsuperscript{151} The ERISA plan has no special burden of compliance beyond what the HMO brings to the relationship.\textsuperscript{152}

\begin{footnotesize}
\begin{enumerate}
\item[146] Id. at 379.
\item[147] Id.
\item[148] Id. at 380.
\item[149] Id. at 381.
\item[150] Id. at 381 n.11.
\item[151] Id.
\item[152] Id.
\end{enumerate}
\end{footnotesize}
A second argument made by the HMO and rejected by the Supreme Court in *Rush Prudential* was that the Illinois independent medical review provision contradicted the ERISA plan’s deferential standard for reviewing benefit denials. The Supreme Court said the state law did not conflict with anything in the text of ERISA. The deferential review may be a matter of plan design or in the drafting of an HMO contract but is not a right under ERISA; the Illinois state law eliminates the power of the parties to grant HMOs unbridled discretion by prohibiting HMOs from entering into contracts giving the HMO unfettered discretion to interpret some contract terms.

The Supreme Court most recently relied on *Pilot Life in Aetna Health Inc. v. Davila*, returning to Pilot Life’s most enduring pronouncement that ERISA plan beneficiaries and participants must seek remedies exclusively pursuant to ERISA’s statutory scheme. The Court concluded Congress intended “to create an exclusive federal remedy in ERISA § 502(a).” Continued the Court, “under ordinary principles of conflict pre-emption, then, even a state law that can arguably

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153 *Id.* at 385.
154 *Id.* at 385-86.
155 *Id.* at 386.
156 *Id.*
158 *Id.* at 217.
159 *Id.*
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.”

Plaintiffs in Davila erred by arguing they should be able to pursue a state-law claim totally independent of ERISA. The proper course would have been to bring suit under ERISA § 502 alleging under the Product Rule and the Savings Clause that the state of Texas could require HMOs marketing HMO services in the state to incorporate the terms of the Texas Health Care Liability Act in to each contract, or to state all HMO products marketed in the state contain the provision. HMO contracts with ERISA plans must contain the provision; and beneficiaries and participants can recover under ERISA § 502(a)(1)(B).

B. ERISA § 502(a)(1)(B)’S BENEFITS AND RIGHTS UNDER THE TERMS OF THE PLAN

ERISA § 502(a) empowers ERISA plan beneficiaries and participants to bring civil actions. While ERISA § 502(a) mentions plan participants in several contexts, three provisions merit attention for this Article. Foremost, the workhorse of § 502, ERISA § 502(a)(1)(B), empowers

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160 Id. at 217-218.
161 See id. at 217.
162 See infra text accompanying notes __.
163 ERISA § 502(a) authorizes three actions by participants and beneficiaries not developed in text: (1) to sue for information and a $100 a day penalty, 29 U.S.C.A. §
ERISA plan beneficiaries and participants to “recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, [and] to clarify his rights to future rights under the terms of the plan.”164 Under the Product Rule and as Supreme Court cases illustrate, once an ERISA plan contracts for a product or service, the plan confers any state-mandated rights and benefits to the plan participants and beneficiaries associated with the purchases service or product.165 The legal reasoning is that, under the Savings Clause or one of the other theories encompassed by the Product Rule, a state can regulate products and services marketed in the state. ERISA’s Deemer Clause prohibits a state’s directly regulating an ERISA plan, but ERISA plans contracting for products and services in the open market are limited to those products and services allowed to be marketed in the state.166 An ERISA plan that chooses to contract with others to provide services confers on its plan participants and beneficiaries the state-mandated benefits and protections that attaches to the marketed product or service.

To illustrate, while ERISA pursuant to the Deemer Clause preempts a state requirement that ERISA plans provide specific benefits,167 ERISA does not preempt a state’s requirement that

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\text{1132(a)(1)(A) & (c); (2) for appropriate relief under § 1025(c) for failing to disclose tax registration statements, id. § 1132(a)(4); and (3) for certain rights in connection with the termination of an individual’s status as participant covered under a pension plan, id § 1132(a)(9).}
\]

165 See supra text beginning at note – for the Product Rule.
166 Id.
insurance policies offer specific coverage benefits. Likewise, ERISA does not preempt a state’s notice-prejudice law requiring an insurer to remain liable even if a claimant files a claim after a policy time limit expires as long as the insurer is not harmed by the delay. Just as a state can regulate insurance products, it can regulate HMO contracts marketed in the state under the Savings Clause. Thus a state can require HMOs to accept any willing providers. A state can require HMOs to subject certain denial of coverage to independent medical review.

Once an ERISA plan subscribes or contracts with a third party – be it insurer, HMO, PPO, utilization review organization, hospital, nursing home, pharmacy, individual physician, or other

168 Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985). Not implicated in this section but while a state under the Product Rule cannot regulate directly the relationship among ERISA plan sponsors, administrators, fiduciaries, beneficiaries and participants, see, e.g., FMC Corp. v. Holliday, 498 U.S. 521 (1990) (ERISA state antisubrogation law that prohibits ERISA plans from seeking reimbursement beneficiaries who collect damages or proceeds from a third party), ERISA does not preempt state laws applied to ERISA plans or to participants and third persons outside the ERISA plan, see, e.g., Mackey v. Lanier Collection Agency, 486 U.S. 825 (1988) (ERISA does not preempt state garnishment law allowing creditors to garnish beneficiary’s ERISA welfare benefit accounts). State malpractice actions, for example, against providers are not preempted. See Pegram v. Herdrich, 530 U.S. 211, __ (2000).


provider of services or products – any state regulation becomes part of the benefit package offered to ERISA plans; and plan participants and beneficiaries can bring suit under ERISA § 502(a)(1)(B) to enforce the provision. The plaintiffs in Moran and UNUM were ERISA plan participants or beneficiaries, for example.\footnote{172}

As discussed more fully below, the Supreme Court interprets ERISA § 502(a)(2) and § 502(a)(3) as not allowing monetary damages.\footnote{173} ERISA § 502(a)(1)(B) is not so restricted. A participant or beneficiary can bring a civil action to recover benefits due to him under the terms of the plan and to enforce his rights under the terms of the plan.\footnote{174} Those benefits and rights can be monetary or nonmonetary. A beneficiary can collect insurance proceeds, receive mental health benefits, have an infant covered from birth, or have access to an optometrist, for example, if the state law requires an insurer or HMO to provide these benefits in every policy or contract.\footnote{175}

Conceptually, a state could require insurers, HMOs and utilization review organizations to pay damages for wrongful benefit denials, including damages for mental anguish or even punitive damages. The Supreme Court has not addressed the issue yet. It almost had the opportunity in Aetna Health Inc. v. Davila,\footnote{176} but the plan beneficiaries at the Supreme Court shunned any

\footnotesize{172 Moran, 536 U.S. at 359; UNUM, 526 U.S. at 365.}
\footnotesize{173 See infra text accompanying notes –.}
\footnotesize{174 29 U.S.C.A. § 1132(a)(1)(B) (West 1997).}
\footnotesize{175 See, e.g., Metropolitan Life In. Co. v. Massachusetts, 471 U.S. 724, 729 (1985).}
\footnotesize{176 542 U.S. 200 (2004).}
argument based on ERISA § 502,\textsuperscript{177} claiming instead that Texas law created an independent legal duty and that a civil action seeking damages for violation of the independent duty was outside the scope of ERISA’s enforcement scheme.\textsuperscript{178} The Supreme Court easily concluded plaintiffs’ actions were to rectify a denial of benefits promised in an ERISA plan.\textsuperscript{179} That conclusion reached, the plaintiffs must fit their claims under ERISA § 502. Since the plaintiffs did not seek a remedy under ERISA, the \textit{Davila} case was effectively over, and with it the opportunity to decide ERISA § 502(a)(1)(B)’s application to damages for wrongful benefit denials, emotional distress and punitive damages.

Three earlier Supreme Court opinions rejected state-imposed damages but they were not brought under ERISA § 502(a)(1)(B).\textsuperscript{180} In \textit{Pilot Life}, the plaintiff brought state common-law tort and

\textsuperscript{177} Id. at 212.

\textsuperscript{178} Id. The plaintiffs also argued the benefit due them under the ERISA plan was not health care services but simply membership in an HMO. \textit{Id.} at 212.n.2. The Court deemed the issue waived for purposes of the appeal and refused to address it.

\textsuperscript{179} Id. at 214.

breach of contract claims, seeking punitive damages and damages for emotional distress. The Supreme Court said ERISA § 502(a) is the exclusive vehicle for actions by ERISA plan benefits and varying state causes of action would pose an obstacle to the purposes and objectives of Congress. The state common law at issue, however, was not directed toward the insurance industry specifically and thus was not saved from ERISA preemption as an insurance regulation.

In Metropolitan Life, the companion case to Pilot Life, the plaintiff brought state common-law and contract claims based on a disability policy. The principal issue in Metropolitan Life was whether the defendant could remove the case from state court to federal court. The Supreme Court concluded the case could be removed since Congress intended all causes of action within the scope of ERISA § 502 be removable to federal court. Since the plaintiff’s case bottomed on

\[181\] 481 U.S. at 48.

\[182\] Id. at 52.

\[183\] Id. at 50.

\[184\] 481 U.S. at 61.

\[185\] Id. at 63.

\[186\] Id. at 66.
general common-law principles that were not saved as insurance regulation,\(^{187}\) the Court found ERISA preempted the plaintiff’s common-law claim for two reasons. First, ERISA § 510\(^{188}\) provided a remedy for wrongful termination such that conflict preemption negated the state common law.\(^{189}\) Second, ERISA plan participant’s causes of action and remedies are limited to those listed in ERISA § 502.\(^{190}\)

ERISA plan plaintiffs must heed the Supreme Court’s counsel: ERISA plan beneficiaries and participants to prevail in actions involving state-mandated rights, remedies and benefits must resort to, not avoid, ERISA § 502. ERISA § 502(a)(1)(B) is an open-ended provision, however. Its only constraint is the beneficiary or participant must identify a right or benefit “under the terms of the plan.”\(^{191}\)

State-required damages for wrongful denials, delays, or choice of treatments should be allowed as long as the damages are part of state insurance regulation. Thus, for example, if an ERISA plan

\(^{187}\) *Id.* at 62.


\(^{189}\) *Id.* at 142-145.

\(^{190}\) *Id.* at 144-145.

sponsor contracts with an HMO or an utilization review organization providing that the HMO or utilization review entity would be liable for wrongful denials or delays in treatment, and that the HMO or utilization review company would pay ERISA plan participants or beneficiaries (or their family members) for injuries including emotional distress, lost wages, or wrongful death as part of the sponsor’s group health plan, an aggrieved participant or beneficiary could seek and receive the damages pursuant to ERISA § 502(a)(1)(B). These are either benefits under the terms of the plan or rights under the terms of the plan.\footnote{192}\

Beneficiaries and participants should have the same benefits and rights if a state legislature identifies coverage delays, wrongful refusals to cover, or cost-saving insurers or HMOs requiring alternate treatment options as a problem, and passes legislation addressed to the perceived problems. The regulation survives ERISA preemption under the Savings Clause. Under the Product Rule, assuming the state made the provisions applicable to all insurance companies, HMOs and utilization review organizations, only health insurance policies, HMO contracts, and utilization review contracts subject to the provision could be marketed in the state, whether to ERISA plans or otherwise. An ERISA plan contracting for the services or coverage includes the mandated provision in its ERISA plan, giving the rights to enforce the provision to its plan participants and beneficiaries. The ERISA plan itself, moreover, suffers no additional burdens of compliance. The onus is on the third party provider.\footnote{193} \\


\footnote{193} See Rush Prudential HMO, Inc. v. Moran, 536 U.S. at 381 n.11.
As an illustration, an HMO cannot operate in the Commonwealth of Virginia without a license\(^\text{194}\) and the state may suspend or revoke a license if an HMO fails to comply with the state regulations.\(^\text{195}\) Among other requirements to be licensed, an HMO must provide basic health services, in and out of area emergency services, inpatient hospital and physician care, outpatient medical services, laboratory and radiology services, preventive health services, and at least minimal treatment of mental illness and substance abuse.\(^\text{196}\) In addition, the HMO must include a hold harmless clause in its contract with its providers that stipulates that even if the HMO fails to pay the provider, the provider cannot collect from a subscriber or enrollee.\(^\text{197}\)

Every member of an HMO in the Commonwealth of Virginia can enforce these rights and benefits because every HMO subscription in the state must contain the provisions. The provisions survive ERISA preemption under the Savings Clause.\(^\text{198}\) An ERISA plan sponsor contracting with an HMO for services at a minimum gets these services, plus others if desired. An ERISA plan

\begin{align*}
\text{\textsuperscript{194}} & \quad \text{Va Code Ann. § 38.2-4300 et seq. (Michie 1996).} \\
\text{\textsuperscript{195}} & \quad \text{Id. § 38.2-4316.} \\
\text{\textsuperscript{196}} & \quad \text{Id. § 38.2-4300, § 38.2-4316.} \\
\text{\textsuperscript{197}} & \quad \text{Id. § 38.2-4311B.} \\
\text{\textsuperscript{198}} & \quad \text{See supra text accompanying notes \_\_.} 
\end{align*}
participant or beneficiary can enforce the provisions as a benefit or right, not pursuant to state law, but “under the terms of the plan.” If the Commonwealth of Virginia added a provision requiring HMOs to compensate for consequential damages, including for emotional distress and even punitive damages, for a wrongful denial or delay or for erroneous determination of benefits, that provision too would become part of the contract with the ERISA plan.

ERISA does not grant beneficiaries these rights and benefits, but it does not deny these rights and benefits either. If a state, such as Texas did, perceives a need to regulate insurers and HMOs more than other states do, the state can, ERISA will not preempt it, and ERISA plan participants and beneficiaries benefit from the state action. On the other hand, if a state chooses not to alter the

199 The HMO contract is not the ERISA plan, see ___________, but the contract are incorporated into the ERISA plan. Plan sponsors, be they employers or unions, commonly contract with an insurer or HMO with the intent and practice of plan participants receiving what the insurance policy or HMO contract provides, no more and no less. ERISA plans adopt the terms of the insurance plan or HMO contract though legally and analytically they remain separate documents.

relationship, or to insulate HMOs from extended liability, the ERISA plan beneficiaries and participants will be limited to those rights the plan sponsor can negotiate in addition to whatever requirements the state may impose on the insurers or HMOs.

A similar analysis applies to state regulation of utilization review organizations. First, under the Product Rule, ERISA does not preempt state regulation of a third party administrator or utilization review organization that provides services to self-funded plans. To illustrate, the State of New York in regulating utilization review agents requires the utilization review agents have a program with minimum standards as to who can be a medical director and who can make utilization review determinations. The organization must make available to all insureds and health care providers a copy of its written policies and procedures that govern all aspects of the utilization review process.

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(d) No person participating in the arrangements other than the actual provider of health care services or supplies directly to enrollees and their families shall be liable for negligence, misfeasance, nonfeasance, or malpractice in connection with the furnishing of such services and supplies.


203 N.Y. Ins. Law § 4902, §4903 (McKinney 1997).
Determinations must be conducted within given time frames, insureds or their designees must be notified of adverse determinations including the reason for the determination, adverse determinations must specify appeal rights and procedures and notice on how to request clinical review criteria (i.e., no black box determinations), and the utilization review entity must have an expedited appeals process for denials of continuing inpatient care or where there is imminent or serious threat to the health of the insured.205

The New York regulations are saved as an insurance regulation. Only those utilization review products complying with the state regulations can be marketed in the state. Once an ERISA plan contracts with the utilization review agent, the state-mandated provisions become benefits and rights to the ERISA plan beneficiaries and participants.206 The plan participants and beneficiaries can enforce these rights pursuant to ERISA § 502(a)(1)(B). If the state legislators added

204 Id. § 4902(a).

205 Id. § 4902(a)(7) & (8).

206 The New York law expressly provides that the utilization review statute “shall not apply to any utilization review conducted by, or on behalf of, a self-insured employee welfare benefit plan, as defined in the Employee Retirement Income Security Act of 1974, as amended.” N.Y. Ins. Law § 4908 (McKinney 1997). Under Mackey v. Lanier Collection Agency & Services, Inc., 486 U.S. 825 (1988), the exception for ERISA plans itself is preempted since it singles out employee welfare benefit plans for special treatment. Id. at __.
provisions mandating independent medical review of adverse determinations\textsuperscript{207} or a requiring utilization review agents pay compensable damages for wrongful denials or delays in benefits or for subjecting enrollees to harmful cost-saving alternatives, once an ERISA sponsor contracts with the utilization review agent, the provision becomes part of the rights and benefits plan participants and beneficiaries enjoy as part of the plan and can enforce these rights and benefits pursuant to ERISA § 502(a)(1)(B).

Assuming the utilization review organization contracting with an ERISA plan becomes an ERISA fiduciary, questions arise as to the right of participants and beneficiaries against the utilization review organization. That conflict segues into the next section discussing the other two major sections granting plan beneficiaries and participants the right to bring a civil action under ERISA § 502.\textsuperscript{208}

\textbf{C. STATUTORY RELIEF AGAINST FIDUCIARIES UNDER ERISA § 502(a)(2)}

ERISA § 502(a)(2) empowers an ERISA plan participant, beneficiary, fiduciary or the Secretary or Labor to bring a civil action for appropriate relief under ERISA § 409.\textsuperscript{209} ERISA § 409, not §502(a)(2), creates the substantive rights and obligations. Section 409, titled “Liability for Breach of Fiduciary Duty,” makes a fiduciary personally liable to make good to the plan any losses to the

\textsuperscript{207} Cf. Rush Prudential HMO, Inc., 536 U.S. at 364 (as applied to HMOs)

\textsuperscript{208} The special issue of HMO fiduciary liability under ERISA and its interrelationship with ERISA preemption is developed in more detail \textit{infra} in Part III.

\textsuperscript{209} 29 U.S.C.A § 1109 (West 1997).
plan resulting from each breach of any responsibility, obligation or duty imposed by ERISA.\textsuperscript{210} In addition, a court may subject the wrongdoing fiduciary to “such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.”\textsuperscript{211}

A wrongdoing fiduciary is liable to the plan itself under ERISA § 409; and individual participants and beneficiaries cannot resort to it to resolve personal grievances.\textsuperscript{212} The Supreme Court delineated the contours of ERISA § 409 in \textit{Massachusetts Life Insurance Company v. Russell}.\textsuperscript{213} The plaintiff in \textit{Russell} received all the promised benefits under her employer’s self-funded disability but suffered secondary mental, physical and financial consequences because the fiduciary administrator’s off-and-on again denial and interruption of benefits.\textsuperscript{214} She brought suit against the fiduciary for extra-contractual damages and for punitive damages.\textsuperscript{215}

The Supreme Court ruled against the plaintiff. First, wrote the Court, ERISA § 409(a) imposes a liability on a fiduciary to an ERISA plan on to “make good to such plan” and not to individual beneficiaries or participants.\textsuperscript{216} The Court relied on legislative history to conclude § 409 was

\begin{itemize}
\item \textsuperscript{210} \textit{Id.} § 1109(a).
\item \textsuperscript{211} \textit{Id.}
\item \textsuperscript{212} \textit{See} Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 1134, 144 (1985).
\item \textsuperscript{213} \textit{Id.}
\item \textsuperscript{214} \textit{Id.} at 136-37.
\item \textsuperscript{215} \textit{Id.} at 137.
\item \textsuperscript{216} \textit{Id.} at 141.
\end{itemize}
geared to the protection of the plan’s financial assets and not to grant remedies to individuals.\textsuperscript{217} The statute and legislative history emphasized § 409’s protection of contractually defined benefits and not extra-contractual damages.\textsuperscript{218} A concurring opinion agreed ERISA § 502(a)(2) in conjunction with ERISA § 409 did not afford participants and beneficiaries an individual recovery for breach of fiduciary duties because the two ERISA sections protect the entire plan rather than individual beneficiaries and participants.\textsuperscript{219} The concurring justices felt the more appropriate provision for individual relief might be ERISA § 502(a)(3),\textsuperscript{220} but ultimately that theory would not carry the day, either.

ERISA §502(a)(2)’s authorizing plan participants and beneficiaries to seek relief for a fiduciary’s violation of ERISA’s statutory duties does not Preclude plan participants and beneficiaries from enforcing additional contractual rights and benefits under the terms of the plan against a fiduciary pursuant to ERISA § 502(a)(1)(B). A fiduciary contractually can assume more liability or offer plan participants and beneficiaries more rights than the minimum ERISA prescribes. State law may require as a condition of marketing its products ans services in the state that a fiduciary assume more obligations than ERISA requires. Once the fiduciary contracts with an ERISA plan, those increased responsibilities are incorporated into the ERISA plan.

\textsuperscript{217} Id. at 145-47.
\textsuperscript{218} Id. at 148.
\textsuperscript{219} Id. at 150 (concurring opinion).
\textsuperscript{220} Id.
D. EQUITABLE RELIEF UNDER § 502(a)(3)

ERISA § 502(a)(3) empowers ERISA plan participants, beneficiaries, and fiduciaries to enjoin any act or practice that violates ERISA or the terms of the ERISA plan, or to obtain other appropriate equitable relief to redress statutory or plan violations.\(^\text{221}\) Despite the \textit{Russell} concurrence identifying § 502(a)(3) as allowing compensatory damages to individual participants, the Supreme Court limited § 502(a)(3) to equitable remedies such as injunction or restitution and specifically rejected its application to monetary damages.\(^\text{222}\)

Even limited to equitable remedies, however, ERISA § 502(a)(3) has been the basis of some relief. In \textit{Varity Corporation v. Howe},\(^\text{223}\) for example, the Court found ERISA § 502(a)(3) authorized individual relief and not just relief for the plan itself.\(^\text{224}\) The plaintiffs brought an action against their former employer in its fiduciary capacity, asserting a breach of its fiduciary duties when the former employer intentionally mislead the employees in a successful effort to persuade the former employees to relinquish their medical benefit rights in the parent company and accept those of a subsidiary that, unbeknownst to the employees, soon would declare


\(^{224}\) \textit{Id.} at 507-508.
bankruptcy. The former employees sought and were granted an order re-instating them into the parent company’s medical plan.

Plan participants and beneficiaries were granted equitable relief once more in Inter-Modal Rail Employees Association v. Railway Company, another case where an employer attempted to shuffle employees to another corporation to save money on ERISA plan benefits. This time the employee contracted with an unrelated company. The employer gave its employees the option of working for the third-party corporation or of being fired. The third-party corporation offered a less generous benefits plan. The employees brought a civil action under ERISA § 502(a)(3) seeking a remedy pursuant to ERISA § 510's prohibition against interfering with a participant’s ERISA benefits. The right of persons to seek equitable relief pursuant to ERISA § 502(a)(3) and § 510 was so well established by the time of the case that ERISA preemption was not an issue in the case.

To summarize the relationship among the three major § 502 subsections, ERISA § 502(a)(1)(B) is the main vehicle for plan participants and beneficiaries to enforce individual rights, and the only

225 Id. at 493-94.
226 Id. at 495.
228 Id. at 512-513.
one of the three sections empowering plan participants to enforce state-mandated rights and benefits. States can regulate services and products marketed in the state, and the regulation is saved, usually as an insurance regulation. An ERISA plan sponsor venturing into the marketplace to secure products or services are limited to ones legally available in the state. Once the service or product is purchased, the state-mandated individual rights and benefits are incorporated by contract into the ERISA plan, rights and benefits enforceable pursuant to ERISA § 502(a)(1)(B).

The other two provisions, ERISA § 502(a)(2) and (a)(3), are independent of §502(a)(1)(B). They authorize equitable remedies to carry out the purposes of ERISA but not damages or extracontractual rights under state law. The two sections authorize rights strictly under federal law. While the two equitable relief sections have a place and function, neither can be used to circumvent the preemption of state laws. They create federal rights and remedies; they do not safeguard state laws. On the other hand, the two equitable relief sections do not preempt state laws, either, nor do they diminish rights plan participants and beneficiaries enjoy under § 502(a)(1)(B).

The expansive role of §502(a)(3) envisioned by the concurring justices in Russell and advocated by the dissenting justices in Mertens retains support by justices and

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230 473 U.S. at 150-51 (concurring opinion).
231 508 U.S. at 263-74 (dissenting opinion).
232 See Aetna Health Inc. v. Davila, 542 U.S. at 222-23 (concurring opinion).
commentators. Someday the Court may reconsider the issue and interpret ERISA § 502(a)(3) to develop federal remedies based on traditional trust concepts to permit individual actions for monetary damages. An expansive reading, recognizing a federal common law for ERISA plans, would not lessen the rights ERISA § 502(a)1)(B) confers on participants and beneficiaries. It would make available protection to plan participants and beneficiaries residing in states that do not regulate providers or do not mandate specific benefits and rights; and it could standardize a wide range of benefits and rights nationally such that individual participants and beneficiaries prefer to bring their actions under § 502(a)(3) rather than pursuant to § 502(a)(1)(B). The actual effects, however, are speculative.

III. CRITIQUE OF AETNA HEALTH INC. v. DAVILA

With the foregoing material in mind, this Part III reviews the Supreme Court’s latest ERISA preemption case, Aetna Health Inc. v. Davila.235

A. THE DAVILA HOLDING UNDER § 514 AND § 502


234 See id. at 1338.

The Supreme Court considered two consolidated cases in *Davila*. Plaintiffs in the consolidated cases brought state law claims under the Texas Health Care Liability Act.\textsuperscript{236} Section 88.002(a) of the Texas law imposes on a health insurance carrier, HMO or other managed care entity “the duty to exercise ordinary care when making health care treatment decisions” and makes them liable to an insured for injuries proximately caused by the failure to exercise such care.\textsuperscript{237} Only the insurance company, HMO, or other managed care entity is liable, not the employer or union that sponsored a group health plan.\textsuperscript{238} “Ordinary care” is the care exercised by an entity or person of “ordinary prudence . . . under the same or similar circumstances.”\textsuperscript{239} “Health care treatment decision” is any determination that “affect[s] the quality of the diagnosis, care or treatment provided.”\textsuperscript{240}

In one of the consolidated cases, a treating physician prescribed medication to treat Juan Davila, a participant in an ERISA plan, for his arthritis pain.\textsuperscript{241} Davila’s employer entered into an

\begin{itemize}
  \item \textsuperscript{236} Tex. Civ. Prac. & Rem. Code §§ 88.001-88.003 (Thomson West 2004 Supp.). See 542 U.S. at 204.
  \item \textsuperscript{237} *Id.* § 88.0002(e).
  \item \textsuperscript{238} *Id.*
  \item \textsuperscript{239} *Id.* § 88.001(10).
  \item \textsuperscript{240} *Id.* § 88.001(5).
\end{itemize}
agreement with an HMO to administer the ERISA plan.  

Before it would agree to pay for the prescribed medication, the HMO required Davila to enter into a “step program” in which Davila tried a cheaper pain medication. After three weeks of taking the HMO-directed drug, Davila was rushed to an emergency room suffering from bleeding ulcers, internal bleeding, and a near heart attack. Davila was in critical condition for five days, and no longer can take any pain medication that is absorbed through his stomach. Davila brought suit under the Texas Health Care Liability Act alleging the HMO failed to use ordinary care in its coverage decision. The HMO argued ERISA preempted Davila’s state law claim.

542 U.S. at __. “Administer” is a loaded term and precision of use would have been appreciated. If administer means the HMO exercised discretion with regard to the plan, the HMO was a fiduciary. If it was merely engaged in ministerial matters, it was not a fiduciary. If it administer meant the HMO provided health care services and maintained its own records and made decisions as to its responsibility to coordinate care for the ERISA plan’s beneficiaries and participants, it is not a fiduciary. According to the Fifth Circuit opinion, the HMO provided plan participants and beneficiaries with health care services, and was not merely a third party administrator. 307 F. 3d at 303. It appears the HMO kept the records and made decisions for its own account, not the ERISA plan.

307 F.3d at 303.

_Id_.

_Id_.


542 U.S. at 204.
In the second case, a surgeon affiliated with CIGNA, an HMO, performed a hysterectomy with rectal, bladder and vaginal repair on Ruby Calad.\textsuperscript{249} Calad was enrolled with CIGNA as a beneficiary under an employer-sponsored group health plan.\textsuperscript{250} Despite her CIGNA-affiliated doctor recommending Calad remain hospitalized, a CIGNA hospital discharge nurse overruled the doctor, deciding a one-day hospital stay was sufficient.\textsuperscript{251} Calad attributed complications that required she be rushed to the hospital emergency room a few days later to CIGNA’s discharging her prematurely.\textsuperscript{252} Calad sued CIGNA alleging, under the Texas Health Care Liability Act, CIGNA failed to use ordinary care in making a “medical necessity” decision, CIGNA’s system made substandard care more likely, and CIGNA through its agent discharge nurse decided Calad did not require more than one day hospitalization following her hysterectomy.\textsuperscript{253} The Supreme Court characterized Calad’s claims as claims she was denied benefits under an ERISA plan.\textsuperscript{254}

\begin{thebibliography}{1}
\bibitem{248} \textit{Id.}
\bibitem{249} Roark v. Humana, Inc., 307 F.3d 298, 302 (5th Cir. 2002).
\bibitem{250} 542 U.S. at 204.
\bibitem{251} \textit{Id. & Roark,} 307 F.3d at 302.
\bibitem{252} 307 F.3d at 302.
\bibitem{253} \textit{Id.}
\bibitem{254} 542 U.S. at 211 & 214.
\end{thebibliography}
Under the Product Rule and the Savings Clause, a state can regulate insurance products and managed care providers, including HMO products and services marketed in the state.\(^{255}\) A state can incorporate rights into HMO products, whether it be the independent review process in Illinois or the ordinary care standard in interpreting an HMO contract under Texas law. Any HMO or insurance product marketed in the state incorporates the state mandates. Thus under the Product Rule or the Savings Clause, ERISA § 514’s conflict preemption clause would permit application of the Texas Health Care Liability Act to HMOs, even to HMOs providing services to ERISA plans. No claim was made in *Davila* that ERISA preempted the Texas Health Care Liability Act as applied to HMOs in general.

The broad issue in *Davila* \(^{256}\) was whether the plaintiffs’ individual causes of action were so completely preempted by ERISA § 502(a) they could be removed to federal court even though the plaintiffs brought their actions under the Texas Health Care Liability Act.\(^{257}\) Generally, under the well-pleaded complaint rule, federal court jurisprudence depends on the plaintiff’s statement of the issue, not the defendant’s anticipated answer.\(^{258}\) An exception applies when a federal statute completely preempts the state cause of action.\(^{259}\) The Supreme Court reasoned that ERISA § 502(a) is a provision of such “extraordinary pre-emptive power” that “it converts an ordinary state

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\(^{255}\) *See supra* text accompanying notes __

\(^{256}\) 542 U.S. at 205.

\(^{257}\) 542 U.S. at 204.

\(^{258}\) *Id.* at 207.

\(^{259}\) *Id.*
common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule.” 260 This has been the consistently-applied rule for ERISA cases since 1989. 261

The issue then narrowed to whether the plaintiffs’ claims were claims for benefits under ERISA or whether the claims were based on an independent legal duty. 262 This was an important issue.

As background, the Supreme Court has said some laws – those of general applicability, those that are too tenuous, remote or peripheral, and those of traditional state regulation – do not relate to employee benefit plans for purposes of ERISA even though they have some effect on the plans. 263 If a state law relates to an ERISA plan, however, the state law is preempted unless it is saved as an insurance, banking or securities regulation. 264 Even if a law is saved by the Savings Clause, individual plan beneficiaries and participants must fit any actions for benefit determinations into one authorized under ERISA § 502(a). 265 On the other hand, a plan beneficiary or participant can bring an action against a third party under state law without implicating ERISA § 502 if the defendant breached an independent duty.

260  Id. at 209 (citing Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 65-66 (1987)).

261  See 481 U.S. at 65-66. See also supra text accompanying notes __.

262  542 U.S. at 210.

263  See supra text accompanying notes __. Some state laws that regulate rights between ERISA plan members and outside parties also have escaped ERISA preemption. See id.


265  See id. § 1132(a). See also supra text accompanying notes __.
The *Davila* plaintiffs claimed Texas law established an independent legal duty of ordinary care that applied whether or not the plaintiffs participated in an ERISA plan. They argued they brought their claims to enforce the HMOs’ independent duty under Texas law and not because of any terms of their ERISA plans. Therefore, their argument went, any civil action to enforce the independent duty was not within the scope of the ERISA §502 (a) civil enforcement regime.

The plaintiffs’ theory may have some merit in that the Texas law imposed on the HMOs an obligation to use ordinary care in making benefit decisions, which sounds in negligence much the same way medical malpractice does, and ERISA does not preempt state law medical malpractice claims. Once the Supreme Court concluded the plaintiffs were ERISA plan participants and beneficiaries complaining about plan coverage denials, with the plaintiffs agreeing they were, however, the case was effectively over. The plaintiffs only legal recourse for plan benefit determinations and wrongful denials was through ERISA § 502. The Supreme Court steadfastly has emphasized ERISA § 502(a) is the exclusive vehicle to bring a suit regarding benefit determinations, so much so a state court case can be removed to federal court since ERISA § 502(a) completely preempts all state actions for ERISA plan benefits. Thus the Davila cases were removed properly to federal courts. More critically for ERISA preemption purposes, since

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266 542 U.S. at 212.

267 *Id.*


269 542 U.S. 211-14.

270 *Id.* at 214.
the plaintiffs refused to amend their complaints to bring an action under ERISA § 502(a),\textsuperscript{271} the
district court had no choice but to dismiss their complaints with prejudice.\textsuperscript{272}

The \textit{Davila} plaintiffs on remand, or better yet, at the beginning of their cases, should have worded
their complaints to enforce the provisions of the Texas law, not as a state law action independent
of ERISA, but as a “term of the plan” pursuant to ERISA § 502(a)(1)(B). The State of Texas can
regulate insurers including HMOs. Every insurance policy or HMO contract marketed in the state
must contain the state mandates. Once an ERISA plan sponsor purchases the insurance contract or
enters into an HMO contract, the policy or contract terms are incorporated into the ERISA plan.
ERISA § 502(a)(1)(B) expressly empowers ERISA plan participants and beneficiaries to recover
benefits or enforce rights granted under the terms of the plan, including any rights for wrongful
denial or choice of treatments if they are part of the plan.\textsuperscript{273}

\textsuperscript{271} \textit{Id.} at 205 & 221 n.7 (majority opinion); \textit{id.} at 223-24 (concurring opinion).
\textsuperscript{272} \textit{Id.} at 221 n.7.
that the plaintiffs could have paid for the treatments and sought reimbursement through a §
502(a)(1)(B) action or sought a preliminary injunction. That’s not an option for plan participants
and beneficiaries who trust the decisionmaker’s judgment or at least give their HMO or utilization
review organization the benefit of the doubt. As discussed in text, a wider range of plaintiffs can
bring an action against HMOs and utilization review organizations after the harm occurs if that
right has been incorporated into the ERISA plan, either voluntarily or by state insurance
regulation.
B. THE DAHLIA CONCURRING OPINION AND § 502(a)(3)

The concurring justices, while agreeing that plaintiffs must present their claims under ERISA § 502(a),\(^{274}\) encouraged future plaintiffs to heed a Government suggestion that § 502(a)(3) may be a viable vehicle for “make-whole relief.”\(^{275}\) The concurring opinion also stated that “fresh consideration of the availability of consequential damages under § 502(a)(3) is in order.”\(^{276}\) The reconsideration would be of *Mertens v. Hewitt Associates*\(^{277}\) that limited ERISA § 502(a)(3) to the narrowest possible interpretation of “equitable relief.”\(^{278}\)

If the Supreme Court revisits *Mertens* and a broader interpretation of “equitable relief” emerges, a § 502(a)(3) action in a Davila-type situation would not grant relief under the state law. Section 502(a)(3) provides for a federal common-law remedy. While a court may grant the same relief sought under a state statute, the relief would be a federal law remedy.\(^{279}\) The benefit to this approach is that any holding pursuant to §502(a)(3) would apply nationwide, even in states that had no similar legislation, and a uniform law would apply.

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\(^{274}\) 542 U.S. at 223-24.

\(^{275}\) *Id.*

\(^{276}\) *Id.* at 223.


\(^{278}\) *See id.*

\(^{279}\) *See supra* text accompanying notes __
An expanded role for ERISA § 502(a)(3) would not eliminate or reduce the power of plan participants and beneficiaries to enforce rights and benefits under ERISA § 502(a)(1)(B), including state mandated rights and benefits incorporated into the ERISA plans. These are rights under the plan.

C. TORT-LIKE CLAIMS AND REMEDIES UNDER ERISA § 502(a)(1)(B)

A paragraph in Part III-B of the Davila majority opinion may lead to confusion in the future. The Court, in responding to the Court of Appeals theory that the plaintiffs could bring a suit under the Texas Health Care Liability Act outside of ERISA enforcement scheme because the defendants’ actions constituted torts and tort claims unlike contract claims do not fall under ERISA’s purview,\textsuperscript{280} said labels don’t control ERISA’s reach.\textsuperscript{281} An ERISA plan beneficiary or participant must bring civil actions for benefit denials pursuant to ERISA § 502(a).\textsuperscript{282} The Court likewise dismissed the theory that the Texas act’s authorizing remedies beyond those authorized by ERISA put the cause of action outside the scope of ERISA.\textsuperscript{283}

In its brief explanation the Court cited to three prior Supreme Court cases – Pilot Life, Metropolitan Life, and Ingersoll-Rand – in a potentially misleading manner. The Court said the

\textsuperscript{280} 542 U.S. at 214.
\textsuperscript{281} Id.
\textsuperscript{282} Id. at 214-15.
\textsuperscript{283} Id.
plaintiffs in all three cases brought state claims that were labeled either tort or tort-like.\textsuperscript{284} And, informed the Court, plaintiffs in all three cases sought remedies beyond those authorized under ERISA.\textsuperscript{285} ERISA preempted the state-law based actions in all three cases.\textsuperscript{286} The Court concluded its analysis by reiterating the familiar refrain that the limited remedies available under ERISA are an inherent part of the “careful balancing” of the goals underlying ERISA.\textsuperscript{287}

That’s all the Supreme Court wrote on the topic. The paragraph should be read for what it says: ERISA plan beneficiaries and participants must bring claims for benefit denials and determinations under ERISA § 502(a) in all cases, contract and tort alike. As support, the opinion identified three cases where the Court held ERISA prevents a plaintiff from bringing a claim under state law unless the plaintiff can fit state law claim into one of the ERISA § 502(a) provisions.

Unfortunately, the paragraph could be read incorrectly to say the three cases stand for the proposition that ERISA preempts all tort-like causes of action and remedies for mental anguish and for punitive damages. The three cases never held that and, in fact, turned on other issues.\textsuperscript{288}

The state laws in\textit{ Pilot Life} and\textit{ Metropolitan Life} were judicially created rules not aimed

\begin{itemize}
\item \textsuperscript{284} \textit{Id.} at 215.
\item \textsuperscript{285} \textit{Id.}
\item \textsuperscript{286} \textit{Id.}
\item \textsuperscript{287} \textit{Id.}
\item \textsuperscript{288} \textit{See supra} text accompanying notes ___ for a fuller discussion.
\end{itemize}
specifically toward the insurance industry and thus not saved as an insurance regulation by the Savings Clause. Another Supreme Court case, *UNUM Life Insurance Company v. Ward*,\(^{289}\) upholding California’s judicially created notice-prejudice rule on insurance claims as saved by ERISA’s Savings Clause, explained the significant difference. The California rule in *UNUM* “firmly applied to insurance contracts,”\(^ {290}\) and thus was saved from preemption under the Savings Clause.\(^ {291}\) The Mississippi law in *Pilot Life* in contrast was not specifically directed to the insurance industry and therefore not saved from ERISA preemption.\(^ {292}\) The test to determine if a state law is an insurance regulation for purposes of the Savings Clause is whether the state law is specifically directed toward insurance contracts or the insurance industry. The state laws in *Pilot Life* and *Metropolitan Life* were not directed toward the insurance industry.\(^ {293}\) The notice-prejudice rule in *UNUM* was.\(^ {294}\)

The third case cited in the paragraph in part III- B of *Davila, Ingersoll-Rand*, differed from *Pilot Life* and *Metropolitan Life* in that the case involved pension plans not welfare benefit plans and no claim was made the judicially created law was saved by the Savings Clause as an insurance regulation. As background to *Ingersoll-Rand*, the Texas Supreme Court created an exception to


\(^{290}\) *Id.* at 371.

\(^{291}\) *Id.* at 375.

\(^{292}\) *Id.* at 377.

\(^{293}\) *Id.* at 369.

\(^{294}\) *Id.*
the common-law employment-at-will doctrine if an employee discharged an employee to prevent
the employee’s pension benefits from vesting.\textsuperscript{295} The Supreme Court in \textit{Ingersoll-Rand} said the
ERISA pension plan was central to a claim for relief under the Texas law so the law was
preempted under ERISA’s general preemption clause.\textsuperscript{296} Moreover, concluded the Court in
\textit{Ingersoll-Rand}, the Texas judicial rule fell squarely within the ambit of ERISA § 510 that makes
it unlawful to discharge a plan participant or beneficiary for the purpose of interfering with a
beneficiary’s becoming vested in the plan.\textsuperscript{297}

Under the Product Rule discussed in part I of this article,\textsuperscript{298} ERISA preempts all state laws that
regulate the relationships between the parties – sponsor, fiduciaries, beneficiaries and participants
-- in an ERISA plan, and ERISA preempted the Texas rule in \textit{Ingersoll-Rand} for attempting to
regulate the relationships between parties in an ERISA plan. Neither rationale for ERISA
preemption in \textit{Ingersoll-Rand} hinged on or even considered that the actions was based on a tort
theory or because of the remedies sought.

To review, ERISA preemption has evolved into two separate analyses. First, the ERISA § 514
Conflict Preemption Clause preempts all state laws related to ERISA plans. A major exception is
that state laws regulating insurance, banking and securities escape preemption through the


\textsuperscript{296} \textit{Id.} at 139-40.

\textsuperscript{297} \textit{Id.} at 142-43.

\textsuperscript{298} \textit{See supra} text accompanying notes __.
Savings Clause. Since ERISA plans offering health care often utilize insurance products from outside the plan, the states exercise significant indirect influence on many health care plans through insurance regulation.

Culled down, states can regulate the insurance product and service providers. Insurance products and services marketed in the state are subject to the state regulations. An ERISA plan sponsor purchasing or contracting for the product or service purchases the product or service subject to the state regulations, and the regulations are incorporated into the ERISA plan. Plan participants and beneficiaries can enforce their rights and benefits so incorporated as part of the ERISA plan under ERISA § 502(a)(1)(B). The Deemer Clause prohibits states from regulating directly the relationships between the ERISA plan parties or the benefits of the plan, but the states can regulate certain matters indirectly because of the Savings Clause. If a state law, such as the Texas Health Care Liability Act, requires HMOs and utilization review organizations to assume liability for negligent decisionmaking concerning benefits or treatment options, that law becomes part of the ERISA plan once a plan sponsor chooses to purchase the HMO or utilization review organization services.299

The second part of ERISA preemption analysis is based on the right of plan beneficiaries and participants to bring civil actions: An ERISA plan participant or beneficiary seeking to enforce a state-mandated insurance regulation must fit his cause of action within ERISA § 502. The workhorse for beneficiary and participant relief is ERISA § 502(a)(1)(B), the section that

299 See supra the Product Rule discussion in text accompanying notes __.
empowers a participant or beneficiary to bring suit to recover benefits and enforce rights under the terms of the plan. An aggrieved plan participant or beneficiary must – must – word his or her claim for relief as one authorized under § 502. Reliance on the state law alone is inadequate. Thus, as occurred in Davila, a court will refuse to consider a claim if an ERISA plan participant or beneficiary brings strictly a state law claim. A plaintiff must assert his claim as a right or benefit traceable to the terms of the plan or a right to seek equitable relief pursuant to ERISA § 502(a).

Courts, including the Supreme Court, have recognized state-mandated rights if brought pursuant to ERISA § 502(a)(1)(B). The Davila plaintiffs relying solely on state law to form an independent claim and refusing to amend their complaints include an ERISA § 502(a)(1)(B) claim resulted in the district court’s dismissing their claims.

The Davila plaintiffs at the Supreme Court argued the Texas law was an insurance regulation and that the Savings Clause saved the law from both ERISA § 514’s Conflict Preemption Clause and § 502’s complete preemption effect. The Court, consistent with prior holdings, rejected that argument. For an ERISA plan beneficiary or participant to prevail in his cause of action involving state law, he must overcome two preemption challenges. First, as in Davila, the plaintiff must

\[\text{See, e.g., Rush Prudential HMO, Inc. v. Moran, 536 U.S. at 371-72 (independent review requirement); UNUM life Ins. Co. v. Ward, 526 U.S. at 376-77 (notice-prejudice rule)}\]

\[\text{542 U.S. at 221 n.7.}\]

\[\text{Id. at 216.}\]
show the state law is not preempted under § 514’s general Preemption Clause or that the Savings Clause preserves the state law. The Texas law, for example, most likely was saved as an insurance regulation. But that’s not enough.

For an ERISA plan participant or beneficiary to prevail, he or she must fit a claim for benefits into ERISA’s remedial scheme: A state law that survives the general preemption and Savings clauses analysis still must confront the § 502 complete preemption clause when a participant brings an action. As announced initially as dicta in Pilot Life, a plan beneficiary or participant relying on a state law that was saved as an insurance regulation under the Savings Clause still must seek relief thorough one of ERISA § 502’s exclusive federal remedies, usually § 502(a)(1)(B). The Supreme Court forcefully affirmed its continued support of the complete preemption doctrine that state law cannot alter a participant’s benefits or remedies available under ERISA and the participant’s ERISA plan. The proper route in most cases is to bring a § 502(a)(1)(B) claim for benefits or rights under the terms of the plan, recognizing an ERISA sponsor choosing to purchase an insurance product or service in the marketplace purchases the product or service as regulated under state law. The rights and benefits associated with the

303 See supra text accompanying notes __.

304 Accord, id. at 217-18.

305 See 542 U.S. at 217-18. See supra text accompanying note [].

306 See id..
product or service are incorporated into the terms of the ERISA plan, enforceable by plan participants and beneficiaries pursuant to ERISA § 502(a)(1)(B).

IV. CONCLUSION

Confusion surrounding ERISA preemption can be minimized if ERISA preemption is recognized as two separate analyses rather than just one. First, under an analysis this article calls the Product Rule, ERISA does not preempt many state laws related to ERISA welfare benefit plans. A state can regulate insurance companies, HMOs, utilization review organizations, physicians, hospitals, nursing homes, pharmacies and other health care service and product providers. While the Deemer Clause keeps a state from regulating directly the relationships within an ERISA plan, the state can regulate the products and services marketed to ERISA plans in the state. An ERISA plan that chooses to purchase a product or service in the marketplace is limited to those services and products legally available under state law. State regulations applicable to service providers or product suppliers are incorporated into the ERISA plans once the plan sponsors contract for those services or products. Otherwise, the regulated parties could defeat the purpose of the Savings Clause.

307 See supra text accompanying notes__.
In a separate step, ERISA limits plan participant or beneficiary’s rights to enforce the state law to those that fit under § 502(a), the sole vehicle for plan participants and beneficiaries to enforce their rights and secure their benefits. A plan participant or beneficiary to bring a claim based on an ERISA plan benefit determination or denial must fit the claim, including any claim originating in state law, into one of the ERISA § 502(a) provisions. A plan participant or beneficiary who sidesteps ERISA § 502(a) and attempts to bring his or her action under state law saved under the Savings Clause rather than under ERISA § 502(a) will see his or her action dismissed. ERISA preempts the action, not because the law is void, but because ERISA limits a plan participant and beneficiary claims under ERISA plans to those ERISA §502 authorizes. While two of ERISA § 502(a)’s provisions authorize equitable relief in relatively limited situations, ERISA § 502(a)(1)(B) is the workhorse provision, empowering ERISA plan participants and beneficiaries to recover benefits and enforce rights under the terms of the ERISA plans.

To receive the benefit of a state law that relates to an ERISA plan, therefore, an ERISA plan participant must prove ERISA’s Savings Clause saves the state law from preemption or the state law avoids ERISA preemption as a health concern or other area of law historically regulated by states, the state law is one of general applicability, or the law is too tenuous, remote or peripheral to congressional concerns about ERISA plans. In addition, the plaintiff must show the ERISA plan sponsor entered the marketplace to contract for a state-regulated service or product. Once the product or service is purchased, the state regulations associated with the purchased product or service are incorporated into the terms of the ERISA plan. Plan participants and beneficiaries can enforce the regulations as § 502(a)(1)(B) rights and benefits under the terms of the ERISA plan.