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ELIGIBILITY, TREATMENT, OR SOMETHING IN-BETWEEN? PLAINTIFFS GET CREATIVE TO GET PAST ERISA PREEMPTION

Linda P. McKenzie

On July 1, 2005 a Bexar County, Texas jury, in the case of Smelik v. Mann, awarded the husband and children of a deceased San Antonio woman 7.4 million dollars in their wrongful death suit against the woman’s physician, his practice group, and Humana Health Plan of Texas, Inc. (Humana). Humana was the Health Maintenance Organization (HMO) that administered the health plan provided to Joan Smelik. Mrs. Smelik died of kidney failure, which the plaintiffs claimed could have been prevented if Humana had simply followed its own utilization management policies. The jury found Humana responsible for thirty-five percent of the actual damages, 7.4 million dollars. In addition, the defendants were ordered to pay punitive damages of 1.6 million dollars, bringing Humana’s total liability to the plaintiffs to over four million dollars.

The case garnered national attention largely because of its unusual outcome with respect to Humana. While it is not uncommon for a plaintiff to win a judgment based on the negligence of a health care provider, it is quite remarkable when the judgment includes an employer-sponsored health plan. Such an occurrence is notable because the Employee Retirement Income Security Act (ERISA), a federal law that governs pension plans and welfare benefit plans provided as a benefit of employment, preempts most state law causes

1. Associate, Jones Vargas, Las Vegas, Nevada. LL.M., Health Law, University of Houston Law Center, 2006; J.D., University of Arizona, Rogers College of Law, 2004; This article received first place in the 2006 Florida Bar Association’s William Trickel, Jr. Memorial Writing Award Competition. The author thanks Professor David Pate for his invaluable insights and guidance.
3. Id.
5. See Bower, supra note 2.
6. See id.
of action against managed care entities.\(^7\) Avoiding federal preemption is critical to a plaintiff's case because ERISA's remedial scheme limits relief for damages to the cost of the treatment or service that was denied by the health plan.\(^8\)

The Supreme Court has held that any claim that could be construed as a claim "to recover benefits due . . . under the terms of [the] plan" is subject to ERISA's limited remedies.\(^9\) The Court has explicitly determined that claims against an HMO for failing to authorize medically necessary surgery and prescribed medication are, in essence, no more than claims to recover benefits due under the plan.\(^10\) On the other hand, the medical negligence of an HMO-employed physician is not subject to ERISA preemption.\(^11\) The facts of the Humana case (Smelik) did not fit neatly into either the denial of services or the medical negligence category. The plaintiffs alleged that Humana failed to identify Mrs. Smelik as a candidate for its case management program, although multiple chronic medical conditions qualified her to participate.\(^12\) Case management combines elements of treatment and eligibility decision making, blurring the distinction between state law claims that are and are not subject to ERISA preemption.\(^13\) The outcome of the Smelik case was significant to the extent that it appeared to carve out this previously unrecognized exception to the


\(^8\) Under ERISA, a plaintiff can recover the value of the medical treatment that was denied. For example, in Aetna Health, Inc. v. Davila, 542 U.S. 200 (2004), plaintiff Juan Davila's HMO substituted a cheaper drug for the medication prescribed by his physician. As a result, Mr. Davila suffered internal bleeding and incurred medical expense, pain and suffering. See id. at 204-05. See also James W. Kim, Managed Care Liability, ERISA Preemption, and State "Right to Sue" Legislation in Aetna Health, Inc. v. Davila, 36 Loy. U. Chi. L.J. 651, 681 (2005). Where state law would have permitted Davila to recover for his injuries, the remedy under ERISA was the value of the denied benefit, the difference in cost between the drug that was prescribed and the drug his HMO authorized. See Davila, 542 U.S. at 209, 210. For an excellent discussion of Davila, see Kim, supra.

\(^9\) See Davila, 542 U.S. at 210 (citation omitted).

\(^10\) See id. at 210-14.


\(^13\) See Pegram v. Herdrich, 530 U.S. 211, 228 (2000). Eligibility decisions are based on whether a plan provides coverage for a particular condition whereas treatment decisions entail choices about how to diagnose or treat a condition. See infra Part IV.
application of ERISA. For reasons not disclosed, however, Humana settled the case with Joan Smelik's family while its appeal was pending. Because so many managed care organizations employ medical case management, it will likely be only a matter of time before another plaintiff claims that his or her HMO's failure to provide these services caused damages. Perhaps a future case will result in an appellate opinion addressing whether ERISA preemption applies in this circumstance.

This article analyzes ERISA's impact on employee welfare benefit plans and on health plans in particular. It concentrates on the two ERISA provisions that, as interpreted by the Court, combine to significantly weaken an injured plaintiff's ability to obtain proper retribution: section 502(a) governs remedies and section 514 expressly authorizes federal preemption. Part I provides a brief overview of the political climate at the time ERISA was enacted and discuss the purpose of the Act. Part II discusses ERISA's express preemption and the two additional types of preemption identified by the Supreme Court. Part III examines ERISA's remedial scheme and the Supreme Court's related jurisprudence. Part IV reviews ERISA in the health care context. Finally, Part V analyzes the Court's holdings that have restricted a plaintiff's potential remedies and suggests ways in which plaintiffs may still be indemnified.

PART I. ERISA HISTORY

Congress enacted the Employee Retirement Income Security Act in 1974 out of concern over the rapid growth of employee pension and benefit plans and the lack of safeguards to protect workers from the loss of promised benefits when these plans failed.


16. Jana K. Strain and Eleanor D. Kinney, The Road Paved With Good Intentions: Problems and Potential for Employer-Sponsored Health Insurance Under ERISA, 31 LOY. U. CHI. L.J. 29, 30 (1999) ("Between 1945 and 1984, the number of workers covered by private pension and employee benefit plans increased from 6.4 million to 65 million, and the value of these plans increased from $5.4 billion in assets to over $900 billion." (footnote omitted)).

17. 29 U.S.C. § 1001(a) (2000) ("The congress finds that . . . despite the enormous growth in such plans many employees with long years of employment
In particular, Congress was alarmed by the failure of some large pension plans, which resulted in employees facing retirement without their anticipated earned pension benefits. For at least a decade prior to enacting ERISA, both the legislative and executive branches of the federal government conducted inquiries into the affairs of pension and benefit plans. The investigations revealed that plans were not operating in a way that served the interests of plan beneficiaries. For example, the Senate's McClellan Committee, led by Robert F. Kennedy, identified widespread misuse of plan funds by labor unions. The results of the investigations were disturbing to Congress on two grounds. First, misuse of pension plan funds could result in a plan becoming insolvent and an employer defaulting on its pension promise. Second, persons responsible for managing plan assets could improperly deny payment for promised benefits.

Congress' stated purpose for enacting ERISA was to safeguard the interests of employees and their beneficiaries who participated in pension and benefit plans from default risk and plan mismanagement. Congress intended to maximize employee protection by modeling ERISA on existing trust law and providing open access to the federal courts. Years later, the Court explained that allowing various state

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19. Id. at 1321-22 (noting that ERISA enactment was preceded by "more than a decade of investigations . . . by Congress, presidential commissions, and the Departments of Labor, Justice, and Treasury." Id. (footnote omitted)).

20. Id. at 1324. (noting that the committee found "looting of plan funds through sweetheart deals, kickbacks, and various forms of cronyism." Id. (footnote omitted)).

21. See id. at 1322-23.

22. See Langbein, supra note 18, at 1323-24.

23. See id. at 1322.

24. See id. at 1324-25, 1331.
causes of action for claims “within the scope of 502(a) would pose an obstacle to these purposes and objectives of Congress.”

The Court’s emphasis on ERISA’s secondary purpose has come at the expense of the Act’s stated primary purpose. Although drafted primarily to protect the interests of employees in their pension and benefit plans, ERISA often erects insurmountable barriers to employees’ claims against these plans. The result is that a beneficiary sustaining damages as a result of his health plan’s denial of a covered benefit often has no adequate remedy under state or federal law.

PART II. ERISA PREEMPTION

The Court has instructed that ERISA has three separate preemption mechanisms. Section 514 expressly preempts state laws that “relate to” ERISA-regulated benefit plans. In addition, the Court has recognized the power of section 502(a) to preempt “any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy . . . .”

A. Section 514 Ordinary / Conflict Preemption

ERISA, section 514(a) reads: “Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . .”


26. See Davila, 542 U.S. at 222 (Ginsburg, J., concurring)(“Because the Court has coupled an encompassing interpretation of ERISA’s preemptive force with a cramped construction of the ‘equitable relief’ allowable under § 502(a)(3), a ‘regulatory vacuum’ exists: ‘[V]irtually all state law remedies are preempted but very few federal substitutes are provided.’” (quoting DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442, 456-57 (3rd Cir. 2003) (Becker, J., concurring))).

27. See id.

28. See N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 654 (1995) (“Our past cases have recognized that the Supremacy Clause . . . may entail pre-emption of state law either by express provision, by implication, or by a conflict between federal and state law.”)


The Court initially construed section 514(a)’s “relate to” language broadly, based on congressional intent to simplify plan administration. Congress, the Court reasoned, intended the words to have broad meaning, because it “reject[ed] more limited pre-emption language that would have made the clause ‘applicable only to state laws relating to the specific subjects covered by ERISA.’” In its first interpretation of “relate to” the Court found that 514(a) applied to laws that directly regulated pension plans as well as laws that merely had an indirect affect on them. When given another early opportunity to delineate the realm of 514(a) preemption, the Court concluded that a law sufficiently relates to a benefit plan if it has “a connection with or reference to such a plan.”

Over time the Supreme Court withdrew from its expansive reading of section 514(a), and in 1995 presumed that Congress did not intend to preempt state law. The Court noted that the language limiting ERISA preemption to “all State laws insofar as they relate to any employee benefit plan,” was so broad that it could be construed not to serve as a limitation at all. The Court found the text “unhelpful” and determined to “look instead to the objectives of the ERISA statute” to ascertain Congress’ intent as to the “scope of the state law that . . . would survive [preemption].” The Court held in this 1995 case that section 514 was intended to preempt only state laws that significantly affect the structure or administration of ERISA plans.

34. Jost, supra note 25, W4-419 (citing Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 523 (1980)).
35. Shaw, 463 U.S. at 97 (footnote omitted).
36. Travelers Ins. Co., 514 U.S. at 654. (“[W]e have never assumed lightly that Congress has derogated state regulation, but instead have addressed claims of pre-emption with the starting presumption that Congress does not intend to supplant state law.”).
37. Id. at 655.
38. Id. at 656.
39. Id. at 668. (“We acknowledge that a state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice
Section 514 contains a "saving clause," which exempts from preemption laws that regulate insurance, banking, or securities. The saving clause has been applied to state laws that mandate minimum health insurance benefits, and laws that require all insurers in the state to pay for the services of a certain type of health care provider.

Another provision of 514, the "deemer clause," clarifies the saving clause. It states that an employee benefit plan covered by ERISA may not "be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts . . . ." The effect of the deemer clause has been to prevent state law suits against self-insured plans. For this discrete subset of plans, the deemer clause has ensured consistent government regulation while also minimizing risk associated with costly state court litigation. The deemer clause is evidence of Congress' efforts to balance competing policies underlying ERISA.

The Supreme Court has commented on the apparent incongruence between the general preemption clause and the saving clause. "The general pre-emption clause broadly pre-empt[s] state law[s]" that relate to benefit plans while the equally broad saving clause gives authority back to the states "over much of the same regulation." Again, this is evidence of the tension in the policies that underlie ERISA: the need to protect beneficiaries' interests while making administration and compliance simple enough that employers choose to offer employment benefit plans. The Court has attempted to find the balance that Congress intended.

41. Id. at 758.
43. Id. at 336 n.1 (citing 29 U.S.C. § 1144(b)(2)(B)).
44. FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990) ("We read the deemer clause to exempt self-funded ERISA plans from state laws that 'regulat[e] insurance' within the meaning of the saving clause.") Id. at 61.
45. Metro. Life Ins. Co., 471 U.S. at 739-40 (noting that "[t]he two pre-emption sections, while clear enough on their faces, perhaps are not a model of legislative drafting . . . ." Id. at 739.).
46. Id. at 739-40. ("For while Congress occasionally decides to return to the States what it has previously taken away, it does not normally do both at the same time." Id. at 740).
B. 502(a)'s Two Preemption Doctrines

Although it does not specifically mention preemption, the Supreme Court has nonetheless construed section 502(a) to have extremely broad preemptive power.\(^47\) The Court has held that the careful crafting of 502(a)'s six civil enforcement provisions, listed immediately below, "provide strong evidence that Congress did not intend to authorize other remedies . . ."\(^48\) Therefore, the Court has held that state contract, tort and statutory claims that could have been brought as claims for benefits or for breach of fiduciary duty are preempted by section 502(a).\(^49\)

A second and distinct type of preemption emanating from 502(a) is termed "complete preemption." Not a true preemption doctrine, complete preemption is more accurately described as a rule of federal jurisdiction.\(^50\) Complete preemption serves to recharacterize a state law claim into one arising under federal law.\(^51\) As such, the claim is removable by a defendant to federal court.\(^52\) According to the Court, sometimes Congress "so completely pre-empt[s] a particular area [of law] that any civil complaint raising this select group of claims is necessarily federal in character."\(^53\)

I. Section 502 Preemption

Section 502(a) provides:

A civil action may be brought-

(1) by a participant or beneficiary-

(A) for the relief provided for in subsection (c) of this section [concerning requests to the administrator for information], or (B) to recover benefits due to him under the terms of his plan, to enforce his rights under

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49. See Jost, supra note 25, at W4-20-W4-21 (quoting Russell, 473 U.S. 134, 146). See also Taylor, 481 U.S. at 60 (noting that it held in Dedeaux "that state common law causes of action asserting improper processing of a claim for benefits under an employee benefit plan regulated by [ERISA] are pre-empted by the Act.").
51. See Taylor, 481 U.S. at 63-65.
52. See id. at 66-67.
53. id., at 63-64.
the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;
(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title [breach of fiduciary duty];
(3) by a participant, beneficiary, or fiduciary
   (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or
   (B) to obtain other appropriate equitable relief
       (i) to redress such violations or
       (ii) to enforce any provisions of this subchapter or the terms of the plan;
(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title [information to be furnished to participants];
(5) except as otherwise provided in subsection (b) of this subsection, by the Secretary
   (A) to enjoin any act or practice which violates any provision of this subchapter, or
   (B) to obtain other appropriate equitable relief
       (i) to redress such violation or
       (ii) to enforce any provision of this subchapter;
(6) by the Secretary to collect any civil penalty under subsection (i) of this section.54

With these civil enforcement provisions in mind, we now turn to case law involving section 502 preemption. Pilot Life Insurance Co. v. Dedeaux involved an employee who injured his back while on the job.55 He was covered under an ERISA governed disability insurance plan. Pilot Life Insurance, honored his initial claim for coverage but subsequently terminated his benefits.56 The employee brought suit in federal court under diversity of citizenship jurisdiction alleging three state law causes of action.57 The district court granted Pilot Life's motion for summary judgment on the grounds that ERISA pre-empted

54. 29 U.S.C.A. § 1132(a) (West 1999).
55. Dedeaux, 481 U.S. at 43.
56. Id.
57. Id. State law claims included: “Tortuous Breach of Contract; Breach of Fiduciary Duties; and Fraud in the Inducement.” Id. (quotation and citation omitted).
all of the plaintiff's claims. The Fifth Circuit reversed and Pilot Life appealed. The Supreme Court granted certiorari to decide whether ERISA preempts state common law causes of action alleging improper processing of a claim for benefits. Interpreting § 514 broadly, the Court found that the state law causes of action at issue, "relate[d] to" a benefit plan. The Court next applied several criteria for determining whether a law "regulates" insurance and concluded that the state law did not. The inquiry did not end at this point; rather, the Court examined evidence of legislative intent, including the statements of legislative sponsors of ERISA and portions of the Congressional Conference Committee's record on ERISA. The Court highlighted the fact that the Conference Committee rejected a more limited preemption clause in favor of the expansive language it ultimately adopted. Given the structure of ERISA's civil enforcement provisions and the legislative history, the Court concluded that the remedies available in section 502 were intended to be exclusive. As a result of this determination, any state law that

58. Id. at 44.
59. Id.
60. Dedaux, 481 U.S. at 43.
61. Id. at 47-48.
62. Such as "the effect of transferring or spreading a policyholder's risk" or if there is a limitation of the practice to those within the insurance industry. Id. at 48-49.
63. See id. at 49-50. These criteria were later abandoned in Miller, 538 U.S. at 341-42.
64. Id. at 45-46. ("[W]hether a certain state action is preempted depends on congressional intent. The purpose of Congress is the ultimate touchstone." Id. at 45 (quotation and citations omitted)).
65. See Dedaux, 481 U.S. at 46. Senator Harrison Williams, while on the floor of the Senate, said Congress intended the "substantive and enforcement provisions . . . to preempt the field for Federal regulations . . . [and for the] principle of preemption to apply in its broadest sense." Id. at 46 (citation omitted).
66. Id. (quoting Shaw, 463 U.S. at 98).
67. Id. (quoting Shaw, 463 U.S. at 98).
68. Congress compared § 301 of the Labor Management Relations Act (LMRA) to ERISA's civil enforcement scheme, observing that § 301 has a "preemptive force so powerful as to displace entirely any state cause of action. . ." Id. at 55-56.
69. Id. at 54. ("Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly." (quoting Russell, 473 U.S. at 146 ) (emphasis in original)).
authorizes a remedy not available in 502(a) is automatically preempted. 70

II. Complete Preemption Under Section 502(a)

In Metropolitan Life v. Taylor, the plaintiff brought an action in state court alleging breach of contract against the administrator of his employment-related disability insurance plan. 71 Metropolitan Life removed the case to federal court, claiming federal question jurisdiction under ERISA. 72 The district court found the case properly removable and granted the defendant's summary judgment motion on the merits. 73 The Court of Appeals for the Sixth Circuit reversed, finding "that the District Court lacked removal jurisdiction." 74

United States Code provides that unless "otherwise expressly provided . . . any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant . . .," 75 Federal courts have original jurisdiction over cases "arising under the Constitution, laws, or treaties of the United States." 76 Generally, determining if a claim arises under federal law, and is thus removable to federal court, depends on whether the plaintiff's complaint explicitly raises federal claims. 77 ERISA preemption, on the other hand, is a federal defense against a state law claim. 78 As such, it provides insufficient justification to remove a case to federal court. 79

In Taylor, the Court applied a common law corollary of the well-pleaded complaint rule, which holds that "Congress may so completely pre-empt a particular area that any civil complaint raising this select group of claims is necessarily federal in character." 80 While rarely applied, complete preemption allows a defendant to remove an action

70. See Dedaux, 481 U.S. at 61.
72. Id. at 61. Plaintiff also alleged wrongful termination and wrongful failure to promote him in retaliation for an earlier worker's compensation claim. Taylor asked for compensatory damages for money owed him, compensation for mental anguish, and immediate reimplemention of benefits and insurance coverage. Id.
73. Id. at 61-62.
74. Id. at 62.
75. 28 U.S.C.A. § 1441(a) (West 2006).
77. See Taylor, 481 U.S. at 63.
78. See id. at 63.
79. See id.
80. Id. at 63-64.
to federal court even though no federal claims were stated in the plaintiff's complaint. In 1968, the Court applied this principle to claims brought under section 301 of the LMRA. The Taylor Court found distinct similarities between the language in section 301 of LMRA and section 502 of ERISA. Based on policy considerations and the notably similar language of the two acts, the Court extended the Avco principle to state law suits displaced by ERISA § 502(a)(1)(B). The effect of this jurisprudence was to "recharacterize the state law complaint" into an action arising under federal law, thereby conferring original jurisdiction upon the federal courts.

PART III. ERISA'S REMEDIAL SCHEME

ERISA section 502(a) defines who may bring a civil action, specifies the allowed purposes for bringing an action, and describes available remedies. The Court frequently praises section 502 as a model of draftsmanship. In Dedeaux, the Court noted "[t]he deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were

81. Id. at 67.
82. Id. at 64 (citing Avco Corp. v. Machinists, 390 U.S. 557 (1968)).
83. See Taylor, 481 U.S. at 65.
84. Id. at 64. ("[T]he policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." (quotations omitted) (quoting Dedeaux, 481 U.S. at 54)).
85. Id. at 66 ("[L]egislative history consistently sets out this clear intention to make § 502(a)(1)(B) suits brought by participants or beneficiaries federal questions for the purposes of federal court jurisdiction in like manner as § 301 of LMRA . . . . [T]he touchstone of the federal district court's removal jurisdiction is . . . the intent of Congress.").
86. See id. at 65-66.
87. See id. at 64.
88. 29 U.S.C.A. § 1132(a) (West 1999).
89. Justice Stevens described section 502 as an "interlocking, interrelated, and interdependent remedial scheme." Russell, 473 U.S. at 146. See also Dedeaux, 481 U.S. at 54 ("[T]he detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans . . . .").
intended to be exclusive.” Despite all of this acclaim, as it has been interpreted, 502(a) has an extremely limited remedial repertoire. This restricted range of remedies coupled with 502(a)’s extensive preemptive power, has made relief for some types of damages unavailable under both ERISA and state law. The Davila case provides such an example. In Davila, the Court held that ERISA completely preempted the Texas Health Care Liability Act (THCLA), which provided a cause of action against a managed care organization for negligent health care treatment decisions. The Court found that THCLA attempted to provide a remedy not authorized under 502(a). A participant or beneficiary in an ERISA regulated plan cannot sue under a common law tort theory or a state statute that authorizes damages that exceed those provided in ERISA.

The plaintiffs in Davila were given leave by the district court to amend their complaints in order to state ERISA causes of action, but they declined to do so. Had they stated ERISA claims, the claims would have fallen under section 502(a)(1)(B). The Supreme Court pointed out that Davila and Calad could have paid for the benefits that their HMOs denied and then sought a recovery of benefits through ERISA section 502(a)(1)(B). While this was certainly practically possible, the plaintiff’s stood to gain nothing from bringing this type of suit. The Court has read §502(a)(1)(B) to authorize damages for the actual benefit lost, not for any consequential damages. Mr. Davila stood to recover the value of a Vioxx prescription; Ms. Calad, the cost of one day of inpatient hospitalization. Given the costs associated with

90. Dedeaux, 481 U.S. at 54.
92. See Davila, 542 U.S. at 200.
93. See id. at 209.
94. Dedeaux, 481 U.S. at 54. (“In sum, the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.”).
95. Such inaction led to the district court dismissing the case, followed by appeals by the plaintiffs. See Davila, 542 U.S. at 205-206.
96. Id. at 214.
97. Id. at 211.
litigation, it stands to reason that most people will not involve the federal judiciary over a claim for relatively minimal damages.

A. Supreme Court Cases Defining the Scope of ERISA's Remedial Scheme

Massachusetts Mutual Life Insurance Co. v. Russell

Massachusetts Mutual Life Insurance Co. v. Russell was the first case to consider whether compensatory and punitive damages were available to plan participants and beneficiaries. The plaintiff brought suit in state court against his plan's administrator for damages related to the administrator's mishandling of a claim for disability benefits. The defendant removed the case to federal court and motioned for summary judgment. The district court granted the motion, finding that ERISA preempted all of the claims derived from state law and that ERISA prohibited consequential or punitive damages arising out of the original denial or the subsequent delay in providing benefits. The Ninth Circuit agreed that the state law causes of action were preempted, but held that the plaintiff had alleged a cause of action under ERISA § 409(a). By taking 132 days to process the plaintiff's claim, the plan administrator breached his obligation, as a fiduciary, to process claims "in good faith and in a fair and diligent manner."

Section 502(a)(2) permits a participant, beneficiary, or fiduciary to bring a civil action for "appropriate relief" under § 409, which in turn grants the court discretion to award "such other equitable or remedial relief as the court may deem appropriate." The Ninth Circuit interpreted this language to include compensatory and punitive damages. The Supreme Court unanimously overruled the circuit

98. See Russell, 473 U.S. at 136.
99. See id. at 136-37.
100. Id. at 137.
101. Id.
102. Id. at 137-38.
103. Id. at 137, 138
104. 29 U.S.C.A. § 1132 (West 1999) (referencing the "appropriate relief" that an eligible person can seek via civil action "under section 1109").
105. 29 U.S.C.A. § 1109(a) (West 1999).
court on the ground that 409(a) is directed at recovery of damages by the plan, not individual participants and beneficiaries.\textsuperscript{107}

The holding in \textit{Russell} is extremely narrow. The Court addressed whether 409(a) permitted an individual plan participant or beneficiary to recover consequential and punitive damages from a fiduciary caused by the fiduciary's "improper or untimely processing of benefit claims."\textsuperscript{108} The respondent in this case made a strategic decision not to rely on § 502(a)(3)(B). Consequently, the Court had "no occasion to consider whether any other provision of ERISA authorizes recovery of extracontractual damages."\textsuperscript{109}

Four members of the Court joined a concurrence, which was quite critical of the majority. The concurring opinion faulted the Court for remarks that it deemed "unnecessary and to some extent completely erroneous."\textsuperscript{110} At least one commentator has suggested that this "bad start" in interpreting section 502(a)(2) biased the Court against reading section 502(a)(3) as an approval of consequential and punitive damages when presented with that issue eight years later.\textsuperscript{111} In the following case, the Court was asked whether a \textit{non-fiduciary} could be held personally liable under section 502(a)(3)'s provision of "appropriate equitable relief" for his knowing participation in the breach of a fiduciary duty imposed by ERISA.\textsuperscript{112}

\textsuperscript{107} Id. at 140 ("[R]ecovery for a violation of § 409 insures to the benefit of the plan as whole. We find this contention supported by the text of § 409, by the statutory provisions defining the duties of a fiduciary, and by the provisions defining the rights of a beneficiary.").

\textsuperscript{108} Id. at 148.

\textsuperscript{109} Id. at 139 n.5 (citation omitted). The Court continued to use the term "extracontractual," which the lower courts had applied, to describe consequential and punitive damages. At least one commentator has pointed out the prejudicial effect of the word. See Langbein, \textit{supra} note 18, at 1346 ("[E]xtra,' meaning 'outside of' is a word that suggests a bonus, something to which one is not entitled. . . [T]he term 'extracontractual' is also a misemphasis in the setting of ERISA remedy law." (footnote omitted)).

\textsuperscript{110} \textit{Russell}, 473 U.S. at 155, (Brennan, J., concurring) (The concurrence criticized the Court's "constrictive judicial role in enforcing ERISA's remedial scheme ..." particularly with respect to section 502(a)(3).) Moreover, the concurrence criticized, "dicta in the Court's opinion [] that could be construed as sweeping more broadly than the narrow ground of resolution set forth above. \textit{Id.} at 150.

\textsuperscript{111} See Langbein, \textit{supra} note 18, at 1342.

Mertens v. Hewitt Associates

Former employees of Kaiser Steel, who participated in the Kaiser Steel Retirement Plan, brought action against the plan's actuary when the plan became insolvent. The district court dismissed the complaint and the Ninth Circuit Court of Appeals affirmed. The circuit court determined that the actuary was not a plan fiduciary and the petitioners did not challenge that holding. The Supreme Court granted certiorari on the question of "whether ERISA authorizes suits for money damages against nonfiduciaries who knowingly participate in a fiduciary's breach of fiduciary duty." Because 502(a)(2) applied to suits against fiduciaries, the petitioners relied on section 502(a)(3)'s "other appropriate equitable relief" provision. The Court commented in dicta that it was unclear whether the actuary had committed an actionable wrong. The Court, however, assumed, arguendo, that a wrong had been committed and addressed only what remedies were available under section 502(a)(3).

Justice Scalia, writing for the majority, defined "equitable relief" as relief that was traditionally available solely in courts of equity, prior to the fusion of courts of equity with courts of law. The Court went on to comment that these remedies included injunction, mandamus, and restitution, but not compensatory damages. While acknowledging that money damages were traditionally available in equity against third parties who knowingly participated in a trustee's breach, the Court determined that this definition was not what Congress meant by "appropriate equitable relief" under ERISA. Applying principles of statutory construction, the Court reasoned that Congress intended "equitable" to actually limit the type of "relief" available under

113. Id. at 250.
114. "[T]he Ninth Circuit affirmed in relevant part." Id. at 251 n.2.
115. Id. at 253.
116. Id. at 251.
117. Mertens 508 U.S. at 252-53.
118. See id. at 254-55. ("No [ERISA] provision explicitly requires [nonfiduciaries] to avoid participation (knowing or unknowing) in a fiduciary's breach of fiduciary duty." Id. at 254.)
119. See id. at 254-55.
120. Id. at 256-57 (footnote omitted).
121. Id. at 256.
122. Mertens 508 U.S. at 256.
123. See id. at 257-58.
124. See id. at 257-58. ("We will not read the statute to render the modifier superfluous." (citation omitted). Id. at 258.).
502(a)(3). It concluded, therefore, that "'[e]quitable' relief must mean something less than all relief." Based on the Court's previous interpretation of similar language contained in the Civil Rights Act of 1964, the Court held that neither compensatory nor punitive damages were available under § 502(a)(3).

**Great-West Life & Annuity Insurance Co. v. Knudson**

In 2002, the Court began the process of refining "those categories of relief that were typically available in equity." Janet Knudson was severely injured in an automobile accident in 1992 and was covered under health insurance provided by her husband's employer, Earth Systems, Inc. Earth Systems, in turn, was covered by a stop-loss insurance policy that it purchased from the defendant, Great-West Life & Annuity Insurance Co. (Great-West). The policy paid the first $75,000 in medical expenses at which time Great-West became obligated under its contract to pay any remaining expenses. Ms. Knudson's total medical costs exceeded $400,000.

The Knudsons first brought a tort action in state court against various parties alleged to be liable for Ms. Knudson's injuries. The parties negotiated and the state court approved a settlement, which allocated $13,828.70 to Great-West for its past medical expenses. Upon receiving a copy of the settlement agreement, Great-West filed suit in federal court "seeking injunctive and declaratory relief under § 502(a)(3) to enforce the reimbursement provision of the Plan by

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125. *Id.* at 257.
126. *Id.* at 258 & n.8.
127. *See Mertens* 508 U.S. at 255.
129. *Id.* at 207.
130. Graydon S. Staring, Law of Reinsurance, § 2:7, http://www.westlaw.com (subscription for database required) ("[S]top loss insurance deals with what we might call spectacularly unhappy coincidences that result in unusually heavy loss in a given year. These pay a high percentage of unusually high losses in a certain class of business and may be set up to operate either when the loss ratio of the reinsured reaches a certain level or when the reinsured's total retentions, after other reinsurances, reach a certain level").
131. *Id.*
132. *See id.*
133. *Id.*
134. Great-West, 534 U.S. at 207-208.
requiring the Knudsons to pay the Plan $411,157.11 . . . ."135 The district court granted the plaintiffs' motion for summary judgment, holding that the language of the policy limited it to recovery of $13,828.70 for past medical expenses.136 The Ninth Circuit Court of Appeals affirmed on other grounds.137

The Supreme Court turned to *Mertens* for the definition of "equitable relief."138 *Mertens* held that equitable relief in the context of section 502(a)(3) is relief that was typically available in common law equity.139 Great-West contended that the relief it sought was equitable because injunctive relief was typically available in equity.140 The Court scrutinized the underlying character of the relief sought and found it to be no more than a demand for payment of money owed because of a breeched legal duty.141 The Court found that "an injunction to compel the payment of money past due under a contract . . .[,] . . ." was not the type of relief typically available in equity.142

Great-West further asserted that it was merely seeking restitution, a form of equitable relief.143 The Court, however, distinguished equitable and legal restitution.144 Equitable restitution does not impose liability, rather it involves a claim that one party holds particular funds that, in good conscience, belong to another.145 Legal restitution, on the other hand, is a judgment that imposes a personal liability upon a

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135. *Id.* at 208.
136. *See id.* at 208-209.
137. *Id.* at 209. The Ninth Circuit "held that judicially decreed reimbursement for payments made to a beneficiary of an insurance plan by a third party is not equitable relief and is therefore not authorized by § 502(a)(3)." *Id.*
140. *Great-West*, 534 U.S. at 210-211.
141. *Id.* at 210.
142. *Id.* at 210-211. For a critique of the Court's analysis of "traditional equitable remedies," see Langbein, *supra* note 18. Professor Langbein notes that, "[t]here was no law of restitution before fusion [of law and equity], only quasi-contract and constructive trust." *Id.* at 1357. He goes on to say that "mandamus . . . never pertained to the courts of equity." *Id.*
143. *Great-West*, 534 U.S. at 212.
144. *Id.* at 212. "[R]estitution is a legal remedy when ordered in a case at law and an equitable remedy . . . when ordered in an equity case, and whether it is legal or equitable depends on the basis for [the plaintiff's] claim and the nature of the underlying remedies sought." *Id.* at 213. (quotations and citation omitted).
145. *See id.* at 214.
defendant as to pay a sum of money.\textsuperscript{146} Great-West was essentially asking the Court to compel the respondents to pay a sum of money that the Court described as "the classic form of legal relief."\textsuperscript{147}

The holdings in \textit{Russell}, \textit{Mertens}, and \textit{Great-West} were a blow to ERISA remedy law and invoked wide criticism. The Court, in the end, found that monetary consequential damages, a traditional trust law remedy, were not "typical" in courts of equity, raising the question of whether a plaintiff could ever obtain section 502(a)(3)'s grant of "other appropriate equitable relief."\textsuperscript{148}

\textbf{PART IV. ERISA REMEDIES IN THE CONTEXT OF MANAGED CARE}

The delivery of health care has changed dramatically since ERISA was enacted in 1973. While most ERISA plans were based on a fee for service model in the seventies, today most are managed care plans.\textsuperscript{149} Fee for service plans placed physicians and patients in the role of health care decision makers whereas insurers were merely a payer of care.\textsuperscript{150} Managed care plans (MCO) usually perform the functions of both payer and provider of health care, thus creating a new paradigm for the courts.\textsuperscript{151} The 1990s were marked with cases brought by beneficiaries claiming that they were injured by the negligent decisions of their health maintenance organizations. Negligence in the context of managed care raised a new set of issues under ERISA: Who is a fiduciary under ERISA? What duties does a fiduciary have in a MCO setting?

\textit{Pegram v. Herdrich}

In 2000, the Court considered the meaning of "fiduciary" in the context of an HMO.\textsuperscript{152} Cynthia Herdrich was covered by an HMO through her husband's employer.\textsuperscript{153} The HMO was operated as a for-

\begin{itemize}
\item\textsuperscript{146} \textit{Id.} at 213.
\item\textsuperscript{147} \textit{Id.} at 210 (citing \textit{Mertens}, 508 U.S. at 255 (emphasis in original)).
\item\textsuperscript{148} See \textit{Mertens}, 508 U.S. at 256-258.
\item\textsuperscript{149} For a brief discussion of fee for service models and HMOs, see \textit{Pegram}, 530 U.S. at 218-219 (2000).
\item\textsuperscript{150} See Russell Korobkin, \textit{The Failed Jurisprudence of Managed Care, and How to Fix It: Reinterpreting ERISA Preemption}, 51 \textit{UCLA L. REV.} 457, 462 (2003).
\item\textsuperscript{151} See id. \& n.14.
\item\textsuperscript{152} \textit{Pegram}, 530 U.S. at 218.
\item\textsuperscript{153} \textit{Id.} at 215.
\end{itemize}
profit business by physicians who were also the owners.\textsuperscript{154} Herdrich went to Dr. Pegram, the defendant and a physician-owner of the HMO, complaining of groin pain.\textsuperscript{155} Dr. Pegram found the painful area to be noticeably inflamed and ordered an ultrasound examination, to be performed at an HMO-staffed facility more than fifty miles away.\textsuperscript{156} Moreover, the facility was unable to perform the procedure for eight days.\textsuperscript{157} Nonetheless, the doctor did not find the plaintiff’s condition severe enough to merit ordering the ultrasound at a local hospital. Prior to the ultrasound, Herdrich’s appendix ruptured causing severe infection.\textsuperscript{158}

Herdrich sued Pegram and the HMO “in state court for medical malpractice [and] . . . state law fraud.”\textsuperscript{159} The HMO and Pegram removed the case to federal court where the court granted Herdrich leave to amend her complaint.\textsuperscript{160} In the amended complaint, Herdrich alleged that the HMO created an incentive for its physicians to limit care and that provision of medical care under the HMO’s incentive structure constituted “an inherent or anticipatory breach of an ERISA fiduciary duty . . . .”\textsuperscript{161} She based her claim on ERISA section 409 and asked that the HMO’s profits be returned to the plan.\textsuperscript{162} The district court granted defendant’s motion to dismiss and Herdrich appealed.\textsuperscript{163} The Court of Appeals for the Seventh Circuit reversed, holding that the HMO was acting as a fiduciary when it made the decision to delay the ultrasound exam.\textsuperscript{164}

The Supreme Court began by clarifying the meaning of “fiduciary” in the context of managed care.\textsuperscript{165} First, the Court explained that “[a] fiduciary within the meaning of ERISA must be someone acting in the

\begin{thebibliography}{99}
\bibitem{154} Id.
\bibitem{155} Id.
\bibitem{156} Id.
\bibitem{157} Id.
\bibitem{158} Pegram, 530 U.S. at 215.
\bibitem{159} Id. The medical malpractice suits were tried and Herdrich prevailed against the physician and the HMO. Id. at 217.
\bibitem{160} See id. at 215-16.
\bibitem{161} Id. at 216.
\bibitem{162} Id. at 217.
\bibitem{163} Pegram, 530 U.S. at 217.
\bibitem{164} Id. at 217-18. The Seventh Circuit noted that incentives can, but do not automatically, give rise to a breach of fiduciary duty. Here, the physician delayed care for the sole purpose of increasing the monetary bonus. See id.
\bibitem{165} Id.
\end{thebibliography}
capacity of manager, administrator, or financial adviser to a ‘plan[].’”\textsuperscript{166} While acting as a fiduciary, an individual must discharge his duties “solely in the interest of the participants and beneficiaries.”\textsuperscript{167} Herdrich argued that, as an employee of the HMO charged with making decisions about access to care, Pegram was a fiduciary. The Court found that Dr. Pegram, although a fiduciary, was only liable to the extent that she caused injury to Herdrich while “performing a fiduciary function.”\textsuperscript{168}

Next, the Court distinguished “eligibility” and “treatment” decisions.\textsuperscript{169} Eligibility decisions are based on whether the plan provides coverage for a particular condition whereas treatment decisions entail choices about how to diagnose or treat a condition.\textsuperscript{170} A physician’s decision to delay care, based on her best medical judgment, is a mixed treatment and eligibility decision.\textsuperscript{171}

The Court differentiated between traditional fiduciary decisions and the types of decisions physicians make in a for-profit HMO.\textsuperscript{172} Private trustees of medical or healthcare trusts, for example, do not make treatment judgments, while physicians make mixed eligibility and treatment decisions, by definition.\textsuperscript{173} Such is the case because private trustees make decisions about purchasing healthcare, whereas an ERISA fiduciary, who is also a physician-healthcare provider, may make treatment and payment decisions.\textsuperscript{174} Similarly, an ERISA fiduciary may have financial interests adverse to beneficiaries, whereas a common-law trustee in traditional trust law could not.\textsuperscript{175} Finally, the Court analyzed the impact of subjecting physician’s treatment and eligibility decisions to a traditional fiduciary standard.\textsuperscript{176} The Court seemed to be swayed by public policy concerns, noting that a finding in favor of Herdrich would subject the federal courts to greater case loads and put nonprofit as well as for-profit HMOs in jeopardy.\textsuperscript{177}

\begin{itemize}
\item \textsuperscript{166} Id. at 222.
\item \textsuperscript{167} Id. at 223. (citing 29 U.S.C § 1104(a)(1)).
\item \textsuperscript{168} Id. at 225-26.
\item \textsuperscript{169} Pegram, 530 U.S. at 228.
\item \textsuperscript{170} Id.
\item \textsuperscript{171} Id. at 229-30.
\item \textsuperscript{172} See id. at 231 -232.
\item \textsuperscript{173} Id. at 232.
\item \textsuperscript{174} Id. at 231 -232
\item \textsuperscript{175} Id. at 225. (“Under ERISA [] a fiduciary may have financial interests adverse to beneficiaries.”)
\item \textsuperscript{176} See Pegram, 530 U.S. at 236.
\item \textsuperscript{177} See id. at 233, 233 n.11, 235-36.
\end{itemize}
After Pegram, lower courts that applied its principles reached opposing conclusions. The Eleventh Circuit, Fifth Circuit, and Second Circuit classified HMO decisions as "mixed eligibility-treatment" decisions, not preempted by ERISA. The Third Circuit, however, found that a similar medical decision was completely preempted by ERISA. In 2004, the United States Supreme Court accepted Aetna v. Davila, the case that resolved these disputes between the circuit courts.

Aetna v. Davila

Juan Davila and Ruby Calad brought suit under the Texas Health Care Liability Act, which imposed a duty on HMOs to exercise ordinary care when making treatment decisions. Their respective HMOs had denied benefits for medication, in the case of Davila, and for in-patient hospitalization, in the case of Calad. In one of the lower court decisions that the Court consolidated for Davila, the Fifth Circuit concluded that the HMOs made mixed eligibility-treatment decisions, which, under Pegram, were not preempted by ERISA. The Supreme Court reversed, taking the view that HMO coverage decisions were pure eligibility decisions, and holding that a determination of benefits under ERISA is an ordinary fiduciary responsibility related to the administration of a plan. The fact that a

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180. See Cicio v. Does, 321 F.3d 83 (2nd Cir. 2003), vacated, Vytra Healthcare v. Cicio, 542 U.S. 933 (2004). (HMO's decision to deny preauthorization for a medical procedure recommended by the treating physician was a mixed eligibility-treatment decision.).

181. See DiFelice v. Aetna, 346 F.3d 442 (3rd Cir. 2003). (Plaintiff's claim that Aetna "interfered with" his medical treatment by declaring the special tube "medically unnecessary" is preempted by ERISA because it could have been brought as an action under section 502(a). See id. at 448.).

182. See Davila, 542 U.S. 200.

183. Id. at 205.

184. See id. at 204-205.


186. See Davila, 542 U.S. at 218-219.
benefits decision involves "medical judgments" does not by itself change the fiduciary nature of the act. 187

The Court distinguished Pegram, where the decision to delay treatment was made by a physician employed by the HMO and not an HMO administrator. Pegram applies only where the treating physician is also the person charged with administering benefits. 188 Here, the petitioners were "neither [the] treating physicians nor the employers of [the] treating physicians." 189

The unanimous Court, emphasized the fact that plaintiffs had the option of paying for the denied treatment. 190 Had they done so, they could have subsequently brought a claim for denied benefits under ERISA § 502(a)(1)(B). Reasoning from this point, the Court concluded that the plaintiffs' claims for damages were essentially section 501(a)(1)(B) claims and thus completely preempted by ERISA. 191

With Davila, the Court seems to be imposing a duty to mitigate on a party whose HMO denies or delays medically necessary care. While mitigation might have been possible for the Davila plaintiffs, due to the relatively low cost of the denied benefits, it would not be practical in many foreseeable cases. The Court's holding is troubling in two ways. First, it will result in a bifurcated standard of care. Patients that can afford to pay out of their own pockets for medically necessary care that has been denied will receive the care they need and then be reimbursed. Those who cannot afford this option will not receive needed care and will be damaged. Under Davila, this latter group of patients, arguably those who are the neediest will have no real remedy. Second, the mandate to HMO patients to pay out of their own funds and recoup the costs later creates an adverse incentive for HMOs. If the most that a patient can recover is the cost of the care, the HMO has nothing to lose in deciding to deny or delay care. 192

187. Id. at 219.
188. Id. at 221.
189. Id. at 221.
190. Id. at 211. ("It is clear, then, that respondents complain only about denials of coverage promised under the terms of ERISA-regulated employee benefit plans. Upon the denial of benefits, respondents could have paid for the treatment themselves and then sought reimbursement through a § 502(a)(1)(B) action, or sought a preliminary injunction . . . ." (citation omitted)).
191. Id. at 214.
192. DiFelice, 346 F.3d at 453-54 ("[E]xisting ERISA jurisprudence creates a monetary incentive for HMOs to mistreat those beneficiaries, who are often in the
PART V. ANALYSIS OF THE COURT’S HOLDINGS, DISCUSSION OF REMEDIES STILL AVAILABLE TO BENEFICIARIES

ERISA was enacted primarily for the benefit of employees. Over the years, it has evolved into more of an obstacle than an advantage to plaintiffs seeking redress for employee-benefit-plan-related injuries.

In Davila, Justice Ginsburg described the problem:

Because the Court has coupled an encompassing interpretation of ERISA’s preemptive force with a cramped construction of the “equitable relief” allowable under § 502(a)(3), a “regulatory vacuum” exists: “[V]irtually all state law remedies are preempted but very few federal substitutes are provided.”

Commentators have suggested that the effect of thirty years of judicial interpretation has so removed ERISA from what Congress intended that nothing short of congressional action will remedy the situation. Perhaps Congress will accept the challenge, but in the meantime plaintiffs must contend with the “state of ERISA” as it exists today. While many remedies are simply unavailable, plan participants and beneficiaries still have some options. This section explores the avenues that might still be open to beneficiaries damaged by a managed care organization’s denial of benefits.

A. Narrowing ERISA’s preemptive power

The Supreme Court has moved away from its original expansive reading of section 514’s “relate to” language and now considers a state law to relate only if it operates directly on the structure or administration of ERISA plans. Under this interpretation, more state statutory and common law claims remain in the control of state courts. A continuing trend in this direction would further the interests of plaintiffs by keeping them out of federal court where state claims are pre-empted.

193. See Mertens, 508 U.S. at 262-63 (citation omitted).
194. DiFelice, 346 F.3d at 453 (Becker, C.J. concurring) (“ERISA has evolved into a shield that insulates HMOs from liability for even the most egregious acts of dereliction committed against plan beneficiaries . . . .”).
195. Davila, 542 U.S. at 222, (Ginsburg, J., concurring) (citation omitted).
196. See DiFelice, 346 F.3d at 453 (Becker, C.J. concurring).
The "saving clause" of section 514 provides another means for states to retain jurisdiction over claims where a plaintiff alleges injuries resulting from a violation of a law that "regulates insurance." Although initially construed quite narrowly, the Court has recently invoked the saving clause to save state laws that require plans to cover a particular medical treatment or the services of a specified care provider.

An example of such a law is Kentucky's Any Willing Provider statute ("AWP"), which prevents health insurers from discriminating against any "provider . . . who is willing to meet the terms and conditions for participation established by the health insurer provider." Several HMOs filed suit against the Commissioner of Kentucky's Department of Insurance, claiming that ERISA preempted the AWP statute. The U. S. Supreme Court did not question whether the law related to ERISA regulated health plans. It

198. See supra Part I p. 8.
199. Prior to 2003, the Court applied factors from the McCarran-Ferguson Act to determine whether a state law regulated insurance. Miller, 538 U.S. at 339. The result was that few laws met the criteria to be saved from ERISA preemption. Id. (Our prior decisions construing § 1144(b)(2)(A) have relied, to varying degrees, on our cases interpreting §§ 2(a) and 2(b) of the McCarran-Ferguson Act. In determining whether certain practices constitute 'the business of insurance' under the McCarran-Ferguson Act (emphasis added), our cases have looked to three factors: 'first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.' Pireno, 458 U.S. at 129.).
200. Id. at 341-42
(Today we make a clean break from the McCarran-Ferguson factors and hold that for a state law to be deemed a "law . . . which regulates insurance" under § 1144(b)(2)(A), it must satisfy two requirements. First, the state law must be specifically directed toward entities engaged in insurance. . . . Second, as explained above, the state law must substantially affect the risk pooling arrangement between the insurer and the insured.)
201. KY. REV. STAT. ANN § 404.17A-270 (Lexis Nexis 2006) (A health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky state Medicaid program and Medicaid partnerships.)
203. The Court acknowledged the district court's determination that the AWP statute "related to" an ERISA regulated plan, but seemed to pass over that
assumed that the "relate to" requirement was met, then applied a two part test to determine whether the statute regulated insurance. The new test, which replaced the McCarran-Ferguson analysis, requires that in order to "regulate insurance" the law must be directed at entities engaged in insurance and must have a substantial affect on risk pooling. The Court found the AWP statute to be directed toward entities engaged in insurance (HMOs) and further found it to substantially affect the risk pooling arrangement.

The Court has found that a variety of state laws "regulate insurance" and consequently are saved from preemption. It could apply this reasoning to state statutes that impose a standard of care on HMO decisions and thereby save state law claims. Davila, however, suggests this is not likely to be a direction the Court will take. Davila virtually read the saving clause out of ERISA. While acknowledging that the Texas Health Care Liability Act was a law governing insurance, the Davila Court simply gave more weight to its prior interpretation of ERISA's civil enforcement scheme than it gave to the plain language of the savings clause.

B. Expanding ERISA's Remedial Scheme

By choosing the particular options for relief provided in its three subsections, Congress endowed section 502(a) with the structure and substance of traditional trust remedy law. Moreover, the legislative record demonstrates that Congress intended the courts to apply the remedial law of trusts to ERISA. In a statement before the House of Representatives introducing the Conference Committee Report, question. See id. at 333. Instead, the Court's analysis began with the issue of whether the law regulated insurance under § 1144(b)(2)(A). Id. at 334.

204. Id. at 342.

205. Id.

206. Id. at 335. (citing FMC Corp. v. Holliday, 498 U.S. 355 (2002) (A law that prevented health care insurers from subrogating against a beneficiary's tort recovery "regulated insurance"); Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002) (A law providing that where an HMO denied the medical necessity of a proposed plan of treatment, it had to obtain a concurring independent review in order to deny coverage)).

207. See Davila, 542 U.S. at 209.

208. See id.

209. Langbein, supra note 18 at 1331 ("[T]he drafters wanted to apply rules and remedies similar to those under traditional trust law to govern the conduct of fiduciaries." (quotation and footnote omitted)).

210. See Langbein, supra note 18, at 1331 n.7.
Congressman Al Ullman, chairman of the Ways and Means Committee, stated that "Title I of ERISA provides rules and remedies similar to those under traditional trust law to govern the conduct of fiduciaries." In the Senate, Senator Harrison A. Williams, Jr., Chair of the Senate Committee on Labor and Public Welfare, echoed similar sentiments concerning ERISA, explaining that the "objectives of these provisions are to make applicable the law of trusts . . . and to provide effective remedies for breaches of trust."

Commenting on evidence in the congressional record and the structure of 502(a), Professor John Langbein concludes that Congress intentionally constructed section 502(a) to embody principles of trust law. Trust remedies include the "make-whole standard of relief," namely the provision of direct and consequential damages necessary to make an injured party whole.

The connection between common law trust remedies and ERISA is apparent from the text of section 502(a). Trust law allows a beneficiary who has sustained losses as a result of the trustee's breach to sue for three types of damages. First, a beneficiary may be compensated for losses resulting from the breach. This corresponds to section 502(a)(1)'s authorization of recovery for "benefits due." Second, a trust beneficiary may recover any profits the trustee made from the breach. This correlates with section 502(a)(2) and section 409, which provide a remedy for losses to the health plan. Third, section 502(a)(3) entitles a beneficiary to compensation for foregone gains, that is, gains that would have accrued had it not been for the breach. Under trust law, a trustee who breaches his duty to manage and protect trust assets may be required to make monetary compensation to trust beneficiaries. Similarly, 502(a)(3)'s "other appropriate equitable relief" provision should provide a 'safety net' for injuries not otherwise compensable under 502(a).

211. Id at 1331 n.77 (citing 120 CONG. REC. 29,198, 29,200 (1974)).
212. Id. (citing 120 CONG. REC. 29,928-29,929, 29,932 (1974)).
213. Id. at 1364-66.
214. Id. at 1319.
215. Langbein, supra note 18, at 1333-38.
216. Id. at 1333.
217. Id. at 1334.
218. Id. at 1333.
219. See id. at 1334-35.
220. Id. at 1333.
221. Langbein, supra note 18, at 1336.
A cursory reading of the Court’s three opinions that interpret ERISA’s remedial scheme suggest that the possibility of money as a form of “other appropriate equitable relief” has been foreclosed. However, each of these cases had either unique facts or an unusual procedural history such that they cannot necessarily be extended beyond their narrow holdings. In *Russell*, the beneficiary relied on the wrong subsection of 502(a). Thus the Court’s holding, that a fiduciary’s breach does not entitle the injured beneficiary to consequential and punitive damages, applied only to section 409(a). The holding in *Mertens* applied only to nonfiduciaries. In *Mertens*, the Court held that ERISA § 502(a)(3) permits relief traditionally available in equity but does not permit recovery of money damages. *Great-Life* applied to a beneficiary whom the plan alleged was contractually obligated to reimburse the plan for monies paid out on her behalf, to the extent that she received money damages in settlement of her tort claims. The Court held that a party empowered to bring an action under 502(a)(3) “could [only] seek restitution in equity . . . .” None of these cases addressed section 502(a)(3) with respect to a fiduciary, thus the option of recovering money damages against a breaching fiduciary remains open. The United States, in its amicus brief in *Davila*, suggested this possibility:

223. Beneficiary brought action under section 502(a)(2) which relates to section 409(a) and is applicable only to compensation for damages to the plan. See *Russell*, 473 U.S. at 148. “This case presents a single, narrow question: whether the § 409 ‘appropriate relief’ referred to in § 502(a)(2) includes individual recovery by a participant or beneficiary of extra-contractual damages for breach of fiduciary duty.”. *Id.* at 149 (Brennan, J., concurring).

224. See id. at 148.
227. See *Great-West*, 534 U.S. at 208. See also supra Part III pp.21-23..
228. *Great-West*, 534 U.S. at 213. The Court described equitable restitution as, “ordinarily in the form of a constructive trust or an equitable lien, where money or property identified as belonging in good conscience to the plaintiff could clearly be traced to particular funds or property in the defendant’s possession.” *Id.*
229. See Sarah Beth Spisich, *The Aftermath of Davila: Are Healthcare Enrollees Now in a Sinking Ship Without a Paddle?*, 17 HEALTH LAWYER 22, 26 (2005). See also AM. BAR ASS’N, SECTION OF LABOR AND EMPLOYMENT LAW, EMPLOYEE BENEFITS LAW 946 (2d ed. 2000) (The Supreme Court has not addressed whether punitive damages are available to plan participants in actions under other subsections of Section 502, or in a Section 502(a)(2) action filed on behalf of the plan by beneficiaries, fiduciaries, or the
Recognizing that "this Court has construed Section 502(a)(3) not to authorize an award of money damages against a non-fiduciary," the Government suggests that [ERISA], as currently written and interpreted, may "allow" at least some forms of 'make-whole' relief against a breaching fiduciary in light of the general availability of such relief in equity at the time of the divided bench.\(^{220}\)

Unless, and until, the Supreme Court construes section 502(a)(3) otherwise, beneficiaries should encourage the federal courts to accept the Court's characterization of this section as a "catchall"\(^{231}\) and use it to develop a body of federal common law. Noting the structure of section 502(a), Justice Bryer observed: "This structure suggests that these 'catchall' provisions act as a safety net, offering appropriate equitable relief for injuries caused by violations that § 502 does not elsewhere adequately remedy."\(^{232}\)

**CONCLUSION**

Congress enacted ERISA out of concern for beneficiaries of employment related benefit plans. Over time, however, the Supreme Court limited the protective nature of ERISA often leaving damaged beneficiaries will little or no recourse. Nonetheless, the Court has not foreclosed all means of making plaintiffs who are injured by ERISA-regulated plans whole. Federal courts remain free to interpret the savings clause in a manner that limits ERISA's preemptive range. Additionally, the possibility of monetary damages for breach of fiduciary duties remains a viable remedial option.

Given Congress' intent to provide a remedy for beneficiaries of employment related benefit plans injured by acts or decisions of plan fiduciaries; its intent to model ERISA's civil enforcement scheme after trust law; given the underlying public policy considerations supporting an expanded reading of ERISA remedies and the possibility of money damages against fiduciaries in breach, federal courts should seize the opportunity to develop a federal common law of remedies consistent with these goals. Unless courts use the avenues still available to

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\(^{231}\) Id. at 512.
compensate those injured by ERISA regulated plans, plaintiffs will continue to look for creative ways to circumvent existing preemption law.