ERISA Preemption: A Product Rule and the Neglected Workhorse

Joseph Snoe*

INTRODUCTION

The Supreme Court often resolves Employment Retirement Income Security Act ("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.\(^2\) Each Supreme Court opinion offers more guidelines.

---

* Professor of Law, Cumberland School of Law, Samford University. This Article benefited from presentations to the Cumberland School of Law faculty and at the 30th Annual Health Law Teachers Conference.


2. 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 (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. Dillingham Constr., 519 U.S. at 334-336 (Scalia, J. concurring opinion, joined by Ginsburg, J.) (footnotes and some citations omitted).

In an earlier dissenting opinion, Justice Stevens wrote:

Given the open-ended implications of today's holding and the burgeoning
ERISA preemption is not a singular theory. In fact, the two main preemption clauses, the conflict preemption clause and the complete preemption clause 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. 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 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. The Supreme Court generally dismisses ERISA plan participants' and beneficiaries' claims against plan sponsors and fiduciaries under state law rather than pursuant to ERISA §

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. D.C. v. Greater Wash. Bd. of Trade, 506 U.S. 125, 135 (1992) (Stevens, J. dissenting opinion).

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." Davila, 542 U.S. at 222.

5 Id. See infra text accompanying notes 66-67 (discussing three categories of law ERISA preemption clause reaches).
6 Id.
8 Id.

---

2007 JOURNAL OF HEALTH & BIOMEDICAL LAW 219
502. Plaintiffs who file 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:

(a) Those protected by ERISA's Savings Clause;¹¹

(b) Those "too tenuous, remote or peripheral;"¹²

(c) Those of "general applicability;"¹³

(d) Those falling under an area of "traditional state regulation" like health care.¹⁴

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 make them subject to state law.

The Product Rule recognizes that state laws in the area of health care survive ERISA preemption as long as the 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, which must choose between using products and services permitted in the state or to perform them internally.

The following graphic illustrates the relationships in an ERISA employee welfare benefit plan providing health care benefits:

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,

---

15 See infra text accompanying notes 41-44.
16 Travelers, 514 U.S. at 655.
17 See infra text accompanying notes 84-103. 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.
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 directly mandate 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 ("HMOs"), even though these are the only products available to the plans; but a state could not require an ERISA plan to 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." 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.

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. This doubt no longer exists and 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,

---

21 See Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 372-373 (2002) (stating that right to independent medical review of denials of service by HMO based on HMO's determining the service is not 'medically necessary').
22 Id.
24 See infra, note 113.
pharmacies, nursing homes, ambulatory clinics, home health agencies, and other products and service providers.26 States actively regulate these products, services, and providers. States, for example, license facilities,27 control expansion of medical facilities and services through certificates of need,28 and regulate insurance.29 HMO,30 PPO,31 and utilization review organizations.32 An ERISA plan that purchases one of the regulated products or services incorporates the terms of the regulation into the plans, including the terms enforceable by participants and beneficiaries under ERISA § 502 (a)(1)(B).33

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 ERISA mainly to safeguard employees' pension plans.34 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

---

26 Preferred provider organizations ("PPOs") 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 ("IPAs") are organizations of providers 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. See U.S. DEPT. OF HEALTH AND HUMAN SERVS. (HHS), Managed Care Terminology, available at http://aspe.os.dhhs.gov/progsys/forum/mcobib.htm (last visited Nov. 30, 2007).

27 See, e.g., GA. CODE ANN.§ 31-7-3 (Michie 1996).
30 See, e.g., VA. CODE ANN. § 38.2-4300 et seq. (Michie 1996)
31 See, e.g., MASS. GEN. L. CH. 176I (Matthew Bender 2005).
32 See, e.g., N.Y. INS. LAW § 4900-16 (McKinney 1997).
33 29 U.S.C. § 1132(a)(1)(B) (West 1997) (providing participants and beneficiaries rights to bring civil actions to recover benefits due under terms of the plans). ERISA plan participant and beneficiary rights to bring a civil action to enforce these rights are discussed in part II infra.
shareholders, individual retirement accounts, distributions, plan termination insurance, and plan terminations. Very little of ERISA addresses welfare benefit plans specifically. Likewise, the legislative history adds little to the workings of the ERISA preemption clause.

The ERISA preemption clause 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. The Conflict Preemption Clause provides that ERISA “supersede[s] 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.” Although the clause never mentions the word ‘preemption,’ the legislative history specifically calls it the

38 Id.
39 Id.
40 Id.
preemption provision. The enacted Preemption Clause is broader than the initial versions proposed by the House and Senate, which preempted only state laws that 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 later, this rationale suits ERISA’s pension plan regulations, which dictate substantive provisions 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.

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.” 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, Senator 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

42 See H.R. 2, 93rd Cong., 1st Sess § 114 (1973) (A bill to revise the Welfare and Pension Plans Disclosure Act). Section 114 provided that the proposed bill would “supersede any and all laws of the States and of political subdivisions thereof insofar as they may now or hereafter relate to the fiduciary, reporting, and disclosure responsibilities of persons acting on behalf of employee benefit plans.”
44 See infra text accompanying notes 222-48
45 Statement of the Hon. Harrison A. Williams Jr., supra note 44.
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 93-95.46

Senator Williams's mention of prepaid legal plans apparently was not accidental. Bar associations were lobbying states to adopt rules of professional conduct that would have stifled the development of prepaid legal plans, or at least restrict them in ways the AFL-CIO disfavored.47

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"), encouraging the formation of health maintenance organizations.48 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.49

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.50 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

50 See Schaefer & Fox, supra note 47, at 51.
legislator, for example, consulted with members of the health care subcommittees.\textsuperscript{51} Similarly, major insurers and health care providers gave the preemption provision no thought at the time.\textsuperscript{52}

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.\textsuperscript{53} The Supreme Court latched onto the words ‘relate to’ as the touchstone to identify state laws that ERISA supersedes.\textsuperscript{54} Quoting Black’s Dictionary for the definition of ‘relate,’\textsuperscript{55} 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.”\textsuperscript{56} Citing legislative history,\textsuperscript{57} 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.\textsuperscript{58} Early on, the Court said ERISA even could preempt state laws that were not specifically designed to affect employee benefit plans.\textsuperscript{59} Under that approach, ERISA preempts all state laws that have a connection with an employee benefit plan, unless an exception applies, even if the state law is consistent with ERISA and even if it fills a gap in the ERISA scheme.\textsuperscript{60}

\textsuperscript{51} Id. at 52.
\textsuperscript{52} Id. at 51.
\textsuperscript{54} Id. at 97.
\textsuperscript{55} Id. at 97 n.16 (defining relate as “[t]o stand in some relation; to have bearing or concern; to pertain; refer; bring into association with or connection with.” (quoting BLACK’S LAW DICTIONARY 1158 (5th ed. 1979))).
\textsuperscript{56} Shaw, 463 U.S. at 96-97.
\textsuperscript{57} Id. at 98-99 & nn.18-20.
\textsuperscript{58} Id.
\textsuperscript{59} FMC Corp. v. Holliday, 498 U.S. 52, 58 (1990) (stating that “[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) (2006). “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. 29 U.S.C. § 1144(c)(2) (2006).
\textsuperscript{60} See Metro. Life Ins. Co. v. Mass., 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. Id. at 740-41. The Court upheld a California notice-prejudice law over the objection that the state law conflicted with ERISA’s substantive notice provision, 29 U.S.C. § 1133, concluding that, “[b]y 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.” See UNUM Life Ins. Co. v. Ward, 526 U.S. 358, 375, 377 (1999).
The Supreme Court subsequently retreated from the truly expansive application of "relate to." In Shaw v. Delta Air Lines, Inc.,61 for example, the Court noted that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan."62

The Court's current view is that while the Conflict Preemption Clause's literal language is "clearly expansive,"63 the clause should not extend to its furthest reach.64 Instead, the Court, gleaned insight from ERISA's congressional sponsors that they wished to "eliminat[e] the threat of conflicting and inconsistent State and local regulation,"65 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."66

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 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.67 State laws mandating that employee group health plans provide certain benefits, for example, relate to employee benefit plans in a very direct sense and are preempted.68

At the other extreme, the Supreme Court has concluded other categories of

---

62 Id. at 100 n.21.
64 Id. The Courts in both Travelers and De Buono quoted Henry James' novel, Roderick Hudson xli, in recognizing that "[i]f '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'really, universally, relations stop nowhere." See Travelers, 514 U.S. at 655 (quoting HENRY JAMES, RODERICK HUDSON 37 (New York ed., World's Classics 1980) (1875)); see also De Buono, 520 U.S. at 813 (quoting HENRY JAMES, RODERICK HUDSON 37 (New York ed., World's Classics 1980) (1875)); Scalia, supra note 2.
66 Travelers, 514 U.S. at 657.
68 See Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 100 (1983). 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. See Id. at 108.
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.69 In a pendulum swing from earlier cases, the Court in 1995 announced it will not find that ERISA preempts a state law unless the Court concludes Congress clearly and manifestly intended the state law be preempted.70 Courts quickly and consistently recognized and enforced state law malpractice actions against negligent providers.71 As another example, the Supreme Court concluded that 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.72 Hence ERISA does not preempt the fee surcharge.73 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.74

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.75 The most informative case in this area may be Mackey v. Lanier Collection Agency & Service, Inc.76 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 ...].77 The

69 De Buono, 520 U.S. at 815-16.
70 Travelers, 514 U.S. at 655.
72 Travelers, 514 U.S. at 659.
73 Id. at 662.
74 De Buono, 520 U.S. at 814-16; see also, Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., 519 U.S. 316, 334 (1997) (illustrating ERISA preemption case unrelated to health care benefits). In California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., the Court held that 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." Dillingham, 519 U.S. at 334.
75 See e.g., Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 140 (1990) (holding common-law exception to employment-at-will doctrine preempted because relies on ERISA plan).
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 owed to 23 of the plan participants. The Court held the garnishment law was a means to collect judgments under state substantive laws. The Court concluded that the garnishment law, a law of general applicability, was not one that relates to any employee benefit plan for purposes of ERISA 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 twenty-three 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

---

78 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. See id.  
79 Id.  
80 See Mackey, 436 U.S. at 827-29.  
81 Id. at 834 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.  
82 See Id. at 832.  
83 See Mackey, 436 U.S. at 841.  
84 See 29 U.S.C. § 1144(a) (2006). 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, including: use by the Secretary of Labor of services or facilities of a State agency as permitted under 29 U.S.C. § 1136; any generally applicable state criminal law; the Hawaii PrepaId Health Care Act as in effect on September 2, 1974; some laws applicable to Multiple Employer Welfare Arrangements (MEWA); qualified domestic relations orders and qualified medical child support orders; state’s rights under certain federal laws related to Medicaid. Id. at § 1144(a), (b)(1), (b)(3)-(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. See Id. at § 1141(a), (d). Section 1144(d) provides, “[n]othing 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 any such law.” Id. at 1144(d). In Rush Prudential HMO, Inc. v. Moran, the Supreme Court relied on § 1144(d) to uphold the state law. See Rush Prudential, 536 U.S. at 386-87;
statutory exception to conflict preemption is found in the Savings or Saving Clause, which shields all state laws that regulate insurance, banking, or securities.\textsuperscript{85} For group health insurance plans, the most important of these exceptions, 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: "nothing in this subchapter shall be construed to exempt or relieve any person from \textit{any law} of any State which regulates insurance, banking, or securities."\textsuperscript{86} 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."\textsuperscript{87} 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."\textsuperscript{88}

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.\textsuperscript{89} Neither the statute nor the legislative history discussions of the preemption provision define insurance.\textsuperscript{90} In the legislative history on fiduciary rules, however, the Senate-House conferees wrote, "[t]he conferees understand that some companies that provide, e.g., health insurance, are not technically considered as 'insurance companies.'"\textsuperscript{91} Furthermore, "[i]t is intended that these companies are to be included within the terms 'insurance service or insurance organization.'"\textsuperscript{92}

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

\textit{see also infra} text accompanying note 109.

\textsuperscript{85} "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. \textit{See infra} text accompanying note 118.


\textsuperscript{89} \textit{See} 29 U.S.C. § 1144(b) (2006); \textit{see also} H.R. REP. No. 93-533, tit. IV; H.R. CONF. REP. No. 93-1280, tit. XI.

\textsuperscript{90} \textit{See} H.R. REP. No. 93-533, tit. IV; \textit{see also} H.R. CONF. REP. No. 93-1280, tit. XI.

\textsuperscript{91} H.R. CONF. REP. No. 93-1280, tit. V.

\textsuperscript{92} \textit{Id.}
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, 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 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\(^9\) to define “insurance” for purposes of the ERISA Savings Clause.\(^10\) 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,\(^11\) and then four years later making a “clean break from the McCarran-Ferguson factors.”\(^12\) Under current Supreme Court guidelines, a state law regulates 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.\(^13\)

The Court to date has refused to impose any limitation on what constitutes insurance regulation under the Savings Clause.\(^14\) The Court, for example, in one case upheld a California notice-prejudice law under which an insurer remains liable on a policy even if the claimant files outside the time for filing claims unless the insurer is prejudiced by the delay.\(^15\) California’s notice-prejudice rule was akin to Mississippi’s bad faith claim rule preempted in Pilot Life Ins. Co. v. Dedeaux.\(^16\) The Court said that 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.”\(^17\) In Rush Prudential HMO, Inc. v. Moran,\(^18\) the Supreme Court held state HMO regulation fell under the auspices of insurance regulation and was not preempted.\(^19\) Specifically, the Court upheld section


\(^10\) See Metro. Life, 471 U.S. at 742-43.

\(^11\) W’ard, 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. Id. at 373-74. 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. Id. at 374-75.


\(^13\) Id.

\(^14\) See Metro. Life, 471 U.S. at 736.

\(^15\) W’ard, 526 U.S. at 364.

\(^16\) 481 U.S. 41 (1987); see infra text accompanying note 145-51.

\(^17\) Id. 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.

\(^18\) 536 U.S.355 (2002).

\(^19\) Id. at 372-73.
4–10 of the Illinois’s 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* observed that 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* – 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 whether the treatment is medically necessary – was not such a conflict with ERISA remedies to invoke the *Pilot Life* categorical preemption.

---

10 *Id.* at 361, 364.

11 *Id.* at 379.

12 See *Rush Prudential*, 536 U.S. at 377.

13 *Id.* at 380. Many ERISA preemption cases involve state regulation of HMOs, because many self-insured plans contract with HMOs to furnish health-care services to beneficiaries and participants. Until the Supreme Court released *Rush Prudential* 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. See *Id.* at 370-80.

On one side, a good argument, ultimately rejected by the Supreme Court, was fervently made that the HMO regulation related to employee benefit plans. See N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 663, 667-68 (1995). 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. See *Travelers*, 514 U.S. at 656-57 (1995) (*quoting* Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990)). Because 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 because HMOs are not insurance companies. *Rush Prudential*, 536 U.S. at 366. Insurance companies indemnify beneficiaries for services received, and bear risk associated with the indemnification obligation. See *Id.* at 371-73. 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. *Id.* at 372-73. The risk is the same any other business agreeing to provide services for a fixed price assumes. *Id.*

Finally, those in favor of a preemption of state laws regulating HMOs, argued that 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. See FMC Corp. v. Holliday, 498 U.S. 52, 63 (1990). 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. See Id.

On the other side, the ultimately prevailing argument contended that HMOs and other providers are not part of the employee benefit plans. See Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 366-67 (2002). An employer-sponsored plan details the internal workings of the plan and the benefits, procedures, financing mechanisms, and so on. See id. at 367. 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 or is a "general health-care regulation, which historically has been a matter of local concern." Travelers, 514 U.S. at 661 (concluding Congress did not choose to preempt); See De Buono v. NYSA-ILA Medical and Clinical Services Fund, 520 U.S. 806, 815 (1997) (finding tax on hospital operated by ERISA fund not preempted).

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. See Metro. Life Ins. Co. v. Mass., 471 U.S. 724, 733 (1985). 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. See Id.

State HMO regulation often specifies minimum benefits, financial reserve requirements, marketing restrictions, insolvency provisions, and licensing of agents. See e.g., VA. CODE ANN. § 38.2-4000 to -4022 (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 but not to enforce the same regulation of HMOs and other managed care organizations. See Metro. Life, 471 U.S. at 744.

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, sided with those arguing that ERISA does not preempt state regulation of HMOs. See Rush Prudential, 536 U.S. at 372-73. The Court concluded that HMOs are both health-care providers and insurers. Id. at 367. The Court indicated that HMOs' risk assumption is greater than that of a typical business or contract. See Id. HMOs actually underwrite and spread the actuarial risk among its members and participants, much like an insurance company. Id. The Court bolstered its conclusion by reviewing the Health Maintenance Act of 1973 (HMO Act), enacted one year prior to the Employee Retirement Income Security Act of 1974, in which Congress viewed HMOs as a novel form of insurers. Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (1973) (codified at 42 U.S.C. § 300e (1974)); Rush Prudential, 536 U.S. at 368-69. 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. Rush Prudential, 542 U.S. at 368. Since Congress enacted ERISA one year after it enacted the 1973 HMO Act, the Court gathered that Congress considered HMOs and other managed care entities to be insurers for purposes of ERISA's Savings Clause. Id.
The Court in *Rush Prudential*, moreover, did not “see anything standing in the way of applying the saving clause” to a contractor that provided only administrative services for a self-funded plan.\(^{114}\) 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.\(^{115}\) The *Rush Prudential* Court was further “convinced” it would find no “further limitations on insurance regulation” to deserve judicial recognition beyond those found in *Pilot Life* and *Ingersoll-Rand*.\(^ {116}\) 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.\(^ {117}\)

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.

**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,

“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, ...

The Court found more support for its ruling in the wording of commentators who considered HMOs to be insurers. *Id.* at 369-70. Finally, the state law at issue qualified as insurance regulation under the three McCarran-Ferguson factors. *Rush Prudential*, 536 U.S. at 373-75. For more on the McCarran- Ferguson factors, see supra note 101. The state law at issue in *Rush Prudential* authorized independent review of an HMO’s coverage denial if the HMO and the beneficiary’s physician disagreed whether the service was “medically necessary.” *Rush Prudential* 536 U.S. at 359-60.

**Footnotes**

\(^{114}\) *Rush Prudential*, 536 U.S. at 371.

\(^{115}\) See *Rush Prudential*, 536 U.S. at n.6 (stating that Illinois’ Act would not be “saved” as an insurance law to the extent it applied to self-funded plans, but fact did not bear on Rush’s challenge to law as one that is targeted toward non-risk-bearing organizations).

\(^{116}\) *Id.* at 381. See *infra* notes 130-134 and accompanying text for a discussion of *Pilot Life* and 307-310 and accompanying text for a discussion of *Ingersoll-Rand*.


\(^{118}\) 29 U.S.C. § 1144(b)(2)(B) (2000). Congress’s rationale for the Deemer Clause may not have
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. 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. State laws relating to self-insured plans cannot be saved as an insurance regulation, either. State laws that regulate insurance are still valid but the state laws cannot apply directly to self-funded employee benefit plans. On the other hand, wrote the Court, state insurance laws do apply to insurance companies. An ERISA plan that buys insurance coverage from an insurance company consequently is bound indirectly by the state insurance law. The Court acknowledged its decision "result[ed] in a distinction between insured and uninsured plans," but left to Congress the option of remediying 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

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 John R. Cornell & James J. Little, Indemnification of Fiduciary and Employee Litigation Costs Under ERISA, 25 B.C. L. Rev. 1 (1983). Whatever Congress' meaning, the 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.

121 Id. at 61.
122 Id.
123 Id.
124 Holliday, 498 U.S. at 61.
125 Id. at 63. The Supreme Court in Rush Prudential concluded HMOs are a form of insurance provider and thus states may regulate HMOs pursuant to the savings clause. 536 U.S. 355, 363-364 (2002).
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 HMOs

The health care product generating the most litigation in ERISA preemption cases has been the HMO. The Supreme Court in *Rush Prudential* concluded HMOs are insurance providers and thus states may regulate HMOs pursuant to the Savings Clause.126

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.127 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.128 The biggest downside on ERISA plans is that a state's laws regulating HMOs including mandating minimum benefits that must be offered could vary from state to state.129 This problem is the same conflict that plans that

126 536 U.S. at 372-73. See supra note 113.
128 See Humana Inc. v. Forsyth, 525 U.S. 299, 310 (1999) (using Shaw, 463 U.S. 85, to illustrate the standard). 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, impair or supersede” 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*, 525 U.S. at 310. (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. *Id.*
129 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
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.

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. 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. But a state could limit the type of insurance and HMO products marketed in the 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 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. 

130 Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 97 (1983) (stating that 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. Id. at 100. The state law in Shaw was not an insurance regulation. Id. 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 Metro. Life Ins. Co. v. Mass., 471 U.S. 724, 740-741 (1985). 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. Id.

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. \footnote{See Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 371-72 & n.6 (2002). The independent review requirement is not preempted and applies even to those non-risk-bearing organizations that provide only administrative services. \textit{Id. See also} Ky. Ass’n of Health Plans, Inc. v. Miller, 538 U.S. 329, 336 n.1 (2003) (noting non-insuring HMOs administering self-insured plans brought under Savings Clause).} 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 administrators. \footnote{See Rush Prudential, 536 U.S. at 371-72 & n.6 (independent review requirement not preempted; applies even to those non-risk-bearing organizations that provide only administrative services).} 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 a utilization review organization incorporates the state laws into the ERISA plans, and beneficiaries and participants can enforce these rights against the utilization review organization. \footnote{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.} Such laws as the Illinois independent medical review approved by the Supreme Court in \textit{Rush Prudential} would survive preemption if applied to utilization review organizations. \footnote{See infra Part II.}

II. THE WORKHORSE: CIVIL ENFORCEMENT UNDER ERISA § 502

A. ERISA § 502(a) as the Exclusive Vehicle for Enforcement Actions

The second part of the ERISA preemption puzzle, centered around the enigmatic \textit{Pilot Life}, is the so-called Complete Preemption Clause of ERISA § 502. \footnote{29 U.S.C.A. § 1132(a) (West 1997).} The label “complete preemption clause” is a misnomer, however. ERISA § 502 is titled “Civil Enforcement” and nowhere mentions or even alludes to preemption. In two 1987 companion cases, the Supreme Court crafted the two facets of the complete preemption clause. \footnote{Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987); Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58 (1987).}

\footnote{See Rush Prudential, 536 U.S. 355, 371-72 & n.6 (2002). The independent review requirement is not preempted and applies even to those non-risk-bearing organizations that provide only administrative services. \textit{Id. See also} Ky. Ass’n of Health Plans, Inc. v. Miller, 538 U.S. 329, 336 n.1 (2003) (noting non-insuring HMOs administering self-insured plans brought under Savings Clause).}
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 that 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.\(^{138}\) Relying on ERISA's legislative history referring to § 301 of the Labor-Management Relations Act of 1947 ("LMRA"), the Court reasoned that 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."\(^{139}\) Therefore, concluded the Court, Congress intended for all suits brought by ERISA participants and beneficiaries asserting improper processing of claims under ERISA-regulated plans be treated as federal questions under ERISA § 502(a).\(^{140}\)

The Court has limited the reach of the complete preemption clause but steadfastly retains § 502(a) as ERISA's exclusive enforcement vehicle.\(^{141}\) In *UNUM Life*, the Court approved a California Supreme Court decisional rule known as the notice-prejudice rule.\(^{142}\) By decision in previous cases, the California Supreme Court 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.\(^{143}\) The United States Supreme Court determined that California's notice-prejudice rule was saved as an insurance regulation.\(^{144}\)

The defendant insurance company based two separate arguments on *Pilot Life*.\(^{145}\) 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*.\(^{146}\) The Supreme Court rejected the 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

\(^{138}\) *Pilot Life*, 481 U.S. at 52.

\(^{139}\) Id. at 55.

\(^{140}\) Id. at 56.


\(^{142}\) Id. at 377.

\(^{143}\) Id. at 366-67.

\(^{144}\) Id. at 373.

\(^{145}\) See *Ward*, 526 U.S. at 368-369.

\(^{146}\) Id. at 368-69.

\(^{147}\) Id. at 369-71 (noting that while Mississippi uses a "bad faith" standard for relief for contract or tort claims, "the law abhors a forfeiture" in California, and holding that "failure to abide by a contractual time condition does not work a forfeiture absent prejudice").
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 observed that 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).

The insurer next argued ERISA § 502's civil enforcement provision preempts any action for plan benefits under state law. The Court rebuffed the argument as irrelevant here since the plaintiff brought his action under ERISA § 502. 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). Next came Rush Prudential, in which the Supreme Court held that Illinois's statutory law that an HMO's treatment decision may be subject to independent medical review was saved as an insurance regulation. 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. The Court rejected that argument. The Mississippi state law in Pilot Life, wrote the Court,

148 Id. at 371.
149 See Ward, 526 U.S. at 371.
150 Id.
151 Id. at 370 n.3.
152 Id. at 376.
153 See Ward, 526 U.S. at 377.
154 Id. at 371.
155 Id. at 377.
156 536 U.S. 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. See supra text accompanying note 126.
158 Id. at 378.
“provided a form of ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA.” 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.” 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.

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

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

---

159 Id. at 379.
160 Id.
161 Rush Prudential, 536 U.S. at 380.
162 Id. at 381.
163 Id. at 381 n.11
164 Id.
165 Rush Prudential, 536 U.S. at 380.
166 Id. at 385-86.
167 Id.
168 Id. at 386.
169 Rush Prudential, 536 U.S. at 386.
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 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. To the contrary, 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 into 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 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." 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

---

171 Id.
172 Id. at 217-218.
173 See id. at 217.
174 See infra text accompanying notes 201-03.
176 ERISA § 502(a) authorizes three actions by participants and beneficiaries not developed in the text. See 29 U.S.C.A. § 1132(a), (c). They may sue for information and a $100 a day penalty. Id. at § 1132(a)(1)(A), (c). They may also sue for appropriate relief under § 1025(c) for failing to disclose tax registration statements. Id. at § 1132(a)(4). Finally, they may sue to enforce certain rights in connection with the termination of an individual’s status as participant covered under a pension plan. § 1132(a)(9).
or product. 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. 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, ERISA does not preempt a state's requirement that 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 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

178 See discussion supra Part I.
179 See discussion supra Part I.C.
180 See discussion supra Part I.D.
plaintiffs in *Rush Prudential* and *UNUM* were ERISA plan participants or beneficiaries, for example.185

As discussed more fully below, the Supreme Court interprets ERISA § 502(a)(2) and § 502(a)(3) as not allowing a plan participant or beneficiary to collect monetary damages.186 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.187 Those benefits and rights can be monetary or non-monetary. 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.188

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*, but the plan beneficiaries at the Supreme Court shunned any argument based on ERISA § 502, 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.189 The Supreme Court easily concluded plaintiffs’ actions were to rectify a denial of benefits promised in an ERISA plan.190 That conclusion reached, the plaintiffs must fit their claims under ERISA § 502. Since the plaintiffs did not seek a remedy under ERISA, the *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).191 In *Pilot Life*, the plaintiff brought state

---

185 See Id. at 359; see also *UNUM Life*, 526 U.S. at 365.
186 See infra text accompanying notes 221-36.
189 *Aetna Health Inc. v. Davila*, 542 U.S. 200, 212 (2004). The plaintiffs also argued the benefit due them under the ERISA plan was not health care services but simply membership in an HMO. Id. at n.2. The Court deemed the issue waived for purposes of the appeal and refused to address it. Id.
190 Id. at 214.
common-law tort and 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 to be removable to federal court. Since the plaintiff's case bottomed on general common-law principles that were not saved as insurance regulation, the Court found ERISA preempted the plaintiff's common-law claim for two reasons. First, ERISA § 510 provided a remedy for wrongful termination such that conflict preemption negated the state common-law. Second, ERISA plan participant's causes of action and remedies are limited to those listed in ERISA § 502.

ERISA plan plaintiffs must heed the Supreme Court's counsel: to prevail in actions involving state-mandated rights, remedies and benefits, ERISA plan beneficiaries and participants 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."

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 sponsor contracts with an HMO or an utilization review organization providing that the HMO or utilization review entity would be liable for


192 Pilot Life, 481 U.S. at 48.
193 Id. at 52.
194 Id. at 50.
195 Taylor, 481 U.S. at 61.
196 Id. at 64-65.
197 Id. at 66.
198 Id. at 62.
200 Taylor, 481 U.S. at 62-63.
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.202

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.203

As an illustration, an HMO cannot operate in the Commonwealth of Virginia without a license204 and the state may suspend or revoke a license if an HMO fails to comply with the state regulations.205 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.206 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.207

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

204 VA CODE ANN. § 38.2-4300 et seq. (Michie 1996).
205 Id. § 38.2-4316.
206 Id. § 38.2-4300, § 38.2-4316.
207 Id. § 38.2-4311B.
provisions. The provisions survive ERISA preemption under the Savings Clause. An ERISA plan sponsor contracting with an HMO for services at a minimum gets these services, plus others if desired. An ERISA plan 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 perceives a need to regulate insurers and HMOs more than other states do, ERISA will not preempt states from doing so, and ERISA plan participants and beneficiaries benefit from the state action. On the other hand, if a state chooses not to alter the 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 insured and health care providers a copy of its written policies and procedures that govern all aspects of the utilization review process.

---

208 See supra text accompanying notes 99-117.

209 The HMO contract is not the ERISA plan, but the contracts 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.


211 See, e.g., ALA. CODE § 27-21A-23(d) (Michie 1996); see also N.J. STAT. ANN. § 2J-25(d) (West 1996): "(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."


213 See 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.

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. The plan participants and beneficiaries can enforce these rights pursuant to ERISA § 502(a)(1)(B). If the state legislators added provisions mandating independent medical review of adverse determinations 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). 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.

Assuming the utilization review organization contracting with an ERISA plan becomes an ERISA fiduciary, questions arise as to the right of participants and

214 Id. § 4902(a).
215 Id. § 4902(a)(7), (8).
216 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, the exception for ERISA plans itself is preempted since it singles out employee welfare benefit plans for special treatment. 486 U.S. at 825.
217 Cf. Rush Prudential, 536 U.S. at 361 (describing an Illinois statute which required HMOs to provide an independent physician review in the event of a dispute).
218 N.Y. Ins. Law. § 4902(a)(7), (8) (McKinney 1997).
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 § 502.219

C. Statutory Relief Against Fiduciaries Under ERISA § 502(a)(2)

ERISA § 502(a)(2) empowers an ERISA plan participant, beneficiary, fiduciary or the Secretary of Labor to bring a civil action for appropriate relief under ERISA § 409.220 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 plan resulting from each breach of any responsibility, obligation or duty imposed by ERISA.221 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.”222

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.223 The Supreme Court delineated the contours of ERISA § 409 in Massachusetts Life Insurance Company v. Russell.224 The plaintiff in 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.225 She brought suit against the fiduciary for extra-contractual damages and for punitive damages.226

219 The special issue of HMO fiduciary liability under ERISA and its interrelationship with ERISA preemption is developed in more detail infra in Part III.
221 Id. § 1109(a).
222 Id.
223 See Russell, 473 U.S. at 144 (holding that § 409 does not provide express authority for an award of extracontractual damages to a beneficiary).
224 Id.
225 Russell, 473 U.S. at 136. In May 1979, “Russell became disabled with a back ailment and received plan benefits until October 17 of that year when, based on the report of an orthopedic surgeon,” her benefits were terminated. Id. Russell “requested internal review of that decision and submitted a report from her own psychiatrist indicating that she suffered from a psychosomatic disability with physical manifestations rather than an orthopedic illness.” Id. “After an examination by a second psychiatrist confirmed that Russell was temporarily disabled, her benefits were reinstated and paid in full.” Id.
226 Russell, 473 U.S. at 136-37 (asserting “that the fiduciaries administering petitioner's employee benefit plans are high-ranking company officials who (1) ignored readily available medical evidence documenting respondent's disability, (2) applied unwarrantedly strict eligibility
The Supreme Court ruled against the plaintiff. First, wrote the Court, ERISA § 409(a) imposes a liability on a fiduciary to an ERISA plan to “make . . . good to such plan” and not to individual beneficiaries or participants. The Court relied on legislative history to conclude § 409 was geared to the protection of the plan’s financial assets and not to grant remedies to individuals. The statute and legislative history emphasized § 409’s protection of contractually defined benefits and not extra-contractual damages. A concurring opinion agreed that 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. The concurring justices felt the more appropriate provision for individual relief might be ERISA § 502(a)(3), 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 and 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.

standards, and (3) deliberately took 132 days to process her claim, in violation of regulations promulgated by the Secretary of Labor.”).

227 Russell, 473 U.S. at 148 (holding “the relevant text of ERISA, the structure of the entire statute, and its legislative history all support the conclusion that in § 409(a) Congress did not provide, and did not intend the judiciary to imply, a cause of action for extra-contractual damages caused by improper or untimely processing of benefit claims.”).

228 Id. at 139.

229 Id. at 145-46 (describing how an “early version of the statute contained a provision for ‘legal or equitable’ relief that was described in both the Senate and House Committee Reports as authorizing ‘the full range of legal and equitable remedies available in both state and federal courts.’ “In the bill passed by the House of Representatives and ultimately adopted by the Conference Committee,” however, the “reference to legal relief was deleted.”) Id.

230 Id. at 148.

231 Russell, 473 U.S. at 150 (concurring).

232 Id. (noting that “since § 502(a)(3) already provides participants and beneficiaries with ‘other appropriate equitable relief ... to redress [ERISA] violations,’ there is no reason to construe § 409 expansively in order to bring these individuals under the penumbra of ‘equitable or remedial relief.’”).
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.233 Despite the 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.234

Even limited to equitable remedies, however, ERISA § 502(a)(3) has been the basis of some relief. In Varity Corporation v. Howe,235 for example, the Court found ERISA § 502(a)(3) authorized individual relief and not just relief for the plan itself.236 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 bankruptcy.237 The former employees sought and were granted an order re-instating them into the parent company’s medical plan.238

Plan participants and beneficiaries were granted equitable relief once more in Inter-Modal Rail Employees Association v. Railway Company,239 another case where an employer attempted to shuffle employees to another corporation to save money on ERISA plan benefits.240 This time the employee contracted with an unrelated company.241 The employer gave its employees the option of working for the third-party

234 Russell, 473 U.S. at 148. But see Mertens v. Hewitt Associates, 508 U.S. 248, 257 (1993) (holding “since all relief available for breach of trust could be obtained from a court of equity, limiting the sort of relief obtainable under § 502(a)(3) to ‘equitable relief’ in the sense of ‘whatever relief a common-law court of equity could provide in such a case’ would limit the relief not at all”).
236 Id. at 507 (holding that “Congress did provide remedies for individual beneficiaries harmed by breaches of fiduciary duty”).
237 Id. at 493-94.
238 Id. at 495.
240 Id. at 510.
241 Id. at 512.
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 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; these rights and benefits are 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 commentators. Someday the Court may reconsider the issue and interpret

242 Id.
243 Inter-Modal, 520 U.S. 510, 512-513.
244 Id. at 513 ("alleging that respondents had violated § 510 of ERISA by ‘discharg[ing]’ petitioners ‘for the purpose of interfering with the attainment of ... right[s] to which’ they would have ‘become entitled’ under the ERISA pension and welfare plans adopted pursuant to the SFTS-Teamsters collective bargaining agreement."). See 29 U.S.C.A. § 1140.
245 473 U.S. at 150-51 (concurring opinion).
246 508 U.S. at 263-74 (dissenting opinion).
247 See Aetna Health Inc. v. Davila, 542 U.S. 200, 222-23 (2004) (concurring opinion); See, e.g., John H. Langbein, If ERISA Means "Equitable": The Supreme Court’s Trail of Error in Russell,
ERISA § 502(a)(3) to develop federal remedies based on traditional trust concepts to permit individual actions for monetary damages.\(^\text{248}\) 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.\(^\text{249}\)

A. The Davila Holding Under § 514 and § 502

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.\(^\text{250}\) 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.\(^\text{251}\) Only the insurance company, HMO, or other managed care entity is liable, not the employer or union that sponsored a group health plan.\(^\text{252}\) “Ordinary care” is the care exercised by an entity or person of “ordinary prudence under the same or similar circumstances.”\(^\text{253}\) “Health care treatment decision” is any determination that “affect[s] the quality of the diagnosis, care or treatment provided.”\(^\text{254}\)

In one of the consolidated cases, a treating physician prescribed medication to

\(^{248}\) See Langbein, 103 COLUM. L. REV. at 1338.


\(^{250}\) TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-88.003 (Vernon 2005); See Davila, 542 U.S. at 204.

\(^{251}\) Id.

\(^{252}\) Id. at § 88.0002(e) (Vernon 2005).

\(^{253}\) Id. at § 88.001(10).

\(^{254}\) Id. at § 88.001(5).
treat Juan Davila, a participant in an ERISA plan, for his arthritis pain. Davila’s employer entered into an 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.

In the second case, a surgeon affiliated with CIGNA, an HMO, performed a hysterectomy with rectal, bladder and vaginal repair on Ruby Calad. Calad was enrolled with CIGNA as a beneficiary under an employer-sponsored group health plan. 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. Calad attributed complications that required she be rushed to the hospital to the HMO’s failure to exercise ordinary care in its coverage decision.

---

256 542 U.S. at 204. “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. See Davila, 542 U.S. at 206. It appears the HMO kept the records and made decisions for its own account, not the ERISA plan; see Roark, 307 F. 3d at 303.
257 Roark, 307 F.3d at 303 (documenting that Davila’s primary care physician prescribed Vioxx for arthritis pain). “Studies have shown that Vioxx has a lower rate of gastrointestinal toxicity (e.g., bleeding, ulceration, perforation of the stomach) than do the other drugs on Aetna’s formulary.” Id. Under Aetna’s “step program,” Davila would first have to try two lower cost medications, and Aetna would only approve the use of Vioxx if Davila “suffered a detrimental reaction to the medications or failed to improve.” Id.
258 Roark, 307 F.3d at 303.
259 Id.
260 TEX. CIV. PRAC. & REM. CODE ANN. § 88.0002 (Vernon 2005); Davila, 542 U.S. at 204.
261 Davila, 542 U.S. at 204.
262 Roark, 307 F.3d at 302.
263 Davila, 542 U.S. at 204.
264 Id.; Roark, 307 F.3d at 302.
hospital emergency room a few days later to CIGNA's discharging her prematurely.\textsuperscript{265} 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{266} The Supreme Court characterized Calad's claims as claims she was denied benefits under an ERISA plan.\textsuperscript{267}

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.\textsuperscript{268} 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 \textit{Daila} that ERISA preempted the Texas Health Care Liability Act as applied to HMOs in general.

The broad issue in \textit{Daila} 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.\textsuperscript{269} 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.\textsuperscript{270} An exception applies when a federal statute completely preempts the state cause of action.\textsuperscript{271} The Supreme Court reasoned that ERISA § 502(a) is a provision of such "extraordinary pre-emptive power" that "it converts an ordinary state common-law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule."\textsuperscript{272} This has been the consistently-applied rule for ERISA cases since 1989.\textsuperscript{273}

\textsuperscript{265} \textit{Roark}, 307 F.3d at 302.
\textsuperscript{266} \textit{Id}.
\textsuperscript{267} 542 U.S. at 211, 214.
\textsuperscript{268} See supra text accompanying note 11.
\textsuperscript{269} \textit{Daila}, 542 U.S. at 204.
\textsuperscript{270} \textit{Id}. at 207.
\textsuperscript{271} \textit{Id}.
\textsuperscript{273} See \textit{Taylor}, 481 U.S. at 65-66. See also supra text accompanying note 269.
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.\(^{274}\) 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.\(^{275}\) 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.\(^{276}\) 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).\(^{277}\) 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.

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.\(^{278}\) 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.\(^{279}\)

The plaintiffs’ theory may have some merit in that the Texas law imposed an obligation on the HMOs 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.\(^{280}\) 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 that ERISA § 502(a) is the exclusive vehicle to bring a suit regarding benefit determinations, so much so that a state court case can be removed to federal court since ERISA § 502(a) completely preempts all state actions for ERISA plan benefits.\(^{281}\) Thus, the Davila cases

\(^{274}\) Davila, 542 U.S. at 210.
\(^{275}\) See supra text accompanying notes 61-70. Some state laws that regulate rights between ERISA plan members and outside parties also have escaped ERISA preemption. Id.
\(^{277}\) 29 U.S.C.A. § 1132(a).
\(^{278}\) Davila, 542 U.S. at 212.
\(^{279}\) Id.
\(^{281}\) Davila, 542 U.S. at 211-14.
were removed properly to federal courts. 282 More critically for ERISA preemption purposes, since the plaintiffs refused to amend their complaints to bring an action under ERISA § 502(a), 283 the district court had no choice but to dismiss their complaints with prejudice. 284

The 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. 285

B. The Davila Concurring Opinion and § 502(a)(3)

The concurring justices, while agreeing that plaintiffs must present their claims under ERISA § 502(a), 286 encouraged future plaintiffs to heed a Government suggestion that § 502(a)(3) may be a viable vehicle for “make-whole standard of relief.” 287 The concurring opinion also stated that “fresh consideration of the availability of consequential damages under § 502(a)(3) is in order.” 288 The reconsideration would be of Mertens v. Hewitt Associates, 289 which limited ERISA § 502(a)(3) to the narrowest

282 Id. at 214.
283 Id. at 205, n.7 (majority opinion); id. at 223-24 (concurring opinion).
284 Id. at 205, n.7.
285 29 U.S.C.A. § 502(a)(1)(B) (West 1997). The Davila majority in dicta indicates that the Davila plaintiffs could have paid for the treatments and sought reimbursement through a § 502(a)(1)(B) action or sought a preliminary injunction. Davila, 542 at 211-212; see also Pryzbowski v. U.S. Healthcare, Inc., 245 F.3d 266, 274 (3rd Cir. 2001) (providing instances where federal courts issued this type of injunctions). That is not an option for plan participants and beneficiaries who trust the decision maker’s judgment or at least give their HMO or utilization review organization the benefit of the doubt. As discussed in the 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.
286 542 U.S. at 223-24.
287 Davila, 542 U.S. at 222.
288 Id.
289 508 U.S. 248.
possible interpretation of 'equitable relief.'

Even if the Supreme Court revisits *Mertens* and more broadly interprets 'equitable relief,' 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 remedy. While a court may grant the same relief sought under a state statute, the relief would be a federal law remedy. 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.

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 theory of the Court of Appeals 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, said labels do not control ERISA's reach. An ERISA plan beneficiary or participant must bring civil actions for benefit denials pursuant to ERISA § 502(a).

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.

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 plaintiffs in all three cases "brought state claims that were labeled either tort or tort-like." The Court also informed that the plaintiffs in all "three cases

---

290 See *Mertens*, 508 U.S. at 248.
291 See supra text accompanying notes 246-47.
292 *Davila*, 542 U.S. at 214.
293 *Id.*
294 *Id.* at 214-15.
295 *Id.*
296 *Davila*, 542 U.S. at 215.
297 *Id.*
sought remedies beyond those authorized under ERISA.” ERISA preempted the state-law based actions in all three cases. 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.

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. The state laws in Pilot Life and Metropolitan Life were judicially created rules not aimed 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, 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,” and thus was saved from preemption under the Savings Clause. The Mississippi law in Pilot Life, in contrast, was not specifically directed to the insurance industry and therefore not saved from ERISA preemption. 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. The notice-prejudice rule in UNUM was.

---

298 Id.
299 Id.
300 Davila, 542 U.S. at 215.
301 Id.
302 526 U.S. 358.
304 Id. at 375.
305 Id. at 377.
307 Ward, 526 U.S. at 369.
308 Id.
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 the common-law employment-at-will doctrine if an employee discharged an employee to prevent the employee's pension benefits from vesting.\textsuperscript{309} The Supreme Court in 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{310} Moreover, concluded the Court in 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{311}

Under the Product Rule discussed in Part I of this article,\textsuperscript{312} 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 Ingersoll-Rand for attempting to regulate the relationships between parties in an ERISA plan. Neither rationale for ERISA preemption in 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 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

\textsuperscript{310} Id. at 139-40.
\textsuperscript{311} Id. at 142-43.
\textsuperscript{312} See supra the Product Rule discussion in Part I.
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 decision making 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.  

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 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 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

---

313 See supra the Product Rule discussion in Part I.
315 Aetna Health Inc. v. Davila, 542 U.S. 200, 205 n.7.
316 Id. at 216.
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 Clause 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 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.

317 See supra text accompanying notes 126-31.
319 Id.
320 Id.
321 See supra text accompanying notes 175-221.
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.