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Will the Supreme Court Finally Eliminate ERISA Preemption?

David L. Trueman, J.D., Ph.D.

The ability to hold a managed care entity responsible for its actions, particularly for the decisions it makes in the utilization review process, has historically been hampered by preemption provisions of the Employee Retirement Income Security Act of 1974 (ERISA). Over the past year and a half, a number of federal courts have decided that ERISA does not preempt allegations that a managed care entity failed to approve the care a patient’s doctor recommended thereby resulting in injury or death. Conflict among the federal circuits regarding this doctrine has recently arisen and the United States Supreme Court granted certiorari to two cases from Texas to clarify ERISA preemption. However, because the cases the Court chose do not address both of the major aspects of ERISA preemption, it is unclear whether the Court will finally put to rest questions regarding the applicability of ERISA to state law tort claims in relation to utilization review determinations.

The issue of preemption is dramatic, often involving life-and-death cases and addressing the question of who has control over medical decision-making. Patients claim that health insurance companies intrude into the sphere of the physician-patient relationship and mandate medical care, which is often contrary to what the treating doctor has recommended. As a result, injured patients or their families file claims in state court for negligence and medical malpractice against the health insurance companies. Health insurance companies insist that Congress provided protection for the managed care enterprise by making ERISA the exclusive remedy for plan beneficiaries, only allowing for contract-like benefit claims and not for personal injury and wrongful death tort suits. Recent decisions, including a seminal Supreme Court decision, have cast doubt on ERISA preemption and what has served for almost two decades as an insulation from liability for managed care organizations. Now, finally, the Supreme Court may decide the issue.

This article will examine the Supreme Court case that articulated a new ERISA jurisprudence and formed the basis for courts to alter their preemption analysis. Next, cases will be presented which have considered
this issue, and the author will speculate on how the Court will rule on the cases under its review. Finally, there will be a consideration of which state law claims may be viable and the available defenses should the Supreme Court limit or eliminate preemption.

I. THE IMPACT OF ERISA ON CLAIMS AGAINST MANAGED CARE ORGANIZATIONS

A. ERISA: Basic Principles

The Employee Retirement Income Security Act is a comprehensive statute originally enacted in 1974 to protect beneficiaries' pension plans; however, Congress included welfare benefit plans under ERISA and thus it applies to health benefits plans. Two ERISA provisions are relevant for claims against health care plans. First, section 502(a) of the Act applies to benefit determinations and provides federal courts with complete jurisdiction over any claim regarding a failure to provide benefits, regardless of how it is pled.¹ This provision has historically been determined as indicating that any state law tort claim alleging wrongful denial of care due to a managed care organization's utilization review determinations falls under federal jurisdiction. Once in federal court, section 514 has traditionally provided a defense against claims by plaintiffs resulting in dismissal of their actions.²

B. ERISA Section 502(a)

1. Claims for Wrongful Denials of Benefits

Section 502(a) provides the exclusive remedy for beneficiaries seeking relief pertaining to the provision of benefits.³ Under section 502(a)(1)(B), a civil action may be brought by a participant or beneficiary to recover benefits due to him under the terms of this plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.⁴

Section 502 limits the relief available to plan participants to obtaining their benefits by either enjoining the Health Maintenance Organization

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(HMO) from continuing a violative practice or obtaining an equitable remedy. This section precludes punitive damages, as well as “make whole” damages for injuries resulting from denied treatment. For example, if an HMO refuses to pay for a needed test, the damages will likely be limited to the cost of the test. Thus, if a company refuses to pay for treatment which a patient’s doctor recommends, and even if the denial was egregious and the patient died, the decedent’s estate or family would receive nothing. Due to what has been determined as ERISA’s “complete preemption” of all claims for health care benefits, the fact that a plaintiff will have no remedy does not affect ERISA supersession of state law.

2. The Well Pledged Complaint Rule and Complete Preemption

The “well pleaded complaint rule,” as stated by the Supreme Court, provides that a civil action falls within federal jurisdiction only when a federal question, “arising under” federal law, appears on the face of the plaintiff’s properly pleaded complaint. A defendant cannot convert a plaintiff’s state law claim into a federal action merely by asserting a defense impliedly provided by the federal statute, “even if the defense is anticipated in the plaintiff’s complaint, and even if both parties admit that the defense is the only question truly at issue.” Since preemption defenses available to the defendant under the federal laws would not be pleaded on the face of the plaintiff’s complaint, the cause of action could not be removed to a federal court.

“Complete preemption” is an exception to the “well pleaded complaint rule.” Complete preemption occurs when Congress “so completely preempts a particular area [of law] that any civil complaint raising this select group of claims is necessarily federal in character.” If complete preemption is implicated, a defendant converts a plaintiff’s state law claim into a federal question merely by utilizing the defense. ERISA section 502 triggers complete preemption regardless of whether the plaintiff pleads the section or alleges anything implicating a denial of benefits.

The availability of complete preemption under ERISA has generally been attributed to two Supreme Court rulings. In Pilot Life Ins. Co. v. Dedeaux, which related to a disability claim in which the condition of the

9. Id. at 14.
11. Id. at 63-64.
beneficiary was not at issue, the Court decided that the state causes of action asserting improper processing of claims under the insured employee benefit plans were preempted by ERISA. The Court stated that ERISA was designed to promote the interests of employees and their beneficiaries by regulating the creation and administration of employee benefit plans. To wit, Congress clearly intended that ERISA be "the exclusive vehicle for actions by ERISA plan participants . . . asserting improper [claim] processing," and that individual state laws should not impede Congress's purposes and objectives.

The second of the two Supreme Court rulings establishing the availability of complete preemption under ERISA is the *Massachusetts Mutual Life Insurance Co. v. Russell* decision. In that case, the Court determined that ERISA does not create compensatory or punitive damages remedies where an administrator of a plan fails to provide the benefits due under the plan.

With the *Pilot's Life* and *Massachusetts Mutual* decisions as a foundation, federal courts have routinely ruled that claims alleging wrongful denials of care are attacks on the mechanism by which benefits are administered and should be preempted and dismissed as attempts to improperly obtain a remedy. Even sympathetic judges have felt

13. Id. at 54.
14. Id. at 52.
16. Id. at 146.
17. D. L. Trueman, *Managed Care Liability Today: Laws, Cases, Theories, and Current Issues*, 33 J. HEALTH L. 191, 199 (2000). Also see the following Circuit Court rulings: Hull v. Fallon, 188 F.3d 939, 943 (8th Cir. 1999) (holding that the claim for "medical malpractice" for the HMO's failure to approve the decedent-patient's physician-recommended stress test was preempted because the claim could have been brought under ERISA section 502(a)); Danca v. Private Health Care Sys., Inc., 185 F.3d 1, 6 (1st Cir. 1999) (holding ERISA preempted claims of inappropriate psychiatric hospitalization resulting in patient's attempted suicide and self-immolation); Tolton v. Am. Biodyne, Inc., 48 F.3d 937, 942 (6th Cir.1995) (holding that because plaintiff's claims arose from the ERISA health plan's refusal to authorize benefits under the plan, the claims were "clearly 'relat[ed] to' the benefit plan," and were therefore preempted); Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482, 1488 (7th Cir. 1996) (holding plaintiff cannot transform a claim for denial of benefits under ERISA into a state law claim by alleging that a utilization review agent negligently denied physical rehabilitation); Spain v. Aetna Life Ins. Co., 11 F.3d 129, 131 (9th Cir. 1993) (holding that ERISA preempted wrongful death claim based on withdrawal of authorization for surgery); Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc., 999 F.2d 298, 303 (8th Cir. 1993) (holding that an HMO's "cancellation" of surgery was a "decision not to precertify payment [which] relates directly" to benefit administration); Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1331 (5th Cir. 1992) (holding that ERISA preempted claims for failure to authorize hospitalization that led to the death of the plaintiff's newborn).
constrained by ERISA and the rulings of the Supreme Court. For example, in *Andrews-Clarke v. Travelers*, the plaintiff’s husband committed suicide by carbon monoxide poisoning after repeatedly having been denied covered psychiatric hospitalization for substance abuse and attempted suicide.\(^{18}\) Even a court-ordered hospitalization was refused by the managed care organization and the decedent was taken to a correctional facility instead where ultimately he was sodomized.\(^{19}\) Judge Young considered Mrs. Andrews-Clarke’s breach of contract claim as a right “predating the Magna Carta” and stated that the right to have contractual promises enforced “is the bedrock of our notion of individual autonomy and property rights . . . which has been zealously guarded by the state judiciary.”\(^{20}\) However, he contended that because of the *Pilot Life* ruling and ERISA section 502(a), the court had “no choice but to pluck Diane Andrews-Clarke’s case out of the state courts . . . and then, at the behest of Travelers and Greenspring, to slam the courthouse doors in her face and leave her without a remedy.”\(^{21}\)

3. Vicarious Liability Claims and Section 502(a)

In contrast to the preemption of claims that raise questions of benefit rights or approval of treatment, allegations that a plan is vicariously liable for its medical personnel’s negligent conduct or malpractice have, in the past few years, avoided removal to federal court pursuant to section 502(a).\(^{22}\) The seminal case standing for the proposition that ERISA section

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19. *Id.* at 51-52.
20. *Id.* at 52-53.
21. *Id.* at 53.
22. *See, e.g.*, *Rice v. Panchal*, 65 F. 3d 637, 646 (7th Cir. 1995) (holding that plaintiff’s vicarious liability claim against HMO based on doctors’ malpractice raised state tort claim issues and was not preempted by ERISA nor removable to federal court); *Pacificare of Okla. v. Burrage*, 59 F.3d 151, 155 (10th Cir. 1995) (holding that “[j]ust as ERISA does not preempt the malpractice claim against a doctor, it should not preempt the vicarious liability claim against the HMO”); *Lancaster v. Kaiser Found. Health Plan of Mid-Atl. States, Inc.*, 958 F. Supp. 1137, 1149 (E.D. Va. 1997) (holding that ERISA does not preempt professional malpractice claims); *Edelen v. Osterman*, 943 F. Supp. 75, 77 (D.D.C. 1996) (holding that a medical malpractice claim against a treating medical provider at an HMO was not preempted); *Fritts v. Khoury*, 933 F. Supp. 668, 671 (E.D. Mich. 1996) (holding that plaintiff’s action for wrongful death of her sons was not preempted by ERISA because she did not allege improper denial or refusal of benefits, and did not seek clarification of future benefits under the plan); *Prihoda v. Shpritz*, 914 F. Supp. 113, 117 (D. Md. 1996) (holding that where the claims involved the quality of services provided, as opposed to whether benefits were provided under the plan, ERISA did not preempt vicarious liability claims against the HMO); *Schacter v. Pacificare of Okla.*, Inc., 923 F. Supp. 1448, 1451 (N.D. Okla. 1995) (holding that ERISA did not preempt vicarious liability/ostensible agency claim against HMO where the underlying claim was malpractice); *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544, 548 (S.D. Ill. 1994) (holding that vicarious liability claim against HMO
502 does not allow a federal court to have jurisdiction over a plaintiff’s vicarious liability claim against a managed care organization is *Dukes v. U.S. Healthcare.* In *Dukes,* the plaintiff’s husband died because the plan physician and hospital failed to conduct necessary blood tests to diagnose what ultimately was a fatal condition. The plaintiff sued the physician for malpractice and the HMO for vicarious liability for the conduct of its plan physician. The Third Circuit ruled that there was a distinction between claims pertaining to the “quality” of plan benefits or the quality of the medical care provided, and those involving the “quantity” of benefits, which include administrative determinations of benefits. The court held that because the “plaintiffs here simply do not claim that the plans erroneously withheld benefits due,” the claims were not encompassed within section 502(a)(1)(B) and the case was not removable to federal court. Notably, the *Dukes* court held that claims asserting wrongful denials of benefits in the utilization review process should be preempted, yet vicarious liability claims based on medical malpractice should not be subject to preemption.

This line of reasoning is important, as well, for claims that allege that wrongful denials of physician-recommended care led to injuries or death of

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23. 57 F.3d 350 (3rd Cir. 1995).
24. *Id.* at 352.
25. *Id.*
26. *Id.* at 357.
27. *Id.* at 356.
28. For a holding that the vicarious liability claim was not preempted, see *supra* note 22; cf. *Jass v. Prudential Health Care Plan, Inc.,* 88 F.3d 1482, 1488 (7th Cir. 1996) (holding that vicarious liability claims against and HMO based on a plan physician’s malpractice were preempted by ERISA because, but for the plan, the HMO would not have formed a relationship with the physician, and plaintiff would not have sought the physician’s services). Therefore, the court held, the negligence claim was “directly related to the [p]lan.” *Id.* Butler v. Wu, 853 F. Supp. 125, 120 (D. N.J. 1994) (holding that vicarious liability claims for negligent supervision were preempted by ERISA because HMO acted more as an insurer rather than health care service provider).
the patient. If a plaintiff can successfully contend that the utilization review determination was medical in nature then it may successfully avoid preemption due to the "quality" of the care at issue.

C. ERISA Section 514

The second type of ERISA preemption, section 514, is a "general preemption" or "conflict preemption" provision which provides a defense against claims or laws which "relate to" an ERISA plan. In pertinent part, the provisions of section 514 supercede any state laws that pertain to any employee benefit plan. 29 Section 514 also provides that certain state laws will be saved from preemption by the "saving clause" which states that nothing in the subchapter "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 30 This language is then limited by the "deemer clause," which provides that plans which self-insure are not considered insurance companies. 31 However, questions of the saving and deemer clauses are generally reserved for claims that a state statute should be invalidated because of ERISA supersession and these issues typically do not arise in relation to claims for wrongful denial of treatment. 32

Initially, the U.S. Supreme Court interpreted section 514 expansively, permitting preemption of almost all claims. 33 Indirect claims or laws having only a tangential relationship to an ERISA plan were invalidated. Recently, however, the Court has narrowed the boundaries of the preemptive scope of section 514, recognizing the almost indefinable reach of its prior expansive reading. The Court stated that previous attempts to clarify the meaning of "relates to" in section 514 had been "less than helpful" and that the phrase "relates to" should be interpreted in its "limiting" sense rather than in its infinitely expansive sense. 34

In California Division of Labor Standards Enforcement v. Dillingham Construction N.A., Inc., the Supreme Court further limited the expansive

32. See, e.g., Fox v. General Motors Corp., 859 F. Supp. 216, 218 (S.D.W.V. 1994) (holding that state law is preempted by ERISA to the extent that the state law relates to any employee benefit plan).
33. Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 98-99 (1983) (stating that Congress used the words "relate to" in section 514(a) in a very broad sense in order to eliminate the threat of conflicting or inconsistent State and local regulation of employee benefit plans and therefore determining that any law that had a connection with or reference to an employee benefit plan was subject to preemption).
reading of "relates to" so that it would not implicate any possible claim that conceivably could make reference to or have a connection with the plan.\textsuperscript{35} The \textit{Dillingham} court clarified that the appropriate inquiry is whether the state law in question applies equally to non-ERISA entities as it does to ERISA entities, that is whether the statute in question is a law of general applicability and not one which only affects ERISA plans.\textsuperscript{36}

In \textit{De Buono v. NYSA-ILA Medical and Clinical Services Fund} the Supreme Court considered a New York tax levied on hospitals, most of which were not owned or operated by ERISA funds, and further limited the interpretation of "relates to."\textsuperscript{37} Although the tax at issue in \textit{De Buono} literally "related to" an ERISA plan, it did not refer exclusively to ERISA plans and, thus, did not "make reference to" the plan within the \textit{Dillingham} definition.\textsuperscript{38} The Court stated although a state law may have some effect on the administration of ERISA plans, not every state law with such an effect may be preempted by the federal statute.\textsuperscript{39}

Accordingly, section 514 is limited and will not be available to a defendant unless there is federal jurisdiction over the case. Therefore, if a federal court to which the claim has been removed does not find that section 502(a) completely preempted the state law, the court cannot rule on the substantive nature of the claim. If this is the case, section 502(a) will not affect the suit and the only question is whether section 514 will serve as a defense. However, any comprehensive ruling on ERISA preemption must encompass both sections 502(a) and 514.

\section*{II. Pegram v. Herdrich: The Supreme Court Paves the Way for a New ERISA Jurisprudence}

\subsection*{A. Pegram Identifies a New Category for Utilization Review Decisions}

The Supreme Court's recent decision in \textit{Pegram v. Herdrich} paved the way for a new line of ERISA jurisprudence, narrowing ERISA preemption by identifying a new category for utilization decisions which could avoid preemption. In \textit{Pegram}, the Supreme Court started down the path of eliminating ERISA preemption for claims alleging injuries resulting from wrongful denials or delays of treatment but only when a patient's symptoms are included in the process of making a pre-certification or utilization

\begin{thebibliography}{9}
\bibitem{35} 519 U.S. 316, 324 (1997).
\bibitem{36} \textit{Id.}
\bibitem{37} 520 U.S. 806, 816 (1997).
\bibitem{38} \textit{Id.} at 815-16.
\bibitem{39} \textit{Id.} at 816.
\end{thebibliography}
review determination.\(^{40}\) Although *Pegram* examined fiduciary duties owed to ERISA plan beneficiaries, the Court fashioned an opinion that extended well beyond the fiduciary duty issue into the arena of utilization review and medical determinations of requests for treatment.

In *Pegram*, Cynthia Herdrich’s appendix ruptured after waiting eight days for her physician, Lori Pegram, M.D., an employee of Carle Clinic Association, to authorize a diagnostic procedure.\(^{41}\) The plaintiff sued Dr. Pegram and Carle Clinic in state court for medical malpractice and two counts of fraud.\(^{42}\) Dr. Pegram and Carle Clinic alleged that ERISA preempted the fraud counts and accordingly, removed the case to a federal district court.\(^{43}\) The district court granted the defendants’ motion for summary judgment on one of the fraud counts, but allowed Ms. Herdrich to amend the remaining count.

Ms. Herdrich’s amended complaint alleged that the HMO breached its fiduciary duty under ERISA by rewarding financial incentives to its physicians to limit medical care, rather than creating incentives that benefit the plan participants, like Ms. Herdrich.\(^{44}\) The district court dismissed the remaining fraud claim stating that Carle Clinic was not an ERISA fiduciary and that Ms. Herdrich failed to state a claim upon which relief could be granted.\(^{45}\) Although Ms. Herdrich prevailed on her medical malpractice counts, she appealed the district court’s dismissal of her ERISA claims. On appeal, the Seventh Circuit reversed and held that Carle Clinic was acting as a fiduciary when its physicians made the decision to prolong diagnostic procedures.\(^{46}\) The Supreme Court granted *certiorari* and reversed the Seventh Circuit Court of Appeals.\(^{47}\)

Although breach of fiduciary duty was the issue, the Court’s discussion of HMOs and their capitated gatekeeper physicians is of far-reaching importance. The Supreme Court first determined whether Carle Clinic, functionally an HMO, owed fiduciary duties to Ms. Herdrich when it acted through its physicians.\(^{48}\) The court stated that a fiduciary under ERISA is someone acting as a manager, administrator, or financial advisor to a plan, in this case Ms. Herdrich’s State Farm medical plan.\(^{49}\) The plaintiff claimed

\(^{40}\) 530 U.S. 211 (2000).
\(^{41}\) *Id.* at 215-16.
\(^{42}\) *Id.* at 215.
\(^{43}\) *Id.* at 215-16.
\(^{44}\) *Id.* at 216.
\(^{45}\) *Id.* at 217.
\(^{46}\) *Pegram*, 530 U.S. at 217.
\(^{47}\) *Id.* at 218
\(^{48}\) *Id.*
\(^{49}\) *Id.* at 222 (citing 29 U.S.C. § 1002(21)(A)(i)-(iii) (2000)).
that Carle Clinic had a fiduciary obligation to her because Carle Clinic was the administrator of the State Farm medical plan. 50

Similar to the responsibilities of a common law trustee, a fiduciary has a duty to act "solely in the interest of the participants and beneficiaries." 51 However, unlike a common law trustee with duties only to the beneficiary, an ERISA fiduciary often wears many hats, sometimes with duties to the plan participant and beneficiaries and other times with duties to the employer and plan sponsors. 52 Health Maintenance Organization physicians act as administrators when they determine whether a patient's condition is covered, yet also act as health care providers when they decide on the type of medical treatment the patient will receive. 53

The Court recognized that HMOs take steps to control costs, and usually employ utilization review, where treatment decisions are made by a "decisionmaker" rather than by the treating physician. 54 Physicians will often receive financial incentives for decreasing utilization of health services, thus, "in an HMO system, a physician's financial interest lies in providing less care, not more." 55 Ms. Herdrich argued that Carle Clinic's physicians received a year-end bonus based on the profitability of Carle Clinic, and the physicians therefore had an incentive to minimize the use of certain costly services, such as diagnostic tests. 56 Ms. Herdrich therefore complained that Carle Clinic, as the fiduciary administrator of the medical plan, breached its fiduciary duty to her because Carle Clinic did not act in Ms. Herdrich's best interests. 57

The Court, however, delineated different types of decisions made by Carle Clinic's physicians. Some types of "eligibility decisions" gave rise to fiduciary duties as the administrator of the plan, while other types of "treatment decisions" were outside the fiduciary's obligations. The Court recognized that "eligibility decisions" include determinations of whether a plan covers a particular medical condition or procedure for treatment. 58 These administrative decisions would give rise to a fiduciary obligation under ERISA. "Treatment decisions," on the other hand, involve choices about how to diagnose and treat the patient's condition and would not give

50. Id. at 227.
51. Id. at 223-24.
52. Pegram, 530 U.S. at 225.
53. Id.
54. Id. at 219.
55. Id.
56. Id. at 216, n.3.
57. Id.
58. Pegram, 530 U.S. at 228.
rise to obligations as a fiduciary under ERISA.\textsuperscript{59} In reality, however, these decisions are often inseparable since there is rarely a pure “eligibility” question, such as whether an appendicitis is covered under the plan.\textsuperscript{60}

The \textit{Pegram} court ruled that Dr. Pegram’s decisions and medical judgments entailed a “mixed eligibility and treatment decision.”\textsuperscript{61} The physician’s decisions about when to use diagnostic tests, decisions about whether to refer a patient to another physician or facility, and conclusions about standards of care, reasonableness of treatment, and the emergency character of a condition, were all mixed eligibility and treatment decisions.\textsuperscript{62} As such, these decisions and determinations fell outside any fiduciary duties owed by Carle Clinic, functioning as an HMO and plan administrator, to a plan participant under ERISA.\textsuperscript{63} The Court doubted that Congress intended mixed eligibility decisions to be fiduciary in nature.\textsuperscript{64}

When creating fiduciary obligations under ERISA, Congress focused on the fiduciaries’ financial decisions, primarily in pension plans and “financial mismanagement that had too often deprived employees of their benefits.”\textsuperscript{65} Congress’s focus was not directed toward the kind of fiduciary obligations Ms. Herdrich complained Carle Clinic owed to her.\textsuperscript{66} The \textit{Pegram} court ultimately held that mixed eligibility decisions by Carle Clinic physicians were not fiduciary decisions under ERISA, and therefore Ms. Herdrich’s ERISA count failed to state a claim upon which relief could be granted.\textsuperscript{67}

The distinction between “pure eligibility decisions” and “mixed eligibility and treatment decisions” is critical for developing a meaningful section 502(a) jurisprudence regarding the regulation of the administration of benefits. Section 502(a) governs claims seeking to (1) recover plan benefits due under the terms of the plan, (2) enforce rights under the terms of the plan, or (3) clarify the right to future benefits due under the terms of the plan.\textsuperscript{68} Such a structure makes sense in the pension and disability context, such as in \textit{Pilot Life}, where there is often no question regarding the insured’s medical condition and the only issue is whether money is due.\textsuperscript{69}

\begin{itemize}
  \item \textsuperscript{59} Id.
  \item \textsuperscript{60} Id.
  \item \textsuperscript{61} Id. at 229.
  \item \textsuperscript{62} Id. at 229-30.
  \item \textsuperscript{63} Id. at 231.
  \item \textsuperscript{64} \textit{Pegram}, 530 U.S. at 231.
  \item \textsuperscript{65} Id. at 232.
  \item \textsuperscript{66} Id.
  \item \textsuperscript{67} Id. at 237.
  \item \textsuperscript{68} 29 U.S.C. 1132(a)(1)(B).
  \item \textsuperscript{69} See \textit{Pilot Life Ins.}, v. Dedeaux, 481 U.S. 41 (1987).
\end{itemize}
Viewed from this perspective, the new jurisprudence recognizes that certain benefits, such as pension and disability, are subsumed under the category of pure eligibility determinations pursuant to section 502(a) and that decisions that include medical determinations are qualitatively distinct.

*Pegram* and its new jurisprudence now seem to make sense of ERISA, a law enacted with the purpose of protecting insureds within the pension context, thus necessitating the statute’s title, “Employee Retirement and Income Security Act.” Commentators have uniformly contended that managed care and HMO decisions regarding the medical necessity or experimental nature of a patient’s treatment could not have been entertained by Congress, were not intended to be covered under ERISA, and do not logically intersect with section 502(a).\(^70\) Indeed, the Supreme Court stated as much when it doubted that “Congress would ever have thought of a mixed eligibility decision as fiduciary in nature.”\(^71\) The *Pegram* ruling seems to recognize Congress’s intent in enacting section 502(a) of ERISA.\(^72\)

Interpreted in this manner, *Pegram* has clarified benefit or administrative decisions, which the Court bifurcated into “pure eligibility” and “mixed eligibility and treatment” categories. This effectively reverses the Court’s practice of subsuming medical review requests for care under the broad category of “administration” and the rule that any medical decision in furtherance of an insurance determination is merely administrative. It also eliminates the simplistic quantity versus quality dichotomy set forth in *Dukes*, which failed to highlight the medical nature of utilization review determinations and replaces it with a mechanism that addresses the nature of the health care system today, as one which has different individuals making decisions and multiple entities providing care and services to patients.

**B. Pegram Should Apply to All Mixed Eligibility and Treatment Decisions Regardless of the Entity Making Those Decisions**

An issue that repeatedly arises is whether the Supreme Court’s opinion in Pegram should be limited and apply only to the facts at issue in that case. A narrow interpretation would limit the *Pegram* jurisprudence to cases involving capitated physician groups where a treating physician made a gatekeeping determination surrounding the physician’s treatment of a

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71. *Pegram*, 530 U.S. at 231

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ERISA Preemption

patient, while not extending to cases involving an HMO’s utilization review of physician recommended treatment.

The argument that Pegram should be narrowly construed fails for several reasons. First, a mixed eligibility and treatment decision is a mixed eligibility and treatment decision regardless of the type of entity making the coverage decisions. The factors supporting the coverage decision and the impact of that decision on the patient should be the same, regardless of whether an HMO through a utilization review or a physician group makes the coverage decision. In fact, the Court specifically stated that the “[p]etitioners, Carle Clinic Association, P.C., Health Alliance Medical Plans, Inc., and Carle Health Insurance Management Co., Inc. (collectively Carle) function as a health maintenance organization (HMO) organized for profit.” Thus, Ms. Herdrich’s claim was not merely against the physician group, but was against a HMO entity.

Second, in any scenario, the physician playing the gatekeeper no longer acts as a physician in the traditional sense. Rather, the physician acts as a balancing agent, accepting dual roles when weighing recommended care, costs of alternative treatments, and the consideration of financial savings. Accordingly, whether the medical director at an HMO or the treating physician at a physician group is making the decision, they are doing the same thing. An expansive reading of Pegram appears to be consistent with the Supreme Court’s recent application of Pegram to a negligence case from the Pennsylvania state courts, Pappas v. Asbel.

In Pappas v. Asbel (Pappas I), the plaintiff, Basile Pappas, a member of an HMO operated by U.S. Healthcare, was admitted to Haverford Community Hospital’s emergency room complaining of paralysis and numbness in his arms, chest, abdomen, and legs. Dr. Stephen Dickter, the emergency room physician, diagnosed an abscess pressing on Pappas’ spinal column. Dr. Dickter consulted with a neurologist and neurosurgeon, all of whom agreed that this was a neurological emergency. Dr. Dickter arranged for Pappas to be transferred to Jefferson University Hospital, which had a spinal cord trauma unit. However, when the ambulance arrived an hour and forty minutes after Pappas’ admission, U.S. Healthcare determined that Mr. Pappas’ condition was not emergent and denied authorization for treatment at Jefferson, a non-approved hospital by

73. Id. at 215.
75. Pappas I, 675 A.2d at 713.
76. Id.
77. Id.
the HMO. U.S. Healthcare, however, authorized Pappas' transfer to Hahnemann University Hospital, Temple University Hospital, or the Medical College of Pennsylvania. Dr. Dickter first contacted Hahnemann University and more than two hours later Hahnemann responded that it would not have information on its ability to receive Pappas for at least another half-hour. The Medical College of Pennsylvania agreed to accept Pappas, who arrived there four hours after his initial admission to Haverford.

As a result of the delays, the abscess compressed Pappas' spine causing quadriplegia. Pappas sued Dr. Asbel, his primary care physician, and Haverford Community Hospital, claiming that Dr. Asbel committed medical malpractice and that Haverford was negligent in causing an inordinate delay in transferring him to an equipped facility that could immediately address his injury. Haverford filed a third-party complaint against U.S. Healthcare for its refusal to authorize the transfer and Dr. Asbel filed a cross-claim against U.S. Healthcare seeking contribution and indemnity. The HMO, U.S. Healthcare, moved for summary judgment on these third party claims alleging that they were preempted by section 514 of ERISA. The trial court granted U.S. Healthcare's motion.

Haverford Community Hospital, through its insurers, appealed to the Pennsylvania Superior Court. The superior court reversed the trial court's order granting summary judgment, holding that ERISA did not preempt Pappas' claims. The superior court recognized that Pappas' negligence claims against U.S. Healthcare did not "relate to" an ERISA plan, as required by the statute, and therefore were not preempted. U.S. Healthcare appealed to the Pennsylvania Supreme Court, which affirmed the superior court. Relying on the United States Supreme Court's opinion in Travelers, the Pennsylvania Supreme Court recognized that Congress did not intend to preempt state negligence laws that had only a "tenuous, remote or peripheral connection with covered plans," such as the laws at

78. Id.
79. Id.
80. Id.
81. Pappas I, 675 A.2d at 713-14.
82. Id. at 714.
83. Id.
84. Id.
85. Id.
86. Id. (noting that Pappas settled his claims against Dr. Asbel and Haverford).
87. Pappas I, 675 A.2d at 718.
88. Id. at 717.
issue in *Travelers* that governed the provision of safe medical care.\(^\text{90}\) Here, Pappas’ negligence claims were intertwined with provisions of safe medical care when U.S. Healthcare provided “contractually-guaranteed medical benefits” in such a “dilatory fashion” that Pappas was injured.\(^\text{91}\) Accordingly, the Pennsylvania Supreme Court held that Pappas’s claims were not preempted by ERISA.

U.S. Healthcare appealed to the United States Supreme Court.\(^\text{92}\) The Court accepted the case and ruled that the judgment of the Pennsylvania Supreme Court be vacated and the case remanded for “further consideration in light of *Pegram v. Herdrich*.”\(^\text{93}\) Unlike *Pegram*, there was no issue of a breach of fiduciary duties in *Pappas I*. It can only be assumed that the Court wished the Pennsylvania Supreme Court to consider *Pappas I* in light of the new “mixed eligibility and treatment decision” language from *Pegram*.\(^\text{94}\)

Seemingly, the only conclusion to draw from the Supreme Court decision in *Pappas I* is that the Court expanded *Pegram*’s scope and application. It is obvious that, if the Court wanted to limit its ruling and only apply the “mixed eligibility and treatment decision” language to breaches of fiduciary duties, the Court would not have vacated and remanded, in light of *Pegram*, the *Pappas* case which was based on a negligence claim. To claim that *Pegram* only applies to breach of fiduciary duty claims under ERISA would be to ignore the Supreme Court’s decision in *Pappas I*.

Based on the Supreme Court’s ruling that *Pegram* be applied to the negligence claims in *Pappas I* and because the *Pegram* opinion itself refused to differentiate a physician group from an HMO, it is clear that the Supreme Court did not intend *Pegram* to be limited to either the claim of fiduciary duty or to the types of entities at issue in *Pegram*. If this is correct then all utilization review determinations that consider the patient’s

\(^{90}\) *Id.* at 892-93.

\(^{91}\) *Id.* at 893.


\(^{93}\) *Id.* at 1241.

\(^{94}\) On remand and in light of *Pegram*, the Pennsylvania Supreme Court adhered to its opinion and order in *Pappas I*. The court recognized that, under *Travelers*, ERISA does not preempt state laws that regulate the adequacy of medical treatment, and under *Pegram* an HMO’s mixed eligibility and treatment decisions fall under a state law claim for medical malpractice and not an ERISA cause of action for breach of fiduciary duty. Therefore, if Haverford’s third party claim against U.S. Healthcare “arose out of a mixed decision, it is according to *Pegram*, subject to state medical malpractice law, which is what Haverford asserted. Moreover, under *Travelers*, it is not preempted by ERISA.” *Pappas v. Asbel*, 768 A.2d 1089, 1095 (Pa. 2001).
constellation of symptoms or the experimental nature of the requested care are no longer preempted by ERISA.

III. FEDERAL COURTS HAVE UTILIZED THE PEGRAM JURISPRUDENCE

A number of federal courts have wrestled with the tripartite jurisprudence from Pegram. With one notable exception, courts have adopted and applied Pegram in the context of a managed care organization’s determination that recommended care was not medically necessary, ruling that federal courts lacked jurisdiction pursuant to section 502(a). Only two courts have ruled on the applicability of section 514 and have reached conflicting results.

A. Cases Eliminating Preemption

1. The Fifth Circuit’s Rulings

In Roark v. Humana, Inc., a panel of the Fifth Circuit Court of Appeals ruled on four district court cases that found preemption. Three of the cases involved section 502(a) preemption and one case involved section 514. In the section 502(a) cases, the court ruled against preemption.

Among the consolidated cases, the Fifth Circuit identified two preemption issues. In the cases of Ruby Calad and Juan Davila, the issue was whether section 502(a) of ERISA preempted claims under a Texas statute that authorized causes of action against a managed care entity. In the matter of Gwen Roark, the issue was whether section 514 preempted the Roarks’ claim of wrongful denial of care.

Ruby Calad filed suit under the Texas Health Care Liability Act (THCLA), which allowed for suits alleging negligent care against an HMO. Ms. Calad alleged that her HMO, CIGNA, negligently caused her injuries when it failed to approve her for a necessary hospital stay following surgery. CIGNA removed the case to federal court based on ERISA preemption. Ms. Calad unsuccessfully moved the district court to remand her case, contending that the managed care entity was not acting as a fiduciary when it denied her medical treatment and therefore section

96. Id. at 302-03.
97. Id. at 311-13.
98. Id. at 302.
99. Id.
100. Id.
502(a) did not preempt her THCLA claim. Since Ms. Calad’s complaint only raised the THCLA claim and did not raise a claim under ERISA, the district court dismissed the claim for Ms. Calad’s failure to state a cause of action upon which relief could be granted.

Juan Davila, in a similar claim, sued Aetna, an HMO, under the THCLA, alleging that the insurer refused to provide him with the medication that his physician prescribed for arthritis pain. Instead, Aetna approved a differing medication for Mr. Davila, which allegedly caused an adverse reaction and bleeding ulcers that led to a near heart attack. Mr. Davila sued in state court claiming that “Aetna had failed to use ordinary care in making medical decisions, Aetna’s systems made substandard care more likely, and Aetna acted negligently in making its medical necessity decisions.” Aetna removed the case to the federal district court and, as with Ms. Calad, the district court concluded that section 502(a) completely preempted Mr. Davila’s state law claims. After informing the court that he would not pursue an ERISA claim, the district court dismissed Mr. Davila’s claim with prejudice for failure to state a cause of action.

A panel of the Fifth Circuit Court of Appeals vacated and remanded the district court’s decisions in Ms. Calad and Mr. Davila’s cases. The Fifth Circuit relied on Pegram and identified the plaintiffs’ claims as mixed eligibility and treatment decisions subject to state medical malpractice law. The court ruled that the HMOs were not acting as plan fiduciaries when denying Ms. Calad and Mr. Davila medical treatment and, accordingly, section 502(a)(2) could not completely preempt their claims. Although the Supreme Court in Pilot Life ruled that ERISA provided a means of collecting benefits as well as an exclusive list of remedies, the Roark court concluded that its “rule is a narrow one.” The rule was simple: a State may not duplicate causes of action provided for in section 502(a) of ERISA. Since the THCLA did not provide an action for collecting benefits, the Roark court held that it was not preempted by

101. Roark, 307 F.3d at 306.
102. Id. at 302.
103. Id. at 303.
104. Id.
105. Id.
106. Id.
107. Roark, 307 F.3d at 303.
108. Id. at 311.
109. Id. at 307 (citing Pegram v. Herdrich, 530 U.S. 211 (2000)).
110. Id. at 306.
111. Id. at 310.
112. Id. at 310-11.
section 502(a)(1)(B) under the *Pilot Life* jurisprudence. Thus, in the matters of Ms. Calad and Mr. Davila, the Court did not have to reach the issue of section 514 conflict preemption, an issue it reached in the claim alleged by the Roarks.

Gwen and Robert Roark sued a number of Humana HMO entities in Texas state court, challenging decisions that were made which failed to provide recommended care for Mrs. Roark, who was bitten by a spider. After three skin graft operations and two other surgeries, Ms. Roark’s physician recommended that Ms. Roark use a vacuum-assisted closure devise to circulate blood around the wound. Several years later, Humana cancelled Ms. Roark’s vacuum and home nursing treatments, even though Ms. Roark’s physician informed them that Roark could lose her leg without treatment. Ms. Roark’s leg subsequently became infected and was amputated.

The Roarks sued under the THCLA, the Texas Deceptive Trade Practice Act (DTPA), and the Texas Insurance Code, and alleged common law claims of breach of good faith and fair dealing and breach of contract. Humana alleged ERISA preemption and removed the case to a federal district court. The Roarks moved to remand, but the district court denied the motion, holding that the DTPA and Texas Insurance Code claims were completely preempted pursuant to section 502(a). Exercising its supplemental jurisdiction over the Roarks’ other claims, the district court then dismissed the THCLA claims based on section 514 preemption, utilizing the typical pre-*Pegram* dichotomy between the administration of benefits and the quality of the medical care rendered. A panel of the Fifth Circuit Court of Appeals reluctantly affirmed.

The Fifth Circuit first determined that the district court properly exercised jurisdiction over the claim because the Roarks, unlike Ms. Calad and Mr. Davila, amended their complaint to allege a breach of contract claim, which was preempted by ERISA. Contract claims, such as the one the Roarks asserted, were “precisely the type of contract claim we recognize

114. *Id.* at 304.
115. *Id.* at 303.
116. *Id.* at 303.
117. *Id.* at 303-04.
118. *Id.* at 311-12.
120. *Id.*
121. *Id.* at 313.
122. *Id.* at 315.
123. *Id.* at 312.
under [section] 502(a)(1)(B)." The Fifth Circuit therefore concluded that the district court had jurisdiction over at least one of the claims and could exercise supplemental jurisdiction over the others.125

Next, addressing the substantive matter, the Roark court recognized that a decision of another panel of the Fifth Circuit, in Corcoran v. United Healthcare, was on point.126 In Corcoran, the HMO determined that the hospitalization of Ms. Corcoran was not necessary, but instead authorized home nursing.127 When a nurse was not on duty, Ms. Corcoran miscarried and her baby died.128 The Corcoran panel stated that the HMO made medical decisions "in the context of" determining the availability of benefits under the plan.129 Since the Corcorans were "attempting to recover for a tort allegedly committed in the course of handling a benefit determination" the cause of action was preempted by ERISA section 514.130

The Roark panel of the Fifth Circuit expressed concerns over the holding of Corcoran, in light of Pegram, where the Supreme Court stated that ERISA could not preempt causes of action that arose out of a mixed eligibility and treatment decision.131 After Corcoran, if the physician recommends treatment and the HMO denies coverage, the patient has no recovery. Therefore, the Corcoran decision allows the HMO to escape liability if the HMO tells the physicians to recommend every possible treatment, but leaves the real decision to the HMO administrator.132

Moreover, the Roark court recognized that Corcoran had been decided before the Supreme Court's "trilogy" of Travelers, Dillingham, and DeBuono, which significantly narrowed the scope of section 514 preemption and undermined Corcoran in two important ways. First, the Court established that traditional preemption rules apply under ERISA. Thus, courts should presume ERISA does not preempt areas such as general health care regulation, which historically has been a matter of local concern. Second, the Court held that a state's economic impact (direct or indirect) on plan structures is not enough to trigger section 514 preemption.133

Nevertheless, the Roark panel concluded, "[i]f we were writing on a clean slate, or deciding this en banc, the Roarks would have a strong case

124. Id.
125. Roark, 307 F.3d at 313.
126. Id. (relying on Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992)).
127. Corcoran, 965 F.2d at 1324.
128. Id.
129. Id. at 1331.
130. Id. at 1332.
131. Roark, 307 F.3d at 315 (citing Pegram v. Herdrich, 530 U.S. 211, 236-37 (2000)).
132. Id. at 315 (citing Corcoran, 965 F.2d at 1338).
133. Roark, 307 F.3d at 315 (internal citations omitted).
against ERISA preemption. But, as a panel we are bound by Corcoran."134
Pursuant to Corcoran, the Roark panel of the Fifth Circuit reluctantly agreed with the district court and held that section 514 of ERISA preempted the Roarks' THCLA claim against Humana.135

The Roarks filed a request for a rehearing en banc, but the Fifth Circuit denied that request.136 The Roarks then petitioned the Supreme Court for certiorari but the matter was settled before a decision was made regarding review.137 However, the Supreme Court did grant Ms. Calad and Mr. Davila's petitions for certiorari and the Supreme Court heard arguments on both cases in March of 2004.138 It is noteworthy that the Supreme Court accepted two cases that only address ERISA section 502(a) preemption and not the section 514 defense.

2. The Second Circuit's Ruling in Cicio

In the first case determined by a circuit court of appeals eliminating both section 502(a) and section 514 preemption, the Second Circuit Court of Appeals ruled that claims against an HMO and its medical directors for alleged wrongful denials of treatment did not provide federal jurisdiction, were not dismissible pursuant to section 514, and could proceed under state medical malpractice law.

In Cicio v. Does, a case which this author argued at the district court and before the Second Circuit Court of Appeals, the decedent's physician had recommended a double stem cell transplant which the defendant, Vytra, had denied on two separate occasions.139 Initially, the company refused the request based on the determination that it was experimental and investigational.140 When the physician appealed, Vytra still denied the double stem cell transplant but approved a single one instead.141 However, by the time approval for the single stem cell transplant was received, nearly two months later, the window of opportunity for a successful transplant had passed and Mr. Cicio subsequently died.142

134. Id.
135. Id. at 315.
140. Id. at 88.
141. Id.
142. Id.
The decedent’s wife filed suit against both Vytra and its medical director alleging negligence, gross negligence, medical malpractice, breach of fiduciary duty, misrepresentation, intentional infliction of emotional distress, tortious interference with the patient-physician relationship, and violation of New York’s Deceptive Business Practices Act. The district court ruled that, pursuant to section 502(a), it had jurisdiction over at least some of the claims and dismissed the case in its entirety based on section 514 and the court’s application of a pre-Pegram dichotomous jurisprudence.

The Second Circuit Court of Appeals analyzed the preemptive scope of ERISA regarding Ms. Cicio’s medical malpractice claim, which challenged the utilization review determinations recommended for the treatment of Mr. Cicio. The court stated that the:

[Q]uestion [of] whether a state law medical malpractice claim brought with respect to a medical decision made in the course of prospective utilization review by a managed care organization or health insurer is preempted under ERISA [section] 514, and therefore beyond the reach of state tort law, is one of first impression in this Circuit.

The court first addressed the nature of utilization review, recognizing that it usually involves “prospective review by a third party of the necessity of medical care,” which is “quasi-medical” in nature. Prospective utilization review, as noted by the court, “blurs boundaries” between traditional aspects of the medical profession and the managerial domain. The court further recognized that utilization reviews often involve the exercise of medical judgment related to a particular patient’s symptoms, that these decisions are made independent of the treating physician, and that these decisions, because of their prospective nature, have dispositive consequences for the treatment that the patient receives.

Relating utilization review to ERISA preemption and considering the preemptive scope of ERISA, the Second Circuit Court of Appeals observed that, over the years, the scope of ERISA preemption had narrowed. The court noted that initially the U.S. Supreme Court afforded ERISA an “expansive preemptive effect that corresponded to the provision’s broad

143. Id. at 88-89.
144. Id. at 89.
145. Cicio, 321 F.3d at 90-91.
146. Id. at 97-98.
147. Id. at 98 (quoting Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1326 (5th Cir. 1992)).
148. Id.
149. Id. at 98-99.
More recently, however, the Supreme Court has "tempered the assumption that the ordinary meaning [of section 514 of ERISA] accurately express[ed] the legislative purpose." The Second Circuit followed the guidance of the Supreme Court, which held that a court must begin with the presumption "that in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestations of congressional purpose."

Importantly, the Second Circuit stated that, "[m]oving beyond presumptions, the Supreme Court has also, in its own words, thrown 'cold water' on the idea that state regulation of health and safety is necessarily preempted even when it overlaps with rights protected by ERISA." In light of the Supreme Court's warning that the state law regulation of medical practice should not be lightly disturbed, the Ciclo court considered the question of whether Ms. Ciclo's medical malpractice claims "related to" the benefits plan administered by Vytra so as to be preempted by ERISA.

Upon identifying the issue, the Ciclo court addressed the purpose of ERISA, which is to protect contractually defined benefits and to ensure that benefits will be paid to plan participants. The court distinguished this from state medical malpractice laws which involve duties of conduct that are independent of ERISA plans. As such, malpractice claims are not among the "'rights and expectations brought into being by [ERISA],' that [section] 502(a) is designed to protect."

In determining whether the medical malpractice claims in the case were preempted by ERISA, the court analyzed the following: (1) the ruling in Pegram and its implications; (2) the application of Pegram's tripartite analysis to ERISA preemption; and (3) the distinction between treating physicians and utilization review agents.

In assessing the decision in Pegram, the Ciclo court initially considered prior cases related to utilization review. In particular, the court cited the

150. Id. at 99.
152. Id. (quoting Pegram v. Herdrich, 530 U.S. 211, 237 (2000)).
153. Id. at 99.
154. Id. at 100.
155. Id. at 99.
156. Id. at 99-100.
157. Ciclo, 321 F.3d at 100 (internal citation omitted) (quoting Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 137 (1990)).
158. Id.
159. Id. at 102.
160. Id. at 104.
earlier cases of *Corcoran v. United Healthcare*, *Jass v. Prudential*, and *Tolton v. American Biodyne*, which stood for the principle that preemption was triggered without regard to the medical content of the decision as long as there was a benefits component to a utilization review decision.\(^{161}\) However, these cases were decided before the Supreme Court’s *Pegram* decision, which abolished the prior cases’ dichotomy of “benefits decisions” and “medical decisions.”\(^{162}\)

The *Cicio* court recognized that a physician does not have to control or influence the patient’s treatment, but can simply make a decision to authorize or deny reimbursement, in order for that decision to be a mixed eligibility and treatment decision under the *Pegram* jurisprudence.\(^{163}\) In essence, the decision of who will “pay for” a procedure is a mixed eligibility and treatment decision if the decision involves figuring out the appropriate medical response to care for a patient.\(^{164}\) The court inferred that “the continued availability of some state law malpractice actions based on at least some varieties of utilization review decisions was a predicate of the [Pegram] holding.”\(^{165}\)

The Second Circuit noted that the *Pegram* holding had ramifications for its decision in *Cicio* because of the Supreme Court’s description and analysis of decision-making in modern healthcare.\(^{166}\) The court duly referenced the tripartite structure from *Pegram* and determined that mixed eligibility and treatment decisions can be made by HMOs, not merely physicians or physician entities as in *Pegram*.\(^{167}\)

Reiterating that *Pegram* altered the framework used in prior cases, such as *Corcoran*, the Second Circuit plainly stated that managed care entities have intruded into the sphere of medical autonomy, thus necessitating responsibility by managed care agents.\(^{168}\) In today’s healthcare environment, third-party payers make decisions analogous to that of the treating physician and the perceived “separation between professional providers and lay financiers” upon which the previous ERISA preemption cases were premised, no longer exists.\(^{169}\) Thus, with the rule of *Pegram*, the *Cicio* court effectively overturned all prior Second Circuit law, specifically

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161. *Id.* at 100.
162. *Id.* at 102.
163. *Cicio*, 321 F.3d at 102.
164. *Id.*
165. *Id.* at 101.
166. *Id.*
167. *Id.* at 102.
168. *See id.*
169. *Cicio*, 321 F.3d at 102 (additional citation omitted).
calling the Corcoran analysis into doubt. 170

The court next applied Pegram’s tripartite analysis to ERISA preemption. 171 Based on the analytic framework of Pegram and Congress’ intent in enacting ERISA, the Second Circuit concluded that a state law malpractice action based on a “mixed eligibility and treatment decision” is not subject to ERISA preemption when the cause of action challenges a flawed medical judgment. 172 In accepting Pegram’s tripartite structure, the Cicio court effectively renounced the “quality/quantity” or “administration/treatment” dichotomy previously used. 173 The dichotomy lineage ignored the nature of “countless medical administrative decisions” made every day in which “the eligibility decision and the treatment decision are inextricably mixed.” 174

In contrast with all previous case law, particularly the oft-cited ruling in Corcoran, the Cicio court determined that the presence of an administrative component is not dispositive of ERISA preemption when the benefits decision also has a medical component. 175 Consequentially, defendants should no longer be able to argue ERISA preemption in any state-based tort claim or in cases where medical decision-making overlays contractual claims, which would ordinarily be preempted by ERISA. 176

Finally, the court reinforced the medical nature of utilization review decisions and the nature of ERISA as a statute designed to protect consumers and not one intended to deprive them of their rights. 177 The court renewed its earlier proclamation that “nothing in ERISA suggests that Congress intended any displacement of ‘the quintessentially state-law standards of reasonable medical care’ as applied to the medical component of a mixed decision.” 178 As such, the court saw no reason to preempt state law medical malpractice actions that rested on the application of standards for medical decision-making. 179

In the last section of the opinion, the Cicio court addressed the distinction between treating physicians and utilization review agents, finding that there was no credible means of distinguishing the two. 180

170. Id. at 100-02.
171. Id. at 102.
172. Id.
173. Id. at 103.
174. Id. (quoting Pegram, 530 U.S. at 229).
175. Cicio, 321 F.3d at 103.
176. Id.
177. Id. at 103-04.
178. Id. at 103 (quoting Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 365 (2002)).
179. Id. at 104.
180. Id.
court stated that "[e]ven when making decisions about whether to pay for particular procedures, 'physicians still must decide what to do in particular cases' on the basis of medical assessments."\(^\text{181}\)

In addition to finding that there was no meaningful distinction between physicians and utilization review agents, the court also stated that it was not possible to separate the benefit determinations from the medical decisions made by doctors in managed care entities.\(^\text{182}\) Even if it could, such a distinction would not vitiate the ability to pursue a state medical malpractice claim.\(^\text{183}\) If Ms. Cicio could establish that the HMO medical director's decision to refuse a double stem cell transplant violated a state law duty of professional care, "they [were] hard pressed to see how the defendants could successfully contend—as a defense to the tort action—that the contract permitted them to violate a state law duty standard of care."\(^\text{184}\)

Although the Cicio decision was handed down recently, it has already been influential in other circuits. In Land v. CIGNA Healthcare of Florida, the Eleventh Circuit Court of Appeals ruled consistently with Pegram and approvingly cited the Second Circuit Court of Appeals' decision in Cicio.\(^\text{185}\) In Land, the plaintiff had developed an infection in his hand which his physicians determined required in-hospital treatment.\(^\text{186}\) The CIGNA approval nurse, upon review of the admission, determined that the infection was not sufficiently severe to warrant hospitalization and decided that the intravenous antibiotic treatment should be provided on an outpatient basis.\(^\text{187}\) By the following week the plaintiff's condition had worsened considerably and ultimately resulted in amputation of his finger.\(^\text{188}\)

The plaintiff filed suit in state court and alleged that CIGNA was negligent in the care and treatment of his infection.\(^\text{189}\) CIGNA removed the case to a federal district court, which dismissed the plaintiff's case ruling that ERISA completely preempted the plaintiff's claims.\(^\text{190}\) The plaintiff appealed and the Eleventh Circuit Court of Appeals reversed the district court in light of the Supreme Court's jurisprudence in Pegram.\(^\text{191}\) The Eleventh Circuit concluded that the nurse's decision was not a "simple yes-

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181. Cicio, 321 F.3d at 104 (citing Pegram, 530 U.S. at 229).
182. Id.
183. Id. at 105.
184. Id.
186. Id. at 1288.
187. Id.
188. Id. at 1289.
189. Id.
190. Id.
191. Land, 339 F.3d at 1290-94.
or-no eligibility determination” but was an eligibility decision that was intertwined with the medical decision that inpatient treatment was unnecessary to treat the plaintiff’s infection. As a “mixed eligibility and treatment decision,” the issue was whether the plaintiff’s claim was completely preempted pursuant to section 502(a)(1)(B) as an attempt to recover benefits. Just as the Second Circuit did in Cicio, the Eleventh Circuit looked at the recent Supreme Court jurisprudence, the role of the states in regulating health care, and Congressional intent in enacting ERISA. Accordingly, the court determined that Congress did not intend to federalize medical malpractice claims and therefore the plaintiff’s claims were not preempted by ERISA section 502(a).

In addition to the Second and Eleventh circuit courts, two other courts have similarly found against preemption. In Isaac v. Seabury & Smith, the District Court for the Southern District of Indiana held that claims related to mixed eligibility and treatment decisions were not preempted by ERISA and as such the federal district court lacked jurisdiction to entertain the claim. In Isaac, Judy Ambrugey did not participate in an HMO but rather participated in a health benefit “fee-for-service” plan through her employer, to which the defendant served as an administrator. After contracting leukemia, Ms. Ambrugey’s oncologist requested that the plan administrator authorize insurance coverage for a bone marrow transplant. Initially, the administrator denied coverage because the procedure was not “medically necessary.” One month later, the administrator gave “conditional approval” for the transplant, but tragically, Ms. Ambrugey died before any transplant could occur.

A representative of Ms. Ambrugey filed suit in an Indiana state court and the defendants removed the case to federal district court, arguing that the

192. Id. at 1292.
193. Id. (quoting Cicio, 321 F.3d at 104).
194. Id. at 1293.
195. Id.
196. Id.
197. Land, 339 F.3d at 1294.
199. Id. at *3.
200. Id.
201. Id. at *4.
202. Id.
ERISA Preemption

claims were completely preempted by ERISA. The district court analyzed the claim based on the tripartite distinction utilized in Pegram and ruled that it was a “mixed eligibility and treatment decision” and therefore not preempted by ERISA section 502(a). According to the court, the defendant made two decisions. One decision denied Ms. Ambrugey coverage because the procedure was not “medically necessary” and the other granted “conditional approval” for the operation. Both involved a coverage decision, whether Ms. Ambrugey was eligible under the plan for the transplant, and a treatment decision, whether the transplant was medically necessary.

More importantly, the district court also clearly announced that the Pegram jurisprudence applied to all decision-makers, whether an HMO, a physician employed by an HMO, or a physician engaged by a third-party administrator. The Pegram decision “focused on decisions: eligibility decisions, treatment decisions, and mixed decisions of treatment and eligibility.” It did not focus on who provided the treatment. Therefore, the third-party administrator that made the decision to deny Ms. Ambrugey coverage fell within the “Pegram regime.”

A similar result was attained in Pappas v. Asbel, infra, after the United States Supreme Court remanded the case for “further consideration in light of Pegram v. Herdrich.” For the second time, Pappas v. Asbel (Pappas II) came to the Pennsylvania Supreme Court. However, unlike Isaac where the district court considered section 502(a) preemption, the Pennsylvania Supreme Court in reviewing Pappas addressed section 514 claims.

In the remanded Pappas II case, the Pennsylvania Supreme Court affirmed its prior decision. The Pappas II court noted that it was irrelevant who made the mixed eligibility and treatment decision, comparing the physician-owned HMO in Pegram to U.S. Healthcare, which contracted independent physicians for services. The HMO’s decision was the seminal factor, not the structure of the HMO making it.

203. Id.
205. Id. at *18.
206. Id.
207. Id. at *25.
208. Id. at *26.
209. Id.
213. Id. at 1094 & n.4.
214. Id.
After reviewing the ERISA preemption jurisprudence, the *Pappas II* court held that the defendant made a mixed eligibility and treatment decision, which was not preempted by ERISA. The HMO physician reviewed Pappas' case, rejected another physician's opinion, and referred Pappas according to his personal medical opinion. In doing so, the physician did not make a "simple yes or no decision" as to whether Pappas' condition was covered; he decided whether it was covered and how it should be treated. Because the case involved a mixed eligibility and treatment decision, the adverse consequences should have been redressed through the state medical malpractice law and not disposed of via ERISA.

3. Even Courts Which Have Found Preemption Have Made Determinations Consistent with *Pegram*

Even courts which have held in favor of the managed care entity on ERISA preemption issues have been consistent with *Pegram*. For example, in *Pryzbowski v. U.S. Healthcare*, the Third Circuit considered whether an HMO's delay in approving benefits to a plan participant, when the participant sought "out of network" care, constituted an administrative decision by the HMO. The court determined that the consideration of in-network versus out-of-network providers was a purely administrative function not preempted by ERISA.

The *Pryzbowski* court approvingly cited *Pegram* and recognized that *Pegram's* distinction between "eligibility decisions" and "treatment decisions" was applicable to complete preemption analyses, and not just fiduciary duty causes of action. Per *Pegram*, the ultimate issue for complete preemption cases rests on whether the claim "challenges the administration of or eligibility for benefits, which falls within the scope of section 502(a) and is completely preempted, or the quality of the medical treatment performed, which may be the subject of a state action." Ultimately, the *Pryzbowski* court held that the claims against U.S. Healthcare were limited to the HMO's delay in approving benefits, which fell squarely within the administrative function of managed care practice.

215. *Id.* at 1096.
216. *Id.*
217. *Id.*
220. *Id.* at 276.
221. *Id.* at 273.
222. *Id.*
and were completely preempted by ERISA. 223

Likewise, in Marks v. Watters, the Fourth Circuit Court of Appeals correctly applied the principles of Pegram and found the claims preempted. 224 In Marks, Robert Cleavenger was hospitalized after he attempted suicide. 225 Health Assurance, a preferred provider organization (PPO), provided Cleavenger’s healthcare benefits. 226 Under this system, Cleavenger could choose his own healthcare provider; if he chose a “participating provider,” Health Assurance would cover 100% of his costs and if Cleavenger chose to go outside the network, Health Assurance would cover 80% of his costs. 227 Four days after being hospitalized, a physician discharged Cleavenger, who expressed concerns that he would lose his job if he stayed. 228 Once released, Shelley Watters, a case manager from Mainstay, a behavioral healthcare component of Health Assurance, contacted Cleavenger to arrange for outpatient services. 229 Cleavenger attended one outpatient appointment but no others. Eight days after being released from the hospital, Cleavenger killed his wife and daughter and then committed suicide. 230

The representatives of the decedents sought damages alleging that Cleavenger had not been properly treated or monitored during his outpatient treatment. 231 In addition to suing the physicians and the hospital, the plaintiffs brought an action against Mainstay, the managed care entity. 232 Health Assurance and Mainstay removed the case to federal court claiming complete preemption under ERISA; thereafter, the district court granted the defendants’ motion for summary judgment. 233 The Fourth Circuit affirmed, stating that Mainstay’s case managers had no authority to decline approval for treatment, but merely managed Cleavenger’s utilization of his healthcare benefits. 234 Accordingly, Mainstay and Health Assurance’s decisions were purely administrative and therefore were within the scope of section 502(a)

223. Id. at 274-75. The court went on to say that to allow Pryzbowski’s claim to go forward would be to open the door for legal challenges to core managed care practices such as, for example, the policy of favoring in-network specialists over out-of-network specialists. Id.


225. Id. at 319.

226. Id.

227. Id.

228. Id. at 320.

229. Id. at 319-20.

230. Marks, 322 F.3d at 320-21.

231. Id. at 321.

232. Id.

233. Id.

234. Id. at 325.
and completely preempted.\textsuperscript{235}

Notably, the Eleventh Circuit in \textit{Land} used \textit{Pryzbowski} and \textit{Marks} to support its holding, even though these cases had contrary results.\textsuperscript{236}

\textbf{B. Courts Finding Preemption}

In \textit{DiFelice v. Aetna U.S. Healthcare}, the Third Circuit Court of Appeals refused to apply the \textit{Pegram} tripartite structure, and determined that section 502(a) provided complete preemption for all but one claim.\textsuperscript{237} The court avoided ruling on section 514 preemption and remanded the remaining "hospital discharge" claim to the district court for further consideration.\textsuperscript{238}

In that case, Joseph DiFelice received a tracheostomy tube for his sleep apnea and an upper airway obstruction.\textsuperscript{239} Since the tube repeatedly came out, his physician requested a special tube.\textsuperscript{240} However, DiFelice's HMO, Aetna U.S. Healthcare, functioning as the administrator of his employer's welfare benefit plan, determined that the requested tube was "medically unnecessary."\textsuperscript{241} As a result, DiFelice's physician inserted a different tube, which caused DiFelice severe pain and resulted in an infection.\textsuperscript{242} DiFelice was subsequently admitted to another hospital for treatment but was allegedly discharged at Aetna's insistence.\textsuperscript{243}

DiFelice filed suit in state court alleging that Aetna's decisions were negligent under state law.\textsuperscript{244} Aetna removed the case to federal court on the basis of ERISA preemption.\textsuperscript{245} The district court, agreeing with Aetna, held that the case was completely preempted and dismissed it in its entirety.\textsuperscript{246} The Third Circuit Court of Appeals affirmed in part, and reversed and remanded in part.\textsuperscript{247}

The Third Circuit considered the allegations separately and held that DiFelice's claim that he was forced to leave the hospital was not preempted,\textsuperscript{248} while the claim that Aetna refused to authorize the special

\begin{itemize}
  \item \textsuperscript{235} Id. at 327.
  \item \textsuperscript{236} Land v. CIGNA Healthcare of Fla., 339 F.3d 1286, 1294 (11th Cir. 2003).
  \item \textsuperscript{237} DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442, 449-50 (3d Cir. 2003).
  \item \textsuperscript{238} Id. at 453.
  \item \textsuperscript{239} Id. at 444.
  \item \textsuperscript{240} Id.
  \item \textsuperscript{241} Id.
  \item \textsuperscript{242} Id.
  \item \textsuperscript{243} DiFelice, 346 F.3d at 444.
  \item \textsuperscript{244} Id. at 445.
  \item \textsuperscript{245} Id.
  \item \textsuperscript{246} Id.
  \item \textsuperscript{247} Id. at 444.
  \item \textsuperscript{248} Id. at 453.
\end{itemize}
tube was preempted.\textsuperscript{249} The court found that Aetna's determination fell between the eligibility-treatment dichotomy established in \textit{Pryzbowski}, and further scrutinized the claim to determine whether it could arise under section 502(a).\textsuperscript{250} The Third Circuit in \textit{Pryzbowski} found that the "quality-quantity" distinction set forth in prior decisions was unclear and suggested that the United States Supreme Court's opinion in \textit{Pegram}, which distinguished \textit{eligibility} from \textit{treatment} decisions, was more helpful.\textsuperscript{251}

Despite the fact that the court made special note of the \textit{Pegram} distinction, in actuality, the court distinguished the \textit{Pegram} tripartite analysis as only applying to claims of breaches of fiduciary duties.\textsuperscript{252} Instead, the court favored the \textit{Pryzbowski} eligibility-treatment dichotomy, which ultimately led the \textit{DiFelice} court to the question of whether the claim could have been the subject of a civil enforcement action under section 502(a).\textsuperscript{253} In quoting \textit{Pryzbowski}, the \textit{DiFelice} court stated:

\begin{quote}
Regardless of the language used, the ultimate distinction to make for purposes of complete preemption is whether the claim challenges the administration of or eligibility for benefits, which falls within the scope of [section] 502(a) and is completely preempted, or the quality of the medical treatment performed, which may be the subject of a state action.\textsuperscript{254}
\end{quote}

Similar to the jurisprudence set forth in pre-\textit{Pegram} cases, the court observed that if the claim could have been brought under section 502(a), it would be preempted.\textsuperscript{255} In setting forth its process of determining preemption, the Third Circuit stated that under \textit{Pryzbowski}, the first question is whether the claim is preempted by section 502(a) and this determination is based on whether a claim is entirely administrative, in which case the claim would be preempted, or entirely treatment, in which case the claim would not be preempted.\textsuperscript{256} If the claim falls in between, then the complaint must be analyzed to determine if any of the alleged wrongdoing could have been the basis for a suit under section 502(a).\textsuperscript{257}

The court applied this analysis to \textit{DiFelice}'s claim regarding Aetna's

\begin{itemize}
\item \textsuperscript{249} \textit{DiFelice}, 346 F.3d at 449.
\item \textsuperscript{250} \textit{Id.} at 448-49.
\item \textsuperscript{251} \textit{Id.} at 446-47 (citing \textit{Pryzbowski} v. U.S. Healthcare, Inc., 245 F.3d 266, 273 (3d Cir. 2001)).
\item \textsuperscript{252} \textit{Id.} at 450.
\item \textsuperscript{253} \textit{Id.} at 447.
\item \textsuperscript{254} \textit{Id.} (quoting \textit{Pryzbowski}, 245 F.3d at 273).
\item \textsuperscript{255} \textit{DiFelice}, 346 F.3d at 447.
\item \textsuperscript{256} \textit{Id.} at 448.
\item \textsuperscript{257} \textit{Id.} at 447.
\end{itemize}
failure to authorize the requested tracheostomy tube. In addressing whether Aetna’s “medical necessity” determination was a treatment decision or an eligibility decision, the court noted that Aetna’s actions in denying approval for the tube had “aspects of treatment and coverage.” However, there was “no allegation that Aetna actually provided the medical care, and Aetna’s use of medical judgment could only have led to an eligibility, not a treatment, decision.”

This statement appears to indicate that the DiFelice court intentionally avoided the literal tripartite jurisprudence expressed in Pegram and utilized by the Second Circuit in Cicio. As a result, the Third Circuit appears to have resorted to a pre-Pegram analysis similar to the Fifth Circuit’s decision in Corcoran where the court ruled that although Aetna made a medical decision, the medical decision was made in the context of an insurance determination and, therefore, was only an eligibility decision.

The DiFelice court engaged in a similar analysis and collapsed the “pure eligibility” and “mixed eligibility and treatment” decision categories, noting that Aetna’s use of medical judgment could only lead to an eligibility decision. However, the court’s analysis did not end there. Because the court felt that DiFelice’s claim was both a medical treatment and an eligibility decision and fell between the two poles discussed in Pryzbowski, the court determined whether the claim could be brought under a section 502(a) civil enforcement action. In reviewing the claim, the court found that DiFelice could have challenged Aetna’s determination not to provide him with the tube by “filing a claim under 502(a)(1)(B) ‘to recover benefits due to him under the term of his plan.’” Because DiFelice could have brought the claim under section 502(a), his claim was held to be completely preempted by ERISA.

Determining that the claim was mixed and preempted because it could have been brought as a request for intervention pursuant to section 502(a) resembles the traditional approach to preemption and is inconsistent with the tripartite jurisprudence. If the determination at issue was held to be a mixed decision and the Third Circuit followed the Supreme Court reasoning in Pegram, this would necessitate a ruling that preemption did not apply. Since the DiFelice court determined that the claim involved a mixed

258. Id. at 449.
259. Id. at 449 (emphasis added).
260. Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1331 (5th Cir. 1992)
261. DiFelice, 346 F.3d at 449.
262. Id.
263. Id.
264. Id.
decision, rather than an eligibility decision, the court implicated a 
trichotomous classification, as in Pegram. However, the Third Circuit 
determined that DiFelice’s claim was mixed and still preempted because it 
could have been brought as a request for intervention pursuant to section 
502(a), an approach based on the old “quality/quantity” distinction. It is 
important to note that if the DiFelice court had determined that this was 
merely an eligibility decision, consistent with the reasoning in Corcoran, 
the court could have dismissed the claim. Instead, the court determined that 
the claim was a new type of claim, a mixed eligibility and treatment 
decision, and the court fashioned a new rule regarding these types of 
determinations, rather than applying the Supreme Court’s rule from 
Pegram.

If DiFelice’s claim truly involved a mixed decision and the Third Circuit 
followed the Supreme Court’s ruling in Pegram, it would have necessitated 
a ruling that preemption did not apply. However, the DiFelice court 
considered Pegram to be limited to situations in which the specific entities 
at issue were physician-owners, and the individuals were acting as 
fiduciaries.265

The DiFelice court did not address the Supreme Court’s ruling in U.S. 
Healthcare, which vacated and remanded Pappas v. Asbel and appeared to 
mandate an expansion of the applicability of the tripartite jurisprudence 
from Pegram to HMO’s and other non-physician-owned entities.266 By 
failing to utilize Pegram and apply the new classification, the DiFelice 
court allowed itself to engage in reasoning typical of pre-Pegram claims, 
resorting to an analysis of whether DiFelice’s claim could have been 
brought pursuant to section 502(a) and finding the claim completely 
preempted.

It is critical to note the consequences of limiting Pegram, and this is 
easily seen when comparing Cicio and DiFelice. A just consideration of 
Pegram, as in Cicio and Land, leads to only one question: whether the 
determination is a mixed eligibility and treatment decision. If it is, then the 
mere classification of a decision into the “mixed eligibility and treatment” 
category would necessitate the denial of ERISA preemption in a federal 
court with an order vacating and remanding the case for further proceedings 
under state medical malpractice law. However, if Pegram is limited, as in 
DiFelice, then a court may view the determination as a mixed eligibility and 
treatment decision, but limit its application, in some sense almost 
eliminating the category of mixed decisions except with entities similar to 

265. Id.
those in Pegram. Such a split interpretation certainly cannot be permitted and would seem to be a motivating force behind the reason why the Supreme Court accepted review of Calad and Davila. 267

After considering DiFelice’s claim regarding Aetna’s failure to authorize the nasal tube, the DiFelice court considered DiFelice’s claim that he was improperly discharged from the hospital. 268 Unlike his first claim, DiFelice did not claim that the discharge was pursuant to a medical necessity decision; indeed, the court stated that it was difficult to tell from DiFelice’s “vague” pleadings what he was actually alleging. 269 The court stated that “the claim on its face [was] not plan-related,” but the pleadings did not suggest that it could not be. 270 Since the court could not rule on whether the hospital discharge claim would be preempted, the court remanded it for further determinations. 271 Courts have repeatedly read behind the face of complaints alleging wrongful denial of care, so it is unusual that this court failed to do so. 272 Yet the court ruled that “[a]t the dismissal stage, it was Aetna’s burden to prove federal jurisdiction by proving that this is an ERISA claim.” 273 Does this mean that the court is expecting the pleadings to be amplified at the district court level? Or is the Third Circuit implying that plaintiffs in these actions word their complaints as vaguely as possible so as to avoid federal preemption?

IV. HOW WILL THE SUPREME COURT RULE?

The Supreme Court has finally accepted two cases that will determine the applicability of ERISA preemption in the context of utilization review determinations. However, it is noteworthy that the cases the Court has accepted, Calad and Davila, are limited in scope and only require rulings on section 502(a) preemption. Because Cicio addressed both section 502(a) and section 514 preemption, it would have been the better vehicle to determine the full range of ERISA preemption issues. It is somewhat
perplexing why the Court failed to accept Cicco, a case which addressed both section 502(a) and section 514 preemption, explicated the Supreme Court's mixed eligibility and treatment decision language, and is not intertwined with any state law pertaining to suits against managed care entities.

It is possible that the Court will rule on both types of preemption. It may, through dicta, rule on section 514 preemption within the context of the cases involving section 502(a). And it is not inconceivable that the Court will decide the section 502(a) issue against preemption and then observe what lower courts do with the questions of the section 514 defense. This is consistent with the Court's refusal to review Pappas II, which only considered section 514, after the Pennsylvania Supreme Court utilized the Pegram jurisprudence.

In relation to the Court's consideration of section 502(a) preemption, prior rulings by the Court may indicate how it will decide Calad and Davila. Two considerations seem to suggest that the Court will eliminate ERISA's complete preemption of utilization review claims. First, the language of Pegram clearly identifies a new jurisprudence. Furthermore, the vacatur and remand in U.S. Healthcare, which vacated and remanded Pappas v. Asbel, would seem to indicate that the Supreme Court believes that this ruling and its tripartite jurisprudence should not be limited to the physician-owned entity at issue in Pegram.

Second, the Supreme Court has repeatedly ruled that matters of health and safety are traditionally relegated to the states and that "the historic police powers of the states [are] not to be superceded by the federal act [ERISA] unless that was the clear and manifest purpose of Congress." Indeed, both of the recent Supreme Court rulings in Pegram and Rush Prudential HMO, Inc. v. Moran support the contention that health care regulation is a matter of traditional state interest.

In Rush Prudential, the plaintiff requested treatment from an out-of-network provider because no in-network physician could perform the

277. See David L. Trueman, The Impact of the Recent Supreme Court Rulings in Pegram and Rush Prudential on State Regulation of Managed Care Organizations, J. HEALTH L., Winter 2003 (providing an analysis of Pegram and Rush Prudential and the Supreme Court's affirmation that the regulation of health care is within the province of the state and the impact of that position on managed care).
surgery that was recommended by the physicians. Illinois’s HMO Act mandated that, in cases of dispute between the recommendations of the patient’s primary care physician and the managed care entity, the patient could request a binding independent review. Although the independent reviewers sided with the plaintiff, the company refused to comply and sought to invalidate the state statute as conflicting with ERISA section 514. In ruling that the Illinois law was saved by the saving clause of section 514 and was not subject to preemption, the Court iterated that the regulation of health care was a state matter, a position it had previously espoused in Pegram.

The Court’s position that health care regulation is a matter of state control along with its decisions in Pegram and U.S. Healthcare would lead to a prediction that the Court will, at a minimum, end section 502(a) preemption. But, what other steps may occur? If the Court chooses not to rule on section 514 preemption, this section would surely be at the heart of the next battle. Presumably, the Court would wait until there is a conflict between the Circuits before accepting a case to decide the section 514 preemption issue.

If the Court decides to end section 514 preemption, then the struggle between HMOs and patients would occur in state court. And since medical malpractice claims seem to be the only actions that would be allowed to proceed in a state court, questions would arise regarding the viability of such actions. Issues regarding duties and relationships between healthcare organizations, its medical personnel, and the insured plan participants would be addressed in the state court forum. Should the Supreme Court end ERISA preemption, it is entirely possible that plaintiffs might be unable to prevail in state court because of barriers to demonstrating elements of medical malpractice claims. Thus, even if the Court takes the most expansive view of Pegram and rules against both types of preemption, there will not be clarity regarding claims against managed care entities for medical decision-making within the context of utilization review.

Oddly, there was no mention of the term “mixed eligibility and treatment” in the oral arguments of Calad and Davila before the Supreme Court on March 23, 2004. Arguing before the court were the attorneys for the health plan, the U.S. Department of Justice, the Solicitor General’s Office (arguing on behalf of the insurer), the plaintiffs-respondents, and the

278. Rush Prudential, 536 U.S. at 360.
279. Id. at 361.
280. Id. at 362.
281. Id. at 387 (citing Pegram v. Herdrich, 530 U.S. 211, 236 (2000)).
Texas attorney general (arguing on behalf of the respondents). As expected, much of the questioning focused on the distinction between benefits determinations and medical treatment.

There was considerable focus on the Texas statute that permitted claims against managed care entities. Additional arguments, relating to section 502(a) and *Pilot Life*, were primarily limited to the context of the Texas statute and whether Texas could create a cause of action that survived ERISA. The justices essentially collapsed the merits questions with the jurisdictional issues and, unlike the complete preemption arguments, conflict preemption pursuant to section 514 was only cursorily addressed. Commenting on the argument that the Texas statute falls within the insurance savings clause of section 514 because the benefit denial was the equivalent of practicing medicine and therefore not preempted, Justice Souter stated, "[i]t seems to me an irrational logical leap."283 Clearly, as demonstrated in *Pappas*, there can be a matter that addresses the substantive issues pertaining to medical necessity decision-making without a jurisdictional question pursuant to section 502(a).

The failure to fully address section 514 highlights the potential problem with the Court's selection of *Calad* and *Davila*. Although significant portions of the argument addressed the decision-making process and the delivery of health care services, as noted, much of the discussion was devoted to section 502(a) and the Texas statute. On the contrary, *Cicio* would, presumably, have been a better vehicle to address the full range of ERISA issues since the Second Circuit had determined both complete and conflict preemption. Furthermore, some of the Court's questions were about whether the plaintiff should have paid for what had been requested, in one case the drug Vioxx, and subsequently sought reimbursement under ERISA. A case with a limited expenditure of money by a beneficiary of a plan, such as the payment for a drug, could easily obscure the reality of many of the struggles of modern day health care when the requested treatment is prohibitively expensive. A consideration of a case with a limited financial exposure might lead to the conclusion that ERISA is adequate to address all utilization review conflict. However, the situation in *Cicio*, where the decedent needed treatment that might have cost as much as $150,000, a sum which he and his family could not have obtained, highlights the real problem of perceiving ERISA as the sole mechanism operating to enforce patients' rights. Unfortunately, the oral argument did not address such cases.

The justices were also interested in the issue of how medical necessity decisions might define the basic standards of medical care. This raises a

clear state law issue. If the Court decides to end ERISA preemption (meaning both complete and, necessarily, conflict preemption), and allows these claims to be pursued in state court under medical malpractice law, what will be their fate? It is not at all clear whether the causes of action may be able to proceed. A variety of issues and potential defenses to these medical malpractice claims are available, including the issues of whether state statutory law would allow such claims, the impact of the ban on the corporate practice of medicine, whether the health care coverage is only a contract not allowing tort recovery, and whether there is a relationship between either the plan and the patient or the medical personnel and the patient to establish a duty of care for the purposes of a medical malpractice claim. These issues will surely be ones of first impression in most states and will, in many ways, force states to come to terms with changes in the health care system.

Although the law pertaining to managed care liability is uncertain, one thing remains clear. This area of the law will remain challenging and unsettled for a long time, offering attorneys exciting opportunities to assist in the shaping of the health care system.

V. CONCLUSION

The U.S. Supreme Court now has the opportunity to finally settle questions about what rights individuals have in holding their insurers and health plans responsible for decision-making regarding care that their doctors have determined is necessary. The Supreme Court is presently reviewing two cases that pertain to ERISA and the decision may clarify an area of the law which has become quite unsettled, and one in which there are many claims of dramatic injustice. The cases which the Court has selected hint that there may not be a complete resolution of the issue, with only one area of preemption resolved. However, if the Supreme Court decides both preemption issues and ends ERISA dismissal of claims about wrongful utilization review decisions, it is quite unclear whether those claims can succeed on their merits in state court.