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HEALTH INSURANCE: PAYING THE PREMIUM, OR PAYING THE PRICE? - ERISA PREEMPTION AND RICO'S RECOURSE

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HEALTH INSURANCE: PAYING THE PREMIUM, OR PAYING THE PRICE? - ERISA PREEMPTION AND RICO'S RECOURSE

Lalena J. Turchi[1]

I. INTRODUCTION

As an employee benefits consultant, I have been exposed to the perils of the health insurance industry in our country. My career requires a commitment to my client, the employer, to structure an employee benefit plan in a way that maintains competitiveness for employees, while maintaining costs associated with offering such benefits. A major portion of my client's bottom line is dedicated to providing health insurance to its current and prospective employees. I also have a commitment to the employee to maximize the positive impact the participant experiences in utilizing their health insurance benefits.

I assist the employee to understand their health plan by explaining eligibility issues, consumerism through use of co-pays, prescription drug formulary lists, and limitations and exclusions under the health insurance program. I also spend a great deal of time helping the employee to get claims paid. Claims are often erroneously rejected because of administrative inefficiencies inherent in the insurer-provider billing system. Claims are also rejected when the insurer decides that a

[1] J.D. Candidate, Rutgers School of Law – Camden (2008); B.S. La Salle University (2001). Account Manager, Johnson, Kendall & Johnson Benefits, Inc. (2001 to present).

provider's treatment is not "medically necessary."[2] This rejection can be incredibly disheartening given the amount of premiums paid by the employer and the amount of contributions paid by the employee.

My frustration lies primarily with the way insurance companies police an insured's access to care, given the high cost of insurance premiums. The price is high (literally), but is much higher when the insured cannot obtain adequate care that his doctor has prescribed, such as medical procedures, testing, or prescription drug therapy. We trust that our doctors will always have our best interest in mind, so we undergo the recommended care only to later discover that we are responsible to pay out of pocket because the insurance company has rejected the provider's recommendations. Even more alarming, the insured may learn that the service will not be covered prior to undergoing care, so they forgo the care because they cannot afford to pay out of pocket. This is the highest price to pay since health care is at the very core of our human existence.

It is a basic human need to receive necessary treatment in order to maintain a long and healthy life. The threat to this basic need is not limited to those at a poverty level income.[3] All of us are at risk of having to decide among forgoing medical care or paying out of pocket for services that can be financially ruinous.[4] The costs are even greater when the amounts are non-

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[2] *See*, *e.g.*, Independence Blue Cross, *Coding Guidelines and Policy Update*, vol. 3, issue 3 (Fall 2006), *available at* http://www.ibx.com/pdfs/providers/communications/coding_guidelines/ibc_fall_2006_cgpu.pdf (outlining "medically necessary" criteria for medical services and procedures applied to participants of all Independence Blue Cross's HMO, POS and PPO programs).

[3] *See* National Coalition on Health Care, Health Insurance Cost (2007), *available at* http://www.nchc.org/facts/2007%20updates/cost.pdf ("One half of workers in the lowest-compensation jobs and one-half of workers in mid-range-compensation jobs either had problems with medical bills in a 12- month period or were paying off accrued debt. One quarter of workers in higher-compensated positions also reported problems with medical bills or were paying off accrued debt."), (last visited Feb. 28, 2008).

[4] National Coalition on Health Care, *supra* note 3 ("One in four Americans say their family has had a problem paying for medical care during the past year ... [n]early 30 percent say someone in their family has delayed medical care in the past year ... 50 percent of all bankruptcy filings were partly the result of medical expenses.").

negotiated. We pay much higher prices for services than what the insurance company would pay on our behalf.[5]

The insurance companies have a great hold on our access to care recommended by our doctors. Our inability to receive adequate remedies if we attempt to bring a lawsuit against the insurer for injuries due to a negligent coverage decision further exacerbates this hold. If we suffer harm due to our insurer's failure to cover services necessary to maintain our health, the Employee Retirement Income Security Act ("ERISA") will likely preempt the cause of action.[6] ERISA allows for contract damages: the ability to clarify rights under the health insurance contract, or a judgment for the services at issue is to be paid for by the insurance company.[7] ERISA preempts any state law right to collect compensatory damages.[8] This unquestionably serves as a litigation shield and an incentive for the insurance carrier to

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[5] *See* Beverly Cohen, *The Controversy Over Hospital Charges to the Uninsured -- No Villains, No Heroes*, 51 VILL. L. REV. 95, 100-01 (2006) (comparing "deeply discounted rates" paid by government programs and private insurers to patient payment of "the full retail price," which is often twice or several times higher. The government or private plan will pay a flat fee per diagnosis, which will encompass all expenses relating to a hospital stay, while the patient will pay "line by line charges, down to band-aids and aspirins." Further, an enormous gap exists between what a hospital charges a patient for these line items and the hospital's actual cost; i.e., a 355% markup on three bottles of dye to image the patient's arteries: $532.50 for the patient, as opposed to the manufacturer charge of $28 to $50 per bottle). *See also* Lucette Lagnado, *Anatomy of a Hospital Bill*, Wall St. J., Sept. 21, 2004, at B1 (describing the price increases employed by hospitals when charging uninsured patients).

[6] 29 U.S.C. § 1132 (2000).

[7] *Id.* § 1132(a)(1)(B). *See* Elizabeth Khoury, *HMO Liability After Aetna Health Inc. v. Davila: Are Patients' Rights At Risk?,* 91 IOWA L. REV. 1621, 1624 (2006) (explaining that "a plaintiff who is wrongfully denied coverage for a hospital stay will be reimbursed for the cost of any care wrongfully denied, but not for any consequences suffered due to such a denial. ERISA does not allow for tort damages or 'extra-contractual' damages.").

[8] *See* Van Natta v. Sara Lee Corp., 439 F.Supp. 2d 911, 917 (N.D. Iowa 2006) (describing ERISA preemption where "plaintiffs ... resisted, not surprisingly, because if their state-law claims are preempted, they are entitled only to the meager, and often inadequate in the eyes of this court, compensation provided for under ERISA").

deny more services than it would if its liability were not so limited.[9]

This Note will explore the health insurance industry in its current state of chaos, and will include a report on the inefficiencies of managed care. It will explore the inadequacy of remedies due to ERISA preemption, and will analyze Congressional intent and the Supreme Court's position through applicable case law.

The Note also takes the position that the invocation of the Racketeer Influence and Corrupt Organizations Act ("RICO")[10] into litigation may be the much needed recourse for our inability to obtain adequate remedies. This portion of the Note will explain the significance of RICO litigation thus far, and the dicta that may symbolize a more promising future for the insured. The health insurance industry is complex, and its socioeconomic impact is equally complicated. An understanding of the laws that govern the health insurance industry may serve as an instrument for change.

II. BACKGROUND

A. THE HEALTH INSURANCE INDUSTRY

1. Impact on Employers

Employers are the principal source of health insurance benefits in our country.[11] "Health insurance expenses are the fastest growing cost component for employers [and] ... [u]nless something changes dramatically, health insurance costs will overtake profits by 2008."[12]

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[9] *See* Jack E. Karns, *Litigating Around ERISA to Quality Managed Healthcare: An HMO Can Breach Fiduciary Duties*, 79 NEB. L. REV. 149, 153-55 (2000) (explaining ERISA's cap on damages).

[10] 18 U.S.C.A. §§ 1961-1968 (2000).

[11] The Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits: 2006 Annual Survey (2006), *available at* http://www.kff.org/insurance/7527/upload/7527.pdf.

[12] National Coalition on Health Care, *supra* note 3.

Fifty-nine percent of workers are covered under their work's health benefits, and those who are not may be covered by their spouse's employer.[13] Between 2005 and 2006, the national average for health insurance premium increases was 7.7%, which was 3.5% more than inflation and 3.8% more than employee wages.[14] "Experts agree that our health care system is riddled with inefficiencies, excessive administrative expenses, inflated prices, poor management, and inappropriate care, waste and fraud ... [and] [t]hese problems significantly increase the cost of medical care and health insurance for employers and affect the securities of families."[15]

The local average for premium increases was even higher at 8.8%,[16] and small businesses were hit the hardest at 10.5%.[17] Employers are faced with difficult decisions that may include a shift of some or all of the increase to its employees through higher deductibles and co-pays, and increased employee contributions.

2. The Impact on Employees

In 2006, workers contributed an average of 16% towards single coverage and 27% towards family coverage.[18] With an

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[13] The Kaiser Family Foundation and Health Research and Educational Trust, *supra* note 11.

[14] *Id.*

[15] National Coalition on Health Care, *supra* note 3. Further, "the Unites States spends more on health care than other industrialized nations, and those countries provide health insurance to all their citizens."

[16] The Kaiser Family Foundation and Health Research and Educational Trust, *supra* note 11, at 25 (indicating a higher-than-national-average increase in the Northeast).

[17] *Id.* at 20 (indicating an average 10.5% increase for firms between three and twenty-four workers).

[18] *Id.* at 25. *See also* National Coalition on Health Care, *supra* note 3 ("The average employee contribution to company-provided health insurance has increased more than 143 percent since 2000. Average out-of-pocket costs for deductibles, co-payments for medications, and co-insurance for physician and hospital visits rose 115 percent during the same period.").

average annual premium of $4,242 for singles and $11,480 for families,[19] the employee's financial impact is significant. The impact to employees is compounded by increases in co-pays and deductibles. For example, 25% of workers experienced additional cost sharing for hospital stays and 20% had additional cost sharing for outpatient services.[20] Employers reportedly will continue to cost shift to their employees as they are faced with double-digit health insurance increases.[21] It will become increasingly difficult for Americans to maintain their health insurance benefits, and will struggle to plan for other financial goals such as education and retirement.

3. A Look at the Past

Health care cost concerns are hardly a recent development. In the early 1990s, health care reform was at the top of the political agenda in the United States.[22] Large employers were experiencing an increase in premiums of 22% per year, and health care spending had reached 12% of GNP.[23] A decade-long trend of high health care inflation was attributable to a combination of societal and health care issues, including an

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[19] The Kaiser Family Foundation and Health Research and Educational Trust, *supra* note 11, at 25.

[20] *Id.*

[21] The Kaiser Family Foundation and Health Research and Educational Trust, *2006 Summary of Findings* (2006), *available at* http://www.kff.org/insurance/7527/upload/7528.pdf, (reporting that employers are "very or somewhat likely to increase what employees pay for coverage (49%), increase plan deductibles (39%), increase co-payments or coinsurance for doctor visits (39%), or increase worker payments for prescription drugs (39%)"). *See also* National Coalition on Health Care, *supra* note 3, ("U.S. health care spending is expected to increase at similar levels for the next decade reaching $4 TRILLION in 2015, or 20 percent of GDP.").

[22] Review and Evaluation of the U.S. Health Reform – The Clinton Plan (Mar. 7, 2007), *available at* http://www.econ.qmul.ac.uk/NHS_reforms.com/student_file/Wang_new.doc.

[23] Sally W. Gilfillan, *Health Insurance in the 1990s*, The CPA Journal Online (Feb. 1993), http://www.nysscpa.org/cpajournal/old/13808651htm.

aging population, development and popularity of "blockbuster" drugs,[24] and technological advances.[25]

A long history of health care inflation has led our nation to develop new and innovative ways to control costs. However, managed care has a long way to go in terms of development and effectiveness. The model has not evolved enough to effectuate a proper balance between cost control and quality of care. The health care system continues to be "undergoing too many shocks and changes."[26] "So many changes are taking place in the health care sector that it may simply be too volatile to permit the types of learning and evolutionary selections that might otherwise appear."[27]

B. MANAGED CARE

1. Provider Payment: Fee-for-Service vs. Managed Care

"The rise of managed care came in response to what was seen as runaway health care costs caused by the traditional-fee-for-service method of reimbursing doctors used by insurance

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[24] *See* Michael Rosen, *Though Pharma growth slides, blockbusters reach new records*, Wisconsin Technology Network, June 6, 2005, http://wistechnology.com/article.php?id=1885 ("[T]he definition of a blockbuster drug is sales of $1 billion or more. Some 20 years ago, there was less than a handful of blockbuster drugs. In 2004, there were a record 82 blockbusters."). *See also* Wikipedia, The Free Encyclopedia (last visited March 2, 2008), http://en.wikipedia.org/wiki/Blockbuster_drug (reporting that the leading blockbuster drugs in 2003-2004 included Lipitor, Celebrex, Prilosec, Nexium, Allegra, Seroquel, Toprol, and Rhinocort).

[25] *See* Adele Kirk & Susan Ettner, *Health Care Costs: Trends and Relationship to Health Insurance Premiums*, Academic Senate (Mar. 2, 2004), *available at* www.universityofcalifornia.edu/senate/reports/hccosts.pdf.

[26] Peter J. Hammer, *Competition and Quality As Dynamic Processes in the Balkans of American Health Care*, 31 J. HEALTH POL. POL'Y & L. 473, 488 (2006).

[27] *Id.*

companies."[28] The traditional health insurance model is fee-for-service, where a physician provides services and submits the bill to the insurer for payment subject to negotiated payment terms under the contract.[29] However, a fee-for-service program has an inherent obstacle to controlling costs because the provider has a financial incentive to provide more care, not less.[30] Insurance companies had no relationship with the providers and the payment method tended to be provider-dominated in that doctors had the final say over treatment, with insurance companies footing the bill.[31] The higher costs were then being passed on to enrollees.[32] Thus in the 1960s, new health care delivery models were spawned, including the Health Maintenance Organization (HMO).[33]

"The defining feature of an HMO is receipt of a fixed fee for each patient enrolled under the terms of a contract to provide specified health care if needed."[34] "The HMO thus assumes the financial risk of providing the benefits promised: if a participant never gets sick, the HMO keeps the money regardless, and if a participant becomes expensively ill, the HMO is responsible for the treatment agreed upon even if its cost exceeds the participant's premiums."[35]

Because HMOs are risk-bearing organizations, they take steps to control costs by making coverage decisions, scrutinizing prescribed services, issuing guidelines for their physicians

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[28] Michael J. Miles, *State Regulation of HMO Physician Financial Incentives: Finding the Proper Balance between Motivating Financial Prudence and Protecting Quality of Care*, 36 RUTGERS L.J. 651, 652 (2005).

[29] Pegram v. Herdrich, 530 U.S. 211, 218 (2000).

[30] *Id.*

[31] Miles, *supra* note 28, at 652-53.

[32] *Pegram*, 530 U.S. at 218.

[33] *Id.*

[34] *Id.*

[35] *Pegram*, 530 U.S. at 218.

regarding appropriate levels of care, utilization review,[36] and precertification.[37] Physicians are rewarded for decreasing utilization of services and are penalized for excessive treatment.[38] Thus an HMO doctor has an inherent financial incentive to provide less care, not more.[39] "HMOs became popular because fee-for-service physicians were thought to be providing unnecessary or useless services."[40]

It has been argued that HMO physicians ignore patient needs because of their own, along with the HMO's, financial interests.[41] These financial interests are generally kept undisclosed to HMO plan participants.[42] Insureds argue HMOs become fiduciaries acting through their physicians; a fiduciary duty is breached through a failure to act solely in the insured's interest, and is influenced by a health care model that provides financial rewards for minimizing medical services.[43] Although

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[36] *Id.* at 219 (explaining that utilization review occurs when "specific treatment decisions are reviewed by a decision maker other than the treating physician").

[37] *Id.* (explaining pre-certification is advanced approval "keyed to standards of medical necessity or the reasonableness of the proposed treatment").

[38] *Id.*

[39] *Id.*

[40] *Id.* at 220.

[41] Pegram v. Herdrich, 530 U.S. 211, 220 (U.S. 2000).

[42] *See* Horvath v. Keystone Health Plan E., Inc., 333 F.3d 450 (3d Cir. 2003) (finding no duty to disclose absent request for such information where member of HMO brought suit alleging ERISA violation due to HMO's failure to disclose cost-control incentives). *See also* In re Managed Care Litig., 150 F.Supp. 2d 1330, 1356 (S.D. Fla. 2001) (finding no duty to disclose "absent a request for information or special circumstances"); Weiss v. CIGNA Healthcare, Inc., 972 F.Supp. 748, 754 (S.D.N.Y. 1997) ("Had Congress seen fit to require the affirmative disclosure of physician compensation arrangements, it could certainly have done so in ERISA §§ 101-111. The general fiduciary obligations set forth in ERISA ... do not refer to the disclosure of information to Plan participants, and it would be 'inappropriate to infer an unlimited disclosure obligation on the basis of general provisions that say nothing about such duties.'").

[43] Pegram v. Herdrich, 530 U.S. 211, 212 (U.S. 2000).

financial incentives will always be a main component in controlling costs through managed care, more must be done to ensure a proper balance between financial incentives and quality of care.[44]

III. ERISA PREEMPTION

A. LIMITED REMEDIES UNDER ERISA

1. A Brief History

ERISA was initially designed as a safeguard against pension plan bankruptcy that could leave employees without pensions they had worked years to earn.[45] ERISA was preceded by the Welfare and Pension Plans Disclosure Act (WPPDA),[46] which failed to regulate the funding of retirement plans and administrative practices of plan fiduciaries, and failed to address unreasonable vesting requirements leading to the denial of anticipated retirement benefits.[47] In 1970, Congress appointed a Subcommittee ("on Labor of the Senate Committee on Labor and Public Welfare") to investigate the private pension industry and to cure abuses resulting from a lack of substantive regulatory controls.[48]

ERISA was passed in 1974, reflecting the reality of political compromise through ERISA's preemption language.[49] Congress

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[44] Hammer, *supra* note 26, at 487-88.

[45] Corporate Counsel's Guide to ERISA § 1:1 (1998). *See* Donald T. Bogan, *ERISA: The Savings Clause, § 502 Implied Preemption, Complete Preemption, and State Law Remedies*, 42 SANTA CLARA L. REV. 105, 116-17 (2001) (explaining ERISA provides for detailed vesting and funding requirements, pension plan termination insurance, reporting and disclosure requirements, and fiduciary standards for plan administrators).

[46] Act of Aug. 28, 1958, Pub. L. No. 85-836, 72 Stat. 997, *repealed by* ERISA § 111(a)(1), 29 U.S.C. § 1031(a)(1).

[47] Bogan, *supra* note 45, at 114-15.

[48] *Id.* at 115-16.

[49] *Id.* at 117. *See also* Michael S. Gordon, *Health Reform and ERISA Preemption After the Travelers Decision – Defining the Role of the States*,

drafted the statute to provide a single, comprehensive set of rules governing private pensions to relieve employers from complying with multiple and divergent state and local regulations in the hopes of encouraging employers to offer retirement benefits.[50] Although the safeguard against bankrupt pensions and the regulatory regime still exists, ERISA has evolved to regulate all employee benefit plans, including deferred compensation and employee welfare benefit plans.[51]

The protection is so broad that Congress has explicitly made ERISA the sole statutory law affecting employee benefit plans through its broad preemption feature.[52] The preemption clause of Section 502 states ERISA "shall supersede *any and all* State laws insofar as they may now or hereafter relate to *any* employee benefit plan."[53]

2. ERISA's Preemptive Force

"Essentially, there are two components to ERISA's extensive preemptive force."[54] First, ERISA expressly preempts any state laws relating to an employee benefit plan.[55] Whether the state law "relates to" an employee benefit plan has been difficult for

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Remarks at the George Washington University Health Policy Forum's Conference: Health Systems Financing After the Travelers Case (July 21, 1995) (stating ERISA's preemption language is a "Congressional act of political expediency").

[50] Bogan, *supra* note 45, at 117-18.

[51] 26 U.S.C. § 414(i), (j) (2006) ("The term 'defined contribution plan' means a plan which provides for an individual account for each participant and for benefits based solely on the amount contributed to the participant's account, and any income, expenses, gains and losses, and any forfeitures of accounts of other participants which may be allocated to such participant's account ... the term 'defined benefit plan' means any plan which is not a defined contribution plan.").

[52] Bogan, *supra* note 45, at 117-18.

[53] 29 U.S.C. § 1144(a) (emphasis added).

[54] Van Natta v. Sara Lee Corp., 439 F. Supp. 2d 911, 924 (N.D. Iowa 2006).

[55] *Id.*

litigants and courts to ascertain. "Because Congress did not define what it meant by state laws that 'relate to' an ERISA benefit plan anywhere in the statute, the Supreme Court has struggled with the inherent nebulousness of that crucial statutory phrase."[56]

However, the Supreme Court has armed the lower courts with a starting point through use of a two-part inquiry.[57] "A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan."[58] The inquiry has been interpreted broadly to preempt state laws having only an incidental effect on benefit plans.[59]

Second, ERISA "contains a comprehensive scheme of civil remedies to enforce ERISA's provisions."[60] Although Congress passed ERISA to protect employees from abusive tactics in the

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[56] *Id.* at 926.

[57] *Id.*

[58] Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97 (1983).

[59] *Van Natta*, 439 F. Supp. 2d at 927. *See, e.g.*, Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) (applying very expansive language relating to ERISA's civil enforcement provisions; ERISA superseded plan member's state law cause of action against insurer for extra-contractual damages from bad faith denial of disability benefits claim).

[60] *Van Natta*, 439 F. Supp. 2d at 925. ERISA's civil enforcement provision provides:

> A civil action may be brought-- (1) by a participant or beneficiary-- (A) for the relief provided for in subsection (c) of this section, or (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan; (2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title; (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

29 U.S.C.A. § 1132(a)(1)-(3) (West 2006).

management of employee benefit plans,[61] "ERISA preemption is [also] the reason managed care health plans, including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and other similar entities, can avoid state-mandated benefits laws, mandated provider laws, and state-law claims for extracontractual damages that would normally protect consumers covered under standard health insurance policies."[62]

ERISA preemption applies to almost all individuals participating in a health plan sponsored by a private employer.[63] Preemption results in federal remedies, rather than state tort law remedies. Section 502 of ERISA allows for civil actions that do not include extracontractual remedies; this results in an incentive for insurers to deny or limit coverage because liability is limited to the payment of medical services under the benefit contract.[64] If insurers were subject to tort liability, they would

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[61] Kristin M. McCabe, *The Texas Health Care Liability Act: Texas Is the First State to Listen to the Concerns of Its Health Care Consumers, but How Much Has It Heard?,* 16 J. CONTEMP. HEALTH L. & POL'Y 565, 571 (2000).

[62] Donald T. Bogan, *Protecting Patient Rights Despite ERISA: Will The Supreme Court Allow States to Regulate Managed Care?*, 74 TUL. L. REV. 951, 953 (2000).

[63] John W. Schuch, *ERISA Preemption of State Tort Law Claims Against Managed Care Entities*, 67 BROOK. L. REV. 1221, 1227 (2002). *But see*, Department of Labor safe harbor provisions:

> [An] "employee welfare benefit plan" ... shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which (1) No contributions are made by an employer ... [to the policy]; (2) Employee [p]articipation [in] the [policy] is completely voluntary ...; (3) The sole function of the employer are ... without endorsing the [policy], to permit the insurer to publicize the [policy] to employees ..., to collect premiums through payroll deductions ... and to remit them to the insurer; and (4) The employer ... receives no consideration ... in connection with the [policy], other than reasonable compensation ... for administrative services actually rendered in connection with payroll deduction ....

29 C.F.R. § 2510.3-1(j) (2002).

[64] Schuch, *supra* note 63, at 1233-34.

be less inclined to deny or restrict benefits because insureds could get damages from injuries resulting from a denial of benefits and from negligent policy limitations, in addition to the cost of medical services.[65]

3. An Exception to Preemption – The Savings Clause

The inquiry does not end with a determination that a benefit plan falls within ERISA. A state law may escape preemption if it falls within ERISA's savings clause, and thus qualifies as a state law that regulates insurance.[66]

The savings clause states "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."[67] For a state law to be one regulating insurance, it must be "specifically directed toward entities engaged in insurance and it must substantially affect the risk pooling arrangement between the insurer and the insured."[68] "But even those laws are trumped by the ERISA law where they interfere with provisions of the ERISA law itself or the remedy provisions of ERISA."[69]

In *Metropolitan Life Insurance Co. v. Massachusetts*, the Supreme Court recognized the difficult tension that exists between the preemption clause and the savings clause.[70] It was noted that "while the general pre-emption clause broadly pre-empts state law, the savings clause appears broadly to preserve the States' lawmaking power over much of the same regulation … while Congress occasionally decides to return to the States what it has previously taken away, it does not normally do both at the same time."[71]

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[65] *Id.* at 1233.

[66] *Van Natta*, 439 F. Supp. 2d 928-29.

[67] 29 U.S.C.A. § 1144 (b)(2)(A) (2006).

[68] Ky. Ass'n of Health Plans v. Miller, 538 U.S. 329, 329 (2003).

[69] Mark D. DeBofsky, Association of Trial Lawyers of America, *State Laws That Survive ERISA Preemption*, 1 Ann.2006 ATLA-CLE 299 (2006).

[70] Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985).

[71] *Id.* at 739.

Metropolitan Life involved a state statute requiring health plans to provide a minimal level of mental health benefits.[72] Insurers argued that ERISA superseded the mandated mental health benefits law because it *related to* an ERISA plan.[73] The state argued alternatively that the state law was exempt from ERISA's preemption because it regulates insurance within the meaning of ERISA's savings clause.[74]

The Court agreed with the state, through the use of a savings clause test, with a common-sense component and a specific list of factors borrowed from the McCarran-Ferguson Act:[75] whether the practice at issue affects the spreading of policyholder risk, whether the practice is an integral part of the policy relationship between the insurer and the insured, and whether the state law specifically targets the insurance industry.[76]

The narrow preemption analysis established in *Metropolitan Life* was later modified by *Pilot Life Insurance* Co.[77] *Pilot Life*

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[72] *Id.* at 734.

[73] *Id.* at 734-35.

[74] *Id.* at 733.

[75] McCarran-Ferguson Act of 1945, 15 U.S.C.A. §§ 1011-1015 (West 2006). The McCarran-Ferguson Act provides:

> Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

Id. § 1011.

[76] *Metro. Life Ins. Co.*, 471 U.S. at 740-43. Justice Blackmun opined

> [N]othing in § 514(b)(2)(A), or in the "deemer clause" which modifies it, purports to distinguish between traditional and innovative insurance laws. The presumption is against pre-emption, and we are not inclined to read limitations into federal statutes in order to enlarge their pre-emptive scope. Further, there is no indication in the legislative history that Congress had such a distinction in mind.

Id. at 741.

[77] Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987).

involved a common law claim for bad faith processing of a disability benefit claim.[78] Similar to *Metropolitan Life*, the insurer argued that the bad faith cause of action was preempted by ERISA because in related to an employee benefit plan, and the insured invoked the savings clause to avoid preemption.[79]

The Supreme Court determined that the state common law remedy for tortious breach of contract did not regulate insurance under the common-sense view. It stated that bad faith remedies law applied to all state contracts, not just insurance contracts; therefore, *Pilot Life* did not meet the McCarran-Ferguson Act test.[80] *Pilot Life* significantly modified *Metropolitan Life's* preemption analysis by finding that the bad faith law conflicted with ERISA's civil enforcement provision, suggesting ERISA impliedly preempts the remedies law.[81] Further, the Court did away with *Metropolitan Life's* broad construction of the savings clause, inferring a broad overall Congressional intent favoring preemption.[82]

Despite ERISA's original intent to create advances in the pension arena, its broad preemption feature has made it "more notorious as a shield against consumer interests in the administration of non-pension employee benefit plans."[83] "As a result of ERISA preemption, AIDS patients who had their health care benefits canceled, women suffering from breast cancer who had been denied potentially life-saving medical treatment, and a myriad of other ERISA plan participants with claims for extra-contractual damages against their plan insurers have had their traditional state law remedies nullified, and the perpetrators of egregious wrongs have not been held accountable."[84]

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[78] Dedeaux v. Pilot Life Ins. Co., 770 F.2d 1311, 1313 (5th Cir. 1985).

[79] *Id.* at 1313-14.

[80] Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 50 (1987).

[81] *Id.* at 51.

[82] *Id.*

[83] Bogan, *supra* note 45, at 105-06.

[84] *Id.* at 106-07.

B. STATE COURTS AND ERISA PREEMPTION

1. State Courts after *Pilot Life*

Not surprisingly, given the Supreme Court's tone in *Pilot Life* and other applications of an expansive view of ERISA preemption, "the majority of lower court decisions following *Pilot Life* concluded that ERISA preempts all manner of state common law and statutory bad faith claims."[85] Many states have bad faith and unfair insurance practices laws that differ from the bad faith law in *Pilot Life* in that they usually are specifically targeted at the insurance industry.[86] These laws typically provide a private right of action and allow for recovery of extra-contractual remedies not available under ERISA.[87]

In *Anschultz v. Connecticut General Life Insurance Co.*,[88] the Eleventh Circuit Court of Appeals "considered whether ERISA preempted a state law claim, arising from an insured ERISA disability benefits plan, under Florida's unfair insurance practices statute."[89] Although the state statute applied only to the insurance industry (thus satisfying the common-sense test under *Pilot Life*), the court found that the law did not regulate insurance because it failed to meet the other two prongs of the McCarran-Ferguson test: the law did not spread policy holder risk, and did not affect an integral part of the insurer-insured policy relationship because it did not mandate specific coverages or define terms of the plan.[90]

"It defies common sense, and plain meaning, to suggest that laws like Florida's unfair insurance practices statute do no impact an integral part of the policy relationship between the insurer and the insured."[91] If state laws governing notification

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[85] *Id.* at 129.

[86] *Id.* at 130.

[87] *Id.* at 130-31.

[88] Anschultz v. Conn. Gen. Life Ins. Co., 850 F.2d 1467 (11th Cir. 1988).

[89] Bogan, *supra* note 45, at 131.

[90] *Id.* at 131-32.

[91] *Id.* at 135.

and settlement processes for denied claims and benefits do not regulate insurance, what do they regulate?[92]

2. One State's Response: The Texas Health Care Liability Act

In 1997, Texas passed the Texas Health Care Liability Act ("THCLA")[93] in response to its citizens' pleas for adequate remedies when suing their health plans.[94] The purpose was to protect consumers in an ever-expanding health care industry and to hold managed care liable for medical mistakes, just as providers are held liable for negligence.[95] Managed care meant more medical decisions being made by managed care entities instead of doctors, and the public was concerned with its ability to hold entities liable for medical decisions resulting in injury.[96]

THCLA aimed to hold managed care entities liable based on a breach of duty to exercise reasonable care when making treatment decisions, and to hold them liable for similar treatment decisions made by its employees, agents, and representatives.[97] The latter cause of action is particularly

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[92] *Id.* at 135-36. *See also* Cisneros v. UNUM Life Ins. Co., 134 F.3d 939, 946 (9th Cir. 1998) (stating "if California's rule [that an insurer must show actual prejudice before denying a late-filed claim] does not regulate insurance, what does it regulate?").

[93] Texas Health Care Liability Act (THCLA), TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001- 88.003 (West 2005).

[94] McCabe, *supra* note 61, at 566-57.

[95] *Id.* at 582. The Texas Health Care Liability Act (THCLA) states:

> A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making healthcare treatment decisions and is liable for damages for harm to an insured or enrollee [where the damage is] proximately caused by its failure to exercise such ordinary care.

TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(A) (2005).

[96] *See* Corporate Health Ins. Inc. v. Tex. Dep't of Ins., 12 F. Supp. 2d 597 (S.D. Tex. 1998); *see also* McCabe, *supra* note 61, at 582.

[97] McCabe, *supra* note 61, at 583-84.

important in holding entities and providers liable for damages from the implementation of utilization review and pre-certification.[98]

THCLA has not proven to be a solution for the inability to obtain adequate remedies for a denial of benefits. Soon after it was passed, Aetna Health Plans of Texas sought injunctive relief in an effort to block the law based on its belief that THCLA would have a negative impact on the managed care industry.[99] Aetna argued that the Texas law was preempted, and sought to enjoin enforcement of the law as it related to ERISA health plans.[100] The court disagreed, concluding that THCLA related to the quality of benefits, an issue not covered by ERISA, thus it was not preempted.[101] However, a year after THCLA was passed, the United States District Court for the Southern District of Texas ruled that insureds could sue their managed care entities over medical treatment decisions, but could not sue for damages from quality of medical care or for denied benefits under THCLA.[102]

Managed care entities will continue to have a strong defense against THCLA claims by arguing treatment decisions to be based on denied benefits that are preempted by ERISA.[103] Even if an insured successfully argues their cause of action based on a treatment decision, the entity can argue that the quality of care was so low that it constituted an actual denial of benefits and thus is preempted.[104] The remedy under the THCLA remains very narrow.[105]

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[98] *Id.* at 584.

[99] *Id.*

[100] *Id.*

[101] *Id.* at 588.

[102] *Id.* at 567-68. *See* Corporate Health Ins. Inc. v. Tex. Dep't of Ins., 12 F. Supp. 2d 597 (S.D. Tex. 1998).

[103] McCabe, *supra* note 61, at 590.

[104] *Id.* at 593.

[105] *Id.*

C. THE SUPREME COURT'S POSITION

1. *Aetna Health, Inc. v. Davila*

The effect of ERISA preemption was portrayed in the Supreme Court case, *Aetna Health, Inc. v. Davila*.[106] In *Davila*, the plaintiffs were participants in employer-sponsored health plans and sued their HMOs for a failure to exercise ordinary care in making coverage decisions.[107]

Plaintiff Juan Davila was prescribed Vioxx by his physician, but his health insurer refused to pay for it.[108] Davila took a covered alternative medication and suffered a severe reaction that required extensive treatment and hospitalization.[109] Plaintiff Ruby Calad's physician recommended an extensive hospital stay after surgery, but a discharge nurse employed by her insurer determined that her condition did not meet the requirements for an extended stay.[110] Calad experienced post-surgery complications that she argued would not have occurred had her insurer approved extended hospitalization.[111] Both Davila and Calad sued their HMOs for a failure to exercise ordinary care in making coverage decisions in violation of a duty imposed by THCLA.[112]

Davila and Calad appealed after it was determined that their causes of action were within the scope of ERISA, thus completely preempted and removable to federal court.[113] The Court of Appeals agreed that their claims could fall under ERISA

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[106] Aetna Health Inc. v. Davila, 542 U.S. 200, 204 (2004).

[107] *Id.* at 205.

[108] *Id.*

[109] *Id.*

[110] *Id.*

[111] Aetna Health Inc. v. Davila, 542 U.S. 200, 204 (2004).

[112] *Id.* at 205.

[113] *Id.*

§ 502(a)(2),[114] which provides for recovery for a breach of a fiduciary duty under the plan.[115] But the Court remanded to state court because the decisions were mixed eligibility and treatment decisions, and not fiduciary in nature.[116]

The Court reasoned that preemption is limited to situations where state law duplicates the causes of action under ERISA, and THCLA did not provide for collecting benefits and thus fell outside the scope of ERISA.[117] However, the Supreme Court reversed, ruling that the causes of action were meant to "to rectify a wrongful denial of benefits … [under ERISA plans], and do not attempt to remedy any violation of a legal duty independent of ERISA." [118]

The Court relied on Congress' intent to protect participants in employee benefit plans "by setting our substantive regulatory requirements … to 'provide for appropriate remedies, sanctions and ready access to Federal courts.'"[119] The Court also argued that the limited remedies under ERISA are an inherent part of balancing the need for prompt and fair claims settlement against public interest in formulating employee benefit plans.[120]

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[114] *See* Robert N. Eccles, Gary S. Tell & Karen M. Wahle, Practicing Law Institute, 719 PLI/Tax 1143, 1192 (2006) *Fiduciary Litigation under ERISA*, explaining:

> Section 502(a)(2) provides a cause of action by the Secretary of Labor, a plan participant, beneficiary, or fiduciary to obtain "appropriate relief" under section 409 to redress violations of the ERISA fiduciary responsibility provisions defined in Title I. The Supreme Court has held that this section authorizes relief for the benefit of a plan only, and relief cannot flow directly to individual plan participants. Individuals who sue under section 502(a)(2) may do so only on behalf of the plan as a whole.

719 PLI/Tax 1143, 1192 (2006).

[115] *Aetna Health Inc*., 542 U.S. at 206.

[116] *Id*.

[117] *Id*.

[118] *Id*. at 214.

[119] *Id*. at 208.

[120] *Id*. at 215.

Davila and Calad's causes of action were preempted by ERISA and kept out of state court where they could have obtained tort damages; their remedy was limited to the ability to clarify or enforce their rights under the health insurance plan. A decision by the court to have the insurance company pay for the services rendered can hardly be seen to remedy a health plan participant who suffered injuries from the initial denial of benefits. The cost of the injuries themselves is without recourse.[121]

2. *Pegram v. Herdrich*

In its *Davila* decision, the Supreme Court distinguished the facts of *Pegram v. Herdrich*.[122] Herdrich was a participant in an HMO who sued for injuries caused by her physician's failure to perform an ultrasound diagnostic procedure immediately after finding a mass in her abdomen.[123] Herdrich's physician decided that she had to wait eight days for an ultrasound, and that it would be performed at a facility staffed by the HMO more than 50 miles away.[124] While waiting for her ultrasound, Herdrich's appendix ruptured, causing peritonitis.[125]

It can be argued that the physician's decision to have Herdrich wait for the ultrasound, and to have it done at a distant facility owned by the HMO, was based on her interest in limiting the cost to the HMO, rather than the patient's need for immediate treatment.[126] The Supreme Court was faced with the question of whether such decisions made by an HMO, acting

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[121] *See* Bogan, *supra* note 45, at 111 (stating "[s]ince ERISA's express enforcement provisions do not permit recovery of extra-contractual damages, ERISA's preemption of state law has often left plan participants without a remedy for a recognized wrong").

[122] Pegram v. Herdich, 530 U.S. 211 (2000).

[123] *Id.*

[124] *Id.* at 215.

[125] *Id.*

[126] *Id.* at 220.

through its physician employees, are fiduciary in nature within the meaning of ERISA.[127]

The Court made a distinction between pure eligibility decisions and treatment decisions.[128] Eligibility decisions turn on coverage for a particular condition or procedure, while treatment decisions concern the choice of appropriate medical response based on a patient's condition.[129] The Court also recognized that eligibility and treatment decisions are often inextricable from one another, and the decision can be considered mixed.[130] For example, whether appendicitis is covered by the plan would be a pure eligibility decision, but when a provider decides "when-and-how" it will be covered, the decision mixes eligibility with treatment.[131]

The Court explained the Congressional intent regarding fiduciary responsibility to involve financial decisions. It focused on pension plans and financial mismanagement of retiree benefits, and not mixed eligibility and treatment decisions.[132] To apply a fiduciary standard in this context would replicate malpractice law already available in state court, and merely bring the same claim into federal court under federal question jurisdiction.[133] The Court thus held that mixed eligibility and treatment decisions are not fiduciary decisions under ERISA and are not preempted.[134]

The limitations of *Pegram*'s holding were applied in *Davila*. Davila and Calad relied on *Pegram* to argue that their causes of

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[127] *Id.* at 215.

[128] Pegram v. Herdich, 530 U.S. 211, 228 (2000).

[129] *Id.*

[130] *Id.*

[131] *Id.* at 228-29.

[132] *Id.* at 232. *See also* S. Rep. No. 93-127 (1974), reprinted in 1974 U.S.C.C.A.N. 4838.

[133] Pegram v. Herdich, 530 U.S. 211, 235-36 (2000).

[134] *Id.* at 237.

action were not preempted by ERISA.[135] However, the Court held that *Pegram*'s holding only makes sense where the underlying negligence also constitutes medical malpractice by a party deemed to be a treating physician, or by the physician's employer.[136] A benefit determination, on the other hand, is a fiduciary act under ERISA.[137]

Davila was responsible for resolving the issue of whether a claim for a negligent denial of treatment against an HMO could be brought in state court.[138] The Court held that benefit denials were preempted by ERISA and must be brought in federal court.[139]

In her concurrence, Justice Ginsburg agreed with the majority and supported ERISA preemption in the case.[140] However, Ginsburg expressed a concern that insureds are unable to obtain "make-whole relief," or the ability to obtain damages beyond the plan's provisions.[141] Ginsburg explained, "a 'regulatory vacuum' exists ... [where] 'virtually all state law remedies are preempted but very few federal substitutes are provided.'"[142] Justice Ginsburg urged Congress and the Court to revisit the "unjust and increasingly tangled ERISA regime."[143]

As a result of ERISA's obscurity, the Supreme Court's decisions have not provided a bright-line method of determining

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[135] Aetna Health Inc. v. Davila, 542 U.S. 200, 216 (2004).

[136] *Id.* at 221.

[137] *Id.* at 218.

[138] *See* Jean Hellwege, *Supreme Court Wades into ERISA's 'Serbonian Bog' Again*, 40-JAN JTLATRIAL 12, Jan. 2004, at 12.

[139] Elizabeth Khoury, *HMO Liability After Aetna Health Inc. v. Davila: Are Patients' Rights At Risk?*, 91 IOWA L. REV 1621, 1635 (2006).

[140] *Aetna Health Inc.*, 542 U.S. at 222 (Ginsburg, J., concurring).

[141] *Id.*

[142] *Id.* (Blecker, J., concurring) (citing DiFelice v. U.S. Healthcare, 346 F.3d 442, 453 (3d Cir. 2003)).

[143] *Id.*

whether a state law cause of action is preempted.[144] Supreme Court involvement in interpreting and applying ERISA preemption prompted Justice Scalia to comment "that our prior decisions have not succeeded in bringing clarity to the law."[145] ERISA impliedly preempts *all* plan participants' state law remedies in *any* action involving an improper processing of a claim for benefits.[146]

If the Supreme Court has been unable to untangle the ERISA web, how can insureds be expected to know how to proceed against insurance companies? Once adverse benefit determinations are made, the insured typically already has paid for the services, just to stay alive in some cases. ERISA preemption is the difference between merely being reimbursed, or actually collecting adequate compensation for life and limb. The difficulty arises when those with viable causes of action against insurance companies have no way of knowing pre-litigation whether their suit will be preempted. Thus they have no way of knowing whether their cause of action is really worth the time and money.

IV. RICO'S RECOURSE

A. THE INVOCATION OF RICO AND ADEQUATE REMEDIES

As explained thus far, an employer-sponsored health plan participant must get out of the ERISA box in order to obtain adequate remedies for injuries that result from a denial of benefits. However, even if a state law is preempted by ERISA, and damages are limited to remedies available under the benefit

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[144] *Van Natta*, 439 F. Supp. 2d at 926.

[145] Bogan, *supra* note 45, at 108, citing Cal. Div. Of Labor Standards Enforcement v. Dillingham Constr., Inc., 519 U.S. 316, 335 (1997) (Scalia, J., concurring). *See also* Sanson v. Gen. Motors Corp., 966 F.2d 618 (11th Cir. 1992) (Birch, J., dissenting) ("I acknowledge the sage observation of the Fifth Circuit … that 'any court forced to enter the ERISA preemption thicket sets out on a treacherous path' … [h]owever, if nothing else is clear it is that the 'path' is not; obviously the Supreme Court needs to do some serious bushhogging in the ERISA preemption thicket.")

[146] Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 57 (1987).

contract, the invocation of RICO can signify another way to obtain adequate remedies.

1. *Humana, Inc. v. Forsyth*

In *Humana, Inc. v. Forsyth*,[147] the Supreme Court ruled that RICO's private right of action and treble damages provision complements state statutory and common law claims for relief.[148] Humana involved an alleged scheme to gain discounts for hospital services not disclosed and not passed on to the health plan beneficiaries.[149]

The health insurance plan contained a coinsurance arrangement where the insurer was responsible for paying 80% of services, and the insured was responsible for the remaining 20%.[150] However, the insurer was paying its portion based on discounted fees given by the hospital, paying much less than 80%, and consequently the insureds paying much more than 20%.[151]

The plan participants brought suit claiming the insurance company had violated RICO "through a pattern of racketeering activity[152] consisting of mail, wire, radio and television fraud."[153]

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[147] Humana, Inc. v. Forsyth, 525 U.S. 299 (1999).

[148] *Id.* at 301 (stating "there is no frustration of Nevada policy in the RICO litigation at issue ... RICO's private right of action and treble damages provision appears to complement Nevada's statutory and common-law claims for relief").

[149] *Id.* at 302.

[150] *Id.* at 299.

[151] *Id.*

[152] "Racketeering activity" is:

> (A) any act or threat involving murder, kidnapping, gambling, arson, robbery, bribery, extortion, dealing in obscene matter, or dealing in a controlled substance or listed chemical (as defined in section 102 of the Controlled Substances Act), which is chargeable under State law and punishable by imprisonment for more than one year; (B) any act which is indictable under any of the following provisions of title 18, United States Code Section ... 1954 (relating to unlawful welfare fund payments)." Section 1954 states: [w]hoever being-- (1) an administrator, officer, trustee, custodian, counsel, agent, or employee of any employee welfare benefit plan or employee pension benefit plan; or

The insurance company moved for summary judgment, citing the "McCarran-Ferguson Act,[154] which provides: 'No Act of Congress shall be construed to *invalidate, impair, or supersede* any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance.'"[155] RICO clearly does not directly *relate to* the business of insurance, so the Court was left to determine whether RICO *invalidates, impairs or supersedes* Nevada's laws governing insurance.[156]

The Court used the standard definitions of the terms "invalidate," "impair," and "supersede" to respond in the negative.[157] RICO does not "invalidate" ("render ineffective without providing a replacement), does not "supersede" ("displace while providing a substitute rule — Nevada's insurance laws"), and RICO does not "impair" ("weaken, make worse, lessen in power, diminish, relax, or otherwise affect in an injurious manner") Nevada's insurance laws.[158] In sum, "[w]hen

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(2) an officer, counsel, agent, or employee of an employer or an employer any of whose employees are covered by such plan; or (3) an officer, counsel, agent, or employee of an employee organization any of whose members are covered by such plan; or (4) a person who, or an officer, counsel, agent, or employee of an organization which, provides benefit plan services to such plan receives or agrees to receive or solicits any fee, kickback, commission, gift, loan, money, or thing of value because of or with intent to be influenced with respect to, any of the actions, decisions, or other duties relating to any question or matter concerning such plan or any person who directly or indirectly gives or offers, or promises to give or offer, any fee, kickback, commission, gift, loan, money, or thing of value prohibited by this section.

18 U.S.C.A. §§ 1961-1968 (2000).

[153] *Humana*, 525 U.S. at 299.

[154] 15 U.S.C.A. § 1012(b) (1948).

[155] *Humana*, 525 U.S. at 299. (emphasis added).

[156] *Id.*

[157] *Id.*

[158] *Id.* at 301.

federal law does not frustrate any declared state policy or interfere with a State's administrative regime, the McCarran-Ferguson Act does not preclude its application."[159]

The Court rejected the argument that Congress intended to cede the entire field of insurance regulation to the states, or that Congress intended to preclude federal regulation merely because a federal regulation imposes liability additional to, or greater than, state law.[160] Since RICO advances the state's interest in protecting against insurance fraud and does not frustrate state policy or administrative regime, the Court held that the McCarran Ferguson Act did not block the plan participants' recourse to RICO.[161] Further, the Court acknowledged that insurers have relied on RICO when they were the fraud victims.[162]

2. *Maio v. Aetna, Inc.*

Not long after *Humana*, a RICO claim came before the Third Circuit in *Maio v. Aetna, Inc.*[163] In *Maio*, HMO plan participants brought an action against their insurer for a RICO violation based on the claim that they paid too much for their

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[159] *Id.*

[160] Humana, Inc. v. Forsyth, 525 U.S. 299 (1999).

[161] *Id.*

[162] *Id.* at 302. *See, e.g.*, Aetna Cas. Sur. Co. v. P & B Autobody, 43 F.3d 1546, 1551 (C.A. 1 1994):

> Insurer brought RICO action against insureds, claimants, body shops, and body shop owners and employees, seeking to recover for false claims submitted to the insurer. The United States District Court for the District of Massachusetts, William G. Young, J., entered judgment on jury verdict in favor of insurer and awarded treble damages, plus prejudgment interest, and defendants appealed. The Court of Appeals, Keeton, District Judge, sitting by designation, held that: (1) insurer was enterprise for RICO purposes; (2) evidence sustained finding of RICO violations; (3) evidence sustained finding of conspiracy; (4) insurer could recover full amount paid on the claims; and (5) body shop owner and employees could be found to have engaged in deceptive business practices.

[163] Maio v. Aetna, Inc., 221 F.3d 472 (3d Cir. 2000).

insurance.[164] Although the *Maio* court dismissed the complaint, it was based on a lack of standing, and not based on a holding that RICO's private right of action and treble damages provision was not available to the plaintiffs.[165]

The Court held that "plaintiffs had no standing to sue under RICO *absent allegation* that health care they received under insurer's plan actually was *compromised or diminished* as a result of insurer's management decisions challenged in [the] complaint."[166] The *Maio* holding indicated availability of the invocation of RICO to health plan participants with correct standing, or those who have been denied benefits.

3. *McClain v. Coverdell & Co.*

Subsequently, in *McClain v. Coverdell & Co*., the U.S. District Court of Michigan reinforced the threshold, standing requirement for RICO claims.[167] In *McClain*, a purchaser of an accidental death and dismemberment policy claimed she was a victim of a fraudulent insurance scheme when she purchased a policy with an extremely limited value.[168]

The court held that the purchaser's loss of funds, through premiums paid to the insurer, constituted a cognizable injury to property as required to state a RICO claim.[169] The court distinguished *Maio*, stating the plaintiff here had a better argument because she did not merely allege that she paid too much for the policy, "[s]he has also alleged that she would never have purchased the insurance without the fraudulent misrepresentations or omissions, which is a property interest."[170]

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[164] *Id*. at 472.

[165] *Id*.

[166] *Id*. (emphasis added).

[167] McClain v. Coverdell & Co., 272 F. Supp. 2d 631 (2003).

[168] *Id*. at 634.

[169] *Id*. at 631; *see also* 18 U.S.C. § 1964(c) ("cognizable injury to business or property" required for to state a claim under RICO).

[170] McClain v. Coverdell & Co., 272 F. Supp. 2d 631, 637 (2003).

The *Maio* and *McClain* rulings are significant because they indicate that when the right plaintiff, with the correct standing and with the correct injury (denied benefits), brings a RICO claim, they will be able to get the remedy they deserve in the form of treble damages.

B. PROVIDER RICO CLAIMS

1. *Genord v. Blue Cross & Blue Shield of Michigan*

More recently, providers have invoked RICO when suing managed care entities.[171] In *Genord v. Blue Cross & Blue Shield of Michigan*, providers participating in group health insurers' billing code reimbursement agreements, sued under RICO, alleging that the insurance companies altered their billing practices to systematically unreimburse the physicians for care provided to health plan participants.[172]

The insurance company moved to dismiss, arguing that the RICO litigation was "reverse preempted" by the state insurance laws, pursuant to the McCarran-Ferguson Act.[173] "In order to make out a civil RICO claim, the doctors must establish that

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[171] Genord v. Blue Cross & Blue Shield of Michigan, 440 F.3d 802 (6th Cir. 2006).

[172] *Id.* at 802.

[173] *Id.* at 803; *see also* § 1012(b):

> (a) State regulation ... The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business. (b) Federal regulation ... No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended [15 U.S.C.A. 41 et seq.], shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

§ 1012(b).

they were 'injured in [their] business or property by reason of a violation' of the criminal RICO provisions.[174] "If such a claim is successful, they are entitled to treble damages and attorney fees."[175] The district court denied the insurance company's motion to dismiss, and the Court of Appeals affirmed.[176]

The court ruled that RICO's private right of action was available to the providers because under the McCarran-Ferguson Act, RICO does not specifically relate to insurance, and the state law was not found to have been enacted for the purpose of regulating insurance.[177] Since the state law was not found to have been enacted for the purpose of regulating insurance, the court did not have to reach the issue of whether RICO invalidates, impairs, or supersedes the state law at issue.[178] Therefore, the providers' civil RICO action was permitted to proceed.[179]

2. *Klay v. Humana*

Similarly, in *Klay v. Humana*,[180] in "a case of almost all doctors versus almost all major health maintenance organizations (HMOs)," the doctors alleged that the HMOs conspired with each other to program their computer systems to systematically underpay them for their services.[181] The conspiracy includes a reimbursement system based on "financially expedient cost and actuarial criteria rather than medical necessity" and a systematic delay in payments.[182] The

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[174] *Genord*, 440 F.3d at 804; *see* 18 U.S.C. § 1962.

[175] *Genord*, 440 F.3d at 804; *see* 18 U.S.C. § 1964(c).

[176] *Genord*, 440 F.3d at 804.

[177] *Id.* at 805-06, 809.

[178] *Id.* at 809.

[179] *Id.*

[180] Klay v. Humana, Inc., 382 F.3d 1241 (11th Cir. 2004).

[181] *Id.* at 1246.

[182] *Id.* at 1247.

physicians argued that they were underpaid under both the fee-for-service and capitation methods of reimbursement.[183]

The class of plaintiff-physicians sued a group of HMOs, arguing that the practice of underpayments was not occurring in isolation, but rather was an "end-product of a decades-long nefarious conspiracy to undermine the American health care system."[184] The physicians felt that the conspiracy between the HMOs must in fact exist because their reimbursement systems operate in substantially the same way.[185] Further, the physicians could perpetuate the scheme by refusing to do business with them if only one of the HMOs was engaging in the activities.[186]

The physicians asserted RICO violations, including racketeering activities by engaging in mail and wire fraud, extortion and violations of the Travel Act.[187] Mail and wire fraud were committed by withholding the information regarding the alleged underpayment activities, and extortion was committed by creating a fear of economic loss in order to force the physicians to accept the capitation contracts, accept the loss of compensation, and to accept the denial, reduction and delay of payments.[188]

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[183] *Id.*

> Under a fee-for-service plan, an HMO agrees to reimburse doctors for any medically necessary services they perform on covered individuals, whether or not those doctors are under contract with the HMO ... [u]nder a capitation agreement, each patient specifies a physician as his "primary care provider." The HMO is obligated to pay each physician a small monthly fee, called a capitation payment, for each patient registered to him. The physician, in turn, is obligated to provide whatever medical services each registered patient requires.

[184] *Id.* at 1249.

[185] Klay v. Humana, Inc., 382 F.3d. 1241, 1249 (11th Cir. 2004).

[186] *Id.*

[187] *Id.* at 1252; 18 U.S.C. §§ 1341, 1343 (mail and wire fraud); §§ 1951(a), (b)(2) (extortion); § 1952(a)(3) (violations of the Travel Act).

[188] *Klay*, 382 F.3d. at 1252-53.

The physicians claimed that the HMOs created the fear that they would lose patients, be blacklisted, and, in the case of noncontract providers, would not be paid at all if they did not cooperate.[189] Violations of the Travel Act were asserted because the HMOs "purportedly used 'the mail or other facilities of interstate commerce ... to carry on their extortion' as described above."[190]

The Supreme Court has had an opportunity to rule on the unfair relationship that exists between providers and managed care entities. The Court held that class certification was superior to other available methods of adjudication, and allowed the providers to move forward with their class action lawsuit against the HMOs.[191] The Court rejected the HMOs' argument that the trial would be devastating to the managed care industry.[192] Instead, the Court stated that "[i]t would be unjust to allow corporations to engage in rampant and systematic wrongdoing, and then allow them to avoid a class action because the consequences of being held accountable for the misdeeds would be financially ruinous."[193] The Court explained "[w]e are courts of justice, and can give the defendants only that which they deserve; if they wish special favors such as protection from high--though deserved--verdicts, they must turn to Congress."[194]

Since health plan participants experience the same calculated wrongdoing when denied benefits by managed care entities, Court rulings on provider-brought RICO litigation may signify a more sympathetic and promising future for the insured when bringing RICO claims.

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[189] *Id.* at 1253.

[190] *Id.*

[191] *Id.* at 1241.

[192] Klay v. Humana, Inc., 382 F.3d 1241, 1274 (11th Cir. 2004).

[193] *Id.*

[194] *Id.*

V. CONCLUSION

The health insurance industry in our nation is a reflection of many administrative inefficiencies and economic complexities. The exponential increases in health insurance are leaving insureds, and the employers that provide them coverage, without the ability to afford the premiums. Managed care was developed in an effort to curb rising health insurance costs, but has also led to damaging results to our health. Providers are given an incentive to provide less care, and we may not receive the care that we need due to the providers' own financial interests. Further, when providers do prescribe services, our insurer may deny coverage based on medical necessity. We are then in a position to decide between undergoing the services and paying out of pocket, or forgoing the care because we are not in a position to pay.

Managed care is a necessary and acceptable component to future efforts to control costs. What is not acceptable is the injury that may result when people are denied coverage and are not in a position to pay out of pocket. The cost of the health insurance premiums alone is making it difficult for our society to plan for other financial goals. When medical services are erroneously denied, and we lose our health or our lives in the process, ERISA preemption often precludes adequate remedies – creating a litigation shield for insurance companies.

The invocation of RICO may lead to the ability to obtain adequate remedies in the form of extra-contractual damages. If a cause of action is preempted by ERISA, RICO can be invoked to provide compensation for life and limb, for injuries from denied benefits. If the Supreme Court allows RICO to be the much needed relief for ERISA preemption when an insurer denies benefits, and the insured suffers injuries, insurance companies will be more conservative in denying coverage. The result will be renewed confidence in our health insurance industry. A proper balance between efforts to control costs and efforts to maintain our health as a society is needed.