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ERISA's Quantity vs. Quality Doctrine: The Eighth Circuit Limits Recovery against an HMO by Completely Preempting State Law

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Brummond: Bummond: ERISA's Quantity vs. Quality Doctrine:
**ERISA's Quantity vs. Quality Doctrine:
The Eighth Circuit Limits Recovery
Against an HMO by Completely Preempting
State Law**

*Hull v. Fallon*¹

I. INTRODUCTION

Health Maintenance Organizations (“HMOs”) were developed to facilitate the provision of effective care at low prices to plan members.² To attain this purpose, HMOs have been required to act as both providers who administer care and gatekeepers who can deny access to care.³ The Employee Retirement Income Security Act (“ERISA”), praised as “the greatest development in the life of the American Worker since Social Security,”⁴ regulates plans administered by HMOs. Congress has stated explicitly that ERISA was enacted to promote the interests of employees and their beneficiaries in employee benefit plans.⁵ In drafting ERISA, Congress sought to protect plan beneficiaries from the historical mismanagement of their pension and benefit funds⁶ and to avoid a patchwork scheme of state regulation that would expose plans and plan sponsors to varying substantive standards, which could potentially increase the cost of health benefits for employees.⁷

The stated purposes of HMOs and ERISA purport to be consumer-friendly. In practice, however, HMOs and their use of ERISA’s preemption provisions have harmed plan participants. Relying on a judiciary that employs fine-line distinctions and ERISA’s procedural nuances to eliminate common law remedies, HMOs often abuse their ability to control the quality of care by denying legitimate claims.⁸ This abuse, sometimes committed through the hands

1. 188 F.3d 939 (8th Cir. 1999), *cert. denied*, 120 S. Ct. 1242 (2000).

2. Richard Epstein, *HMO Lawsuits: A Liability for Patients, Too*, WALL ST. J., Oct. 28, 1999, at A26.

3. *Id.*

4. Richard Rouco, *Available Remedies Under ERISA Section 502(a)*, 45 ALA. L. REV. 631, 672-73 (1994).

5. 29 U.S.C. § 1001 (1994); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983).

6. Craig M. Stephens, Note, *ERISA: The Inevitable But Unexpected Hurdles of the Plaintiff's Welfare Benefit Plan*, 20 AM. J. TRIAL ADVOC. 151, 151 (1996) (citing George L. Flint, Jr., *ERISA: Extracontractual Damages Mandated for Benefit Claims Actions*, 36 ARIZ. L. REV. 611, 614 (1994)).

7. *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1333 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992).

8. See generally Rouco, *supra* note 4, at 672-73 (“The protection of employees’ interests envisioned by ERISA . . . quickly dissipated in the hands of the federal judiciary . . . [r]eferences to concerns about separation of powers and the proper role of the

of someone with no more than a high school diploma,⁹ has resulted in extensive injury and, sometimes, death to plan participants.

In *Hull v. Fallon*,¹⁰ the United States Court of Appeals for the Eighth Circuit limited the plaintiff's recovery against his HMO and the plan's administrator to those remedies provided for by ERISA's civil enforcement scheme. The court applied the "quantity vs. quality" doctrine and determined that because the plaintiff's claim was for a denial of benefits (a quantity claim) rather than poor treatment (a quality claim), his state medical malpractice action was completely preempted by ERISA.¹¹ As a result, the plaintiff was stripped of his common law remedies. Many federal courts have applied an analysis similar to the analysis used in *Hull*;¹² this is not contested. This Note argues, however, that the analysis used by the court in *Hull* reaches results that are inconsistent with ERISA's underlying objectives and the language of the Act, which makes clear that ERISA was designed to promote the interests of employees.¹³

II. FACTS AND HOLDING

Jeffery Hull ("Hull") was an employee of Prudential Insurance Company.¹⁴ As a Prudential employee, Hull participated in a health insurance plan issued by Prudential Health Care Plan, Inc. ("the Plan"), which qualified as an employee welfare benefit plan under ERISA.¹⁵ In January 1996, Hull went to see his primary care physician under the Plan, Dr. Delcau, complaining of shortness of breath and pain in his arm and chest.¹⁶ As a result of Hull's complaints, Dr. Delcau in January and February contacted the Plan's administrator, Dr. Richard H. Fallon ("Dr. Fallon") and requested authorization to administer a thallium

judiciary ring hollow when procedural canons are used to justify the unilateral, and even fraudulent, denial of employee benefits . . . [s]uch divergent interpretive approaches to [ERISA] suggests that the Court seeks to effectuate a result that Congress never endorsed, namely, limiting an employee access to judicial remedies.").

9. Eric M. Eusanio, Note, *Control, Quality, and Cost: The Need For Federal Legislation Amending ERISA's Failure to Protect Consumers From Liability-Free MCOs*, 7 J.L. & POL'Y 627, 628-29 (1999) (referring to legislative history that suggests giving managed care organizations control over a patient's treatment "compromises the health care system because mere high school graduates, not experienced doctors, are often entrusted with the power to provide or deny treatment") (citing 144 CONG. REC. S9733 (daily ed. Sept. 1, 1998) (statement of Sen. Durbin)).

10. 188 F.3d 939 (8th Cir. 1999), *cert. denied*, 120 S. Ct. 1242 (2000).

11. *Id.* at 943.

12. *See infra* note 99.

13. *See Hull*, 188 F.3d at 942.

14. *Id.* at 941.

15. *Id.*

16. *Id.*

stress test as part of his diagnosis and treatment plan for Hull. On both occasions, Dr. Fallon denied the requests and instead authorized a treadmill stress test.¹⁷

Hull filed a medical malpractice action in state court claiming that he suffered a myocardial infarction and developed additional heart disease as a result of Dr. Fallon denying the thallium stress test,¹⁸ and that Dr. Fallon failed to exercise sufficient care in diagnosing and treating him.¹⁹ Hull also claimed that the Plan was vicariously liable for Dr. Fallon's negligence.²⁰ Dr. Fallon and the Prudential defendants removed the case to federal district court,²¹ arguing that federal question jurisdiction was created because Hull's state medical malpractice claims were preempted by ERISA.²²

The district court found that Dr. Fallon was acting as the Plan administrator and not as a treating physician.²³ Therefore, the court determined that Hull's claims were based on a denial of benefits and were cognizable only under Section 502(a) ("§ 502(a)") of ERISA.²⁴ From this conclusion, the district court held that Hull's claims were completely preempted by federal law.²⁵

17. *Id.* The stress tests mentioned in *Hull* are used to unmask coronary artery disease and to monitor its treatment. Janet Pinner, RN, 54 *PATIENT TEACHING FOR X-RAY AND OTHER DIAGNOSTICS* 32 (1991). During a "treadmill stress test," the patient walks on a treadmill at gradually increasing speeds and increasing angles of incline while his cardiovascular response is recorded. *Id.* The thallium stress test is a variation of the treadmill stress test in which a small amount of radioactive material is injected into a vein in the patient's arm or hand while he exercises; the patient is then positioned so that a camera-like scanning device can record which areas are receiving adequate amounts of blood. *Id.* A doctor uses a thallium stress test to attain more detailed information about the flow of blood to the patient's heart and the patient's response to monitored exercise. *Id.*

18. *Hull v. Fallon*, 188 F.3d 939, 941 (8th Cir. 1999), *cert. denied*, 120 S. Ct. 1242 (2000).

19. *Id.*

20. *Id.*

21. *Id.* See 28 U.S.C. § 1441 (1994).

22. *Hull*, 188 F.3d at 941. The defendants also filed a motion to dismiss for failure to state a cognizable cause of action under ERISA; the Honorable Rodney W. Sippel, District Judge for the Eastern District of Missouri, agreed and granted Hull thirty days to amend his complaint. *Id.* at 942 n.3. Hull did not file an amended complaint, and on appeal Hull did not contest the district court's conclusion on this point. *Id.* at 943.

23. See 29 U.S.C. § 1002(16)(A) (1994).

24. *Hull v. Fallon*, 188 F.3d 939, 941 (8th Cir. 1999), *cert. denied*, 120 S. Ct. 1242 (2000); 29 U.S.C. § 1132(a) (1994).

25. *Hull*, 188 F.3d at 942. The Supreme Court has indicated "there is complete preemption under § 502(a) whenever a plaintiff's cause of action falls within the scope of an ERISA provision that the plaintiff can enforce via § 502(a)." *Rice v. Panchal*, 65 F.3d 637, 644 (7th Cir. 1995) (citing *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142-45 (1990)).

On June 17, 1999, Hull appealed, arguing that his cause of action was not based on a denial of a requested benefit but on his doctor-patient relationship with Dr. Fallon, the Plan administrator.²⁶ The United States Court of Appeals for the Eighth Circuit found that Dr. Fallon's action as the Plan administrator in refusing to authorize the thallium stress test was a determination of benefits and held that Hull's state claims for medical malpractice were completely preempted by ERISA.²⁷

III. LEGAL BACKGROUND

A. *An Introduction to ERISA*

Congress enacted ERISA in 1974 in response to the growth in size, scope, and number of employee benefit plans.²⁸ The Act, as noted previously, has two primary goals. First, ERISA seeks to protect beneficiaries of pension and welfare benefit plans from mismanagement.²⁹ Traditionally, beneficiaries of pension plans and benefit plans who assumed that their invested funds would be available at retirement (or in a medical situation) were often disappointed to find that their money had been invested poorly or not at all.³⁰ Prior to the enactment of ERISA, beneficiaries were forced to bring state court actions in order to recover their benefits.³¹ In state court, however, beneficiaries often encountered jurisdictional and procedural impediments that left them in no better position than when they started their action to recover the benefits.³² The second goal of ERISA is to provide a uniform statutory framework that protects plans from state regulatory schemes that could expose them and their sponsors to varying substantive standards, inadvertently increasing the cost of health benefits for employees.³³

26. *Id.* at 942.

27. *Id.* at 943.

28. 29 U.S.C. § 1001(a) (1994).

29. Stephens, *supra* note 6, at 151.

30. Stephens, *supra* note 6, at 151.

31. Stephens, *supra* note 6, at 151.

32. Stephens, *supra* note 6, at 151 (citing *Miller v. Davis*, 507 F.2d 308, 310 (6th Cir. 1974); *Menke v. Thompson*, 140 F.2d 786, 790 (8th Cir. 1944)); *see also* Angela M. Easley, *A Call to Congress to Amend ERISA Preemption of HMO Medical Malpractice Claims: The Dissatisfactory Distinction Between Quality and Quantity of Care*, 20 CAMPBELL L. REV. 293, 298 & n.33 (1998) (citing *Fickling v. Pollard*, 179 S.E. 582, 583 (Ga. Ct. App. 1935); *Wallace v. Northern Ohio Traction & Light Co.*, 13 N.E.2d 139, 143 (Ohio Ct. App. 1937); *David v. Veitscher Manesitwerke Actien Gesellschaft*, 35 A.2d 346, 349 (Pa. 1944)).

33. *See Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1333 (5th Cir. 1992).
<https://scholarship.law.missouri.edu/mlr/vol65/iss2/5>

ERISA subjects plans providing employees with fringe benefits to federal regulation.³⁴ The statute's comprehensive regulatory scheme encompasses those pension and welfare benefit plans that provide "'medical, surgical, or hospital care or benefits' for plan participants or their beneficiaries 'through the purchase of insurance or otherwise.'"³⁵ ERISA does not require that employers provide any particular benefits; it simply controls benefit plan administration.³⁶ ERISA imposes reporting and disclosure mandates, participation and vesting requirements, funding standards, and fiduciary responsibilities for plan administrators.³⁷ The Act also imposes criminal sanctions, establishes a civil enforcement scheme, and preempts some state law.³⁸

Section 502 of ERISA establishes the Act's civil enforcement scheme.³⁹ Section 502(a) allows a plan participant or beneficiary to bring an action 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."⁴⁰ It is important to note, however, that when a plaintiff brings an action under § 502(a), her remedies are limited to the amount of benefits she is entitled to under the plan.⁴¹

Section 502(e)(1) states that "the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, or fiduciary. . . ."⁴² However, if an action is brought by a participant or beneficiary under § 502(a) to recover benefits due, to enforce rights under the terms of a plan, or to clarify rights to future benefits, state courts have concurrent jurisdiction.⁴³

34. See *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983).

35. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 650-51 (1995); see 29 U.S.C. § 1002(1) (1994).

36. See *Travelers*, 514 U.S. at 651.

37. See 29 U.S.C. §§ 1021-1031, 1051-1061, 1081-1086, 1104-1114 (1994); *Travelers*, 514 U.S. at 651.

38. See 29 U.S.C. §§ 1131-1145 (1994); *Travelers*, 514 U.S. at 651.

39. 29 U.S.C. § 1132 (1994).

40. 29 U.S.C. § 1132(a)(1)(B) (1994).

41. See *Rouco*, *supra* note 4, at 639-40. Because § 502(a) limits a plaintiff's recovery to the amount of benefits she is entitled to under the plan, preemption often has a serious effect on a plaintiff's motives to litigate. *Id.* See also *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987) (holding that preemption under ERISA limits the claims and remedies exclusively to those provided by § 502(a)).

42. 29 U.S.C. § 1132(e)(1) (1994).

43. See *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 25 n.26 (1983).

B. ERISA Preemption

Under ERISA, there are two distinct categories of preemption: (1) federal preemption under ERISA's preemption clause, Section 514(a) ("§ 514(a)"),⁴⁴ and (2) complete preemption under § 502(a).⁴⁵ Only those claims that are subject to complete preemption are removable to federal court;⁴⁶ hence, the distinction between preemption under § 514(a) and complete preemption is often critical.⁴⁷ If the plaintiff's claims are preempted, the plaintiff will only recover if she has a cognizable cause of action under ERISA's civil enforcement scheme, and her remedies will be limited to those available in § 502.⁴⁸

Congress drafted § 514(a) in broad terms.⁴⁹ Section 514(a) preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" ⁵⁰ Under § 514(a), a state law may "relate to" an employee

44. 29 U.S.C. § 1144(a) (1994).

45. See *Easley*, *supra* note 32, at 301. The doctrine of complete preemption acts as an exception to the general principle that original federal question jurisdiction can only be created when the plaintiff's well-pleaded complaint raises an issue of federal law. See *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 64 (1987). The doctrine provides that "to the extent that Congress has displaced a plaintiff's state law claim . . . a plaintiff's attempt to utilize the displaced state law is properly 'recharacterized' as a complaint arising under federal law." *Rice v. Panchal*, 65 F.3d 637, 640 n.2 (7th Cir. 1995).

46. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 64 (1987); *Franchise Tax Bd.*, 463 U.S. at 24-25. When a case has been removed to federal court and it is determined that the doctrine of complete preemption does not apply, even if the plaintiff's state claim is arguably preempted under § 514(a), the district court is without the power to decide the preemption dispute and must remand the case to the state court. *Id.* at 27-28; see also *Easley*, *supra* note 32, at 301.

47. See, e.g., *Hull v. Fallon*, 188 F.3d 939 (8th Cir. 1999), *cert. denied*, 120 S. Ct. 1242 (2000); *Taylor*, 481 U.S. at 58; *Franchise Tax Bd.*, 463 U.S. at 1; *Rice*, 65 F.3d at 637.

48. See *Hull*, 188 F.3d at 942 (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987)); *Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc.*, 999 F.2d 298, 302 (1993).

49. See *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137 (1990).

50. 29 U.S.C. § 1144(a) (1994). Section 514(a), it should be noted, does not preempt "any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A) (1994). This exception for regulation of insurance, banking, or securities is itself limited, however, by the provision that states an employee welfare benefit plan shall not be:

[D]eemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(b)(2)(B) (1994); *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 651 (1995).

benefit plan and therefore be preempted, even though the state law affects the employee benefit plan only incidentally.⁵¹ Complete preemption under § 502(a) is more difficult to establish and requires a more detailed explanation than what is offered for federal preemption under § 514(a).

The application of the complete preemption doctrine in the ERISA context originated in *Franchise Tax Board v. Construction Laborers Vacation Trust*.⁵² In *Franchise Tax Board*, the Supreme Court held a suit by the state against a welfare benefit trust to collect taxes was not completely preempted by ERISA, and therefore, was not removable to federal court.⁵³ The Court looked to precedent governing Section 301 of the Labor Management Relations Act⁵⁴ in holding that only causes of action falling within the scope of § 502(a) of ERISA are removable under the complete preemption rule.⁵⁵ The Court noted, however, that § 502(a) “does not purport to reach every question relating to plans covered by ERISA.”⁵⁶

51. *Kuhl*, 999 F.2d at 302 (citing *Ingersoll-Rand Co.*, 498 U.S. at 139).

52. 463 U.S. 1 (1983), cited in *Rice v. Panchal*, 65 F.3d 637, 639 (7th Cir. 1995).

53. *Franchise Tax Bd.*, 463 U.S. at 1.

54. In *Avco Corp. v. Aero Lodge No. 735, International Ass'n of Machinists & Aerospace Workers*, 390 U.S. 557 (1968), the Court held that any cause of action arising under § 301 of the Labor Management Relations Act is purely a creature of federal law and therefore removable.

55. *Franchise Tax Bd.*, 463 U.S. at 23-27. The Supreme Court has subsequently indicated that there is complete preemption under § 502(a) whenever a plaintiff's cause of action falls within the scope of an ERISA provision, e.g., § 510, that the plaintiff can enforce via § 502(a). *Rice*, 65 F.3d at 641-42, (citing *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142-45 (1990) (holding a state common law action for wrongful discharge to defeat pension benefits was preempted under § 510 as enforced via § 502(a)).

56. *Franchise Tax Bd.*, 463 U.S. at 25. One might note the Court's use of the “relating to” language from § 514. *Franchise Tax Board* has been cited as holding that “preemption under [S]ection 514(a) does not permit a defendant to remove a suit brought in state court to federal court when the plaintiff's state claim does not fall within the scope of ERISA's civil remedy provisions.” *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 355 (3d Cir.), cert. denied, 516 U.S. 1009 (1995); see also *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 64 (1987) (stating that ERISA preemption under Section 514(a) “without more, does not convert [the] state claim into an action arising under federal law”). The Court in *Taylor* cited *Franchise Tax Board* for the proposition that a state action must not only be preempted by ERISA § 514, but also must come within the scope of § 502(a) to fall within the *Avco* rule. *Id.* See *supra* note 54. *But see Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc.*, 999 F.2d 298, 300 (1993). In *Kuhl*, the HMO filed a notice of removal asserting that ERISA provides federal question jurisdiction over the plaintiff's claims. The plaintiffs sought remand, arguing that ERISA did not apply. *Id.* The district court denied the motion to remand, stating that the plaintiff's claims were “related to” the ERISA plan and therefore were preempted. *Id.* at 301. On appeal, the plaintiff-appellants argued that the district court erred in denying their motion to remand because their state law claims were not preempted by ERISA. *Id.* The Eighth Circuit upheld the district court's order denying the motion to remand on the grounds that *Kuhl's*

Interpreting the holdings of *Franchise Tax Board* and subsequent Supreme Court authority,⁵⁷ the Seventh Circuit in *Rice v. Panchal*⁵⁸ set out two elements that must be satisfied before a state claim can be completely preempted under ERISA. According to *Rice*, the first prerequisite of complete preemption under § 502(a) is that the plaintiff have standing to bring a claim under § 502.⁵⁹ The second element, according to *Rice*, is that the claim be within the subject matter of § 502(a).⁶⁰ In addition to articulating this two-part analysis, the *Rice* court found a common thread running through the cases discussing complete preemption under ERISA. According to the court, “complete preemption is required where a state law claim cannot be resolved without an interpretation of the contract [*i.e.* the benefit plan] governed by federal law.”⁶¹ The *Rice* court stated that this finding seemed consistent with earlier Supreme Court cases because those cases finding complete preemption involved claims for benefits due under an ERISA plan, or they involved state law claims measuring the quality of contractual performance, thereby interpreting an ERISA plan.⁶²

C. Preemption of Medical Malpractice Claims and HMO Liability: *The Quantity vs. Quality Doctrine*

Courts determining whether ERISA preempts direct and vicarious liability claims for negligent treatment of patients enrolled in benefit plans have distinguished between claims alleging poor quality of care from a physician and claims involving quantity of care or denials of plan benefits.⁶³ The general rule is that claims concerning the quality of care are not preempted by ERISA, while claims involving the quantity of care are completely preempted.⁶⁴ It has been

claims “related to” the benefit plan in question. *Id.* at 303. Kuhl’s application of a § 514 analysis to justify removal, however, is contrary to the weight of authority. *See Franchise Tax Bd.*, 463 U.S. at 4.

57. *See Taylor*, 481 U.S. at 58.

58. 65 F.3d 637 (7th Cir. 1995).

59. *See Rice*, 65 F.3d at 641 (stating that the underlying rationale for the decision in *Franchise Tax Board* that § 502(a) did not completely preempt either state law action was that the State could not act as a plaintiff to bring suit under § 502(a)); *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 26 (1983).

60. *See Rice*, 65 F.3d at 641 (reiterating that, in *Taylor*, the Court held that a plaintiff’s claims were completely preempted by §502(a) because his claim for benefits was within the scope of §502(a)(1)(B)); *Taylor*, 481 U.S. at 66.

61. *Rice*, 65 F.3d at 644.

62. *Id.*

63. Easley, *supra* note 32, at 302.

64. *Id.*; *see In re U.S. Healthcare, Inc.*, 193 F.3d 151, 162 (3d Cir. 1999) (stating that claims that fall within the essence of an administrator’s activities (*i.e.*, determining eligibility of benefits, calculating those benefits, disbursing them to the participant, monitoring available funds, and keeping records), fall within § 502(a)(1)(B) and are <https://scholarship.law.missouri.edu/mlr/vol65/iss2/5>

recognized, however, that the distinction between a claim involving the quantity of care and a claim involving quality of benefits is not always crystal clear.⁶⁵

*Jass v. Prudential Health Care Plan, Inc.*⁶⁶ provides an example where a court preempted the plaintiff's claim because it involved a quality or denial of benefits claim. In *Jass*, the plaintiff sued a registered nurse who also was acting as a utilization review administrator for the plaintiff's HMO, Prudential.⁶⁷ The plaintiff alleged that the nurse negligently determined that the plaintiff did not need physical therapy to rehabilitate her knee and discharged her from the hospital.⁶⁸ The Seventh Circuit held that when the nurse determined the physical therapy was unnecessary and discharged the plaintiff from the hospital, the nurse made a benefits determination within the meaning of ERISA and, therefore, the plaintiff's claim was completely preempted under § 502(a).⁶⁹ The plaintiff in *Jass* also brought a cause of action against her HMO for the nurse's alleged negligence on a vicarious liability theory.⁷⁰ The court found, however, that because it had already held that the nurse's actions were appropriately characterized as a denial of benefits, any vicarious liability claim against the plaintiff's HMO would be a claim arising from a benefits denial and would be completely preempted under § 502(a).⁷¹

completely preempted; whereas, claims that fall within the essence of a health care provider (i.e., arranging and providing medical treatment, directly or through contracts with hospitals, doctors, or nurses), are subject to the prevailing state law standard of care).

65. *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 358 (3d Cir.), *cert. denied*, 516 U.S. 1009 (1995) (stating the distinction is difficult where the benefit contracted for is health care services rather than money to pay for such services).

There well may be cases in which the quality of a patient's medical care or the skills of the personnel provided to administer that care will be so low that the treatment received simply will not qualify as health care at all. In such a case, it will may be appropriate to conclude that the plan participant or beneficiary has been denied benefits due under the plan.

Id.

66. 88 F.3d 1482 (7th Cir. 1996).

67. *Id.* at 1489.

68. *Id.* at 1485.

69. *Id.* at 1489.

70. *Id.* at 1490.

71. *Id.* at 1491. *Jass* is also instructive because suit was brought against the treating physician, one of the many doctors on the HMO's list of physicians participating in the plan, asserting negligence in the quality of treatment. *Id.* at 1485. The court held that the plaintiff's vicarious liability claim against her HMO for her treating physician's negligence was not completely preempted; however, because the court already had established subject matter jurisdiction, the court could exercise supplemental jurisdiction over the claim that the HMO was vicariously liable for the treating physician's negligence. *Id.* at 1491-92. The court then found that although the plaintiff's claim that the HMO was vicariously liable for the treating physician's negligence, the claim was not completely preempted under § 502(a), however, the claim was preempted under § 514

Dukes v. U.S. Healthcare, Inc.,⁷² on the other hand, provides an example where a plaintiff's malpractice and vicarious liability claims were not preempted under the quantity vs. quality doctrine because they were determined to be claims about the quality of the benefits received, not claims to recover benefits due under the plan.⁷³ In *Dukes*, two separate cases were consolidated on appeal. The claims at issue included: (1) a claim that certain doctors and medical service providers were negligent in failing to perform particular blood tests and that the HMO was vicariously liable, and (2) a claim that doctors were negligent in ignoring the plaintiff's symptoms of pre-eclampsia in her third trimester of pregnancy, which resulted in the death of the unborn.⁷⁴ The Third Circuit held that the claims fell outside the scope of § 502(a) because they involved the quality of the benefits received.⁷⁵ Therefore, the court remanded the claims to state court.⁷⁶

IV. THE INSTANT DECISION

In *Hull*, the Eighth Circuit first noted that the propriety of the district court's consideration of the case was dependent on the existence of federal question jurisdiction,⁷⁷ which generally is determined by the issues raised in the plaintiff's well pleaded complaint.⁷⁸ The court then recognized an exception to

because the claim "relate[d] to" the benefit plan. *Id.* at 1495. The court rested this holding on the fact that the doctor's alleged negligence concerned a failure to treat rather than the poor execution of treatment. *Id.* at 1493. *But see* *Pacificare of Okla., Inc., v. Burrage*, 59 F.3d 151 (10th Cir. 1995). In *Pacificare*, the court held the vicarious liability claim against the HMO was not preempted by § 514. *Id.* at 154. The court stated, "the present claim does not involve the administration of benefits or the level or quality of benefits *promised* by the plan; the claim alleges negligent care by the doctor and an agency relationship between the doctor and the HMO." *Id.* at 155 (emphasis added).

72. 57 F.3d 350 (3d Cir.), *cert. denied*, 516 U.S. 1009 (1995).

73. *Id.* at 357.

74. *Id.* at 352-53.

75. *Id.* at 356-57.

76. *Id.* at 356. The court did not address whether the vicarious liability claims that were remanded would be preempted by § 514; the federal court was without jurisdiction to decide this issue. *Id.* at 355. Cases have held that § 514 preempts vicarious liability claims, and cases have also held that HMOs may be vicariously liable for the malpractice of their physicians. *See generally* *Easley*, *supra* note 32, at 309-14. The possibility that a state court may hold that a vicarious liability claim is not preempted adds importance to a federal court's determination of whether a claim is completely preempted. If a claim is not preempted, the plaintiff will not be limited to the remedies under § 502(a) but rather will be able to pursue common law remedies. *See supra* note 41.

77. *Hull v. Fallon*, 188 F.3d 939, 942 (8th Cir. 1999), *cert. denied*, 120 S. Ct. 1242 (2000) (recognizing there was not complete diversity between the parties).

78. *Id.* (citing *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987)).

the general rule—the complete preemption doctrine.⁷⁹ Applying this doctrine, the court reasoned, “federal question jurisdiction exists—and the case may be removed to federal court—if Hull’s state law claims arise in an area that has been displaced by ERISA.”⁸⁰

Next, the court noted that ERISA was designed to promote the interests of employees,⁸¹ and it recognized that ERISA’s preemption clause was drafted in broad terms to facilitate a comprehensive federal scheme.⁸² The court then articulated its version of the general rule for determining whether claims are completely preempted under ERISA: any “[c]auses of action within the scope of, or that relate to, the civil enforcement provisions of 502(a) are removable to federal court despite the fact [that] the claims are couched in terms of state law.”⁸³

The court in *Hull* agreed with the district court that the “gravamen of Hull’s claims” was that he was denied a thallium stress test.⁸⁴ Contrary to Hull’s arguments, the Eighth Circuit found that the only relationship Dr. Fallon had with Hull was as the Plan administrator.⁸⁵ The court then discussed *Kuhl v. Lincoln National Health Plan, Inc.* as a case addressing similar facts.⁸⁶ In *Kuhl*, a spouse brought an action for medical malpractice after the defendant plan had canceled her husband’s surgery because it was scheduled at an out-of-network hospital.⁸⁷ The *Hull* court quoted *Kuhl*’s reasoning and noted that because *Kuhl*’s claims were essentially based on the manner in which his plan responded

79. *Hull*, 188 F.3d at 942 (“[The complete preemption] doctrine provides that ‘to the extent that Congress has displaced a plaintiff’s state law claim . . . a plaintiff’s attempt to utilize the displaced state law is properly ‘recharacterized’ as a complaint arising under federal law.’”) (quoting *Rice v. Panchal*, 65 F.3d 637, 640 n.2 (7th Cir. 1995)).

80. *Hull*, 188 F.3d at 942. Due to the fact that the plaintiff did not explicitly raise any issues of federal law in his complaint, the complete preemption doctrine was the only way to establish federal question jurisdiction. *Id.* at 941.

81. *Id.* at 942.

82. *Id.*

83. *Hull v. Fallon*, 188 F.3d 939, 942 (8th Cir. 1999), *cert. denied*, 120 S. Ct. 1242 (2000). Although the analysis used by the court in *Hull* is sound, one should be careful in following the complete preemption rule in the way the court in *Hull* set it out. The Supreme Court has only held that causes of action within the scope of § 502(a) are removable; the court has rejected the argument that all claims relating to a benefit plan fall within that section’s scope. *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 25 (1983). It is possible that the court in *Hull* was only reiterating the “within the scope of” language when it said “or relate to”; however, because the court relied on *Kuhl* to frame this rule, such a possibility is unlikely. *Kuhl*, if the reader recalls, went against the weight of authority by applying a “relate to” analysis under § 514 to determine if removal was proper. *Id.*

84. *Hull*, 188 F.3d at 942.

85. *Id.* at 943.

86. *Id.* (citing *Kuhl*, 999 F.2d at 298).

87. *Id.*

to a request for authorization of surgery, they involved the administration of benefits and were preempted by ERISA.⁸⁸

According to the court in *Hull*, however, a case with greater similarity could be found in the Seventh Circuit.⁸⁹ The Eighth Circuit explained the facts of *Jass*⁹⁰ and noted that under those facts the Seventh Circuit had deemed the plaintiff's claim to be a determination of benefits preempted by ERISA.⁹¹ The court in *Hull* agreed with the district court that, like the nurse in *Jass*, Dr. Fallon denied the thallium test as part of a determination of benefits.⁹² The court further noted that as a plan participant, Hull could have brought an action under § 502(a).⁹³ "Because [Hull's] claims relate to the administration of benefits," the court reasoned, the claims fall squarely within the scope of § 502(a).⁹⁴

Finally, the court in *Hull* justified its holding with policy considerations. It noted that plan administrators necessarily exercise medical judgment in determining plan benefits.⁹⁵ Finding that Hull's claims were not preempted, the Eighth Circuit reasoned, would expose plan administrators to varying state causes of action for claims within the scope of § 502(a).⁹⁶ This, the court believed, "would pose an obstacle to the purposes and objectives of Congress."⁹⁷

88. *Id.*

89. *Hull v. Fallon*, 188 F.3d 939, 942 (8th Cir. 1999), *cert. denied*, 120 S. Ct. 1242 (2000) (citing *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996)).

90. *Hull*, 188 F.3d at 943.

In *Jass*, the plaintiff had a knee replaced. The utilization review coordinator (a registered nurse) for the defendant plan made a medical determination that rehabilitation was not necessary As a result, the plaintiff suffered permanent damage. This injury, the plaintiff claimed, gave rise to a state law negligence claim not preempted by ERISA.

Id. (citing *Jass*, 88 F.3d at 1485, 1489).

91. *Hull*, 188 F.3d at 943.

92. *Id.*

93. *Id.*

94. *Id.* The court's use of the "relates to" language in this context, however, is in accord with the Supreme Court's rulings in *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1 (1983) and *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987). See *supra* note 56. The court in *Hull* is stating that claims relating to the administration of benefits are within the scope of § 502(a) and are completely preempted; they are not saying that claims relating to those claims within the scope of § 502(a) are completely preempted. *Id.*

95. *Hull v. Fallon*, 188 F.3d 939, 943 (8th Cir. 1999), *cert. denied*, 120 S. Ct. 1242 (2000).

96. *Id.*

97. *Id.* (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987)).

V. COMMENT

Hull, although arguably misstating ERISA's complete preemption rule,⁹⁸ adhered to an analysis that many courts would apply when deciding whether a doctor or HMO may be directly or vicariously liable for negligent treatment of an ERISA plan participant.⁹⁹ *Hull*, although not expressly, adopted an analysis that distinguishes between claims of quantity and quality of benefits, completely preempting those claims involving the quantity, or denial, of benefits.¹⁰⁰ Many federal courts have used an analysis that is similar to the one used in *Hull*. As a result, this fine-line distinction has relieved HMOs from responsibility and sent a signal that plans can ignore their duty to pay legitimate claims, a duty that is arguably imposed by ERISA. In an era when the quality of medical treatment is often determined by what care is made available to patients, the distinction used in *Hull* is not a distinction that benefits many plan participants.¹⁰¹ The following section considers whether the "quantity vs. quality" doctrine is consistent with the explicit purpose of ERISA and discusses recent proposed legislation that would reinstate patients' rights against their HMOs.

A. ERISA: Is It Really for the Benefit of Employees?

The court in *Hull* recognized at the outset that ERISA was designed to promote the interests of employees.¹⁰² In applying the "quality vs. quantity" doctrine, however, *Hull* and other courts have inadvertently harmed employees by limiting participants' remedies to the amount of benefits due under their plans.¹⁰³ In many situations, federal courts that categorize a plaintiff's claims as "quantity" claims could label the plaintiff's claims as "quality" claims with little or no change in the facts of the case.¹⁰⁴ With a judicial stamp that says "quality,"

98. See *supra* note 56.

99. See, e.g., *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996); *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995); *Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir.), *cert. denied*, 516 U.S. 1009 (1995); *Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th Cir. 1993).

100. *Hull*, 188 F.3d at 943. See generally *Dukes*, 57 F.3d at 356-61.

101. See *Easley*, *supra* note 32, at 314; *Rouco*, *supra* note 4, at 633 (arguing that limiting recovery under § 502(a) to the benefits a party would have been able to receive "sends a signal that fiduciaries can ignore many of the duties imposed by ERISA, especially when dealing with welfare benefit claims").

102. *Hull*, 188 F.3d at 942; see also 29 U.S.C. § 1001 (1994).

103. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). See generally *Rouco*, *supra* note 4, at 633.

104. See, e.g., *supra* note 65.

the court could remand the claims to state court, where a plaintiff could possibly recover common law damages.¹⁰⁵ Judicial discretion in applying the “quantity vs. quality” doctrine, unfortunately, has not facilitated the use of common law remedies but has led to their demise. The ramifications of this development are severe. It has been argued that without traditional common law remedies, a plaintiff will likely never have the chance to be made whole when injured by a negligent denial of benefits.¹⁰⁶ This argument gains support when one looks, for example, to the *Kuhl* decision cited by the court in *Hull*.¹⁰⁷

In *Kuhl*, it was determined that the plaintiff Buddy Kuhl (“Kuhl”) needed heart surgery after suffering a heart attack on April 29, 1989.¹⁰⁸ The HMO in *Kuhl*, Lincoln National, arranged for a second opinion wherein Lincoln National was informed that Kuhl was “at high risk of sudden death.”¹⁰⁹ Accordingly, arrangements were made for Kuhl to undergo surgery at Barnes Hospital in St. Louis because his chances of survival would be greater than if the surgery were performed in Kansas City.¹¹⁰ On June 23, 1989, Lincoln National refused to precertify payment for Kuhl’s surgery because Barnes Hospital was outside the Lincoln National service area; instead, Lincoln National scheduled an appointment for Kuhl to see a doctor at the Research Medical Center in Kansas City to determine if the surgery could be performed in Kansas City.¹¹¹ The doctor at the Research Medical Center agreed that the surgery should be performed in St. Louis and, two weeks later, Lincoln National informed Kuhl that it would now authorize the surgery at Barnes Hospital.¹¹² Kuhl immediately attempted to schedule the surgery, but the surgery team was unavailable until September.¹¹³ By this time, Kuhl’s heart had deteriorated to such an extent that the only way he could be helped was through a heart transplant; unfortunately, Lincoln National refused to precertify payment for the transplant.¹¹⁴ Kuhl died

105. See *supra* notes 75-76 and accompanying text.

106. See Easley, *supra* note 32, at 293 (“In effect, the ERISA provisions which overrule state law mean that the majority of Americans have been stripped of their historical legal protections against injury or death resulting from the actions of health insurance companies.”) (quoting Stephenie Overman, *Legislation Seeking to Close Loophole Protecting HMO’s From Liability Suits*, PHYS. FIN. NEWS, May 15, 1997, at 34).

107. *Kuhl v. Lincoln Nat’l Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th Cir. 1993).

108. *Id.* at 300.

109. *Id.*

110. *Id.*

111. *Id.*

112. *Id.*

113. *Id.*

114. *Id.*

on December 28, 1989 while awaiting the much-needed transplant.¹¹⁵ In a situation like *Kuhl*, or in any situation where permanent damage is caused by a refusal of benefits, it is unlikely that plan participants, or their beneficiaries, would be adequately compensated by an award of the benefits that the participant was wrongly refused. In such cases, a plaintiff needs common law remedies in order to be made whole.

Attacking the "quantity v. quality" doctrine from a different angle, one could argue that such a distinction, *i.e.* one that ultimately enables HMOs to control the quality of medical treatment and escape responsibility, provides an incentive for HMOs to deny benefits.¹¹⁶ Logically, if an HMO's liability is limited to unpaid benefits, an HMO has little incentive to refrain from denying benefits.

In response, HMOs argue that allowing state causes of action for negligent denials of benefits will force them to increase premiums and reduce benefits for patients to offset increased litigation costs.¹¹⁷ This argument, however, ignores the principle that liability for wrongs comes with the territory in all professions as an ordinary cost of business.¹¹⁸ Furthermore, HMOs are arguably in a much better position to bear losses than plan participants and, therefore, as a matter of policy, should carry the heavier burden.¹¹⁹

In a related contention, opponents of ERISA reform argue that allowing malpractice claims against HMOs for negligent benefit denials would defeat one of ERISA's primary purposes, the goal of developing a cost-efficient uniform administrative scheme for health plans.¹²⁰ Proponents of this argument contend that nonpreemption of state tort claims would be contrary to the clear intent of Congress because nonpreemption imposes a burden on the administration of benefit plans.¹²¹ One can argue, however, that allowing malpractice claims against HMOs does not contradict congressional intent. Medical malpractice claims for wrongfully denying benefits would infringe upon an HMO's benefit plan administration only tangentially;¹²² it is unclear that requiring a plan

115. *Id.*

116. *Id.* at 304 ("We recognize the obvious salutary effect that imposing state law liability on Lincoln National might have on deterring poor precertification decisions."). See generally Rouco, *supra* note 4, at 633.

117. See Easley, *supra* note 32, at 313. See generally Epstein, *supra* note 2, at A26.

118. See Easley, *supra* note 32, at 313.

119. Easley, *supra* note 32, at 314.

120. See Seema R. Shah, Comment, *Loosening ERISA's Preemptive Grip on HMO Medical Malpractice Claims: A Response to Pacificare of Oklahoma v. Burrage*, 80 MINN. L. REV. 1545, 1572-73 (1996).

121. See *Shaw v. Delta Air Lines, Inc.* 463 U.S. 85, 98-99 (1983) (citing 120 CONG. REC. 29197 & 29933 (1974)).

122. See Jose L. Gonzalez, *A Managed Care Organization's Medical Malpractice*

administrator or utilization review coordinator to abide by state medical malpractice laws would be any more burdensome than requiring that plan's staff or the surgeons retained by the plan who give second opinions to abide by state law.¹²³ Courts have already required these plan officials to adhere to state medical malpractice standards;¹²⁴ therefore, it is unlikely that the additional burden placed on plans in requiring their administrators to abide by state law would be significant. Because the interference in allowing malpractice claims against HMOs for their plan administrator's negligence is slight, the goal of administrative uniformity for health plans is not disturbed by allowing plaintiffs to bring suit when they are improperly denied benefits.¹²⁵

B. A Statutory Solution?

One recent proposal would remedy the injustice patients endure by amending ERISA's preemption clause.¹²⁶ The amendment would add the following subsection to § 514:

(e) Preemption Not To Apply To Certain Actions Arising Out of Provision Of Health Benefits

(1) Non Preemption of Certain Causes of Action

(A) In General . . . nothing in this title shall be construed to invalidate, impair, or supersede any cause of action by a participant or beneficiary (or the estate of a participant or beneficiary) under State law to recover damages resulting from personal injury or for wrongful death against any person (i) in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health plan . . . , or (ii) that arises out of the arrangement by such person for the provision of such insurance, administrative services, or medical services or other persons.¹²⁷

Liability for Denial of Care: The Lost World, 35 HOUS. L. REV. 715, 774 (1998).

123. Jonathan J. Frankel, Note, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 YALE L.J. 1297, 1313-14 (1994).

124. *Id.*

125. See Shah, *supra* note 120, at 1572-73.

126. H.R. 2723, 106th Cong. (1999).

127. *Id.*; see also Amy Goldstein & Juliet Eilperin, *House Votes to Increase Rights of HMO Patients*, WASH. POST, Oct. 8, 1999, at A1 (reporting that the House decided resoundingly to pass HR 2723, a bill enabling participants to protest HMOs' medical decisions in and out of court).

If Congress were to enact this subsection, it would, for all intensive purposes, invalidate an entire body of law interpreting ERISA's preemption clause and the doctrine of complete preemption under § 502(a).¹²⁸ The law would no longer limit patients' remedies to those provided in ERISA's civil enforcement scheme. Accordingly, patients would be allowed to pursue legitimate tort claims against their HMOs in state court. Although the ultimate fate of this proposed solution is uncertain,¹²⁹ the resounding support for the legislation in the House serves as a positive indicator that a change in the law regarding HMO liability is on the horizon.¹³⁰

Federal legislators, it should be noted, are not the only ones recognizing the need for ERISA reform.¹³¹ Texas, for example, has enacted the Texas Health Care Liability Act, which subjects HMOs to liability when they act negligently in treating patients.¹³² Under the Texas Act, HMOs may be held liable if they "fail to use 'ordinary care' when deciding whether to pay for a medical procedure."¹³³ According to Texas State Senator David Sibley, who introduced the bill, "[i]f the HMOs choose to make medical decisions—stand in the shoes of the doctor, as it were—they ought to stand in the shoes of the doctor in court, too."¹³⁴

128. At first glance, one may question whether the House's bill would affect the doctrine of complete preemption; after all, the amendment is to the preemption clause, an aspect of ERISA preemption distinct from complete preemption under § 502(a). *See supra*, note 57. This concern, however, quickly dissolves when one looks at the bill's text that reads "nothing in this title shall be construed to invalidate . . ." H.R. 2723, 106th Cong. (1999) (emphasis added).

129. Goldstein & Eilperin, *supra* note 127 (reporting that the leader of the Senate negotiators would be "drawing a line" against broad reforms that allow more litigation against HMOs).

130. Goldstein & Eilperin, *supra* note 127 (reporting that HR 2723 passed on a vote of 275 to 151).

131. Easley, *supra* note 32, at 317; *see also* Goldstein & Eilperin, *supra* note 127 (noting that the federal legislation resembles laws adopted recently by three states—Texas, Georgia, and California—that make it easier for patients to sue HMOs).

132. *See* TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (West Supp. 1999); Easley, *supra* note 32, at 317.

133. Easley, *supra* note 32, at 317; *see* TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (West Supp. 1999). *But see* Corporate Health Ins. Inc. v. Texas Dep't of Ins., 12 F. Supp. 2d 597, 597 & 621 (S.D. Tex. 1998) (holding that provisions of Texas Health Care Liability Act making managed care entities liable for substandard health care treatment decisions are not preempted by ERISA, but recognizing that "a suit may only be brought under the Act that challenges the quality of care received, not a benefit termination").

134. Easley, *supra* note 32, at 317. Legislative solutions, however, are only one method of dealing with substandard health care treatment decisions. For a nonlegislative

VI. CONCLUSION

Congress explicitly stated that the primary objective of ERISA is to promote the interests of employees and their beneficiaries in employee benefit plans.¹³⁵ The court in *Hull v. Fallon*, however, applied an analysis that can inadvertently harm employees. Since the creation of the HMO, the quality of medical treatment is all too often dictated by a determination of what benefits the HMO will or will not approve. When federal courts preempt those claims involving the quantity of treatment, they indirectly lower the quality of medical treatment by giving HMOs free passes to close doors that legitimately should remain open to plan participants. The analysis applied in *Hull* is in sync with an approach a majority of courts would apply; however, this analysis is hardly consistent with ERISA's overarching objective of promoting the interests of employees. There may be a day when the reasoning in *Hull* is superseded by congressional action. Until that day, however, plan participants' claims involving the denial or quantity of benefits will continue to be preempted.

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solution, see David S. Hilzenrath, *HMO to Leave Care Decisions Up to Doctors*, WASH. POST, Nov. 9, 1999, at A1 (reporting that United Healthcare, one of the nation's largest managed care companies said that it will stop overruling doctors' decisions about what care patients should receive). *But see id.* (quoting Rep. Greg Ganske (R-Iowa) stating that "United's announcement may be part of the industry's effort to show that legislation is unnecessary, but 'what we really need is something that has the force of law' for all health plans").

135. 29 U.S.C. § 1001 (1994); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983).