

WITH GREAT POWER COMES NO RESPONSIBILITY: THE TRAGEDY AND THE IRONY OF ERISA PREEMPTION

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Under the current health care financing regime, managed care organizations have significant power to determine patients' care but no legal responsibility when they use that power to pursue profits and harm patients. Managed care organizations are shielded from liability because the Employee Retirement Income Security Act of 1974 (ERISA) preempts state causes of action and does not provide a comparable remedy. This Comment attempts to restart a conversation about the dangers of allowing managed care organizations to retain significant power over patient care without any risk of liability of an especially vulnerable subgroup of patients: the severely mentally ill. It begins by recounting the conditions under which managed care first emerged. Next, this Comment illustrates through three case vignettes how ERISA's preemption provisions transform otherwise cognizable claims for wrongful death into claims that cannot be heard on their merits. It then argues that the severely mentally ill are at special risk of harm from managed care cost cutting and exposes the social tragedies and legal ironies engendered by ERISA preemption. Finally, this Comment argues that solutions exist to remedy ERISA preemption but predicts that these solutions will not be implemented barring a shift in national priorities.

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INTRODUCTION

“This story . . . is about a managed care industry operating without the most basic safeguards and protections—an industry that ignores reprehensible conduct so long as it benefits the bottom line.”¹ So began then-Attorney General, now-Senator Richard Blumenthal’s scathing report on the abuses of a Connecticut managed behavioral health care organization.² The corporation opportunistically denied claims

1. RICHARD BLUMENTHAL, REPORT OF THE ATTORNEY GENERAL’S INVESTIGATION CONCERNING PSYCH MANAGEMENT, INC. AND ANTHEM BLUE CROSS AND BLUE SHIELD OF CONNECTICUT 1 (2002), http://www.ct.gov/ag/lib/ag/press_releases/2002/health/pmi1.pdf [<https://perma.cc/WC5U-LXDP>].

2. Although there is no single agreed upon definition of managed care, *see, e.g.*, Jacob S. Hacker & Theodore R. Marmor, *How Not to Think About “Managed Care”*, 32 U. MICH. J.L. REFORM 661, 667–76 (1999), at their most basic, managed care organizations are health care organizations that exercise some control over the health care decisions made by insureds and their doctors. Amy K. Fehn, *Are We Protected From HMO Negligence?*, 30 AKRON L. REV. 501, 505 (1997). Managed care organizations use a number of mechanisms in varying combinations to exercise control over care in order to cut costs. Hacker & Marmor, *supra*, at 677. First, managed care organizations restrict their insureds’ choices of health care providers by only covering care provided by doctors within their networks or by requiring insureds to pay more to use doctors outside of the network of providers with whom the insurer has contracted. Fehn, *supra*, at 505 n.36 (describing the three basic structures managed care organizations use to restrict insureds’ choices of providers). Second, managed care organizations shift the financial risk of expensive care to providers. Vernellia R. Randall, *Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1, 30–32 (1993). One common form of financial risk sharing is capitation, in which the provider is paid a fixed fee per patient, and if the patient’s cost of care exceeds the fee, the provider bears the financial loss. *Id.* at 30–31 n.133. Other managed care organizations use different payment structures to shift risk to providers, *id.*, but the precise forms are not particularly relevant here. This Comment is concerned with the third common feature of managed care organizations: cost containment through utilization review. *Id.* at 27–29. *See infra* notes 25–30 and accompanying text for a definition of utilization review.

Managed care organizations can contract with third-party administrators to conduct utilization review for their insureds or they can conduct utilization review internally. Jonathan P. Weiner & Gregory de Lissovoy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. HEALTH POL., POLY & L. 75, 101 (1993). Many insurance companies contract with

for medically necessary treatment requested by participants and beneficiaries in the behavioral health plans it administered.³ So too begins this story—that of the harms managed care organizations inflict on the severely mentally ill, on their loved ones, and on society by opportunistically denying necessary inpatient⁴ and residential⁵ psychiatric and

specialized third-party administrators to manage the behavioral health care benefits of insureds. Richard G. Frank & Rachel L. Garfield, *Managed Behavioral Health Care Carve-Outs: Past Performance and Future Prospects*, 28 ANN. REV. PUB. HEALTH 303, 304–05 (2007). These specialized administrators are called managed behavioral health care organizations, and they can be structured in the form of carve-outs or carve-ins. Jeffrey L. Poston & Elliot R. Golding, *Managed Behavioral Health Care Litigation*, in *MANAGED CARE LITIGATION* 517, 517 (2d ed. 2013). Managed behavioral health care carve-outs exist when a managed care organization contracts with an external managed behavioral health care organization to administer behavioral benefits under its plans. *Id.* Conversely, managed behavioral health care carve-ins are separate divisions within a managed care organization that specialize in administering behavioral care benefits. *Id.* Whether a managed care organization keeps its utilization review in house or contracts with a third-party administrator has no impact on ERISA's preemptive effect. *See, e.g.*, *Tolton v. American Biodyne*, 48 F.3d 937 (6th Cir. 1995) (holding that ERISA preemption applied to plaintiff's state law tort claims, including wrongful death, against her deceased husband's managed care plan and the third-party managed behavioral health care carve-out company that denied authorization of his psychiatric treatment); *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992) (holding that ERISA preempted plaintiff's tort claims against a third-party administrator that conducted utilization review for plaintiff's plan provider).

3. BLUMENTHAL, *supra* note 1, at 32. The report details the behavior of Dr. Peter Benet, who established the organization, won a contract with Anthem Blue Cross Blue Shield in Connecticut to administer the behavioral health benefits for its enrollees by promising to provide care at low costs, and used the assets of the corporation to fund personal purchases, extravagant offices and furniture, and lavish parties. *Id.* at 32–35, 41–44. At the end of the report, Blumenthal recommended that the appropriate state agency revoke Dr. Benet's medical license, *id.* at 51, but the state apparently took no action against him. Hilary Waldman, *Earlier Warning Ignored*, HARTFORD COURANT (Aug. 11, 2008), http://articles.courant.com/2008-08-11/news/benetdoc0808.art_1_public-health-patients-attorney-general-richard-blumenthal [<https://perma.cc/9DBH-VPT2>]. In 2008, Dr. Benet faced two separate complaints from patients he treated, *id.*, but it is not clear whether Dr. Benet still practices medicine despite “abandoning his sacrosanct obligation to help [patients], or at least do them no harm” in 2002. BLUMENTHAL, *supra* note 1, at 1.

4. Inpatient care is the most intensive form of mental health treatment. *What's the Difference Between Inpatient and Residential Mental Health Treatment?* PASADENA VILLA (Apr. 14, 2015), <http://www.pasadenavilla.com/2015/04/14/what-is-the-difference-between-inpatient-and-residential-mental-health-treatment/> [<https://perma.cc/PF3V-LVJ8>] [hereinafter PASADENA VILLA]. Inpatient treatment takes place in a hospital setting and involves 24-hour monitoring by medical professionals. *What's the Difference Between Inpatient, Residential, and Partial Hospitalization?*, ROGERS

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substance abuse care.

Managed care organizations are allowed to profit on the backs of insureds—to operate “without the most basic safeguards” and “ignore[] reprehensible conduct”⁶—because they are insulated from legal liability for the harm they cause to participants in employer-sponsored health plans.⁷ Specifically, the Employee Retirement Income Security Act of 1974 (ERISA)⁸ transforms otherwise-cognizable tort-based claims for relief related to health care coverage decisions into claims that cannot be examined on their merits. This is true even when the worst-case scenario comes to pass—when a patient dies after the managed care organization denies coverage for necessary care.⁹

This Comment explores the harm ERISA preemption causes to a particularly vulnerable group of patients: the

MEMORIAL HOSPITAL, <https://www.rogershospital.org/faq/what%E2%80%99s-difference-between-inpatient-residential-and-partial-hospitalization> [<https://perma.cc/768D-LYUN>] (last visited Jan. 14, 2017). The intensive hospital setting is appropriate for individuals in crisis: those who need constant monitoring and care and those who are acutely depressed or suicidal. *Id.* Inpatient treatment is focused on stabilizing patients until they can safely receive treatment in a less intensive setting. *Id.* Thus, inpatient hospitalizations tend to be short-term. *Id.*

5. Residential treatment is rendered in a slightly less intensive setting than inpatient treatment and tends to be lengthier than inpatient treatment. PASADENA VILLA, *supra* note 4. Residential treatment occurs in “more comfortable, home-like” environments, not in hospitals. *Id.* And while medical professionals do still provide therapy and counseling to patients in residential treatment, they are not involved in monitoring patients around the clock. *Id.* Instead, non-medically trained staff monitor and supervise residents. *See Residential Treatment Programs*, AM. ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY (Sept. 2016), http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Residential-Treatment-Programs-097.aspx [<https://perma.cc/RZ6Y-MQDL>].

6. BLUMENTHAL, *supra* note 1, at 1.

7. ERISA governs most, but not all, employer-provided health plans. ERISA does not apply to plans provided to government employees or employees of religious organizations. 29 U.S.C. § 1003(a)–(b) (2012). As of 2006, approximately 161.7 million people in the United States had employer-provided health plans. WILLIAM PIERRON & PAUL FRONSTIN, EMP. BENEFIT RES. INST., ISSUE BRIEF NO. 314, ERISA PRE-EMPTION: IMPLICATIONS FOR HEALTH REFORM AND COVERAGE 9 (Feb. 2008), https://www.ebri.org/pdf/briefspdf/EBRI_IB_02a-20082.pdf [<https://perma.cc/ABR7-V2VT>]. Eighty-two percent of those with employer-based plans were covered by ERISA. *Id.* at 11.

8. Pub. L. No. 90-406, 88 Stat. 829 (codified as amended in scattered sections of 29 U.S.C.).

9. See *infra* Part II for an illustration of the mechanics of ERISA preemption of wrongful death claims against managed care organizations arising from utilization review.

severely mentally ill.¹⁰ Part I discusses the conditions under which managed care first emerged. Part II illustrates through three vignettes how ERISA preemption of state law transforms a cognizable claim for wrongful death into one that will never be heard on the merits. Part III then argues that the severely mentally ill are particularly vulnerable to harm from utilization review, the process through which managed care organizations make coverage decisions. Part IV exposes the social tragedies and legal ironies created by ERISA preemption. Finally, Part V discusses two solutions that would close ERISA's remedial gap and cure its resulting harms. Ultimately, however, this Comment concludes that ERISA preemption will not be addressed absent a seismic shift in legislative or judicial priorities.

But first, a cautionary note: the purpose of this Comment is not to propose a solution but to restart a conversation about the dangers of allowing for-profit corporations to make decisions that effectively control the course of patient care without any mechanism for holding those corporations accountable. Although it discusses solutions to the problems created by ERISA's remedial gap, the solutions are fairly straightforward. Accordingly, this Comment emphasizes the impact of the behavior legitimized by ERISA preemption on people like John Yardley and Richard Clarke, who both died after their managed care organizations denied adequate inpatient care for alcoholism, and on their families, who were left with no legal remedy.¹¹ The heart of this Comment lies not in the solutions to ERISA preemption, but in the all too often ignored social tragedies and legal ironies perpetuated by the statute. Solutions *do* matter, but they stand little chance of being implemented without renewed conversation about the

10. When referring to "severe mental illness," this Comment adopts the definition of "serious mental illness" developed by the Substance Abuse and Mental Health Services Administration (SAMHSA), with a slight adjustment—this Comment does not distinguish between minors and adults in defining severe mental illness, while SAMHSA limits its definition to adults. 58 Fed. Reg. 29,422, 29,425 (May 20, 1993). The expansion of the definition in this Comment to include minors has no impact on the other aspects of the definition used by SAMHSA. Under this definition, individuals with serious mental illnesses are those: (1) "who currently or at any time during the past year, [(2)] have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within [DSM-V], [(3)] that has resulted in functional impairment which substantially limits one or more major life activities." *Id.*

11. See *infra* section II.B–C.

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dangers created by ERISA preemption in the managed care system of health care financing.

I. BACKGROUND

Until the 1980s, the dominant form of private health insurance was fee-for-service.¹² Under a fee-for-service system, insurance companies reimbursed providers for each individual service¹³ and tended not to interfere with a doctor's recommended treatment.¹⁴ This system incentivized overutilization of health care services by both providers and patients. Under the fee-for-service system, the more services doctors provided, the more money they made.¹⁵ Patients had no reason to seek less expensive providers or treatments because insurers rarely interfered with their health care choices, no matter how costly.¹⁶ As a result of this overutilization, health care spending in America skyrocketed.¹⁷

The traditional benefit structure for mental health services compounded the overutilization problem in the behavioral health realm.¹⁸ Typical fee-for-service plans paid only for the most intensive—and expensive—forms of behavioral care.¹⁹ During the 1980s, fee-for-service's perverse incentives combined with the structure of behavioral care benefits led to an explosion of adolescent hospitalization and substance abuse treatment programs, with the number of adolescent admissions to private inpatient programs quadrupling between 1980 and

12. Randall, *supra* note 2, at 14.

13. *Id.* at 14 n.45.

14. Jesse A. Goldner, *Managed Care and Mental Health: Clinical Perspectives and Legal Realities*, 35 HOUS. L. REV. 1437, 1445–46 (1999).

15. Randall, *supra* note 2, at 14–16.

16. Goldner, *supra* note 14, at 1445–46; Randall, *supra* note 2, at 14–16.

17. *See* Goldner, *supra* note 14, at 1445–46.

18. Mary Jane England, *From Fee-for-Service to Accountable Health Plans*, in *ALLIES AND ADVERSARIES: THE IMPACT OF MANAGED CARE ON MENTAL HEALTH SERVICES* 3, 4 (Robert K. Schreter et al., eds., 1994); Goldner, *supra* note 14, at 1446.

19. Goldner, *supra* note 14, at 1446; England, *supra* note 18, at 1446. Typically, fee-for-service plans covered “45 days of inpatient treatment and 20 days of outpatient treatment at 50% copayment.” Goldner, *supra* note 14, at 1446. This coverage provided insureds with access to the most intensive forms of treatment without also providing coverage for mental health care in less intensive settings. *Id.* Accordingly, at least some patients unnecessarily used the most intensive and expensive kinds of treatment simply because it was what their insurance would cover. *See id.*

1986.²⁰ “The consequence was a dramatic overbuilding of psychiatric hospitals, which then generated a need for even greater utilization to support them.”²¹ Moreover, as managed care organizations began to control costs in other health care contexts, hospitals expanded their psychiatric and substance abuse capacity to recoup some of the profits lost to managed care in other health care realms.²² Given the incentives for overutilization of psychiatric and substance abuse treatment and the profit motives of private sector programs, it is hardly surprising that growth in mental health care costs outpaced growth of general health care costs.²³ Managed behavioral health care emerged in this context of overspending and overutilization of mental health and substance abuse treatment services, promising to cut the cost of care without compromising its quality.²⁴

One mechanism managed care organizations use to cut costs is utilization review, the process by which an insurance company or the third party retained by the insurer determines whether the doctor’s recommended course of action is medically necessary.²⁵ If the reviewer determines that care is not medically necessary,²⁶ the insurer will not cover the cost of that care.²⁷ Although fee-for-service plans did engage in utilization review, they did not do so until after patients received care.²⁸ Conversely, managed care organizations engage in prospective or concurrent utilization review to ensure that costs are cut, not by refusing to pay for services already rendered, but by

20. Goldner, *supra* note 14, at 1446.

21. *Id.*

22. Henry T. Harbin, *Inpatient Services: The Managed Care View*, in *ALLIES AND ADVERSARIES: THE IMPACT OF MANAGED CARE ON MENTAL HEALTH SERVICES* 11, 13–14 (Robert K. Schreter et al. eds., 1994).

23. England, *supra* note 18, at 3.

24. See Goldner, *supra* note 14, at 1445–46.

25. Randall, *supra* note 2, at 27.

26. See *infra* section III.B.1 for a discussion of medical necessity determinations.

27. Randall, *supra* note 2, at 27.

28. See *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1331 (5th Cir. 1992) (“United argues that the decision it makes in this, the prospective context, is no different than the decision an insurer makes in the traditional retrospective context. The question in each case is what the medical plan will pay for, based on a review of [the beneficiary’s] clinical information and nationally accepted medical guidelines for the treatment of [the beneficiary’s] condition.”) (internal quotation marks omitted).

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attempting to alter the patient's course of treatment.²⁹ Prospective utilization review occurs prior to any treatment being rendered, while concurrent review involves the insurer constantly monitoring the patient's progress to stop treatment once the patient no longer meets the insurer's guidelines.³⁰

By inserting a third party into the doctor-patient relationship—a relationship that was sacrosanct until the emergence of managed care—managed care organizations also created new ways for patients to be injured.³¹ When doctors had exclusive control over care, patients could be injured in the course of medical treatment only by their doctors' decisions.³² As insurers gained control over care, patients faced an entirely new kind of harm: injuries resulting from their insurer's failure to approve necessary care.³³ The severely mentally ill are at high risk of suffering these cost-containment injuries because they are, on the one hand, most likely to be targeted for cost-savings by managed care organizations while, on the other hand, most likely to be injured by the interference of managed care with their treatment.³⁴ Without an adequate check on insurers' perverse incentives to cut care in pursuit of profit, the severely mentally ill are injured by opportunistic cost cutting.

II. ERISA PREEMPTION AS AN OBSTACLE TO RECOVERY

Tort law is the typical mechanism through which the United States legal system creates incentives for actors to avoid careless behavior.³⁵ So, even though managed care

29. *See id.* at 1332 (“By its very nature, a system of prospective decision[-] making influences the beneficiary's choice among treatment options to a far greater degree than does the theoretical risk of disallowance of a claim facing a beneficiary in a retrospective system. Indeed, the perception among insurers that prospective determinations result in lower health care costs is premised on the likelihood that a beneficiary, faced with the knowledge of specifically what the plan will and will not pay for, will choose the treatment option recommended by the plan in order to avoid risking total or partial disallowance of benefits.”).

30. Randall, *supra* note 2, at 27 n.111.

31. *Id.* at 4–5.

32. *Id.* at 5 (“Before the new relationships were created, the only way a patient could be medically injured was through the physician's conduct.”).

33. *Id.* at 4–5.

34. *See infra* section III.A for a discussion of the special risk that managed care poses to the severely mentally ill.

35. *See, e.g.*, Louis Kaplow & Steven Shavell, *Economic Analysis of Law*, in 3 HANDBOOK OF PUBLIC ECONOMICS 1661, 1668 (A.J. Auerback & M. Feldstein eds., 2002),

creates perverse incentives for insurers to pursue profits by cutting necessary care, tort liability can force managed care organizations to internalize the costs of this opportunistic behavior and thereby realign the organizations' incentives away from profiteering at the expense of patient welfare toward approving necessary care.³⁶ However, ERISA preemption creates a remedial gap into which wrongful death and other malpractice suits against the administrators of ERISA plans tumble, leaving managed care organizations immune from tort liability.³⁷ Accordingly, ERISA preemption leaves managed care organization incentives misaligned toward opportunistic cost cutting in the pursuit of profits.

This Part illustrates how ERISA's remedial gap is created and how it operates to prevent recovery on an otherwise-valid claim through three vignettes. Section A shows how tort law operates in a context in which ERISA does not apply—a wrongful death suit against a doctor for prematurely releasing a psychiatric patient. Next, section B introduces the first of ERISA's two preemptive provisions and illustrates how ERISA—a federal law—prevents recovery on a state law claim for relief filed against a managed care organization and heard in state court. Finally, section C explores ERISA's second preemptive provision and shows how it forces state plaintiffs suing managed care organizations for wrongful death into federal court only to foreclose recovery in that forum. Together, these three cases show how ERISA's preemption provisions eliminate liability for opportunistic utilization review even though an analogous claim against a physician for a similar decision is fully cognizable.³⁸ This Part also shows how ERISA entirely forecloses examination of the merits of any claim stemming from the utilization review-related death of an insured—whether state or federal—against a managed care organization filed and heard in any forum.

http://www.law.harvard.edu/faculty/shavell/pdf/99_Economic_analysis_of_law.pdf [<https://perma.cc/4CLT-P58T>].

36. *See id.*

37. *See infra* section II.C.

38. It would not make sense for a patient or the patient's survivors to sue a doctor for any injury caused by the utilization review decision of a managed care organization. Because the patient's injury would be caused by the managed care organization's utilization review decision, not the decisions or actions of the patient's doctor, the doctor is not a proper defendant in the scenarios that this Comment considers absent some separate malpractice on the doctor's part.

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A. *Recovery on a Claim of Wrongful Death Against a Provider: The Case of John Bell*

Consider first the case of John Bell.³⁹ John, a veteran, was discharged from the Army because of his mental illness.⁴⁰ Some years after his discharge, John's wife, Linda, petitioned for and received a court order for John's involuntary commitment after he began experiencing hallucinations and reporting that "he and his oldest son had to die."⁴¹ John was admitted to an inpatient ward.⁴² Dr. Hermann, John's psychiatrist, released him after six days even though John continued to experience delusions and had to be restrained for five hours on the morning of his release.⁴³ Although some delusional patients may safely be treated in less intensive settings depending on the nature of their delusions, Dr. Hermann did not ask John about the nature of his delusions prior to releasing him.⁴⁴ A week after he left the hospital, John committed suicide "by dousing himself with gasoline and setting himself on fire."⁴⁵

After John's suicide, Linda sued Dr. Hermann for wrongful death based on his decision to prematurely release John from inpatient treatment.⁴⁶ Because the suit was against John's doctor, not his insurance company, ERISA was not implicated and so did not prevent an examination of Linda's claim on its merits.⁴⁷ The jury returned a verdict for Linda in the amount of \$564,225.⁴⁸ On appeal, Dr. Hermann challenged the jury

39. Most of this vignette comes directly from *Bell v. N.Y.C. Health & Hosps. Corp.*, 456 N.Y.S.2d 787 (N.Y. App. Div. 1982). The facts have been changed slightly to fit better with the rest of the vignettes. In the actual case, Mr. Bell survived his suicide attempt, and he recovered damages on a claim of malpractice. *Id.* at 788. These differences are of no import for the purposes of this Comment.

40. *Id.* at 789.

41. *Id.*

42. *Id.* at 790.

43. *Id.*

44. *Id.*

45. *Id.* at 788.

46. *Id.*

47. ERISA regulates employer-provided pension and benefit plans. 29 U.S.C. § 1003 (2012). Accordingly, ERISA preemption is implicated only when a law or suit involves an employer-provided plan to which the statute applies. A quotidian medical malpractice suit against a treating doctor does not involve an employer-provided health plan, so ERISA preemption cannot be invoked.

48. *Bell*, 456 N.Y.S.2d at 788. Technically, in the actual case, Mr. Bell was awarded the damages.

verdict on the ground that releasing John was a medical decision and that doctors cannot be held liable for a medical judgment, even if it was mistaken.⁴⁹ Finding that Dr. Hermann's decision to release John did not constitute a medical judgment at all because it lacked "proper medical foundation," the court affirmed the jury's verdict.⁵⁰

When inpatient psychiatric and substance abuse patients like John die as a result of their providers' care, there is no *per se* bar to relief for a claim of wrongful death. Under economic theory, this result is good because it serves to incentivize Dr. Hermann, and other doctors like him, to take care in making discharge decisions.⁵¹ However, when the defendant sued for wrongful death is not the patient's doctor but is instead the administrator of the patient's employer-provided insurance plan, ERISA preempts liability and prevents insurers from internalizing the cost of opportunistic decision making.⁵² Accordingly, ERISA preemption shields insurers from liability for decisions that, when made by a doctor, could result in liability.⁵³ The next case, *Yardley v. U.S. Healthcare*,⁵⁴ illustrates how ERISA prevents a realignment of incentives in the context of a wrongful death suit against a managed care organization when the case is decided in state court.

*B. ERISA and Express Preemption under Section 514:
The Case of Yardley v. U.S. Healthcare*

John Yardley, an alcoholic, worked for Mars Electronics, which provided his health insurance as an employee benefit.⁵⁵ In 1991, John was admitted to a detoxification facility, where the staff recommended that he enter a twenty-eight day inpatient treatment program.⁵⁶ U.S. Healthcare, the managed care organization that administered John's plan, denied coverage for the inpatient program.⁵⁷ Two days after U.S.

49. *Id.* at 793.

50. *Id.* at 795, 798.

51. *See* Kaplow & Shavell, *supra* note 35, at 1668.

52. *See infra* section II.B–C.

53. *See infra* section II.B–C.

54. 698 A.2d 979 (Del. Super. Ct. 1996).

55. *Id.* at 981.

56. *Id.*

57. *Id.* Technically, the insurance company denied payment for the treatment, not the treatment itself, but given the cost of care, payment denials are virtually

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Healthcare denied his request, John fell while he was intoxicated, incurring fatal injuries to which he eventually succumbed.⁵⁸

John's widow, Diane, filed suit on behalf of herself and her children against U.S. Healthcare for wrongful death in a Delaware state court.⁵⁹ U.S. Healthcare moved for summary judgment on the ground that section 514 of ERISA, the statute's express preemption provision, preempted Diane's state law claim.⁶⁰ Under section 514, state laws—common law or statutory—are preempted if they “relate to” an ERISA plan.⁶¹ A state law cause of action relates to an ERISA plan, and is therefore preempted under section 514, when the heart of the complaint is an “improper processing of a claim for benefits under an employee benefit plan.”⁶² Because a claim for wrongful death based on the denial of coverage during utilization review qualifies as an allegation of improper processing of benefits,⁶³ Diane's claim was preempted under

the same thing as a treatment denial; absent some other source of funds that would be large enough to cover expensive treatments, insureds who have payment denied by their insurance company have effectively been denied the treatment entirely. *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1332 (5th Cir. 1992).

58. *Yardley*, 698 A.2d at 981.

59. *Id.* at 982.

60. *Id.*

61. 29 U.S.C. § 1144(a) (2012).

62. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48 (1987).

63. Because utilization review is, by definition, the process of determining whether or not a plan covers a requested benefit—if, in other words, the requested treatment is medically necessary—a claim arising from a medical necessity denial or other utilization review outcome is an allegation of improper processing of benefits. *E.g.*, *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1332 (5th Cir. 1992). There are, however, cases between 2000 and 2004 holding otherwise. *E.g.*, *Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003). These cases interpreted the Supreme Court's 2003 decision in *Pegram v. Herdrich*, 530 U.S. 211 (2003), as standing for the proposition that utilization reviewers made “mixed eligibility and treatment decisions” and that the element of medical judgment present in medical necessity determinations was enough to defeat preemption of claims arising from utilization review. *Cicio*, 321 F.3d at 100–04 (“Focusing on mixed eligibility and treatment decisions, then, we conclude that § 514 preemption does not obtain with regard to those claims predicated on the violation of a state tort law by a failure to meet a state-law defined standard of care in diagnosing or recommending treatment of a . . . ‘patient’s constellation of symptoms.’” (quoting *Pegram*, 530 U.S. at 228)). *Pegram* was a case about fiduciary duties under ERISA, not about preemption, but the Court's opinion included dicta that could be read as establishing that such mixed eligibility and treatment decisions could be remedied by state tort law claims, *see* 530 U.S. at 235, which indicated to the *Cicio* court that preemption did not apply, 321 F.3d at 103–04. In *Pegram*, a plaintiff sued her physician-owned

managed care organization. 530 U.S. at 214. The same physicians who provided her care owned her insurance company. *Id.* at 214–19. The insurance company incentivized its physicians to minimize treatment costs by “annually paying physician owners the profit resulting from their own decisions rationing care.” *Id.* at 220. According to the plaintiff, these physicians made treatment decisions in violation of the fiduciary duty that they owed to patients under ERISA because they made such decisions in the face of incentives that ran against patients’ best interests. *Id.* at 216. The Court held that the physicians were not violating their fiduciary duty to patients when they made mixed eligibility and treatment decisions because they did not act in the capacity of ERISA fiduciaries when making such decisions. *Id.* at 237. In so holding, however, the Court noted in dicta that if it found in favor of the plaintiff:

[T]he defense of any HMO[, one variety of managed care,] would be that its physician did not act of financial interest but for good medical reasons, the plausibility of which would require reference to standards of reasonable and customary medical practice in like circumstances. . . . Thus, for all practical purposes, every claim of fiduciary breach by an HMO physician making a mixed decision would boil down to a malpractice claim, and the fiduciary standard would be nothing but the malpractice standard traditionally applied in actions against physicians. What would be the value to the plan participant of having this kind of ERISA fiduciary action? It would simply apply the law already available in state courts and federal diversity actions today, and the formulaic addition of an allegation of financial incentive would do nothing but bring the same claim into a federal court under federal-question jurisdiction. It is true that in [s]tates that do not allow malpractice actions against HMOs the fiduciary claim would offer the plaintiff a further defendant to be sued for direct liability, and in some cases the HMO might have a deeper pocket than the physician. But we have seen enough to know that ERISA was not enacted out of concern that physicians were too poor to be sued, or in order to federalize malpractice litigation in the name of fiduciary duty It is difficult, in fact, to find any advantage to participants . . . except that allowing them to bring malpractice actions in the guise of federal fiduciary breach claims against HMOs would make them eligible for awards of attorney’s fees if they won.

Id. at 235–36 (citations omitted). According to the *Cicio* court, *Pegram* meant that ERISA’s preemption provisions did not apply to malpractice (and malpractice-like) claims arising out of utilization review decisions, since the Court indicated that they would essentially replicate state law actions already available to plaintiffs. *Cicio*, 321 F.3d at 103 (“The Court’s analysis strongly suggests, without holding, that the plaintiff’s malpractice action against Dr. Pegram would not be preempted even though Dr. Pegram simultaneously made a contractual interpretation concerning Herdrich’s eligibility for given benefits, and that a defendant can no longer simply point to the overlay of medical decision-making on contractual claims and ask the court to conclude that, because ERISA preempts the contract claims, it also preempts all state tort . . . claims based on the same decision.”). *Pegram*, then, could have represented a sea change in ERISA preemption jurisprudence—and it does seem rather careless for a Court that was well aware of the search for causes of action that ERISA would not preempt to use language indicating that there was, indeed, a malpractice route around ERISA’s preemptive provisions. Nevertheless, the Court definitively rejected this interpretation of

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section 514.⁶⁴ Section 514 also contains ERISA's savings clause, which saves from preemption any state law regulating "insurance, banking, or securities;"⁶⁵ however, the Delaware wrongful death statute, a law of general application, was not saved by ERISA's savings clause.⁶⁶

Pegram in *Aetna Health Inc. v. Davila*, and limited *Pegram* to its facts. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 218–21 (2004). According to the *Davila* Court:

[I]t was essential to *Pegram*'s conclusion that the decisions challenged there were truly "mixed eligibility and treatment decisions," *i.e.*, medical necessity decisions made by the plaintiff's treating physician *qua* treating physician and *qua* benefits administrator. Put another way, the reasoning of *Pegram* "only make[s] sense where the negligence also plausibly constitutes medical maltreatment by a party who can be deemed to be a treating physician or such physician's employer." Here, however, petitioners are neither respondents' treating physicians or the employers of respondents' treating physicians. Petitioners' coverage decisions, then, are pure eligibility decisions, and *Pegram* is not implicated.

Id. at 220–21 (internal citations omitted). Thus, *Pegram* has been cabined to cases in which the physician or the physician's employer is also the person who makes medical necessity decisions on behalf of the patient's managed care organization.

64. The *Yardley* court did not cleanly run through the section 514 analysis. Instead, the court noted that "[a] number of other opinions make it clear that state law claims [including claims for wrongful death] are preempted by ERISA." *Yardley v. U.S. Healthcare*, 698 A.2d 979, 984 (Del. Super. Ct. 1996). The *Yardley* court was, however, correct in holding that section 514 preempts wrongful death claims for the reasons described above.

65. 29 U.S.C. § 1144(b)(2) (2012). Technically, section 514 contains a third provision that bears on section 514 preemption, but it is not particularly relevant here. The so-called 'deemer clause' under section 514(b)(2)(B) states that a self-insured plan may not be deemed to be an insurance company. Practically, this means that a state law that is otherwise saved is still preempted when applied to a self-insured plan. The deemer clause is not relevant to a discussion of claims for wrongful death because even if a state law providing a wrongful death action could be saved, it would still be preempted as conflicting with the exclusive remedies provided under section 502.

66. *Ky. Ass'n of Health Plans v. Miller*, 538 U.S. 329 (2003). Under the current savings clause test, a law regulates insurance if it is "specifically directed toward entities engaged in insurance . . . [and it] substantially affect[s] the risk pooling arrangement between the insurer and the insured." *Id.* at 342. According to the *Miller* court, a law is not specifically directed toward insurance companies if it is a law of general application that simply has some impact on insurers. *Id.* at 334. The second prong of the *Miller* test is intended to ensure that laws that are saved actually regulate the practice of insurance, not just the insurer. Under this prong, "[a] state law requiring all insurance companies to pay their janitors twice the minimum wage would not 'regulate insurance,' even though it would be a prerequisite to engaging in the business of insurance, because it does not substantially affect the risk pooling arrangement undertaken by insurer and insured." *Id.* at 338. Conversely, laws that mandate coverage of certain benefits would pass both prongs of the *Miller* test because they are directed at insurance companies and "alter the scope of permissible bargains between insurers and

Because section 514 preempted the Delaware wrongful death statute, the *Yardley* court granted the insurance company's motion for summary judgment, leaving Diane and her children without a remedy for John's death.⁶⁷ ERISA, a federal law, foreclosed examination of the merits of Diane's state law claim even though it was filed and heard in state court. Thus, ERISA's express preemption provision effectively operated as a procedural bar. This lack of substantive scrutiny remains the rule when an ERISA case filed in state court finds its way to federal court through ERISA's complete preemption provision.

C. *ERISA and Complete Preemption under Section 502: The Case of Andrews-Clarke v. Travelers Ins. Co.*

Richard Clarke died a preventable and predictable death after his insurance company denied inpatient care for his addiction and mental illness.⁶⁸ Richard, a father of four and an alcoholic, was trying to get help before his death.⁶⁹ He was admitted to a hospital for detoxification and a medical evaluation, but even though Richard's policy allowed for at least thirty days in rehabilitation, his insurance company would approve only a five-day stay.⁷⁰ Twenty-five days after he was released, he again attempted to check into an inpatient rehabilitation program, but his insurance company approved only another eight days in treatment.⁷¹ Less than a full day after leaving the program, Richard drank heavily and ingested cocaine and a number of prescription drugs before attempting suicide by locking himself in his garage with his car running.⁷² Although Richard did not have a pulse when his wife discovered him in the garage, he was revived by paramedics and eventually treated for carbon monoxide poisoning.⁷³

At a commitment hearing held after his recovery, a district

insureds." *Id.* (citing *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985)).

67. 698 A.2d at 989.

68. *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 50–53 (D. Mass. 1997).

69. *Id.*

70. *Id.* at 50–51.

71. *Id.* at 51.

72. *Id.*

73. *Id.*

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court ordered Richard to complete a thirty-day rehabilitation program.⁷⁴ Even still, Richard's insurance company refused to authorize coverage for private inpatient treatment, so the court committed Richard to a correctional institution to receive treatment.⁷⁵ Richard received little treatment for his condition in the correctional center, but he did experience further trauma when he was raped by another inmate.⁷⁶ Upon release, Richard could not stay sober, and after a three-week binge, Richard was admitted to a hospital in full respiratory arrest and with a head injury but was released the next morning.⁷⁷ Then, "[a]t 3:06 a.m. . . . the . . . police discovered [Richard's] body in a parked car, with a garden hose extending from the tailpipe to the passenger compartment. [Richard,] age forty-one, sat lifeless in the front seat, clasping a sixteen-ounce beer can in his right hand."⁷⁸

After his death, Richard's wife, Mrs. Andrews-Clarke, filed suit in Massachusetts state court for wrongful death against his insurance company and the third-party administrator of his benefits.⁷⁹ The defendants invoked ERISA's section 502⁸⁰ to remove the case to federal court even though the plaintiffs pled only state law claims.⁸¹ Section 502(a) sets out the exclusive remedial scheme for participants and beneficiaries in ERISA plans. Among the remedies provided in section 502 are two potential avenues of relief for beneficiaries or participants⁸² in benefit plans alleging wrongful denial of benefits.⁸³ First, section 502(a)(1)(B)⁸⁴ provides a remedy for a participant or

74. *Id.*

75. *Id.*

76. *Id.*

77. *Id.* at 51–52.

78. *Id.* at 52.

79. *Id.*

80. 29 U.S.C. § 1132(a)(1)(B).

81. *Andrews-Clarke*, 984 F. Supp. at 52.

82. In the case of a wrongful death suit, these remedies are available to the estate of the participant or beneficiary. *See id.* at 52 (“Diane Andrews-Clarke commenced this action against [the defendants] . . . as administratrix of Clarke’s estate and as next friend of their four minor children.”).

83. A claim of wrongful death as a result of negligent utilization review would qualify as a complaint that alleges a wrongful denial of benefits, as would a variety of other state contract or tort claims. A complaint that alleges any of these state causes of action based on a wrongful denial of benefits is transformed into a federal complaint under section 502 and will also be preempted under section 514 as the state law giving rise to the cause of action “relates to” an ERISA plan.

84. This provision states that “[a] civil action may be brought . . . by a

beneficiary in a health plan who believes coverage of treatment due under his or her plan has been wrongfully denied. Once benefits are denied, the participant or beneficiary can pay “for the treatment themselves and then [seek] reimbursement through a [section] 502(a)(1)(B) action, or [seek] a preliminary injunction.”⁸⁵ Second, section 502(a)(3) permits a participant or beneficiary to bring a civil action “(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.”⁸⁶

Although section 502 does not contain any explicit preemptive language, the Supreme Court has declared that Congress expressed a clear intent for the remedies set out in the provision to be the exclusive relief available for enforcement of rights and obligations under ERISA.⁸⁷ In order to effectuate congressional intent, ERISA preempts under section 502 “any state[] law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement” scheme.⁸⁸ The preemptive power of section 502 is so strong that it is a rare exception to the well-pleaded complaint rule, which permits removal of a suit filed in a state court to federal court only when the federal claim is on the face of the complaint.⁸⁹

Therefore, even though Mrs. Andrews-Clarke pled only a state law claim for relief, the defendants were able to remove

participant or beneficiary . . . to recover benefits due . . . 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.” 29 U.S.C. § 1132(a)(1)(B) (2012).

85. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 211 (2004).

86. 29 U.S.C. § 1132(a)(3) (2012).

87. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987) (“[T]he detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. “The six carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted . . . provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.”) (quoting *Mass. Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)).

88. *Davila*, 542 U.S. at 209.

89. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 65–66 (1987).

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the case to federal court under section 502.⁹⁰ After the case was removed, the insurance company moved to dismiss for failure to state a claim on which relief can be granted.⁹¹ Because a state law claim for wrongful death provides for compensatory and punitive damages—a remedy that does not exist under section 502—Mrs. Andrews-Clarke’s wrongful death claim was preempted by ERISA’s complete preemption provision. Moreover, because section 502 does not provide any remedy to compensate participants, beneficiaries, or their survivors for harm caused by the administration of benefit plans, Mrs. Andrews-Clarke had no cognizable claim under ERISA itself. Accordingly, the court was forced to dismiss Mrs. Andrews-Clarke’s suit.⁹²

According to the *Andrews-Clarke* court:

Under traditional notions of justice, the harms alleged . . . should entitle Diane Andrews-Clarke to *some* legal remedy on behalf of herself and her children against [the administrators of her husband’s health insurance plan]. . . . Nevertheless, this court had no choice but to pluck Diane Andrews-Clarke’s case out of the state court in which she sought redress (and where relief to other litigants is available) and then, at the behest of [the defendants], to slam the courthouse doors in her face and leave her without any remedy. This case, thus, becomes yet another illustration of the glaring need for Congress to amend ERISA to account for the changing realities of the modern health care system. Enacted to safeguard the interests of employees and their beneficiaries, ERISA has evolved into a shield of immunity that protects health insurers, utilization review providers, and other managed care entities from potential liability for the consequences of their wrongful denial of health benefits.⁹³

The *Andrews-Clarke* court drew on ERISA’s history as a law intended to protect beneficiaries of employee benefit plans to highlight the perverse role it now plays as the strongest

90. See *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 52 (D. Mass. 1997).

91. *Id.*

92. *Id.* at 53.

93. *Id.* (emphasis added).

defense against liability for managed care organizations and the fact that it leaves plaintiffs who have suffered enormous harms without a legal remedy.⁹⁴ ERISA's remedial gap clears the way for managed care organizations to increase their profit margins by targeting the sickest and most vulnerable members of society and gives rise to the irony and the tragedy of ERISA preemption.

III. MANAGED CARE AND THE SPECIAL DANGER TO THE SEVERELY MENTALLY ILL

ERISA preemption poses a special risk to the severely mentally ill because it legitimizes managed care's opportunistic cost cutting. While managed care organizations use utilization review in administering both medical and behavioral care, the severely mentally ill are at a particularly high risk of harm from cost containment decisions. This Part describes the two ways in which managed care poses a unique risk to the severely mentally ill. Section A explains that the severely mentally ill are most likely to be targeted for cost containment.⁹⁵ Section B shows that, unlike in medical care contexts, utilization review actually interferes with psychiatric and substance abuse treatment.

A. *Managed Care Organizations Target the Severely Mentally Ill*

One reason that the managed care poses a special risk to the severely mentally ill is that they are the subgroup of patients most likely to be targeted for cost cutting. First, behavioral care is more likely to be subject to stringent utilization review than is medical care.⁹⁶ Additionally, within the population of all behavioral care patients, the severely mentally ill are most likely to have their treatment scrutinized by managed care organizations.⁹⁷

1. Managed Care Scrutinizes Behavioral Care More

94. See *infra* section III.C.1.

95. See *infra* section III.A.1.

96. See *infra* section III.A.1.

97. See *infra* section III.A.2.

Closely Than Physical Care⁹⁸

To begin, the severely mentally ill face special danger from managed care cost cutting because these companies target behavioral care for savings more than they target medical care. In one study, psychiatrists were over twice as likely to experience more stringent utilization reviews and to report compromising their treatment standards because of utilization review than were primary care doctors.⁹⁹ They were also three times more likely to report frequent treatment denials.¹⁰⁰ Another study found that utilization review decreased the length of inpatient hospitalizations more for behavioral care than for medical care.¹⁰¹ Practical experience confirms the results of these empirical studies. For example, New York Attorney General Eric Schneiderman recently settled a case against three companies: two managed care organizations and a third-party company that both managed care organizations used to administer benefits to their insureds; in the settlement, all three companies acknowledged that they violated New York's parity law¹⁰² by denying mental health and substance abuse claims more frequently than medical claims.¹⁰³

98. Where this Comment refers to physical care or claims as medical care or claims, it is only because the parity statutes refer to those claims as such. *See, e.g.*, Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68,240, 68,240 (Nov. 13, 2013) (requiring parity between “mental health . . . benefits and medical/surgical benefits”).

99. Mark Schlesinger et al., *Some Distinctive Features of the Impact of Managed Care on Psychiatry*, 8 HARV. REV. PSYCHIATRY 216, 224 (2000).

100. *Id.*

101. M. Audrey Burnam & José J. Escarce, *Equity in Managed Care for Mental Disorders*, HEALTH AFF., Sept. 1999, at 22, 27.

102. New York's parity law requires large employers to offer plans with equal limitations on treatment for certain mental health conditions and medical conditions. Vera Oziransky et al., *Parity from the Consumer Perspective: Implications for Federal Implementation from New York's Parity Evaluation*, 62 PSYCHIATRIC SERVS. 344, 344 (2011).

103. Press Release, Attorney General Eric T. Schneiderman, A.G. Schneiderman Announces Settlement with ValueOptions to End Wrongful Denial of Mental Health and Substance Abuse Treatment Services (Mar. 5, 2015), <http://www.ag.ny.gov/press-release/ag-schneiderman-announces-settlement-valueoptions-end-wrongful-denial-mental-health> [https://perma.cc/LR4E-UZHT]; Press Release, Attorney General Eric T. Schneiderman, A.G. Schneiderman Announces Settlement with Emblem Health for Wrongly Denying Mental Health and Substance Abuse Treatment for Thousands of New York Members (July 9, 2014), <http://www.ag.ny.gov/press-release/ag-schneiderman-announces-settlement-emblem-health-wrongly-denying-mental-health-and>

The mentally ill are targets for savings in part because there is far more uncertainty regarding diagnosis criteria and treatment effectiveness for behavioral conditions than for most physical conditions.¹⁰⁴ According to one academic, “[t]reatment decisions characterized by professional uncertainty are ideal candidates for stringent review because [those] decisions are most often supported more by tradition than by medical science.”¹⁰⁵ Insurers are more likely to harshly apply vague

[<https://perma.cc/D75K-HFDX>]; Press Release, Attorney General Eric T. Schneiderman, A.G. Schneiderman Announces Settlement with Health Insurer that Wrongfully Denied Mental Health Benefits to Thousands of New Yorkers (Mar. 20, 2014), <http://www.ag.ny.gov/press-release/ag-schneiderman-announces-settlement-health-insurer-wrongly-denied-mental-health> [<https://perma.cc/EQ4E-EH2L>]. The Mental Health Parity Act of 1996 actually amended ERISA to require that employer-provided plans have equal “aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits.” Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68,240, 68,240 (Nov. 13, 2013). Later federal parity laws also amended the same section of ERISA to add more substantive parity requirements. *Id.* Congress intended that the amendments added by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”) would *not* preempt state parity laws unless a particular standard or requirement “prevents the application of a requirement’ of MHPAEA.” *Id.* at 68,252 (quoting H.R. REP. NO. 104-736, at 205 (1996) (Conf. Rep.), reprinted in 1996 U.S. Code Cong. & Admin. News 2008). “States have primary enforcement authority over health insurance issuers regarding . . . MHPAEA.” *Id.* at 68,252. This enforcement authority permits the kind of settlement that Attorney General Schneiderman reached with health insurers for violations of parity laws. However, even this authority does not solve the problem of opportunistic cost cutting going unpunished because California and New York are the only states that consistently act to enforce parity laws. Michael Ollove, *Despite Laws, Mental Health Still Getting Short Shrift*, PEW CHARITABLE TR.: STATELINE (May 7, 2015), <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/5/07/despite-laws-mental-health-still-getting-short-shrift> [<https://perma.cc/K5MQ-G5VG>].

104. *E.g.*, Goldner, *supra* note 14, at 1441 (“[T]here seems to be a less than clearly defined set of boundaries for clinical psychiatric and psychological diagnosis, a lack of distinct treatment criteria or other guidelines, and an enormous variation between clinicians in how mental health services are utilized.”); Schlesinger et al., *supra* note 99, at 218 (“For most medical conditions, there is some disagreement, even among experts, as to the most appropriate forms or settings for treatment. Variation among clinicians tends to be considerably greater. For mental health care, this clinical variation is exacerbated by greater disagreement among established protocols defining appropriate treatment, greater challenges in appropriately diagnosing disorders, and a greater diversity of potential settings or forms of treatment, as well as the complexities of defining appropriate care when significant familial and societal consequences can result from inadequate treatment.”).

105. Nancy Wolff & Mark Schlesinger, *Risk, Motives, and Styles of Utilization Review: A Cross-Condition Comparison*, 47 SOC. SCI. & MED. 911, 914 (1998).

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medical necessity standards to more costly and intensive treatment for behavioral care because it is difficult for providers to push back without clear, objective indicators for that treatment.¹⁰⁶

Furthermore, mental illness and substance abuse have long been stigmatized conditions, and this stigma contributes to behavioral care's attractiveness as a target for cost containment.¹⁰⁷ "Unlike those with physical illness, persons with mental illness are often perceived to be the cause of their own problems and, for that reason, to be less entitled to generous benefits."¹⁰⁸ Because mental illness is often seen as a character problem, not a medical one, insurers know they can apply medical necessity criteria more stringently to decline behavioral care.¹⁰⁹

2. Managed Care Cuts Behavioral Care Costs by Targeting the Severely Mentally Ill

Among all behavioral care patients, the severely mentally ill are most likely to have their care impacted by utilization review because their illnesses are chronic and far more expensive to treat.¹¹⁰ Managed care organizations realize profits by cutting costs, and patients who require long-term, high-intensity care present insurers with the greatest opportunity to profit.¹¹¹

106. *Id.*

107. David Mechanic et al., *Management of Mental Health and Substance Abuse Services: State of the Art and Early Results*, 73 MILBANK Q. 19, 26 (1995) ("High levels of stigma affect the ability of patients to advocate for their interests within a managed care system and affect the resources that system will devote to treating these conditions."); Philip J. Boyle & Daniel Callahan, *Managed Care in Mental Health: The Ethical Issues*, HEALTH AFF., Aug. 1995, at 7, 9 ("In combination [stigma has] conspired to minimize treatment and funding for mentally ill persons.").

108. Boyle & Callahan, *supra* note 107, at 9–10.

109. *See id.*; Burnam & Escarce, *supra* note 101, at 28 ("Mental health services may be more vulnerable to skimping because they are viewed as more discretionary by managed care organizations.").

110. Mechanic et al., *supra* note 107, at 26 ("Although acute episodes of mental illness are common, most costs are associated with those who have severe and persistent mental disorders and comorbidity."). Importantly, while these patients may be more costly over time for insurers to treat, significant costs are shifted onto other societal actors when managed care organizations inappropriately cut care for the severely mentally ill. *See infra* section III.B.2.c.

111. *See, e.g.*, Mechanic et al., *supra* note 107, at 46 ("Most of the predicted cost savings from managed care rest on theories about the potential for substituting

Managed care companies achieve most cost savings by cutting inpatient psychiatric care.¹¹² Although utilization reviewers frequently approved inpatient care in one study, the initial approvals were for much shorter stays than originally requested, with all additional time in treatment closely monitored through concurrent review.¹¹³ Additionally, between 1986 and 1990, the length of inpatient mental health treatment for patients with private insurance decreased from an average of twenty to forty days to an average of 10.6 days.¹¹⁴ One study found that the costs per patient of inpatient care dropped by thirty percent between 1993 and 1995, due mostly to a decrease in the number of days spent in inpatient treatment per patient.¹¹⁵

Troublingly, even though managed care is cutting inpatient services, it is not clear that those services are being replaced with lower intensity care. According to one study, decreases in per patient spending on inpatient care¹¹⁶ were not accompanied by per patient increases in outpatient care spending, suggesting that inpatient services for severely mentally ill patients are not being substituted with outpatient care.¹¹⁷ It is not clear whether these patients are dropping out

less expensive alternative care for inpatient services.”); Douglas L. Leslie & Robert Rosenheck, *Shifting to Outpatient Care? Mental Health Care Use and Cost Under Private Insurance*, 156 AM. J. PSYCHIATRY 1250, 1250 (1999) (“A principal goal of [managed care organizations] is to reduce total health costs by substituting . . . outpatient services for more expensive inpatient services.”).

112. Goldner, *supra* note 14, at 1460 (“[T]he evidence seems uncontroverted that managed mental health care costs are reduced largely through reductions in the utilization of inpatient services.”).

113. Thomas M. Wickizer et al., *Controlling Inpatient Psychiatric Utilization Through Managed Care*, 153 AM. J. PSYCHIATRY 339, 342 (1996).

114. Goldner, *supra* note 14, at 1460 (citing Michael S. Jellinek & Barry Nurcombe, *Two Wrongs Don’t Make a Right: Managed Care, Mental Health, and the Marketplace*, 270 JAMA 1737, 1738 (1993)).

115. Leslie & Rosenheck, *supra* note 111, at 1256.

116. See *supra* note 4 for a definition of inpatient care.

117. Leslie & Rosenheck, *supra* note 111, at 1256. Outpatient care is less intensive than inpatient and residential treatment. See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., MENTAL HEALTH, UNITED STATES, 2010, at 345 (2012). Outpatient care is:

[c]are provided in an ambulatory setting [when] treatment does not require an overnight stay. . . . [T]his setting may include a hospital outpatient department; an emergency room; physician’s or other medical professional’s (private therapist, psychologist, psychiatrist, social worker, or counselor) office or clinic; mental health clinic or center; partial day hospital or day treatment program; and in-home therapist,

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of care entirely or whether the burden of providing care is being shifted to other actors.¹¹⁸ What is clear, however, is that managed care organizations achieve cost savings by cutting services for the severely mentally ill.

B. Utilization Review Impedes Behavioral Care in Ways it Does Not Interfere with Medical Care

Additionally, the severely mentally ill are at special risk of harm because managed care practices interfere with treatment for severe mental illness in ways that they do not interfere with the effectiveness of medical care. First, medical necessity—the basis for coverage decisions—is a medical construct that does not translate well to the behavioral care context and often inappropriately cuts off care for psychiatric and substance abuse patients before they are ready to leave treatment.¹¹⁹ Additionally, utilization review can impede psychiatric and substance abuse patients' progress in treatment by reinforcing their underlying pathologies.¹²⁰ Both the inapplicability of medical necessity and the potential for impeding progress in treatment are unique to the behavioral care context and therefore place the severely mentally ill at special risk of harm from utilization review.

1. Medical Necessity Does Not Translate to the Behavioral Care Context and Cuts Off Behavioral Treatment Too Early

Utilization reviewers decide whether to cover requested care by determining whether that care is medically necessary according to the insurance company's standards.¹²¹ Insurers define medical necessity for themselves and most definitions are confidential.¹²² Still, after a review of available definitions, the Department of Health and Human Services concluded that

counselor, or family preservation worker.

Id.

118. See *infra* section III.B.2.c for a discussion of cost shifting.

119. See *infra* section III.A.2.a.

120. See *infra* section III.A.2.b.

121. See SARA ROSENBAUM ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., MEDICAL NECESSITY IN PRIVATE HEALTH PLANS: IMPLICATIONS FOR BEHAVIORAL HEALTH CARE 11 (2003).

122. *Id.*

most definitions encompass five dimensions.¹²³ One particularly problematic dimension, patient safety and setting, considers whether the proposed treatment is carried out in the least intrusive setting and emphasizes the biological nature of the medical necessity determination.¹²⁴

The safety and setting dimension does not translate well to the behavioral care context and results in shorter and potentially less effective inpatient and residential psychiatric and substance abuse treatment. The safety and setting prong of medical necessity means that insurers will provide care in a more restrictive setting only when the patient's functioning is so impaired that they cannot safely be in a less intensive environment.¹²⁵ According to one provider:

When I was running an inpatient unit, I would have to . . . speak to a clerk on the phone to say, "I need approval for this patient to stay here for another five days." And they would say to me, "Well, is the patient acutely suicidal or acutely homicidal?" "Well, not right now because he's in the hospital. We took the knife away. We took the gun away. We took the poison away." And they would say, "Well, then why does he have to be in the hospital?"¹²⁶

Because behavioral care patients can rapidly decompensate outside of an intensive treatment environment, this dimension of medical necessity forces providers to cut off care after the patient has been stabilized but before the patient has internalized treatment.¹²⁷ Accordingly, the safety and setting dimension interferes most at the front end of behavioral care—once the patient is stabilized, the insurer will demand treatment in a less intensive setting. This gives psychiatrists

123. *Id.* at 12–13.

124. *Id.* at 1, 13. The other four dimensions of medical necessity are not particularly relevant here. They are: whether the service is within the contractual scope of the plan, whether the treatment comports with professional standards, whether the treatment is for a medical problem and not for the patient's convenience, and whether the treatment is the least costly option. *Id.*

125. See, e.g., Ira D. Glick et al., *Inpatient Psychiatric Care in the 21st Century: The Need for Reform*, 62 PSYCHIATRIC SERVS. 206, 207 (2011) (describing safety as the determinant of medical necessity).

126. *Denied*, CBS NEWS (Dec. 14, 2014), <http://www.cbsnews.com/news/mental-illness-health-care-insurance-60-minutes-2/> [<https://perma.cc/MDB8-C9HX>] (quoting Harold Koplewicz, founder of the Child Mind Institute).

127. See *id.*

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no opportunity to begin building the trusting relationship necessary to permit patients to disclose deep-seated traumas and issues.¹²⁸

Additionally, around ten to thirty percent of those hospitalized for mental health problems are considered treatment resistant.¹²⁹ Unless those patients are able to address the reasons they are reluctant to change, treatment will likely be ineffective in the long term.¹³⁰ Medical necessity only permits psychiatrists to stabilize patients without addressing the patients' underlying issues and treatment resistance. This likely impedes the long-term effectiveness of treatment and keeps the severely mentally ill cycling in and out of crises rather than focusing on recovery.¹³¹

128. Steven Stern, *Managed Care, Brief Therapy, and Therapeutic Integrity*, 30 *PSYCHOTHERAPY* 162, 164 (1993) (“[I]t is often the case that the unsolved problem that ultimately becomes the focus of treatment is not exactly the same as the patient’s initial presenting complaint. . . . Some patients deliberately withhold aspects of their problem out of embarrassment. Others whose problems stem from severe psychological trauma may, as a result of repression or disassociation, be unable to recall the relevant painful events until a trusting relationship with a therapist is well established. Still others lack the requisite . . . capacity for introspection to make any connections between their symptoms and possible causes, requiring painstaking work by the therapist just to gain a preliminary understanding of the interpersonal or emotional factors giving rise to the patient’s conscious symptoms.”).

129. Glenn O. Gabbard et al., *A Psychodynamic Perspective on the Clinical Impact of Insurance Review*, 148 *AM. J. PSYCHIATRY* 318, 319 (1991).

130. Glenn O. Gabbard, *Inpatient Services: The Clinician’s View*, in *ALLIES AND ADVERSARIES: THE IMPACT OF MANAGED CARE ON MENTAL HEALTH SERVICES* 23, 27–28 (Robert K. Schreter et al. eds., 1994) (“In most cases, patients are hospitalized because they are not compliant with medication and other aspects of their treatment plan. The hospital unit provides the patient with an opportunity to benefit from an interpersonal holding environment not possible in outpatient settings. Psychosocial factors involved in noncompliance and decompensation can be understood and addressed in such an environment. Psychiatric treatment simply does not lend itself to a surgical model involving a specific disease entity, a specifically tailored intervention, and a specifically predictable number of days spent in recovery. The majority of patients who are seriously disturbed enough to require hospitalization resist their treatment in a variety of ways. To prevent repeated episodes of noncompliance and rehospitalization, the psychosocial reasons for the patient’s resistance to treatment must be addressed in addition to stabilizing a self-destructive crisis. ‘Treatment resistant’ is not synonymous with ‘custodial.’ For many patients, the safe structure of a holding environment is crucial, so that sufficient time and attention can be given to understanding the patient’s reluctance to change.”).

131. See Goldner, *supra* note 14, at 1466 (“The perception is that the treatment of the underlying chronic difficulties and underlying character issues are beyond the scope of reimbursable psychiatric interventions. Too often . . . the treatment will terminate before it is clinically sound to do so.”); Stern, *supra* note 128, at 162

Empirical evidence shows that shorter inpatient treatment is harmful to the severely mentally ill. One study found that patients who had shorter stays in inpatient psychiatric treatment were at higher risk of suicide.¹³² Another found that former psychiatric patients' risk of readmission to inpatient care within sixty days of discharge increased for each day that inpatient treatment was reduced through utilization review.¹³³ Others have shown that the effectiveness of substance abuse treatment depends in part on the length and intensity of treatment.¹³⁴ By decreasing the length and intensity of inpatient treatment for the severely mentally ill, managed care places these patients at special risk of harm.

2. Utilization Review Can Reinforce Patients' Underlying Pathologies and Impede Their Progress

Managed care also poses a special danger to inpatient psychiatric and substance abuse patients by actively impeding the therapeutic process. When insurers determine that care for treatment resistant patients is not medically necessary, the denial can reinforce the patients' conviction that they are not in need of care and delay progress.¹³⁵ On the other end of the treatment experience, patients who have made significant progress may feel a great deal of anxiety at the prospect of leaving the place in which they have made such strides.¹³⁶ For

("[Utilization reviewers'] ostensible objective is to determine the 'medical necessity' of treatment, but medically necessary care is increasingly defined as short-term therapy for acute conditions."); Glick et al., *supra* note 125, at 208 ("The objective which is lost in the ultrashort model [of inpatient care] is to treat the current episode but, equally important, to put measures in place that will prevent subsequent episodes. . . . Focusing primarily on safety issues requires a parsing of clinical judgments that is too narrow and specific for the ambiguous realities we so often face. As a result, risk may actually be increased while the utility of hospitalization to fully address the episode of illness and to prevent recurrence is diminished.").

132. Rani A. Desai et al., *Mental Health Service Delivery and Suicide Risk*, 162 AM. J. PSYCHIATRY 311, 313 (2005).

133. Thomas M. Wickizer & Daniel Lessler, *Do Treatment Restrictions Imposed by Utilization Management Increase the Likelihood of Readmission for Psychiatric Patients?*, 36 MED. CARE 844, 847 (1998).

134. MARGARET EDMUNDS ET AL., INST. OF MED., *MANAGING MANAGED CARE: QUALITY IMPROVEMENT IN BEHAVIORAL HEALTH* 84 (1997).

135. See Gabbard, *supra* note 130, at 32.

136. See Roger Lewin & Steven S. Scharfstein, *Managed Care and the*

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example, two clinicians have described their experience with a patient who had improved so much in inpatient care that her insurance wanted to begin the process of downgrading her to a less intensive—and less costly—environment:

[The patient] began to express more and more suicidal ideation Once again, she started to cut and burn [herself]. . . . [S]he was placed on suicidal observation.

While on suicidal observation, Sarah [, the patient,] barricaded herself in a bathroom and cut herself very severely. . . . [A nurse] kicked the door down. Rapid blood loss was controlled. . . . [In explanation for her actions,] Sarah said she thought there was no other way to get across to the insurance company just how serious her situation was.¹³⁷

Managed care's intrusion into the treatment process has the potential to impact the progress made by severely mentally ill patients. Either told to leave before they have overcome treatment resistance to fully embrace change or before they have adequately transitioned away from the intensive environment, severely mentally ill patients' conditions may worsen because of utilization review. The potential to reinforce underlying conditions or set back treatment progress is unique to the behavioral health context and, for this reason, the severely mentally ill are at greater risk of harm from utilization review.

IV. THE TRAGEDY AND THE IRONY OF ERISA PREEMPTION

Although ERISA preemption does not directly endanger the severely mentally ill, it does facilitate the harm that managed care organizations inflict on patients. This Part unpacks how ERISA's remedial gap gives rise to social tragedies and legal ironies. Section A describes how ERISA preemption facilitates social harm. Section B argues that ERISA preemption has created two legal ironies by perverting the statute's policy goal of protecting employer-provided

Discharge Dilemma, 53 PSYCHIATRY 116, 119 (1990).

¹³⁷. *Id.* at 119.

benefits.

A. *ERISA's Social Tragedies*

This section argues that ERISA preemption has created two social tragedies. Subsection 1 explains how ERISA preemption leaves insurer incentives misaligned toward pursuing profit, instead of protecting patients, and facilitates the harm that insurers cause to the severely mentally ill. Subsection 2 then argues that ERISA preemption prevents scrutiny into the costs engendered by managed care and legitimizes the cost containment fiction that any harm to patients is an inevitable reflection of the need to ration care.

1. ERISA's Remedial Gap Reinforces Perverse Incentives

I [, Linda Peeno,] wish to begin by making a public confession: In the spring of 1987, as a physician, I caused the death of a man. . . . I have not been taken to account for this in any professional or public forum. In fact, just the opposite occurred: I was “rewarded” for this. It bought me an improved reputation in my job, and contributed to my advancement afterwards. Not only did I demonstrate I could indeed do what was expected of me, I exemplified the “good” company doctor: I saved a half million dollars!

. . . The primary ethical norm [for a physician] is: do no harm. I did worse. I caused a death. Instead of using a clumsy, bloody weapon, I used the simplest, cleanest of tools: my words. The man died because I denied him a necessary operation to save his heart. I felt little pain or remorse at the time. The man's faceless distance soothed my conscience. Like a skilled soldier, I was trained for this moment. When any moral qualms arose, I was to remember: I am not denying care; I am only denying payment.¹³⁸

138. Linda Peeno, *Managed Care Ethics: The Close View*, HOSPICE PATIENTS ALL., <http://www.hospicepatients.org/drpeenotestimony.html> [https://perma.cc/Y3JK-W47A] (last visited Feb. 2, 2016) (public testimony prepared for the U.S. House of Representatives Committee on Commerce, Subcommittee on Health and Environment hearing on May 30, 1996). Although

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ERISA preemption facilitates patient harm by removing the specter of liability for opportunistic cost cutting, leaving utilization reviewers like Linda Peeno free to place profit-seeking above patient welfare. For managed care organizations, the economics are simple: the less care approved and financed, the more profit.¹³⁹ Put another way, “[W]e give the money to the managed care companies and say, How much do you want to spend on patients and how much do you want to keep in profits?”¹⁴⁰

By all indications, managed care organizations have answered with a resounding “quite a lot.” In 2009, the five biggest for-profit health insurance companies had net earnings of \$12.2 billion.¹⁴¹ Cigna paid \$136 million to its CEO that year, or “enough money to pay for 204,000 infants to receive the recommended series of seven well-baby visits in their first year.”¹⁴² That same year, UnitedHealth Group paid its CEO a total of \$107.5 million (including exercised stock options).¹⁴³ That amount “would pay for up to 1.1 million women to receive mammograms.”¹⁴⁴ Aetna, Inc. paid its CEO \$18.1 million in 2009, “enough to pay for 4,853 people to undergo arthroscopic

Peeno described a utilization review decision about a heart operation, her statement details the identical incentives that exist for utilization reviewers making decisions about requests to approve psychiatric and substance abuse treatment.

139. Peter K. Stris, *ERISA Remedies, Welfare Benefits, and Bad Faith: Losing Sight of the Cathedral*, 26 HOFSTRA LAB. & EMP. L.J. 387, 396 (2009) (“[A] self-serving or careless welfare plan is better off financially whenever it denies or delays coverage if the amount of money immediately saved by failing to pay the insurance benefit is greater than the expected present value of (i) the amount of money the plan will be required to ultimately pay the claimant plus (ii) any additional expenditures that the plan will likely incur as a result of the denial or delay (e.g., legal fees, an award of fees to the claimant’s attorney) plus (iii) the reputational cost of the wrongful denial.”).

140. Sandra G. Boodman, *Managed Care Comes to Mental Health*, WASH. POST (May 6, 1997), <https://www.washingtonpost.com/archive/lifestyle/wellness/1997/05/06/managed-care-comes-to-mental-health/ae43b2c0-c000-460f-85c6-0da89332f86a/> [https://perma.cc/L2GW-UZ85] (quoting Bryant L. Welch, former Director of Practice, American Psychological Association).

141. *CEOs From 10 Health Insurers Took Nearly \$1 Billion in Compensation*, HEALTH CARE FOR AMERICA NOW (Aug. 9, 2011), <http://web.archive.org/web/20160625164340/http://healthcareforamericanow.org/2011/08/09/ceos-from-10-health-insurers-took-nearly-1-billion-in-compensation/> [https://perma.cc/685P-HJQW].

142. *Id.*

143. *Id.*

144. *Id.*

knee surgery.”¹⁴⁵ Finally, the CEO of Wellpoint Inc. made \$13.1 million in 2009, which “would cover the cost of 2,500 hernia operations.”¹⁴⁶

Under a theory of law and economics, legal liability forces actors to “internalize the negative externalities” of their behavior and thus incentivizes that actor and others similarly situated to avoid the behavior that created the liability in the future.¹⁴⁷ So, while managed care organizations face perverse incentives to cut necessary care, the theory goes that liability for the harm their profiteering causes should counterweigh the profit-seeking motive. By eliminating the possibility of liability, ERISA preemption leaves managed care organizations with all the power to determine the course of treatment for the sickest and most vulnerable members of society with no specter of legal accountability for their decisions to counterpoise their profit-seeking incentives.¹⁴⁸

Under ERISA, insurers have little reason to approve treatment.¹⁴⁹ To begin, few beneficiaries or participants appeal utilization review denials.¹⁵⁰ To challenge the benefit decision in federal court, the beneficiary must exhaust the insurer’s internal appeals process.¹⁵¹ In the event that an insured does

145. *Id.*

146. *Id.*

147. *See* Stris, *supra* note 139, at 396.

148. *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1338 (5th Cir. 1992). Reflecting on the ruling that it was forced to make, the court noted:

The result ERISA compels us to reach means that the Corcorans have no remedy, state or federal, for what may have been a serious mistake. This is troubling for several reasons. First, it eliminates an important check on the thousands of medical decisions routinely made within the burgeoning utilization review system. With liability rules generally inapplicable, there is theoretically less deterrence of substandard decisionmaking. Moreover, if the cost of compliance with a standard of care (reflected either in the cost of prevention or the cost of paying judgments) need not be factored into utilization review companies’ cost of doing business, bad medical judgments will end up being cost-free to the plans that rely on those companies to contain medical costs.

Id.

149. Of course, this statement excludes the possibility that insurers take seriously the consequences of unjustifiably cutting care. There may be some insurers that do so. But there is no legal reason for an insurer to do this because of ERISA.

150. Katherine T. Vukadin, *Unfinished Business: The Affordable Care Act and the Problem of Delayed and Denied ERISA Health Care Claims*, 47 J. MARSHALL L. REV. 887, 896 (2014).

151. Brendan S. Maher, *The Affordable Care Act, Remedy, and Litigation*, 63

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take the unlikely step of challenging the decision at the first level of appeal, there is dropout between each successive level, with fewer insureds pursuing appeals after each step of the process.¹⁵²

If the challenge does reach a federal court, the court reviews the denial under a standard deferential to the insurer.¹⁵³ And if the court rules that the insurance company improperly denied a claim, ERISA limits the participant's remedies to reimbursement for wrongfully denied care that the participant paid for out-of-pocket or an injunction ordering the insurer to cover the care.¹⁵⁴ The court has the discretion to award a successful plaintiff attorney's fees,¹⁵⁵ but this discretionary relief is the only potential cost to the insurance company above what it would have paid had it simply authorized care in the first place.¹⁵⁶

On the other hand, if participants are injured or die as a result of coverage denials, ERISA preemption means that the participants or their survivors have no valid claim for relief against the insurance company. If plaintiffs sue with a tort-based claim for relief—including wrongful death—the claim is either preempted by ERISA's express preemption provision or its complete preemption provision. And because ERISA does not provide for compensatory or punitive damages, the claim tumbles into ERISA's remedial vacuum and costs the managed care organization nothing at all.

One attorney described the benefits of ERISA preemption in an internal memo:

The advantages of ERISA coverage in litigious situations are enormous: state law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of the

AM. U. L. REV. 649, 657 (2014).

152. Vukadin, *supra* note 150, at 910.

153. ROSENBAUM ET AL., *supra* note 121, at 20.

154. 29 U.S.C. § 1132(a)(1)(B) (2012).

155. 29 U.S.C. § 1132(g)(1) (2012).

156. Dana M. Muir, *Fiduciary Status as an Employer's Shield: The Perversity of ERISA Fiduciary Law*, 2 U. PA. J. LAB. & EMP. L. 391, 459 (2000) ("From the plan's perspective, in the worst case it must pay or provide the benefits it has denied, and, in the discretion of the court, attorney's fees. Thus, the direct economic incentives for a plan to avoid opportunistic behavior when deciding whether to pay disputed benefits are almost nil.").

benefit in question, and claims administrators may receive a deferential standard of review. The economic impact on Provident from having policies covered by ERISA could be significant. As an example, . . . [we] identified 12 claim situations where we settled for \$7.8 million in the aggregate. If those 12 cases had been covered by ERISA, our liability would have been between zero and \$0.5 million.¹⁵⁷

ERISA changes the economics of coverage denials for insurers. Under the worst-case scenario—a successful challenge to a claim denial in federal court—the most the insurer *may* have to pay beyond what it would have paid had it initially approved coverage is the plaintiff's attorney's fees. Given the numerous barriers to that scenario and the potential profit from denying care, insurers have every incentive to pursue profits at the expense of participant welfare. As one commenter concluded:

The H.M.O.s know the economics as well as anybody, and better than most. . . . Deny a treatment at the initial or emergency stage and the patient may go away or seek another or more expensive policy. Or die—thus conclusively tidying up the books on the right side of the ledger.¹⁵⁸

2. ERISA Legitimizes the Fiction of Managed Care Rationing

Managed care organizations justify cost containment decisions as necessary to keep health care costs from spiraling out of control and to ration scarce health care resources.¹⁵⁹

157. Memorandum from Jeff McCall to IDC Management Group (Oct. 2, 1995), <http://www.erisa-claims.com/library/Provident%20memo.pdf> [<https://perma.cc/DR7T-BKBS>].

158. Christine Lockhart, *The Safest Care is to Deny Care: Implications of Corporate Health Insurance, Inc. v. Texas Department of Insurance on HMO Liability in Texas*, 41 S. TEX. L. REV. 621, 631 (2000) (quoting Christopher Hitchens, *Bitter Medicine*, VANITY FAIR, Aug. 1998, at 64).

159. *E.g.*, Peeno, *supra* note 138. As used in this Comment, health care rationing is the idea that health care resources are too scarce to meet all health care demand and that, accordingly, choices must be made about what care to cover and what care to deny. See Lanis L. Hicks, *Making Hard Choices*, 32 J. LEGAL MED. 27, 27–28 (2011) (“No society can afford to provide to individuals every health care service that might be beneficial (or that a member of society wants); there has to be some way of limiting the use of health care services.”)

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Whether or not the premise that health resources are scarce is true,¹⁶⁰ ERISA preemption legitimizes the fiction that managed care cost containment actually reduces costs of health care by preventing scrutiny of insurer motivations. This subsection argues that the economic realities of managed care undermine the claim that managed care organizations save health care costs, but ERISA preemption prevents scrutiny into these economic realities and legitimizes the cost-saving fiction. Subsection a describes the administrative costs necessary to

Because resources are not unlimited, *choices* must be made regarding how those limited, or scarce, resources are distributed and who gets to make the decisions about who gets what. Rationing is simply about making choices among competing alternative uses of the limited resources; the issue is how those choices are made and by whom.”); *see also* Peter Singer, *Why We Must Ration Health Care*, N.Y. TIMES MAG. (July 15, 2009), http://www.nytimes.com/2009/07/19/magazine/19healthcare-t.html?_r=2&pagewanted=1&https://perma.cc/HU3C-YE95 (“You have advanced kidney cancer. It will kill you, probably in the next year or two. A drug called Sutent slows the spread of the cancer and may give you an extra six months, but at a cost of \$54,000. Is a few more months worth that much? If you could afford it, you would probably pay that much, or more, to live longer, even if your quality of life wasn’t going to be good. But suppose it’s not you with the cancer but a stranger covered by your health insurance fund. If the insurer provides this man—and everyone else like him—with Sutent, your premiums will increase. Do you still think the drug is a good value? Suppose the treatment cost a million dollars. Would it be worth it then? Ten million? Is there any limit to how much you would want your insurer to pay for a drug that adds six months to someone’s life? If there any point at which you say, ‘No, an extra six months isn’t worth that much,’ then you think that health care should be rationed.”).

160. Peeno challenges the notion that health resources are, in fact, scarce: When we talk about “scarcity,” we use it as leverage for some economic gain or justification. For example, we use the language of “infinite needs” to dramatize the limitations, but do we need infinite hip replacements? No, this is absurd. . . . The real question which we are not asking is: are we willing to pay for all the hip replacements that are needed? If not, the thorny corollary is: who will not get something they need? Someone too poor to pay? Someone in too much pain to figure out the game? Someone with money and the means to play by the rules but who has a physician who has exceeded his or her quota and who will never offer the procedure?

Peeno, *supra* note 138. Other critics of ERISA accept the need to ration care but insist that ERISA preemption allows rationing to occur where it perhaps should not by permitting opportunistic cost cutting to go unscrutinized. *See* Peter D. Jacobson & Michael D. Cahill, *The Changing Face of Law and Medicine in the New Millennium: Applying Fiduciary Responsibilities in the Managed Care Context*, 26 AM. J.L. & MED. 155, 156 (2000) (“[T]he question is not whether there will be cost containment but how to structure and oversee the process of cost containment. . . . The mission facing whoever arbitrates managed care disputes is to ensure fair, accurate, and efficient administration while also preventing bias or the provision of inadequate care in the name of short-sighted profiteering.”).

run the utilization review apparatus. Next, subsection b exposes the lavish salaries and bonuses managed care organizations give to their executives. Finally, subsection c argues that, instead of saving health care costs, managed care organizations simply shift the costs of wrongfully denied care onto society while pocketing the profits they make by doing so.

a. Managed Care Creates Significant Administrative Costs

Utilization review is a rather cumbersome process. Doctors report spending significant time and resources on the administrative burden created by utilization review.¹⁶¹ Provider time is not the only resource drain created by utilization review; a significant amount of health care expenditures go to administrative costs. According to one study, after Massachusetts delegated administration of its Medicaid program to a managed care organization, spending on plan administration increased by around *600 percent*.¹⁶² Additionally, the United States spends much more per capita on health care administration than other wealthy nations.¹⁶³ Indeed, the amount of money spent creating the administrative apparatus necessary to cut health care costs was so high that in the early 1990s, the cost containment industry was one of the fastest growing sectors of the health care economy.¹⁶⁴

For an industry predicated on cutting the cost of health care, managed care has created an astronomical amount of administrative costs. Under managed care, resources that could be spent providing services are diverted to operating the

161. *E.g.*, *Between You and Your Doctor: The Bureaucracy of Private Health Insurance—Day 1: Hearing Before the Subcomm. on Domestic Policy of the H. Comm. on Oversight and Government Reform*, 111th Cong. 38 (2009) (Statement of Melvin S. Stern, Solo Practitioner).

162. Gerald Schamess, *Who Profits and Who Benefits from Managed Mental Health Care?*, 66 SMITH C. STUD. SOC. WORK 209, 219 (1996) (citing Richard H. Beinecke & Sylvia B. Perlman, *Managed Medicaid: The Massachusetts Experience*, 16 BEHAV. HEALTH MGMT. 14 (1996)).

163. Janet L. Dolgin, *Unhealthy Determinations: Controlling Medical Necessity*, 22 VA. J. SOC. POL'Y & L. 435, 482 (2015).

164. Janet Shapiro, *The Downside of Managed Mental Health Care*, 23 CLINICAL SOC. WORK J. 441, 444–45 (1995) (citing Steffie Woolhandler & David U. Himmelstein, *The Deteriorating Administrative Efficiency of the US Health Care System*, 324 NEW ENG. J. MED. 1253 (1991)).

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machinery that further reduces the resources spent on care.¹⁶⁵ This would, perhaps, be an acceptable, if somewhat ironic, outcome if costs saved through utilization review were truly being rationed—that is, if dollars saved through utilization review went directly toward coverage of services for other plan participants. But evidence suggests that dollars saved through cost containment are reallocated to other, less acceptable alternatives.¹⁶⁶

b. Managed Care Cost Cutting Finances Lavish Executive Compensation and Corporate Perks

Someone has benefitted from the money being diverted from patient care through utilization review, but it is not plan participants. Rather, it is health care executives who appear to benefit most. Compensation continues to increase year after year for private health insurance executives.¹⁶⁷ Additionally, anecdotal reports suggest that executive-level staffing is bloated at the largest health insurance companies. For example, WellPoint had thirty-nine different executives on its payroll in one year, with each taking home over \$1 million per year.¹⁶⁸ WellPoint also spent over \$27 million on corporate retreats at resorts in Arizona and Hawaii in 2007 and 2008.¹⁶⁹

Every single dollar spent by managed care organizations on outrageous salaries and perks is a dollar that could be spent on care for plan participants. Managed care organizations claim to carry out the noble charge of protecting American society from unsustainable spending on needless care,¹⁷⁰ but

165. *Id.*

166. See Peeno, *supra* note 138 (“Certainly our macro-level savings in health care are not going back to providing for more research, more access, more services, etc.—the areas which benefit patients. If anything, we are seeing just the opposite: benefits to consumers are increasingly cut, while the ‘benefits’ to executives, stockholders, etc. are increasing. . . . Is there any evidence that a managed care plan has ever added benefits proportional to their ‘savings’ or profits over the years of their operation?”).

167. See Dolgin, *supra* note 163, at 480.

168. John N. Maher, *The Corporate Profit Motive & Questionable Public Relations Practices During the Lead-Up to the Affordable Care Act*, 25 J.L. & HEALTH 1, 13 (2012).

169. *Id.*

170. See Shapiro, *supra* note 164, at 443 (“Resources that could be used to provide healthcare services are instead removed as profit and salaries, while we are told that if everyone could have all the healthcare they wanted[,] we would need rationing. In actuality[,] there is no way to know if there would be enough

all too often it seems they are protecting their pocketbooks. By allowing managed care organizations to cut care without scrutinizing their motives for doing so, ERISA preemption legitimizes the fiction that, however painful, cost containment is necessary because it rations scarce health care resources.

c. Managed Care Does Not Save Costs, It Shifts Them

Instead of driving down the cost of health care in the United States, managed care shifts the costs of providing necessary care to the severely mentally ill onto other actors. Cost shifting occurs in different ways—some of the costs borne by society are economic, others more ephemeral. Whether quantifiable or not, the costs that are shifted onto society cannot be considered saved by utilization review. By preventing scrutiny of insurers' profit motives, ERISA also prevents scrutiny into where the money that is not spent on care goes or where the participant in need of that care turns in the face of a coverage denial.

Often, severely mentally ill individuals who are denied treatment turn to the public sector for care, pushing the cost of that care onto taxpayers.¹⁷¹ The public system is the “provider of last resort,” serving those otherwise unable to obtain care.¹⁷² Because private insurers frequently fail to approve long-term, intensive care, the public sector has typically borne the costs of managed care coverage denials.¹⁷³ Indeed, some parents who are unable to get help for their sick children have gone so far as to relinquish custody to the state so their children can receive adequate treatment.¹⁷⁴ In 2001, at least 12,000 children were relinquished to state custody by parents who had no other option for providing sufficient mental health care.¹⁷⁵

healthcare for everyone if there were no (or much less) profit being extracted from the healthcare system.”).

171. Burnam & Escarce, *supra* note 101, at 24; EDMUNDS ET AL., *supra* note 134, at 92; Schlesinger et al., *supra* note 99, at 216.

172. EDMUNDS ET AL., *supra* note 134, at 52.

173. See Burnam & Escarce, *supra* note 101, at 24.

174. Maia Szalavitz, *America's Failing Mental Health System: Families Struggle to Find Quality Care*, TIME (Dec. 20, 2012), <http://healthland.time.com/2012/12/20/americas-failing-mental-health-system-families-struggle-to-find-quality-care/> [<https://perma.cc/KE77-FFFR>].

175. *Id.*

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Managed care coverage denials also impose costs on taxpayers through the criminal justice system. Indeed, because state mental health funding has diminished, the criminal justice system has become the largest provider of mental health care in America.¹⁷⁶ The number of mentally ill inmates in jails and prisons is ten times larger than the number of mentally ill patients in state hospitals.¹⁷⁷ According to the Bureau of Justice Statistics, fifty-four percent of the federal prison population and twenty percent of the total state prison population are inmates sentenced for low-level drug offenses who may be more effectively treated in substance abuse programs.¹⁷⁸ The lifetime prevalence of psychiatric disorders, including substance abuse problems, in incarcerated populations is estimated to be between sixty-two and eighty percent.¹⁷⁹

It is unclear how much of this population was denied care by private insurers, though there is a strong correlation between rates of incarceration and a lack of access to behavioral care.¹⁸⁰ What is clear, though, is that “the largest mental health institutions in 44 of our 50 states are jails or prisons.”¹⁸¹ And when individuals in need of treatment are instead dealt with through the criminal justice system, they are put at risk. For example, inmates suffering from mental illness are more likely to be victimized in criminal justice settings than are other prisoners.¹⁸² They are also more likely to be put in solitary confinement than are other inmates.¹⁸³ Furthermore, mentally ill inmates tend to be incarcerated longer than other inmates, contributing to prison

176. Thomas J. Dart, Opinion, *American Jails Have Become the New Mental Asylums—And You’re Paying the Bill*, *GUARDIAN* (May 28, 2014), <http://www.theguardian.com/commentisfree/2014/may/28/sp-american-jails-mental-health-funding> [<https://perma.cc/FHC8-FGYF>].

177. *Id.*

178. EDMUNDS ET AL., *supra* note 134, at 113.

179. Kyle L. Grazier et al., *Rationing Psychosocial Treatments in the United States*, 28 *INT’L J.L. & PSYCHIATRY* 545, 555 (2005).

180. *Access to Mental Health Care and Incarceration*, *MENTAL HEALTH AM.*, <http://www.mentalhealthamerica.net/issues/access-mental-health-care-and-incarceration> [<https://perma.cc/6BDB-F8TJ>] (last visited Nov. 27, 2016) (“Six out of [ten] of the states with the least access to mental health care also have the highest rates of incarceration.”).

181. Dart, *supra* note 176.

182. *Id.*

183. *Id.*

overcrowding.¹⁸⁴

Not all individuals denied necessary care by their insurance companies are shifted into public care. Sometimes managed care organizations shift the cost of care to informal caregivers instead of taxpayers. Although it is difficult to estimate the costs borne by informal caregivers who were forced to fulfill this role specifically as a result of medical necessity denials, studies and anecdotal evidence suggest that, regardless of the impetus for informal caregiving, those who do find themselves responsible for mentally ill loved ones bear a number of emotional and financial costs. For example, Jenny Ghowrwal absorbed the cost of caring for her mentally ill mother, who was diagnosed with schizophrenia when Jenny was in college.¹⁸⁵ Her mother refused treatment and lost her job.¹⁸⁶ Jenny moved back home and got a job to pay her mother's expenses.¹⁸⁷ While trying to earn her degree, Jenny's emotional state suffered from the stress of taking care of her mother.¹⁸⁸ Her mother's delusions included distrusting the government, so she refused to accept any state-provided financial assistance,¹⁸⁹ putting further financial strain on Jenny. In the six years following Jenny's assumption of caregiving duties, Jenny estimated that she and her brother had spent more than \$140,000 caring for their mother.¹⁹⁰

According to a survey of American caregivers in 2015, those who care for mentally ill adults spend, on average, more time per week providing care than do general caregivers.¹⁹¹

184. E. FULLER TORREY ET AL., TREATMENT ADVOC. CTR. & NAT'L SHERIFF'S ASS'N, THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN PRISONS AND JAILS: A STATE SURVEY 7 (Apr. 8, 2014), <http://tacreports.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf> [https://perma.cc/P8ZH-JMX3].

185. Ruth Spencer, *America's Mental Health Care Crisis: Families Left to Fill the Void of a Broken System*, GUARDIAN (May 27, 2014), <http://www.theguardian.com/world/2014/may/27/sp-americas-mental-health-care-system-crisis> [https://perma.cc/SG7Y-8U26].

186. *Id.*

187. *Id.*

188. *Id.*

189. *Id.*

190. *Id.*

191. NATIONAL ALLIANCE FOR CAREGIVING, ON PINS & NEEDLES: CAREGIVERS OF ADULTS WITH MENTAL ILLNESS 4 (2016), http://www.caregiving.org/wp-content/uploads/2016/02/NAC_Mental_Illness_Study_2016_FINAL_WEB.pdf [https://perma.cc/239R-RYL] (reporting that, on average, caregivers of mentally ill adults spend 32 hours of care per week while aggregate numbers for all caregivers

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And on average, those who care for mentally ill adults provide care for nine years, or five years more than the average duration of caregiving for general caregivers.¹⁹² Forty-nine percent of those who care for mentally ill adults report that those for whom they care are financially dependent on their caregivers.¹⁹³ Twenty-two percent of these caregivers said that they are unable to find “a medical provider who understands mental health,” and twenty-eight percent of caregivers cannot locate a mental health professional to treat their loved one.¹⁹⁴ Thirty-one percent report that they thought it would be helpful to have parity between physical care and behavioral care¹⁹⁵—a result that indicates that caregivers of mentally ill adults have not had any of their burdens lifted by the parity requirements under the Affordable Care Act.¹⁹⁶

Informal caregiving for adults with mental illnesses imposes emotional pressures on caregivers. Only thirty-seven percent of those who care for adults with serious mental illnesses feel that the person for whom they care can rely on other friends and family for that care.¹⁹⁷ And forty-eight percent of caregivers report that they feel that they cannot talk to others about their loved ones’ mental health issues.¹⁹⁸ Given the pressure and isolation these caregivers feel, it is hardly surprising that seventy-four percent of caregivers for adults with mental illnesses report feeling emotionally stressed by caretaking, with fifty-three percent reporting high levels of emotional stress.¹⁹⁹ Moreover, fifty-two percent of mental health caregivers report that caregiving has negatively impacted their own physical health.²⁰⁰ When informal caregivers are forced to assume their caregiving roles because of insurance denials, they are absorbing the costs that managed care organizations purport to save society while really just lining their own pocketbooks.

in the U.S. average out to 24 hours of care per week).

192. *Id.*

193. *Id.*

194. *Id.* at 5.

195. *Id.* at 29.

196. See *infra* notes 262–265 and accompanying text for a discussion of the limitations of parity under the Affordable Care Act.

197. NATIONAL ALLIANCE FOR CAREGIVING, *supra* note 191, at 40.

198. *Id.*

199. *Id.* at 42–43.

200. *Id.* at 44.

But informal caregivers and public systems are not the only parts of society onto whom managed care shifts the cost of caring for the severely mentally ill. Without a family member willing to care for them and suffering from severe mental illnesses, some of those who are unable to get treatment lose their homes. According to one academic, “[h]omelessness among persons with serious and persistent mental illness is perhaps the most visible consequence of the current mental health rationing system.”²⁰¹ An estimated thirty-five to fifty percent of the homeless population would have avoided homelessness had they received adequate mental health care when they were younger.²⁰² In addition to the human cost of homelessness, increased homelessness is correlated with increased risk of random violence and the spread of infectious disease.²⁰³

There are also serious indirect costs shifted onto society when managed care organizations wrongfully deny mental health treatment. According to one report, the global indirect cost of mental illness in 2010 was \$1.67 billion.²⁰⁴ Much of these costs come from the impact of mental illness on individual economic productivity.²⁰⁵ Unlike most physical diseases, which impact older individuals, mental illnesses tend to burden individuals during their traditional working years.²⁰⁶ Eighty-eight percent of individuals suffering from a severe mental illness report that they are less productive at work because of their illness.²⁰⁷ Mental illness also diminishes

201. Grazier et al., *supra* note 179, at 554.

202. Elizabeth S. Boison, Comment, *Mental Health Parity for Children and Adolescents: How Private Insurance Discrimination and ERISA Have Kept American Youth from Getting the Treatment They Need*, 13 J. GENDER, SOC. POLY & L. 187, 192 n.30 (2005) (citing *Talk of the Nation: Mental Health Parity* (NPR radio broadcast Apr. 30, 2002)).

203. Matthew P. Dumont, *Privatization & Mental Health in Massachusetts*, 66 SMITH C. STUD. SOC. WORK 293, 296 (1996).

204. EMILY HEWLETT & VALERIE MORAN, OECD HEALTH POLICY STUDIES, MAKING MENTAL HEALTH COUNT: THE SOCIAL AND ECONOMIC COSTS OF NEGLECTING MENTAL HEALTH CARE 42 tbl.1.4 (2014), http://www.oecd-ilibrary.org/social-issues-migration-health/making-mental-health-count_9789264208445-en [<https://perma.cc/MNT9-3A57>].

205. *Id.* at 43.

206. *Id.*

207. *Id.* In comparison, sixty-nine percent of individuals with moderate mental illness report decreased productivity as a result of their illness, while twenty-six percent of individuals with no mental illness report diminished productivity as a result of emotional problems. *Id.*

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productivity through absenteeism.²⁰⁸ Forty-two percent of workers suffering from severe mental illnesses reported absences from work in the week before the study was conducted.²⁰⁹ And estimates of unemployment among the mentally ill suggest that those with severe mental illnesses are six to seven times more likely to be unemployed than are those with no mental illness; individuals with mild to moderate mental illnesses are two to three times more likely to be unemployed than are individuals who do not have a mental illness.²¹⁰ Finally, the indirect costs of mental health include the cost of suicide.²¹¹ “[I]n the United States, the economic cost of suicide is estimated to be . . . \$34 billion annually, with the burden of suicide falling most heavily on adults of working age[.] [T]he cost to the economy results almost entirely from lost wages and work productivity.”²¹²

In addition to these quantifiable costs, wrongful denials of mental health care by managed care organizations shift costs onto society in two more ephemeral ways. First, beyond the decreased production power of individuals suffering from severe mental illnesses, society may be losing innovators, artists, scientists, academics, and a whole host of other figures who could positively contribute to society. According to one ethicist, health care has a special moral significance because it restores those suffering from disease to the normal range of functioning and thus protects the “fair equality of opportunity.”²¹³ The special moral importance of health care derives from the fact that “[t]he impairment of normal functioning by significant pathology, such as serious disease, injury, or disability, restricts individuals’ opportunity relative to the portion of the normal range that their skills and talents would have made available to them were they healthy.”²¹⁴ In

208. *Id.*

209. *Id.*

210. *Id.* at 44. Unemployment is also associated with causing mental health problems, suggesting that unemployed mentally ill individuals are stuck in a vicious cycle. The more severe their mental illnesses, the more likely individuals are to be unemployed; the longer individuals remain unemployed, the more their mental illnesses are exacerbated. *Id.*

211. *Id.* at 45.

212. *Id.*

213. NORMAN DANIELS, JUST HEALTH: MEETING HEALTH NEEDS FAIRLY 44 (2008).

214. *Id.* at 44–45.

other words, adequate treatment removes the barriers that mental illness places on access to and growth of the skills and talents that individuals naturally have. If mental illness is not adequately treated, there is a cost to society in the loss of whatever may have been the result of those natural skills and talents.

Finally, although individuals with mental illnesses are far more likely to be victims of violent crimes, not perpetrators,²¹⁵ there is a societal cost associated when individuals who were denied necessary care commit acts of violence. Studies have shown that youth with mental health issues have “higher rates of violence and aggression.”²¹⁶ Other studies report that both perpetrators and victims of domestic violence are likely to have suffered from mental illness prior to acts of violence.²¹⁷ And when those who have not received adequate treatment because of a coverage denial go on to commit violent crimes like homicide, the cost to society of managed care cost cutting is intolerable. This is not an entirely hypothetical discussion. In analyzing the systematic failures that resulted in the Sandy Hook shooting, the Sandy Hook Commission pointed to medical necessity criteria resulting in delayed and denied care as one of the many failures that contributed to the shooting.²¹⁸

215. *See Now Is the Time*, WHITE HOUSE 13 (Jan. 16, 2013), https://obamawhitehouse.archives.gov/sites/default/files/docs/wh_now_is_the_time_full.pdf [<https://perma.cc/V9TV-PA8F>].

216. Allison Evans Cuellar et al., *Mental Health and Substance Abuse Treatment and Juvenile Crime*, 7 J. MENTAL HEALTH POL'Y & ECON. 59, 59 (2004) (citations omitted).

217. Ronald C. Kessler, *The Costs of Depression*, 35 PSYCHIATRIC CLINICS N. AM. 1, 4 (2012).

218. SANDY HOOK ADVISORY COMM'N, FINAL REPORT OF THE SANDY HOOK ADVISORY COMMISSION 81–83 (2015), http://www.shac.ct.gov/SHAC_Final_Report_3-6-2015.pdf [<https://perma.cc/8TAE-J73M>]. Specifically, the Commission stated that it:

recognizes that a narrow understanding of mental health remains insufficient to identify what could have been done to improve [the shooter's] chances of living a functional, nonviolent life. . . . [However,] although the [shooter's] family was fortunate enough to have financial resources that permitted them access to potentially helpful evaluation and treatment services, those resources proved insufficient to ensure that his complex needs were adequately met or to protect against increasing social isolation. . . . [O]ur fragmented payment structure . . . undermines care coordination and consistency, denies care to many who most need it, and limits care for reasons that often have little to do with its clinical justifications or efficacy. . . . [T]he employment of “medical necessity” criteria in the precertification and review process around

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Managed care justifies its existence on the necessity of cutting the cost of care, but in truth, society pays when managed care opportunistically cuts necessary mental health care. ERISA preemption facilitates this cost shifting because it prevents any scrutiny of managed care's profit seeking incentive and allows insurers to hide behind claims of scarce health care resources. By allowing managed care to claim that it is simply protecting the system from spiraling costs without scrutiny into the exceedingly high profit margins of managed care organizations or the costs shifted onto society when managed care denies necessary care, ERISA preemption legitimizes the managed care fiction of cost savings.

B. ERISA's Legal Ironies

Beyond the human tragedies engendered by ERISA, the statute's preemptive provisions also create two legal ironies. First, ERISA preemption has transformed the law from a statute intended to protect employee benefits into one that permits opportunistic profiteering at the expense of the very employees who were supposed to be protected by it. Next, ERISA preemption renders toothless the statutorily imposed fiduciary duty of loyalty for administrators of employer-provided health plans.

1. ERISA Preemption Transforms a Shield into a Sword

ERISA is a comprehensive federal statute that regulates employee pension and welfare benefit plans.²¹⁹ Ironically—given that ERISA now protects managed care organizations from virtually all liability for negligent administration of employee health benefits—ERISA was created to *protect*

behavioral health services too often results in the delay or denial of needed care.
Id. at 81–83, 121.

219. Generally speaking, ERISA governs rights and obligations under any benefit plan provided by an employer. The statute exempts a small number of plan types, including government benefit plans and plans provided through employment by a church, 29 U.S.C. § 1003(b) (2012), but it otherwise applies to all plans provided by employers, assuming the plans meet the qualifying provisions under the statute, none of which are relevant here.

employee benefits from fraud and abuse.²²⁰ ERISA was passed in the wake of “highly publicized instances of fraud and mismanagement in employee pension funds, which had resulted in [many] workers losing retirement benefits accumulated over a lifetime of work,”²²¹ and drafters were primarily concerned with preventing these pension plan abuses from recurring.²²² Accordingly, ERISA provides “detailed vesting and funding requirements for pension plans and a program of pension plan termination insurance.”²²³

To counterbalance these increased regulatory requirements, Congress limited the remedies available to plan participants and beneficiaries under ERISA to the statutorily provided remedial scheme and included ERISA’s express preemption provision.²²⁴ This provision was “drafted . . . with the intent that ERISA would provide a comprehensive set of rules to govern the private pension industry, thereby relieving large employers from the headache of complying with multiple and divergent state and local regulations in the administration of their retirement plans.”²²⁵ In contrast to the detailed substantive provisions regulating pension plans, ERISA provides virtually no substantive rights for participants and beneficiaries in employee welfare plans—things like health insurance, life insurance, and disability insurance—even though the preemption provisions apply to both kinds of plans.²²⁶ The lack of substantive requirements for welfare

220. *E.g.*, 29 U.S.C. § 1001(b) (2012) (“It is hereby declared to be the policy of this chapter to protect . . . the interests of participants in employee benefit plans and their beneficiaries, by . . . establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.”).

221. Jeffrey W. Stempel & Nadia von Magdenko, *Doctors, HMOs, ERISA, and the Public Interest After Pegram v. Herdrich*, 36 TORT & INS. L.J. 687, 694 n.32 (2001) (quoting BARRY R. FURROW ET AL., HEALTH LAW 419 (2d ed. 2000)).

222. *E.g.*, *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 53 (D. Mass. 1997).

223. Donald T. Bogan, *ERISA: The Savings Clause, § 502 Implied Preemption, Complete Preemption, and State Law Remedies*, 42 SANTA CLARA L. REV. 105, 116 (2001).

224. *Id.* at 117–18.

225. *Id.* at 118.

226. See Catherine L. Fisk, *The Last Article About the Language of ERISA Preemption?: A Case Study of the Failure of Textualism*, 33 HARV. J. LEGIS. 35, 56 (1996) (“Congress did not give a great deal of thought to whether the scope of preemption should reflect the different degrees of federal regulation of pension plans, as opposed to welfare benefit plans. Broad preemption of state law may make sense when Congress decides to regulate a field extensively, as it did with

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plans combined with ERISA's exclusive remedies gives rise to the statute's remedial gap and permits managed care organizations to profiteer at the expense of beneficiaries.

Congress clearly could not have intended this result—managed care organizations and the possibility of cost containment injuries emerged *after* ERISA's enactment.²²⁷ Under a fee-for-service system, no one would have needed a remedy against their health insurance company for compensation for medical injuries.²²⁸ But with the emergence of managed care organizations and their new ways of injuring patients, ERISA's remedial vacuum has led to unjust results, leaving plaintiffs with no legal redress, and—crucially—leaving insurers' incentives misaligned toward the pursuit of profit at the expense of patient welfare. Accordingly, ERISA preemption in an age of managed care transforms ERISA from a shield against plan administrator incompetence and self-interest into a sword that enables administrators to behave opportunistically, thereby harming plan participants.

2. ERISA's Toothless Fiduciary Duty

ERISA imports trust law principles to hold plan administrators to a fiduciary duty of loyalty.²²⁹ The statute designates as a “fiduciary with respect to a plan” anyone who “has any discretionary authority or discretionary responsibility in the administration of such plan.”²³⁰ The statute explicitly imports trust law's duty of loyalty by requiring fiduciaries to act “solely in the interest of the participants and beneficiaries

respect to pensions. But broad preemption makes little sense when Congress does not extensively regulate in an area, as is the case with nonpension benefits.”).

227. *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1338 (5th Cir. 1992). (“[C]ost containment features such as the one at issue in this case did not exist when Congress passed ERISA. While we are confident that the result we have reached is faithful to Congress's intent neither to allow state-law causes of action that relate to employee benefit plans nor to provide beneficiaries in the Corcorans' position with a remedy under ERISA, the world of employee benefit plans has hardly remained static since 1974. Fundamental changes such as the widespread institution of utilization review would seem to warrant a reevaluation of ERISA so that it can continue to serve its noble purpose of safeguarding the interests of employees.”).

228. *See* Randall, *supra* note 2, at 4–5 (describing the new kind of health care injuries created by managed care organizations).

229. Muir, *supra* note 156, at 396.

230. 29 U.S.C. § 1002(21)(A)(iii) (2012).

and . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries.”²³¹

ERISA preemption renders this fiduciary duty toothless by foreclosing scrutiny of managed care motives in any particular utilization review decision even though decision makers have a perverse incentive to act against the interests of plan beneficiaries and participants. This is strange. The heart of any fiduciary relationship is the fiduciary’s duty of loyalty, which encompasses a duty to act in the interest of the beneficiary.²³² In then-Judge Cardozo’s words:

Many forms of conduct permissible in a workaday world for those acting at arm’s length[] are forbidden to those bound by fiduciary ties. A trustee is held to something stricter than the morals of the market place. Not honesty alone, but the punctilio of honor the most sensitive, is . . . the standard of behavior. As to this there has developed a tradition that is unbending and inveterate. Uncompromising rigidity has been the attitude of courts of equity when petitioned to undermine the rule of undivided loyalty by the “disintegrating erosion” of particular exceptions. Only thus has the level of conduct for fiduciaries been kept at a level higher than that trodden by the crowd.²³³

ERISA preemption inverts the typical treatment of the fiduciary duty of loyalty. Courts should protect beneficiaries owed “the punctilio of honor the most sensitive”²³⁴ by rigorously scrutinizing fiduciaries’ motivations where the temptation for self-dealing is high.²³⁵ Yet courts are unable to

231. Muir, *supra* note 156, at 397 (quoting 29 U.S.C. § 1104(a)(1)(A)(i) (2012)); *see also* Muir, *supra* note 156, at 397.

232. Paul B. Miller, *Justifying Fiduciary Duties*, 58 MCGILL L.J. 969, 976–77 (2013) (“Whatever else fiduciary law might require of fiduciaries, it undeniably demands that they act faithfully toward beneficiaries. The duty of loyalty applies to all fiduciaries regardless of differences among the mandates under which they act.”).

233. *Meinhard v. Salmon*, 164 N.E. 545, 546 (N.Y. 1928) (internal citation omitted).

234. *Id.*

235. *See, e.g., Bayer v. Beran*, 49 N.Y.S.2d 2, 6–7 (N.Y. Spec. Term 1944) (“The dealings of a director with the corporation for which he is the fiduciary are therefore viewed with ‘jealousy by the courts.’ Such personal transactions of directors with their corporations, transactions as may tend to produce a conflict between self-interest and fiduciary obligation, are, when challenged, examined

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examine plan administrator motivations *at all* when ERISA fiduciaries are challenged for breaching their duty of loyalty and causing wrongful death, leaving managed care organizations free to self-deal despite their statutorily mandated duty to act solely in the interest of plan participants and beneficiaries.

IV. POSSIBLE SOLUTIONS TO ERISA'S REMEDIAL GAP: A PESSIMISTIC PREDICTION

ERISA preemption *is* fixable. Legislative and judicial remedies exist that would permit plaintiffs to successfully sue for compensatory damages under ERISA without sacrificing national uniformity of benefits administration.²³⁶ First, Congress could amend section 502 to explicitly permit recovery of compensatory damages. Alternatively, the Supreme Court could revisit the meaning of "other appropriate equitable relief" under section 502(a)(3) to find that compensatory damages are included as a remedy therein in light of ERISA's trust law underpinnings. Unfortunately, neither solution seems likely to be implemented unless national attention is redirected to the tragedy and the irony of ERISA preemption.

A. *Legislative Reform*

Perhaps the most obvious solution to ERISA's remedial gap is legislative reform. So obvious, in fact, that Congress attempted to reform ERISA throughout the late-1990s and early-2000s.²³⁷ Congress could, in theory, take up the cause of ERISA preemption again, and if it did so, it would have two basic options for closing ERISA's remedial gap. First, Congress could eliminate or amend section 514 to permit state law

with the most scrupulous care, and if there is any evidence of improvidence or oppression, any indication of unfairness or undue advantage, the transactions will be voided.") (internal citations omitted).

236. See *infra* sections IV.A–B.

237. See JEAN P. HEARNE & HINDA RIPPS CHAIKIND, CONG. RESEARCH SERV., IB98017, PATIENT PROTECTION AND MANAGED CARE: LEGISLATION IN THE 107TH CONGRESS 15 (2002), http://digital.library.unt.edu/ark:/67531/metacrs3137/m1/1/high_res_d/IB98017_2002Sep16.pdf [<https://perma.cc/WJ22-P7M7>] (listing the various bills introduced in the 107th Congress to address ERISA preemption and patients' rights more broadly).

causes of action against administrators of employer-provided plans. This option, however, would sacrifice national uniformity in benefits administration and would contravene the legislative intent behind ERISA's exclusive remedial scheme. Alternatively, Congress could amend section 502 to explicitly authorize a federal cause of action under ERISA for compensatory—and, if Congress could muster the political will, punitive—damages against a managed care organization.

In reality, though, the moment for ERISA reform has passed. The last serious attempt to suture ERISA's remedial gap occurred in 2001.²³⁸ Both chambers of Congress passed a version of the Bipartisan Patient Protection Act by the beginning of August that year.²³⁹ Most of the provisions were substantially similar between the two versions, but one of the two main differences left to resolve in conference was how to eliminate ERISA's remedial gap.²⁴⁰ Under the Senate bill, state law causes of action for medically reviewable decisions—including medical necessity decisions—would no longer be preempted by ERISA.²⁴¹ The House version of the bill would instead have created a federal cause of action under ERISA for cost containment decisions that resulted in injury or death.²⁴² It also would have created concurrent jurisdiction for these federal causes of action, which would have eliminated section 502's exception to the well-pleaded complaint rule and would have permitted state courts to hear cases under the newly created federal cause of action.²⁴³ Successful plaintiffs could have been awarded economic and noneconomic damages, with noneconomic damages capped at \$1.5 million.²⁴⁴ Finally, under the House version of the Bipartisan Patient Protection Act, punitive damages would have been available up to \$1.5 million, but only when an insurer failed to abide by an independent reviewer's determination that benefits should have been provided.²⁴⁵

Significantly, the major point of contention between the House and Senate versions of the bill was *not* the availability of

238. See Vukadin, *supra* note 150, at 897–98.

239. HEARNE & CHAIKIND, *supra* note 237, at 4.

240. *Id.* at 11.

241. *Id.*

242. *Id.* at 11–12.

243. *Id.* at 12.

244. *Id.*

245. *Id.*

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compensatory or even punitive damages under the amended ERISA.²⁴⁶ Instead, the differences revolved around whether the federal government would reign supreme in adjudicating ERISA claims or whether administrators of ERISA plans could be subject to state law causes of action.²⁴⁷ Still, a version of the bill passed both chambers, and all that was left to do was to reconcile the versions in conference. And according to commentators, the 107th Congress was expected to succeed.²⁴⁸ Until, that is, September 11, 2001 and the terrorist attacks on the World Trade Center and the Pentagon.²⁴⁹ “What soon became clear was that no part of the bill could survive the September 11, 2001 attacks. At that point, matters of national security became all consuming, [and] patients’ rights toppled from the legislature’s agenda”²⁵⁰ With attention focused on national security, the momentum behind fixing ERISA preemption faltered and the widespread discussion of managed care abuses largely disappeared.²⁵¹

Although health care reform again became a national priority after President Obama was elected, ERISA preemption was no longer the center of reform efforts.²⁵² With the national conversation about managed care abuses silent, any reform efforts involving ERISA preemption were unable to gain traction due to business opposition.²⁵³ Indeed, even before President Obama was the official Democratic nominee in 2008, business groups consulted by Senate staffers explicitly stated that they would reject any health reform efforts involving changes to ERISA.²⁵⁴ This opposition remained once Congress began drafting the Patient Protection and Affordable Care Act.²⁵⁵ At one point, an amendment was offered that would

246. *Id.* But see *infra* note 268, for an explanation of the fact that support for amending ERISA was uncharacteristic of congressional Republicans in 2001 and that, going forward, Republicans are unlikely to support any attempt to amend ERISA to permit tort liability of managed care organizations.

247. HEARNE & CHAIKIND, *supra* note 237, at 11–12.

248. Vukadin, *supra* note 150, at 897–98.

249. *Id.* at 898.

250. Mary Ann Chirba-Martin, *Drawing Lines in Shifting Sands: The U.S. Supreme Court’s Mixed Messages on ERISA Preemption Imperil Health Care Reform*, 36 J. LEGIS. 91, 136 (2010).

251. See Vukadin, *supra* note 150, at 898.

252. *Id.* at 899.

253. See JOHN E. McDONOUGH, *INSIDE NATIONAL HEALTH REFORM* 37 (2011).

254. *Id.*

255. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148,

have eliminated ERISA preemption of state actions related to benefit denials.²⁵⁶ Employers and their lobbyists reacted quickly, and the amendment was never adopted.²⁵⁷

The Affordable Care Act does provide for mandatory external review of denials²⁵⁸ and requires parity between mental health benefits and medical benefits,²⁵⁹ but neither of these requirements can be fully effective so long as managed care organizations retain the ability to define “medical necessity” for themselves. Mandated external review provisions do little in a system in which the existing appeals structure already presents so many barriers to overturning a wrongful denial of benefits, and the external review provisions leave the difficult appeals process weighed heavily in favor of plan administrators.²⁶⁰

Additionally, although the Affordable Care Act does require that insurers apply any treatment limitations equally to medical and behavioral care,²⁶¹ parity is not a panacea to opportunistic cost cutting in the realm of behavioral care benefits because the law permits insurers to hide behind vague medical necessity standards.²⁶² Advocacy groups report that

124 Stat. 119, *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified as amended in scattered sections of 42 U.S.C.).

256. Vukadin, *supra* note 150, at 899–900.

257. *Id.* at 900. *See also* BARRY R. FURROW ET AL., HEALTH LAW 660 (7th ed. 2013) (“The ACA neither expands nor contracts the scope of ERISA preemption of state law. Under 29 U.S.C. § 1144, state law that ‘relates to’ employee benefit plans will still be preempted except insofar as it ‘regulates insurance,’ and self-insured plans will continue to be completely exempt from state regulation. ERISA remedies provided under 29 U.S.C. § 1132 will continue to . . . preempt all state remedies and permit removal of litigation by ERISA plans to federal court.”).

258. Vukadin, *supra* note 150, at 899–900.

259. Michael C. Barnes & Stacey L. Worthy, *Achieving Real Parity: Increasing Access to Treatment for Substance Abuse Disorders Under the Patient Protection and Affordable Care Act and the Mental Health and Addiction Equity Act*, 36 U. ARK. LITTLE ROCK L. REV. 555, 557 (2014).

260. *See supra* section IV.A. *See* Vukadin, *supra* note 150, for a critique of the Affordable Care Act’s substitution of mandatory external review for fixing ERISA’s remedial gap.

261. The Ctr. for Consumer Info. & Ins. Oversight, *The Mental Health Parity and Addiction Equity Act (MHPAEA)*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html [<https://perma.cc/7RXL-NE4Y>] (last visited Mar. 12, 2016).

262. Jenny Deam, ‘Medical Necessity’ Decried as a Loophole for Insuring the Mentally Ill, HOUSTON CHRON. (Oct. 17, 2015), <http://www.houstonchronicle.com/business/medical/article/Medical-necessity->

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even under the Affordable Care Act's parity requirements, insurers continue to use medical necessity standards to review behavioral care requests "more aggressively than medical claims and find ways to limit coverage by refusing to authorize more than a few days in the hospital."²⁶³ If insurers were applying medical necessity standards equally to both kinds of care, rates of denial should be about the same for medical and behavioral claims.²⁶⁴ However, in 2015, a national survey of patients who had received behavioral care and their families reported that those patients had behavioral care denied as medically unnecessary about twice as much as they had their medical claims denied.²⁶⁵ The Affordable Care Act's parity requirements, though well intentioned, permit insurers to continue to discriminate against behavioral care and so do not eliminate the need to close ERISA's remedial gap.

While it is theoretically possible that legislative priorities may again shift toward remedying ERISA preemption, it seems highly unlikely that it will happen in the foreseeable future. The Affordable Care Act has been a political target since it was passed. The newly sworn in Republican majorities in the 115th Congress committed to repealing and replacing the Affordable Care Act as their first legislative priority, though those efforts have stalled under the weight of Republican disagreement as to the particulars of the replacement.²⁶⁶ But even under President Obama, who would certainly have vetoed any bill to repeal or significantly change the Affordable Care Act that managed to pass in both chambers, the House of Representatives "voted more than 60 times to repeal or alter" the law.²⁶⁷ The failure of repeal efforts notwithstanding, the continuous political fight over the most recent health reform legislation makes it unlikely that any attempt to amend ERISA would gain traction

decried-as-a-loophole-for-6576016.php [https://perma.cc/WTB2-G6KC].

263. *Id.*

264. *Id.*

265. *Id.*

266. See Robert Pear et al., *In Major Defeat for Trump, Push to Repeal Health Law Fails*, N.Y. TIMES (Mar. 24, 2017), https://www.nytimes.com/2017/03/24/us/politics/health-care-affordable-care-act.html?hp&action=click&pgtype=Homepage&clickSource=story-heading&module=span-ab-top-region®ion=top-news&WT.nav=top-news&_r=0 [https://perma.cc/4TZZ-NFU6].

267. Richard Cowan & Susan Cornwell, *House Votes to Begin Repealing Obamacare*, REUTERS (Jan. 14, 2017, 4:04 PM), <http://www.reuters.com/article/us-usa-obamacare-idUSKBN14X1SK> [https://perma.cc/TR4L-KJ6F].

in Congress.²⁶⁸ Accordingly, legislative reform of ERISA preemption is a theoretically possible but politically unlikely solution.

B. *Judicial Reinterpretation*

The Supreme Court could also fix ERISA's remedial gap by revisiting its prior interpretation of the phrase "other appropriate equitable relief" in section 502(a)(3)(B). The origins of this potential solution derive from Justice Brennan's concurrence in *Massachusetts Mutual Life Insurance Co. v.*

268. This is particularly true given the composition of Congress at the time of publication: both chambers are controlled by Republicans. *E.g.*, Carl Hulse, *Republicans in Washington Are in Control, But Not in Agreement*, N.Y. TIMES (Mar. 1, 2017), <https://www.nytimes.com/2017/03/01/us/politics/republicans-congress-obamacare-agenda.html> [<https://perma.cc/EP3M-SW3N>]. Republicans repeatedly opposed efforts to impose liability on managed care organizations by amending ERISA throughout the 1990s. Roderick M. Hills, Jr., *Against Preemption: How Federalism Can Improve the National Legislative Process*, 82 N.Y.U. L. REV. 1, 45–50 (2007). According to Hills, the Republican support for managed care liability in 2001 was uncharacteristic of the party and was prompted by what appeared to be the Court's departure from its prior interpretation of the scope of ERISA preemption in *Pegram v. Herdrich*. *Id.* at 51 ("Pegram seemed to smash a massive hole in the wall of ERISA preemption that had protected the managed care industry. To plug the hole, the industry would have to ask for specific preemptive protection from state lawsuits alleging [managed care organizations'] negligent evaluation of medical necessity. But asking for the indefensible is a difficult thing to do, and blanket immunity for one's own negligence comes close to being indefensible. *Pegram*, therefore, seemed to force the House and Senate Republicans to propose their own legislation allowing suits against [managed care organizations], hedged with defensibly specific limits on liability."). See *supra* note 63 for a discussion of *Pegram*. However, once the Court cabined *Pegram* in *Aetna Health Inc. v. Davila*, see *supra* note 63, Republicans resumed their antipathy toward malpractice liability in general. Hills, *supra* note 268, at 52–53. The Republican support for "ever broader forms of preemption of state tort law, including caps on health providers' liability for pain and suffering and punitive damages for medical malpractice" suggests that, had amendments to ERISA preemption been proposed after 2001, Republicans would have opposed them as they had throughout the 1990s. *Id.* at 52.

Amending ERISA to provide a remedy for wrongful death and other negligent administration of benefits claims was a nonstarter when Democrats controlled both the House and the Senate in 2010 and passed the Affordable Care Act. See *supra* notes 256 and 257 and accompanying text. Although the new Republican Congress has, at the time of publication, failed to repeal and replace the Affordable Care Act, Pear et al., *supra* note 266, should it try again in the future, it is highly unlikely that congressional Republicans will concern themselves with ERISA's remedial gap when the party more likely to seek a solution—the Democrats—barely considered doing so when they passed the Affordable Care Act, see *supra* notes 256 and 257 and accompanying text.

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*Russell*²⁶⁹ and Justice White's dissent in *Mertens v. Hewitt Associates*.²⁷⁰ In *Russell*, Justice Brennan observed that Congress intended to "incorporate the fiduciary standards of trust law into ERISA."²⁷¹ According to Justice Brennan, compensatory damages were available as equitable relief for a breach of trust.²⁷² Given the role of trust law in ERISA, "other equitable relief" under section 502(a)(3) should include the make-whole relief of compensatory damages²⁷³ even though monetary relief is traditionally considered a form of legal damages.²⁷⁴

Unfortunately, the *Mertens* majority held that "other equitable relief" in section 502(a)(3) must be limited to "those categories of relief that were *typically* available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)."²⁷⁵ According to the majority, "all relief available for a breach of trust could be obtained from a court of equity," so there would be no limit to the kind of remedy that a participant or beneficiary could seek under section 502(a)(3) were it construed to incorporate trust law principles.²⁷⁶ The *Mertens* Court thus foreclosed the only possible avenue for relief under ERISA as it is currently written for plaintiffs suing the administrator of an ERISA plan for wrongful death or other state-based tort claims.

Much like the theoretically possible, but realistically

269. *Mass. Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 148–58 (1985) (Brennan, J., concurring).

270. *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 263–74 (1993) (White, J., dissenting); see generally John H. Langbein, *What ERISA Means by "Equitable": The Supreme Court's Trail of Error in Russell, Mertens, and Great-West*, 103 COLUM. L. REV. 1317 (2003).

271. *Russell*, 473 U.S. at 152 (Brennan, J., concurring).

272. *Id.* at 154 n.10.

273. *Mertens*, 508 U.S. at 266–67 (White, J., dissenting).

274. *Chauffeurs, Teamsters & Helpers, Local No. 391 v. Terry*, 494 U.S. 558, 570 (1990) (citing *Curtis v. Loether*, 415 U.S. 189, 196 (1974)). The *Terry* court goes on to discuss two exceptions to the rule that monetary damages are a legal form of relief: when damages are restitutionary and when the monetary relief is awarded "incidental to or intertwined with injunctive relief." *Id.* (quoting *Tull v. United States*, 481 U.S. 412, 424 (1987)). Neither exception is relevant here.

275. *Mertens*, 508 U.S. at 256.

276. *Id.* at 257. Incidentally, Justice White rejected the notion that there would be no limit to the relief available under section 502(a)(3) by stating that punitive damages were not available under trust law as equitable relief. Accordingly, Justice White's conception of "other equitable relief" would have permitted plaintiffs to receive compensatory, but not punitive, damages. *Mertens*, 508 U.S. at 270–72 (White, J., dissenting).

unlikely solution of legislative reform, there is nothing to prevent the Supreme Court from revisiting its *Mertens* holding, but it seems highly doubtful that the Court will do so. To begin, where the Court has revisited its previous ERISA jurisprudence, it has done so out of concern for doctrinal coherence, not fairness to plaintiffs.²⁷⁷ Moreover, the Court has reiterated the *Mertens* holding that equitable relief under section 502(a)(3) is limited to relief that was “typically available”²⁷⁸ in courts of equity in a recent case.²⁷⁹ Under these circumstances, it seems improbable that the Court will revisit the availability of compensatory damages under section 502(a)(3)(B) in the foreseeable future.

Because the Court seems reluctant to reexamine its prior interpretation of section 502(a)(3)(B) and because the Court is, at least in theory, insulated from political pressure, the slightly more likely preemption solution lies in imposing political pressure on Congress to amend ERISA. But the public is virtually silent on the issue of ERISA preemption and managed care profiteering, making the legislative solution unlikely as well. Without renewed national conversation about ERISA preemption and patients’ rights under managed care, insurer incentives will remain misaligned toward the pursuit of profit at the expense of patient care.

CONCLUSION

Despite the inherent conflict of interest present in managed care, insurance companies face few consequences for improperly placing profits above patient welfare. This is because ERISA poses an obstacle to recovery when the worst-case scenario comes to pass—when patients die because

277. For example, the Court used to interpret “relates to” under section 514 according to the phrase’s broad, ordinary meaning, but it abandoned this approach in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company*, recognizing that “really, universally, relations stop nowhere.” 514 U.S. 645, 655 (1995) (quoting HENRY JAMES, RODERICK HUDSON xli (New York ed., World’s Classics 1980)). See also *Cal. Div. of Labor Stds. Enft v. Dillingham Constr.*, 519 U.S. 316, 335 (1997) (Scalia, J., concurring) (“[A]pplying the ‘relate to’ provision according to its terms was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else.”).

278. *Mertens*, 508 U.S. at 257.

279. See *Montanile v. Bd. of Trs. of the Nat’l Elevator Indus. Health Ben. Plan*, 136 S. Ct. 651, 657 (2016).

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insurance companies make medical necessity decisions in an opportunistic manner. If the patient's doctor made a similar decision in a negligent or self-interested manner, the doctor would face medical malpractice liability. Yet managed care organizations are virtually unaccountable for their medical necessity decisions due to ERISA preemption, which prevents recovery when patients die because of managed care decisions during utilization review.

ERISA preemption does not just prevent recovery by family members; it also keeps insurance companies' incentives misaligned toward profit seeking. This opportunistic profit seeking often comes on the backs of the severely mentally ill, who are more likely to be targeted and more likely to be harmed by managed care cost containment. ERISA preemption prevents scrutiny into insurer motivations in cost containment decisions, allowing managed care organizations to accrue obscene profits while simultaneously cutting care, creating huge administrative costs, and passing the cost of wrongfully denied care onto society. ERISA preemption also creates legal ironies by transforming a statute intended to protect employee benefits into one that shields corporations from any liability for wrongful behavior at the expense of plan participants and beneficiaries and by rendering toothless the fiduciary duty imposed on plan administrators in the statute. Worse still, implementation of possible solutions to ERISA's social tragedies and legal ironies seems highly improbable because legislative and judicial priorities are not focused on ERISA's insidious impact. Unless a national discussion of the dangers of the current system restarts, it seems that this story will end where it began: with rampant profiteering going unscrutinized and unpunished at the expense of the severely mentally ill and their loved ones.