

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

GERALD L. SPRECHER :
 :
 Plaintiff, :
 : CIVIL ACTION
 v. :
 : No. 02-CV-00580
 AETNA U.S. HEALTHCARE. INC., :
 :
 Defendant. :

MEMORANDUM

BUCKWALTER, J.

August 19, 2002

Currently before the Court is Defendant's Motion to Dismiss Counts I (ERISA) and II (Bad Faith) of Plaintiff's Complaint. Defendant argues that Plaintiff's ERISA claim should be dismissed because he has not exhausted his administrative remedies as provided under the subject ERISA Benefits Plan.¹ Defendant further argues that Plaintiff's bad faith claim under 42 Pa. Cons. Stat. Ann. § 8371 is preempted. For the reasons stated below, Defendant's motion is Denied as to Count I of Plaintiff's Complaint and Granted with respect to Count II of Plaintiff's Complaint.

1. The subject ERISA Benefits Plan was filed in its entirety with the Court on February 4, 2002 as part of Plaintiff's Complaint.

I. FACTS

Plaintiff filed this suit after Defendant partially denied payment for surgical services Plaintiff received November 22 through 25, 2000 after suffering a heart attack. It is undisputed that Plaintiff obtained approval for the surgical procedures, as well as for his admission to the hospital, prior to undergoing any treatment as required under the ERISA Benefits Plan. Despite receiving prior approval, on December 22, 2000, Defendant issued a statement denying payment totaling \$258.00 for treatment rendered by Plaintiff's surgical group on grounds that there was no evidence that services had been pre-authorized. On January 3, 2001, Defendant issued a statement denying payment totaling \$6,125.00 for treatment rendered by Plaintiff's surgical group, again on grounds that there was no evidence that services had been pre-authorized.

Plaintiff contested both denials of benefits by placing a telephone call to Defendant and pointing out that he had obtained pre-certification. Upon checking Plaintiff's file, Defendant realized that pre-certification had been obtained, however, it did not immediately or fully reverse its denial determination. On February 8, 2001, Defendant issued a statement showing that it had paid the \$258.00 that it had previously refused to pay on the statement of December 22, 2000. On February 27, 2001, Defendant issued a statement showing that it

had paid \$3247.40 of the \$6125.00 that it had previously refused to pay on January 3, 2000. This statement specified that Aetna would not make full payment because the charges exceeded the usual and prevailing fee.

Plaintiff's surgical group contested this partial denial. Defendant responded by way of letter dated April 27, 2001, stating that it had reviewed its benefits determination and concluded that its original, partial reimbursement was correct. However, on May 15, 2001, Defendant issued a revised statement for the bills totaling \$6125.00, which specified that it would pay \$3,642.00, but that the balance had been denied as exceeding the usual and prevailing fee. Thus, Defendant altered its already revised benefits determination and increased the permitted fees by some \$395.00.

By letter dated November 29, 2001, Plaintiff requested that Defendant provide the statistical profiles of physicians' charges for the same or similar services in a geographic area that it relied upon in making its benefits determinations. Defendant failed to respond to Plaintiff's November 29, 2001 letter. Plaintiff now brings the instant action, seeking payment for the balance of his medical bills for treatment rendered after he suffered his heart attack.

II. STANDARD

Under Fed. R. Civ. P. 12(b)(6), the party moving for dismissal has the burden of proving that no claim has been stated. Kehr Packages v. Fidelcor, Inc., 926 F.2d 1406, 1409 (3d Cir. 1991). To prevail, the movant must show "beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief." Conley v. Gibson, 355 U.S. 41, 45-46, 78 S. Ct. 99, 102, 2 L. Ed. 2d 80, 84 (1957). A complaint should be dismissed if "it is clear that no relief could be granted under any set of facts that could be proved consistent with the allegations." Hishon v. King & Spalding, 467 U.S. 69, 73, 104 S. Ct. 2229, 2232, 81 L. Ed. 2d 59, 65 (1984).

III. DISCUSSION

A. Count I - ERISA

Defendant argues that Plaintiff's ERISA claim should be dismissed for failure to exhaust administrative remedies.

"Except in limited circumstances . . . a federal court will not entertain an ERISA claim unless the plaintiff has exhausted the remedies available under the plan." Harrow v. Prudential Ins. Co. of Am., 279 F.3d 244, 249 (3d Cir. 2002).

Pursuant to the terms of the ERISA Plan at issue, Plaintiff had the right to appeal any denial of benefits. The procedure set forth in the ERISA Plan required Plaintiff to submit an appeal in writing within 90 days from the date Defendant issued its denial. Further, if Plaintiff disagreed

with that appeal decision, he had the right to a second appeal. It is not clear that Plaintiff technically appealed Defendant's benefit determinations as outlined in the Plan. In particular, it appears that Plaintiff failed to meet the writing requirement.

However, it is clear that Plaintiff contested the denial of benefits, once by telephone to dispute the incorrect denial on grounds that his medical treatment had not been pre-authorized and once by Plaintiff's surgical group on his behalf after partial payment was made for submitted medical bills. It is also clear that Defendant responded to Plaintiff's challenges by amending its benefits determination in favor of Plaintiff.

Despite Plaintiff's challenges, Defendant argues that Plaintiff did not avail himself of the two levels of appeal afforded him and instead of taking an administrative appeal, he precipitously filed this lawsuit. Defendant characterizes Plaintiff's challenges as requests to reconsider its initial reimbursement amount, and does not recognize Plaintiff's attempts to resolve the benefit dispute as an appeal within the meaning of the Plan. The record currently before the Court is lacking the required writing stipulated by the appeal procedures, however, it appears that Defendant in effect waived the writing requirement by responding to Plaintiff's oral challenges.

At the pleading stage I must give Plaintiff the benefit of all reasonable inferences. Because it is apparent that

Plaintiff, in some manner, petitioned Defendant to reconsider its decisions to deny benefits and Defendant so responded, I find that Plaintiff has adequately pled that he met his administrative requirements before filing suit.

B. Count II - Bad Faith

Next, Defendant argues that Plaintiff's bad faith statute is preempted by ERISA. Pennsylvania's bad faith statute, 42 Pa. Cons. Stat. Ann. § 8371, provides:

In an action arising under an insurance policy, if the court finds that the insurer has acted in bad faith toward the insured, the court may take all of the following actions:

1. Award interest on the amount of the claim from the date the claim was made by the insured in an amount equal to the prime rate of interest plus 3%.
2. Award punitive damages against the insurer.
3. Assess court costs and attorney fees against the insurer.

District courts in the Eastern District of Pennsylvania have consistently held that Pennsylvania's bad faith statute is preempted by ERISA. However, in a very recent Eastern District opinion, the Honorable Judge Newcomer re-examined this issue in light of a "new trend in the federal law" established by two recent United States Supreme Court decisions, Rush Prudential HMO, Inc. v. Moran, ___ U.S. ___, 122 S. Ct. 2151, ___ L. Ed. 2d ___ (2002) and UNUM Life Ins. Co. of Am. v. Ward, 526 U.S. 358, 119 S. Ct. 1380, 143 L. Ed. 2d 462 (1999). Judge Newcomer held

that Pennsylvania's bad faith statute is not preempted by ERISA as it falls under ERISA's saving clause. See Rosenbaum v. UNUM Life Ins. Co. of Am., No. CIV.A. 01-6758, 2002 WL 1769899, at *3 (E.D. Pa. Jul. 29, 2002). For the reasons stated below, I respectfully disagree with the Rosenbaum decision and find that Pennsylvania's bad faith statute is preempted by ERISA.

The ERISA preemption clause, ERISA § 514(a), 29 U.S.C. § 1144(a), provides:

Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan....

There is no dispute that the Pennsylvania statute relates to the subject employee benefit plan, thus placing it within the broad sweep of the preemption clause.

ERISA's saving clause, however, exempts from preemption "any law of any State which regulates insurance." ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). In order to determine whether a state law "regulates insurance" within the meaning of the saving clause, first, a court must determine whether, from a "common-sense view of the matter," the state statute in question regulates insurance. UNUM Life Ins. Co., 526 U.S. at 367, 119 S. Ct. at 1386 (citations omitted). Second, consideration of three factors is employed to determine whether the regulation fits within the "business of insurance" as that phrase is used in the

McCarran-Ferguson Act, 59 Stat. 33, as amended, 15 U.S.C. § 1011 et seq.: "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry."

Id. The parties dispute whether Pennsylvania's bad faith statute regulates insurance for purposes of ERISA's saving clause, preventing it from being pre-empted.

1. Common-Sense View

In order for a state law to regulate insurance from a common-sense view of the matter, "a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." Rush Prudential, 122 S. Ct. at 2159 (quoting Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 50, 107 S. Ct. 1549, 1554, 95 L. Ed. 2d 39 (1987)). The plain language of Pennsylvania's bad faith statute suggests that the state law "regulates insurance" because § 8371 is applicable only to insurers in actions arising under an insurance policy. In addition, this statute is never applied outside the insurance industry. Therefore, Pennsylvania's bad faith statute appears to satisfy the common-sense view of a state law that regulates insurance.

2. McCarran-Ferguson Test

It is now established that a state regulation need not satisfy all three McCarran-Ferguson factors in order to "regulate insurance" under ERISA's saving clause. See Rush Prudential, 122 S. Ct. at 2163, UNUM Life Ins. Co., 526 U.S. at 373, 119 S. Ct. at 1389. The first question, (addressed above), is whether the law in dispute fits a common-sense understanding of insurance regulation, (Pennsylvania's bad faith statute arguably does), then the McCarran-Ferguson factors are used as checking points or guideposts to confirm that the state rule does in fact regulate insurance, not separate essential elements that must each be satisfied to save the State's law. See id., 526 U.S. at 374, 119 S. Ct. at 1389.

The first McCarran-Ferguson factor asks whether the state law "ha[s] the effect of transferring or spreading a policyholder's risk." Rush Prudential, 122 S. Ct. at 2163, UNUM Life Ins. Co., 526 U.S. at 374, 119 S. Ct. at 1389. This factor requires an examination into whether Pennsylvania's bad faith statute alters "the allocation of risk for which the parties initially contracted." UNUM Life Ins. Co., 526 U.S. at 374, 119 S. Ct. at 1389. In the instant litigation, the subject ERISA Plan provided health care benefits to Plaintiff. Thus, Defendant assumed the financial risk of providing the medical benefits promised in return for premiums paid for by Plaintiff's employer on behalf of Plaintiff.

Plaintiff argues that Pennsylvania's bad faith statute satisfies the McCarran-Ferguson "risk-spreading" factor because it transfers the risk that a policyholder's claim will be improperly handled from the policyholder to the insurer. However, Plaintiff's argument misses the mark because this is not the type of risk for which the parties initially contracted. The availability of punitive damages and interest penalties to a policyholder whose insurer has improperly processed a claim for benefits does not allocate risk typical of medical insurance. At most, this may cause the insurer to raise premiums, which it would then pass on to the policyholder. However, an insurer's method for recuperating losses resulting from unsuccessful litigation does not alter the risk bearing arrangement of medical insurance: that the insurer will pay covered medical expenses, at any cost, and the insured will pay the stipulated premium. Furthermore, ERISA already accounts for the risk that a policyholder's claim will be improperly handled through its exclusive remedial scheme, without necessitating resort to state laws allowing alternative remedies. See ERISA § 502(a), 29 U.S.C. § 1132(a). I find that Pennsylvania's bad faith statute does not serve to spread the policyholder's risk. Therefore, the first McCarran-Ferguson factor does not aid in verifying the common-sense view that Pennsylvania's bad faith statute regulates insurance within the meaning of ERISA's saving clause.

The second McCarran-Ferguson factor, finding that the state statute serves as "an integral part of the policy relationship between the insurer and the insured," requires that the state statute in some manner control the terms of the insurance relationship by changing the bargain between insurer and insured. See UNUM Life Ins. Co., 526 U.S. at 374, 119 S. Ct. at 1389.

In UNUM Life Ins., the United States Supreme Court held that California's notice-prejudice rule met McCarran-Ferguson's second factor because it effectively created a mandatory contract term and thus, dictated the terms of the relationship between the insurer and the insured. In that case, the subject insurance policy contained a provision that required the insured to furnish proofs of claim to the insurer within a specified time limit. All untimely claims would be strictly denied by the insurer. California's notice-prejudice rule, however, superseded this policy provision by providing that an insurer could not avoid liability in cases where a claim was not filed in a timely manner absent proof that the insurer was actually prejudiced because of the delay. In other words, the state statute effectively barred enforcement of the policy's time limitation on submitting claims. Therefore, the Supreme Court held that the California rule served as an integral part of the policy relationship between the insurer and the insured by forcing a mandatory contract term upon

the parties that had not been otherwise agreed upon. See UNUM Life Ins. Co., 526 U.S. at 374, 119 S. Ct. at 1389-90.

The United States Supreme Court further illustrated this principal in Rush Prudential, holding that an Illinois state law was not preempted by ERISA. The state law in dispute in that case required HMOs to provide a mechanism for review by an independent physician when the patient's primary care physician and HMO disagreed about the medical necessity of a treatment proposed by the primary care physician. The Supreme Court found that this review process affected the "policy relationship" between HMOs and covered persons because it provided a legal right to the insured, enforceable against the HMO, to obtain an authoritative determination of the HMO's medical obligations, a legal right which was not enforceable under the terms of the insurance contract alone. Rush Prudential, 122 S. Ct. at 2164. Without the state law, the Rush Prudential policy only provided for coverage determinations based upon whether the HMO, in its broad discretion, found the service "medically necessary" pursuant to specified criteria set forth in the policy. Therefore, the state law created an "extra layer of [independent] review," which translated the parties original contract for insurance. See Rush Prudential, 122 S. Ct. at 2163.

Pennsylvania's bad faith statute, on the other hand, does not alter the terms of the contract between the insurer and

the insured. Insurer's have the obligation to act in good faith. However, a state statute providing a remedy for breach of this obligation does not have the effect of creating a new, mandatory contract term. Pennsylvania's bad faith statute creates an opportunity for a policyholder, whose claim has been improperly handled by the insured, to seek punitive damages and interest penalties. This opportunity is the insured's unilateral choice to seek certain, specified damages. This creates a deterrence for insurance carriers to refuse to pay a claim when there is no reasonably credible basis to deny it. The deterrence, however, does not change the bargain between the insurer and the insured that the insurer will act in good faith.

The insurance regulations involved in UNUM Life Ins. Co. and Rush Prudential supplemented and supplanted the procedures in which the insurer was to engage in making benefits determinations, procedures which were differently defined in the respective insurance contracts. Pennsylvania's bad faith statute in no way effects claims-procedures provided for in the policy, but rather declares only that whatever terms have been agreed upon in the insurance contract, a policy holder may obtain punitive damages and interest penalties when an insurance carrier improperly processes a claim for benefits. Pennsylvania's bad faith statute "does not define the terms of the relationship between the insurer and the insured," Pilot Life, 481 U.S. at 51,

107 S. Ct. at 1555, nor does it "translat[e] the relationship under the . . . agreement into concrete terms of specific obligation or freedom from duty." Rush Prudential, 122 S. Ct. at 2163. The statute affects the parties after the procedures initially agreed upon by the insurer and the insured have been fully complied with, albeit improperly. Therefore, I find that Pennsylvania's bad faith statute does not serve as "an integral part of the policy relationship between the insurer and the insured." Consequently, the second McCarran-Ferguson factor does not confirm the common-sense view that Pennsylvania's bad faith statute regulates insurance within the meaning of ERISA's saving clause.

The final McCarran-Ferguson factor, that the law be aimed at a "practice . . . limited to entities within the insurance industry," is met for the same reasons that Pennsylvania bad faith statute satisfies the requirements of the common-sense test. See Rush Prudential, 122 S. Ct. at 2164. However, meeting this one prong of the McCarran-Ferguson test does not guide the Court to save Pennsylvania's bad faith statute from preemption. Although the statute at issue is aimed at the insurance industry, this alone is not enough to lead the Court to a finding that the statute "regulates insurance" in a manner which would exempt the State statute from preemption.

3. Categorical Preemption

As a second and alternative theory that Pennsylvania's bad faith statute should not be saved from preemption, it is evident that the state statute, and its provision for interest penalties and punitive damages, is more akin to an "alternative remedy," which is categorically preempted by ERISA. See Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 107 S. Ct. 1549, 95 L. Ed. 2d 39 (1987). Pilot Life established that it was Congress' clearly expressed intent that the civil enforcement provisions of ERISA § 502(a), 29 U.S.C. § 1132(a), be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries. See Pilot Life, 481 U.S. at 52, 107 S. Ct. 1549. Even if I were to hold Pennsylvania's bad faith statute was a law which regulates insurance within the meaning of ERISA's saving clause, (which I do not), the Pilot Life rule carves out a limited exception to the saving clause when state insurance laws allow plan participants "to obtain remedies under state law that Congress rejected in ERISA." Pilot Life, 481 U.S. at 54, 107 S. Ct. at 1556. I believe preemption of Pennsylvania's bad faith statute is proper under this analysis as well.

Congress intended ERISA § 502(a), 29 U.S.C. 1132(a), to be the exclusive remedy for rights guaranteed under ERISA. Id. Therefore, even a state law "regulating insurance" will be preempted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme

or enlarges that claim beyond the benefits available in any action brought under § 1132(a). See Pilot Life, 481 U.S. at 54, 107 S. Ct. at 1556, Rush Prudential, 122 S. Ct. at 2167.

The question therefore, is whether Pennsylvania's bad faith statute provides such a vehicle. I conclude that it clearly does. ERISA's enforcement scheme authorizes an action to recover benefits, obtain a declaratory judgment that one is entitled to benefits, and to enjoin an improper refusal to pay benefits. 29 U.S.C. § 1132(a). ERISA's civil enforcement provision also authorizes suits to seek removal of the fiduciary as well as claims for attorney's fees. Id. In contrast, punitive damages and interest penalties are not provided for under ERISA. Thus, Pennsylvania's bad faith statute, authorizing punitive damages and interest penalties, would significantly expand the potential scope of ultimate liability imposed upon employers by the ERISA scheme. In short, the relief ultimately available would not be what ERISA authorizes in a suit for benefits under § 1132(a). Therefore, because Pennsylvania's bad faith statute provides a form of ultimate relief in a judicial forum that adds to the judicial remedies provided by ERISA, it is incompatible with ERISA's exclusive enforcement scheme and falls within Pilot Life's categorical preemption.

IV. CONCLUSION

Defendant's Motion to Dismiss as it relates to Count I of Plaintiff's Complaint is Denied. However, because Pennsylvania bad faith statute does not regulate insurance, within the meaning of ERISA's saving clause and there is a clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive, Defendant's Motion to Dismiss Count II of Plaintiff's Complaint is Granted and Plaintiff's bad faith claim is Dismissed.

An appropriate Order follows.

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ORDER

AND NOW, this 19th day of August, 2002, upon consideration of Defendant's Motion to Dismiss (Docket No. 3), Plaintiff's response in opposition thereto (Docket No. 4), along with other matters of record, it is hereby **ORDERED** that Defendant's motion is **DENIED** part and **GRANTED** in part.

Defendant's Motion to Dismiss Count I of Plaintiff's Complaint (ERISA) is **DENIED**. Defendant's Motion to Dismiss Count II of Plaintiff's Complaint (Bad Faith) is **GRANTED**. Plaintiff's bad faith claim pursuant to 42 Pa. Cons. Stat. Ann. § 8371 is **DISMISSED**.

BY THE COURT:

RONALD L. BUCKWALTER, J.