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RICO RIGHTS FOR ERISA WRONGS: CAN PLAINTIFFS FIND RELIEF DESPITE ERISA PREEMPTION OF STATE-LAW CLAIMS?

Alan R. Ross

Abstract: The Employee Retirement Income Security Act of 1974 (ERISA) preempts state laws that relate to employee benefit plans and allows only equitable relief for those who are injured by decisions of ERISA plan administrators. Even though the interpretation of ERISA's preemptive power has changed since 1974, ERISA still poses a significant challenge to plaintiffs in actions for damages against plan administrators. This Comment suggests that another federal law, the Racketeer Influenced and Corrupt Organizations Act (RICO), which is explicitly not preempted by ERISA, may provide relief. The challenges that a plaintiff bringing an action against plan administrators may face include proving the "pattern" element of the RICO violation and overcoming the requirement that a civil plaintiff be "injured in his business or property." This Comment posits that in a case where the plaintiff proves that the denial of rightful benefits is an administrator's regular way of doing business, the "pattern" element may be met. It also argues that the damage caused by a fraudulent denial of benefits under an ERISA plan may well be an injury to the business or property of the participant and concludes that the civil cause of action under RICO may be a mechanism for litigants to use in obtaining a remedy when ERISA's remedies are insufficient.

In late 1990, Rhonda Bast learned she had breast cancer.¹ In 1991, after conventional treatment had failed, her oncologist recommended that she undergo an autologous bone marrow transplant procedure (ABMT) and high-dose chemotherapy.² Prudential, the administrator of her employer's self-funded health plan, refused to authorize the treatment on the ground that it was an experimental procedure excluded by her employer's plan.³ Over the course of six months, Prudential insisted that Ms. Bast had no right to the procedure and sent her multiple mailings to that effect.⁴ After Ms. Bast's attorney advised Prudential of cases requiring insurance companies to pay for the ABMT procedure, Prudential agreed that the procedure was covered.⁵ By then it was too late. The cancer had metastasized to Ms. Bast's brain, and she was medically ineligible for the procedure.⁶ Ms. Bast died in January 1993.⁷

1. See *Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1005 (9th Cir. 1998).

2. See *id.*

3. See *id.*

4. See *id.*

5. See *id.* at 1005-06.

6. See *id.* at 1006.

7. See *id.*

Her estate, husband, and minor son sued Prudential alleging breach of contract, breach of the duty of good faith and fair dealing, and violations of the state consumer protection act, the state insurance code, and the Employer Retirement Security Act (ERISA).⁸ The district court granted Prudential's motion for summary judgment on the grounds that ERISA preempted the state law claims and that ERISA itself provided no remedy.⁹ The Ninth Circuit Court of Appeals affirmed, concluding that "[a]lthough this case presents a tragic set of facts, the district court properly concluded that under existing law the Basts are left without a remedy."¹⁰

This Comment argues that plaintiffs such as the Basts may have a cause of action that would survive summary judgment and afford them a remedy. While ERISA preempts state laws and may itself provide inadequate relief, the Racketeer Influenced and Corrupt Organizations Act (RICO) authorizes a civil cause of action that provides treble damages and attorney's fees to those injured by racketeering activity.¹¹ Thus, a plaintiff may obtain money damages if improper denial of medical coverage amounts to a RICO violation. Part I of this Comment traces the history of the ERISA preemption doctrine in the courts, examines the parallel history of the health care payment system in the United States, and discusses attempts to expand patients' rights by statute. Part II discusses the elements of a civil RICO cause of action. Part III argues that ERISA preemption of state-law remedies offers inadequate relief for damage caused by plan administrators and creates a problem that demands a solution. Part III also argues that despite obstacles to invoking civil RICO in the context of improper benefit determinations, a plaintiff in the proper circumstances can allege a RICO injury, avoid the preemptive powers of ERISA, and obtain relief. This Comment concludes that ERISA fails to provide adequate relief to injured plan participants and fails to deter improper benefit determinations by ERISA plan administrators, but a civil RICO action may effectively provide both.

8. *See id.*

9. *See id.*

10. *Id.* at 1005.

11. *See* 18 U.S.C. § 1964(c) (1994).

I. ERISA PREEMPTION OF STATE LAW

ERISA makes the regulation of private employee benefit plans an exclusively federal concern.¹² Employee benefit plan administrators have used the federal shield of ERISA to avoid liability to individual plan participants and beneficiaries beyond the limited remedies provided by ERISA itself.

A. *The Purpose and Scope of ERISA*

Congress passed ERISA in 1974.¹³ In so doing, Congress hoped to encourage employers to offer benefits to their employees by reducing the cost and complexity of compliance with divergent state laws by providing a homogeneous national framework for the regulation of private employee benefit plans.¹⁴

As its title implies, ERISA serves the primary purpose of protecting the “retirement income” or pensions of workers.¹⁵ It mandates certain reporting and disclosure,¹⁶ participation,¹⁷ vesting,¹⁸ funding,¹⁹ and fiduciary²⁰ requirements for pension plans maintained by most private employers.²¹ However, ERISA also applies to private “welfare benefit plans,” including employer-sponsored plans providing health benefits to workers and their families.²² Plan sponsors²³ must put both pension and

12. See 29 U.S.C. § 1144(a) (1994).

13. See Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified in scattered sections of 5 U.S.C., 18 U.S.C., 26 U.S.C., and 29 U.S.C.).

14. See Daniel M. Fox & Daniel C. Schaffer, *Semi-Preemption in ERISA: Legislative Process and Health Policy*, 7 Am. J. Tax Pol’y 47, 49 (1988).

15. The Act was the result of public concern over termination of pension benefits either through the termination of older employees or because of the insolvency of the employer. See John H. Langbein & Bruce A. Wolk, *Pension and Employee Benefit Law* 77 (1995); see also United States Gen. Accounting Office, *Report to Congressional Requesters, Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA* 30 (1995) [hereinafter *Employer-Based Health Plans*].

16. See 29 U.S.C. § 1021 (1994).

17. See 29 U.S.C. § 1052 (1994).

18. See 29 U.S.C. § 1053 (1994).

19. See 29 U.S.C. § 1082 (1994).

20. See 29 U.S.C. § 1104 (1994).

21. Government and church plans are exempted. See 29 U.S.C. § 1003(b) (1994).

22. The statute defines an employee “welfare benefit plan” as:

[A]ny plan, fund, or program which . . . was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or

welfare plans in writing,²⁴ issue summary plan descriptions to participants,²⁵ and meet federal reporting requirements.²⁶ Any person²⁷ with discretionary authority or responsibility in administering an ERISA plan is a fiduciary under ERISA.²⁸ The duty of an ERISA fiduciary is to act exclusively in the best interest of the participants and their beneficiaries.²⁹ Unlike most participation and funding requirements that apply only to pension plans,³⁰ ERISA's fiduciary rules apply to pension and welfare benefits alike.³¹

B. *ERISA's Enforcement Mechanisms Are Limited to Equitable Remedies*

ERISA provides a system of enforcement that allows private causes of action for participants or beneficiaries to enjoin any breach of fiduciary duty or to "obtain other appropriate equitable relief."³² Specifically, the civil enforcement provisions of ERISA allow for actions to recover benefits due under the plan,³³ to recover on behalf of the plan for breach

otherwise, . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services."

29 U.S.C. § 1002(1) (1994).

23. The employer is the "plan sponsor" in a plan established by a single employer. *See* 29 U.S.C. § 1002(16)(B) (1994).

24. *See* 29 U.S.C. § 1102(a)(1) (1994). However, the lack of a written instrument does not necessarily mean that a plan is not covered by ERISA. *See* Langbein & Wolk, *supra* note 15, at 483.

25. *See* 29 U.S.C. § 1022(a)(1) (1994).

26. *See* Langbein & Wolk, *supra* note 15, at 508.

27. A "person" is defined as "an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization." 29 U.S.C. § 1002(9) (1994). Benefit plans, with certain limited exceptions, most notably those that provide benefits exclusively through insurance contracts with insurance companies qualified by the states, must hold their assets in trust. *See* 29 U.S.C. § 1103 (1994). Therefore uninsured plans themselves are "persons" within the meaning of the statute.

28. *See* 29 U.S.C. § 1002(21)(A)(iii) (1994).

29. *See* 29 U.S.C. § 1104(a)(1) (1994).

30. *See* Langbein & Wolk, *supra* note 15, at 508.

31. *See* 29 U.S.C. § 1002(3) (1994) (defining "plan" to include both); *see also* 29 U.S.C. § 1104(a)(1) (applying fiduciary rules to "plans").

32. 29 U.S.C. § 1132(a)(3) (1994).

33. *See* 29 U.S.C. § 1132(a)(1)(B) (1994).

of fiduciary duties,³⁴ to enjoin violations of ERISA or an ERISA plan itself, or to obtain “other appropriate equitable relief” for such breaches and violations.³⁵ In *Massachusetts Mutual Life Insurance Co. v. Russell*,³⁶ the U.S. Supreme Court interpreted “other equitable relief” to mean that damages—extracontractual, compensatory, or punitive—are not allowed.³⁷ Because there was no evidence that Congress intended such a remedy, the Court reversed the lower court’s ruling that a beneficiary could obtain such damages.³⁸

C. *ERISA Preempts State Laws That “Relate to” ERISA Plans*

To ensure that, as much as practicable, the regulation of private employee benefit plans would be exclusively federal, Congress mandated that ERISA preempts all state laws that “relate to” plans covered by ERISA.³⁹ The savings clause of ERISA explicitly exempts from preemption state laws that regulate insurance, banking, and securities.⁴⁰ However, to prevent states from labeling ERISA plans as “insurers” for the purpose of evading preemption, Congress specifically provided that plans themselves could not be considered insurers.⁴¹ Insurance companies commonly provide administrative services to employee benefit plans, but in such situations they commonly provide no insurance; rather, the plan itself bears the risk of loss and is said to be self-funded or self-insured.⁴²

The courts initially interpreted ERISA’s preemptive power very broadly. In the seminal case *Shaw v. Delta Airlines*,⁴³ a unanimous U.S. Supreme Court held that New York’s Human Rights and Disability

34. See 29 U.S.C. § 1109(a) (1994) (allowing recovery only for plan); see also 29 U.S.C. § 1132(a)(2) (1994) (authorizing civil action).

35. 29 U.S.C. § 1132(a)(3).

36. 473 U.S. 134 (1985).

37. See *id.* at 144.

38. See *id.* at 144–45.

39. 29 U.S.C. § 1144(a) (1994).

40. See 29 U.S.C. § 1144(b)(2)(A) (1994).

41. See 29 U.S.C. § 1144(b)(2)(B) (1994) (providing that no ERISA-covered plan “shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks trust companies, or investment companies”).

42. See Fox & Schaffer, *supra* note 14, at 63.

43. 463 U.S. 85 (1983).

Benefits Laws “related to” employee benefit plans and therefore could not be enforced against ERISA plans.⁴⁴ In interpreting ERISA’s preemption provision, the Court simply quoted the dictionary definition of “relate,” noted that the legislative history lacked any indication of a more restrictive meaning, and held that a law “relates to” a plan “if it has a connection with or reference to such a plan.”⁴⁵ Throughout the 1980s and early 1990s, the Court stuck to *Shaw*’s broad interpretation of the “relates to” language of ERISA’s preemption provision.⁴⁶

In *Metropolitan Life Insurance Co. v. Massachusetts*,⁴⁷ the U.S. Supreme Court found that the insurance savings clause was similarly broad.⁴⁸ In *Metropolitan Life*, Massachusetts sought declaratory and injunctive relief to require insurers covering Massachusetts residents through insured ERISA plans to provide minimal mental-health benefits as required by Massachusetts law.⁴⁹ The insurers maintained that they were exempt from the state-mandated benefit law since the law clearly “related to” ERISA plans.⁵⁰ The Court reasoned that because the Massachusetts law would not frustrate the federal regulatory scheme—ERISA did not mandate any particular benefits or benefit structure—and because Congress had specifically exempted state insurance regulations from preemption, the mandated benefit laws were not preempted.⁵¹

The *Metropolitan Life* decision created a key distinction under ERISA between benefit plans that purchase insurance contracts to provide benefits and those that self-fund, with the employer maintaining the risk

44. *Id.* at 100. In *Shaw*, airlines and other employers sought a declaratory judgment that ERISA preempted New York’s Human Rights Law and Disability Benefits Law. *See id.* at 92. According to the Court, New York could not enforce the provisions of its Human Rights Laws that were more restrictive than federal civil rights laws against ERISA plans. *See id.* at 108. While ERISA allowed states to regulate plans that are designed solely to comply with state worker’s compensation, unemployment compensation, or disability insurance laws, the Disability Benefits Law was preempted to the extent that it attempted to regulate plans not solely designed for those purposes. *See id.* at 108–09.

45. *Id.* at 96–98.

46. *See, e.g.*, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987) (holding preemption “deliberately expansive”); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985) (according preemption “broad common-sense meaning”). For a comprehensive discussion of this history, see *Pappas v. Asbel*, 724 A.2d 889, 891–92 (Pa. 1998).

47. 471 U.S. 724 (1985).

48. *See id.* at 746.

49. *See id.* at 734.

50. *See id.* at 735.

51. *See id.* at 746.

of financial loss from larger-than-expected claims.⁵² States may indirectly regulate the former through regulation of insurance contracts, as long as they do not frustrate the federal enforcement scheme.⁵³ However, states may not directly regulate ERISA plans themselves.⁵⁴ Because of this distinction, ERISA encourages employers to self-fund their benefit plans and avoid even indirect state regulation.⁵⁵

The likelihood that an employee is covered by a self-funded plan is rising. Between 1989 and 1993, enrollment in self-funded health plans increased by nearly six million participants.⁵⁶ Between 1993 and 1996 the percentage of employers sponsoring a self-funded traditional health plan rose from nineteen percent to thirty percent.⁵⁷ Among employers with at least 500 employees, seventy percent offered self-funded plans in 1996.⁵⁸ Because self-funded plans often act as insurance companies in spreading risk and use insurance companies to administer benefits, it is difficult for observers and participants to distinguish an insured plan from a self-funded plan.⁵⁹ The dichotomy between insured plans, which are subject to state regulation, and self-funded plans, which are exempted by ERISA, continues today.⁶⁰

Even though the insurance savings clause was to be interpreted broadly, in *Pilot Life Insurance Co. v. Dedeaux*,⁶¹ the U.S. Supreme Court held that state laws that conflict with the substantive provisions of ERISA, though regulating insurance, were not saved from preemption.⁶² In *Pilot Life*, an employee brought common-law breach of contract and tort causes of action for improper claims handling against the insurer that issued the employer's group disability insurance policy.⁶³ Speaking for a

52. For a discussion of the mechanics of self-funded versus insured plans, see Kenneth R. Wing et al., *The Law and American Healthcare* 83–87 (1998).

53. See *Metropolitan Life*, 471 U.S. at 747 (“We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not.”).

54. See *id.*

55. See *Employer-Based Health Plans*, *supra* note 15, at 34.

56. See *id.* at 15.

57. See Ken McDonnell et al., *EBRI Databook on Employee Benefits* 237 (4th ed. 1997).

58. See *id.*

59. See *Employer-Based Health Plans*, *supra* note 15, at 5.

60. See Andy Miller, *Election '98 Health Care*, *Atlanta J. & Const.*, Oct. 11, 1998, at 7B.

61. 481 U.S. 41 (1987).

62. See *id.* at 57.

63. See *id.* at 43.

unanimous Court, Justice O'Connor reasoned that common-law breach of contract and tort causes of action, though involving state laws for purposes of the insurance savings clause,⁶⁴ are not saved from preemption because they are not exclusively designed to regulate insurance.⁶⁵ The Court distinguished the mandated benefit laws at issue in *Metropolitan Life* that operated exclusively on insurance contracts and regulated in an area where ERISA was silent.⁶⁶ By contrast, the claims in *Pilot Life* were based on general laws, the enforcement of which would frustrate the clear intent of Congress that fiduciary standards for employers and their agents in the context of ERISA plans be an exclusively federal concern.⁶⁷

The Supreme Court's broad interpretation of ERISA's "relates to" language came to an end in 1995 in *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co.*⁶⁸ The Court admitted that the plain meaning of "relates to" is too broad and too vague to be useful.⁶⁹ In *Travelers*, insurers challenged New York statutes that imposed a surcharge on hospital patients covered by commercial health insurance but not on patients covered by Blue Cross and Blue Shield plans.⁷⁰ The courts below held that such statutes clearly "had a connection to" the ERISA plans that purchased health insurance and were thus preempted.⁷¹ However, because everything on some level "relates to" or "has a connection with" everything else, the Supreme Court examined the objectives of ERISA to determine whether the particular state law at issue was preempted.⁷² This analysis forced the Court to try to separate those claims that should be preempted because of the closeness of their connection to ERISA plans and their impact on the

64. *See id.* at 48 n.1 ("For purposes of [29 U.S.C. § 1144], '[t]he term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State.' 29 U.S.C. §§ 1144(c)(1) and (2).") (second alteration in original).

65. *See id.* at 57.

66. *See id.*

67. *See id.*

68. 514 U.S. 645 (1995).

69. *See id.* at 655-56.

70. *See id.* at 651-52.

71. *Id.* at 651-54.

72. The unanimous Court reasoned that if "'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course." *Id.* at 655. The Court went on to point out that while "makes reference to" is a relatively straightforward test, "has a connection with" is just as potentially limitless as "relates to." *Id.* at 656.

purposes of ERISA from those claims that were not so closely related or had too tenuous an impact to require preemption.⁷³ The Court held that the connection between the New York surcharge statutes and ERISA plans was too remote to require preemption.⁷⁴ The Court expressly declined to overrule its prior ERISA preemption decisions but indicated that the issue was no longer as clear as it had appeared prior to *Travelers*.⁷⁵

Since *Travelers*, courts have been more willing to find state laws not preempted.⁷⁶ The *Travelers* Court noted in dicta that “nothing in [ERISA] indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern.”⁷⁷ As a result, several courts have held that notwithstanding ERISA, medical malpractice state claims can proceed.⁷⁸

D. Health Care Payment Systems Have Changed

The health insurance industry has changed dramatically since the 1974 ERISA enactment.⁷⁹ In the 1970s and 1980s, most health plans were structured on a “fee for service” basis, rarely requiring authorization prior to treatment.⁸⁰ In response to rising costs, “managed care organizations” (MCOs) grew in popularity.⁸¹ MCOs use various methods to manage the cost of health care.⁸² One common practice of MCOs is prospective review of recommended or desired medical treatment to

73. See *id.* at 656.

74. See *id.* at 668.

75. See *id.*

76. Of the three ERISA preemption cases decided in 1997 by the U.S. Supreme Court, two found that the state laws in question were not preempted. See *De Buono v. NYSA-ILA Medical & Clinical Servs. Fund*, 520 U.S. 806, 809 (1997); *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 319 (1997).

77. *Travelers*, 514 U.S. at 661.

78. See, e.g., *Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151, 155 (10th Cir. 1995) (holding vicarious liability claim against HMO not preempted where claim did not involve administration of benefits); *Dukes v. U.S. Healthcare*, 57 F.3d 350, 356 (3d Cir. 1995) (holding malpractice not preempted so as to permit removal to federal court).

79. See *Wing et al.*, *supra* note 52, at 69.

80. See Jose L. Gonzalez, *A Managed Care Organization's Medical Malpractice Liability for Denial of Care: The Lost World*, 35 *Hous. L. Rev.* 715, 723–24 (1998).

81. See *Wing et al.*, *supra* note 52, at 83.

82. See *id.* at 84.

determine whether it is medically necessary, cost effective, and covered under the terms of an ERISA plan.⁸³

Combining the administration of benefits with the delivery of health care services in one entity is a principal MCO technique designed to hold down costs.⁸⁴ In “integrated delivery systems,” the entity that makes benefit determinations, including what services are excluded under the plan as experimental, also hires or contracts with the health care providers who deliver services to participants.⁸⁵ Blurring the line between benefit administration and delivery of care has allowed some plaintiffs to characterize denial of benefits as medical malpractice.⁸⁶ Some courts, based on *Travelers*, have agreed and refused to find ERISA preemption.⁸⁷ MCOs are especially vulnerable if they hire providers directly, resulting in potential liability on the theory of *respondeat superior*.⁸⁸ However, where there is no such close relationship, most courts have continued to draw a clear distinction between administration and treatment and have dismissed state law causes of action that implicate only benefit administration decisions.⁸⁹

E. States Have Attempted to Expand Patients' Rights

Many states have considered “patients’ rights” legislation that would allow patients to sue integrated delivery systems for money damages.⁹⁰ Texas was the first state to enact such legislation,⁹¹ and the Texas law⁹²

83. *See id.*

84. *See id.* at 69.

85. The terms MCO and HMO are often used interchangeably, but the HMO model is just one subset (although arguably the most extreme, directly controlling providers through financial incentives) of the various popular MCO models that manage care through integration of the financing and delivery of health care services. *See id.* at 83–84.

86. *See* Robert Pear, *Series of Rulings Eases Constraints on Suing H.M.O.'s*, N.Y. Times, Aug. 15, 1999, § 1, at 1.

87. *See, e.g.*, Pappas v. Asbel, 724 A.2d 889, 894 (Pa. 1998) (holding claim against HMO for administrative refusal to authorize transfer to particular hospital best characterized as medical malpractice).

88. *See* Michael Higgins, *Second Opinions on HMOs*, A.B.A. J., Apr. 1999, at 60, 62.

89. *See, e.g.*, Brandon v. Aetna Servs., Inc., 46 F. Supp. 2d 110, 114 (D. Conn. 1999) (holding that malpractice claim against plan administrator for refusing to approve treatment was preempted by ERISA); Huss v. Green Spring Health Servs., Inc., 18 F. Supp. 2d 400, 405–06 (D. Del. 1998) (holding that claim of malpractice for plan’s administrative error was preempted).

90. *See Confidence in HMOs Sinks, But Congress Is Still Offering Placebos*, USA Today, Sept. 24, 1999, at 17A.

91. *See* Charles Ornstein, *Joining the Battle*, Dallas Morning News, Apr. 12, 1999, at 1D.

has had mixed results in the courts.⁹³ The law gives a patient the right to sue HMOs and other managed-care entities for damages if the patient is injured because of a health care treatment decision and the law mandates an independent review process for adverse benefit determinations.⁹⁴ In *Corporate Health Insurance, Inc. v. Texas Department of Insurance*,⁹⁵ the first challenge to the Texas law, the federal district court held that the portion of the law mandating independent review of benefit determinations was preempted to the extent that it applied to ERISA plans because states cannot mandate a particular benefit structure for such plans.⁹⁶ On the other hand, the *Corporate Health* court upheld the portions of the law that imposed health plan liability for improper treatment decisions that affected the quality of benefits actually received.⁹⁷

Under Texas law, the portions of a statute that conflict with federal law are severable from other provisions.⁹⁸ The *Corporate Health* court determined that the portions of the Texas law that mandated independent review of benefit determinations could be severed.⁹⁹ Consequently, portions of the law that granted the right to sue health plans for poor-quality care could still be given effect.¹⁰⁰ The court held that claims must be reviewed on a case-by-case basis to determine whether the individual claim addresses the quality of care and would be valid, or seeks review of an adverse benefit determination and would be preempted.¹⁰¹ Thus the explicit Texas statute yields the same result that the courts have already begun to reach in the absence of state legislation: malpractice is actionable, but denial of benefits by administrators is not.

92. See Tex. Civ. Prac. & Rem. Code Ann. §§ 88.001–003 (West 1998).

93. See Charles Ornstein, *Judge Upholds State Law That Lets Patients Sue over HMO Denials; But Ruling Strikes Much of Independent Review Process*, Dallas Morning News, Sept. 19, 1998, at 1A.

94. See Tex. Civ. Prac. & Rem. Code Ann. §§ 88.002–003.

95. 12 F. Supp. 2d 597 (N.D. Tex. 1998).

96. See *id.* at 625.

97. See *id.* at 620.

98. See *id.* at 625–26.

99. See *id.* at 628.

100. See *id.*

101. See *id.* at 629.

F. *Federal Patients' Rights Legislation Has Stalled*

At the federal level, the prospects of amending ERISA to allow state-law causes of action are dim. The powerful business and insurance lobby is firmly against such proposals, viewing them as the most threatening of all patients' rights provisions.¹⁰² These proposals are unlikely to be passed into law as long as the Republicans hold a majority in the House and Senate.¹⁰³ Furthermore, patients' rights are seen as a second-tier issue.¹⁰⁴ In the 1998 congressional elections, most Americans based their voting on issues such as the economy, education, Social Security, and taxes,¹⁰⁵ and a majority of candidates who advocated patients' rights lost.¹⁰⁶

Despite massive changes in our health care system and in society as a whole since 1974, changes in the interpretation of ERISA's preemptive power have been incremental. The states have tried to expand patients' rights but lack the power to supersede a federal law that powerful interests continue to support.

II. THE RACKETEER INFLUENCED AND CORRUPT ORGANIZATIONS ACT

While ERISA does establish a comprehensive federal system covering pensions and employee welfare benefits, plaintiffs may look to other federal legislation for relief as well, because ERISA itself makes clear that it does not preempt other federal laws.¹⁰⁷ ERISA's broad preemption of state tort and contract actions, and the lack of adequate remedies within ERISA itself, make it difficult both to compensate victims of benefit denials and to deter ERISA plan administrators from denying legitimate benefits due under the plans. However, the Racketeer

102. See Alissa J. Rubin, *Democrats Push Tough Health Care Standards*, L.A. Times, Feb. 17, 1998, at A1.

103. See *Immune from Suit, HMOs Crimp Fearlessly on Care*, USA Today, July 15, 1998, at 10A.

104. See Daniel B. Moskowitz, *Health Reform '99: A Modest Proposal*, Bus. & Health, Dec. 1, 1998, at 19.

105. See Michael Pretzer, *Will Congress Stop Playing Politics with Health Care?*, Med. Econ., Jan. 11, 1999, at 83.

106. See *id.*

107. See 29 U.S.C. § 1144(d) (1994) ("Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States.").

Influenced and Corrupt Organizations Act (RICO),¹⁰⁸ another federal statute, may provide plaintiffs with a surprising avenue to press claims and secure relief.

A. Purpose and Scope of RICO

Congress passed RICO as Title IX of the Organized Crime Control Act of 1970 with the declared purpose of eradicating organized crime.¹⁰⁹ Congress was concerned about the spread of organized crime into legitimate businesses.¹¹⁰ Although RICO is primarily a criminal statute, it includes a civil remedies provision¹¹¹ that allows recovery of treble damages and attorney's fees for private plaintiffs who are injured by violations of the criminal provisions.¹¹²

B. Elements of a RICO Cause of Action

RICO criminalizes four types of conduct: (1) using the proceeds of a pattern of racketeering activity to invest in or acquire an enterprise,¹¹³ (2) acquiring an enterprise through a pattern of racketeering activity,¹¹⁴ (3) conducting the affairs of an enterprise through a pattern of racketeering activity,¹¹⁵ or (4) conspiring to commit any of the first three violations.¹¹⁶ This Comment focuses on the third type of conduct, a so-called § 1962(c) violation.¹¹⁷ To establish a violation of § 1962(c), the following elements must be satisfied: (1) a person (2) conducted or

108. See 18 U.S.C. §§ 1961–1968 (1994).

109. Organized Crime Control Act of 1970, Pub. L. No. 91-452, 84 Stat. 922. Congress stated that its purpose was “to seek the eradication of organized crime in the United States by strengthening the legal tools in the evidence-gathering process, by establishing new penal prohibitions, and by providing enhanced sanctions and new remedies to deal with the unlawful activities of those engaged in organized crime.” 84 Stat. at 923.

110. See 84 Stat. at 923.

111. See 18 U.S.C. § 1964.

112. See 18 U.S.C. § 1964(c).

113. See 18 U.S.C. § 1962(a).

114. See 18 U.S.C. § 1962(b) (1994).

115. See 18 U.S.C. § 1962(c) (1994).

116. See 18 U.S.C. § 1962(d) (1994).

117. Sections 1962(a) and (b) involve a racketeer “acquiring” an enterprise and do not implicate the activities of an ongoing enterprise. The conspiracy section, § 1962(d), might be implicated as well, but is beyond the scope of this Comment.

participated in the affairs of an enterprise (3) through racketeering activity that (4) formed a pattern.¹¹⁸

Only “persons” may be sued under RICO.¹¹⁹ RICO defines “person” as “any individual or entity capable of holding a legal or beneficial interest in property.”¹²⁰ As such, the defendant in a RICO action under § 1962(c) may be an individual or a business organization, provided they are “employed by or associated with any enterprise . . . [and] participate, directly or indirectly, in the conduct of such enterprise’s affairs through a pattern of racketeering activity.”¹²¹

A RICO “enterprise” includes “any individual, partnership, corporation, association, or other legal entity, and any union or group of individuals associated in fact although not a legal entity.”¹²² This definition encompasses legitimate business entities as well as purely criminal ones.¹²³ To trigger federal jurisdiction, the enterprise must be engaged in, or affect, interstate or foreign commerce.¹²⁴ The courts have generally held that the person in violation of RICO and the enterprise must be separate entities on the theory that one cannot “associate” with oneself.¹²⁵

“Racketeering activity” refers to a broad list of predicate state and federal offenses.¹²⁶ The list covers violent offenses such as murder, kidnapping, gambling, arson, and robbery.¹²⁷ It also includes many “white collar” criminal acts indictable under or involving federal laws, such as bribery, extortion in credit transactions, embezzlement from pension and welfare funds, money laundering, securities fraud, making unlawful welfare fund payments, securities fraud, and mail and wire fraud.¹²⁸ These predicates are made criminal elsewhere in state and

118. See 18 U.S.C. § 1962(c).

119. See 18 U.S.C. § 1962(a)–(d) (1994) (“It shall be unlawful for any person . . .”).

120. 18 U.S.C. § 1961(3) (1994).

121. 18 U.S.C. § 1962(c).

122. 18 U.S.C. § 1961(4) (1994).

123. See *United States v. Turkette*, 452 U.S. 576, 585 (1981).

124. See 18 U.S.C. § 1962(a)–(c). This requires a showing of the effect on commerce in each RICO case, but the effect may be minimal. See Norman Abrams & Sara Sun Beale, *Federal Criminal Law and Its Enforcement* 476–77 (2d ed. 1993).

125. See Abrams & Beale, *supra* note 124, at 477–78.

126. 18 U.S.C. § 1961(1) (1994).

127. See 18 U.S.C. § 1961(1)(A).

128. See 18 U.S.C. § 1961(1)(B)–(E).

federal statutes.¹²⁹ RICO simply defines them as “racketeering activity” and significantly heightens the penalties when they are committed in such a way as to satisfy the RICO elements.¹³⁰

Finally, racketeering activity must form a “pattern” to be actionable.¹³¹ The statutory minimum requires at least two predicate acts within a ten-year period.¹³² However, in *H.J., Inc. v. Northwestern Bell Telephone Co.*,¹³³ the U.S. Supreme Court ruled that two acts alone do not form a pattern.¹³⁴ According to the Court, the facts establishing the pattern element must pass a two-prong test: the “relatedness” prong requires that the predicate acts be related to each other, and the “continuity” prong requires that the acts amount to or pose a threat of continued criminal activity.¹³⁵ Under this test, the predicate acts relate to each other if they “have the same or similar purposes, results, participants, victims, or methods of commission, or otherwise are interrelated by distinguishing characteristics and are not isolated events.”¹³⁶ Predicate acts occurring over at least a one-year time period satisfy the continuity prong.¹³⁷ This prong may also be established when the facts of the case demonstrate that either the acts themselves include a specific threat of repetition or that the predicate acts are an entity’s “regular way of doing business.”¹³⁸

129. See 18 U.S.C. § 1961(1).

130. See *Abrams & Beale*, *supra* note 124, at 452.

131. 18 U.S.C. § 1962(a)–(d) (1994).

132. See 18 U.S.C. § 1961(5) (1994).

133. 492 U.S. 229 (1989).

134. See *id.* at 238–39.

135. *Id.* at 239–43.

136. *Id.* at 240 (quoting 18 U.S.C. § 3575 (1994)). This definition may be as unhelpfully broad as the construction of the “relates to” language of ERISA’s preemption clause. See *id.* at 252 (Scalia, J., concurring).

137. According to the Court, continuity may be proved by showing a series of related predicate acts extending over a “substantial period of time.” *Id.* at 242. Appellate courts have, at a minimum, required one year to be “substantial.” See, e.g., *Uni*Quality, Inc. v. Infotronx, Inc.*, 974 F.2d 918, 922 (7th Cir. 1992) (holding that seven to eight months is insufficient); *Aldridge v. Lily-Tulip, Inc. Salary Retirement Plan Benefits Comm.*, 953 F.2d 587, 593 (11th Cir. 1992) (holding that six months to one year is insufficient); *Hughes v. Consol-Pennsylvania Coal Co.*, 945 F.2d 594, 609–11 (3d Cir. 1991) (stating that “twelve months is not a substantial period of time”); *American Eagle Credit Corp. v. Gaskins*, 920 F.2d 352, 354–55 (6th Cir. 1990) (holding that six months is insufficient); see also *Primary Care Investors, Seven, Inc. v. PHP Healthcare Corp.*, 986 F.2d 1208, 1215 (8th Cir. 1992) (holding that between 10 and 11 months is insubstantial).

138. *Northwestern Bell*, 492 U.S. at 242–43.

C. *Mail Fraud as RICO's Predicate Offense*

Mail fraud is the most frequently used predicate offense under RICO because of its simplicity and flexibility.¹³⁹ Thus, this Comment will focus exclusively on this crime as a framework for injured ERISA plan participants or beneficiaries who seek redress for their injuries under RICO. The elements of mail fraud are relatively simple to prove. It requires a scheme to defraud, intent, and use of the mail in that scheme.¹⁴⁰ Each separate mailing in furtherance of the scheme constitutes a separate offense.¹⁴¹ Thus two fraudulent mailings can satisfy the minimum of two or more predicate offenses required to establish a pattern of racketeering activity.¹⁴² However, mailings alone, especially if they involve the same transaction, are unlikely to establish a pattern.¹⁴³

The concept of a "scheme to defraud" under the mail fraud statute is broad. During the 1970s and 1980s, the courts expanded the concept to include not just deprivation of property from the victim and ill-gotten gain by the perpetrator, but also deprivation of "intangible rights."¹⁴⁴

139. See *Abrams & Beale*, *supra* note 124, at 120.

140. The mail fraud statute provides:

Whoever, having devised or intending to devise any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretenses, representations, or promises, . . . for the purpose of executing such scheme or artifice or attempting so to do, places in any post office or authorized depository for mail matter, any matter or thing whatever to be sent or delivered by the Postal Service, or deposits or causes to be deposited any matter or thing whatever to be sent or delivered by any private or commercial interstate carrier, . . . shall be fined under this title or imprisoned not more than five years, or both.

18 U.S.C. § 1341 (1994).

141. See *Badders v. United States*, 240 U.S. 391, 394 (1916).

142. See *Sedima S.P.R.L. v. Imrex Co.*, 473 U.S. 479, 502 (1985) (Marshall, J., dissenting).

143. See, e.g., *Wisdom v. First Midwest Bank*, 167 F.3d 402, 407 (8th Cir. 1999) (holding mailings insufficient to establish continuity factor unless they contain misrepresentations themselves, and court must look to underlying scheme to defraud); *Anderson v. Foundation for Advancement, Educ. and Employment of Am. Indians*, 155 F.3d 500, 506 (4th Cir. 1998) ("We are especially cautious when the acts involved are mail . . . fraud: 'It will be the unusual fraud that does not enlist the mails . . . at least twice.'") (citation omitted); *Schultz v. Rhode Island Hosp. Trust Nat'l Bank, N.A.*, 94 F.3d 721, 731-32 (1st Cir. 1996) (holding continuity not established where very few acts of mail fraud were alleged and only one scheme was alleged); *Vicom, Inc. v. Harbridge Merchant Servs., Inc.*, 20 F.3d 771, 780-81 (7th Cir. 1994) (holding multiple mailings over short period fail to satisfy continuity element).

144. See, e.g., *United States v. Bush*, 522 F.2d 641, 648 (2d Cir. 1975) (concluding that city official defrauded citizens of honest services); *United States v. Bryza*, 522 F.2d 414, 422-23 (7th Cir. 1975) (concluding that failure to disclose conflict of interest to employer violated mail fraud statute); see also *United States v. Boffa*, 688 F.2d 919 (3d Cir. 1982) (concerning scheme to defraud union members of honest and faithful services). For a discussion of the development of the

Although this judicial construction was overruled by the U.S. Supreme Court in *McNally v. United States*,¹⁴⁵ Congress reinstated the “intangible rights” doctrine.¹⁴⁶ These “intangible rights” include the right of private parties to expect honesty from one in a fiduciary relationship with them.¹⁴⁷

To establish actionable fraud under the mail fraud statute, a plaintiff must prove that the defendant acted with intent.¹⁴⁸ Intent generally means that the defendant knew of the fraudulent nature of the scheme.¹⁴⁹ However, intent can also be proven by establishing that the defendant acted with reckless disregard for the truth.¹⁵⁰

Mail fraud requires use of the mail in furtherance of a scheme to defraud.¹⁵¹ The mailing must be at least incidental to an essential part of the scheme or a step in the plot.¹⁵² If the mailings include fraudulent misrepresentations, then each may be treated as a separate fraudulent scheme, and the continuity prong of the pattern element is easily established.¹⁵³ If the mailings do not include misrepresentations, each mailing may be actionable as an individual count of mail fraud.¹⁵⁴ However, they may not form the pattern that RICO requires.¹⁵⁵

“intangible rights doctrine,” see generally Michael R. Dreeben, *Insider Trading and Intangible Rights: Redefinition of the Mail Fraud Statute*, 26 Am. Crim. L. Rev. 181 (1988).

145. 483 U.S. 350, 360 (1987).

146. See 18 U.S.C. § 1346 (1994) (providing that “[f]or the purposes of this chapter, the term ‘scheme or artifice to defraud’ includes a scheme or artifice to deprive another of the intangible right to honest services”).

147. See *United States v. Von Barta*, 635 F.2d 999, 1007 (2d Cir. 1980) (holding bond trader employee who knowingly established account for bogus firm in which he held interest deprived employer of honest services).

148. See *Laura A. Eilers & Harvey B. Silikovitz, Mail and Wire Fraud*, 31 Am. Crim. L. Rev. 703, 712 (1994).

149. See *id.*

150. See *United States v. Coyle*, 63 F.3d 1239, 1243 (3d Cir. 1995).

151. See 18 U.S.C. § 1341 (1994).

152. See *Schmuck v. United States*, 489 U.S. 705, 710–11 (1989) (holding mailings of title-transfer paperwork in scheme to sell cars with bogus odometer readings sufficient for mail fraud).

153. See *Wisdom v. First Midwest Bank*, 167 F.3d 402, 407 (1998).

154. See *Murr Plumbing, Inc. v. Scherer Bros. Fin. Servs. Co.*, 48 F.3d 1066, 1069–70 & n.6 (8th Cir. 1995).

155. See *Wisdom*, 167 F.3d at 407 (“Though mail fraud can be a predicate act, mailings are insufficient to establish the continuity factor unless they contain misrepresentations themselves. The court must look to the underlying scheme to defraud.”); *Kehr Packages, Inc. v. Fidelcor, Inc.*, 926 F.2d 1406, 1414 (3d Cir. 1991) (“[T]he continuity question should not be affected by the fact that a particular fraudulent scheme involved numerous otherwise ‘innocent’ mailings.”).

D. *Civil RICO Cause of Action*

RICO allows for a private cause of action for any person injured in his or her business or property by reason of a violation of the RICO criminal provisions.¹⁵⁶ It provides for treble damages and recovery of costs and attorney's fees.¹⁵⁷ Courts in civil RICO actions are authorized to order divestiture of an interest in an enterprise, restrict the future activities of persons involved in the type of activity in which the enterprise was engaged, or order dissolution or reorganization of any enterprise.¹⁵⁸ To prevail and recover in a civil RICO action, a private plaintiff must prove each of the elements of the criminal RICO offense.¹⁵⁹ Plaintiffs must also prove that they have standing to sue—that they have been injured in their business or property and that the criminal offense was the cause of their injury.¹⁶⁰

1. *Purpose and History of the Civil RICO Cause of Action*

Civil RICO has been used in ways that Congress may not have intended.¹⁶¹ Even though Congress intended RICO to rein in the influence of organized criminal activity on and within legitimate businesses,¹⁶² the impact of civil RICO has been greatest on legitimate businesses.¹⁶³ The legislative history of RICO indicates that Congress added the civil cause of action as an additional tool both to provide a remedy for those who had been injured by organized crime and to discourage organized criminal activity.¹⁶⁴ However, Congress did not limit the scope of the criminal RICO provisions to membership in organized crime.¹⁶⁵ Instead, it defined criminality under RICO on the

156. See 18 U.S.C. § 1964(c) (1994).

157. See 18 U.S.C. § 1964(c).

158. See 18 U.S.C. § 1964(a) (1994).

159. See 18 U.S.C. § 1964(c).

160. See 18 U.S.C. § 1964(c).

161. See *Sedima S.P.R.L. v. Imrex Co.*, 473 U.S. 479, 500 (1985) (“[I]n its private civil version, RICO is evolving into something quite different from the original conception of its enactors.”).

162. See *id.* at 525–26 (Powell, J., dissenting).

163. See *id.* at 499 & n.16.

164. See *id.* at 487–88.

165. See Mark Stephen Paker, *Reaching the Deep Pocket Under the Racketeer Influenced and Corrupt Organizations Act*, 72 Marq. L. Rev. 511, 517 (1989).

basis of conduct.¹⁶⁶ Had Congress written the law to apply only to members of traditional organized crime, RICO may have been subject to constitutional challenge.¹⁶⁷ As a result, private plaintiffs have commonly brought civil RICO actions against what are otherwise legitimate businesses.¹⁶⁸

2. *Civil RICO Has Had a Tumultuous History in the Courts*

Because private litigants have used civil RICO in ways not foreseen by Congress, courts have attempted to limit RICO's scope.¹⁶⁹ During the 1970s, civil RICO was seldom used by private litigants, but in the early 1980s the number of such suits skyrocketed.¹⁷⁰ To contain the flood of civil RICO litigation, some courts read additional requirements into the statute:¹⁷¹ first, a requirement that the defendant have a prior criminal RICO conviction;¹⁷² and second, a requirement that the plaintiff not simply be injured by the predicate acts, but suffer a further "racketeering injury" caused by the pattern of racketeering activity.¹⁷³ Other courts of appeals disagreed.¹⁷⁴

The Supreme Court addressed this split in the circuits in *Sedima S.P.R.L. v. Imrex Co.*¹⁷⁵ After reviewing the language and legislative history of § 1964(c), the Court held that no prior conviction was required because there was no evidence that Congress intended such a requirement.¹⁷⁶ Further, the Court rejected the "racketeering injury" requirement because RICO was intended to reach both legitimate and illegitimate businesses and because racketeering activity was defined

166. *See id.*

167. *See Sedima*, 473 U.S. at 525 (Powell, J., dissenting).

168. *See id.* at 499 n.16.

169. *See, e.g., id.* at 499.

170. *See id.* at 481 n.1.

171. *See id.* at 485–86 & n.6.

172. *See, e.g., Alexander Grant & Co. v. Tiffany Indus., Inc.*, 742 F.2d 408, 413 (8th Cir. 1984).

173. *See, e.g., Sedima S.P.R.L. v. Imrex Co.*, 741 F.2d 482, 496 (2d Cir. 1984), *rev'd*, 473 U.S. 479 (1985).

174. *See, e.g., Haroco v. American Nat'l Bank & Trust Co.*, 747 F.2d 384, 394, 398–99 (7th Cir. 1984) (holding no "racketeering injury" requirement); *USACO Coal Co. v. Carbomin Energy, Inc.*, 689 F.2d 94, 95 & n.1 (6th Cir. 1982) (finding no prior conviction required).

175. 473 U.S. 479 (1985).

176. *See id.* at 493.

broadly in the statute.¹⁷⁷ The Court held that the only injury required was that flowing from the predicate acts themselves.¹⁷⁸ Finally, the Court emphasized that RICO was intended to attack not only the “archetypal, intimidating mobster,” but also otherwise legitimate businesses that engage in organized crime as RICO defines it—a pattern of racketeering activity.¹⁷⁹

Civil RICO places a great deal of pressure on defendants.¹⁸⁰ It has a broad scope—the list of predicate “racketeering activity” offenses is long, and many of the underlying predicate acts, such as mail fraud, are sweeping themselves.¹⁸¹ The potential for treble damages and attorney’s fees provides pressure.¹⁸² Finally, a RICO judgment carries with it the stigma of being branded a “racketeer.”¹⁸³ This combination results in strong pressure on a defendant to settle a dispute and avoid not only protracted litigation, but also the risk of tremendous financial exposure and poor public relations.¹⁸⁴

3. *Standing to Sue Under Civil RICO*

Standing to sue under civil RICO requires two elements: (1) that the plaintiff suffered an injury; and (2) that the defendant’s racketeering activity caused the injury.¹⁸⁵ Civil RICO requires that the plaintiff be “injured in his business or property.”¹⁸⁶ The lower courts have generally interpreted this term to require injury of a commercial nature to business persons.¹⁸⁷ This construction is borrowed directly from the federal

177. *See id.* at 497–98.

178. *See id.*

179. *See id.*

180. *See id.* at 504 (Marshall, J., dissenting).

181. *See* G. Richard Strafer et al., *Civil RICO in the Public Interest: “Everybody’s Darling,”* 19 *Am. Crim. L. Rev.* 655, 657 (1982).

182. *See Sedima*, 473 U.S. at 504 (Marshall, J., dissenting).

183. *See* 1 Kathleen Brickley, *Corporate Criminal Liability: A Treatise on the Criminal Liability of Corporations, Their Officers and Agents* § 7A:02, at 427 (1992) (“[A]dding a civil RICO count to a complaint serves as a potent inducement for defendants to settle the case and avoid the stigma of being publicly associated with nefarious ‘racketeering activities.’”) (footnote omitted).

184. *See Sedima*, 473 U.S. at 504 (Marshall, J., dissenting).

185. *See* *Beck v. Prupis*, 162 F.3d 1090, 1095 (11th Cir. 1998).

186. 18 U.S.C. § 1964(c) (1994).

187. *See* Annette M. Sansone, Annotation, *Recovery of Damages for Personal Injuries in Civil Action for Damages Under Racketeer Influenced and Corrupt Organizations Act (18 U.S.C.S. § 1964(c))*, 96 A.L.R. Fed. 881, § 2 (1990).

antitrust statutes that contain civil treble-damage provisions that long predate those of RICO.¹⁸⁸ The courts have generally construed the term “business or property” in that context to be a limitation on standing excluding personal injuries.¹⁸⁹ However, the U.S. Supreme Court has held that it is not necessary for a plaintiff in a civil antitrust action to be a business entity, only that the loss suffered be a loss to either “business” or “property” as each term is independently understood.¹⁹⁰ Furthermore, the Court in *Sedima* made clear that the restrictive standing requirements found in antitrust jurisprudence are inappropriate in the civil RICO context due to RICO’s broader scope.¹⁹¹ Many courts have indicated a willingness to consider loss of income or employment proximately caused by racketeering activity as a RICO injury on the theory that an individual’s employment is his or her business.¹⁹² At least one court has also found the inability to enjoy one’s property caused by an attempted murder that resulted in a coma to be a RICO injury.¹⁹³

188. See 15 U.S.C. § 15 (1994).

189. See *Reiter v. Sonotone Corp.*, 442 U.S. 330 (1979). An analysis of antitrust jurisprudence is helpful in understanding the phrase. For a discussion of the relevance of antitrust doctrine to civil RICO jurisprudence, see *Sedima*, 473 U.S. at 498–99 (majority opinion) and 510–20 (Marshall, J., dissenting).

190. See *Reiter*, 442 U.S. at 337–41 (holding consumers had standing to sue for treble damages under Clayton Act for higher prices charged to consumers caused by anticompetitive activity in violation of antitrust laws).

191. See *Sedima*, 473 U.S. at 498–99.

192. See, e.g., *Libertad v. Welch*, 53 F.3d 428, 437 n.4 (1st Cir. 1995) (stating that allegations of intimidation and harassment did not state RICO injury, but evidence of injury to business or property “such as lost wages” as result of predicate acts could be sufficient); *Schiffels v. Kemper Fin. Servs., Inc.*, 978 F.2d 344, 353 (7th Cir. 1992) (“Schiffels’ firing [was] probably an injury to her ‘business.’”); *Genty v. Resolution Trust Corp.*, 937 F.2d 899, 918 n.12 (3d Cir. 1991) (“This court has held that the loss of employment due to racketeering activity is injury to ‘business’ and not personal injury and so resulting loss of wages, benefits, and damage to reputation are compensable under section 1964(c).”); *Snead v. Hygrade Food Prods. Assocs.*, No. Civ. A. 98-2657, 1998 WL 910223, at *3 (E.D. Pa. 1998) (stating that termination of employment may be injury to business or property); *Jerry Kubecka, Inc. v. Avellino*, 898 F. Supp. 963, 968 (E.D.N.Y. 1995) (“If [decedents] had been merely disabled by the attempt on their lives but survived, presumably they would have had a RICO claim for lost earnings from their business activities because they had been injured in their ‘business or property.’”).

193. See *Von Bulow v. Von Bulow*, 634 F. Supp. 1284, 1309 (S.D.N.Y. 1986) (“[P]ermanent unconsciousness deprives her of the ability to rearrange her affairs The inability to do so is a financial injury to Mrs. von Bulow . . . and her inability to enjoy her personal and real property may well be compensable monetary injuries under RICO.”).

The second element of standing requires that the predicate acts of racketeering caused the plaintiff's injury.¹⁹⁴ The RICO violation must be both the "but for" cause and the proximate or "legal" cause of the injury.¹⁹⁵ The U.S. Supreme Court addressed the proximate cause issue in *Holmes v. Securities Investor Protection Corp.*¹⁹⁶ In *Holmes*, a stock manipulation scheme caused two broker-dealers to default on obligations and required the Securities Investor Protection Corp. (SIPC), a nonprofit corporation, to reimburse the broker-dealers' customers.¹⁹⁷ Court-appointed trustees supervising the liquidation of the broker-dealers and the SIPC sued under civil RICO.¹⁹⁸ The Court explained that the notion "proximate cause" reflects "ideas of what justice demands, or of what is administratively possible and convenient."¹⁹⁹ In evaluating whether a plaintiff has standing to make a RICO claim, the Court discussed four factors: (1) whether others are positioned to make the same claims; (2) whether the plaintiff would have difficulty showing that the damages flowed from the defendant's conduct; (3) whether there was a risk of double recovery; and (4) whether the defendant's conduct was sufficiently harmful to warrant deterrence.²⁰⁰ Based on this evaluation, the Court held that because the SIPC stood at too remote a distance from the alleged fraud it had no standing to sue in its own right.²⁰¹ However, the case was remanded with the comment that the SIPC still had a potential remedy because it could share appropriately in whatever damages the trustees were able to recover in their suit.²⁰²

III. CIVIL RICO PROVIDES A POSSIBLE SOLUTION FOR ERISA'S FAILURE

ERISA fails to deter fraudulent benefit denials and fails to protect consumers adequately when benefits are denied by a plan administrator and damage ensues that cannot be rectified by "equitable" remedies.

194. See 18 U.S.C. § 1964(c) (1994) ("Any person injured in his business or property *by reason of* a violation of section 1962 of this chapter may sue therefor . . .") (emphasis added).

195. See *Chisolm v. Transouth Fin. Corp.*, 95 F.3d 331, 336 (4th Cir. 1996).

196. 503 U.S. 258 (1992).

197. See *id.* at 261.

198. See *id.* at 263.

199. *Id.* at 268 (internal citation omitted).

200. See *id.* at 268-69.

201. See *id.* at 274.

202. See *id.*

There is a widespread perception that plan administrators routinely deny needed and deserved medical care for financial reasons.²⁰³ State laws that purport to grant plaintiffs a “right to sue” their medical plans are preempted to the extent that they attempt to regulate self-funded ERISA plans.²⁰⁴ At the federal level, Congress has been unwilling to reform ERISA to provide relief.²⁰⁵ Several courts have wrung their hands in frustration at their inability to provide relief for those injured and their survivors through the mechanisms of ERISA alone.²⁰⁶

A. *ERISA Fails to Deter Fraudulent Denials of Benefits*

ERISA offers little or no deterrence against administrators denying legitimate benefits because it does not provide money damages.²⁰⁷ Equitable remedies may be adequate in the context of pension plans where benefits that are denied can be provided after the fact. These remedies were also adequate under the predominantly “fee for service” health insurance model of the 1970s because benefit claims were generally not scrutinized until after procedures were performed.²⁰⁸ However, the health insurance model has changed from “fee for service” to “managed care” with prospective review features.²⁰⁹ Under this model, administrators determine whether or not to grant benefits before the procedure is performed.²¹⁰ Thus, a wrongful denial of benefits can result in a lost opportunity for care, with catastrophic results that cannot be remedied equitably after the fact.²¹¹ Health benefits that are prescribed by the attending physician as necessary, but which are denied or delayed by the administrator as not covered under the terms of the plan, have caused

203. See *infra* notes 215–19 and accompanying text.

204. See *supra* notes 92–101 and accompanying text.

205. See *supra* notes 102–06 and accompanying text.

206. See, e.g., *Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1011 (9th Cir. 1998); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1339 (5th Cir. 1992).

207. See David S. Hilzenrath, *At Stake in Senate Debate: HMOs' Shield Against Damage Suits*, *Wash. Post*, July 11, 1999, at A12 (“If the only thing health plans stand to lose in litigation is the cost of the care they denied, they have every financial incentive to delay and delay and deny and deny.”) (internal quotation omitted).

208. See *Gonzales*, *supra* note 80, at 723–24.

209. See *id.* at 727.

210. See Larry J. Pittman, *ERISA's Preemption Clause and the Health Care Industry: An Abdication of Judicial Law-Creating Authority*, 46 *Fla. L. Rev.* 355, 361–62 (1994).

211. See *Higgins*, *supra* note 88.

death—a result for which equity provides no remedy.²¹² ERISA precludes any type of restitution that amounts to “money damages.”²¹³ Thus, a participant’s only option under ERISA in such a case is to sue for an injunction during the critical time immediately following the benefit denial.²¹⁴

B. Fraudulent Denial of Benefits Is the “Regular Way of Doing Business”

A public perception of widespread abuse by insurers and administrators stems from the liability exemption that ERISA affords managed-care organizations (MCOs).²¹⁵ Although it is difficult to prove statistically that coverage decisions are made for purely financial reasons, it appears to the public that these entities are driven primarily by their bottom lines.²¹⁶ There is also objective evidence of abuse. In 1998, a training videotape surfaced during discovery in a lawsuit against Aetna, a large insurer and benefit administrator.²¹⁷ In the tape, Aetna lawyers teach claims managers to treat claims made under policies sold to ERISA plans differently from claims made under non-ERISA policies.²¹⁸ The tape implies that the claims administrator can deny ERISA plan claims with impunity because ERISA removes the threat of a lawsuit.²¹⁹

212. See, e.g., *Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1010 (9th Cir. 1998) (concerning participant’s death when bone marrow transplant approval came too late); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992) (concerning fetal death when hospital stay for high-risk pregnancy was denied).

213. See, e.g., *Corcoran*, 965 F.2d at 1339 (holding emotional distress damages not available to mother of dead fetus).

214. See *Bast*, 150 F.3d at 1010 n.1.

215. See *Miller*, *supra* note 60, at 7B.

216. See *id.*; see also Donald W. Light, *Life, Death, and the Insurance Companies*, 330 *New Eng. J. Med.* 498, 498 (1994).

217. See *Aetna Video Fuels Renewed HMO Fight*, *San Diego Union-Trib.*, Oct. 13, 1998, at A6. The tape concerned disability insurance benefits, but the company indicated their policies are no different for health insurance benefits. See *id.*

218. See *id.*

219. Note the following from a recent newspaper article:

If the patient is in an ERISA plan and therefore can’t sue, then his claims simply can be denied by a claims agent. It’s up to the patient to challenge the denial. And Aetna decides when the appeals process is over. “After we send the final letter, it doesn’t matter what they send us any more,” says one of the [Aetna] lawyers.

Patients’ Right to Sue Needed Check on Health Care Industry, *USA Today*, Oct. 19, 1998, at 26A.

To date, the means available to provide relief to plaintiffs injured by the fraudulent denial of necessary medical care have been ineffective. Where possible, in keeping with the *Travelers* decision, courts have characterized administrative coverage decisions as medical malpractice to allow state remedies.²²⁰ However, this is a viable option only where the administrator exercises enough control over the providers of care to establish vicarious liability.²²¹ State laws that allow patients to sue their medical plans are, at best, effective only against insured plans,²²² and more and more employers are choosing to self-fund.²²³ Congress refuses to enact meaningful reform of ERISA that allows injured plaintiffs the full remedies they deserve.²²⁴

C. Civil RICO May Provide a Remedy for ERISA Violations

A broad reading of civil RICO and an examination of its historical use in the ERISA context illustrate that RICO may provide an alternative remedy to victims of ERISA violations. Courts that have addressed the lack of remedies for damages caused by ERISA plan administrators have indicated that the possibility of relief lies only in changing ERISA itself.²²⁵ However, civil RICO plaintiffs can recover treble damages for their injuries, costs, and attorney's fees if they can establish that (1) a person employed by or associated with an enterprise conducted or participated in the affairs of the enterprise through a pattern of racketeering activity, and (2) the conduct proximately caused injuries to the plaintiff's business or property.²²⁶ Although this remedy may or may not be adequate to compensate for all injuries, it provides a powerful incentive for benefit administrators to treat claims of ERISA plan participants with the same care as they treat those not covered by ERISA.

RICO exempts neither ERISA plans nor those who violate ERISA from its scope. Both case law and congressional intent demonstrate that

220. See *supra* notes 77–78 and accompanying text.

221. See *supra* notes 87–88 and accompanying text.

222. See *supra* notes 52–54 and accompanying text.

223. See *supra* notes 55–59 and accompanying text.

224. See *supra* notes 102–06 and accompanying text.

225. See, e.g., *Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1011 (9th Cir. 1998); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1339 (5th Cir. 1992).

226. See *supra* notes 159–60 and accompanying text.

RICO is an appropriate avenue of relief for ERISA violations. Predicate offenses within RICO include several that relate specifically to ERISA plans.²²⁷ Civil RICO is a weapon used by insurers and administrators of ERISA plans themselves to combat fraud and abuse by participants and providers.²²⁸

While numerous cases refer to ERISA as the “exclusive” source of remedies for violations of ERISA, exclusivity is always cited in the context of preemption of state laws, rather than other federal laws.²²⁹ Enforcement of other federal laws does not frustrate the intent of ERISA because the purpose of ERISA is to provide for a uniform federal enforcement system, and giving full effect to other federal laws such as RICO does not subject employers to a patchwork of regulation.²³⁰

Patients have used civil RICO to obtain a remedy when their health plan defrauded them. *Forsyth v. Humana, Inc.*²³¹ involved insured patients’ challenge of fraudulent MCO billing activity through civil RICO.²³² In *Forsyth*, an MCO failure to disclose secret discounts negotiated between the MCO and providers resulted in higher co-payments charged to patients than what their managed-care agreements stipulated.²³³ The district court held that the patients’ RICO claim was improper because the harsh penalties of RICO would “invalidate, impair, or otherwise supersede” state law²³⁴ as proscribed by the McCarren-Ferguson Act.²³⁵ The plaintiffs’ only available remedy thus became ERISA restitution.²³⁶ The Ninth Circuit Court of Appeals reversed the district court and remanded, holding that federal RICO is not barred by

227. RICO defines “racketeering activity” to include “any act which is indictable under . . . title 18, United States Code . . . section 664 (relating to embezzlement from pension and welfare funds) . . . [and] section 1954 (relating to unlawful welfare fund payments) . . .” 18 U.S.C. § 1961(1)(B) (1994).

228. See Steven P. Del Mauro, *Health Insurance Fraud: Fighting Back*, The Brief, Winter 1997, at 10, 14.

229. See, e.g., *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 104–05 (1983) (holding federal nondiscrimination statutes and regulations not preempted).

230. See *id.*

231. 827 F. Supp. 1498 (D. Nev. 1993), *rev’d*, 114 F.3d 1467, 1480 (9th Cir. 1997), *aff’d*, 119 S. Ct. 710 (1999).

232. See *id.* at 1501.

233. See *id.*

234. See *id.* at 1521.

235. The McCarren-Ferguson Act establishes that insurance is primarily an area left to the states. See 15 U.S.C. § 1012(b) (1994).

236. See *Forsyth*, 827 F. Supp. at 1508–09.

the McCarren-Ferguson Act, so that both the RICO claim and the ERISA claim already approved by the district court could go forward.²³⁷ The U.S. Supreme Court affirmed.²³⁸

Congressional intent also supports a RICO cause of action for ERISA violations. Congress has acted where it has determined that RICO is an inappropriate supplement to other federal remedial schemes.²³⁹ In 1995, in response to the flood of RICO litigation over securities law violations, Congress amended § 1964(c) to prohibit civil RICO actions with respect to securities fraud, including the use of mail and wire fraud in a securities context, unless there had been a prior criminal conviction.²⁴⁰ The justification was that ample remedies already existed in the securities laws.²⁴¹ There is no such impediment with respect to ERISA violations.

D. How to Establish a RICO Claim for Fraudulent Benefit Denials

To establish a RICO claim, a plaintiff must establish standing to sue and prove that the actions of the benefit administrator amounted to a RICO violation.²⁴² The latter involves proving the underlying predicate acts and the elements of RICO itself.²⁴³ The former involves proving causation and establishing that the injury the plaintiff suffered was to his or her business or property.²⁴⁴

1. The Person

When a participant in a self-insured ERISA medical plan is injured because benefits and treatment are delayed or denied due to fraud on the part of the administrator, the defendant—the RICO “person”—will typically be the third-party administrator or insurance company that administers the claims for the employer’s plan. The administrator is a plan “fiduciary” under ERISA to the extent that the administrator

237. *Forsyth v. Humana, Inc.* 114 F.3d 1467, 1480 (9th Cir. 1997) (noting that district court’s ERISA holding as to co-payers’ claims was not appealed), *aff’d*, 119 S. Ct. 710 (1999).

238. *See Humana, Inc., v. Forsyth*, 119 S.Ct. 710, 719 (1999).

239. *See Abrams & Beale, supra* note 124, at 77–78 (2d ed. Supp. 1998).

240. *See id.*

241. *See id.*

242. *See supra* notes 159–60 and accompanying text.

243. *See supra* notes 113–38 and accompanying text.

244. *See supra* notes 185–202 and accompanying text.

exercises any discretionary authority or responsibility in plan administration, that is, claims adjudication.²⁴⁵ As a fiduciary, the administrator owes the participants a duty to act in the participants' best interest.²⁴⁶

2. *The Enterprise*

The "enterprise" may either be the ERISA plan itself or the employer who provided the benefit, as both entities clearly meet the loose definition of "enterprise" in § 1961(4).²⁴⁷ In either case, the defendant and the enterprise are separate entities as required by judicial construction of § 1962.²⁴⁸ The defendant participates directly not only in the affairs of the ERISA plan, but also in the affairs of the employer, via the employer's medical plan.

Even though pleading the required nexus between the enterprise and interstate or foreign commerce in this scenario would not typically be a problem, it must be alleged in the complaint.²⁴⁹ Almost any business that self-funds its medical plan, as well as any third-party administrator, will be engaged in interstate commerce on some level, and a minimal level is all that is required.²⁵⁰

3. *Proving the Pattern of Racketeering Activity*

In establishing a RICO violation, the threshold barrier is alleging multiple predicate acts that form a pattern. Using mail fraud as the predicate acts requires at least two mailings improperly denying benefits to the same victim and would be the simplest way to establish the "relatedness" prong. Mailings used to communicate the fraudulent denial of benefits are more than merely incidental to the fraud; they are necessary to the scheme.

245. See *supra* notes 27–28 and accompanying text; see also *Libby-Owens-Ford Co. v. Blue Cross & Blue Shield Mut. of Ohio*, 982 F.2d 1031, 1035 (6th Cir. 1993) ("When an insurance company administers claims for an employee welfare benefit plan and has the authority to grant or deny the claims, the company is an ERISA 'fiduciary.'").

246. See *supra* note 29 and accompanying text.

247. See *supra* notes 122–23 and accompanying text.

248. See *supra* note 125 and accompanying text.

249. See *supra* note 124 and accompanying text.

250. See *supra* note 124 and accompanying text.

Though most of America apparently believes that denial of legitimate benefits by insurers and administrators is a regular way of doing business,²⁵¹ proving the “continuity” prong of the “pattern” element will likely be the most difficult hurdle for plaintiffs in establishing a violation of § 1962(c). The particular predicate acts perpetrated against any one victim are not likely to extend over a period of one year. It is also unlikely that any one defendant will be the victim of more than one scheme. A victim will probably need to prove that the fraudulent denial of claims is an administrator’s regular way of doing business. This may involve finding other victims of similar denials, or establishing, through serendipitous discoveries like the Aetna videotape or the testimony of whistleblowers, that administrators routinely denied claims when they knew or should have known that the claim should be approved.

4. *Establishing Standing*

Prolonged illness or death is an injury to both the victim’s business and property because an employee’s continued employment is that employee’s business.²⁵² Medical benefits are offered to employees as a part of their overall compensation package, negotiated in a commercial setting. Because the right to enjoy one’s property is a fundamental property interest, an employee’s business and property is injured when the employee can no longer work and earn a salary due to an accident or illness and an agent of the employer denies health benefits rightfully due under a compensation arrangement with the employer.²⁵³

Even though the U.S. Supreme Court has not ruled on the issue of whether such an injury should be characterized as a personal injury, the majority of lower courts have held that personal injuries are not cognizable under RICO.²⁵⁴ The cases that have so held have generally followed the analogous antitrust case law²⁵⁵ and the presumption that Congress does not intend to supplant state jurisdiction unless it does so

251. *See supra* notes 215–16 and accompanying text.

252. *See supra* note 192 and accompanying text.

253. *See supra* note 193 and accompanying text.

254. *See Sansone, supra* note 187, § 3.

255. *See Reiter v. Sonotone Corp.*, 442 U.S. 330, 339 (1979) (commenting in dictum that “[t]he phrase ‘business or property’ also retains restrictive significance... [and] would, for example, exclude personal injuries suffered”).

explicitly.²⁵⁶ However, the U.S. Supreme Court has expressly warned that RICO standing should not be bound by antitrust jurisprudence.²⁵⁷ The Court said that relying on antitrust concepts “could create inappropriate and unnecessary obstacles in the way of . . . a private litigant [who] would have to contend with a body of precedent—appropriate in a purely antitrust context—setting strict requirements on questions such as ‘standing to sue’ and ‘proximate cause.’”²⁵⁸

The fact that plaintiffs are left without any other remedy under ERISA weighs heavily in favor of a more liberal standing requirement. Courts have not ruled on this civil RICO standing issue in the ERISA context,²⁵⁹ but in other contexts those courts that have found no standing for RICO plaintiffs with personal injuries have uniformly done so based on the belief that adequate remedies existed in state law.²⁶⁰ In the context of ERISA, that justification is improper. Because Congress has expressly preempted state-law causes of action related to administrative benefit denials under an ERISA plan²⁶¹ and has expressly intended that RICO be broadly construed to effectuate its remedial purposes,²⁶² an exception to the civil RICO standing requirement should be carved out for personal injuries caused by a pattern of racketeering activity within the ERISA context.

Based on the four factors used to evaluate proximate cause in *Holmes v. Securities Investor Protection Corp.*, plaintiffs injured by fraudulent

256. See *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654–55 (1995).

257. See *Sedima S.P.R.L. v. Imrex Co.*, 473 U.S. 479, 498 (1985).

258. *Id.* (internal quotation omitted).

259. A search of federal cases dealing with a RICO claim alleging personal injuries in the denial of benefits under an ERISA plan has yielded no results.

260. See, e.g., *Genty v. Resolution Trust Corp.*, 937 F.2d 899, 918 (3d Cir. 1991) (“Ample law already existed to provide recovery for wrongfully inflicted personal injuries We discern no injustice in limiting a RICO plaintiff’s recovery for his personal injuries to ordinary non-RICO legal measures.”); *Grogan v. Platt*, 835 F.2d 844, 848 n.9 (11th Cir. 1988) (“Appellants of course have a remedy in a state law action based on wrongful death . . .”).

261. See 29 U.S.C. § 1144(a) (1994).

262. The U.S. Supreme Court has said:

RICO is to be read broadly. This is the lesson not only of Congress’ self-consciously expansive language and overall approach, but also of its express admonition that RICO is to ‘be liberally construed to effectuate its remedial purposes.’ The statute’s ‘remedial purposes’ are nowhere more evident than in the provision of a private action for those injured by racketeering activity.

Sedima, 473 U.S. at 498 (citations omitted).

claim denials should have standing.²⁶³ Others are not in a position to make the same claims, and the damages clearly flow from the defendant's conduct. There is no risk of double recovery because the plaintiff has no remedy under ERISA, and state-law causes of action are preempted. Fraudulent denial of medical claims and the resultant lack of necessary treatment certainly warrant deterrence.

If a plaintiff injured by a fraudulent denial of care can overcome the substantial hurdle of establishing the elements of a RICO violation—most notably the “pattern” element, the fact that the business or property injuries flow from a personal injury should not deny them standing to sue and recover civil RICO penalties.

IV. CONCLUSION

Judicial interpretation of ERISA's preemption of state tort and contract actions has evolved since ERISA's enactment in 1974. Today, with the advent of integrated delivery systems where the line between benefit administration and provision of care has been blurred, private plaintiffs who are participants in MCOs have a better chance than ever of overcoming ERISA preemption. Courts are more willing to allow claims for denial of care to be characterized as medical malpractice and are more likely to allow such state law claims to go forward. However, two trends are alarming. First, MCOs are retreating behind the shield of ERISA preemption by distancing themselves from the providers of care, making it more difficult to characterize their decisions as medical malpractice. Second, employers are increasingly choosing to self-fund rather than insure, thereby avoiding state regulation. The prospect of ERISA's amendment is dim, and those participants, like Rhonda Bast, who find themselves the victims of purely administrative decisions of self-funded plan administrators still have no meaningful remedy.

Proving all the required elements of a civil RICO violation will be difficult for many plaintiffs. Judgments awarded to successful plaintiffs may be somewhat smaller than those awarded in state malpractice or wrongful death actions and may not be as satisfying for ERISA plan participants like Rhonda Bast and her survivors²⁶⁴ who became victims of

263. *Holmes v. Securities Investor Protection Corp.*, 505 U.S. 258, 268–69 (1992).

264. Whether the survivors of a deceased victim have standing to sue will be a question of the underlying state law. A plaintiff in a civil RICO action based on wrongful denial of ERISA benefits may have to initiate the suit before the plaintiff dies. A complete discussion of this issue is beyond

the administrative decisions of self-funded plan administrators. Nonetheless, the civil RICO solution is a worthwhile and compelling avenue because the threat of branding otherwise legitimate business organizations with the “racketeer” and “corrupt” labels may provide the sort of deterrence so sorely lacking in the ERISA regulatory scheme.

the scope of this Comment, but in *Jerry Kubecka, Inc. v. Avellino*, 898 F. Supp. 963, 969 (E.D.N.Y. 1995), the personal representative of the deceased did not have standing to sue under § 1964(c) because under the New York wrongful-death statute the personal representative did not step into the shoes of the decedent and therefore was not “injured in his business or property.” However, if the injured plaintiff initiates a civil RICO action, the lawsuit should survive the death of the plaintiff. See *Faircloth v. Finesod*, 938 F.2d 513, 518 (4th Cir. 1991) (holding civil RICO remedial, not punitive, so actions survive death of plaintiff).