

Note

Managed Care Liability, ERISA Preemption, and State “Right to Sue” Legislation in *Aetna Health, Inc. v. Davila*

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I. INTRODUCTION

A physician in Joliet contacted an insurance company in order to obtain approval to admit a patient for treatment. An employee of the insurer responded, “No, we won’t go along with your suggestion, your medical advice, send the patient home.” The doctor in Joliet asked, “Are you a doctor?”

He said, “No.”

The doctor asked, “Are you a nurse?”

He said, “No.”

The doctor asked, “Do you have a college degree?”

The man said, “Well, no.”

The doctor asked, “Well, what is your training?”

He said, “Well, I have a high-school diploma, and I have the insurance company manual that I’m reading from.”¹

As insurance companies increasingly rely on administrative decisions based on written policy rather than individual consideration, health insurer liability for denials of necessary treatment is an area of law that has seen considerable growth in litigation over the past thirty years.² A

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1. 144 CONG. REC. S9733-36 (daily ed. Sept. 1, 1998) (statement of Sen. Durbin).

2. See generally David L. Trueman, *Will the Supreme Court Finally Eliminate ERISA Preemption?*, 13 ANNALS HEALTH L. 427 (2004) (detailing the history of federal and state litigation regarding treatment denials and the evolution of various theories of liability in the judicial system).

Health Maintenance Organization (“HMO”) is a type of Managed Care Organization (“MCO”) that provides comprehensive health care to voluntarily enrolled individuals and families with limited referral to outside specialists financed by premium payments in advance.³ Congress established MCOs through the Health Maintenance Act of 1973 in an attempt to curtail rising health care costs in the United States.⁴ MCOs, in part, provide discounted prices for health insurance by utilizing cost-containment mechanisms that reduce the quantity and availability of medical treatments to the beneficiary or participant.⁵

At least 170 million Americans are currently enrolled in MCOs for the purposes of health care insurance.⁶ Every day, MCOs make numerous administrative decisions such as the one described above that routinely deny sick persons medically necessary treatments, which can sometimes lead to serious injury.⁷ Annually, a lack of necessary medical care contributes to nearly 66.5 million avoidable sick days and more than \$1.8 billion in excess medical costs in the United States.⁸

In 1974, Congress passed the Employment Retirement Income Security Act (“ERISA”) with the primary focus of guaranteeing uniform regulation of pension benefits to preserve the economic advantages of large multi-state corporations.⁹ ERISA, in part, created an exclusive

3. MERRIAM-WEBSTER ONLINE DICTIONARY, at www.m-w.com (last visited March 8, 2005) (defining an HMO as “an organization that provides comprehensive health care to voluntarily enrolled individuals and families in a particular geographic area by member physicians with limited referral to outside specialists and that is financed by fixed periodic payments determined in advance”).

4. See Michael Misocky, *The Patients’ Bill of Rights: Managed Care Under Siege*, 15 J. CONTEMP. HEALTH L. & POL’Y 57, 57–58 (1998) (noting the development of MCOs as a means of controlling “skyrocketing health care costs”); 42 U.S.C. § 300e (2000) (defining the purpose of the Act as a means to provide financial assistance to qualified HMOs in order to promote their development to reduce healthcare costs). MCOs were established in an attempt to reduce costs by taking advantage of pooling health risks into large groups, permitting easier predictability of need and lower costs through bulk purchasing.

5. See Misocky, *supra* note 4, at 58 (illustrating the means with which an MCO controls costs by reducing freedom of choice, freedom of speech, and freedom of association for physicians).

6. National Conference of State Legislatures, *MANAGED CARE INSURER LIABILITY*, available at <http://ncsl.org/programs/health/liable.htm> (last updated Feb. 2005) [hereinafter NCSL Report].

7. National Committee for Quality Assurance, *THE STATE OF HEALTH CARE QUALITY 2004: INDUSTRY TRENDS AND ANALYSIS*, available at <http://www.ncqa.org/communications/SOMC/SOHC2004.pdf> (2004) [hereinafter NCQA Report].

8. *Id.*

9. H.R. REP. NO. 93-533 (1973), reprinted in 1974 U.S.C.C.A.N. 4639, 4646–47.

The enactment of progressive and effective pension legislation is also certain to increase stability within the framework of our nation’s economy, since the tremendous resources and assets of the private pension plan system are an integral part of our economy [I]t is evident that the operations of employee benefit plans are increasingly interstate. The uniformity of decision that [ERISA] is designed to foster

remedy for certain wrongful denial of care claims in federal court, effectively preempting any state claims against qualified health care insurers.¹⁰ This remedial scheme limited monetary recovery to the cost of the wrongfully denied services and precluded punitive damages against the insurer.¹¹

In an attempt to circumvent the restrictive nature of remedies under ERISA, the Texas legislature passed the Texas Health Care Liability Act (“THCLA”) in 1997.¹² THCLA made available a remedy for negligent denial of care in state courts, allowing for compensatory as well as punitive damage recovery.¹³ Ruby Calad and Juan Davila separately brought claims under THCLA against their HMOs in state court, that removed the cases to federal court.¹⁴ This Note will investigate the procedural history and eventual Supreme Court decision relating to the consolidated Calad and Davila cases.¹⁵

In a unanimous decision, the United States Supreme Court reversed the Fifth Circuit’s ruling, holding that both Calad and Davila’s claims for relief in state court under THCLA were preempted by section 502(a) of ERISA.¹⁶ This holding invalidated sections of THCLA related to raising state claims for negligent denials of treatment by ERISA-qualified HMOs and had a broad impact for similar statutes passed in a number of additional states.¹⁷

Part II of this Note will begin with a discussion of ERISA, the historical interpretation of ERISA preemption under section 502(a) and

will help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws.

Id. at 4646–50.

10. 29 U.S.C. § 1132 (2000 & West Supp. 2004).

11. *See id.* (limiting recovery to equitable forms of recovery, including recovery for the cost of treatment denied and injunctive relief).

12. TEX. CIV. PRAC. & REM. CODE ANN. § 88.002 (Vernon Supp. 2004).

13. *Id.*

14. *Roark v. Humana, Inc.*, 307 F.3d 298, 302 (5th Cir. 2002), *rev’d sub nom. Aetna Health, Inc. v. Davila*, 124 S. Ct. 2488 (2004).

15. The federal district courts in both cases refused to remand back to the state courts based upon the preemptive power of ERISA. *Id.* The Fifth Circuit Court of Appeals consolidated both Calad’s and Davila’s claims with two similar claims brought under THCLA and reversed the district courts’ decisions concerning Calad’s and Davila’s claims. *Id.* at 306. The HMOs appealed and were granted certiorari to the United States Supreme Court, and raised the issue of defining the preemptive scope of ERISA concerning wrongful denials of treatment by HMOs. *Aetna Health Inc. v. Davila*, 124 S. Ct. 2488, 2492 (2004).

16. *Id.* at 2493.

17. *See* NCSL Report, *supra* note 6 (reviewing states that have passed “right to sue” legislation that could have a potential negative impact from the *Davila* holding, including Arizona, California, Georgia, Louisiana, Maine, New Jersey, North Carolina, Oklahoma, Oregon, Texas, Washington, and West Virginia).

section 514, and legislative responses at the state and federal level through 2004.¹⁸ Part III will analyze the district court, United States Court of Appeals for the Fifth Circuit, and United States Supreme Court opinions concerning Ruby Calad and Juan Davila's cases leading up through the *Aetna Health v. Davila* case.¹⁹ Part IV will then argue that the Supreme Court correctly interpreted the preemptive scope of ERISA pertaining to wrongful denial claims.²⁰ Next, Part V will analyze the impact of the *Davila* decision on subsequent ERISA claims, state legislation outside of Texas, and potential congressional legislation revising ERISA.²¹ Finally, this Note will conclude by predicting that *Davila* has shifted political pressures and will result in more expedient congressional passage of ERISA revision through an effective federal Patients' Bill of Rights, rendering *Davila*'s holding obsolete.²²

II. BACKGROUND

ERISA is a comprehensive federal statute that regulates the creation and administration of employee pension and benefits plans.²³ Since employers traditionally provide health insurance as an important part of retirement benefits, providers of health insurance are potentially subject to ERISA regulation.²⁴

A number of actions brought in state court against HMOs have been preempted by federal law through sections 502(a) and 514 of ERISA.²⁵ Federal courts characterize the scope of ERISA preemption related to health insurance under sections 502(a) and 514 as a struggle between

18. See *infra* Part II (discussing the history, judicial interpretation, and state and federal legislative responses to ERISA preemption); see also *infra* notes 42–45 and accompanying text (discussing the codification of sections 502(a) and 514 of ERISA).

19. See *infra* Part III (reviewing the *Davila* case).

20. See *infra* Part IV (analyzing the unanimous and concurring opinions from *Davila*).

21. See *infra* Part V (examining the impact of the *Davila* case on individuals, states and the federal government).

22. See *infra* Part VI (concluding that the net result of the *Davila* decision will be to catalyze change to ERISA through congressional action).

23. 29 U.S.C. §§ 1001-03 (2000 & West Supp. 2004).

24. 29 U.S.C. § 1132(a)(1).

A civil action may be brought—(1) by a participant or beneficiary—(A) for the relief provided for in subsection (c) of this section, or (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

Id.

25. Kathleen J. McKee, Annotation, *Liability of Third-Party Health-Care Payor for Injury Arising from Failure to Authorize Required Treatment*, 56 A.L.R. 5th 737 (2004) (collecting and discussing healthcare cases dealing with liability and ERISA preemption for negligent denial of authorization to treat).

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the need for consistent national regulatory policy and a desire to provide substantive remedies for injured parties.²⁶

Accordingly, this Part begins by describing ERISA's statutory structure and the legislative intent behind ERISA's enactment.²⁷ Next, this Part discusses the historical interpretation of ERISA's preemptive scope in the federal judiciary.²⁸ This Part concludes by examining THCLA, its counterparts in various states, and prior attempts at ERISA reform in Congress.²⁹

A. ERISA—Construction and Design

ERISA's scope is extraordinarily wide and its construction complex; the provisions of ERISA have been widely litigated in the judicial system.³⁰ The Supreme Court has relied on its interpretation of congressional intent and the plain language reading of the statute in its rulings concerning ERISA preemption.³¹ Therefore, a critical reading of the statutory language of ERISA and its underlying legislative intent is vital to gain a thorough understanding of its judicial interpretation over the years.³²

1. ERISA's Statutory Structure and Remedial Mechanism

ERISA was enacted in 1974 to provide for comprehensive federal regulation of employee benefits, including both pension plans and welfare benefit plans such as health insurance.³³ These statutory

26. Andrew M. Campbell, Annotation, *Construction and Application of Employee Retirement Income Security Act of 1974 (29 U.S.C.A. §§ 1001 et seq.) by United States Supreme Court*, 150 A.L.R. FED. 441, § 2 (2004) (noting that “the Supreme Court cases interpreting the ERISA preemption provisions reflect a tension between the goals of preempting state regulation of the administration of employee benefit plans . . . and traditional federal deference to state regulation of insurance embodied in the insurance-savings clause”).

27. See *infra* Part II.A (discussing ERISA's statutory construction and intentional design by Congress).

28. See *infra* Part II.B (analyzing the judicial interpretation of ERISA's preemptive scope).

29. See *infra* Part II.C (detailing the various state and federal attempts at legislation to either circumvent or amend ERISA prior to 2004).

30. See generally Campbell, *supra* note 26, § 3–5 (reviewing litigation in over fifty cases that reached the Supreme Court concerning various provisions of ERISA and their judicial interpretations).

31. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 44–46 (1987) (reviewing the intent behind ERISA's enactment as a justification for the Supreme Court's interpretation of ERISA's wide preemptive scope).

32. See, e.g., Lorraine Schmall & Brenda Stephens, *ERISA Preemption: A Move Towards Defederalizing Claims for Patients' Rights*, 42 BRANDEIS L.J. 529, 541–43 (2004) (analyzing the legislative intent of the drafters of § 502(a)(2) of ERISA compared to the interpretation of that section by the Supreme Court).

33. Campbell, *supra* note 26, § 2.

provisions regulate funding and vesting provisions for pension plans, fiduciary responsibility of plan trustees, government pensions, plan termination, multi-employer pension plans, and civil and criminal penalties for violations of its provisions.³⁴ The provisions of ERISA were enacted initially, in part, to address public concern that funds of private pension plans were being mismanaged and abused.³⁵

The primary rationale used by the courts justifying preemption of state claims is the legislative intent behind ERISA.³⁶ When enacting ERISA, Congress intended to create a uniform national regulatory scheme for employee benefits and pension plans.³⁷ As health insurance is often made available through employer-provided benefits in the United States, ERISA regulates the provision and administration of that benefit.³⁸ ERISA's language indicates its function as a mechanism to allow for multi-state organizations to more efficiently manage their employee benefit plans by minimizing interference from state legislatures.³⁹ In order to successfully create a uniform regulatory mechanism, ERISA requires the implementation of a uniform enforcement mechanism as well.⁴⁰

The structure of ERISA delineates a remedial mechanism for

34. *Id.*

35. U.S. Department of Labor, *History of EBSA and ERISA*, at <http://www.dol.gov/ebsa/aboutebsa/history.html> (last visited Feb. 20, 2005).

36. *See* 29 U.S.C. § 1001(a) (2000) (discussing benefit plans that affect interstate commerce and the federal taxing power); *Pilot Life*, 481 U.S. at 45–46 (summarizing the congressional intent behind ERISA as providing that “[i]f a state law ‘relate[s] to . . . employee benefit plan[s],’ it is pre-empted” and concluding that the expansive express preemption provisions of ERISA are designed to establish pension plan regulation as an exclusively federal issue); *see generally infra* Part II.A.2 (describing in detail the legislative intent of Congress concerning ERISA's passage).

37. Schmall & Stephens, *supra* note 32, at 542.

The federal statute does not go about protecting plan participants and their beneficiaries by requiring employers to provide any given set of minimum benefits, but instead controls the administration of benefit plans, as by imposing reporting and disclosure mandates, participation and vesting requirements, funding standards, and fiduciary responsibilities for plan administrators.

Id.

38. *See generally* Campbell, *supra* note 26, § 2 (summarizing the content and scope of ERISA regulation of health insurance providers).

39. *See* 29 U.S.C. § 1001(a) (2000) (revealing the intent of Congress to protect the “revenue of the United States” through the creation of minimum standards for uniform treatment of employee benefit plans through enactment of ERISA); Schmall & Stephens, *supra* note 32, at 542 (explaining the intent of the drafters of ERISA concerning protection of pension funds without specific concern for medical care).

40. *See* 29 U.S.C. § 1001(a) (2000) (describing the policy behind the enactment of ERISA and describing the need for protections to be afforded participating beneficiaries of ERISA-regulated plans).

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qualified denials of health benefits.⁴¹ Section 502(a)(3), codified in 29 U.S.C. § 1132(a), specifically applies to civil enforcement for potential wrongful denials of claims by beneficiaries of ERISA-regulated plans.⁴² This remedial plan, founded on principles of equity, limits recovery of damages for wrongful denial of treatment claims to the cost of benefit denied.⁴³ Alternatively, under this section injunctive relief is made available to claimants, as well as a description of future eligibility prior to an actual denial of benefits.⁴⁴ Section 514 of ERISA, codified in 29 U.S.C. § 1144(a), establishes a defense against laws enacted by state legislatures that regulate ERISA plans.⁴⁵

Although the intent behind ERISA was to create a uniform regulatory mechanism that superseded state law, Congress created a narrow exception in deference to the traditional regulation of insurers by the states.⁴⁶ The “savings clause” of section 514 provides that state laws in the general regulation of insurance, banking, or securities are not subject to preemption, permitting states to preserve some regulatory power over certain ERISA-regulated organizations.⁴⁷ Nevertheless, the “deemer clause” of section 514 limits the scope of the savings clause by creating an exception for self-insured health plans, putting them outside the scope of state regulation of insurance companies.⁴⁸ This nuance of the ERISA scheme permits traditionally state-regulated industries to be subject to general state supervision, while limiting certain benefit plans that meet the self-insured exception to regulation by federal statute alone.⁴⁹

41. See 29 U.S.C. § 1132(a) (2000) (reciting the various means of civil enforcement for infractions made by ERISA-regulated employee benefit plans in federal courts).

42. 29 U.S.C. § 1132(a)(1) (2000) (stating that “[a] civil action may be brought . . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan”).

43. *Id.*

44. 29 U.S.C. § 1132(a)(1).

45. 29 U.S.C. § 1144(a) (2000) (“[T]he 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.”).

46. See Trueman, *supra* note 2, at 433–35 (describing the legislative intent behind the enactment of the “savings clause” of ERISA).

47. 29 U.S.C. § 1144(b)(2)(A) (2000) (stating that “nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.”).

48. 29 U.S.C. § 1144(b)(2)(B) (2000) (stating that “an employee benefit plan described in section 1003(a) . . . shall be deemed to be an insurance company . . . for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies”).

49. Trueman, *supra* note 2, at 433–34 (detailing the scope of section 514 of ERISA and its application to organizations that meet the terms of the “deemer clause” exception).

The Supreme Court has interpreted nearly all state-based claims against HMOs that supplant or enhance the civil remedial scheme of ERISA as being completely preempted by section 502(a).⁵⁰ Under the doctrine of complete preemption, section 502(a) of ERISA precludes state jurisdiction over wrongful denial of treatment claims even if the body of the original complaint does not contain a controlling federal question issue.⁵¹ Section 514(a) of ERISA, in contrast, has been interpreted as an example of conflict preemption based on the language of the statute.⁵² Under the conflict preemption doctrine, section 514(a) is regarded as preempting claims that “relate to” the determination of benefits under an employee benefit plan regulated by ERISA.⁵³

50. See BLACK'S LAW DICTIONARY 302 (8th ed. 2004) (defining “complete preemption” as “[t]he rule that a federal statute’s preemptive force may be so extraordinary and all-encompassing that it converts an ordinary state-common-law complaint into one stating a federal claim for purposes of the well-pleaded-complaint rule”); see also *id.* at 303 (defining the “well-pleaded complaint rule” as requiring the body of the complaint to state a “controlling issue of federal law” in order for federal-question jurisdiction to exist).

A number of actions originally brought in state court have been pre-empted by federal law, specifically by sections of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C.A. §§ 1001, et seq. ERISA is a comprehensive federal statute which regulates the creation and administration of employee pension and benefits plans. It contains a pre-emption clause which provides that ERISA supersedes any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.

McKee, *supra* note 25, § 2a. See Ronald F. Hoffman & Mark O. Hiepler, *An Easy Out for Managed Care*, WASH. POST, Apr. 4, 1998, at A19 (describing the preemptive scope of ERISA as denying state-law remedies for HMO misconduct). See generally *FMC Corp. v. Holliday*, 498 U.S. 52, 70–71 (1990) (holding a state law prohibiting subrogation of health plans to a plan member’s tort recovery was preempted by section 514(a) of ERISA). The doctrine of preemption has its basis in the Supremacy Clause of the United States Constitution, which permits federal statutes to supersede state legislation.

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

U.S. CONST. art. VI, cl. 2.

51. Trueman, *supra* note 2, at 429 (“‘Complete preemption’ is an exception to the ‘well-pleaded complaint rule.’ . . . If complete preemption is implicated, a defendant converts a plaintiff’s state law claim into a federal question merely by utilizing the defense.” (quoting *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63–64 (1987))).

52. See BLACK'S LAW DICTIONARY 518 (8th ed. 2004) (defining the “doctrine of conflict preemption” as “[t]he principle that federal or state law can supersede or supplant state or local law that stands as an obstacle to accomplishing the full purposes and objectives of the overriding federal or state law”).

53. See 29 U.S.C. § 1144(a) (2000) (“Except as provided in subsection (b) of this section, 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* described in section 1003(a) of this title and not exempt under section 1003(b) of this title.” (emphasis added)); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45 (1987) (summarizing the scope of section

Although this distinction is subtle, the preemptory power of section 502(a) is therefore greater in scope than section 514, and more likely to be used as a basis for preemption of state-law based claims, while section 514 will be more often utilized as a defense by the insurer.⁵⁴

2. Legislative Intent Underlying ERISA's Enactment

Prior to 1974, plaintiffs claiming recovery for treatment denials from employee benefit plans relied upon state contract and trust law to recover benefits in the judicial system.⁵⁵ This approach had substantial procedural and jurisdictional hurdles to overcome in order to allow injured beneficiaries to recover.⁵⁶ Realizing the inadequacy of this system, Congress decided to provide a federal system that would permit beneficiaries to recover for wrongful benefit denials in federal court and provide a uniform standard of regulation.⁵⁷

On January 3, 1973, Representative John H. Dent from Pennsylvania introduced House Resolution Two, the Employee Benefit Security Act, during the Ninety-Third Session of Congress.⁵⁸ This proposal eventually led to the passage of Public Law 93-406 on September 2, 1974, in the form of ERISA, which repealed the Welfare and Pension Plans Disclosure Act.⁵⁹ Initially, Congress primarily intended to regulate the pension plans of multi-state employers for the benefit of their participants.⁶⁰ A large portion of these benefits entailed health

514(a) of ERISA as preempting state law claims relating to employee benefit plans).

54. See Trueman, *supra* note 2, at 434 (contrasting the effect of sections 502(a) and 514's preemptive scope and applicability).

55. See George Lee Flint, Jr., *ERISA: Reformulating the Federal Common Law for Plan Interpretation*, 32 SAN DIEGO L. REV. 955, 955-56 (stating that before ERISA's enactment, participants had to use state contract and trust law to recover denied benefits from private employee plans); H.R. REP. NO. 93-533 (1973), reprinted in 1974 U.S.C.C.A.N. 4639, 4643 (describing the system of regulation prior to ERISA's passage by stating that "[i]n the absence of adequate federal standards, the participant is left to rely on the traditional equitable remedies of the common law of trusts").

56. See Flint, *supra* note 55, at 956-58 (discussing such jurisdictional obstacles for recovery of benefit denials prior to ERISA's enactment such as rules requiring service on all trustees).

57. *Id.*

58. H.R. 2, 93rd Cong. (1973), available at <http://thomas.loc.gov> (last visited Feb. 20, 2005).

59. *Id.* ("Repeals the Welfare and Pension Plans Disclosure Act except that such Act shall continue to apply to any conduct and events which occurred before the effective date of this Act"). The Welfare and Pension Plans Disclosure Act was passed in 1958 to reduce welfare and pension plan abuses by requiring the administrators of all such plans to furnish participants and beneficiaries with a written description and annual financial status report for each plan. Welfare and Pension Plans Disclosure Act of 1958, Pub. L. No. 85-836, 72 Stat. 997 (1958).

60. H.R. REP. NO. 93-533 (1973), reprinted in 1974 U.S.C.C.A.N. 4639, 4640.

The Employee Benefit Security Act as reported by the Committee is designed to remedy certain defects in the private retirement system which limit the effectiveness of the system in providing retirement income security. The primary purpose of the bill is

insurance coverage; therefore, Congress also brought health benefit plans under the umbrella of ERISA jurisdiction.⁶¹ Over the years, the vast increase in health insurance coverage through employment-based insurance has defined ERISA as a primary means of regulation for health benefits for millions of Americans.⁶²

Congress enacted 29 U.S.C. § 1001 as part of the statutory scheme of ERISA to protect the various pension and retirement plans of multi-state corporations through a uniform series of regulations that superceded state-level regulations.⁶³ Congress considered the establishment of ERISA preemption as an essential element of that regulatory scheme in order to prevent inconsistent state-level regulation of pension programs.⁶⁴ As an integral part of the regulation of benefit determinations, the House sponsors of the bill explicitly noted the civil remedial mechanism as exclusively available under federal law, not to be circumvented by other state-imposed liability.⁶⁵ These remedial

the protection of individual pension rights. . . . In broad outline, the bill is designed to:

- (1) establish equitable standards of plan administration;
- (2) mandate minimum standards of plan design with respect to the vesting of plan benefits;
- (3) require minimum standards of fiscal responsibility by requiring the amortization of unfunded liabilities;
- (4) insure the vested portion of unfunded liabilities against the risk of premature plan termination; and
- (5) promote a renewed expansion of private retirement plans and increase the number of participants receiving private retirement benefits.

Id.

61. Michael B. Snyder, Benefits Guide § 3:28.5 (2004) (stating that “[i]t is clear that the original drafters of this extremely broad body of law intended to cover mainly retirement benefits, even though the definition of “plan” certainly covers health care (and other welfare) plans”).

62. NCSL Report, *supra* note 6.

63. See H.R. REP. NO. 93-533 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4643 (“The proposed bill would, therefore, establish minimum standards of vesting, funding, and fiduciary and a system of compulsory benefit insurance to protect the security of pension rights.”). See generally 29 U.S.C. § 1001 (2000) (delineating the general purpose behind ERISA’s enactment as to protect pension and retirement plans of employees from non-uniform state regulation).

64. See H.R. Rep. No. 93-1280 (1973), *reprinted in* 1974 U.S.C.C.A.N. 5038, 5162 (“[T]he provisions of title I are to supersede all State laws that relate to any employee benefit plan that is established by an employer engaged in or affecting interstate commerce or by an employee organization that represents employees engaged in or affecting interstate commerce.”).

65. See *id.* at 5188. The civil remedies in section 502(a) allow:

[I]ndividual participants and beneficiaries will also be able to bring suit in Federal court in such instances, as well as to obtain redress of fiduciary violations. In addition, participants and beneficiaries may bring suit to recover benefits denied contrary to the terms of their plan, and where such claims by participants or beneficiaries do not involve application of the substantive requirements of this legislation, they may be brought in either State or Federal courts of competent jurisdiction. It is intended that such actions will be regarded as arising under the laws of the United States, in similar

mechanisms were created in order to protect the general welfare of the people and to prevent from abuses; nevertheless, their application has deviated from this original goal.⁶⁶

B. Judicial Interpretation of ERISA Preemption

Over the past thirty years, federal judiciary interpretation of ERISA preemption has evolved.⁶⁷ Although courts broadly interpreted ERISA's preemptive scope expressed in sections 502 and 514 in cases prior to the year 2000, this has been subject to substantial debate within the judiciary in recent years.⁶⁸ Accordingly, this Section will review ERISA interpretation in the federal courts and state responses to the litigation leading up to *Davila*.

1. Preemption Cases Prior to 2000

Prior to 2000, federal courts generally interpreted ERISA as having broad preemptory power that precluded a wide variety of claims from being raised in state court.⁶⁹ The Supreme Court's ruling in a pair of cases—*Massachusetts Mutual Life Insurance Co. v. Russell* and *Pilot Life Insurance Co. v. Dedeaux*—set a precedent for broad preemption

fashion to those brought under section 301 of the Labor Management Relations Act. *Id.*; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 55–56 (1987) (describing the preemptive scope of section 301 of the Labor Management Relations Act as having “pre-emptive force . . . so powerful as to displace entirely any state cause of action ‘for violation of contracts between an employer and a labor organization.’ Any such suit is purely a creature of federal law . . .”); McKee, *supra* note 25, § 2a (stating that ERISA's preemptive scope extends so far as to preempt claims that leave no comparable federal remedy under the regulatory scheme of ERISA).

66. 29 U.S.C. § 1001 (2000).

[T]hat owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans.

Id.

67. See generally Campbell, *supra* note 26, § 2 (considering the construction and application of ERISA's preemptive scope in United States Supreme Court cases since ERISA's passage in 1974).

68. See *id.* (detailing an overview of the history of Supreme Court cases dealing with interpretations of ERISA's preemptive scope relating to state claims for treatment denials).

69. See, e.g., *Turner v. Fallon Cmty. Health Plan, Inc.*, 127 F.3d 196 (1st Cir. 1997) (holding that ERISA does not provide damages remedy for a wrongful denial of treatment); *Kuhl v. Lincoln Nat'l. Health Plan of Kan. City, Inc.*, 999 F.2d 298, 299 (8th Cir. 1993) (ruling that a state-based claim against an insurer for delaying a surgery under a welfare benefit plan was preempted by ERISA); see McKee, *supra* note 25, § 6 (reviewing a series of cases decided prior to 2000 by the Fifth, Eighth, and Ninth Circuits that upheld broad preemptory power of ERISA concerning a failure to authorize treatment by ERISA-qualified health benefit plans).

that the federal judiciary followed until *Pegram v. Herdrich* in 2000.⁷⁰

The Supreme Court has interpreted section 502(a) as providing an exclusive remedy for wrongful denial of treatment claims in federal court, with particularly broad application in early interpretations.⁷¹ The first interpretation of ERISA's preemptive scope was *Massachusetts Mutual Life Insurance Co. v. Russell*, a case concerning the untimely processing of a health care plan beneficiary's claims.⁷² The Court considered the issue of whether a plan participant could recover punitive or extracontractual compensatory damages under section 409 of ERISA.⁷³ After analyzing the legislative intent and amendments made to ERISA prior to its passage in light of section 502(a)'s comprehensive remedial scheme, the Court concluded that section 409 did not provide for extracontractual damages.⁷⁴ Nevertheless, the Court specifically left open a small window of opportunity, restricting its decision to section 409(a) and not considering the possibility of extracontractual damages under section 502(a).⁷⁵

70. *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); see Trueman, *supra* note 2, at 430 (describing the foundational complete preemption cases of *Pilot Life* and *Russell* as being followed by federal courts that "routinely ruled that claims alleging wrongful denials of care are attacks on the mechanism by which benefits are administered and should be preempted and dismissed as attempts to improperly obtain a remedy"); *infra* Part II.B.3 (discussing *Pegram v. Herdrich* case). In *Pegram*, the Supreme Court ruled on a claim for wrongful denial of treatment relating to the actions of an HMO employee in the dual role of treating physician as well as administrative agent. *Pegram v. Herdrich*, 530 U.S. 211, 215 (2000). The Court held that determinations involving the mixture of treatment and eligibility decisions made by the administrative employee were outside of the scope of ERISA and therefore subject to liability in state courts. *Id.* at 237 ("We hold that mixed eligibility decisions by HMO physicians are not fiduciary decisions under ERISA.").

71. See *Pilot Life*, 481 U.S. at 56 (holding that ERISA section 502(a)'s civil remedial scheme was clearly intended for all suits alleging improper processing of claims).

72. *Russell*, 473 U.S. at 136.

73. *Id.* See 29 U.S.C. § 1109(a) (2000) (detailing section 409 of ERISA). The language of 29 U.S.C. § 1109(a) details section 409 of ERISA as providing that:

(a) Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this title shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.

Id.

74. *Russell*, 473 U.S. at 148. See generally Misocky, *supra* note 4, at 97–98 (noting that persons injured by their managed care companies' decisions concerning medical treatment are in many cases limited to the dollar value of the benefit denied).

75. *Mass Life*, 473 U.S. at 139 n.5 ("Because respondent relies entirely on § 409(a), and expressly disclaims reliance on § 502(a)(3), we have no occasion to consider whether any other provision of ERISA authorizes recovery of extracontractual damages."); *id.* at 145–46 ("It is true that an early version of the statute contained a provision for 'legal or equitable' relief that was

Following its decision in *Massachusetts Life*, the Supreme Court reinforced and expanded its determination of ERISA's preemptive scope in several key cases.⁷⁶ First, in *Pilot Life Insurance Co. v. Dedeaux*, the Court considered claims for denial of disability benefits to an ERISA-regulated plan beneficiary.⁷⁷ The Court affirmed the granting of summary judgment in favor of the insurer, declaring that the doctrine of complete preemption invoked by ERISA preempted state law claims.⁷⁸ The Supreme Court stated that section 514(a) of ERISA expressly preempts a claim that "relates to" an employee benefit plan.⁷⁹ Furthermore, the Court also emphasized the broad complete preemptive power of section 502(a), particularly looking to policy-based rationale for exclusive civil enforcement of benefit denials through ERISA.⁸⁰ The Court emphasized the necessity of a uniform system of enforcement in order to guarantee equitable treatment of multi-state insurers and to permit their efficient function.⁸¹ Finally, the Court expanded the rule of law from *Massachusetts Life*, concluding that extracontractual damages could not be awarded for any ERISA-based claim, stating that Congress only authorized those damages expressly stated within the civil remedial mechanism of section 502(a)(3).⁸²

Following the precedent set forth in the *Pilot Life* and *Massachusetts Life* cases, the Supreme Court continued to uphold the wide-ranging

described in both the Senate and House Committee Reports as authorizing 'the full range of legal and equitable remedies available in both state and federal courts.'" (citing H.R. REP. NO. 93-533 (1973), reprinted in 1974 U.S.C.C.A.N. 4838, 4871)). But that language appeared in Committee Reports describing a version of the bill before the debate on the floor and before the Senate-House Conference Committee had finalized the operative language. *Id.* In the bill passed by the House of Representatives, and ultimately adopted by the Conference Committee, the reference to legal relief was deleted. *Id.*

76. See, e.g., *Pilot Life Ins.*, 481 U.S. 41, 44-46 (citing Congressional intent as justifying ERISA's wide preemptive scope).

77. *Id.* at 43.

78. *Id.* at 56 ("[T]he civil enforcement scheme of ERISA makes clear its intention that all suits brought by beneficiaries or participants asserting improper processing of claims under ERISA-regulated plans be treated as federal questions governed by § 502(a).").

79. *Id.* at 47.

80. *Id.* at 56.

81. *Id.*

82. *Id.* at 56

The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. 'The six carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted . . . provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.'

Id. (quoting *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)).

preemptive power of ERISA.⁸³ In 1987, the Court decided the case of *Metropolitan Life Insurance Co. v. Taylor*.⁸⁴ In *Metropolitan Life*, the Court considered a wrongful termination of disability benefits by an ERISA-regulated employer.⁸⁵ In most circumstances, a claim can only be subject to preemption if it follows the “well-pleaded complaint” rule.⁸⁶ Nevertheless, the Court held that the “well-pleaded complaint” rule did not apply to cases of ERISA preemption because of ERISA’s extraordinary preemptive power, preempting claims where the complaint brought by the plaintiff only raised state law causes of action.⁸⁷

Consistent with the broad interpretation of ERISA’s preemptive scope evidenced in prior rulings by the United States Supreme Court, the Fifth Circuit in *Corcoran v. United Healthcare* held that a state-based tort claim for wrongful denial of hospitalization by an ERISA-regulated health plan was preempted by ERISA.⁸⁸ The court considered the language of the statute, noting that there was an explicit provision stating that ERISA’s remedial mechanism would supersede any and all state laws affecting ERISA-regulated employee benefit plans.⁸⁹ The Fifth Circuit determined that the boundary of ERISA’s preemptive scope extended to regulate medical or benefit decisions made by the utilization reviewer in denying authorization for hospitalization.⁹⁰ In this case, the court determined that the utilization reviewer made a medical decision related to the determination of benefits and therefore

83. See generally Trueman, *supra* note 2, at 430–35 (reviewing the broad preemptive scope of ERISA in the federal judiciary prior to 2000 following the *Pilot Life* and *Russell* cases).

84. *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987).

85. *Id.* at 60–61.

86. *Id.* at 63–67 (defining the extraordinary preemptive power of ERISA section 502(a) as similar to that of section 301 of the Labor Management Relations Act of 1947 and therefore not subject to the “well-pleaded complaint” rule).

87. *Metro. Life*, 481 U.S. at 67 (“Accordingly, this suit, though it purports to raise only state law claims, is necessarily federal in character by virtue of the clearly manifested intent of Congress.”). It, therefore, arise[s] under the laws of the United States, and is removable to federal court by the defendants. *Id.* (internal citations omitted). See *infra* note 50 (defining the “well-pleaded complaint” rule).

88. *Corcoran v. United Health Care, Inc.*, 965 F.2d 1321, 1339 (5th Cir. 1992).

89. *Id.* at 1328 (“In performing this analysis we begin with any statutory language that expresses an intent to pre-empt, but we look also to the purpose and structure of the statute as a whole”).

90. *Id.* at 1332 (“The principle of *Pilot Life* that ERISA pre-empts state-law claims alleging improper handling of benefit claims is broad enough to cover the cause of action asserted here”); See THE AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE (4th ed. 2000), available at <http://education.yahoo.com/reference/dictionary> (defining “utilization review” as “[a] process for monitoring the use and delivery of services, especially one used by a managed care provider to control health care costs”).

held that ERISA preempted the state claim.⁹¹

Corroborating this view in another jurisdiction, the Seventh Circuit in *Jass v. Prudential Health Care Plan, Inc.* also interpreted ERISA's preemptive scope broadly.⁹² The court held that vicarious liability claims against an ERISA-regulated benefits provider for the negligent actions of a treating physician were not preempted by section 502 complete preemption but were preempted by the conflict preemption doctrine of section 514(a) because the claims "related to" an employee benefits plan.⁹³ In addition, the court found that a claim of negligent denial of benefits brought against an employee nurse of the insurer, who had the responsibility to make treatment decisions concerning benefits, was completely preempted under section 502(a).⁹⁴ The *Jass* court applied a three-part analysis of characteristics that considered: (1) whether the claim could have been brought under ERISA; (2) whether the claim concerned a denial of benefits; and (3) whether the claim could be resolved without interpreting the benefits contract.⁹⁵ The court ultimately found that, under this analysis, the claim brought against the nurse met each of these characteristics and was therefore subject to complete preemption, barring it from resolution under state law.⁹⁶

Following the same logic applied in *Jass*, the Eighth Circuit in *Kuhl*

91. *Corcoran*, 965 F.2d at 1331 ("Ultimately, we conclude that United makes medical decisions—indeed, United gives medical advice—but it does so in the context of making a determination about the availability of benefits under the plan.").

92. *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1485 (7th Cir. 1996) ("We conclude that Jass' [sic] state law negligence claim against Margulis and her vicarious liability claim against PruCare for Margulis' [sic] alleged negligence are within the scope of § 502(a) of ERISA and therefore completely preempted.").

93. *Id.* at 1488 ("A claim brought against a plan administrator for vicarious liability of an actual or apparent agent, while subject to 'conflict preemption' under § 514(a) is not subject to the jurisdictional doctrine of 'complete preemption' under § 502(a)").

94. *Id.* at 1495. "Dismissal of the vicarious liability claims against PruCare for Dr. Anderson's alleged negligence was also appropriate because these claims 'relate to' the benefit plan and as such are preempted by § 514." *Id.* The *Jass* court interpreted 'related to' as defined by their plain language. *Id.* at 1493. "The structure and legislative history indicate that the words 'relate to' are intended to apply in their broadest sense." *Id.* (quoting *Central States v. Neurobehavioral Ass'n.*, 53 F.3d 172, 174 (7th Cir. 1995)).

95. *Jass*, 88 F.3d at 1489.

96. *Id.*

The Rice factors all support the conclusion that Jass' [sic] claim against Margulis is really a § 502(a) denial of benefits claim. First, as a plan participant Jass was entitled to bring suit under § 502(a). In fact, the record contains an earlier complaint that Jass filed arising out of the same events Second, Jass' [sic] claim against Margulis is in effect a claim for denial of benefits Third, Jass' [sic] negligence claim against Margulis cannot be resolved without interpreting the benefits contract because that contract provided the benefits to which Jass was entitled.

Id.

v. Lincoln National Health Plan of Kansas City, Inc. held that an insurer who refused to pre-certify a surgical treatment in a timely manner was taking part in the administration of benefits.⁹⁷ The court held that the claim primarily relied on Kuhl's status as a beneficiary of the health insurance plan and was therefore preempted by ERISA.⁹⁸ The Seventh Circuit interpreted the congressional intent of ERISA section 514(a) as preempting all state laws related to any employee benefit plan.⁹⁹ The court held that even a state law that only has an incidental effect on ERISA would be preempted by its broad preemptive scope.¹⁰⁰ The court also affirmed its holding from a prior case, ruling that claims for monetary damages under section 502(a) of ERISA were not appropriate, because money damages were a legal remedy, unlike the equitable remedies provided for in ERISA.¹⁰¹ The Supreme Court again confirmed the exclusion of extracontractual damages in *Mertens v. Hewitt Associates*, where the Court held that the provision for "appropriate equitable relief" in ERISA section 502(a) precluded relief in the form of punitive damages.¹⁰²

In *Spain v. Aetna Life Insurance Co.*, the United States Court of Appeals for the Ninth Circuit held that ERISA preempted a state-law based cause of action against the administrator of an employee-health benefit plan who approved and later denied authorization for treatment.¹⁰³ The court reviewed the actions of the administrator who authorized a procedure, withdrew authorization, and then ultimately authorized the procedure two days after the patient brought suit to

97. Kuhl v. Lincoln Nat'l Health Plan of Kan. City, Inc., 999 F.2d 298, 302 (8th Cir. 1993).

98. *Id.*

99. *Id.*

Moreover, ERISA's preemption clause is not limited to laws which relate to the specific provisions of ERISA. A state law may "relate to" an employee benefit plan, and therefore be preempted, even though the state law was not designed to affect benefit plans and its effect on such plans is only incidental.

Id.

100. *Id.* ("The key to determining whether a state law is preempted is whether the state law in question 'relates to' an ERISA plan.>").

101. *Id.* at 304.

After an extensive review of the history of equitable remedies and the statutory language of section 502(a)(3), the Court concluded that damages do not constitute 'other equitable relief.' . . . The district court properly held that the Kuhls' [sic] claim for monetary damages was not cognizable under section 502(a)(3)(B)(i).

Id. (citing *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 255 (1993)).

102. *Mertens*, 508 U.S. at 260 ("We cannot agree, however, that § 502(l) establishes the existence of a damages remedy under § 502(a)(5)—i.e., that it is otherwise so inexplicable that we must give the term 'equitable relief' the expansive meaning 'all relief available for breach of trust.'").

103. *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 131 (9th Cir. 1993).

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compel authorization.¹⁰⁴ The Ninth Circuit characterized these actions as “related to” the administration and disbursement of ERISA-plan benefits, placing it within the scope of ERISA preemption in spite of the lack of available remedies within the ERISA scheme.¹⁰⁵

2. Prior Consideration of Preemption of State Law

Since federal courts generally held cases filed in state court for treatment denials to be preempted by ERISA, states responded by enacting statutory mechanisms with the intent of circumventing ERISA’s limited recovery scheme.¹⁰⁶ Prior to 2004, the Supreme Court heard several cases concerning ERISA preemption and the superseding of state-law attempts to provide regulation outside the scope of ERISA.¹⁰⁷ This precedent helped to define the boundaries of ERISA’s regulatory scheme and the scope of the “savings clause” exception to ERISA regulation.¹⁰⁸

In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, the Court considered a New York law that imposed a surcharge on commercial insurers for hospital bills that exempted Blue Cross/Blue Shield from the surcharge.¹⁰⁹ The Court rejected a pure textual interpretation of the preemptive scope of ERISA in favor of an equitable construction, noting that the broad textual interpretation of the “relates to” clause would preempt nearly any insurance regulation.¹¹⁰ Relying on the Congressional intent behind

104. *Id.*

105. *Id.* at 131–32; see McKee, *supra* note 25, § 6 (detailing the holding of the Ninth Circuit in the *Spain* case as upholding the doctrine of complete preemption as applied to ERISA).

106. See generally Robin Cheryl Miller, Annotation, *Construction and Application of State Patient Bill of Rights Statutes*, 87 A.L.R. 5th 277 (2000) (considering federal court interpretations of various attempts by states to expressly provide for state claims for treatment denials).

107. See, e.g., *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) (reviewing an Illinois statute requiring HMOs to provide independent review of disputes between primary-care physicians and HMOs for potential ERISA preemption).

108. See generally Larry J. Pittman, *ERISA’s Preemption Clause: Progress Towards a More Equitable Preemption of State Laws*, 34 IND. L. REV. 207, 212 (2001) (detailing the various holdings of federal courts reviewing potential superseding of state-law regulations affecting HMOs for ERISA preemption).

109. *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 649 (1995). See Pittman, *supra* note 108, at 214–17 (detailing the Court’s holding in *Travelers*).

110. *Travelers Ins.*, 514 U.S. at 655.

The governing text of ERISA is clearly expansive. Section 514(a) marks for preemption ‘all state laws insofar as they . . . relate to any employee benefit plan’ covered by ERISA, and one might be excused for wondering, at first blush, whether the words of limitation (‘insofar as they . . . relate’) do much limiting.

Id.

ERISA's preemptive power, the Court noted that the New York state regulation only acted as an indirect economic influence on health insurers and did not directly contradict the purpose of ERISA as a means of uniform enforcement.¹¹¹ Based on this interpretation of the statute, the Court held that the imposition of a surcharge on hospital bills was a general regulation of insurance within the "savings clause" of ERISA and therefore not preempted.¹¹²

In *Rush Prudential HMO, Inc. v. Moran*, the Supreme Court reviewed a Illinois Health Maintenance Organization Act provision of that required HMOs to provide binding independent review of disputes between a treating physician and the HMO.¹¹³ Analyzing the details of the Illinois statute, the Court found that it embodied a state regulatory scheme that provided no new cause of action under state law and did not enlarge any claims beyond the benefits already made available in section 502(a).¹¹⁴ The Court held that this state regulation fell within the "savings clause" of ERISA, did not conflict with ERISA by supplementing or supplanting its civil enforcement scheme, and thus was not subject to preemption.¹¹⁵

The Supreme Court revisited the issue of preemption of state law in *Kentucky Association of Health Plans, Inc. v. Miller*.¹¹⁶ Kentucky had enacted an "any willing provider" statute that required health insurers to include all health care providers that agreed to meet their payment terms within their networks.¹¹⁷ The Court held that this statute was a general regulation of insurance as it affected the risk pooling arrangement

111. *Id.* at 659–60 ("An indirect economic influence, however, does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself; commercial insurers and HMO's may still offer more attractive packages than the Blues.").

112. *Id.* at 668.

We acknowledge that a state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and that such a state law might indeed be pre-empted under § 514. But as we have shown, New York's surcharges do not fall into either category; they affect only indirectly the relative prices of insurance policies, a result no different from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate.

Id.

113. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 359 (2002).

114. *Id.* at 386–87 ("[T]he independent reviewer's *de novo* examination of the benefit claim mirrors the general or default rule we have ourselves recognized; and its effect is no greater than that of mandated-benefit regulation."). See Miller, *supra* note 106, § 51 (reviewing the holding in *Rush Prudential* concerning preemption under ERISA).

115. *Rush Prudential*, 536 U.S. at 387.

116. *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 331–32 (2003).

117. *Id.*

between the insurers and its beneficiaries.¹¹⁸ Affirming its prior decision in *Rush Prudential*, the Court ruled that since the “any willing provider” statutes such as the one challenged in Kentucky were general laws regulating insurance, they fell within the “savings clause” of ERISA, and were not subject to preemption.¹¹⁹

3. *Pegram v. Herdrich*: A Turning Point for ERISA Jurisprudence?

Prior to 2000, the federal courts had uniformly interpreted ERISA as broadly preempting all claims for wrongful denial of treatment that were “related to” the administration of a benefit plan.¹²⁰ The Supreme Court took the opportunity to revise this wide-ranging preemptive power in the case of *Pegram v. Herdrich*.¹²¹

In *Pegram*, the Court considered the issue of whether treatment decisions made by physician employees of an ERISA-regulated HMO are fiduciary acts and therefore preempted by ERISA.¹²² Dr. Lori Pegram, an employee of the HMO providing benefits, examined Cynthia Herdrich, the beneficiary, who had been suffering from abdominal pain.¹²³ Dr. Pegram determined that Herdrich would have to wait for eight days in order to receive an ultrasound exam.¹²⁴ Prior to the expiration of the eight day waiting period, Herdrich suffered from a ruptured appendix, resulting in peritonitis.¹²⁵ Herdrich sued Dr. Pegram

118. *Id.* at 338 (“We have never held that state laws must alter or control the actual terms of insurance policies to be deemed ‘laws . . . which regulat[e] insurance’ under § 1144(b)(2)(A); it suffices that they substantially affect the risk pooling arrangement between insurer and insured.”).

119. *Id.*

Kentucky law provides that “[a] health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky state Medicaid program and Medicaid partnerships.”

Id. (quoting KY. REV. STAT. ANN. § 304.17A–270 (Banks-Baldwin 2001)). See also David L. Bacon, *U.S. Supreme Court Holds ERISA Does Not Preempt “Any Willing Provider” Laws*, 3 BENDER’S LAB. & EMP. BULL. 5 (2003), available at <http://library.lp.findlaw.com> (last visited Jan. 16, 2005) (reviewing the Supreme Court’s ruling in the *Miller* case). “Any Willing Provider” laws are laws that require all providers that wish to take part in an HMO’s plan terms must be permitted to join the network of providers. *Id.*

120. See generally Trueman, *supra* note 2, at 430–35 (detailing the history of federal interpretation of ERISA preemption prior to 2000).

121. See *Pegram v. Herdrich*, 530 U.S. 211 (2000) (limiting the preemptive scope of ERISA as not applicable to certain cases of HMO-employed physicians making “mixed decisions of eligibility and treatment”).

122. *Id.* at 214.

123. *Id.* at 215. See generally Trueman, *supra* note 2, at 435–36 (reviewing the facts of the *Pegram* case).

124. *Pegram*, 530 U.S. at 215.

125. *Id.* See MERRIAM WEBSTER ONLINE DICTIONARY, available at <http://www.m-w.com>

and Carle, the HMO, for medical malpractice in state court, which the defendants promptly removed to federal court, arguing ERISA preemption.¹²⁶

In its opinion, the Supreme Court first differentiated prior decisions based on “treatment” relative to decisions concerning “eligibility.”¹²⁷ Next, the Court noted that many decisions fell into the category of “mixed eligibility and treatment decisions,” and that the alleged actions by Dr. Pegram fell into this category as a treating physician and administrator acting on behalf of the HMO.¹²⁸ The Court ruled mixed eligibility and treatment decisions made by HMO-employed physicians were not fiduciary decisions and therefore were not regulated by the civil remedial scheme of ERISA.¹²⁹ The Court held that a mixed eligibility and treatment decision was outside the fiduciary relationship because of the physician-patient relationship between the treating physician and the claimant.¹³⁰ Accordingly, the Court held that Herdrich’s claims were not subject to removal to federal court under ERISA, and her state-based claim of malpractice was permitted to proceed outside of the ERISA enforcement scheme.¹³¹

(last visited Oct. 25, 2004) (defining peritonitis as an inflammation of the peritoneum, which is a membrane that lines the cavity of the abdomen).

126. *Pegram*, 530 U.S. at 215–16.

127. *Id.* at 228.

What we will call pure ‘eligibility decisions’ turn on the plan’s coverage of a particular condition or medical procedure for its treatment. ‘Treatment decisions’, by contrast, are choices about how to go about diagnosing and treating a patient’s condition: given a patient’s constellation of symptoms, what is the appropriate medical response?

Id.

128. *Id.* at 229–30.

The kinds of decisions mentioned in Herdrich’s ERISA count and claimed to be fiduciary in character are just such mixed eligibility and treatment decisions: physicians’ conclusions about when to use diagnostic tests; about seeking consultations and making referrals to physicians and facilities other than Carle’s; about proper standards of care, the experimental character of a proposed course of treatment, the reasonableness of a certain treatment, and the emergency character of a medical condition.

Id.

129. *Id.* at 237.

130. *Id.*

131. *See id.* at 237 (reversing the judgment of the Court of Appeals which affirmed the preemption and removal of Herdrich’s original claims in state court to federal court under ERISA); Campbell, *supra* note 26, at § 8.5 (describing the holding of the Supreme Court in *Pegram* as ruling that “[m]ixed eligibility and treatment decisions made by health maintenance organization (HMO), acting through its physician employees, were not fiduciary acts within meaning of ERISA and, thus, could not form basis for breach of fiduciary duty claim under ERISA”).

4. Interpretation of *Pegram* in the Federal Courts Leading Up to *Aetna Health*

Following the Supreme Court's decision in *Pegram*, a series of controversial decisions in the federal judiciary and commentary from legal scholars interpreted the practical result of the *Pegram* holding on ERISA's preemptive scope both broadly and narrowly.¹³² Narrowly interpreting the holding in *Pegram*, commentators argued that *Pegram* only permitted state claims to be brought in cases where an employee physician of an HMO was making a mixed eligibility and treatment decision concerning denial of benefits.¹³³ Broader interpretations of *Pegram* contended that any mixed eligibility and treatment decision concerning denial of medical treatment permitted circumvention of ERISA preemption.¹³⁴

In 2003, the Second Circuit was the first appellate court to apply the *Pegram* exception to sections 502(a) and 514 preemption in *Cicio v. Vytra Healthcare*, holding that claims against an HMO and its physician directors for wrongful denial of treatment were not preempted as a decision involving mixed eligibility and treatment considerations.¹³⁵ The court reasoned that the precedent set in *Pegram* was a contraction of the preemptive scope of ERISA generally and that *Pegram* stood for the principle that any mixed decisions of eligibility and treatment were outside the scope of ERISA.¹³⁶

The Eleventh Circuit adopted this interpretation in *Land v. CIGNA Healthcare of Florida*, ruling on a case concerning negligent denial of hospitalization by an HMO-employed nurse for an infection in a patient's hand and finger.¹³⁷ The court held that the nurse's determination involved a "mixed eligibility and treatment decision."¹³⁸

132. See Trueman, *supra* note 2, at 438–39 (arguing for a broad interpretation of the *Pegram* exception to ERISA preemption); Dionne Koller Fine, *Physician Liability and Managed Care: A Philosophical Perspective*, 19 GA. ST. U. L. REV. 641, 663 (2003) (describing the changing environment of managed care and arguing for a more restrictive view of treating physician liability concerning mixed decisions of eligibility and treatment).

133. See generally J. Keith Pollette, *ERISA Preemption of "Mixed Eligibility and Treatment Decisions" by HMOs*, 27 AM. J. TRIAL ADVOC. 393, 420–21 (2003) (describing the more narrow interpretation of *Pegram* as applied in the circuit courts following *Davila*).

134. See Trueman, *supra* note 2, at 438–39 (arguing for a broader interpretation of *Pegram* that holds administrative agents of HMOs liable in state courts for "mixed decisions of treatment and eligibility" as well as treating physician-employees of the HMO).

135. *Cicio v. Does*, 312 F.3d 83, 106 (2d Cir. 2003); Trueman, *supra* note 2, at 446.

136. *Cicio*, 312 F.3d at 99.

137. *Land v. CIGNA Healthcare of Fla.*, 339 F.3d 1286, 1288 (11th Cir. 2003), *rev'd* 381 F.3d 1274 (11th Cir. 2004).

138. *Id.* at 1292.

Relying on its interpretation of the Supreme Court's holding in *Pegram*, the circuit court held that the actions of the nurse-administrator employed by the HMO were outside of the scope of ERISA's preemptive power.¹³⁹

In contrast, the Third Circuit read *Pegram* more narrowly in the case of *Pryzbowski v. U.S. Healthcare, Inc.*, in which the court responded to a claim of delayed approval of medically necessary surgery by the HMO's administrators that allegedly caused injury to the plan participant.¹⁴⁰ The court agreed with a narrow interpretation of *Pegram*, stating that the Supreme Court implied that ERISA section 502(a) did not preempt all mixed eligibility and treatment decisions.¹⁴¹ The court stated that for the purposes of complete preemption analysis the critical issue was whether the claim challenged an eligibility determination for benefits or the quality of medical treatment performed.¹⁴² The court specifically stated that claims alleging a denial of benefits made by an HMO based on a lack of coverage decision would fall underneath the former category as an eligibility determination for benefits and therefore be completely preempted by ERISA. Conversely, a claim challenging the quality of medical treatment would be outside of ERISA's preemptive scope.¹⁴³

Applying its holding in *Pryzbowski*, the Third Circuit again ruled in favor of a more narrow interpretation of the *Pegram* exception to preemption in *DeFelice v. Aetna U.S. Healthcare*.¹⁴⁴ The *DeFelice*

139. *Id.* at 1293.

140. *Pryzbowski v. U.S. Healthcare Inc.*, 245 F.3d 266, 270 (3d Cir. 2001) ("She asserts six counts against U.S. Healthcare, which allege that U.S. Healthcare 'negligently and carelessly delayed in giving its approval for the necessary surgery which the plaintiff . . . urgently needed,' causing Pryzbowski severe and permanent injury, emotional distress, and future expenses for medical care and treatment").

141. *Id.* at 279.

Moreover, there is a strong suggestion in *Pegram* that claims based on medical treatment decisions remain outside the preemptive effect of ERISA. In holding that mixed eligibility/treatment decisions made by an HMO are not encompassed by the fiduciary duties imposed by ERISA, the Court made clear its view that ERISA was not designed to allow plan participants 'to bring malpractice actions in the guise of federal fiduciary breach claims against HMOs.'

Id. (quoting *Pegram v. Herdrich*, 530 U.S. 211, 236 (2000)).

142. *Id.* at 273.

143. *Id.*

[A] claim alleging that an HMO declined to approve certain requested medical services or treatment on the ground that they were not covered under the plan would manifestly be one regarding the proper administration of benefits. Such a claim, no matter how couched, is completely preempted and removable on that basis.

Id.

144. *DeFelice v. Aetna U.S. Healthcare, Inc.*, 346 F.3d 442 (3d Cir. 2003). *See generally*

opinion set out a two-part analysis, where courts must first examine the claim for wrongful denial of treatment to fit wholly within the category of a pure treatment decision or an entirely administrative decision.¹⁴⁵ For those claims which do not fit within these two extremes, the complaint is scrutinized to reveal whether a claim could have alternatively been brought under section 502(a) of ERISA.¹⁴⁶ Based on this analysis, the claim is preempted if the state-based claim could have been brought under ERISA instead.¹⁴⁷

C. State and Federal Legislative Responses to ERISA Preemption

Following the *Pegram* decision, and in response to growing pressure from the public, Congress and several states considered passage of Patients' Bill of Rights statutes.¹⁴⁸ These statutes, in some cases, expressly provided the right to sue an HMO for wrongful or negligent denials of medically necessary treatment.¹⁴⁹ This section will begin by introducing and analyzing the Texas Health Care Liability Act of 1997, proceed to consideration of other state legislation, and conclude by discussing federal changes to ERISA.¹⁵⁰

1. The Texas Health Care Liability Act

In 1997, the Texas Legislature passed THCLA.¹⁵¹ Texas was the first state to pass a statute that granted health plan beneficiaries the ability to sue their HMO.¹⁵² THCLA was a Patients' Bill of Rights Act passed by Texas in response to growing public demand for such

Pollette, *supra* note 133, at 416–17 (detailing the holding in the *DeFelice* case and describing the Eleventh Circuit's reading of *Pegram*).

145. *DeFelice*, 346 F.3d at 448 (“*Pryzbowski* thus instructs us to determine whether a claim is preempted under section 502(a) by first examining whether the claim falls at either of the two poles, entirely treatment or entirely administrative.”).

146. *Id.*

In the more difficult situation in which the claim falls somewhere in between, we must scrutinize the complaint for ‘artful pleading,’ and then refer to section 502(a) itself and determine whether the actual alleged wrongdoing underlying the cause of action could have formed the basis of a suit under that section.

Id.

147. *Id.*

148. *See generally* Miller, *supra* note 106, Part II (reviewing the passage and interpretation of Patients' Bill of Rights statutes following the *Pegram* case).

149. *See, e.g.*, TEX. CIV. PRAC. & REM. CODE ANN. § 88.002 (Vernon Supp. 2004) (detailing the specific right to sue HMOs granted to health plan beneficiaries).

150. *See infra* Part II.C.1–3 (discussing the impact of THCLA, other state “right to sue” statutes, and ERISA amendments).

151. S.B. 386, 75th Leg. (Tex. 1997), available at www.harp.org/sb386.htm.

152. *See* NCSL Report, *supra* note 6 (detailing THCLA and its provision for a private “right to sue” in case of a wrongful denial of benefits).

legislation.¹⁵³ THCLA guaranteed certain rights in relation to health care plan beneficiaries and participants, and applied to ERISA-regulated plans as well as non-ERISA plans.¹⁵⁴

THCLA section 88.022(a) contains a specific provision that is aimed at circumvention of ERISA preemption.¹⁵⁵ This section provides a state-based claim for damages proximately caused by negligence on the part of the managed care company.¹⁵⁶ This statute permits a claim to be brought in state court for the negligent denial of authorization for treatment that has the potential to recover both compensatory and punitive damages.¹⁵⁷ The availability of punitive and compensatory damages is the main attraction for plaintiffs to sue under THCLA or a similar state law, as opposed to the equitable relief available under ERISA section 502(a).¹⁵⁸ In addition to its provision of a state-based claim for recovery of damages for negligent practice by the insurer, THCLA also permits independent medical review of the benefit determination to be requested by the HMO.¹⁵⁹

153. *See generally* American Benefits Council, PATIENTS' BILL OF RIGHTS: MYTHS AND REALITIES, available at http://www.americanbenefitscouncil.org/issues/health/myths_reality.htm (describing a Patients' Bill of Rights Act as a statute outlining patient protections that includes the right to sue the health care plan administrator for failure to provide necessary treatments). Public support for a Patients' Bill of Rights reached a peak in 1997, when President Clinton urged Congress to enact such a bill in his State of the Union Address.

154. *See generally* TEX. CIV. PRAC. & REM. CODE ANN. § 88.002 (Vernon Supp. 2004) (detailing the specific rights granted to health plan beneficiaries within the state of Texas under THCLA).

155. *Id.* at § 88.002(a).

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

Id.

156. *See id.* at § 88.002 (imposing liability upon managed care companies for damages proximately caused by negligent activity defined as a failure to exercise "ordinary care when making health care treatment decisions"). Ordinary care is defined as "that degree of care a health insurance carrier . . . of ordinary prudence would use under the same or similar circumstances." *Id.* at § 88.001(10) (Vernon Supp. 2004).

157. Michael B. Snyder, *Health Maintenance Organizations*, BENEFITS GUIDE § 3:28.5 (2004).

158. *See generally* Geri Aston, *Texas Trial: HMO Liability Law*, AM. MED. NEWS, May 28, 2001, available at <http://www.ama-assn.org/amednews/2001/05/28/gvsa0528.htm> (last visited Jan. 16, 2005) (describing THCLA "right to sue" provisions and the additional remedies as compared to ERISA).

159. TEX. CIV. PRAC. & REM. CODE ANN. § 88.003 (Vernon Supp. 2004).

The insured or enrollee or the insured's or enrollee's representative must submit the claim to a review by an independent review organization if the health insurance carrier, health maintenance organization, or managed care entity against whom the claim is made requests the review not later than the 14th day after the date notice under

Since its enactment in 1997 through May 2001, an estimated fifteen to twenty-five lawsuits have been brought under THCLA.¹⁶⁰ During this same period the state received 1,234 requests for independent reviews under THCLA, the quick turnaround of which has been attributed to the lack of lawsuits going to trial.¹⁶¹

2. Other State Legislation Circumventing ERISA

Since 1997, other state legislatures have enacted statutes similar to THCLA.¹⁶² In the years leading up to 2004, substantial support among the public helped to push legislation in this realm.¹⁶³ Georgia was the second state to authorize such a law with the enactment of H.732 in 1999.¹⁶⁴ California quickly followed suit, passing SB21 in 1999, which took effect in 2001.¹⁶⁵ Washington State enacted its own “right to sue”

Subsection (a)(2)(A) is received by the health insurance carrier, health maintenance organization, or managed care entity.

Id.

160. Aston, *supra* note 158 (estimating the number of lawsuits since the enactment of the THCLA).

161. *Id.*

162. William Branigin, *High Court Sides with HMOs on Malpractice Suits: Unanimous Ruling in Texas Cases Strikes at Heart of Patients' Rights Debate*, WASH. POST (June 21, 2004), available at <http://www.washingtonpost.com/wp-dyn/articles/A57585-2004Jun21.html> (last visited Jan. 16, 2005) (“Besides Texas, nine other states have laws that allow patients to sue their health maintenance organizations in state courts. They are Arizona, California, Georgia, Maine, New Jersey, North Carolina, Oklahoma, Washington and West Virginia.”).

163. See KAISER FAMILY FOUND., KAISER HEALTH POLL REPORT: THE PUBLIC, MANAGED CARE, AND CONSUMER (Aug. 2004), available at http://www.kff.org/healthpollreport/archive_aug2004/index.cfm (“From 1998 through 2001, when a comprehensive Patients’ Bill of Rights was being debated in Congress, large majorities of the public said they were in favor of such legislation.”) [hereinafter KFF Report]. During the Patients’ Bill of Rights debate, in 2001, “seven in ten (69%) said that it would be very or somewhat important to them that patients’ rights legislation includes the right to sue a health plan.” *Id.* “More recently, in August 2004, 57% said they would favor a new law giving people the right to sue.” *Id.*

164. GA. CODE ANN., § 51-1-48 (1999) (stating that “any injury or death to an enrollee resulting from a want of such ordinary diligence shall be a tort for which a recovery may be had against the managed care entity offering such plan, but no recovery shall be had for punitive damages for such tort.”). See generally H.B. 732, available at <http://www.ganet.org/cgi-bin/pub/leg/legdoc?billname=1999/HB732&docpart=full> (detailing the full text of the Bill as passed by the Georgia legislature in 1999). Texas’ “right to sue” statute is considered in the *Aetna Health v. Davila* case by the Supreme Court and is the primary focus of this Note.

165. CAL. CIV. CODE § 3428 (West Supp. 2005).

For services rendered on or after January 1, 2001, a health care service plan or managed care entity, as described in subdivision (f) of Section 1345 of the Health and Safety Code, shall have a duty of ordinary care to arrange for the provision of medically necessary health care service to its subscribers and enrollees, where the health care service is a benefit provided under the plan, and shall be liable for any and all harm legally caused by its failure to exercise that ordinary care

Id.

regulation in March 2000, scheduled to take effect in July 2001.¹⁶⁶ Arizona, Maine, and Oklahoma passed similar HMO liability laws in April 2000.¹⁶⁷ In 2001, the states of West Virginia, New Jersey, and North Carolina also enacted comparable regulations.¹⁶⁸ Oregon, Louisiana, Missouri, and New Mexico enacted additional laws that impose limited liability on health insurance companies when certain conditions are met.¹⁶⁹ In total, nine states outside of Texas authorized

166. S.B. 6199, 56th Leg., Reg. Sess. (Wash. 2000), *available at* http://www.leg.us.gov/pub/billinfo/1999-00/senate/6175-6199/6199_s2_s1_03152000.txt. (“[H]ealth carrier is also liable for damages under (a) of this subsection for harm to an enrollee proximately caused by health care treatment decisions that result from a failure to follow the accepted standard of care made by its: (i) Employees; (ii) Agents”).

167. H.B. 2600, 44th Leg., 2d Reg. Sess. (Ariz. 2000), *available at* http://www.azleg.state.az.us/legtext/44leg/2r/summary/h.hb2600_4-06-00_astransmittedtogovernor.doc.htm (establishing the right to sue a health care insurer for damages caused to an enrollee by the insurer’s delay in authorizing or failure to authorize a request for a covered service that is medically necessary or by the insurer’s denial of payment of benefits covered under the health care plan if the health care insurer acted in bad faith); H.P. 543, 119th Leg., 2d Regular Session (Me. 2000); *see also* ME. REV. STAT. ANN. 24-A, § 4313(1)(a) (West Supp. 2004).

[C]arrier has the duty to exercise ordinary care when making health care treatment decisions that affect the quality of the diagnosis, care or treatment provided to an enrollee and is liable for damages as provided in this section for harm to an enrollee proximately caused by the failure of the carrier or its agents to exercise such ordinary care

Id.; S.B. 1206, 47th Leg., 2d Reg. Sess. (Okla. 2000), *available at* http://www.lsb.state.ok.us/1999-00SB/SB1206_int.rtf (“A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and shall be liable for damages for harm to an enrollee”).

168. N.C. GEN. STAT. § 90-21.51(a) (West Supp. 2004) (“(a) Each managed care entity for a health benefit plan has the duty to exercise ordinary care when making health care decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise ordinary care”); W. VA. CODE § 3-25c-7(a).

After settlement or exhaustion of all legal appeals involving determinations of whether health care services are medically necessary or experimental, a managed care plan must comply with the decision rendered in an external review under this article and may be held civilly liable for all damages proximately caused to an enrollee for its failure to so comply

Id.; S.B. 1333, 209th Leg., Reg. Sess. (N.J. 2000), *available at* http://www.njleg.state.nj.us/2000/Bills/AL101/187_.htm.

Under the provisions of this section, a carrier or organized delivery system shall be liable for the health care treatment decisions of its employees, agents or other representatives over whom the carrier or organized delivery system has the right to exercise influence or control, or has actually exercised influence or control.

Id.

169. LA. REV. STAT. ANN. §22.3085(D).

A covered person or his representatives, heirs, assigns, or health care providers shall have a cause of action for benefits or damages against an MNRO, health insurance issuer, health benefit plan, or independent review organization for any action involving or resulting from a decision made pursuant to this Chapter if the determination or opinion was rendered in bad faith or involved negligence, gross negligence, or

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general “right to sue” legislation and four states passed more limited liability statutes through June 2004.¹⁷⁰

Analogous to the terms of THCLA, these state liability acts provided punitive and compensatory damages recovery for violations brought in state court.¹⁷¹ Claimants who contended they were wrongfully denied necessary medical treatment actively utilized these statutes leading up to the *Davila* decision, with California’s medical review process deciding 614 cases in its first year of operation.¹⁷²

3. Federal Legislative ERISA Reform

To address the changing needs of the United States regarding the regulation of benefits provision, Congress made three major amendments to ERISA in 1996 and has considered several other proposed amendments.¹⁷³ The amendments addressed situations where families change jobs, have children, or require mental health care.¹⁷⁴ Congress enacted the first of these amendments, the Health Insurance Portability and Accountability Act (“HIPAA”), in order to protect those people who encounter difficulties in obtaining health-care coverage when they change employers.¹⁷⁵ HIPAA has far-ranging and wide application to privacy and security issues concerning provision of health benefits, but does not contain any provision to revise the remedies available for wrongful denial of benefits claims.¹⁷⁶ Congress also enacted the Newborns’ and Mothers’ Health Protection Act

intentional misrepresentation of factual information about the covered person’s medical condition.

Id.

If an insurer has agreed under the provisions of a health benefit plan to be bound by the decision of an independent review organization and the insurer fails to comply with such a decision, the Director of the Department of Consumer and Business Services shall impose on the insurer a civil penalty of not less than \$100,000 and not more than \$1 million.

H.B. 3040, 71st Leg., Reg. Sess. (Or. 2001).

170. *See id.* (stating that the number of states passing legislation that permitted beneficiaries to sue their managed care companies in state court equal to “ten states as of the date of the U.S. Supreme Court decision in June 2004”).

171. *See id.* (summarizing the liability terms for each of the state “right to sue” statutes as being similar to that imposed by THCLA or a more limited form).

172. Snyder, *supra* note 157, § 3:28.5.

173. 29 U.S.C. § 1181(a)–(g) (2000); 29 U.S.C. § 1185 (2000); 29 U.S.C. § 1185(a) (2000).

174. 29 U.S.C. § 1181(a)–(g) (2000); 29 U.S.C. § 1185 (2000); 29 U.S.C. § 1185(a) (2000).

175. 29 U.S.C. § 1181(a)–(g) (2000).

176. *See generally* Office of Civil Rights, U.S. Department of Health & Human Services, MEDICAL PRIVACY—NATIONAL STANDARDS TO PROTECT THE PRIVACY OF PERSONAL HEALTH INFORMATION, available at <http://www.hhs.gov/ocr/hipaa/> (describing in detail the security, privacy and code set transactions requirements of HIPAA).

(“NMHPA”) in 1996.¹⁷⁷ NMHPA forbids group health plans, HMOs, and insurance companies from mandating the discharge of a mother and newborn sooner than forty-eight hours after a normal vaginal delivery or ninety-six hours after a cesarean section birth.¹⁷⁸ Finally, Congress enacted the Mental Health Parity Act (“MHPA”) in 1996, requiring that annual or lifetime dollar limits on mental health benefits of employee health plans cannot be less than those dollar amounts provided for medical and surgical benefits.¹⁷⁹ None of these amendments have any relevance to the denial of benefits made by HMOs and do nothing to revise the civil remedial scheme of ERISA.¹⁸⁰

Although ERISA amendments in prior years have not led to substantial change related to its preemptive scope, Congress unsuccessfully attempted to create new remedies for wrongful denials of treatment by developing federal common law within the judiciary.¹⁸¹ Congress also considered several proposals that attempted to revise the regulatory system of ERISA to exempt health insurers, which were also met with failure.¹⁸² In a proposal made in Congress in 1989, ERISA would have been amended to preserve state law remedies only against insurance companies.¹⁸³ The second proposal involved establishing federal procedures and judicial remedies for improper handling of claims only with respect to welfare plans.¹⁸⁴ In 1993, the Clinton

177. 29 U.S.C. § 1185 (2000 & West Supp. 2004).

178. *Id.*

179. 29 U.S.C. § 1185(a).

180. *See, e.g.*, CENTERS FOR MEDICARE & MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, HIPAA INSURANCE REFORM: THE MENTAL HEALTH PARITY ACT, available at <http://www.cms.hhs.gov/hipaa/hipaa1/content/mhpa.asp> (last modified Sept. 17, 2004) (describing the passage and impact of the Mental Health Parity Act on ERISA plan participants).

181. *See* H.R. REP. NO. 247, 101st Cong. (1st Sess. 1989), 55–56, reprinted in 1989 U.S.C.C.A.N. 1906, 1948 (detailing the Budget Committee recommendation on the Omnibus Budget Reconciliation Act of 1989). The Committee felt that the legislative history of ERISA clearly indicated that Congress intended courts, through federal common law, to develop “appropriate remedies, even if they are not specifically enumerated in section 502 of ERISA,” for improper claims processing. *Id.* The Committee reaffirmed the authority of the Federal courts to shape legal and equitable remedies to fit the facts and circumstances of the cases before them, even though those remedies may not be specifically mentioned in ERISA, by drawing upon principles enunciated in state law, including such remedies as the awarding of punitive and/or compensatory damages against the person responsible for the failure to pay claims in a timely manner. *Id.*

182. *See generally* George Lee Flint, Jr., *ERISA: Reformulating the Federal Common Law for Plan Interpretation*, 32 SAN DIEGO L. REV. 955, 964–65 (1995) (reviewing the various proposals in Congress made to exempt certain areas of insurance provision from ERISA’s general regulatory scheme).

183. S. 794, 102d Cong. (1st Sess. 1991); H.R. REP. NO. 1602, 102nd Cong. (1st Sess. 1991).

184. *See* H.R. REP. NO. 1881, 103rd Cong. (1st Sess. 1993) (proposing the Health Insurance

administration proposed a third change that involved removing health care plans from ERISA and establishing a new system of procedures, administrative hearings, and judicial review for the sole purpose of regulation within the limited sphere of healthcare.¹⁸⁵ Congressman Charles W. Norwood also proposed an amendment to ERISA, the Patient Access to Responsible Care Act of 1997 (“PARCA”), which permitted subscribers to hold health plans legally accountable for malpractice.¹⁸⁶ In 1998, the House passed the Republican-sponsored Patient Protection Act, which did not provide for a right to hold an MCO responsible for negligent care.¹⁸⁷ Of the above-mentioned proposals, only the Patient Protection Act was successfully enacted.¹⁸⁸ Nevertheless, the passage of the Patient Protection Act failed to provide an adequate means of recovery for plan participants who were wrongfully denied necessary treatment by their HMO, as it did not provide an express right to sue beyond the ERISA remedial scheme.¹⁸⁹

III. DISCUSSION

In *Aetna Health v. Davila*, the United States Supreme Court clarified the scope of the preemptive power of section 502(a) of ERISA by narrowing the applicability of the *Pegram* exception to ERISA regulation.¹⁹⁰ The Supreme Court consolidated two cases that challenged the removal of claims based on a denial of care in violation of THCLA.¹⁹¹ The primary issue in these cases was whether an HMO administrative body denying medical care based upon mixed determinations of eligibility and treatment was acting as a fiduciary and

Claims Fairness Act of 1993 that permitted recovery of punitive damages against certain parties in cases of fraud).

185. H.R. REP. NO. 3600, 103d Cong. (1st Sess. 1993) (detailing the 1993 Clinton Administration proposal for the Health Security Act that would have established civil penalties for wrongful denial or delay of claims).

186. H.R. REP. NO. 1415, 105th Cong. (1st Sess. 1997).

187. See generally MICHELE M. GARVIN, HEALTH MAINTENANCE ORGANIZATIONS, IN HEALTH CARE CORPORATE LAW: MANAGED CARE (M. Hall & W. Brewbaker eds., 1996) (detailing the provisions of the Patient Protection Act of 1998 and noting its failure to include a “right to sue” section).

188. H.R. REP. NO. 4250, 105th Cong. (2004), available at <http://www.thomas.loc.gov/>.

189. *Id.*

190. See *Aetna Health Inc. v. Davila*, 124 S. Ct. 2488, 2502 (2004) (“Here, however, petitioners are neither respondents’ treating physicians nor the employers of respondents’ treating physicians.”). Petitioners’ coverage decisions, then, are pure eligibility decisions, and *Pegram* is not implicated. *Id.*

191. *Id.* at 2492–93. See generally TEX. CIV. PRAC. & REM. CODE ANN. § 88.002 (Vernon Supp. 2004) (detailing the specific rights granted to health plan beneficiaries within the state of Texas under THCLA).

therefore subject to ERISA preemption under section 502(a).¹⁹²

Ruby Calad and Juan Davila filed cases in state court claiming wrongful denial of treatment in violation of the standard of care required by THCLA.¹⁹³ Both Calad and Davila based their claims on THCLA instead of pursuing an ERISA claim because of the availability of recovery for compensatory and punitive damages under the state regulation.¹⁹⁴ Cigna Healthcare of Texas (“Cigna”) and Aetna Health Inc. (“Aetna”), the defendant HMOs, removed the cases to federal court based on ERISA preemption.¹⁹⁵ The district courts refused Ms. Calad’s motion to remand to state court and dismissed Mr. Davila’s case with prejudice after he refused to file an ERISA claim.¹⁹⁶ The Fifth Circuit Court of Appeals consolidated the *Calad* and *Davila* cases on appeal with two additional cases concerning section 502(a) preemption.¹⁹⁷ A panel of the Fifth Circuit vacated and remanded the district court’s decisions with respect to Ms. Calad and Mr. Davila’s claims, holding that these mixed eligibility and treatment decisions were outside of the scope of ERISA preemption.¹⁹⁸ After certiorari was granted in *Calad* and *Davila*, the United States Supreme Court held in a unanimous decision that the claims were completely preempted by section 502(a) of ERISA and that sections of THCLA were invalidated by this preemption.¹⁹⁹

A. Facts

Ruby Calad was a beneficiary of an ERISA-regulated employee health benefit plan administered by Cigna.²⁰⁰ Cigna was responsible for

192. *Davila*, 124 S. Ct. at 2492.

193. *Roark v. Humana, Inc.*, 307 F.3d 298, 302 (5th Cir. 2002). The Fifth circuit consolidated Ruby Calad, Juan Davila, Walter Thorn, and Gwen Roark’s claims into a single appeal. *Id.*

194. *See supra* Part II.C.1 (analyzing the availability of additional recovery under THCLA of compensatory and punitive damages, in contrast to the recovery of the treatment denied under ERISA). Had Calad and Davila raised ERISA claims, they would have been limited to recovering the cost of a Vioxx prescription or additional hospital stay. This would have been economically impractical, considering the cost of litigation alone would have far exceeded any potential recovery under ERISA.

195. *Roark*, 307 F.3d at 302–03.

196. *Id.* at 302.

197. *Id.* at 302–03. Walter Thorn and Gwen Roark also presented challenges to ERISA’s preemptive scope relating to wrongful denials of treatment. *Id.*

198. *Id.* at 311 (“Having concluded that § 502(a) does not completely preempt Calad’s and Davila’s THCLA claims, we vacate and remand to the district court for proceedings consistent with this decision.”). *See generally* Trueman, *supra* note 2, at 442–46 (analyzing the Fifth Circuit’s holding in *Roark* relating to Calad and Davila’s claims as being consistent with the Supreme Court ruling in *Pegram*).

199. *Aetna Health, Inc. v. Davila*, 124 S. Ct. 2488, 2493 (2004).

200. *Id.*

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plan benefits and coverage decisions under the health plan sponsor agreement.²⁰¹ Calad underwent a hysterectomy with extensive related surgery, performed by a Cigna surgeon.²⁰² Following surgery, the surgeon recommended a post-operation stay in excess of the one day permitted by Cigna's benefit plan.²⁰³ A Cigna discharge nurse overrode this decision based on a failure to meet the plan's criteria for a continued hospital stay.²⁰⁴ Based on this recommendation, Cigna denied coverage for the extended hospital stay, resulting in Calad's discharge from the hospital.²⁰⁵ Following her discharge, Calad suffered from post-surgical complications that forced her to return to the emergency room several days after leaving the hospital.²⁰⁶ Calad eventually recovered from her injuries but suffered financial and physical harm caused by the complications that she alleged were a direct result of the shortened hospital stay.²⁰⁷

Juan Davila was a participant in an ERISA-regulated health plan administered by Aetna.²⁰⁸ Davila is a post-polio patient who suffers from diabetes and arthritis.²⁰⁹ Davila's treating physician prescribed Vioxx to treat his arthritis due to its lower rate of gastrointestinal toxicity.²¹⁰ Aetna denied coverage of this medication and stated it would only cover his Vioxx prescription if Davila first used Naprosyn, a less expensive pain medication, and experienced a detrimental reaction.²¹¹ After taking Naprosyn based on the HMO's approval, Davila experienced severe intestinal bleeding, required emergency room treatment, and was no longer able to take oral pain medication as a result.²¹²

B. State Court Claims and District Court Rulings

Both Davila and Calad filed claims in state court against their HMOs under THCLA section 88.002(a) for negligently breaching the duty of

201. *Id.*

202. Brief of the Amicus Curiae National Conference of State Legislatures at 1, *Aetna Health, Inc. v. Davila*, 124 S. Ct. 2488 (2004) (No. 03-83).

203. *Id.*

204. *Davila*, 124 S. Ct. at 2493.

205. *Id.*

206. *Id.*

207. *Id.*

208. *Id.*

209. Brief of Amicus Curiae National Conference of State Legislatures at 1, *Aetna Health, Inc. v. Davila*, 124 S. Ct. 2488 (2004) (No. 03-83).

210. *Id.*

211. *Id.*

212. *Id.*

ordinary care when making their health care treatment decisions and proximately causing their injuries.²¹³ Calad alleged that her HMO, Cigna, negligently caused her injuries by denying her the extended post-operative hospital stay recommended by her treating surgeon.²¹⁴ Calad unsuccessfully argued that Cigna was not acting as a fiduciary when it denied her medical treatment and therefore her claim was outside the scope of section 502(a) preemption.²¹⁵ Cigna removed the case to federal district court based on 28 U.S.C. § 1441(a), arguing the claim was preempted by ERISA section 502(a).²¹⁶ If successful, Cigna would avoid liability for compensatory and punitive damages, limiting Calad and Davila's recovery to the cost of treatment denied.²¹⁷

Davila filed a similar claim against Aetna, alleging that Aetna refused to provide him with medication that his treating physician had prescribed.²¹⁸ Davila alleged in his claim that Aetna: (1) failed to use ordinary care in making medical decisions; (2) acted negligently in making its medical necessity decisions; and (3) its systems made substandard care more likely.²¹⁹ Aetna successfully removed the case to federal district court under 28 U.S.C. § 1441(a), arguing that section 502(a) of ERISA completely preempted the claim under THCLA section 88.002(a).²²⁰

The district courts refused to remand both Calad and Davila's claims to state court, agreeing with Cigna and Aetna's arguments for complete preemption of THCLA claims for negligent denial of treatment.²²¹ The district court dismissed Calad's claim with prejudice since her complaint only raised a THCLA claim and did not raise an ERISA

213. *Davila*, 124 S. Ct. at 2493; *see also* BLACK'S LAW DICTIONARY 234 (8th ed. 2004) (defining proximate cause as "the limitation which the courts have placed upon the actor's responsibility for the consequences of the actor's conduct").

214. *Roark v. Humana, Inc.*, 307 F.3d 298, 302 (5th Cir. 2002).

215. *Id.* *See also* BLACK'S LAW DICTIONARY 658 (8th ed. 2004) (defining a fiduciary as "[a] person who is required to act for the benefit of another person on all matters within the scope of their relationship; one who owes to another the duties of good faith, trust, confidence, and candor").

216. *Davila*, 124 S. Ct. at 2493. *See* 28 U.S.C. § 1441(a) (2000) ("[A]ny civil action brought in a State court of which the district courts have original jurisdiction, may be removed by the defendant."); 29 U.S.C. § 1144 (2000) ("[T]he 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 described in section 1003(a) of this title and not exempt under section 1003(b) of this title.").

217. *See supra* Part II.C.1 (contrasting the availability of compensatory and punitive damages recovery under THCLA and the limitation of recovery to cost of treatment denied under ERISA).

218. *Roark*, 307 F.3d at 303.

219. *Id.*

220. *Id.*

221. *Id.* at 302-03.

claim.²²² The district court dismissed Davila's claim with prejudice after he informed the court that he would not amend his complaint to raise an ERISA claim.²²³

C. *The Fifth Circuit Decision*

Calad and Davila appealed to the Fifth Circuit on the grounds that the district court erred in finding that section 502(a) of ERISA preempted their claims for negligent denial of treatment under THCLA section 88.002(a).²²⁴ The Fifth Circuit consolidated four claims involving ERISA preemption that included Calad and Davila's appeals.²²⁵ Three of the four cases concerned section 502(a) complete preemption and one of the cases concerned section 514 conflict preemption of claims.²²⁶ The court vacated and remanded Calad and Davila's claims, holding that section 502(a) did not preempt their claims.²²⁷

The court primarily relied on the holding from *Pegram*, identifying Calad and Davila's claims as not based on mixed decisions of eligibility and treatment because of the exclusively administrative role of the HMO's agent, placing the denials outside the scope of ERISA preemption.²²⁸ Second, the court noted that the claims asserted by Calad and Davila were based in tort, while the remedies from ERISA section 502(a)(1)(B) were limited to contract claims.²²⁹ Third, the court limited complete preemption to situations where the state mimicked the causes of action from section 502(a).²³⁰ Since THCLA created a remedy allowing for compensatory and punitive damages and was not limited to benefits collection, section 502(a) did not preempt the claims

222. *Id.* at 302.

223. *Id.* at 303.

224. *Id.* at 302.

225. *Id.* The Supreme Court only granted certiorari for two of the four cases consolidated by the Fifth Circuit in the *Davila* case. *Aetna Health, Inc. v. Davila*, 124 S. Ct. 2448, 2492 (2004). Therefore, this Note only concerns itself with discussion concerning Calad and Davila's claims, which were eventually heard by the Supreme Court.

226. *Roark*, 307 F.3d at 302–03.

227. *Id.* at 311. See generally Jayne Elizabeth Zanglein, *Employee Benefits Law: Betrayed Without a Remedy—Again*, 35 TEX. TECH. L. REV. 805, 810–15 (2004) (reviewing the Fifth Circuit's holding in *Roark* and concluding that ERISA plan participants were left without an avenue for adequate recovery).

228. *Roark*, 307 F.3d at 307 (citing *Pegram v. Herdrich*, 530 U.S. 211 (2000)); see *supra* Part II.B.3 (discussing the *Pegram* holding in detail and the terms of the Supreme Court's ruling).

229. *Roark*, 307 F.3d at 309. See generally Zanglein, *supra* note 227, at 814–15 (analyzing the holding of the *Roark* court in detail).

230. *Roark*, 307 F.3d at 310–11 (“We glean from *Rush Prudential* that *Pilot Life*'s rule is a narrow one: States may not duplicate the causes of action listed in ERISA § 502(a).”).

brought by Calad and Davila.²³¹

Dissatisfied with the results of the *Roark* decision by the Fifth Circuit concerning their consolidated cases, Aetna and Cigna petitioned the United States Supreme Court for certiorari.²³² On November 3, 2003, the United States Supreme Court granted certiorari to hear the case.²³³

D. *The United States Supreme Court Decision*

In a unanimous decision, the Supreme Court reversed and remanded the Fifth Circuit's decision, holding that ERISA section 502(a) completely preempted THCLA claims filed by Calad and Davila, making them removable from state to federal court.²³⁴ This section will examine the opinion and its interpretation of the scope of complete preemption under section 502(a) of ERISA.²³⁵ Next, this section will examine the concurring opinion of Justice Ginsberg, with particular emphasis on her call for congressional intervention.²³⁶

1. The Unanimous Opinion

Justice Thomas wrote the unanimous opinion for the Court.²³⁷ The Court began its discussion by illustrating the basis for removal under 28 U.S.C. § 1441(a) and the exception made to the "well-pleaded complaint" rule made for complete preemption cases.²³⁸ The Court stated that complete preemption statutes such as ERISA create an exclusive remedial formula for certain types of claims within the federal court system.²³⁹ The Court explained that the removal of THCLA claims from state to federal court would therefore be appropriate if the scope of section 502(a) included the claims.²⁴⁰

In order to come to this conclusion, the Court discussed the

231. *Id.* at 311.

232. *Aetna Health, Inc. v. Davila*, petition for cert. filed, 2003 WL 22428332 (U.S. Jun. 20, 2003) (No. 02-1826); *Cigna v. Calad*, petition for cert. filed, 2003 WL 22428549 (U.S. Jul. 14, 2003) (No. 03-83).

233. *Aetna Health, Inc. v. Davila*, 124 S. Ct. 2488, 2488 (2004).

234. *Id.* at 2493.

235. *See infra* Part III.D.1 (discussing the unanimous opinion of the Court as delivered by Justice Thomas).

236. *See infra* Part III.D.2 (analyzing the concurrence of Justice Ginsburg).

237. *Davila*, 124 S. Ct. at 2493.

238. *Id.* at 2494-95 ("There is an exception, however, to the well-pleaded complaint rule. '[W]hen a federal statute wholly displaces the state-law cause of action through complete preemption,' the state claim can be removed." (quoting *Beneficial Nat'l. Bank v. Anderson*, 539 U.S. 1, 8 (2003))).

239. *Davila*, 124 S. Ct. at 2495.

240. *Id.* at 2494-95.

legislative intent behind ERISA's passage in 1974.²⁴¹ The Court referred to 29 U.S.C. § 1001(b), which states that ERISA was enacted to protect the interests of participants in employee benefit plans and to provide for appropriate remedies, sanctions, and ready access to the federal courts.²⁴² The Court examined the comprehensive legislative scheme of ERISA as including an integrated system of procedures for enforcement.²⁴³ The Court stated that the comprehensiveness of the scheme was an essential feature in order to provide uniform regulation of employee benefit plans in furtherance of ERISA's legislative goals.²⁴⁴ Allowing state claims for ERISA plan participants and beneficiaries in addition to those permitted by the federal scheme of enforcement would undermine the entire policy intent behind ERISA's passage.²⁴⁵ Therefore, the Court concluded that a state law cause of action that duplicates the remedial scheme in ERISA was preempted by ERISA.²⁴⁶

The Supreme Court then examined the complaints, THCLA, and documents concerning the health plans' administration.²⁴⁷ The Court, by looking to the wording of the respondents' benefit plans, found that the complaints only contained allegations concerning denials of coverage for treatments as part of their ERISA-regulated employee benefit plans.²⁴⁸ Justice Thomas noted in particular that the respondents could have sought injunctive relief or paid for the treatment themselves and sought reimbursement through an ERISA section 502(a)(1)(B) claim.²⁴⁹ Although the respondents argued that the duty of ordinary care required by THCLA was an independent legal duty, the Court read section 88.002(d) as justifying the conclusion that the duty of care imposed by the statute did not arise independently of ERISA.²⁵⁰ The

241. *Id.* at 2495.

242. 29 U.S.C. §1001(b) (2000); *Davila*, 124 S. Ct. at 2495. "The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans . . . intended to ensure that employee benefit plan regulation would be 'exclusively a federal concern.'" *Id.* (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)).

243. *Davila*, 124 S. Ct. at 2495 (quoting *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985)).

244. *Id.*

245. *Id.*

246. *Id.* ("[A]ny state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted.")

247. *Id.* at 2496.

248. *Id.*

249. *Id.* at 2497.

250. *Id.* at 2497-98. "More significantly, THCLA clearly states that '[t]he standards in Subsections (a) and (b) create no obligation on the part of the health insurance carrier . . . or other

Court found that a managed care entity could not be subject to liability under THCLA if it denied coverage for any treatment that it was not administering.²⁵¹

The Supreme Court then examined the Fifth Circuit's three-part rationale concluding that the respondents' claims were outside the scope of ERISA section 502(a).²⁵² The Court found that each of the three reasons for reversal of the district court's decision that the claims were preempted under ERISA were erroneous.²⁵³

The first reason proffered by the circuit court stated that the respondents' tort claim was distinguishable from ERISA claims, which it characterized as contractual in nature.²⁵⁴ The Court considered the *Pilot Life* and *Metropolitan Life* cases, where all of the plaintiffs brought tort-like claims that were found to be preempted by ERISA.²⁵⁵ Based on the clear precedent in these prior cases, the Court held that the circuit court's characterization of the claims as torts and not contract disputes did not preclude preemption under section 502(a).²⁵⁶

The Supreme Court then considered the second reason for the Fifth Circuit's holding.²⁵⁷ The Court found the lower court's conclusion that the wording of the employee benefit plans was immaterial to the respondents' cause of action was erroneous.²⁵⁸ The Court held that the discussion of the benefit plans was relevant to the link between THCLA claims and ERISA preemption.²⁵⁹

To reverse the lower court's decision, the Supreme Court then examined the primary rationale proffered by the Fifth Circuit, which was based upon *Rush Prudential*.²⁶⁰ The appellate court interpreted the

managed care entity to provide . . . treatment which is not covered by the health care plan of the entity." *Id.* (quoting THCLA section 88.002(d)).

251. *Id.* at 2498.

252. *Id.* at 2498–99. *See supra* notes 224–33 and accompanying text (describing the three-part rationale of the circuit court).

253. *Davila*, 124 S. Ct. at 2498–99.

254. *Id.* at 2498 (citing *Roark v. Humana, Inc.*, 307 F.3d 298, 309 (5th Cir. 2002)).

255. *Id.* at 2499. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 43 (1987) (holding that a suit requesting damages for tortious breach of contract was held to be within the preemptive scope of ERISA); *Mass. Mut. Life Ins. v. Russell*, 473 U.S. 134, 148 (1985) (deciding that a suit requesting damage for mental anguish caused by breach of contract for an ERISA-qualified employee benefit plan was preempted by ERISA section 502(a)); *supra* Part II.B (discussing the *Pilot Life* and *Metropolitan Life* cases in detail and the precedent set by these decisions).

256. *Davila*, 124 S. Ct. at 2499.

257. *Id.*

258. *Id.*

259. *Id.* *See infra* Part III.D.1 (discussing the Supreme Court's examination of the wording of the benefit plans held by the respondents as relevant to the determination of ERISA preemption.)

260. *Davila*, 124 S. Ct. at 2499.

Supreme Court in *Rush Prudential* as holding that a state cause of action was preempted by ERISA section 502(a) only when it precisely duplicated an ERISA remedy.²⁶¹ The Supreme Court clarified this interpretation, stating that the preemptive power of ERISA section 502(a) was not limited to those claims that mimic the remedies provided by ERISA.²⁶² The Court justified this interpretation of the language of *Rush Prudential* by referring to the legislative intent behind ERISA, stating that the congressional intent to create a uniform remedial mechanism required broad preemptive power.²⁶³

The Supreme Court then turned to the respondents' argument that THCLA avoids preemption by meeting the "savings clause" of ERISA section 514(b)(2)(A).²⁶⁴ The respondents argued that THCLA was a part of the state's general regulation of insurance and therefore met the "savings clause" exception to ERISA preemption.²⁶⁵ In order to resolve this issue, the Court considered its holding from the *Pilot Life* case as it applied to the respondents' claims.²⁶⁶ The Court noted that state law claims in the past were determined to be exclusive of the remedial scheme of ERISA's civil enforcement scheme.²⁶⁷ The Court cited *Rush Prudential*, in which it determined that the existence of a comprehensive remedial scheme could be demonstrative of an overpowering federal policy that would require preemption of a state law that regulates insurance generally.²⁶⁸ The Supreme Court held that the reasoning in *Pilot Life* that a claim that "relates to" an employee benefit plan is expressly preempted under section 514(a) of ERISA applied with full force in this case, and that the state-law claims provided by THCLA in section 88.002(b) would be in conflict with the purpose of ERISA were they permitted to stand.²⁶⁹ Therefore, based

261. *Id.* See *Roark v. Humana, Inc.*, 307 F.3d 298, 310 (5th Cir. 2002) (interpreting the holding in *Ingersoll-Rand* as described in the *Rush Prudential* case as limiting ERISA section 501(a)'s preemptive scope to state causes of action duplicating a cause of action under ERISA).

262. *Davila*, 124 S. Ct. at 2499.

263. *Id.* at 2500 (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987)).

264. *Id.* See *supra* Part II.A.1 (describing the "savings clause" of ERISA section 514(b)(2)(A) as precluding regulations of insurance generally from being subject to ERISA and therefore subject to preemption); see also *supra* Part II.A.1 (illustrating the "conflict preemption" of ERISA section 514 and ERISA's limited application in most cases to laws which are not part of the general regulatory scheme of insurance).

265. Brief for Respondents at 51–58, *Davila*, 124 S. Ct. 2448 (2004) (Nos. 02-1845, 03-83). See *supra* Part II.A.1 (detailing the source and interpretation of the "savings clause" exception to ERISA and its scope).

266. *Davila*, 124 S. Ct. at 2500.

267. *Id.*

268. *Id.* (citing *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 375 (2002)).

269. *Id.* ("Allowing respondents to proceed with their state-law suits would 'pose an obstacle

upon the legislative intent of ERISA as defined in *Pilot Life* and the holding in *Rush Prudential*, the Court held that state laws such as THCLA that regulate insurance broadly could circumvent the “savings clause” of section 514(a)(1)(B) because of the presence of an overpowering federal policy.²⁷⁰

Finally, the Supreme Court clarified the holding in *Pegram*, a case which had been relied upon heavily by the respondents in arguing against preemption of their claims, but which had been interpreted both narrowly and broadly by the circuit courts.²⁷¹ The respondents and their amici argued that *Pegram* stood for the proposition that all denials of treatment based on “mixed decisions of eligibility and treatment” were not fiduciary acts and therefore outside of the scope of ERISA preemption.²⁷² The Court distinguished the holding in *Pegram*, stating that *Pegram* was based upon the treating physician’s wrongful denial of care, while in this case the petitioners were acting in an administrative role similar to that of a trustee for a traditional medical trust, not in the role of direct treatment.²⁷³ The Supreme Court reviewed the *Pilot Life* and *Metropolitan Life* cases again, in which claims based on disability determinations made by the insurers of ERISA-regulated benefit plans were found to be preempted by section 502(a) of ERISA.²⁷⁴ Since the petitioners in these cases were acting in the role of insurers when they made the treatment denials, the Court used this precedent as additional support for a narrower interpretation of the holding in *Pegram*.²⁷⁵ The Court clarified and distinguished the holding in *Pegram* by clearly

to the purposes and objectives of Congress.”) (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987)).

270. *Id.* “[E]ven a state law that can arguably be characterized as ‘regulating insurance’ will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA’s remedial scheme.” *Id.*

271. *Id.* at 2501. See *infra* Part II.B.3 (reviewing the broad and narrow interpretations of the holding in *Pegram* by the circuit courts in the years prior to 2004 that led to the need for the Supreme Court’s clarification).

272. See Brief for Respondents at 35–38, *Davila*, 124 S. Ct. 2488 (2004) (Nos. 02-1845, 03-83) (arguing for a broad recognition of the Court’s ruling in *Pegram* that would exempt all mixed decisions of eligibility and treatment from ERISA regulation); *supra* Part II.B.3 (analyzing the circuit court rulings relating to a broad interpretation of *Pegram*). See generally Tanya Albert, *Both Sides Ready for HMO Liability Fight*, AM. MED. NEWS, Feb. 16, 2004, available at <http://www.ama-assn.org/amednews/2004/02/16/gvsb0216.htm> (“The two camps spelled out their opinions in seven friend-of-the-court briefs.”).

273. *Davila*, 124 S. Ct. at 2501.

274. *Id.* at 2501 n.6. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 44–45 (1987) (reversing the lower court’s determination that the plaintiff’s claims were not preempted by ERISA); see also *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 61 (1987) (holding that the “well-pleaded complaint” rule did not apply to statutes such as ERISA under the complete preemption doctrine).

275. *Davila*, 124 S. Ct. at 2501 n.6.

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stating that “[t]he fact that a benefits determination is infused with medical judgments does not alter [the preemption of this claim under ERISA].”²⁷⁶

Next, the Supreme Court examined the definition of a fiduciary within the provisions of ERISA itself.²⁷⁷ The Court also considered section 503 of ERISA, which requires plans to provide an opportunity for all participants to appeal a denial of treatment to a named fiduciary.²⁷⁸ Using this as evidence, the Supreme Court determined that the ultimate decision-maker in a plan regarding benefits determinations must be a fiduciary, therefore implying determinations concerning medical judgments for denials of care were actions by plan fiduciaries and within the scope of ERISA regulation.²⁷⁹

The Court concluded its opinion by narrowly interpreting *Pegram* while leaving the door open for a certain class of claims that can potentially circumvent ERISA preemption.²⁸⁰ The Supreme Court clarified that cases where there was a “mixed eligibility and treatment decision” only existed when medical necessity decisions made by the treating physician in the role of benefits administrator.²⁸¹ The Court left open the possibility of state claims in cases where the agent of an HMO is acting in the dual role of treating physician or a treating physician’s employer as well as benefits administrator.²⁸² Nevertheless,

276. *Id.* at 2501.

277. *Id.* at 2501–02. Under ERISA,

[A] person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

29 U.S.C. § 1002(21)(A)(iii) (2000).

278. *Davila*, 124 S. Ct. at 2502.

In accordance with regulations of the Secretary, every employee benefit plan shall—(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for denial, written in a manner calculated to be understood by the participant, and (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

29 U.S.C. § 1133 (2000).

279. *Davila*, 124 S. Ct. at 2502. “Classifying any entity with discretionary authority over benefits determinations as anything but a plan fiduciary would thus conflict with ERISA’s statutory and regulatory scheme.” *Id.*

280. *Id.*

281. *Id.* (quoting *Pegram v. Hendrich*, 120 S. Ct. 2143, 2155 (2000)).

282. *Id.* (“Put another way, the reasoning of *Pegram* ‘only make[s] sense where the

in this case, the Court distinguished *Pegram* from *Davila* because the petitioners in *Davila* were neither the treating physicians nor were they the employers of the treating physicians.²⁸³

Based on the fiduciary role of the petitioners and the Court's rulings that the denials of treatment were within the preemptive scope of ERISA, the Court reversed and remanded the claims for further proceedings.²⁸⁴ This effectively invalidated THCLA section 88.002(a) and dismissed the claims of Calad and Davila, since they refused to bring claims under ERISA's remedial scheme.²⁸⁵ Calad and Davila chose not to bring ERISA claims because of the limitation of recovery to the cost of the benefit denied, which would have been negligible relative to the amount they were seeking through punitive and compensatory damages, especially in light of the prohibitive cost of litigation.²⁸⁶

2. Justice Ginsburg's Concurring Opinion

Justice Ginsburg, joined by Justice Breyer, wrote separately in a concurring opinion in order to emphasize her own views on the responsibility of Congress to rectify the "regulatory vacuum" of ERISA preemption.²⁸⁷ Justice Ginsburg agreed with the decision of the Court, stating that the decision was consistent with precedent concerning ERISA preemption.²⁸⁸ Nevertheless, she specifically noted both her own dissenting opinion from prior Supreme Court case law and her continued insistence that Congress take action to resolve the unjust

underlying negligence also plausibly constitutes medical maltreatment by a party who can be deemed to be a treating physician or such a physician's employer.") (quoting *Cicio v. Does*, 321 F.3d 83, 109 (2003) (Calabresi, J., dissenting in part)).

283. *Id.*

284. *Id.*

285. *Id.* at 2502-03 n.7 ("Respondents have thus chosen not to pursue any ERISA claim, including any claim arising under ERISA § 502(a)(3).").

286. *See supra* Part II.B.1-2 (detailing the unavailability of extracontractual damages recovery in an ERISA claim); Hoffman & Hiepler, *supra* note 50, at A19 ("When [ERISA preemption is] applied to managed care health plans, the clause creates an incentive to deny care because it removes ('preempts') state law protections for patients, while federal law offers them virtually no effective remedy."). *See generally* 29 U.S.C. § 1132 (2000) (providing the equitable forms of relief available under the ERISA civil enforcement mechanism).

287. *Davila*, 124 S. Ct. at 2503 (Ginsburg, J., concurring). *See generally* William H. Sage, *Health Law 2000: The Legal System and the Changing Health Care Market*, HEALTH AFF., Fall 1996, at 12 (defining the "ERISA vacuum" created by the lack of remedies set forth in ERISA's civil remedy scheme combined with the preemption of most state-law attempts at providing a more adequate form of relief).

288. *Davila*, 124 S. Ct. at 2503 (Ginsburg, J., concurring) ("That decision is consistent with our governing case law on ERISA's preemptive scope.").

remedial scheme of ERISA.²⁸⁹

Ginsburg's concurrence noted that the Court's interpretation of ERISA's broad-ranging preemptive power along with the narrow remedial mechanism created by ERISA in section 502(a)(3) created a "regulatory vacuum" where achieving make-whole relief is impossible.²⁹⁰ She stated that the equitable relief created by ERISA precludes personal liability for personal injuries, excluding recovery of extracontractual damages.²⁹¹

The concurring opinion referred to the lower court case and opinions in prior years that had called for a narrowing of ERISA's preemptive scope, including the *Cicio* and *DeFelice* cases.²⁹² Justice Ginsburg called for a reconsideration of the availability of consequential damages under section 502(a)(3) based on the lack of make-whole relief for treatment denials.²⁹³

Justice Ginsburg noted that the United States, in its *amicus* brief, recognized a potential opportunity for consequential damages recovery.²⁹⁴ The government suggested that the Court had previously precluded the recovery of monetary damages against a non-fiduciary in the Court's interpretation of section 502(a)(3).²⁹⁵ The *amicus* brief suggested that the respondents could have amended their complaints to contain a request for make-whole relief against the agents of the HMO acting as fiduciaries under ERISA.²⁹⁶ Thus, Justice Ginsburg stated that the respondents could contend that Aetna and Cigna, as fiduciaries, were not subject to the rule precluding make-whole recovery that had

289. *Id.* (Ginsburg, J., concurring) ("But, with greater enthusiasm . . . I also join 'the rising judicial chorus urging that Congress and [this] Court revisit what is an unjust and increasingly tangled ERISA regime.'" (quoting *DeFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 453 (3d Cir. 2003) (Becker, J., concurring))).

290. *Id.* (Ginsburg, J., concurring).

291. *Davila*, 124 S. Ct. at 2503 (Ginsburg, J., concurring). See generally *Cicio v. Vytra Healthcare*, 312 F.3d 83, 83 (2d Cir. 2003); *DeFelice*, 346 F.3d at 442.

292. *Davila*, 124 S. Ct. at 2503 (Ginsburg, J., concurring).

293. *Id.* (Ginsburg, J., concurring). "[The] 'gaping wound' caused by the breadth of preemption and limited remedies under ERISA, as interpreted by this Court, will not be healed until the Court 'start[s] over' or Congress 'wipe[s] the slate clean.'" *Id.* (Ginsburg, J., concurring) (quoting *DeFelice*, 346 F.3d at 467).

294. *Id.* (Ginsburg, J., concurring); see Brief of Amicus Curiae United States at 27–28 n.13, *Davila*, 124 S. Ct. 2488 (2004) (No. 02-1845) (suggesting ERISA "allows at least some forms of 'make-whole' relief against a breaching fiduciary in light of the general availability of such relief in equity at the time of the divided bench").

295. *Davila*, 124 S. Ct. at 2504 (Ginsburg, J., concurring) (citing Brief of Amicus Curiae United States at 27–28 n.13, *Davila*, 124 S. Ct. 2488 (2004) (No. 02-1845)).

296. *Id.* (Ginsburg, J., concurring).

been applied to non-fiduciaries under ERISA.²⁹⁷

Justice Ginsburg concluded her concurrence by making a last appeal to Congress, looking for a revision of ERISA's language in order to allow for a more adequate recovery scheme to be developed.²⁹⁸

IV. ANALYSIS

The Supreme Court in *Aetna Health v. Davila* correctly held that ERISA preempted the state-based claim for negligent denial of treatment brought by the respondents.²⁹⁹ The Court properly determined that the federal regulatory mechanism created by ERISA section 502(a)(3) completely preempted and effectively superceded the civil recovery provisions of THCLA section 88.002(a).³⁰⁰ This Part begins by arguing that the Court correctly interpreted ERISA's broad preemptive scope under prior case precedent, particularly by correctly distinguishing the holding in *Pegram*.³⁰¹ Next, this Part contends that the legislative intent behind ERISA and the reading of THCLA's plain language support the conclusion of the Court.³⁰² Finally, this Part concludes by arguing that Justice Ginsburg's concurring opinion appropriately places the burden upon Congress to reform ERISA in order to create more just outcomes.³⁰³

A. The Court Correctly Found that Calad and Davila's State-Based Claims Were Preempted by ERISA

The Supreme Court correctly distinguished the claims of Davila and Calad from the "mixed decisions of eligibility and treatment" in *Pegram*.³⁰⁴ Both the unanimous and concurring opinions recognized the important distinction between a decision made by a treating

297. *Id.* (Ginsburg, J., concurring).

298. *Id.* (Ginsburg, J., concurring). "Congress . . . intended ERISA to replicate the core principles of trust remedy law, including the make-whole standard of relief.' I anticipate that Congress, or this Court, will one day so confirm." *Id.* (Ginsburg, J., concurring) (quoting John Langbein, *What ERISA Means by "Equitable": The Supreme Court's Trail of Error in Russell, Mertens, and Great-West*, 103 COLUM. L. REV. 1317, 1319 (2003)).

299. *See Davila*, 124 S. Ct. at 2502 (explaining the holding of the case).

300. *See id.* (discussing preemption of THCLA section 88.002(a) claims in state court by ERISA section 502(a)).

301. *See infra* Part IV.A (analyzing the consistency of the *Davila* holding with prior case law, including *Pegram*).

302. *See infra* Part IV.B (reviewing the legislative intent behind ERISA and the language of THCLA for consistency with the Court's holding).

303. *See infra* Part IV.C (arguing in support of Justice Ginsburg's call for congressional reform of ERISA).

304. *See Davila*, 124 S. Ct. at 2502 (distinguishing the claim in *Pegram* from that raised in the *Davila* case).

physician-employee such as in the *Pegram* case and a decision made purely in an administrative capacity as in the *Davila* case.³⁰⁵ The Court in *Pegram* was clear in framing its holding and limiting the rule concerning “mixed decisions of eligibility and treatment” to situations where the decisionmaker was a treating physician as well as an administrative employee of the HMO.³⁰⁶ Since the administrator in *Davila* who made the treatment denial was acting solely in an administrative role, this decision was appropriately held by the Court to be outside the scope of the *Pegram* exception to ERISA preemption.³⁰⁷ Although recent attempts by the circuit courts to read *Pegram* expansively were considered by the Court, the Court was correct in its narrower interpretation of specific language in the *Pegram* opinion.³⁰⁸ Relying on a more precise reading of *Pegram*, the Court affirmed the preemptive scope of ERISA concerning administrative decisions regarding benefits eligibility.³⁰⁹

B. The Court Correctly Overruled the Applicability of the “Right to Sue” Section of THCLA and Other Similar State Statutes

The legislative intent behind ERISA was to create a uniform system of regulation of retirement benefit plans.³¹⁰ Essential to this objective is a civil enforcement mechanism that is the exclusive means of enforcing actions regulated by ERISA.³¹¹ The Court appropriately relied on this basic principle in determining that THCLA section 88.002(a) was inapplicable to ERISA-regulated health plans.³¹² The unanimous

305. *See id.* (recognizing the difference in treatment decisions made by a treating physician as contrasted to a decision made by an administrative employee of the HMO); *id.* at 2503 (Ginsburg, J., concurring) (agreeing with the majority’s determination that the facts in *Pegram* were distinguishable from those in *Davila*).

306. *See Pegram v. Herdrich*, 530 U.S. 211, 231 (2000) (describing the Supreme Court’s holding as limited in scope to situations involving a treating physician placed in the dual role of administrative benefit determination); *supra* Part II.B.3 (describing in detail the holding of the Supreme Court in *Pegram*).

307. *Davila*, 124 S. Ct. at 2502 (“[P]etitioners are neither respondents’ treating physicians nor the employers of the respondents’ treating physicians. Petitioners’ coverage decisions, then are pure eligibility decisions, and *Pegram* is not implicated.”).

308. *See id.* at 2500–02 (considering the arguments made regarding the prior circuit court holdings interpreting *Pegram* more broadly); *supra* Part II.B.4 (describing the expansive reading of *Pegram* by the circuit courts leading up to the *Davila* decision).

309. *See Davila*, 124 S. Ct. at 2502 (detailing the rationale behind holding that ERISA preemption under section 501(a) applied to the case).

310. *See* 29 U.S.C. § 1001 (2000) (detailing the intentions of Congress behind ERISA’s enactment).

311. *See supra* Part II.A (analyzing the necessity of an exclusive civil enforcement mechanism in order to promote the primary intent of ERISA).

312. *See Davila*, 124 S. Ct. at 2502 (holding that the civil enforcement remedy provided in

opinion in *Davila* accurately concluded that the statute was specifically designed to provide a state-based remedy that directly related to the administration of benefits by reviewing the structure of THCLA.³¹³ Relying on the holding in *Pilot Life*, the Court correctly determined that ERISA therefore superseded the civil remedy in THCLA section 88.002(a).³¹⁴

Alternatively, the Supreme Court could have affirmed the holding of the circuit court and permitted the state claims under THCLA section 88.002(a) to progress.³¹⁵ Had the Court affirmed the circuit court's holding, this would have permitted claims based on state-based "right to sue" statutes to proceed relating to wrongful denials of treatment by ERISA-regulated health benefit plan providers.³¹⁶ Permitting state-based treatment denial claims to circumvent ERISA would have permitted a patchwork of non-uniform state regulations to impose liability upon HMOs, resulting in the precise circumstance ERISA was enacted to prevent.³¹⁷

Nevertheless, it is important to note, as did the Court, that options exist for beneficiaries under ERISA's remedial scheme that could reduce the need for extracontractual damages.³¹⁸ The HMO could be required to provide payment for the claim if the beneficiary sought an injunction under ERISA section 502(a) after the initial denial of treatment.³¹⁹ Similarly, the denial of payment for treatment does not preclude treatment on the part of the beneficiary.³²⁰ *Davila* and *Calad*

THCLA section 88.002(a) was preempted by ERISA section 502).

313. See *id.* at 2496–97 (considering the scope of THCLA section 88.002(a) as being directly related to the civil enforcement mechanism of ERISA section 502(a)).

314. See *id.* at 2500 (citing the Court's holding in *Pilot Life* as a basis for superseding THCLA section 88.002(a) claim); *supra* Part II.B.2 (detailing the holding in *Pilot Life*).

315. See *Davila* 124 S. Ct. at 2494 (describing the holding of the appellate court).

316. See *supra* Part II.C (reviewing the state legislative attempts enacting "right to sue" statutes that permit state-court remedies for negligent denials of treatment by HMOs); see generally NCSL Report, *supra* note 6 (highlighting the ten states that have had their "right to sue" statutes affected by the *Davila* decision).

317. See *supra* Part II.B.1 (analyzing the intent behind ERISA's enactment and the congressional intent behind its remedial scheme and preemptive power).

318. See *Davila*, 124 S. Ct. at 2503 (recognizing the availability of alternate means of remedial action available to the respondents).

319. See 29 U.S.C. § 1132 (2000) (listing the various relief mechanisms available under the civil enforcement scheme of ERISA as including "recover[y of] benefits due to him under the terms of his plan . . . enforc[ing] his rights under the terms of the plan, or . . . clarify[ing] his rights to future benefits under the terms of the plan"); *supra* Part II.A (detailing the civil remedies available under ERISA section 502(a)).

320. See *Davila*, 124 S. Ct. at 2503 (describing the variety of options available to the respondents within section 502(a) of ERISA); News Release, American Benefits Council, *Supreme Court Ruling on Health Care Claims Raises Important Policy Issues: American Benefits*

had the opportunity to pay for their own treatment and then file a suit for recovery of cost of treatment.³²¹ The potential availability of recovery for attorney costs explicitly provided within ERISA makes this option all the more viable to injured parties.³²²

C. Justice Ginsburg's Concurrence Appropriately Places the Burden on Congress to Reform ERISA to Create "Make-Whole" Relief

Justice Ginsburg's concurring opinion appropriately emphasizes the need for a revision of ERISA's remedial scheme in order to meet the needs of modern society.³²³ The precedent in *Pegram* and *Pilot Life* and the legislative intent of ERISA's passage clearly demonstrate the Court's interpretation of ERISA's preemptive scope as applying to claims for wrongful denials of treatment made by an administrative agent of the benefit provider.³²⁴ Nevertheless, the underlying intent of ERISA must be revised to provide for uniform regulation of benefits provisions in light of the rapidly evolving role of healthcare insurance in the United States.³²⁵ As Justice Stevens noted in his dissenting opinion in *District of Columbia v. Greater Washington Board of Trade*, a fresh look at the ERISA regulatory scheme is necessary in light of the changing environment and growing numbers of claims preempted by ERISA.³²⁶

Council Responds to Critics of Today's Davila, Calad Rulings, June 21, 2004, available at <http://www.americanbenefitscouncil.org/newsroom/pr04-32.cfm> (quoting James A. Klein, president of the American Benefits Council commenting on the *Davila* ruling, stating, "[t]he refusal of the plaintiffs or their doctors to follow the procedures to either have the plan decision promptly reviewed, or to go forward with their preferred medical course of action—taking a different drug (*Davila*) and staying an extra night in the hospital (*Calad*)—even if their eligibility for financial reimbursement was in doubt—makes the plaintiffs' lawsuits far less justifiable").

321. See 29 U.S.C. § 1132 (2000) (making available the cost of the treatment in the case of a wrongful denial by the benefits provider).

322. See 29 U.S.C. § 1132 (2000) (providing for the potential recovery of attorney costs at the discretion of the court under equitable relief theory for an ERISA claim).

323. See *Davila*, 124 S. Ct. at 2503 (Ginsburg, J., concurring) (detailing the growing judicial insistence on congressional reform of the ERISA remedial scheme in light of the modern healthcare system and lack of "make-whole" relief).

324. See *supra* Part IV.A (detailing the appropriateness of the Court's reliance on the precedent in *Pegram* and *Pilot Life* in determining the result of the *Davila* case).

325. See Tony Mauro, *Health Industry Wins Big at Supreme Court*, LEGAL TIMES, June 22, 2004, available at <http://www.law.com> ("'Consumers are foreclosed from any meaningful recovery,' said Sarah Lock, senior attorney at the AARP. 'ERISA remedies are just not sufficient.'"). Under ERISA insured patients can recover the cost of the benefit that was denied and can get injunctive relief, but not lost wages or pain-and-suffering damages that might be available under state tort law. *Id.*

326. *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 135 (Stevens, J., dissenting) ("Given the open-ended implications of today's holding and the burgeoning volume of litigation involving ERISA preemption claims, I think it is time to take a fresh look at the

Justice Ginsburg appropriately wrote that it is squarely the responsibility of Congress to reform ERISA's remedial scheme in order to meet with the changing needs of society today.³²⁷ The concurring opinion correctly stated that the judiciary is bound by the terms of the statute and is not granted discretion to change the terms of ERISA as enacted, no matter what the practical need.³²⁸ Further narrowing of the preemptive scope of ERISA would not only be a violation of the precedent set forth in prior case law, it would have disastrous effects on the ability of health insurance plans to operate effectively.³²⁹ Therefore, Justice Ginsburg correctly stated that the most appropriate means of reform is through legislative, rather than judicial, change.³³⁰

V. IMPACT

The ruling in *Davila* has a potentially wide-ranging impact on current and future legislation, as well as judicial interpretation of ERISA at the state and federal levels.³³¹ This Part begins by describing the impact of *Davila*, clarifying the scope of preemption of state claims for wrongful denial of treatment in previously decided and newly heard cases in the circuit courts.³³² Next, this Part illustrates the impact of *Davila* on

intended scope of the pre-emption provision that Congress enacted.”).

327. See *Davila*, 124 S. Ct. at 2503 (Ginsburg, J., concurring) (calling for congressional reform in light of the lack of appropriate “make-whole” relief in ERISA’s regulatory scheme). See generally Theodore W. Ruger, *The United States Supreme Court and Health Law: The Year in Review*, 32 J.L. MED. & ETHICS 528, 529 (Fall 2004).

In reality, ERISA’s remedial provisions are so penurious that *Aetna*’s holding of complete preemption produces a legal regime that vastly under-compensates plan members who suffer a wrongful denial of care . . . [T]his means that a patient who suffers grievous harm as a direct result of an improper denial of treatment may recover ex post only the value of that treatment, and nothing for the injuries that were a foreseeable consequence of such denial.

Id.

328. See *Davila*, 124 S. Ct. at 2503–04 (Ginsburg, J., concurring) (noting the inability of the judiciary to enact legislative reform).

329. See *supra* Part IV.A-B (analyzing the effects of an alternative decision made by the Court in *Davila* and reviewing the clear precedent of prior case law).

330. See *Davila*, 124 S. Ct. at 2503 (Ginsburg, J., concurring) (joining the “the rising judicial chorus urging that Congress and [this] Court revisit what is an unjust and increasingly tangled ERISA regime” (citing *DeFelice v. Aetna U.S. Healthcare, Inc.*, 346 F.3d 442, 453 (3d Cir. 2003))).

331. See generally Sara Rosenbaum & Joel Teitelbaum, *Aetna Health v. Davila: Implications for Public Health Policy*, 119 PUB. HEALTH REP. 510, 510–12 (2004) (reviewing the implications of the *Davila* ruling on future claims for wrongful denial of treatment and the impact on managed care liability laws in various states).

332. See *infra* Part V.A (arguing that the *Davila* ruling virtually eliminates all state claims for recovery under wrongful denial of treatment theories for ERISA-regulated health plans).

THCLA and other state legislative mechanisms for HMO liability.³³³ Finally, this Part analyzes the additional pressures placed on Congress to enact legislative reform to ERISA.³³⁴

A. *Judicial Response to Davila in the Federal Courts*

After the Court published its opinion in *Davila*, a series of cases were heard in lower courts, both on remand and independent of the Supreme Court's involvement.³³⁵ The response of the federal judiciary in these cases is illustrative of the potential role of *Davila* relating to claims for wrongful treatment denial in federal courts.³³⁶

1. Revision of Rulings Inconsistent with *Davila* in the Circuit Courts

Following its ruling in *Davila*, the Supreme Court remanded several cases to the appellate courts for reconsideration in light of *Davila* concerning ERISA preemption.³³⁷ The rationale behind remanding cases was to correct prior misapplications of the narrow exception to ERISA preemption permitted by *Pegram*.³³⁸

In *Cicio v. Does*, the Supreme Court remanded the case back to the Second Circuit for review consistent with the Court's decision in *Davila* on June 28, 2004.³³⁹ The Second Circuit noted that the *Davila* opinion undermined the legal foundation of its ruling in 2003.³⁴⁰ Based on the clarification of the rule in *Pegram*, and noting that in this case the defendants were not in the dual role of administrator and treating physician, the court vacated its prior decision and affirmed the dismissal

333. See *infra* Part V.B (reviewing the impact of *Davila* on THCLA and each of the state statutes affected by the decision).

334. See *infra* Part V.C (describing the pressure being placed upon Congress to reform the civil remedial mechanism of ERISA).

335. See, e.g., *Cicio v. Does*, 385 F.3d 156 (2d Cir. 2004) (remanding to the circuit court in light of the *Davila* holding); *Mayeaux v. La. Health Serv. & Indem. Co.*, 376 F.3d 420 (5th Cir. 2004) (relying on the Supreme Court's ruling in *Davila* in deciding a case concerning an alleged wrongful treatment denial).

336. See generally 1 EMP.COORDINATOR BENEFITS § 5:170 (2004) (detailing the impact of the *Davila* decision and illustrating several cases decided immediately following *Davila* that apply the narrow interpretation of *Pegram*'s ERISA preemption exception).

337. See, e.g., *Cicio*, 385 F.3d at 156 (noting that the Supreme Court had remanded the decision of the appellate court in 2003 for reconsideration in light of the *Davila* holding).

338. See generally *id.* (reversing the prior decision of the court in 2003 and holding that ERISA preemption precluded state claims against the non-treating physician employees of the HMO).

339. *Id.* at 157–58.

340. *Id.* at 158 (“*Aetna Health Inc.* fatally undermines our reasoning in the panel decision in *Cicio*.”).

of the complaint based on ERISA preemption.³⁴¹

Similarly, the Supreme Court remanded *Land v. Vytra Healthcare* to the Eleventh Circuit for reconsideration in light of *Davila*.³⁴² The Eleventh Circuit specifically noted that the *Pegram* exception based on a “mixed determination of eligibility and treatment” was clarified in *Davila* to be limited to situations where the treating physician is the object of the claim.³⁴³ Relying on this analysis, the Eleventh Circuit vacated its previous decision and affirmed the lower court decision holding that ERISA precluded Land’s state-based claim for negligence.³⁴⁴

2. Cases Heard Concerning Preemption Following *Davila*

In the months immediately following *Davila*, the clarification of the Court’s prior ruling in *Pegram* was relied upon to decide several cases concerning treatment denials.³⁴⁵ The clear limitation of the “mixed decision of eligibility and treatment” exception to ERISA preemption by the Court in *Davila* led to the rejection of a series of state-based claims for wrongful denials of treatment by HMO administrators.³⁴⁶

The Fifth Circuit decided *Mayeaux v. Louisiana Health Service and Indemnity Co.* on July 1, 2004, immediately following the *Davila* ruling.³⁴⁷ Relying substantially on the *Davila* holding, the court found that ERISA preempts state-law claims against a health plan administrator by a plan participant and her physician based on denial of an experimental treatment.³⁴⁸ The Fifth Circuit noted that the Supreme Court decision limited the mixed eligibility and treatment exception to ERISA to wrongful determinations made by employee physicians of

341. *Id.*

342. *Land v. CIGNA Healthcare of Fla.*, 381 F.3d 1274 (11th Cir. 2004).

343. *Id.* at 1276 (“The Court also cast doubt on our analysis of and reliance on *Pegram*, finding that *Pegram* is only implicated in circumstances in which the healthcare professionals brought to suit are either the injured party’s treating physicians or the employers of the injured party’s treating physicians”).

344. *Id.* (“In light of the Supreme Court’s conclusions, we find that Land’s causes of action, brought to remedy the denial of benefits under an ERISA-regulated benefit plan, fall within the scope of, and are completely preempted by ERISA § 502(a)(1)(B), and are thus removable to federal court.”).

345. *See generally* 1 EMP. COORDINATOR BENEFITS § 5:170 (2004) (detailing the impact of the *Davila* decision and illustrating several cases decided immediately following *Davila* that apply the narrow interpretation of *Pegram*’s ERISA preemption exception).

346. *See, e.g.*, *Mayeaux v. La. Health Serv. & Indem. Co.*, 376 F.3d 420, 431 (5th Cir. 2004) (holding that ERISA preempted the insured’s tort claim against a group health care provider).

347. *Id.*

348. *Id.* at 431–32. *See* 1 EMP. COORDINATOR BENEFITS § 5:170 (2004) (describing the holding of the fifth circuit in *Mayeaux* immediately following *Davila*).

HMOs acting as both plan administrators and caregivers.³⁴⁹

Additionally, following the precedent of *Davila* in holding certain aspects of state legislation superceded by ERISA's exclusive regulatory scheme, the Third Circuit in *Barber v. Unum Life Insurance Co.* ruled that ERISA preempted and invalidated a Pennsylvania "bad faith" statute.³⁵⁰ The Pennsylvania "bad faith" law permitted insurance plan participants and beneficiaries to file a suit for punitive damages in state court based upon an action in bad faith by an insurer to the insured.³⁵¹ The plaintiff requested punitive damages based on a termination of disability benefits by the defendant that was allegedly in bad faith.³⁵² The defendant insurer claimed that the state-law based claim conflicted with the exclusive remedial scheme of ERISA by supplementing the available remedies with punitive damages.³⁵³ The court, relying on *Davila*, noted that state laws that permit judicial relief that add to the exclusive remedial scheme in section 502(a) are preempted by ERISA and dismissed the plaintiff's bad faith claim.³⁵⁴

B. Impact on THCLA and Other State Patients' Rights Statutes

The *Davila* holding substantially impacted THCLA and the other state "right to sue" statutes passed prior to 2004.³⁵⁵ Based upon the

349. *Mayeaux*, 376 F.3d at 431–32. See 1 EMP. COORDINATOR BENEFITS § 5:170 (2004) ("The Fifth Circuit opinion said that the Supreme Court decision 'expressly rejects' any effort to extend the principle that mixed eligibility and treatment decisions by health maintenance organizations are not preempted by ERISA to cover traditional indemnity insurers such as the one in this case.").

350. *Barber v. Unum Life Ins. Co. of Am.*, 383 F.3d 134, 136 (3d Cir. 2004) ("Because we hold 42 Pa. C.S. § 8371 is conflict preempted by ERISA, or alternatively expressly preempted under ERISA § 514(a), we will reverse the judgment of the District Court and remand with instructions to dismiss Barber's bad faith claim"); see also Shannon P. Duffy, *Ruling Boots Theory Allowing Bad-Faith ERISA Litigation; Decision No Surprise on Heels of U.S. Supreme Court's Recent Ruling in Davila*, PA. L. WKLY., Sept. 13, 2004 (detailing the Third Circuit's holding in *Barber* that ERISA supercedes the Pennsylvania bad-faith "right to sue" statute based upon the precedent in *Davila*).

351. 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.

42 PA. CONS. STAT. ANN. § 8371 (West Supp. 2004).

352. *Barber*, 383 F.3d at 136.

353. *Id.* at 136–37.

354. *Id.* at 140 ("[A] state statute is preempted by ERISA if it provides 'a form of ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA'" (quoting *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002))).

355. See *supra* Part II.B.4 (listing the various states that have passed "right to sue" statutes

precedent set by *Barber* interpreting *Davila*, ERISA will likely supercede and preempt subsequent cases brought in state court under a state “right to sue” statute.³⁵⁶ In fact, the ruling in *Davila* directly affects twelve of the state “right to sue” statutes, leaving patients with an ERISA claim as the exclusive avenue of recovery in most circumstances following a wrongful denial of treatment by an administrative agent of an HMO.³⁵⁷ This effectively limits any claim for a wrongful denial of treatment that does not fit into the limited *Pegram* exception to the recovery of cost of treatment denied and bars any potential recovery of compensatory or punitive damages.³⁵⁸ For all practical purposes, the cost of pursuing litigation of an ERISA claim relative to the low potential for recovery in most cases will bar potential plaintiffs from pursuing such claims and attorneys from pursuing such litigation.³⁵⁹

In comparison to the more narrow preemption of state attempts at regulation of HMOs in prior federal cases such as *Rush Prudential*, *Davila* clearly creates a presumption that state regulation of the administrative role of HMOs concerning treatment denials is in conflict with the exclusive regulatory scheme of ERISA and therefore preempted.³⁶⁰ This trend is evident in the cases heard concerning state “right to sue” statutes based on wrongful treatment denials following the *Davila* decision to date.³⁶¹

similar in effect to THCLA).

356. See *supra* Part IV.A (reviewing the holding in the *Barber* case where the court held that a Pennsylvania state law permitting recovery of punitive damages for bad faith was superceded by ERISA).

357. Janet L. Kaminski, *ERISA Bars HMO Liability Lawsuits in State Court*, July 16, 2004, available at <http://www.cga.ct.gov/2004/rpt/2004-R-0550.htm> (“According to the National Conference of State Legislatures (NCSL), 12 states have laws relating to a patient’s right to sue his managed care company that are affected by the U. S. Supreme Court’s June 2004 decision. The 12 states are: Arizona, California, Georgia, Louisiana, Maine, New Jersey, North Carolina, Oklahoma, Oregon, Texas, Washington, and West Virginia”); see *supra* Part II.B.4 (detailing the individual states that have passed “right to sue” statutes similar to THCLA); see also NCSL Report, *supra* note 6 (listing each of the states with “right to sue” statutes passed prior to the *Davila* court ruling and noting that twelve of them are adversely affected by the *Davila* holding).

358. See *supra* Part V.A.2 (describing the holding of cases applying the *Davila* holding to claims for wrongful treatment denials as being limited to ERISA-based claims for relief); *supra* Part II.A.1 (analyzing the various remedies available under § 514(a) of ERISA to private parties).

359. See, e.g., *supra* Part III (explaining the rationale of the plaintiffs in the *Davila* case for pursuing state-based claims and their refusal to pursue ERISA-based claims based on the disparate potential for recovery).

360. See *supra* Part II.B.2 (detailing the history of cases considered in the federal courts relating to potential preemption of state statutes regulating health insurance administration).

361. See *supra* Part V.A.2 (recounting several cases decided based on the *Davila* decision in the lower courts that have held state-law based claims for wrongful treatment denials to be preempted by ERISA).

C. Increase in Political Pressure for Congressional Reform

Throughout the last ten years, passage of a Patients' Bill of Rights that would reform ERISA's limited remedial mechanism for health plan participants has received extremely strong popular support.³⁶² Prior to *Davila*, the inconsistency in judicial interpretation of the scope of ERISA's preemptive power created a split in the reform movement between legislative change at the state and federal level.³⁶³ The inability of popular support to focus on a single avenue of change resulted in the failure of reform at the federal legislative level.³⁶⁴ *Davila*, however, effectively closes off the avenue of state legislation to circumvent ERISA as well as the availability of reform through litigation resulting in judicial reinterpretation of ERISA's preemptive scope.³⁶⁵ *Davila*, although negatively affecting plan beneficiaries in the short run by excluding the chance for more adequate recoveries in state courts, will benefit them in the long run by leading to stronger pressure being placed on Congress to provide relief.³⁶⁶

This increased pressure was evident immediately following *Davila*.³⁶⁷ For example, California's state legislature recently proposed a Joint Resolution urging Congress for changes to ERISA as a response to the pressures placed upon it by constituents pushing for ERISA reform.³⁶⁸ Additionally, the Patients' Bill of Rights is again being

362. See KFF Report, *supra* note 163 (reporting the results of surveys concerning the support for a Patients' Bill of Rights as averaging over fifty-seven percent in the past six years).

363. See Alex Calcagno, *High Court Ruling Rekindles Interest in National Patients' Bill of Rights*, MASS. MED. SOC'Y ONLINE, Aug. 2004, available at <http://www2.mms.org/vitalsigns/aug04/ga2.html> (describing the lack of perceived need for federal reform of ERISA due to state legislative action in the past six years).

364. See *id.* ("But as states passed their own patients' rights laws and the courts ruled in favor of harmed patients, the need for federal legislation appeared to diminish.").

365. See NCSL Report, *supra* note 6 (detailing the wide-ranging affect of *Davila* upon the state attempts at passage of "right to sue" legislation); *Aetna Health, Inc. v. Davila*, 124 S. Ct. 2488, 2502 (2004) (holding conclusively that ERISA preempts claims for wrongful denials of treatment made by an administrative agent of a benefits plan).

366. See, e.g., S.J. Res. 2 (Ca. 2003), available at http://info.sen.ca.gov/pub/bill/sen/sb_0001-0050/sjr_2_cfa_20040630_161250_sen_floor.html (calling upon Congress to enact substantive reform to ERISA's civil enforcement mechanism by enacting a federal Patients' Bill of Rights).

367. See, e.g., H.R. 4628, 108th Cong. (2004), available at <http://www.thomas.loc.gov> (proposing an amendment to ERISA that provides for a more substantive recovery for patients who are subject to wrongful denials of care).

368. S.J. Res. 2 (Ca. 2003), available at http://info.sen.ca.gov/pub/bill/sen/sb_0001-0050/sjr_2_cfa_20040630_161250_sen_floor.html.

This SJR calls upon: 1. Congress and the President to enact a meaningful and enforceable Patient's Bill of Rights that includes the ability of HMO patients to hold their HMO legally responsible for harm caused by the HMO's wrongdoing, or in the alternative, to enact legislation that amends ERISA to allow states to provide their own citizens with greater protections and rights than federal law.

reconsidered for passage within Congress, containing elements that are directly intended to provide for ERISA reform.³⁶⁹ Proposed H.R. 4628, the Patients' Bill of Rights Act of 2004, guarantees certain rights to health insurance plan subscribers.³⁷⁰ In part, this measure would provide plan beneficiaries and participants the right to hold a health plan liable if the HMO's negligent medical decision resulted in injury.³⁷¹

In time, although *Davila* represents a short-term loss for the proponents of ERISA reform, the elimination of state legislative and judicial reform mechanisms will hasten the eventual victory of plan beneficiaries in obtaining make-whole relief under ERISA.³⁷²

VI. CONCLUSION

In *Aetna Health v. Davila*, the Supreme Court clarified the scope of ERISA's preemptive scope as applied to administrative determinations of health benefits. The Court did so correctly, consistent with established precedent, holding that the federal remedies in section 502(a)(3) of ERISA superceded THCLA section 88.002(a)'s remedial scheme. This decision will have a wide impact on similar legislation in a number of states, focusing the need for legislative reform on the shoulders of Congress. The ruling has a potentially detrimental impact on current participants in ERISA-regulated health plans by eliminating a means of recovery for compensatory and punitive damages relating to wrongful treatment denials by HMO administrators. Nevertheless, future attempts at reform will be more concentrated, going forward firmly in the realm of federal legislation. The net effect of this increased pressure will likely result in the expedient passage of a substantive federal Patient's Bill of Rights in the near future that will make *Davila* immaterial.

Id.

369. H.R. 4628, 108th Cong. (2004), available at <http://thomas.loc.gov> (providing a cause of action for plan beneficiaries and participants who are wrongfully denied medically necessary treatment where "such plan, plan sponsor, or issuer shall be liable to the participant or beneficiary (or the estate of such participant or beneficiary) for economic and noneconomic damages (but not exemplary or punitive damages) in connection with such personal injury or death").

370. See National Association of Wholesaler-Distributors, HEALTH CARE REFORM, at http://www.naw.org/Content/ContentGroups/Government_Relations1/Advisories1/Health_Care_Reform.htm (describing the reintroduction of the "Patients' Bill of Rights" in the U.S. Congress by Representative Dingell).

371. H.R. 4628, 108th Cong., at 160 (2004), available at <http://thomas.loc.gov>.

372. See Ruger, *supra* note 327, at 528 (predicting that the *Davila* ruling's "catalyzing force will be vastly greater than its immediate ruling on ERISA's remedial exclusivity" by instigating more rapid congressional reform of ERISA).