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AETNA V. DAVILA: ABSOLUTION FOR MANAGED HEALTH CARE ORGANIZATIONS

I. INTRODUCTION

When you go to the doctor seeking treatment for some ailment, who do you think decides what treatment is necessary to remedy your condition? Unquestionably, most people would answer that it is the doctor's charge to treat his or her patients. Doctors are meticulously trained to assess their patients' conditions and provide the appropriate and required medical treatment. Furthermore, if patients do not receive the correct treatment and are injured as a result, medical malpractice liability acts as an important check on physicians while protecting the patients' rights.

With this framework in mind, imagine a woman goes to the hospital complaining of severe stomach pains. After a thorough examination, the woman's physician recommends a treatment regimen that includes an overnight hospital stay. However, when the hospital calls the woman's insurance company to obtain approval for the physician-recommended treatment, the insurance administrator refuses to cover the hospital stay. The woman, unable to immediately pay out-of-pocket for her clinically indicated treatment, is forced to go home where she suffers severe complications.

What is the woman's remedy? A medical malpractice claim against her physician would be ineffective because her doctor did nothing wrong. Who is to blame for the woman's avoidable pain and suffering? Her health insurance company refused her doctor-prescribed treatment. If the company's refusal was negligent, should it be held liable? Although holding the company liable for injuries resulting from its unqualified assessment of what treatment is medically necessary seems like the logical, just conclusion, the United States Supreme Court recently ruled that health insurance companies in these situations are effectively exempt from any tort

liability.¹

In *Aetna v. Davila*,² the United States Supreme Court held that state claims against a Health Maintenance Organization (HMO) for injuries resulting from the HMO's allegedly negligent denial of benefits were completely preempted by the Employee Retirement Income Security Act³ (ERISA). Specifically, the Court unanimously ruled that patients who receive their health care through an employer-sponsored ERISA health plan cannot sue their HMOs under state law for injuries resulting from their HMOs' administrative treatment decisions.⁴

In so ruling, the Court reversed the Fifth Circuit's decision and thereby crushed patient bill of rights laws in Texas and nine other states.⁵ At issue was whether HMOs should be subject to medical malpractice rules if they make medical judgments about the quality of medical care when determining health care coverage.⁶ The Supreme Court answered with a resounding no, marking a major victory for health insurers.⁷ As a result, if an HMO negligently denies or delays a patient's physician-recommended treatment, it appears that the patient cannot sue the HMO for injuries caused by its negligence. Rather, the patient can only recover severely limited ERISA remedies: the cost of the denied benefit or injunctive relief.⁸

This Comment will evaluate the Court's holding in *Davila* and its implications on the vast majority of working Americans who receive health coverage through their employers, and as a result, through an ERISA-sponsored benefit plan. In addition, this Comment will explain how the Supreme Court's recent decision marks a reversion to pre-1995 expansive preemption, a shift that effectively closed the door to lower courts' attempts to limit ERISA

1. *Aetna v. Davila*, 542 U.S. 200 (2004).

2. *Id.*

3. 29 U.S.C. §§ 1001–1461 (2000).

4. 542 U.S. at 204.

5. Patty Reinert, *Court Ruling Favors HMOs; Patients Can't Seek Damages at State Level*, HOUSTON CHRON., June 22, 2004, at A1. The other states affected are Arizona, California, Georgia, Louisiana, Maine, New Jersey, Oklahoma, Washington and West Virginia. *Id.*

6. *See Davila*, 542 U.S. at 212–14.

7. *Id.* at 213–14; *see Reinert, supra* note 4.

8. *See* 29 U.S.C. § 1132; *Davila*, 542 U.S. at 214; *see also infra* Part II.B (discussing ERISA remedies).

preemption through the implied authority of a 1995 Supreme Court decision, *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*⁹ In particular, this Comment will show how the current state of ERISA preemption has left millions of patients without a complete remedy because of limited access to the courts under ERISA's civil enforcement provisions.

Part II relays the history behind ERISA's enactment and its subsequent application. Part III describes the background of the instant case, and Part IV reviews the reasoning the Court employed to reach its current holding. The analysis of the Court's ruling and its resulting implications are analyzed in Part V.

II. HISTORICAL FRAMEWORK

The history of ERISA is long and complicated. Congress enacted ERISA in 1974 to protect employees' interests in their retirement and pension benefits and to prevent benefit plan administrators from having to comply with different state pension laws and regulations.¹⁰ Although ERISA's primary purpose was to regulate and guarantee the solvency of pension plans, the legislature expanded ERISA's scope to provide federal oversight of numerous employer-sponsored fringe benefit plans, including health coverage plans.¹¹ As a result, ERISA now regulates both pension and welfare plans.

A. *Managed Care and Medical Necessity*

In 1974, HMOs were not as prevalent as they are today;¹² the legislature simply could not have anticipated the far reaching application ERISA now commands three decades later. Today, over

9. 514 U.S. 645 (1995).

10. J. Keith Pollette, *ERISA Preemption of "Mixed Eligibility and Treatment Decisions" by HMOs*, 27 AM. J. TRIAL ADVOC. 393, 394 (2003).

11. See 120 CONG. REC. 31,065 (1974) (explaining that ERISA would affect "defined benefit plans, defined contribution plans, target benefit plans . . . and similar plans"). There are limited exceptions regarding the types of employee benefit plans to which ERISA applies, e.g., church plans and government-sponsored plans. See 29 U.S.C. § 1003(b) (2000).

12. See Russell Korobkin, *The Failed Jurisprudence of Managed Care, and How to Fix It: Reinterpreting ERISA Preemption*, 51 UCLA L. REV. 457, 462 (2003) (explaining the transition from a "fee-for-service" system to the "managed care" system).

130 million American workers are insured through a “managed care” plan, which include HMOs.¹³ Managed care plans operate through a system whereby one company provides an insurance function and also provides or arranges healthcare services.¹⁴ Because managed health care organizations receive fixed payments from customers, their profits are therefore dependent on how much they can minimize the cost of providing care.¹⁵ As a result, it is financially beneficial for HMOs to limit what treatment they cover.¹⁶

HMOs often limit coverage by evaluating physician-recommended treatment and approving or denying coverage based on what the HMO deems is medically necessary.¹⁷ Services that are not considered “medically necessary” can include treatment that is experimental, investigational, cosmetic, or for the convenience of the patient.¹⁸ Such determinations, however, often reflect disagreements between administrators and treating physicians as to the appropriateness of choosing one treatment or medication over another that is more expensive.¹⁹ Other cost-controlling measures involve giving financial incentives to physicians by rewarding them for decreased use of health-care services, such as recommended hospital stays, and penalizing physicians for what the HMOs believe is excessive treatment.²⁰ HMOs first introduced these cost-cutting techniques and coverage exclusions as a result of cost pressures that also forced HMOs to make their own decisions about what treatment was medically necessary rather than rely on physician recommendations.²¹

*B. ERISA’s Preemptory Provisions:
Conflict and Complete Preemption*

ERISA has broad preemptive effect over state-based causes of

13. David G. Savage, *High Court Limits Right to Sue HMOs*, L.A. TIMES, June 22, 2004, at A1.

14. Korobkin, *supra* note 12, at 462.

15. *Id.* at 463.

16. *Id.*

17. *Id.*

18. William M. Sage, *Managed Care’s Crime: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance*, 53 DUKE L.J. 597, 605 (2003).

19. *See id.*

20. *Pegram v. Herdrich*, 530 U.S. 211, 219 (2000).

21. Sage, *supra* note 18, at 605.

action against an ERISA-sponsored HMO because the statute provides specific federal remedies for violations of its provisions.²² These remedies are embodied in two preemptory provisions: conflict preemption and complete preemption.²³

1. Section 514 Conflict Preemption

Conventional conflict preemption principles require preemption “where compliance with both federal and state regulations is a physical impossibility . . . or where state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.”²⁴ ERISA’s express preemption provision is defined in ERISA § 514. Section 514 mandates that ERISA’s welfare plan regulations “shall supersede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan.”²⁵ This provision supplants state laws that “relate to” or try to regulate any employee benefit plan.²⁶ The Supreme Court has explained that a “law ‘relates to’ an employee benefit plan . . . if it has a connection with or reference to such a plan.”²⁷ In addition, § 514 provides a federal law defense to state common law causes of action that “relate to” an employee benefit plan.²⁸

Under the above provision, a defendant HMO that is sued in state court under the provisions of an ERISA-sponsored benefit plan may invoke preemption and have the claim dismissed. As a result, a plaintiff’s only course of action would be to sue under ERISA in federal court seeking ERISA remedies.

The Supreme Court has explained that the ERISA preemption provision reflects broad congressional intent to preempt all state laws

22. See *Aetna v. Davila*, 542 U.S. 200, 208–10 (2004).

23. 29 U.S.C. §§ 1132, 1144(a) (2000).

24. *Gade v. Nat’l Solid Wastes Mgmt. Ass’n*, 505 U.S. 88, 98 (1992) (internal quotation marks and citations omitted).

25. 29 U.S.C. § 1144(a) (emphasis added).

26. See *Pollette*, *supra* note 10, at 395.

27. *Shaw v. Delta Air Lines*, 463 U.S. 85, 96–97 (1983).

28. See *id.* Section 514 has one exception whereby federal preemption is inapplicable: the “savings clause.” Under this provision, claims that would normally be preempted are “saved” if they are brought under state laws regulating insurance, banking, or securities. 29 U.S.C. § 1144(b)(2)(A); see also *infra* Part IV.B (discussing why the savings clause is inapplicable to the instant case).

in connection with or reference to ERISA plans.²⁹ In fact, federal courts have historically found that “ERISA preemption extends to state law civil actions against . . . managed care entities if the claim . . . arises from a coverage determination even if the determination . . . was based on a finding that recommended treatment [was] not medically necessary,” with very limited exceptions.³⁰

2. Section 502(a) Complete Preemption

Unlike conflict preemption, complete preemption “is less a principle of substantive preemption than it is a rule of federal jurisdiction.”³¹ The complete-preemption doctrine applies when “the pre-emptive force of a statute is so ‘extraordinary’ that it ‘converts an ordinary state . . . complaint into [a federal] one.’”³² Section 502(a)(1)(B) specifies that a “civil action may be brought (1) by a participant or beneficiary” to an ERISA-regulated plan “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.”³³ As a result, § 502(a) provides for federal jurisdiction over claims brought under ERISA and limits the remedies for such claims.

To enforce removal under § 502(a), the state civil action must be one over which the district courts of the United States have original jurisdiction.³⁴ Accordingly, there must be diversity jurisdiction, or the claim must be within “federal question” jurisdiction, i.e., a claim “arising under the Constitution, laws, or treaties of the United

29. Karen A. Jordan, *Recent Modifications to the Preemption Doctrine & Their Impact on State HMO Liability Laws*, 1 IND. HEALTH L. REV. 51, 63 (2004); see, e.g., *Shaw*, 463 U.S. 85 (holding that state laws requiring benefits to be provided to employees disabled by pregnancy were “related to” employee benefit plans under ERISA because they had a connection with, or reference to, such plans).

30. Jordan, *supra* note 29, at 53 n.2. Cf. *Pegram v. Herdrich*, 530 U.S. 211 (2000) (holding that decisions involving both eligibility and treatment do not give rise to ERISA claims).

31. *McClelland v. Gronwaldt*, 155 F.3d 507, 516 (5th Cir. 1998).

32. *Caterpillar, Inc. v. Williams*, 482 U.S. 386, 393 (1987) (citing *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 65 (1987)).

33. 29 U.S.C. § 1132.

34. 28 U.S.C. § 1441(a) (2000).

States.”³⁵ Under the well-pleaded complaint rule, federal question jurisdiction exists only where an issue of federal law appears on the face of the complaint.³⁶

Federal preemption is applicable as a federal defense to a plaintiff’s state-law cause of action.³⁷ However, federal preemption does not actually appear on the face of a well-pleaded complaint; therefore, it does not authorize removal to federal court.³⁸ Yet, if Congress so completely preempts a particular area, then any state complaint within this specific area is “necessarily federal in character.”³⁹

The Court has concluded that Congress “clearly manifested an intent to make causes of action within the scope of” § 502(a)’s civil enforcement provisions removable to federal court.⁴⁰ However, ERISA preemption under § 502(a) is an exception to the well-pleaded complaint rule.⁴¹ In other words, when a state-law claim “‘comes within the scope of [an exclusively] federal cause of action’, it . . . ‘arises under federal law,’ and is completely preempted.”⁴² Applied to § 502(a), this means that if a state law cause of action seeks to vindicate rights already protected under § 502(a), the Court will consider the claim a federal claim and that claim will thus serve as a basis for “arising under” subject matter jurisdiction.⁴³ Therefore, a state law cause of action arises under federal law and is removable to federal court if “(1) the cause of action is based on a state law that is preempted by ERISA, and (2) the cause of action is ‘within the scope of’” § 502(a)’s civil enforcement provisions.⁴⁴

C. Effects of ERISA Preemption

ERISA’s preemption provisions require removal of a claim

35. 28 U.S.C. §§ 1331, 1332.

36. *Franchise Tax Bd. of Cal. v. Constr. Laborers Vacation Trust for S. Cal.*, 463 U.S. 1, 9–10 (1983).

37. *See id.* at 12.

38. *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987).

39. *Id.* at 63–64.

40. *Id.* at 66.

41. *See id.* at 66–67.

42. *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 446 (3d Cir. 2003) (first alteration in original) (quoting *Franchise Tax Bd. of Cal. v. Constr. Laborers Vacation Trust for S. Cal.*, 463 U.S. 1, 9–10 (1983)).

43. *Cicio v. Does*, 321 F.3d 83, 94 (2d Cir. 2003).

44. *Romney v. Lin*, 94 F.3d 74, 78 (2d Cir. 1996).

brought by an employee under an ERISA-covered plan.⁴⁵ ERISA further limits the monetary remedies available for such claims to recovery of the cost of the denied benefit.⁴⁶ Accordingly, a patient who has suffered injury as a result of a denied benefit may only recover the cost of the denied benefit or secure injunctive relief that forces the HMO to cover the disputed benefit.⁴⁷ However, the patient is *not* entitled to any compensatory or punitive damages.⁴⁸

The effect of this provision is severe. Consider the following illustration: Patient A's doctor prescribes a specific pain reliever known to have more mild side effects than its leading generic counterpart. However, Patient A's HMO refuses to cover the prescribed medication because it decides that the prescribed medication is not medically necessary. Patient A, unable to pay for the prescribed medication out-of-pocket, or wait to bring suit and force his HMO to cover the medication, accepts the covered generic medication. As a result, he suffers severe intestinal bleeding and a heart attack. If Patient A feels his HMO's negligent denial of benefits proximately caused his injuries, Patient A's *only* recourse is to sue under ERISA § 502(a) and seek one of two remedies: (i) the amount of money it would have cost the HMO to cover the prescribed medication in the first instance, or (ii) an injunction requiring the HMO to now cover the prescribed medication.⁴⁹ However, § 502 does not permit Patient A to sue the HMO to recover for the pain and suffering or medical expenses resulting from his internal bleeding and heart attack, circumstances arguably caused by the HMO's negligent denial of benefits.⁵⁰

Because of circumstances such as those illustrated in the above hypothetical, some have sharply criticized ERISA's sweeping preemption provisions for insulating managed care organizations from liability.⁵¹ Under the Supreme Court's interpretation, ERISA creates incentives for HMOs to "deny claims in bad faith or

45. See *Metro. Life Ins.*, 481 U.S. at 66–67 (1987).

46. 29 U.S.C. § 1132 (2000); see also *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 53–54 (1987) (noting that the ERISA civil enforcement provisions were carefully crafted to include certain remedies and exclude other remedies).

47. *DiFelice*, 346 F.3d at 457–58 (Becker, J., concurring).

48. See *id.* at 458.

49. See 29 U.S.C. § 1132.

50. See *DiFelice*, 346 F.3d at 458.

51. See, e.g., *id.* at 457–59.

otherwise 'stiff' participants."⁵² For example, because ERISA preempts the state tort of bad-faith claim denial,⁵³ if an HMO wrongfully denies a participant's claim, the greatest cost it could face is that of the denied procedure, the very cost it would have faced initially.⁵⁴ As a result, an HMO would conceivably pay more out of pocket if it initially authorized coverage than it would by denying claims up front.⁵⁵ Furthermore, ERISA does not allow for punitive damages, which might guard against such profiteering, thus creating "a 'race to the bottom' in which, all else being equal, the most profitable HMOs will be those that deny claims most frequently."⁵⁶

Nonetheless, the Supreme Court has repeatedly reinforced the breadth of ERISA preemption.⁵⁷ ERISA, therefore, continues to insulate HMOs state law claims arising from an HMO's decision to deny benefits under an ERISA-regulated benefit plan.

III. STATEMENT OF THE CASE

Aetna v. Davila began when respondents Juan Davila and Ruby Calad brought suit against their respective HMOs, Aetna Health and CIGNA Healthcare of Texas for alleged failures to exercise ordinary care in the administration and handling of their health coverage plans.⁵⁸ Davila and Calad brought their claims under the Texas Health Care Liability Act (THCLA),⁵⁹ which imposed a statutory duty on HMOs to exercise ordinary care when making health care treatment decisions.⁶⁰ The Act also held HMOs liable for damages when patients suffered injury as a result of a HMO's negligent denial of benefits.⁶¹

Davila was a participant and Calad a beneficiary in an ERISA-regulated employee benefit plan when they suffered their injuries.⁶²

52. *Id.* at 459.

53. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54-56 (1987).

54. *DiFelice*, 346 F.3d at 459.

55. *Id.*

56. *Id.*

57. *See, e.g., Dedeaux*, 481 U.S. 41; *Shaw v. Delta Airlines*, 463 U.S. 85 (1983).

58. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 204 (2004).

59. TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-003 (Vernon 2005).

60. *Davila*, 542 U.S. at 204; TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a).

61. TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a).

62. *Davila*, 542 U.S. at 204.

In Davila's case, pursuant to an agreement with his plan sponsor, Aetna reviewed requests for coverage and paid health care providers.⁶³ In Calad's case, CIGNA contracted with the plan sponsor to make CIGNA responsible for plan benefits and coverage decisions.⁶⁴

Calad claimed her injuries arose after she "underwent a hysterectomy with rectal, bladder, and vaginal repair" that was performed by a CIGNA physician under her health plan.⁶⁵ After the procedure, Calad's surgeon recommended that she remain at the hospital for an extended period to monitor her recovery.⁶⁶ However, against the doctor's recommendation, CIGNA's hospital discharge nurse discharged Calad after a standard one-day hospital stay.⁶⁷ Furthermore, because the nurse concluded Calad did not meet the plan's criteria for an extended stay, CIGNA denied her further coverage for in-hospital recovery.⁶⁸

After Calad's discharge, she suffered post-surgery complications that forced her to return to the emergency room.⁶⁹ Calad subsequently sued CIGNA in state court under the THCLA alleging that: (i) CIGNA failed to use ordinary care and acted negligently when it made its decision about what treatment was medically necessary, and (ii) the way CIGNA administered its coverage made substandard care more likely.⁷⁰ Essentially, Calad alleged that her post-surgery complications would not have occurred if CIGNA had approved her physician-recommended hospital stay.⁷¹

Davila also suffered medical complications because his HMO refused to cover his physician-recommended treatment. Davila's physician prescribed a certain pain killer for his arthritis pain because studies showed that this medication had less severe gastrointestinal bleeding and ulceration side-effects than other arthritis pain medications.⁷² Aetna, however, required Davila to complete a "step

63. *Id.*

64. *Id.*

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

66. *Davila*, 542 U.S. at 205.

67. *Roark*, 307 F.3d at 302.

68. *Davila*, 542 U.S. at 205.

69. *Roark*, 307 F.3d at 302.

70. *Id.*

71. *Davila*, 542 U.S. at 205.

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

program” in which he would have to first take two different medications known for causing a higher incidence of such side-effects before it would cover his prescribed medication.⁷³ If Davila suffered a “detrimental reaction” or his condition “failed to improve” after taking the “step program” medications, Aetna would then consider covering Davila’s physician-prescribed pain medication.⁷⁴

After three weeks on the “step program,” Davila was rushed to the emergency room, suffering from “bleeding ulcers, which caused a near heart attack and internal bleeding.”⁷⁵ Davila’s ailments required extensive treatment and hospitalization, and he is now unable to take any pain medication that is absorbed through the stomach.⁷⁶

Davila, like Calad, sued Aetna in state court under the THCLA.⁷⁷ Davila claimed that Aetna’s refusal to cover his recommended treatment violated its “duty to exercise ordinary care when making health care treatment decisions” and that those refusals proximately caused his injuries.⁷⁸ Davila and Calad’s claims were both state tort claims that attempted to recover under HMO medical malpractice liability.⁷⁹ However, Aetna and CIGNA removed the cases to Federal District Court arguing that the state claims fit “within the scope of” ERISA and were thus completely preempted by the federal law.⁸⁰

According to the defendant HMOs, since both of the plaintiffs’ claims were based on wrongful or negligent denial of benefits (an extended hospital stay with respect to Calad and received medications with Davila) this seemed to fit squarely within a § 502(a) claim.⁸¹ The district courts agreed and found that both claims were completely preempted under ERISA.⁸² Both claimants appealed to the Court of Appeals for the Fifth Circuit, where the

73. *Id.*

74. *Id.*

75. *Id.*

76. *Id.*

77. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 204 (2004).

78. *Id.* at 205.

79. *Roark*, 307 F.3d at 309.

80. *Davila*, 542 U.S. at 205.

81. *Id.*

82. *Id.*

court consolidated their claims.⁸³

The Fifth Circuit recognized that state causes of action that duplicate or fall within the scope of an ERISA § 502(a) remedy are preempted.⁸⁴ However, the court found that because Davila and Calad did not bring explicit ERISA claims, but rather tort claims arising from their HMOs “mixed eligibility and treatment decisions,”⁸⁵ the claims were outside the scope of preemption because they did not duplicate the causes of action outlined under ERISA § 502(a).⁸⁶

Furthermore, the Fifth Circuit held that ERISA should not preempt state malpractice laws or create a federal common law of medical malpractice when a patient seeks compensation for injuries resulting from an HMO’s mixed eligibility and treatment decisions.⁸⁷ The Fifth Circuit therefore remanded both claims to state court.⁸⁸ Aetna and Cigna appealed.

IV. REASONING OF THE COURT

The primary issue before the Supreme Court in *Davila* was whether Aetna and Cigna’s removal of respondents’ claims to federal court was proper.⁸⁹ To determine this, the Court examined whether ERISA preempted state laws that provided alternate remedies for patients under an ERISA-governed health plan when an HMO’s benefit decisions included assessing whether a physician’s recommended treatment was medically necessary.⁹⁰ Reversing the

83. *Id.* at 205. The Fifth Circuit consolidated respondents’ claims with two other plaintiffs, Gwen Roark and Walter Thorn, who also sued their HMOs under Texas state law. *Roark*, 307 F.3d at 302. However, the court ultimately remanded Roark and Thorn’s claims back to the district court. *Id.* at 311.

84. *Roark*, 307 F.3d at 305.

85. *See infra* Part IV.C (discussing mixed eligibility and treatment decisions).

86. *Davila*, 542 U.S. at 206. The Fifth Circuit also relied on the Supreme Court’s ruling in *Rush Prudential HMO Inc. v. Moran*, which held that complete preemption is limited to situations where the state law duplicates ERISA. *Rush Prudential HMO Inc. v. Moran*, 536 U.S. 355, 378 (2002); *Roark*, 307 F.3d at 310–11.

87. *Roark*, 307 F.3d at 311 (citing *Pegram v. Herdrich*, 530 U.S. 211, 236–37 (2000)).

88. *Id.*

89. *Davila*, 542 U.S. at 204.

90. *Id.* at 218–21.

Fifth Circuit's decision, the Supreme Court held that such state laws were completely preempted by ERISA.⁹¹

A. Complete Preemption under ERISA § 502 (a)(1)(B)

The Court began its analysis by assessing ERISA § 502(a)(1)(B) to determine whether Davila's and Calad's causes of action fell "within the scope of" ERISA preemption.⁹² The Court established that

if an individual brings suit complaining of a denial of coverage for medical care, where the individual is entitled to such coverage only because of the terms of an ERISA-regulated employee benefit plan, and where no legal duty (state or federal) independent of ERISA or the plan terms are violated, then the suit falls 'within the scope of' ERISA 502(a)(1)(B) . . . [and thus] the individual's cause of action is completely preempted.⁹³

In an attempt to avoid preemption, Davila and Calad contended that their HMOs' decisions violated legal duties that arose independently of either ERISA or the terms of their employee benefit plans.⁹⁴ Specifically, both claimants sued under the THCLA, alleging that the petitioners "'controlled, influenced, participated in and made decisions which affected the quality of the diagnosis, care, and treatment provided' in a manner that violated 'the duty of ordinary care set forth in §§ 88.001 and 88.002'" of the THCLA.⁹⁵ Nonetheless, the Court rejected this argument and found that the duties imposed by the THCLA did not arise independently of ERISA or the terms of the claimants' health care plans.⁹⁶

The Court reasoned as follows: Davila and Calad received health coverage under ERISA-regulated benefit plans, and it was only through their HMO's partial administration of these benefit plans that each claimant had any connection whatsoever with their HMOs.⁹⁷ Accordingly, Davila and Calad's claims only concerned

91. *Id.* at 221.

92. *Id.* at 211.

93. *Id.* at 210.

94. *Id.* at 212.

95. *Id.* (citation omitted).

96. *Id.*

97. *Id.* at 211 (highlighting Aetna's refusal to pay for Davila's Vioxx

the HMOs' denial of coverage under an ERISA-regulated employee benefit plan.⁹⁸ The Court also pointed out that under the THCLA, the petitioner HMOs would be liable only if they failed to provide treatment that was covered by the respondents' benefit plans.⁹⁹ Therefore, the Court concluded that any liability under the THCLA "derives entirely from the particular rights and obligations established by the benefit plans."¹⁰⁰ The respondents' THCLA causes of action were inextricably dependent on the existence and administration of an ERISA plan and thus subject to ERISA's federal regulation, including preemption.¹⁰¹

Given that respondents only sought to recover from their HMOs' alleged wrongful denial of benefits under their ERISA-regulated plans, the Court held that their claims fell "within the scope of" ERISA § 502(a)(1)(B) and were completely preempted.¹⁰² In so holding, the Court denounced the Fifth Circuit's contrary conclusion.¹⁰³ First, the Court asserted that the Appellate Court's finding that Davila and Calad asserted "a tort claim for tort damages," as opposed to an ERISA "contract claim for contract damages," was immaterial.¹⁰⁴ The Court reasoned that hinging preemption on the label of the claim would "elevate form over substance and allow parties to evade the pre-emptive scope of ERISA simply 'by relabeling their contract claims as claims for tortious breach of contract.'"¹⁰⁵ Furthermore, the Court criticized the Fifth Circuit's failure to apply ERISA preemption where the respondents sought tort damages rather than ERISA remedies

prescription and CIGNA's refusal to cover Calad's hospital stay).

98. *Id.*

99. *Id.* at 213. The THCLA states that the duty to exercise ordinary care when making health care treatment decisions, and the imposition of liability for harm arising from failure to exercise such ordinary care, "create[s] no obligation on the part of the health insurance carrier, health maintenance organization, or other managed care entity to provide to an insured or enrollee treatment which is *not covered by the health care plan* of the entity." TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(d) (Vernon 2005) (emphasis added).

100. *Davila*, 542 U.S. at 213.

101. *Id.* at 212-14.

102. *Id.* at 214.

103. *Id.* (holding that respondents' claims were removable to federal district court).

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

105. *Id.*

because Supreme Court precedent clearly upheld ERISA preemption for claims seeking remedies beyond those provided for under ERISA.¹⁰⁶

Second, the Court rebuffed the Fifth Circuit's alternate assessment that the labels of respondents' claims were immaterial because the claims asserted an "external, statutorily imposed duty of care."¹⁰⁷ The Court referred to its previous assessment that the THCLA did not create duties external to those under ERISA to support its conclusion.¹⁰⁸

B. Application of the Savings Clause under ERISA § 514(b)(2)(A)

The Court next tackled respondents' claim that the THCLA was a law that regulated insurance and was thereby "saved" under ERISA § 514(b)(2)(A).¹⁰⁹ Although recognizing the "savings clause" as a means to save state law from ERISA preemption, the Court noted that the civil enforcement provisions of § 502(a) reflected congressional intent to create an exclusive federal remedy.¹¹⁰ Accordingly, the Court found that a state law that could arguably be characterized as "regulating insurance" will nonetheless be preempted if it provides means to assert benefit claims separate or in addition to ERISA's remedial scheme.¹¹¹ Given ERISA's comprehensive remedial scheme and THCLA's extra remedial provisions, the Court concluded that THCLA was not saved under ERISA § 514(b)(2)(A).¹¹²

C. Fiduciary Duty and the Narrow Reading of Pegram v. Herdrich

The last issue the Court addressed was its holding in *Pegram v.*

106. *Id.* at 214–15; *see* *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 136 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45 (1987); *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 62–63 (1987).

107. *Davila*, 542 U.S. at 215 (internal quotations omitted).

108. *Id.*; *see supra* notes 92–101 and accompanying text (detailing the Court's analysis regarding ERISA independent duties).

109. *Id.* at 216–17. ERISA section 514(b)(2)(A) states that "[n]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A) (2000). For discussion of the "savings clause" *see supra* note 28.

110. *Davila*, 542 U.S. at 217.

111. *Id.* at 217–18.

112. *Id.* at 216–18.

Herdrich regarding the fiduciary duties of HMOs under ERISA.¹¹³ In *Pegram*, the Court outlined three different kinds of administrative decisions that HMOs make throughout the treatment process: (i) *pure eligibility decisions* that turn on the plan's coverage of a particular condition or medical procedure for that condition's treatment, i.e., decisions strictly about whether a condition is covered;¹¹⁴ (ii) decisions about how a patient's condition should be diagnosed and treated, also called *treatment decisions*;¹¹⁵ and (iii) *mixed eligibility and treatment decisions*, or decisions that assess whether one treatment option is so superior and necessary that a decision to proceed with such a treatment would mean that it was medically necessary.¹¹⁶ The Court concluded that "mixed eligibility and treatment decisions" were not "fiduciary decisions" under ERISA and thus do not "relate to" an employee benefit plan.¹¹⁷

The Court defined an ERISA fiduciary as "someone acting in the capacity of manager, administrator, or financial adviser to a 'plan.'"¹¹⁸ Section 1109(a) of the United States Code imposes liability for breach of a fiduciary duty under ERISA.¹¹⁹ The Court in *Pegram* explained that it did not believe Congress intended that HMOs be treated as fiduciaries to the extent that they make mixed eligibility treatment decisions.¹²⁰ The Court reasoned that ERISA attempted to regulate fiduciaries as they are regulated under common law, i.e., as trustees, not as administrators that make for-profit health care decisions that may not be in the patient's best interests.¹²¹

In *Pegram*, the plaintiff's treating physician owned and administered the plaintiff's HMO.¹²² The physician discovered an inflamed mass in the plaintiff's abdomen yet did not order an ultrasound diagnostic procedure at a local hospital.¹²³ Instead, the physician made the plaintiff wait eight days for an ultrasound to be

113. 530 U.S. 211 (2000).

114. *Id.* at 228.

115. *Id.*

116. *Id.* at 229.

117. *Id.* at 237.

118. 29 U.S.C. §§ 1002(21)(A)(i)–(iii) (2000); *Pegram*, 530 U.S. at 222.

119. 29 U.S.C. § 1109(a).

120. *Pegram*, 530 U.S. at 231.

121. *Id.* at 231–32.

122. *Id.* at 215.

123. *Id.*

performed more than fifty miles away at a facility staffed by the physician's HMO.¹²⁴ However, before the eight days were over, the plaintiff's appendix ruptured.¹²⁵ Because of the unique situation in *Pegram*, where the physicians covered by the HMO also owned and administered the same, the HMO's necessary for-profit decisions removed it from the realm of a fiduciary and thus precluded ERISA preemption.¹²⁶

The Court in *Davila* consequently clarified and narrowed the application of *Pegram* so that it applies only in those cases where a patient's administering HMO is also run by his treating physicians.¹²⁷ In such situations, eligibility decisions are inextricably mixed with treatment decisions¹²⁸ because of the inherent financial incentive to provide treatment that may not be in the patient's best interest. Based on this interpretation of *Pegram*, the Court found that because Aetna and Cigna were not *Davila* or *Calad*'s physicians, the benefit determinations were pure eligibility decisions,¹²⁹ and thus *Pegram* was inapplicable.

V. ANALYSIS

The Supreme Court's decision in *Davila* marks a definitive blow to patients' rights protection. The THCLA was one of more than ten state laws that codified the right to hold HMOs accountable for benefit determinations that are, in essence, medical decisions about medically necessary treatment.¹³⁰ Such state laws, all of which are now invalid, were driven by common law precedents which, in turn, were spurred by Congress' inaction in amending ERISA—inaction that left millions of ERISA-sponsored patients without a complete remedy.

Before 1995, "ERISA preemption was interpreted broadly, essentially immunizing insurers from tort liability under state law and shielding self-funded plans from state regulation."¹³¹ However,

124. *Id.*

125. *Id.*

126. *See id.* at 223–26.

127. *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 218 (2004).

128. *Id.* at 219–21; *see Pegram v. Herdrich*, 530 U.S. 211, 231–34 (2000).

129. *Davila*, 542 U.S. at 221.

130. *Jordan*, *supra* note 29, at 93.

131. *Sage*, *supra* note 18, at 614; *see, e.g., Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983).

the Court later changed course and limited ERISA preemption, giving state legislatures greater leeway to regulate health coverage “unless and until” Congress stepped in and clearly defined the boundary between state and federal law.¹³² Yet Congress did not step in. Lower courts, equipped with implied Supreme Court authority, continued to narrow the preemptive effect of ERISA as to the increasingly prevalent HMOs.¹³³ This common law regulation ended with the Court’s holding in *Davila*, in which the Court unmistakably reverted to its pre-1995 interpretation of ERISA preemption.

*A. Competing Preemption Interpretations:
What Did Congress Intend?*

Strictly looking at the Court’s preemption analysis, substantial authority supports the broad holding in *Davila*. Generally, state law can be preempted in two ways: (i) where Congress evidences an intent to occupy a given field, any state law falling within that field is preempted because there is effectively no room for state authority;¹³⁴ and (ii) where Congress does not entirely occupy the field in question, state law is nonetheless preempted if it conflicts with federal law,¹³⁵ or stands as an obstacle to the accomplishment of the full purpose and objectives of Congress.¹³⁶

Before 1995, the Court found that ERISA engendered a broad preemptive effect, citing the Act’s House and Senate sponsors and

132. Sage, *supra* note 18, at 614; *see, e.g.*, N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 661 (1995) (limiting ERISA preemption to those state laws that substantially affect employee benefits plans and holding that courts should presume ERISA does not preempt areas such as “general health care regulation, which historically has been a matter of local concern. . .”).

133. *See, e.g.*, *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 357 (3d Cir. 1995) (holding that a claim about the quality of a benefit received is not preempted because it is “not a claim under § 502(a)(1)(B) to ‘recover benefits due . . . under the terms of [the] plan.’”); *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995) (holding that a claim brought against a health care provider under the state doctrine of respondeat superior was not preempted under ERISA); Sage, *supra* note 18, at 614.

134. *Pac. Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm’n*, 461 U.S. 190, 203–04 (1983).

135. *Id.* at 204; *see also Fla. Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 142 (1963).

136. *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941).

the Act's express language.¹³⁷ However, the Court must review ERISA's legislative intent alongside the context of ERISA's enactment: in 1974, Congress could not have envisioned the prominence and power managed care organizations wield today. When placed in this perspective, the Court should recognize ERISA's limitations and adopt a more restrictive application of its crippling preemptive provisions.

1. Shifting from Sweeping Preemption to Make-Whole Relief

To decide whether a federal law preempts a state statute, a court's task is to ascertain Congress' intent in enacting the federal statute at issue.¹³⁸ Pre-1995, the Court unquestionably embraced a sweeping construction of ERISA's congressional intent. For example, the Court found that Congress intended that ERISA be the "exclusive vehicle for actions by ERISA-plan participants" for claims regarding improper processing and that state laws should not impede Congressional purposes and objectives.¹³⁹ Furthermore, the Court held that ERISA implicated both complete and conflict preemption.¹⁴⁰

To reach this conclusion, the Court in *Shaw v. Delta Air Lines*¹⁴¹ examined ERISA's legislative history and cited to ERISA's House and Senate sponsors, Representative Dent and Senator Williams.¹⁴² Representative Dent asserted that ERISA's "crowning achievement" was "the reservation to Federal authority the sole power to regulate the field of employee benefit plans."¹⁴³ Similarly, Senator Williams emphasized:

[T]he substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local

137. See *infra* notes 142–144 and accompanying text.

138. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 95 (1983).

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

140. See *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63–67 (1987).

141. *Shaw*, 463 U.S. 85.

142. *Id.* at 99.

143. 120 CONG. REC. 29,197 (1974).

governments, or any instrumentality thereof, which have the force or effect of law.¹⁴⁴

The Supreme Court's pre-1995 cases also broadly interpreted the terms "relate to" in § 514(a) and "within the scope of" in § 502(a)(1)(B).¹⁴⁵ The Court held that both terms embodied expansive preemptive effect: a law "relates to" an employee benefit plan if it has any connection with or reference to such a plan.¹⁴⁶ Furthermore, a plaintiff's cause of action falls "within the scope" of ERISA's civil enforcement provisions if the claimant asserts improper processing of a claim for benefits.¹⁴⁷

In *Metropolitan Life Insurance Co. v. Taylor*¹⁴⁸ the Court articulated the principle that ERISA § 502(a)(1)(B) has such "extraordinary pre-emptive power" that it "converts an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule."¹⁴⁹ With the backdrop of the pre-1995 holdings, the Court clearly established ERISA's extremely broad preemptive effect.

In 1995, however, the Court decided *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*¹⁵⁰ There, the Court limited ERISA preemption to state laws that "directly, or indirectly but substantially, affect employee benefit plans."¹⁵¹ This ruling signaled a change: liability could indeed be imposed on managed care organizations.

Lower courts jumped on this authority to chip away at ERISA preemption.¹⁵² The courts used the vague standard articulated in *Travelers* to react ad hoc to the rapid growth of managed care.¹⁵³ For

144. *Id.* at 29,933.

145. *See Pilot Life Ins.*, 481 U.S. at 41, 52–54; *Shaw*, 463 U.S. at 96–97.

146. *Shaw*, 463 U.S. at 96–97.

147. *Pilot Life Ins.*, 481 U.S. at 41, 52.

148. 481 U.S. 58 (1987).

149. *Id.* at 65; *see supra* Part II.B.2 (discussing the removal principles of section 502(a)(1)(B)).

150. 514 U.S. 645 (1995).

151. *Sage*, *supra* note 18, at 615; *see also* N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 661 (1995).

152. *See Sage*, *supra* note 18, at 615; *see, e.g., In re U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir. 1999); *Dukes v. U.S. Healthcare*, 57 F.3d 350 (3d Cir. 1995); *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995); *Pappas v. Asbel*, 768 A.2d 1089 (Pa. 2001).

153. *Sage*, *supra* note 18, at 615.

example, in *Dukes v. U.S. Healthcare*,¹⁵⁴ the Third Circuit held that § 502(a) did not preempt tort claims against an HMO arising from the negligence of one of its physicians.¹⁵⁵ Particularly relevant, the *Dukes* court could have reached the same result simply by finding that the medical services provided by the defendant HMO were not ERISA benefits subject to § 502(a) preemption. However, the court pursued a different analytical path. The court determined that because the HMO had provided benefits under the plaintiff's plan, the plaintiff was not suing to recover any denied benefits, which was the precise remedy provided for under § 502(a).¹⁵⁶ In other words, § 502(a) did not preempt the plaintiff's state tort claim because the claim was based on the negligent administration of the benefits, not a refusal to provide those benefits. The *Dukes* decision was important because it opened the door for some liability against HMOs, albeit not justified by reference to ERISA itself. Nonetheless, *Dukes* was a start.

*Pappas v. Asbel*¹⁵⁷ is also indicative of the post-1995 common law response to the implied authority granted in *Travelers*. In *Pappas*, the court held that a cross-complaint by a hospital against an HMO for refusing to authorize a patient transfer to another facility selected by the hospital's physicians was not preempted by ERISA.¹⁵⁸ The court did not find that the HMO's refusal to approve the patient's transfer to a facility where the care he needed was available fell within the rubric of an employee benefit plan's administration.¹⁵⁹ Rather, the court found that the claims against the defendant HMO were based on negligence attributable to a "cost containment protocol set by a for-profit organization . . . which is aimed at conserving and increasing its profits, an intention diametrically opposed to ERISA's general purpose of protecting the rights of a plan's beneficiaries."¹⁶⁰

154. 57 F.3d 350.

155. *Id.* at 351–52.

156. *Id.* at 356–57.

157. 675 A.2d 711 (Pa. Super. Ct. 1996), *aff'd*, 724 A.2d 889 (Pa. 1998), *vacated*, U.S. Healthcare Systems of Pa., Inc. v. Pa. Hosp. Ins. Co., 530 U.S. 1241 (2000).

158. *Id.* at 717–18.

159. *Id.* at 717.

160. *Id.* at 716. Although this decision was ultimately vacated, the opinion is nonetheless relevant to highlight the change in perspective initiated by

Despite the efforts of the lower courts to secure more encompassing relief for patients, *Davila* marks the beginning of a new trend reverting back to pre-1995 sweeping preemptive authority. Regrettably, alongside this regression, the Court has eviscerated states' attempts to provide patients with make-whole relief.

2. Returning to Its Roots: *Davila*'s Preemption Analysis

Davila embraces pre-1995 interpretations by holding that Davila's and Calad's claims "relate[d] to" employee benefit plans within the meaning of § 514(a) and fell "within the scope of" ERISA § 502(a)(1)(B).¹⁶¹ In *Davila*, the Court referenced and adopted the rationale cited from pre-1995 cases such as *Pilot Life Ins. Co. v. Dedeaux*¹⁶² and *Metropolitan Life*.¹⁶³ In addition, the Court re-introduced the holding in *Shaw* that ERISA includes expansive preemption provisions that are intended to ensure "that employee benefit plan regulation would be 'exclusively a federal concern.'"¹⁶⁴

By concluding that Davila's and Calad's claims were "within the scope" of ERISA § 502(a)(1)(B), the Court embraced the complete preemption holding of *Metropolitan Life*.¹⁶⁵ Given that Davila's and Calad's claims sought only to rectify wrongful denials of coverage promised under ERISA-regulated employee benefit plans, without any other ERISA-independent duty, the claims were "within the scope" of ERISA and subject to removal.¹⁶⁶ The Court in essence declared that state laws such as the THCLA were nothing more than futile attempts by state legislatures to circumvent ERISA preemption.¹⁶⁷ As a result, the Court slammed the door shut on lower court attempts to restrict ERISA's preemptive effect.

The Fifth Circuit attempted to develop an arena for make-whole relief by interpreting the *Pegram* holding to apply to claims such as

Travelers.

161. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 214 (2004).

162. 481 U.S. 41 (1987).

163. *Davila*, 542 U.S. at 207-08; *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987).

164. *Davila*, 542 U.S. at 208 (citing *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)).

165. *Id.* at 209 (citing *Metro. Life Ins.*, 481 U.S. at 55-56).

166. *Id.*

167. *See id.* at 212-13.

those asserted by Davila and Calad.¹⁶⁸ The Fifth Circuit also tried to evade § 502(a) preemption by distinguishing the essence of a plaintiff's claims, that is, tort claims as opposed to breach of contract claims which ERISA covers.¹⁶⁹ Yet *Davila* intercepted this sort of reasoning, thereby halting lower court attempts to create a niche for make-whole relief under an ERISA-sponsored plan.¹⁷⁰

3. ERISA Preemption and Today's Employee Welfare Plans

Although the Court's decision in *Davila* is arguably sound, its rationale is questionable in at least two respects: (i) the Court misinterprets Congress' underlying purpose in enacting ERISA; and (ii) the Court fails to analyze the context under which ERISA proponents promulgated the Act's provisions. The legislature did not intend that ERISA apply to today's HMOs.

The legislative history evidences a congressional desire to create a sweeping preemptive effect.¹⁷¹ However, Congress enacted ERISA to preempt state law regarding employee benefits to protect employees' expectations and minimize the administrative burdens for employers who provide benefit plans in more than one state.¹⁷² The goal was to create uniform federal regulation for employers providing such plans as opposed to numerous state-imposed laws.¹⁷³ By restricting numerous forms of liability under state law, Congress eliminated a disincentive to provide employee benefit plans; the intent was to streamline regulations to encourage employers to sponsor such plans.¹⁷⁴

Under the Court's current interpretation of ERISA, HMOs are immunized from non-ERISA liability when they deny an employee coverage.¹⁷⁵ This result does not conform to Congress' administrative streamlining goal: permitting lawsuits against HMOs

168. See *Roark v. Humana, Inc.*, 307 F.3d 298, 307–08 (5th Cir. 2002) (citing *Pegram v. Herdrich*, 530 U.S. 211, 216 (2000)).

169. *Id.* at 309.

170. See *Davila*, 542 U.S. at 214.

171. See *supra* notes 142–144 and accompanying text.

172. Korobkin, *supra* note 12, at 483–84.

173. See 120 CONG. REC. 29,197 (1974) (“With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation.”) (statement of Rep. Dent).

174. Korobkin, *supra* note 11, at 484.

175. See *supra* notes 161–70 and accompanying text.

that contract with employers to provide health coverage to employees would protect the employees' expectations under the plan, *not* create additional administrative burdens for employers.¹⁷⁶ Thus, the Supreme Court's current preemption analysis has incorrectly assessed the legislative intent behind ERISA's preemption provisions.

Furthermore, the Court overlooks the fact that Congress could not have anticipated or intended for ERISA to apply to today's managed health care system. The legislature's main goal was a national regulatory scheme for fringe benefits, that is, pension and welfare plans.¹⁷⁷ Medical care plans were *not* a part of such welfare plans at the time of ERISA's enactment.¹⁷⁸ Moreover, since managed care organizations did not develop until the late 1980s and did not gain full strength until the early 1990s,¹⁷⁹ Congress could not have expected ERISA's sweeping effects to apply to modern managed care. Nonetheless, the Court has ignored these arguments. As a result, employees who receive their benefits through an ERISA-regulated plan are left with cramped and inequitable relief because they are only entitled recovery under ERISA's scant remedial provisions.

*B. The Possibility for an Alternate Remedy
Under ERISA's Equitable Relief Provision*

Before making their way to the Supreme Court, Davila and Calad declined to amend their complaints to bring ERISA-specific claims at the trial court level.¹⁸⁰ Nonetheless, Justice Thomas noted at the end of the Supreme Court's unanimous decision that there could have existed the possibility for some form of "make-whole" relief under ERISA § 502(a)(3) if the claimants had made such amendments.¹⁸¹ Justice Ginsburg further advanced this position in

176. Korobkin, *supra* note 12, at 484.

177. Lorraine Schmall & Brenda Stephens, *ERISA Preemption: A Move Towards Defederalizing Claims for Patient's Rights*, 42 BRANDEIS L.J. 529, 542 (2004); *see also* 120 CONG. REC. 29,197 (1974) (referring to ERISA as "private pension reform") (statement of Rep. Erlenborn).

178. *See* Schmall, *supra* note 177, at 542.

179. *Id.* at 535-36.

180. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 205 (2004).

181. *Id.* at 221 n.7. ERISA section 502(a)(3) states that a civil action may be brought "by a participant, beneficiary, or fiduciary (A) to enjoin any act or

her concurring opinion.¹⁸²

Justice Ginsburg stressed that some form of “make-whole” relief was needed in light of the existing “regulatory vacuum” that has resulted from the Court’s encompassing interpretation of ERISA preemption and its cramped construction of § 502(a)(3)’s “equitable relief” provision: “[V]irtually all state law remedies are preempted but very few federal substitutes are provided.”¹⁸³ She further urged Congress and the Court to “revisit what is an unjust and increasingly tangled ERISA regime” by reconsidering the availability of consequential damages under ERISA § 502(a)(3).¹⁸⁴

Justice Ginsberg’s concurrence echoed Third Circuit Judge Becker’s admonition of ERISA’s preemptory effect in *DiFelice v. Aetna U.S. Healthcare*.¹⁸⁵ Judge Becker’s position was that ERISA § 514(a) preempts state causes of action where a claimant seeks to enforce ERISA-guaranteed rights even when § 502 provides no substitute federal cause of action.¹⁸⁶ This “regulatory vacuum” gives beneficiaries little or no recourse for even the most egregious violations because § 502 does not provide whole relief.¹⁸⁷

The concurring opinions of Justices Ginsburg and Breyer in *Davila* leave some hope for state causes of action. Ginsburg wrote that Congress should revisit ERISA to ensure that the federal statute provides “make-whole” relief.¹⁸⁸ This means that although ERISA does not provide for make-whole relief as currently constructed, such relief should be available. “Make-whole” relief under ERISA itself would obviate the need for state-created patient bill of rights laws.

practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan.” 29 U.S.C. § 1132(a)(3) (2003).

182. See *Davila*, 542 U.S. at 222 (Ginsburg, J., concurring).

183. *Id.* (citing *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 456–57 (3d Cir. 2003)).

184. *Id.* at 222–23 (citing *DiFelice*, 346 U.S. at 453).

185. 346 F.3d 442.

186. *Id.* at 457.

187. *Id.* Judge Becker asserts that “ERISA’s remedial scheme gives HMOs every incentive to act in their own and not in their beneficiaries best interest while simultaneously making it incredibly difficult for plan participants to pursue what meager remedies they possess, a confounding result for a statute whose original purpose was to protect employees.” *Id.* at 459.

188. *Davila*, 542 U.S. at 222–24.

Although the possibility of such a remedy is beyond the scope of this comment, Justice Ginsburg's concurrence evidences that the option merits evaluation.

C. *Davila's Implications*

1. Medical Malpractice Liability as a Deterrent Measure

Doctors and patients generally feel that health care plans should be held responsible when they cause harm to patients by denying them their physician's recommended treatments.¹⁸⁹ On the other hand, HMOs argue that holding managed care organizations liable for such decisions would substantially raise the cost of health care.¹⁹⁰ Yet, recent statistics belie the HMOs' arguments.

Health care costs were increasing at double-digit increments in late 2003.¹⁹¹ Yet in *Davila*, CIGNA, Aetna, and the Justice Department lawyers advised the Supreme Court that if respondents' state claims were allowed, health care costs would skyrocket.¹⁹² They further stressed that upholding preemption would keep health care costs down and ensure that workers continue to receive affordable health insurance through their jobs.¹⁹³ However, insurance premiums rose 11% in 2001, 13% in 2002 and 14% in 2003, with employees bearing the costs through "out of pocket" payments.¹⁹⁴ Thus, contrary to petitioners' claims, health care costs were already "skyrocketing," and the workers themselves were forced to absorb the burden. Clearly, *Davila* alone would not forecast the future of employee health insurance.

The holding in *Davila* also shields HMOs under ERISA plans from tort liability, but it does not extend that protection to physicians and hospitals.¹⁹⁵ The Supreme Court has ruled that ERISA does not

189. See Savage, *supra* note 13 (noting that the American Medical Association and Families USA, a healthcare advocacy group, denounced *Davila's* preemption of state claims as a "sad day for America's patients and the physicians who care for them").

190. See *id.*

191. Arthur D. Rutkowski & Barbara Lang Rutkowski, *U.S. Supreme Court Will Hear Consolidated Case on ERISA's Impact on HMO Negligence Cases*, 17 EMP. L. UPDATE 6 (2003).

192. See Reinert, *supra* note 5, at A1.

193. *Id.*

194. *Id.*

195. See generally Korobkin, *supra* note 12, at 479 (stating that the Court's

preempt medical malpractice claims against physicians by patients who are enrolled in ERISA-sponsored plans.¹⁹⁶ As such, if physicians are employed under HMOs and they receive incentives to cut costs, physicians would be liable for any injury resulting from their negligence. This means that if a physician provides poor quality care in an effort to benefit from cost-cutting HMO incentives, the physician is still subject to medical malpractice liability.¹⁹⁷ Moreover, an HMO can be held vicariously liable for its physician's negligence, just not its administrative decisions.¹⁹⁸

The problem that the Supreme Court's broad preemption analysis engenders, and what *Davila* solidifies, is that HMOs can effectively hide behind their treating physicians to insulate themselves from liability. *Davila* "insulates HMOs from any responsibility for delaying or denying care that injures patients and shifts responsibility unfairly to doctors."¹⁹⁹ For example, ERISA allows HMOs to encourage their doctors to over-recommend treatment in order to preempt physician-based negligence. Yet, HMOs may also limit what they cover by deeming that the treatment is not "medically necessary." The resulting situation leaves HMOs without any serious liability and patients are left with the shortcomings of the present state of the law. For most patients, denial of coverage by their HMOs practically equates to no access to coverage at all. For patients who cannot afford to pay for their recommended treatment up front, or who need treatment immediately, denial of coverage by their HMOs is not just about the

rulings indicate that ERISA shields HMOs but not physicians).

196. See *Pegram v. Herdrich*, 530 U.S. 211, 235–36 (2000).

197. See *Lancaster v. Kaiser Found. Health Plan*, 958 F. Supp. 1137, 1145–46 (E.D. Va. 1997) (holding ERISA preemption inapplicable to state malpractice claims against treating physicians even when those physicians were employed by the HMO and received incentives for refraining from ordering costly treatments).

198. See, e.g., *Dearmas v. Av-Med, Inc.*, 865 F. Supp. 816, 818 (S.D. Fla. 1994) (holding that "[t]ort actions that seek to hold defendant health maintenance organizations vicariously liable for medical malpractice have been held not to be pre-empted by ERISA"); *Paterno v. Albuerne*, 855 F. Supp. 1263 (S.D. Fla. 1994) (finding no ERISA preemption of a tort action alleging vicarious liability against a health plan because it did not involve the administration of the plan). Accordingly, an HMO is still subject to liability, albeit through an alternate route.

199. Raymond Flandez, *HMOs Welcome Court Ruling*, WASH. POST, June 22, 2004, at E1.

coverage, but about health risks as well.

Aetna and Cigna argued that their decisions not to cover Davila and Calad's doctor-recommended treatment involved whether those treatments were covered under the health plans, not whether the patients should receive treatment.²⁰⁰ Accordingly, their decisions were simply coverage decisions, not medical treatment decisions. Yet this argument begs the question of what constitutes a covered treatment. Health care policies grant HMOs wide discretion to reserve the right to assess what is "medically necessary."²⁰¹ Yet health care professionals generally view "not medically necessary" to mean "not clinically indicated."²⁰² Thus, when an HMO decides that a treatment is not medically necessary, it effectively determines that the treatment is not clinically indicated. But why should a health plan have the right to challenge a doctor's opinion as to what treatment a patient's condition requires? It should not. Nonetheless, when an HMO makes a determination about what treatment is "medically necessary," the HMO is in fact making a medical determination, not simply an administrative decision.

Because "medically necessary" determinations are often medical treatment decisions, opponents of broad ERISA preemption argue that such decisions should be treated as medical malpractice decisions.²⁰³ To hold otherwise would promote substandard treatment. The purpose of medical malpractice is not only to provide patients with make-whole relief, but also to act as a deterrent. "[A] health plan is not a health plan, i.e., whatever process or person is used to treat and care for patients, if it provides rights without remedies. Simply put, rights without fair and just remedies is the *sine qua non* of no accountability within any patient rights

200. See Brief for Petitioner Cigna Healthcare of Tex., Inc. at 6, *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004) (No. 03-83); Reply Brief for Petitioner Aetna Health Inc. at 2-3, *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004) (No. 02-1845).

201. See generally Sage, *supra* note 18, at 601-05 (discussing the varied meanings of "medically necessary," and that "decisions about health care have become responsibilities of the health plan or other system that also determines coverage, and not merely of that system's constituent physicians").

202. *Id.* at 601.

203. See DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442, 459-63 (3d Cir. 2003) (discussing at length the inequity of a broad interpretation of ERISA preemption and arguing that the HMOs make medical rather than administrative determinations when deciding on a patient's treatment).

initiatives”²⁰⁴

The Supreme Court acknowledged the need for a deterrent in the form of medical malpractice liability in *Pegram*, stating: “in an HMO system, a physician’s financial interest lies in providing less care, not more. The check on this influence . . . is the professional obligation to provide covered services with a reasonable degree of skill and judgment in the patient’s interest.”²⁰⁵ Yet the Court’s holding in *Davila* eviscerates the exact requirement it acknowledged in *Pegram* by insulating HMOs from deterrent-motivated liability. Consequently, even if the Court reevaluated ERISA § 502(a)(3) and established some form of make-whole relief, that would still not solve the problem: HMOs are better off denying coverage up front and risking the few times they will be taken to court and forced to atone for their negligence. ERISA thus engenders the substandard care Judge Becker admonished; there is no deterrent for HMOs.

2. A Call to the Legislature

As the issue stands, HMOs “can escape all liability if they instruct their doctors to recommend every possible treatment and leave the real medical decisions to HMO administrators.”²⁰⁶ Legislators created ERISA in 1974, and only they can make clear that they did not intend to preclude an HMO—that makes medical decisions regarding health care and treatment—from being held accountable for its decisions.²⁰⁷

To be fair, Congress has attempted to remedy the problem. In early 2001 the House and Senate passed versions of a “patients’ bill of rights” that would have allowed patients nationwide to sue their HMOs for medical malpractice.²⁰⁸ However, the legislation never became law.²⁰⁹ One problem the legislature faces is the fear that enacting a uniform federal regulation for HMOs would allow a torrent of malpractice litigation into federal court, a realm

204. Miles J. Zaremski, *Patients Rights and Accountability: Can There Exist Rights Without Remedies in an American Legal and Legislative Framework?*, 22 MED. & L. 429, 450 (2003).

205. *Pegram v. Herdrich*, 530 U.S. 211, 219 (2000).

206. *Roark v. Humana, Inc.*, 307 F.3d 298, 315 (5th Cir. 2002).

207. Zaremski, *supra* note 204, at 450.

208. Reinert, *supra* note 5, at A1.

209. *Id.*

traditionally viewed as exclusive to state law.²¹⁰ Nonetheless, just as Justice Ginsberg acknowledges in her concurring opinion, the current state of the matter is “an unjust and increasingly tangled ERISA regime” that beseeches Congressional intervention.²¹¹ Perhaps now, given that *Davila* has definitively quashed any attempt to create make-whole relief, Congress will step in. The legislature could remedy the inherent flaws in the Supreme Court’s ERISA interpretation by either increasing the damages available under ERISA itself or simply allowing state tort claims.

VI. CONCLUSION

The Supreme Court’s interpretation of ERISA as applicable to employee benefit plans necessarily means that federal provisions govern HMOs’ decisions regarding whether benefits will be extended to those who are covered under ERISA-regulated benefit plans. The effect is far reaching. In general, primary care physicians who negligently provide treatment are liable for malpractice.²¹² Likewise, an HMO is vicariously liable for its physician’s negligence.²¹³ However, if a patient’s health plan is purchased through her employer, whereby the employer and the HMO contract to provide coverage as a benefit to employment, the HMO is insulated from any non-ERISA third-party beneficiary claims.²¹⁴ Because ERISA does not provide for tort liability, compensatory or punitive damages, a patient cannot recover for injuries resulting from a negligent denial of benefits.²¹⁵ These patients are thus left at a disadvantage, without make-whole relief, solely because their health care is provided through their employer and not independently.

210. See Sage, *supra* note 18, at 617–18. The Court has acknowledged this problem. In *Pegram*, the Court held “mixed-eligibility treatment decisions” did not implicate a fiduciary duty under ERISA and thus mandated that such claims, which involve medical necessity determinations, be heard in state court. *Pegram*, 530 U.S. at 237. The Court acknowledged that to hold otherwise would mean that federal courts would have to evaluate medical malpractice claims in order to determine whether a plan violated its duties under ERISA. See *id.* at 235–37.

211. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 222 (2004).

212. Korobkin, *supra* note 12, at 458.

213. *Id.* at 458–59.

214. *Id.* at 459–61; see also *Davilla*, 542 U.S. 200.

215. See 29 U.S.C. § 1132(a) (2000).

Davila is therefore not just about preemption under an extremely complicated and powerful federal regulation, it is about health risks and quality of care. Practically speaking, the Supreme Court's holding in *Davila* has profound repercussions on American workers and their families simply because they happen to receive their health coverage through their employer.

Without deterrent-based liability, HMOs will continue to restrict access to necessary medical treatment under the guise of "medically necessary" limitations. These limitations are possible because *Davila* declared that such decisions are pure eligibility decisions, despite the fact that they are reached by assessing medical risks and reevaluating a skilled physician's treatment recommendations.

The evolution of the Supreme Court's preemption interpretation has left ERISA beneficiaries inadequately protected. As a result, only Congress maintains the authority to remedy this increasingly unfair regime. Congress must take immediate measures to protect employees and their families from their HMOs often unqualified and misplaced medical decisions.

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