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ERISA PREEMPTION AND PATIENTS' RIGHTS IN THE WAKE OF AETNA HEALTH INC. V. DAVILA

Kelly M. Loud*

When Gwen Roark was bitten by a brown recluse spider in 1990, the bite damaged the skin, muscle, and bone of her left leg, necessitating antibiotics, skin grafting procedures, and several surgeries.1 Gwen was required to wear a vacuum-assisted closure device (VAC) twenty-two hours a day in order to quicken the healing process and a nurse was hired to treat Gwen's wound on a daily basis.2 These treatments were recommended by Gwen's doctor, who considered all the treatments to be medically necessary.3 When Humana Health Plan (Humana), the Roarks' health maintenance organization (HMO), refused to pay for the VAC and the home visits, Gwen's treatment stopped for a month despite warnings by her doctor that a discontinuation of treatment could result in Gwen losing her leg.4 During this month, the wound developed into a serious infection, and Gwen's leg had to be amputated.5 After the amputation, Humana continued to deny coverage for the VAC treatment, again ignoring the recommendations of Gwen's doctors.6 Sadly, her condition worsened and she was required to undergo a second amputation treatment.7

The Roarks filed a lawsuit against Humana in a Texas state court alleging negligence and failure to exercise ordinary care; however, their claims were dismissed as being completely preempted by the Employee Benefits Act.

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1. Roark v. Humana, Inc., 307 F.3d 298, 303-04 (5th Cir. 2002), rev'd sub nom. Aetna Health Inc. v. Davila, 124 S. Ct. 2488 (2004). Roark was an appeal of a remand order; the Roarks' claim was preempted by ERISA, and the Roarks failed to amend their complaint to bring a suit under section 502(a). Id. at 304. In Roark, the court held that two of the four plaintiffs in a consolidated action could sue their health maintenance organization (HMO) for malpractice under state law. See id. at 308-09. However, this holding was reversed by Davila. 124 S.Ct. at 2502.
2. Roark, 307 F.3d at 303.
3. Id.
4. Id.
5. Id. at 303-04.
6. Id.
7. Id.

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Retirement Income Security Act of 1974 (ERISA). ERISA has no provisions for a negligence action and the Roarks declined the opportunity to replead under ERISA's civil enforcement provisions.

ERISA governs employee welfare benefit plans, including health plans like the Roarks'. Under ERISA, a participant or beneficiary of a health plan may sue "to recover benefits due to him under the terms of the plan, to enforce his rights under the terms of his plan, or to clarify his rights to future benefits under the terms of the plan." ERISA also allows an aggrieved participant or beneficiary to seek "appropriate equitable relief" under § 502(a)(3); however, the courts, including the Supreme Court, have severely limited this remedy. Participants and beneficiaries are thus limited to contract-like benefit claims. This remedial scheme precludes other claims for compensatory or punitive damages, claims of personal injury, and wrongful death actions. For Gwen Roark, this

10. Roark, 307 F.3d at 304.
11. 29 U.S.C. § 1003 (2000). This section provides:
[T]his subchapter shall apply to any employee benefit plan if it is established or maintained—
(1) by any employer engaged in commerce or in any industry or activity affecting commerce; or
(2) by any employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce; or
(3) by both.

Id.

HMOs, preferred provider organizations (PPOs), and other types of managed care organizations (MCOs) are not "health plans" per se, but are service providers or "health insurance issuers." See Phyllis C. Borzi, ERISA and Employer-Sponsored Group Health Plans, in HEALTH AND WELFARE BENEFIT PLANS: THE PRESSURE IS ON 1-2 (2003). ERISA defines "health insurance issuer" as an insurance company, insurance service, or insurance organization (including [an HMO] .....) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 1144(b)(2) of this title). Such term does not include a group health plan.

13. Id. § 1132 (a)(3).
14. See infra note 40.
16. Id. at 956-57; see Mertens v. Hewitt Assocs., 508 U.S. 248, 260-62 (1993) (holding that a plaintiff is not entitled to compensatory damages under ERISA section 502(a));
means she can sue to recover the cost of the VAC treatment and perhaps the cost of the nurses’ visits, but cannot seek redress or compensation for the tragic loss of her limb.\textsuperscript{17}

The unfortunate reality of the managed care industry is that managed care companies seek to reduce their costs in a market where health care costs are rising faster than the inflation rate, and in order to do so they must pay out as few benefits as possible.\textsuperscript{18} A health plan participant or beneficiary in need of a medication or other treatment must submit her claim to her HMO or insurer, which will conduct a “utilization review” to determine the “medical necessity” of the benefit requested.\textsuperscript{19} Services that the HMO determines to be medically unnecessary are denied through this process and thus are not covered by the HMO.\textsuperscript{20} If the claim is denied, a participant must engage in an administrative process to appeal the HMO’s decision, even when the need for the treatment is urgent and any delay may prove injurious or sometimes fatal.\textsuperscript{21}

\begin{footnotesize}

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\item Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 148 (1985) (holding that ERISA does not allow for punitive or compensatory damages for injuries arising from a plan’s failure to provide benefits due to a participant); Cicco v. Does, 385 F.3d 156, 158 (2d Cir. 2004) (affirming trial court’s dismissal of state law medical malpractice claim that sought compensation beyond value of benefit denied, including consequential and punitive damages); Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1335, 1339 (5th Cir. 1992) (holding that tort actions for wrongful death and emotional distress were preempted by ERISA, and money damages for emotional distress were not available under ERISA).

\item See supra notes 15-16 and accompanying text. A court in its discretion may award attorney’s fees to a successful participant, beneficiary, or fiduciary. 29 U.S.C. § 1132(g)(1) (2000). Were Gwen a participant in a non-ERISA plan such as a managed Medicaid plan, she would be free to seek legal redress against her HMO. See Jones v. Chi. HMO Ltd. of Ill., 730 N.E.2d 1119, 1128 (Ill. 2000) (holding that a Medicaid recipient could hold her HMO liable for institutional negligence). Participants in government health plans, church health plans, and people who purchase individual health plans for themselves and their beneficiaries, are not subject to the remedial constraints imposed by ERISA. See 29 U.S.C. § 1003 (2000).

\item See, e.g., Pegram v. Herdrich, 530 U.S. 211, 219-20 (2000) (comparing HMOs with other risk-bearing organizations and discussing measures taken by HMOs to control costs); Russell Korobkin, The Failed Jurisprudence of Managed Care, and How To Fix It: Reinterpreting ERISA Preemption, 51 UCLA L. REV. 457, 462-63 (2003) (noting that MCOs have financial incentives to “underprovide rather than overprovide” healthcare services and coverage).

\item Pegram, 530 U.S. at 219-20 (discussing system of utilization review); Korobkin, supra note 18, at 463-64 (discussing utilization review procedures as a measure to control the provision of healthcare services).

\item Korobkin, supra note 18, at 494.

\item 29 U.S.C. § 1133 (2000). ERISA section 503 requires employee benefit plans to set up a claims-processing procedure whereby a participant’s claim for a benefit receives a “full and fair review.” Id.

\item In accordance with regulations of the Secretary, every employee benefit plan shall—
\end{itemize}
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Department of Labor has established claims regulations that require expedited review for "urgent" claims, requiring that an HMO or insurer provide the participant or beneficiary with notification of its denial (or approval) of a claim within seventy-two hours of submission. 22

(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 such 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.

Id. Should the claim be denied, regulations issued by the Department of Labor set guidelines for appeals procedures for group health plans, providing for a 180 day period within which the participant may appeal a denied claim, and a subsequent thirty day period in which the plan must respond to the appeal. 29 C.F.R. § 2560.503-1(h)(3)(i), .503-1(h)(4) (2003).


(e) Claim for benefits. For purposes of this section, a claim for benefits is a request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. In the case of a group health plan, a claim for benefits includes any pre-service claims ... and any post-service claims ....

(f) Timing of notification of benefit determination. (1) In general. ... [I]f a claim is wholly or partially denied, the plan administrator shall notify the claimant ... of the plan's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the plan, unless the plan administrator determines that special circumstances require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. ....

(2) Group health plans. In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination ....

(i) Urgent care claims. In the case of a claim involving urgent care, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. In the case of such a failure, the plan administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the plan, of the specific information necessary to complete the claim. ... The plan administrator shall notify the claimant of the plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of—

(A) The plan's receipt of the specified information, or

(B) The end of the period afforded the claimant to provide the specified additional information.

Id. § 2560.503-1(e) to -(f)(1)(i) (sixth emphasis added). Most courts require a participant or beneficiary to exhaust his or her insurer's or HMO's internal claims procedures before seeking adjudicative relief. Borzi, supra note 11, at 19.
The Roarks' case is by no means rare, and for years similar cases have been the subject of discussion among lawmakers. With increasing frequency, state legislatures attempt to fill ERISA's remedial void by adding laws that attempt to provide more fairness to participants and beneficiaries in group health plans. However, in its October 2003 Term, the Supreme Court declared in *Aetna Health Inc. v. Davila* that any attempts to supplement causes of action or remedies available under ERISA's civil enforcement provisions will fail, as such laws are completely preempted by federal law. Thus, the issue now becomes how to provide greater protections for participants and beneficiaries in group health plans, and more importantly, how to implement such protections in a way that does not conflict with ERISA's preemptive scope.

This Comment first examines the history of the enactment of ERISA as it pertains to health care benefit plans. Next, this Comment traces the Supreme Court's evolving interpretation of ERISA's preemptive language, from the first case brought under its civil enforcement provisions to its current jurisprudence of complete preemption of certain causes of action. Next, this Comment discusses the types of claims that the courts have stated will not be preempted by ERISA. This Comment then analyzes the opinions set forth in *Davila* as calling upon Congress to remedy the injustice that flows from ERISA's limited remedial scheme.


26. *Id.* at 2492, 2502 (holding that claims brought pursuant to the Texas Health Care Liability Act (THCLA) were completely preempted by ERISA).

This Comment next assesses the viability of several avenues that Congress, the courts, or plaintiffs' attorneys may take to protect participants or their beneficiaries from any injury they may sustain due to a wrongful denial of benefits. Finally, this Comment argues that patients' rights will best be served if the Federal Government works within the framework of ERISA, drafting a Patients' Bill of Rights that targets practices and mechanisms used by HMOs in their review of medical benefits claims, and more specifically, provides participants and beneficiaries with a right to external and independent medical review of adverse benefit determinations.

I. WHERE WE CAME FROM AND HOW WE GOT HERE

A. The Employee Retirement Income Security Act of 1974

Congress enacted ERISA in response to reported fraud and mismanagement of employee pension funds and at its inception the statute was aimed at regulating pension plans. The law's stated purpose was to "protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal Courts." Over the years, Congress expanded the scope of ERISA to cover health insurance and health benefits. Today, ERISA applies to employee welfare benefit

31. See generally id. §§ 1161-1185(b). The Health Insurance Portability and Accountability Act of 1996 (HIPAA), id. §§ 1181-1187, and the Consolidated Omnibus Budget Reconciliation Act of 1985, id. §§ 1161-1169, expanded the scope of ERISA into the healthcare arena. See Jennings et al., supra note 28, §§ 1.01, 1.06. However, unlike its regulation of pension plans, Congress did not impose vesting requirements on health and welfare benefit plans for fear that doing so "would seriously complicate the administration
plans maintained by an employer for the purpose of providing health benefits.\textsuperscript{32}

Section 402(a) of ERISA mandates that every employee welfare benefit plan name a fiduciary to oversee the plan, and often this is the plan administrator.\textsuperscript{33} A plan fiduciary has certain duties under ERISA.\textsuperscript{34} In addition to the plan administrator, other persons or organizations involved with an employee welfare benefit plan may also be considered fiduciaries if they exercise discretion over plan administration.\textsuperscript{35} HMOs are considered ERISA fiduciaries to the extent that HMOs make administrative decisions about which health benefits an ERISA-plan


\textsuperscript{33} Id. § 1102(a). The statute requires:

(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

(2) For purposes of this subchapter, the term “named fiduciary” means a fiduciary who is named in the plan instrument, or who, pursuant to a procedure specified in the plan, is identified as a fiduciary (A) by a person who is an employer or employee organization with respect to the plan or (B) by such an employer and such an employee organization acting jointly.

\textsuperscript{34} Id. § 1104(a)(1). The statute reads:

[A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter.

\textsuperscript{35} See id. § 1002(21)(A). ERISA specifically provides a test to determine fiduciary status:

[A] person is a fiduciary with respect to a plan to the extent (i) he exercises any 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 . . . or, (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

Id.; see also Borzi, supra note 11, at 10-11.
participant or beneficiary will receive. Thus, when a participant or beneficiary is denied benefits to which she feels that she is entitled, and such denial was a breach of the fiduciary duty owed to her, she may bring a suit against her HMO, the ultimate arbiter of the coverage decision, under ERISA.

1. The Civil Enforcement Provisions

ERISA expressly provides a plan participant or beneficiary with a menu of remedies under its civil enforcement provisions. Section 502(a)(1)(B) provides:

A civil action may be brought—

(1) by a participant or beneficiary—

. . . .

(B) to recover benefits due to [the participant] under the terms of his plan, to enforce [the participant's or beneficiary's] rights under the terms of the plan, or to clarify [the participant's or beneficiary's] rights to future benefits under the terms of the plan.

36. Aetna Health Inc. v. Davila, 124 S. Ct. 2488, 2502 (2004) (“When administering employee benefit plans, HMOs must make discretionary decisions regarding eligibility for plan benefits, and, in this regard, must be treated as plan fiduciaries.”); Pegram v. Herdrich, 530 U.S. 211, 223 (2000) (“[A]lthough [the HMO] is not an ERISA fiduciary merely because it administers or exercises discretionary authority over its own HMO business, it may still be a fiduciary if it administers the plan.”).

37. See 29 U.S.C. § 1132(a)(2) (2000). ERISA section 502(a)(2) allows a plan participant or beneficiary to sue “for appropriate relief under section 1109 of this title.” Id. Section 1109(a) in turn provides:

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 subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach . . . and shall be subject to such other equitable or remedial relief as the court may deem appropriate . . . .

Id. § 1109(a). Damages awarded for breach of fiduciary duty are awarded to the plan. Id.

38. Id. § 1132(a)(1)(B), (b)(1)(B). A “participant” in an ERISA-governed plan is any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.


Also relevant to participants and beneficiaries seeking relief for benefits denied is section 502(a)(3), which allows for

a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.40

Thus, the statute expressly allows a participant or beneficiary to seek recovery for benefits due, or to obtain some form of "equitable relief."41

The most frequently invoked provision within ERISA section 502 is the action to recover benefits due, which can either be brought as an action for reimbursement, or as an action seeking precertification for a certain treatment or benefit.42

2. ERISA Section 514—Preemption and the Savings Clause

ERISA’s preemption clause, section 514(a), states that ERISA “shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan.”43 Certain laws are excepted from preemption

40. Id. § 1132(a)(3) (emphasis added). The Supreme Court has read this provision very narrowly, holding in Mertens v. Hewitt Associates, 508 U.S. 248 (1993), that Congress intended the term “appropriate equitable relief” only to refer to “those categories of relief that were typically available in equity (such as injunction, mandamus, and restitution, but not compensatory damages),” id. at 256-58. The Court further narrowed “equitable relief” in Great-West Life & Annuity Insurance Co. v. Knudson, 534 U.S. 204 (2002), where Justice Scalia limited the remedy of restitution to only those cases where an action does not seek “to impose personal liability on the defendant” but instead seeks “to restore to the plaintiff particular funds or property in the defendant’s possession,” id. at 214.


42. See DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442, 449 (3d Cir. 2003) (stating that a plaintiff could have paid for the benefit himself, then sought reimbursement); Marro v. K-III Communications Corp., 943 F. Supp. 247, 248, 253 (E.D.N.Y. 1996) (granting a preliminary injunction to plaintiff and ordering plaintiff’s group health plan to precertify requested high dosage chemotherapy treatment); Kekis v. Blue Cross & Blue Shield of Utica-Watertown, Inc., 815 F. Supp. 571, 585 (N.D.N.Y. 1993) (granting preliminary injunction requiring coverage for high dose chemotherapy with autologous bone marrow transplantation treatment for patient with breast cancer). A section 502(a)(1)(B) cause of action to recover benefits wrongfully denied is “to be reviewed under a de novo standard” by the court unless the plan documents explicitly state that the plan administrator or fiduciary has discretionary authority to decide benefits claims or construe the terms of the plan, in which case benefits decisions will be reviewed under a more deferential standard. Firestone, 489 U.S. at 115.

under the savings clause in section 514(b)(2)(A), which applies to "any law of any State which regulates insurance, banking or securities." Thus, while a state law that regulates an HMO may "relate to" an employee benefit plan, the law may also "regulate insurance" and therefore may be saved from preemption. A final application of

has a connection with or reference to such a plan." Shaw, 463 U.S. at 96-97. Despite this broad language, the reach of section 514 and its "relate to" language is not limitless. N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 659-60 (1995) (holding that a New York law requiring hospitals to collect surcharges and HMOs involved with ERISA-governed plans did not "relate to" an ERISA plan because it involved an area of traditional state regulation and did not "bind plan administrators to any particular choice" or "preclude uniform administrative practice"). Furthermore, certain plans are exempted from ERISA under § 1003(b), such as government plans and church plans. 29 U.S.C. § 1003(b) (2000).

An action is removable to federal court "if (1) the cause of action is based on a state law that is preempted by ERISA [conflict preemption], and (2) the cause of action is 'within the scope of the civil enforcement provisions' of ERISA § 502(a) [triggering complete preemption]." Romney v. Lin, 94 F.3d 74, 78 (2d Cir. 1996) (quoting Metro. Life Ins. Co. v. Taylor, 481 U.S. 58, 64-66 (1987)). Thus, preemption under ERISA section 514 is not sufficient to support removal to federal court, but it may be raised as a defense to a state law cause of action. Id. at 78.


In Kentucky Ass'n of Health Plans v. Miller, 538 U.S. 329 (2003), the Supreme Court crafted a new test to be used in determining whether a state law "regulates insurance" for the purpose of the savings clause, id. at 341-42. The state law must (1) "be specifically directed towards entities engaged in insurance," and (2) have a substantial affect on the "risk pooling arrangement between the insurer and the insured." Id.; see also Elliot v. Fortis Benefits Ins. Co., 337 F.3d 1138, 1145 (9th Cir. 2003) (stating that under the Miller test, state laws may be deemed to "regulate insurance" in a greater number of instances than earlier Supreme Court case law suggested).

Stated another way, state laws must "home[] in on the insurance industry." UNUM Life Ins. Co. of Am. v. Ward, 526 U.S. 358, 368 (1999); see Kidneigh v. UNUM Life Ins. Co. of Am., 345 F.3d 1182, 1186-87 (10th Cir. 2003) (holding that the savings clause did not apply to a Colorado bad faith cause of action against an ERISA provider because it failed to satisfy the second "risk pooling" prong of the test); Nguyen v. Healthguard of Lancaster, Inc., 282 F. Supp. 2d 296, 303, 306 (E.D. Pa. 2003) (finding that although a Pennsylvania bad faith insurance statute was directed at the insurance industry, it did not alter the risk pooling arrangement between insurer and insured, and thus did not satisfy the second prong of the Miller test). But see Stone v. Disability Mgmt. Servs., Inc., 288 F. Supp. 2d 684, 692-95 (M.D. Pa. 2003) (finding that a Pennsylvania bad faith insurance statute satisfied both prongs of the Miller test, and did affect the risk pooling arrangement between insurer and insured).

45. See Rush Prudential, 536 U.S. at 359, 365-68. The "deemer clause" provides that a state may not "deem" ERISA plans to be insurers for the purpose of saving laws
ERISA preemption analysis asks whether a state insurance law that falls within the savings clause will nevertheless be preempted because it conflicts with the policy of exclusive federal remedies embodied in ERISA.46

Though section 514 serves to preempt all laws that "relate to" an employee benefit plan,7 the civil enforcement provisions of section 502(a) carry an even stronger preemptive power.8 An action brought pursuant to a state law that provides remedies in excess of those provided for in section 502(a), or an action brought under a state law that could have been brought under section 502(a) will not be saved by section 514(b)(2)(A), regardless of its relation to insurance.49

B. Complete and Conflict Preemption and ERISA's Civil Enforcement Provisions

The Federal Rules of Civil Procedure dictate that "any civil action brought in a State court of which district courts have original jurisdiction, may be removed by the defendant" to federal court.50 Federal courts have original jurisdiction over questions that "aris[e] under the regulating such plans from federal preemption. 29 U.S.C. § 1144(b)(2)(B) (2000). In FMC Corp. v. Holliday, 498 U.S. 52 (1990), the Supreme Court applied the deemer clause to a Pennsylvania anti-subrogation law which "related to" a self-funded welfare plan that was arguably "saved" because it regulated insurance, but ultimately was preempted under the deemer clause because the state law applied to a plan that was not insured, id. at 58-61, 65.

The deemer clause also prohibits states from regulating self-funded health plans as insurers. 29 U.S.C. § 1144(b)(2)(B). The Court in Rush Prudential held that an HMO is both a heath care provider and an insurer, because HMOs in practice "underwrite and spread risk among their participants." 536 U.S. at 367; see also Holliday, 498 U.S. at 61 (stating that as a result of the deemer clause, "self-funded ERISA plans are exempt from state regulation insofar as that regulation 'relate[s] to' the plans" (alteration in original)).

46. See Rush Prudential, 536 U.S. at 367.
48. Aetna Health Inc. v. Davila, 124 S. Ct. 2488, 2496 (2004); see also discussion infra Part II.
49. E.g., Davila, 124 S. Ct. at 2495 (holding that plaintiffs' state law claims for compensatory damages were preempted by ERISA because the state law provided for remedies additional to those in ERISA's civil enforcement provisions); Metro. Life Ins. v. Taylor, 481 U.S. 58, 62-63 (1987) (holding that ERISA's civil enforcement provisions displaced a state law cause of action to recover benefits wrongfully denied, characterizing the state law action as a federal claim); Pilot Life Ins. Co. v. Dedeeaux, 481 U.S. 41, 57 (1987) (holding that a state law is preempted because it provides for remedies in excess of those provided in ERISA's civil enforcement provisions). The preemption at issue in Pilot Life and Davila involved conflict preemption. See discussion infra Part I.B. The preemption at issue in Taylor involved complete preemption. See discussion infra Part I.B.
Constitution, laws, or treaties of the United States.” 51 The “well-pleaded complaint” rule dictates that a cause of action “arises under” federal law when the plaintiff’s complaint raises issues of federal law. 52 When federal preemption is raised solely as a defense to a plaintiff’s suit, and a federal question does not appear “upon the face of the complaint,” a defendant may not remove the case to federal court. 53 Two additional types of preemption relevant to ERISA preemption analysis are complete and conflict preemption. 54

Complete preemption, an exception to the “well-pleaded-complaint rule,” 55 occurs where “a federal statute’s preemptive force [is] 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.” 56 Under complete preemption, a state law cause of action that falls within the scope of a federal statute with such preemptive force is removable to federal court and will be dismissed unless a plaintiff re-pleads under the controlling federal law. 57

The Supreme Court applied the doctrine of complete preemption to ERISA’s civil enforcement provisions in Metropolitan Life Insurance v. Taylor, 58 stating that ERISA’s civil enforcement provisions carried “extraordinary preemptive power.” 59 The Court in Metropolitan Life held that all state-law suits brought to enforce benefit rights against an

53. Id. at 113.
54. See supra notes 55, 62-63 and accompanying text (discussing doctrines of complete and conflict preemption).
56. BLACK’S LAW DICTIONARY 303 (8th ed. 2004). The Seventh Circuit in Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482 (7th Cir. 1996), set forth several factors that should be considered when determining whether removal is proper based upon complete preemption:
   (1) whether the “plaintiff is eligible to bring a claim under [ERISA § 502(a)]”;
   (2) whether the plaintiff’s “cause of action falls within the scope of an ERISA provision that the plaintiff can enforce via § 502(a)”;
   (3) whether the plaintiff’s “state law claim cannot be resolved without [looking to an ERISA-governed contract].”

   id. at 1487 (quoting Rice v. Panchal, 65 F.3d 637 (7th Cir. 1995)). Indeed, any suit brought by an ERISA plan participant to “enforce his rights” to a certain benefit should be completely preempted when his claim “cannot be resolved without an interpretation of the contract governed by federal law.” Rice, 65 F.3d at 644.
57. Anderson, 539 U.S. at 8 (“When the federal statute completely pre-empts the state-law cause of action, a claim which comes within the scope of that cause of action, even if pleaded in terms of state law, is in reality based on federal law.”); DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442, 446 (3d Cir. 2003).
59. Id. 63-66.
ERISA-governed plan are wholly displaced by section 502(a)(1)(B) and will be characterized as actions arising under federal law.\textsuperscript{60}

Under the doctrine of conflict preemption, a state law is preempted if it conflicts with the "provisions and objectives" of a federal law.\textsuperscript{61} The Supreme Court applied the doctrine of conflict preemption in \textit{Pilot Life Insurance Co. v. Dedeaux}\textsuperscript{62} to causes of action falling within the scope of ERISA section 502(a).\textsuperscript{63} In this case, the Court noted that the section 502(a) remedial scheme was carefully designed to be comprehensive, and intended to maintain a balance between "the need for prompt and fair claims settlement" and "the public interest in encouraging the formation of employee benefit plans."\textsuperscript{64} Thus, certain remedies were excluded to comport with this balancing test, and allowing ERISA-plan participants and beneficiaries to obtain other remedies under state law would undermine congressional intent.\textsuperscript{65} In other words, additional remedies not provided for in ERISA ultimately conflict with ERISA’s remedial scheme and Congress’ intent to keep such a scheme exclusive.\textsuperscript{66}

Having laid the foundation for complete and conflict preemption as applied to ERISA’s civil enforcement provisions, the courts subsequently

\textsuperscript{60} Id. at 66-67. Complete preemption also applies to § 301 of the Labor Management Relations Act (LMRA), which the court found to carry "preemptive force . . . so powerful as to displace entirely any state cause of action for violation of contracts between an employer and a labor organization." Id. (citing Franchise Tax Bd. of Cal. v. Constr. Laborers Vacation Trust for S. Cal., 463 U.S. 1, 23 (1983)). In determining whether ERISA section 502(a) claims give rise to complete preemption, the Court in \textit{Taylor} compared language within the jurisdictional subsection of section 502 to that of LMRA section 301 and found the language to be similar. \textit{Metro. Life Ins. v. Taylor}, 481 U.S. 58, 65 (1987). The Court drew additional support from a House conference report describing ERISA section 502(a), which states: "All such actions [to enforce benefit rights under the plan or to recover benefits] in Federal or State courts are to be regarded as arising under the laws of the United States in similar fashion to those brought under section 301 of the Labor-Management Relations Act of 1947." Id. at 65-66 (emphasis omitted) (quoting H.R. CONF. REP. NO. 93-1280, at 327 (1974)).

\textsuperscript{61} See, e.g., \textit{Boggs v. Boggs}, 520 U.S. 833, 844 (1997) (holding that a state law that "undermined[] the purpose" of ERISA "cannot stand," and that states may not “change ERISA’s structure and balance”).


\textsuperscript{63} Id. 54-56.

\textsuperscript{64} Id. at 54.

\textsuperscript{65} Id.

\textsuperscript{66} Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 146 (1985) ("[T]he six carefully integrated civil enforcement provisions found in § 502(a) of [ERISA] as finally enacted . . . provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly."). \textit{Contra} Franklin H. Williams Ins. Trust v. Travelers Ins. Co., 50 F.3d 144, 151 (2d Cir. 1995) (stating that "it would be quixotic to rule that a claim under a state statute that is saved from ERISA preemption . . . may nonetheless be enforced only via ERISA’s provisions and remedies").
defined which kinds of claims would fall victim to these types of ERISA preemption, and which claims may escape.67

C. Certain Claims Escape the Preemptive Power of ERISA: The Quality-Quantity Distinction

In Dukes v. U.S. Healthcare, Inc.,68 the Third Circuit held that claims attacking the quality of benefits received fall outside the preemptive scope of ERISA section 502(a).69 In Dukes, the participant sought a blood test as suggested by his primary care physician.70 The participant sought treatment in a hospital that refused to perform the test, so the participant was forced to seek treatment elsewhere.71 Due to the delay in receiving the blood test, the participant's dangerously high blood sugar went unnoticed, and he died from related causes.72 The participant's wife brought a lawsuit in state court against the couple's HMO, alleging that it was vicariously liable for the negligence of its providers, and that the HMO itself was negligent in "fail[ing] to exercise reasonable care in selecting, retaining, screening, monitoring, and evaluating the personnel who actually provided the medical services."73

The HMO argued for removal to federal court under the complete preemption doctrine.74 After the district court denied the Dukes' motion to remand to state court, the Third Circuit stated that the participant's claims attacked the quality of benefits received rather than the actual receipt of the benefits and, therefore, the plaintiff's claim was distinct

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67. See DiFelice, 346 F.3d at 446 ("We have had numerous occasions to consider the question of whether a plaintiff's claim against an HMO is covered by section 502(a) and is therefore completely preempted. Determining whether a claim could have been brought under ERISA has proven to be anything but an exact science." (citations omitted)); see also discussion infra Part I.C.

68. 57 F.3d 350 (3d Cir. 1995).

69. Id. at 357. The court found that the plaintiff's claims "do not concern a denial of benefits due or a denial of some other plan-created right" and therefore "bear no significant resemblance to the claims described in § 502(a)(1)(B) [regarding claims for benefits wrongfully denied]." Id. at 361; see also Lazorko v. Pa. Hosp., 237 F.3d 242, 249-50 (3d Cir. 2000) (finding that plaintiff's allegation, that an HMO's financial disincentives acted to discourage the hospitalization of a mentally ill woman, fell within the ambit of a "quality of care" claim because the decision was made in the context of treatment).

70. Dukes, 57 F.3d at 352.

71. Id.

72. Id.

73. Id. Mrs. Dukes brought a suit against the HMO under the "agency theory," in that the HMO's conduct made it apparent to the Dukes that the personnel treating Mr. Dukes were employees of the HMO, even though they were not. Id. (citing Boyd v. Albert Einstein Med. Ctr., 547 A.2d 1229, 1234-35 (Pa. Super Ct. 1988) (applying agency theory to hold HMO liable for malpractice)). She also brought a suit directly against the HMO for its own negligence by employing incompetent personnel. Id.

74. Id. at 352-53.
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from a section 502(a) claim to recover benefits wrongfully denied. The court, however, found that the plaintiff did not claim that their HMO withheld benefits due to them, but rather complained “about the low quality of the medical treatment that they actually received.”

In the *Dukes* case there was no indication that the participant’s HMO refused to pay for a treatment (the blood test), but rather it was the poor decisions made on behalf of the medical personnel that caused the delay in treatment. In other words, as the court stated, “[A] claim about the quality of a benefit received is not a claim under section 502(a)(1)(B).” Quality control, according to the Third Circuit, “is a field traditionally occupied by state regulation and we interpret the silence of Congress as reflecting an intent that it remain such.”

2. The Pegram “Treatment” and “Eligibility” Distinction

In *Pegram v. Herdrich*, the Supreme Court indicated another kind of claim that fell outside ERISA’s preemptive scope when it distinguished among three kinds of health-related decisions that HMOs make during the treatment process. First are “pure eligibility decisions” which “turn on the plan’s coverage of a particular condition or medical procedure for its treatment.” For example, an HMO’s decision whether to cover a participant’s treatment for appendicitis is an eligibility decision; the HMO asks itself, is appendicitis a covered condition under our plan, or if not explicitly covered, is it medically necessary? Such a decision is fiduciary in nature and thus would fall within the scope of ERISA. Second, HMOs, via the doctors they employ, may make “treatment decisions” which involve choices about how a participant’s condition will

75. *Id.* at 353, 356. The court in *Dukes* considered the fact that the plaintiff’s complaint was void of any allegation that the ERISA-governed plan failed to provide benefits due, i.e., the hospital that refused to conduct the blood test did not do so because the HMO refused to pay. *Id.* at 356-57.

76. *Id.* (emphasis added).

77. *Id.* at 357 (“Instead of claiming that the welfare plans in any way withheld some quantum of plan benefits due, the plaintiffs... complain about the low quality of the medical treatment they actually received...”).

78. *Id.* The court went on to cite legislative history as being absent of an intent for ERISA to govern quality of benefits received by plan participants. *Id.*

79. *Id.*


81. *Id.* at 227-29.

82. *Id.* at 228.

83. *See id.*

84. *Id.* An eligibility decision is analogous to a benefits determination, which is fiduciary in nature. *Aetna Health Inc. v. Davila*, 124 S. Ct. 2488, 2502 (2004); see also *supra* notes 33-36 and accompanying text (discussing fiduciary responsibilities under ERISA).
be diagnosed and treated.\textsuperscript{85} An example of a treatment decision is whether immediate action needs to be taken for an inflamed abdomen (a signal of appendicitis).\textsuperscript{86} Pure treatment decisions are not governed by ERISA as they are not fiduciary in nature.\textsuperscript{87} The third kind of decision, the subject of the lawsuit in \textit{Pegram}, is the “mixed eligibility” determination.\textsuperscript{88} Examples of such determinations include decisions involving the proper standard of care and the reasonableness of a proposed treatment.\textsuperscript{89}

Under \textit{Pegram}, the Court noted that although “pure eligibility decisions” fall within the scope of ERISA, the “mixed eligibility decisions,” like treatment decisions, are not fiduciary decisions under ERISA and thus claims brought challenging these decisions are not preempted by ERISA.\textsuperscript{90} The Court reasoned that to hold an HMO liable for breach of fiduciary duty for their physicians’ mixed eligibility decisions would ultimately destroy HMOs.\textsuperscript{91} The Court further noted that most decisions involve “mixed eligibility” determinations, and often pure eligibility decisions cannot be untangled from decisions regarding medical necessity.\textsuperscript{92}

Subsequently, lower courts used the \textit{Pegram} distinction to uphold state law causes of action, if such actions were based on “mixed eligibility and treatment decisions.”\textsuperscript{93}

\begin{itemize}
\item \textsuperscript{85} \textit{Pegram}, 530 U.S. at 228.
\item \textsuperscript{86} \textit{See id.}
\item \textsuperscript{87} \textit{Id.} at 232. These decisions are not administrative, per se, and thus are not fiduciary in nature. 29 U.S.C. § 1002(21)(A) (2000); \textit{see supra note 35-36 and accompanying text.}
\item \textsuperscript{88} \textit{Pegram}, 530 U.S. at 229-30.
\item \textsuperscript{89} \textit{Id.} In \textit{Pegram}, the Court listed the different types of decisions that fall into the category of 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 [HMO’s]; about proper standards of care, the experimental character of a proposed course of treatment, the reasonableness of a certain treatment, and the emergency nature of a medical condition.
\item \textit{Id.}
\item \textsuperscript{90} \textit{Id.} at 237.
\item \textsuperscript{91} \textit{Id.} at 232-34. “[T]he Federal Judiciary would be acting contrary to the congressional policy of allowing HMO organizations if it were to entertain an ERISA fiduciary claim portending wholesale attacks on existing HMOs solely because of their structure ….” \textit{Id.} at 234.
\item \textsuperscript{92} \textit{Id.} at 228-29.
\item \textsuperscript{93} \textit{See, e.g., Cicco v. Does}, 321 F.3d 83, 102 (2d Cir. 2003) (holding that a state law malpractice action is not preempted by ERISA since it is based on a “mixed eligibility and treatment decision” challenging a flawed medical judgment), \textit{vacated sub nom.} Vytra Healthcare v. Cicco, 124 S. Ct. 2902 (2004); \textit{see also} Roark v. Humana, Inc., 307 F.3d 298, 308 (5th Cir. 2002) (upholding claims for breach of duty of ordinary care brought pursuant
3. Procedural Regulations: Independent Medical Reviews Do Not Conflict with ERISA's Remedial Scheme

Recent case law suggests that state laws mandating independent medical review (IMR) of adverse benefit determinations are not preempted by ERISA.\(^9\) In *Rush Prudential HMO v. Moran*,\(^9\) a patient who was denied her request for a surgical procedure brought a state-court action against her HMO under the Illinois HMO Act, which provides participants and beneficiaries a right to an IMR for disputed claims and mandates compliance with a reviewer's decision.\(^9\)

In *Rush Prudential*, the defendant removed the case to federal court, claiming that ERISA preempted the plaintiff's action.\(^\text{g7}\) Having granted certiorari, the Supreme Court held that the law "relates to" ERISA plans under section 514(a), thus placing the case in federal court.\(^\text{g6}\) But the Court went on to consider the savings clause, and determined that the
law specifically "regulates insurance" and is therefore saved from preemption under section 514(b)(2)(A).\textsuperscript{99}

The \textit{Rush Prudential} Court further noted that the savings clause \textit{will not} save from complete preemption those state laws that conflict with ERISA by providing for remedies in addition to those already provided for in the statute.\textsuperscript{100} Additional remedies conflict with the policy of exclusive federal remedies embodied in ERISA.\textsuperscript{101} Laws providing for additional remedies are preempted even if such laws regulate insurance under the meaning of the savings clause.\textsuperscript{102} However, the Court ultimately found that the substantive provisions of the Illinois law do not add to or conflict with remedies available under section 502(a), stating that while the independent review procedure mandated by state law may "settle the fate of a benefit claim," such a regulatory scheme does not provide for any new cause of action or form of relief under state law.\textsuperscript{103} Thus the Court held that conflict preemption as set out by \textit{Pilot Life} does not apply where the substantive portion of the law does not conflict with section 502(a).\textsuperscript{104} Therefore, the cause of action was subject to section 514 preemption, from which it was exempted under the savings clause.\textsuperscript{105}

\begin{enumerate}
\item[99.] \textit{Id.} at 387. The savings clause states: ["N]othing in \textsection{1144] 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. \textsection{1144(b)(2)(A) (2000).
\item[100.] \textit{Rush Prudential}, 536 U.S. at 377-79.
\item[101.] \textit{Id.}
\item[102.] \textit{Id.} at 377; see also \textit{Pilot Life Ins. Co. v. Dedeaux}, 481 U.S. 41, 57 (1987) (holding that ERISA's civil enforcement scheme is exclusive, and a state law suit challenging an ERISA-governed plan for a denial of benefits will not be saved by the section 514(b)(2)(A) savings clause); \textit{Metro. Life Ins. Co. v. Taylor}, 481 U.S. 58, 62-63 (1987) (holding that a state law tort claim for wrongful denial of benefits is within the scope of ERISA section 502(a)(1)(B), as an action arising under federal law). For a discussion of complete preemption, see discussion \textit{supra} Part I.A.1-B.
\item[103.] \textit{Rush Prudential}, 536 U.S. at 379-80 ("[T]his case addresses a state regulatory scheme that provides no new cause of action under state law and authorizes no new form of ultimate relief.").
\item[104.] \textit{Rush Prudential}, 536 U.S. at 380 ("[T]he procedure provided by \$ 4-10 does not fall within \textit{Pilot Life}'s categorical preemption.").
\item[105.] 29 U.S.C. \textsection{1144(b)(2)(A) (2000).
Similarly, in *Corporate Health Insurance, Inc. v. Texas Department of Insurance*, the Fifth Circuit found that a Texas law which permitted participants and beneficiaries to seek review of managed care medical necessity determinations did not conflict with ERISA’s civil enforcement provisions because it did not create or enlarge upon available remedies. Under *Rush Prudential*, a state law creating a right to independent review “regulates insurance” under section 514(b)(2)(A), and such a law ordinarily would be saved from preemption under the savings clause. However, the law at issue in *Corporate Health* was challenged as applied to self-funded ERISA plans and federal health plans. As opposed to an insured plan, a self-funded, or “self-insured” plan, is one where benefits are paid through the employer-organization as opposed to being paid by an insurance carrier. Under the “deemer” clause, found within the savings clause, a state cannot regulate self-funded plans as insurers.

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106. 314 F.3d 784 (5th Cir. 2002).
107.  *Id.* at 786 (stating that there are no relevant differences between Texas law and the Illinois law at issue in *Rush Prudential*).
109.  *Corporate Health Ins.*, 314 F.3d at 786.
110.  See 42 U.S.C.A. § 1395y(b)(2)(A) (West Supp. 2004) (stating that “[a]n entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part”); LAWRENCE & RUSSELL, supra note 43, at 53.
111.  FMC Corp. v. Holliday, 498 U.S. 52, 58 (1990) (distinguishing between insured and uninsured (self-funded) plans and holding that uninsured plans are not subject to state insurance regulations); see also Bill Gray Enter., v. Gourley, 248 F.3d 206, 213-14 (3d Cir. 2001) (holding that state laws may not regulate uninsured, or “self-funded” health plans, even if the self-funded plan purchases stop-loss insurance). The “deemer” clause states in pertinent part: “Neither an employee benefit plan . . . shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.”  *Id.* at 213 (quoting 29 U.S.C. § 1144(b)(2)(B)). The *Rush Prudential* Court acknowledged the distinction between self-funded and insured plans, stating that the Illinois law mandating IMR “would not be ‘saved’ as an insurance law to the extent that it applied to self-funded plans.” 536 U.S. at 371 n.6; see also supra note 45 (discussing “deemer” clause in relation to other clauses in section 514).
D. The Davila Decision

1. Supreme Court Dismisses Plaintiffs’ Claims Brought Under the Texas Health Care Liability Act

During the summer of 2004, the Supreme Court halted states’ attempts to provide additional remedies to aggrieved health plan participants and beneficiaries. In Aetna Health Inc. v. Davila, the Court held that claims brought under the Texas Health Care Liability Act (THCLA) were completely preempted by ERISA section 502(a)(1)(B). The case consolidated two different lawsuits arising under Texas law, one brought by Ruby Calad, a beneficiary in a CIGNA plan, and the other by Juan Davila, a participant in an Aetna health plan. Juan Davila’s physician prescribed Vioxx to treat his arthritis pain, but when Davila sought pretreatment approval for the drug, Aetna refused to pay for it. He instead took Naprosyn, had a severe reaction to the drug, and was hospitalized. Ruby Calad’s physician recommended an extended hospital stay following her surgery; however, CIGNA refused to cover this stay. Because of the denial, Calad left the hospital and, as a result, suffered serious post-surgery complications. Both plaintiffs brought

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112. Aetna Health Inc. v. Davila, 124 S. Ct. 2488, 2498 (2004) (holding that claims brought pursuant to a Texas law were completely preempted by ERISA). Eleven other states have enacted laws similar to THCLA authorizing state lawsuits for damages, but after Davila, these laws will be limited to public health plans or individual (non-employer-based) health plans. PATRICIA A. BUTLER, VOL. V, NO. 2, ERISA UPDATE: THE SUPREME COURT TEXAS DECISION AND OTHER RECENT DEVELOPMENTS 2 (2004), available at http://statecoverage.net/pdf/issuebrief804.pdf.


114. Id. at 2502.

115. Id. at 2492-93. Two additional plaintiffs, Gwen Roark and Walter Thorn, were also parties to the original litigation. See Roark v. Humana, Inc., 307 F.3d 298, 302-04 (5th Cir. 2002), rev’d sub nom. Aetna Health Inc. v. Davila, 124 S. Ct. 2488 (2004). Walter Thorn’s finger was amputated following injuries sustained in a car accident and his doctors recommended follow-up surgery, indicating that without such surgery he would risk losing his hand. Id. at 302. Although an Aetna specialist scheduled the surgery, Aetna decided it would refuse the surgery until it had more time to review the claim. Id. Aetna ultimately approved the surgery but only after some delay, and Thorn alleged that delay caused scarring and subsequent loss of mobility. Id. Gwen Roark did not replead under section 502(a) when given the opportunity by the court and was thus not a party to the Supreme Court case. Id. at 304; see also supra note 1.

116. Davila, 124 S. Ct. at 2493. The 2000 Department of Labor regulations draw a distinction between postservice claims (requests for reimbursement after treatment has been rendered) and preservice claims (requests for a benefit when claims condition receipt of benefit on approval or precertification). See 29 C.F.R. § 2560.503-1(m)(2) (2004) (preservice claim); id. § 2560.503-1(m)(3) (post-service claim).

117. Davila, 124 S. Ct. at 2493.

118. Id.

119. Id.
separate suits in state court under THCLA, which allowed tort claims for negligence, and specifically for breach of the duty of ordinary care.\textsuperscript{120}

The Supreme Court held that the "duty of ordinary care" imposed by the Texas law did not arise independently of ERISA or the terms of the plan in question.\textsuperscript{121} Accordingly, the Supreme Court found that although the law arguably could be characterized as a law regulating insurance for the purposes of the savings clause, state causes of action under THCLA fell "within the scope of" ERISA Section 502(a)(1)(B).\textsuperscript{122}

Unlike \textit{Rush Prudential}, where the dispute was over an HMO's refusal to comply with a "regulatory scheme,"\textsuperscript{123} the plaintiffs in \textit{Davila} brought a specific cause of action for benefits wrongfully denied, asserting rights supplemental to those under ERISA section 502(a).\textsuperscript{124} The Illinois law at issue in \textit{Rush Prudential} mandated independent review in the event of a dispute over medical necessity, but did not create any new cause of action for wrongful denial of benefits.\textsuperscript{125} In contrast, the Texas law at issue in \textit{Davila} purported to allow an action to recover damages for injuries caused by an HMO's failure to exercise ordinary care in making benefits determinations.\textsuperscript{126} The Court noted that allowing the action would patently contradict Congress' intent to make the ERISA civil enforcement mechanism exclusive.\textsuperscript{127}

\begin{itemize}
\item \textsuperscript{120} Id.
\item \textsuperscript{121} Id. at 2497. The Court stated that the interpretation of the benefit plan's terms, whether certain treatments are covered under the plan, was "an essential part of [plaintiffs'] THCLA claim, and THCLA liability would exist here only because of [the HMOs'] administration of ERISA-regulated benefit plans." Id. at 2498. Furthermore, because the HMOs' liability derives from participants' rights with regard to the contract between the HMO-administered plan and plan participant, which is regulated by ERISA, the THCLA claims "are not entirely independent of the federally required contract itself." Id.
\item \textsuperscript{122} Id. at 2498, 2500.
\item \textsuperscript{124} Davila, 124 S. Ct. at 2499-500.
\item \textsuperscript{125} Rush Prudential, 536 U.S. at 379-80; 215 ILL. COMP. STAT. ANN. 125/4-10 (West 2000). The Rush Prudential Court implied that were the HMO still to refuse to comply after the independent review determined medical necessity of a certain benefit, only then would the plaintiffs be asserting a section 502(a) claim. See Rush Prudential, 536 U.S. at 379-80.
\item \textsuperscript{126} TEX. CIV. PRAC. & REM. CODE ANN. § 88.002 (Vernon 2004). The statute provided that
\begin{quote}
(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.
\end{quote}
\item \textsuperscript{127} Davila, 124 S. Ct. at 2498 n.4.
\end{itemize}
The *Davila* Court also clarified the confusion surrounding the *Pegram* "mixed eligibility" decisions. The Court held that a benefits determination is a fiduciary act, and "[t]he fact that a benefits determination is infused with medical judgments does not alter this result." In clarifying *Pegram*, the Court held that true "mixed eligibility and treatment decisions" are those where medical necessity decisions are made in the capacity of a participant's physician who is *both* the treating physician and benefits administrator—meaning that the reasoning employed in *Pegram* only applies to situations where medical malpractice is alleged against a treating physician. However, *Davila* did not involve "mixed" treatment decisions, as there was no action on the part of a CIGNA or Aetna physician. The plaintiffs' treatments were prescribed by doctors who were independent from the HMOs, and not fiduciaries of the plan. Because the benefits decisions made by CIGNA and Aetna did not fit the mold of decisions made by both physician and benefits administrator, the distinction in *Pegram* was not implicated. The Court held that the plaintiffs' causes of action for failure to exercise ordinary care were completely preempted by ERISA section 502(a)(1)(B), and although they sought compensatory damages, their recovery was limited to the cost of the benefits denied.

128. *Id.* at 2501. The plaintiffs in *Davila* relied upon the reasoning employed in *Pegram v. Herdrich*, 530 U.S. 211 (2000), in asserting that their claims are not preempted, as their causes of action do not "relate to" an ERISA-governed employee benefit plan, *Davila*, 124 S. Ct. at 2500.

129. *Davila*, 124 S. Ct. at 2501. The Court went on to say: "[A]dministrators making benefits determinations, even determinations based extensively on medical judgments, are ordinarily acting as plan fiduciaries . . . ." *Id.* at 2502.

130. *Id.* Thus, if an HMO review board, independent of a participant's treating physician, makes a mixed decision, any challenge to the decision will be preempted. *See id.* In *Roark*, holding that Calad's and Davila's HMOs were liable under THCLA, the Fifth Circuit erroneously extended *Pegram* reasoning to Calad and Davila's claims seeking to hold their HMOs directly liable for their "mixed eligibility and treatment decisions." *Id.* at 2493 (citing *Roark v. Humana*, 307 F.3d 298, 307-08 (2002), rev'd sub nom. Aetna Health Inc. v. Davila, 124 S. Ct. 2488 (2004)). In *Pegram*, the Court held that, because they are not purely administrative (i.e., also involve medical judgments), such "mixed" decisions made by a physician who is also a benefits administrator are not fiduciary in nature. 530 U.S. at 229. But for the "mixed eligibility and treatment" label to apply, a decision challenged must be a "truly" mixed decision—a decision made by the plaintiffs' physician who is *both* the treating physician and the benefits administrator. *Id.*


132. *Id.* at 2502. Thus, the challenged decisions were not truly "mixed eligibility and treatment" decisions because they did not involve a physician acting as both a treating physician and a plan administrator. *Id.*

133. *Id.*

134. *Id.* The Eleventh Circuit applied *Davila* to strike down a plaintiff's negligence claim against his HMO in *Land v. CIGNA Healthcare of Florida*, 381 F.3d 1274, 1275 (11th Cir. 2004). The patient in *Land* sought emergency room treatment when a cat-bite
2. Justice Ginsburg's Concurrence and the "Regulatory Vacuum"

The injustice that flows from limiting aggrieved participants and beneficiaries to ERISA's current menu of remedies has not gone unnoticed by the courts, as evidenced by the many judges urging congressional action or judicial reconsideration of the ERISA remedies issue. Justice Ginsburg's concurrence in Davila particularly merits attention. A broad preemptive scope coupled with a "cramped construction" of section 502(a)(3)'s equitable relief creates what has been called a "regulatory vacuum" where participants and beneficiaries are left with few remedies. Justice Ginsburg suggests two ways in which this remedial void should be addressed. First, she invites congressional action, acknowledging "the rising judicial chorus urging that Congress and [this] court revisit what is an unjust and increasingly tangled ERISA regime." Next, she suggests that the Court reconsider the issue of equitable relief and the availability of consequential damages under section 502(a)(3). Similarly, Justice Ginsburg cites to the Government's Amicus brief, which recognizes another remedy that aggrieved participants and beneficiaries may be able to pursue.

The Government points out in note 13 of its brief that although the Court has foreclosed an award of money damages as "equitable relief" under

wound became infected. *Id.* Despite his doctor's orders that he be hospitalized, a CIGNA approval nurse determined that his infection was localized and he should be discharged. *Id.* at 1275-76. Plaintiff's condition worsened until amputation became necessary and Land filed a suit against CIGNA in state court alleging negligence, which was dismissed pursuant to *Davila.* *Id.* at 1276.

135. See DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442, 453-61 (3d Cir. 2003) (Becker, J., concurring) ("ERISA has evolved into a shield that insulates HMOs from liability for even the most egregious acts of dereliction committed against plan beneficiaries, a state of affairs that I view as directly contrary to the intent of Congress."); see also Cicio v. Does, 321 F.3d 83, 106 (2d Cir. 2003) (Calabresi, J., dissenting in part) ("[T]he injury that the courts have done to ERISA will not be healed until the Supreme Court reconsiders the existence of consequential damages under the statute, or Congress revisits the law to the same end."). *Vacated sub nom.* Vytra Healthcare v. Cicio, 124 S. Ct. 2902 (2004).


137. *Id.* (Ginsburg, J., concurring) (quoting *DiFelice,* 346 F.3d at 453 (Becker, J. concurring)).

138. *Id.* (Ginsburg, J., concurring) ("[F]resh consideration of the availability of consequential damages under § 502(a)(3) is plainly in order."). ERISA section 502(a)(3) allows a participant or beneficiary to bring an action to recover "appropriate equitable relief." 29 U.S.C. 1132(a)(3) (2000).

139. *Davila,* 124 S. Ct. at 2504 (Ginsburg, J., concurring) (citing Brief for the United States as Amicus Curiae Supporting Petitioners at 27 n.13, *Davila* (Nos. 02-1845, 03-83)).
section 502(a)(3) in an action against a non-fiduciary, this approach has not been tested in an action against a fiduciary.\textsuperscript{140}

3. Congressional Response and the Patients’ Bill of Rights

On the same day that \textit{Davila} was decided, Congress reintroduced a bill that would amend ERISA by adding new protections for aggrieved health plan participants and beneficiaries.\textsuperscript{141} This bill, the Patients’ Bill of Rights Act of 2004 (PBRA 2004), sets forth requirements aimed at strengthening internal utilization review and appeals procedures (claims review procedures),\textsuperscript{142} and in addition, creates a new right to external appeal.\textsuperscript{143} The bill also would amend ERISA section 502 by adding a new cause of action for failure to exercise ordinary care in providing health benefits.\textsuperscript{144} More significantly, PBRA 2004 would allow participants and beneficiaries in ERISA-governed plans to recover economic and non-economic damages.\textsuperscript{145}

\textsuperscript{140} Brief for the United States as Amicus Curiae Supporting Petitioners at 27 n.13, \textit{Davila} (Nos. 02-1845, 03-83). Neither \textit{Mertens v. Hewitt Associates}, 508 U.S. 248 (1993), nor \textit{Great-West Life & Annuity Insurance v. Knudson}, 534 U.S. 204 (2002), involved actions against a fiduciary, see id. at 207-08 (involving restitution action against plan beneficiary brought by plan itself), \textit{Mertens}, 508 U.S. at 249-51 (involving action against an actuarial firm, an external service provider and not a plan fiduciary under ERISA). The brief goes on to propose that although \textit{Mertens} limited section 502(a)(3)’s “appropriate equitable relief” to injunction, mandamus, and restitution, a “make whole” remedy against a breaching fiduciary was historically available in equity. Brief for the United States as Amicus Curiae Supporting Petitioners at 27 n.13, \textit{Davila} (Nos. 02-1845, 03-83); \textit{Mertens}, 508 U.S. at 256.


\textsuperscript{143} \textit{See} id. § 104 (providing that a health plan provide participants with “access to an independent external review for any denial of a claim for benefits”).

\textsuperscript{144} \textit{See} id. § 402(a).

\textsuperscript{145} \textit{See} id. The new provision would read:

“(n) CAUSE OF ACTION RELATING TO PROVISION OF HEALTH BENEFITS.—

“(1) IN GENERAL.— In any case in which—

“(A) a person who is a fiduciary of a group health plan, a health insurance issuer offering health insurance coverage in connection with the plan, or an agent of the plan, issuer, or plan sponsor, upon consideration of a claim for benefits of a participant or beneficiary ... or upon review of a denial of such a claim ... fails to exercise ordinary care in making a decision—

“(i) regarding whether an item or service is covered under the terms and conditions of the plan or coverage,

“(ii) regarding whether an individual is a participant or beneficiary who is enrolled under the terms and conditions of the plan or coverage (including the applicability of any waiting period under the plan or coverage), or
II. FILLING THE REGULATORY VACUUM: PROPOSED SOLUTIONS

The current ERISA framework as interpreted by the courts has left health plan participants and beneficiaries with only a few options for legal relief: injunction and reimbursement.\(^6\) If a participant is denied a benefit or treatment to which he believes he is entitled, he may seek an injunction forcing the plan to pay for such benefit or treatment.\(^7\) Alternatively, a participant may pay for the treatment himself and then sue for reimbursement.\(^8\) The latter alternative is riskier and less practical. The risk is that a court may find the treatment unnecessary and deny reimbursement. The impracticality lies in the fact that many Americans cannot afford to pay for costly medical treatment.

\(^{146}\) See DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442, 449 (3d Cir. 2003) (stating that a plaintiff could seek an injunction under section 502(a) to enforce his right to claimed benefits or could pay for the benefit himself, and subsequently seek reimbursement).

\(^{147}\) See Pryzbowski v. U.S. Healthcare, Inc., 245 F.3d 266, 273-74 (3d Cir. 2001) (stating that the plaintiff sought to accelerate U.S. Healthcare’s approval of her benefit claim, “she could have sought an injunction under § 502(a) . . . thereby using the provisions of the civil enforcement scheme provided by Congress”). Courts will issue injunctions in favor of participants or beneficiaries who are seeking pretreatment authorization for certain claims. See, e.g., Marro v. K-III Communications Corp., 943 F. Supp. 247, 248, 253 (E.D.N.Y. 1996) (claim for high dosage chemotherapy treatment); Mattive v. Healthsource of Savannah, Inc., 893 F. Supp. 1559, 1561 (S.D. Ga. 1995) (claim for high dose chemotherapy); Dozsa v. Crum & Forster Ins. Co., 716 F. Supp. 131, 132, 140 (D.N.J. 1989) (claim for bone marrow transplant treatment). However, although a participant or beneficiary who is denied a benefit from their HMO may bring a suit for an injunction against their HMO, few individuals have the financial means to do so. DiFelice, 346 F.3d. at 459 (Becker, J., concurring) (“[P]articipants . . . are completely at the mercy of HMOs unless they are fortunate enough to have the financial means to bring a suit for an injunction, a circumstance which is no doubt exceptional.”).

\(^{148}\) See DiFelice, 346 F.3d at 444, 449 (stating that the plaintiff who was seeking coverage for a specially designed tracheostomy tube could have paid for the tube himself and then sought reimbursement from his HMO). In Rush Prudential, plaintiff Debra Moran, had surgery that her HMO deemed medically unnecessary, and thus did so at her own expense. Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 362 (2002). She sought reimbursement from her HMO thereafter. Id.
A. Federal Patients' Bill of Rights: Are Additional Remedies Necessary?

On many occasions, both the House and Senate have introduced legislation that would provide more protections to health plan participants and beneficiaries by way of increasing the liability of insurers and HMOs. The most recent patients' rights bill to be introduced in Congress is the PBRA 2004. Legislators have taken different approaches to creating a patients' bill of rights; some support bills that both require external review procedures for contested benefits and impose liability on HMOs and insurers who fail to exercise ordinary care in their decisions. Another approach includes only mandatory external review procedures, stopping short of creating a new cause of action for participants and beneficiaries to pursue against their HMOs and insurers.

Supporters of a patients' bill of rights, like the PBRA 2004, that would create a new cause of action against insurers and HMOs cite tragic cases like Gwen Roark's as evidence that additional ERISA remedies are

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149. See, e.g., H.R. 4628, 108th Cong. §§ 103(a), 104(a), 714(a), (b)(3)-(4), 402(a)(1)(n)(10) (2004); Bipartisan Patient Protection Act of 2004, S. 2083, 108th Cong. §§ 103(a), 104(a), 714(a), (b)(3)-(4), 402(a)(1)(n)(1) (2004); Bipartisan Patient Protection Act, S. 1052, 107th Cong. §§ 103(a), 104(a), (f)(3) (2001); Patients' Bill of Rights Act, H.R. 2990, 106th Cong. §§ 121(a), 503(a),(c)-(e) (1999); Patients' Bill of Rights Act, S. 326, 106th Cong. §§ 121(a), 503(a), (c)-(e) (1999); Patients' Bill of Rights Plus Act, S. 300, 106th Cong. §§ 121(c), 503(a), (c)-(e) (1999); Patients' Bill of Rights Act, S. 6, 106th Cong. §§ 131(a), 132(c), 133(a) (1999); Patients' Bill of Rights Act, S. H.R. 358, 106th Cong. §§ 131(a), 132(c), 133(a) (1999); Patients' Bill of Rights Act, S. 240, 106th Cong. §§ 131(a), 132(a), 133(a) (1999); Access to Quality Care Act of 1999, H.R. 216, 106th Cong. §§ 122(a), (d)-(e), 137 (1999).

150. See H.R. 4628, 108th Cong. (2004). This bill did not pass during the 108th Congress.

151. E.g., id. § 502(n) (creating a new cause of action for participants and beneficiaries via section 502(n), strengthening and streamlining internal claims reviews, and also mandating an option to external independent review).

152. E.g., Patients' Bill of Rights Plus Act, H.R. 2990, 106th Cong. (1999) (amending ERISA to provide for a uniform internal appeals procedure and mandating that participants and beneficiaries be granted a right to independent review of adverse determinations); see also Access to Quality Care Act of 1999, H.R. 216, 106th Cong. § 122(a)-(b), (c) (1999); Bipartisan Consensus Managed Care Improvement Act of 1999, H.R. 2723, 106th Cong. §§ 102(a)-(b), 103(a), 104(a) (1999). Unlike House Bill 2990, House Bills 216 and 2723 proposed to amend ERISA's preemption provision, section 514, to read that ERISA preemption would not apply to state law causes of action for personal injury and wrongful death in connection with the provision of insurance or medical benefits in group health plans. H.R. 216, 106th Cong. § 302(a) (1999); H.R. 2723, 106th Cong. § 302(a) (1999). One Third Circuit justice has advocated the solution proposed in House Bill 2723 as being "promising," because in allowing state law causes of action to escape ERISA preemption, participants could recover compensatory damages. DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442, 465 (3d Cir. 2003) (Becker, J., concurring).
needed to redress such horrific injuries. They believe that the threat of liability may deter health plan misconduct. Those opposed to expanding HMO and insurer liability argue that patients' rights legislation will only encourage litigation by driving up costs that will ultimately be passed onto participants and beneficiaries or alternatively, will motivate an employer to drop their health plan altogether. Others argue that a federal patients' bill of rights fails to address the real shortcomings in managed care, and legislators advocating a patients' bill of rights are relying on nothing more than

153. ERISA, the Foundation of Employee Heath Coverage: Hearing Before the House Subcomm. on Employer-Employee Relations of the Comm. on Educ. & the Workforce, 107th Cong. 13-14, 16-17 (2001) [hereinafter ERISA Hearing] (statement of Alice Weiss, Director of Health Policy, National Partnership for Women & Families). In advocating for passage of a federal patients' bill of rights, Ms. Weiss states in her written testimony that

real people are hurt by the absence of meaningful accountability. There are too many examples of those who are left without redress after the tragic results of a health plan's decision to delay or deny care. The parents who lost their baby after the health plan refused to authorize round-the-clock hospital monitoring . . . . The man who committed suicide after his health plan denied him admission to a health plan's alcohol rehabilitation program . . . . These are the real faces behind the need for health plans to be accountable for their decisions.

Id. at 86-87. This hearing was held before House Bill 4628 was introduced but concerns a virtually identical bill.

154. BUTLER, supra note 112, at 3 (stating that the "threat of liability for economic damages for needed additional medical care, pain, and suffering and punitive damages for "outrageous' health plan actions" will curb misconduct). Health plans express contrary opinions, stating that litigation to recover economic and punitive damages will increase insurance premiums by disrupting utilization review procedures. Id. However, before Davila, few suits to recover such damages were actually brought under the then-existing state managed care liability laws. Id.

155. ERISA Hearing, supra note 153, at 10-11 (statement of James A. Klein, President, American Benefits Council) (stating that a patients' bill of rights "encourages litigation instead of the expeditious resolution of honest disputes and exposes employer sponsors and health plans to the reality of enormous . . . financial penalties"). Republicans in the House and Senate also voice concern that creating a new cause of action that allows participants to hold their HMOs liable will have the effect of creating more litigation, which in turn will cause insurance premiums to rise. William M. Welsh, Democrats Renew Push for Patient Bill of Rights: Legislation Bogged Down on Specifics, USA TODAY, June 22, 2004, at 7B. Some legislators, such as Speaker of the House Dennis Hastert (R-Ill.), are concerned that increased lawsuits will impede efforts to help uninsured. Id. However, some health plans do not see increased liability as posing a huge threat to their business, indicating that such liability concerns may be speculative at best. See Agrawal & Hall, supra note 24, at 239. Yet other health plans see the threat of increased liability as very real. Id. at 240 (quoting one health plan representative as saying it "‘only takes one big case to put you out of business’").

156. Hyman, Managed Care, supra note 23, at 244.
anecdotal evidence to support the bill’s necessity. Indeed, Gwen Roark’s story was used as such anecdotal evidence at a 2001 House committee hearing on a Patient’s Rights bill. While her story does strike an emotional chord, it remains unclear whether Gwen’s interests would have been best served by an independent external review of her claim for VAC treatment, or an opportunity to sue her HMO for money damages. James Klein, a witness at the 2001 hearing, would agree with the former remedy, that Gwen’s best interests would have been served by “[r]esol[ution] of these issues upfront, rather than the cold comfort of a huge damage award that comes after the fact and after the tragic amputation of a leg.”

One must also consider the effect that a new remedy would have on Congress’ intended balance between “the need for prompt and fair claims settlement” and “the public interest in encouraging the formation of employee benefit plans,” which supports a limited set of remedies. In Pilot Life, the Court cited this balance when it preempted state-created remedies, making note of the “deliberate care with which ERISA’s civil enforcement remedies were drafted and the balancing policies embodied in its choice of remedies.” A new remedy that would allow recovery in excess of what is already provided in ERISA’s civil enforcement provisions would disrupt the balance outlined by the Supreme Court, regardless of whether the remedy is state or federal in nature. Such a remedy may weigh against the public interest of encouraging the formation of employee benefit plans.

157. Id. at 236 ("Legislators tend to identify ‘necessary reforms’ on the basis of bad anecdotes and popular appeal, but that strategy is hardly a recipe for sensible public policies.").
158. ERISA Hearing, supra note 153, at 16-17.
159. Id. at 22 (statement of James A. Klein, President, American Benefits Council).
161. Pilot Life, 481 U.S. at 54.
162. Id.
163. DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442, 455-56 (3d Cir. 2003) (Becker, J., concurring) (suggesting that if states were able to supplement ERISA’s regulations as they pleased, some employers would cease to offer employee welfare benefit plans because of the difficulty in tailoring plans to different jurisdictions). Indeed, ERISA does not require that an employer provide its employees with health benefits, Shaw v. Delta Airlines, Inc. 463 U.S. 85, 91 (1983), but only regulates those organizations that establish employee welfare benefit plans as defined in § 1002, H.R. REP. NO. 93-533, at 5 (1973), reprinted in 1974 U.S.C.C.A.N. 4639, 4643.
B. Judicial Reinterpretation

1. Wiping the Slate Clean: Reconsidering Section 502(a)(3)

In *Mertens v. Hewitt Associates*, the Supreme Court held that the language of ERISA section 502(a)(3), which allows a participant to bring a suit for "appropriate equitable relief," does not authorize a suit for compensatory damages. Justice Scalia, the author of the five-to-four majority opinion, based this conclusion on his assertion that money damages were not a remedy typically available in courts of equity and, therefore, were not "equitable relief." But there is a sizeable contingent, which includes other Supreme Court justices, that disagree with Justice Scalia’s interpretation and support the notion that "appropriate equitable relief" does in fact include compensatory damages. Justice Ginsburg expressed doubt that Congress focused on the distinction between actions in law and equity at the time they were drafting ERISA’s civil enforcement provisions. Indeed, by 1974 when President Gerald Ford signed ERISA into law, almost forty years had passed since the courts of law and equity merged. In Justice Ginsburg’s concurrence in *Davila*, she cites the need for "fresh consideration of the availability of consequential..."
damages under § 502(a)(3), ”171 and with only a five-to-four majority favoring Justice Scalia’s interpretation, this may be a viable remedy that an aggrieved participant may pursue in seeking monetary compensation. 172

2. Who and What Was ERISA Intended to Regulate?

As the title suggests, ERISA, the Employee Retirement Income Security Act, was enacted by Congress with the intent to regulate retirement plans taking the form of pensions. 173 Indeed, ERISA was enacted in response to the pension plan abuses that were prevalent at that time. 174 Although the title refers to pension plans, ERISA’s introductory text is less specific, stating the legislative purpose as “protect[ing] . . . the interests of participants in employee benefit plans

171. Davila, 124 S. Ct. at 2503 (Ginsburg, J., concurring).
172. Mertens, 508 U.S. at 249. Justices Blackmun, Kennedy, Souter, and Thomas joined Justice Scalia’s majority opinion and Justices White, Rehnquist, Stevens, and O’Connor dissented. Id.
173. Introductory remarks of Mr. Ribicoff, supra note 28.
174. See Introductory Remarks of Mr. Ribicoff, supra note 28.

All too often working men and women contribute to these pension plans only to find when they retire that the benefits they had been promised are denied them.

In addition, frequently the pension funds themselves are abused by those responsible for their management who manipulate them for their own purposes or make poor investments with them.

It is time controls were imposed to safeguard the workers’ valuable funds. Genuine pension reform will be achieved only by Federal regulation.

The pension reform legislation being introduced today attempts to bring orderly regulation to a field now fraught with insecurity for the working man.

Id.; see also Jennings et al., supra note 28.
Some argue that ERISA was never intended to regulate healthcare benefits. However, the addition of several sections to ERISA that govern health insurance suggests that while Congress initially did not intend ERISA to cover health benefits, its purpose has evolved to include them.

Russell Korobkin, a commentator on managed care jurisprudence, argues that medical benefits from managed care organizations (MCOs), which include HMOs, are not ERISA plan benefits under the meaning of the term "employee benefit plan." Pilot Life held that ERISA preempts actions not only against plans, but also against insurers and HMOs when an employer, as part of his health plan, purchases insurance or membership in an HMO. Pegram was the first case to address the issue of whether benefits provided through the employer via an HMO constituted an ERISA-governed plan, and answered in the affirmative. But Korobkin argues that although a membership with an MCO may be a plan benefit offered from employer to employee, a health service provided (or not provided) by the MCO is not an employee benefit. Logically, therefore, a suit by a participant against the MCO for failure to provide a benefit is not a suit over an ERISA plan benefit, and thus is not preempted by section 502(a)(1)(B).

While Korobkin may well point out a "failed jurisprudence" on the part of the Supreme Court, there is scant dissent among the Supreme Court justices over the notion that HMOs fall within the ambit of an ERISA-governed "employee benefit plan." Therefore, without a

176. ERISA Hearing, supra note 153, at 80 ("ERISA was never intended to regulate health insurance.").
177. See supra note 31.
178. Korobkin, supra note 18, at 470-73.
180. Pegram v. Herdrich, 530 U.S. 211, 223 (2000) (holding that health benefits administered by an HMO are ERISA plan benefits, and an HMO acting in this capacity is an ERISA fiduciary).
181. Korobkin supra note 18, at 485 (stating that there is a "fundamental difference between what the employer promises to an employee and what a third-party contractor promises to an employee").
182. Id. The author also states that because of the distinction between services promised by an employer and those promised by a third-party, a lawsuit against an MCO does not "relate to" an ERISA-governed plan and would therefore withstand ERISA preemption. Id.
183. Pegram, the only Supreme Court decision to expressly touch on the issue of whether an HMO delivering benefits was governed by ERISA section 502, was a unanimous decision. 530 U.S. at 214. Additionally in Pilot Life, the Supreme Court unanimously held that ERISA precludes common law causes of action against insurers. 481 U.S. at 43.
major departure from ERISA jurisprudence, this argument may not be viable in a court of law and promises no immediate relief for an aggrieved participant.

III. WORKING WITHIN THE ERISA FRAMEWORK: THE FEDERAL GOVERNMENT SHOULD PASS LEGISLATION PROVIDING PATIENTS WITH A RIGHT TO IMR

IMR mandates are a viable and practical solution to the injustice resulting from ERISA’s limited remedial scheme, and a federal law mandating IMR would provide the much needed rights for participants and beneficiaries in a way that (1) does not conflict with ERISA’s exclusive remedial scheme, and (2) would prevent or reduce the number of many serious injuries that often result from a denial or a delay in benefits.

A. IMR Is Consistent with ERISA’s Exclusive Remedial Scheme

In Rush Prudential, the Supreme Court left open the possibility that states may pass health insurance-related legislation mandating IMR procedures, and that this legislation would escape ERISA preemption. The Court held that state laws mandating IMRs will not be preempted provided that the independent review scheme “provides no new cause of action.” As of 2001, forty-two states, including the District of Columbia, had enacted IMR laws, providing health plan participants and beneficiaries in their states with a right to an independent appeal of an adverse benefits determination. Since 2001, North Carolina has


185. See POLLITZ ET AL., supra note 103, at v-vi (finding that in forty-five percent of state-mandated independent external reviews, the review board overturns the decision of the insurer in favor of the participant).


187. Id. at 379-80.

followed this trend and enacted a law allowing participants and beneficiaries to seek external review.\textsuperscript{189}

\textbf{B. Independent Review Reduces the Number of Injuries that Result from Denials or Delays in Treatment}

Under the independent external review procedure proposed in the PBRA 2004, Gwen Roark would have received a decision on coverage within seventy-two hours.\textsuperscript{190} Under the PBRA 2004, the determination of the independent medical review is binding on the plan or HMO.\textsuperscript{191} A Kaiser Family Foundation Report found that under state laws that mandate IMR, almost half of appeals that go to IMR are decided in favor of the participant.\textsuperscript{192} This means that the insurer or HMO’s decision that

\begin{footnotesize}
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\item 189. N.C. GEN. STAT. § 58-50-75 (2003). As of the date of this Comment, the following states have not enacted laws mandating independent review mechanisms: Alabama, Arkansas, Idaho, Mississippi, Nebraska, Nevada, North Dakota, South Dakota, and Wyoming. As of 2003, Nevada statutory law provides for a limited right to external review, allowing a participant in a health plan to seek external review when his plan has failed to render a decision in the time frame provided for by statute, and allows a participant and his physician to request external review after exhausting the internal appeals process. NEV. REV. STAT. ANN. 695G.241, 695G.251 (Michie 2003).
\item 191. H.R. 4628, 108th Cong. § 104(d) (2004); see infra note 212 (comparing Illinois HMO Act, chapter 215, act 125, section 4-10 of the Illinois Compiled Statutes, with House Bill 4628).
\item 192. POLLITZ ET AL., supra note 103, at v (stating that, on average, forty-five percent of cases result in the independent reviewer overturning the decision of the insurer or HMO, and in six percent of the cases, the insurer’s or HMO’s decisions are modified in some way).
\end{itemize}
\end{footnotesize}
a treatment or procedure was medically unnecessary was overruled by
the IMR almost fifty percent of the time.  

Presumably, if an HMO anticipates that its decision may be second-
guessed when it denies a benefit based on a lack of medical necessity or
the experimental nature of treatment, the HMO will most likely be more
careful in making its coverage determinations. Unlike the internal
review procedure, in which the HMO's concern for limiting benefit
awards in the interest of cost-containment is factored into the coverage
decision, the independent reviewer is not influenced by the same cost-
control concerns and thus presumably would have no incentive to limit
benefits awarded.

Some authors criticize past attempts by Congress to include a right to
IMR in federal legislation. Since it is necessary for a participant to first
exhaust internal appeals procedures before bringing their claim to an
independent review board, patients often do not have the time to
engage in a lengthy appeals process. Federal legislation, however,
could avert this problem by regulating and streamlining the internal
appeals procedure.

C. Patients' Rights to an Independent Medical Review Should Be
Federalized

Despite the almost nation-wide recognition of a patient's right to
independent medical review, action needs to be taken on a federal level

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193. See generally id. In all but three jurisdictions granting a statutory right to external
review (District of Columbia, Oklahoma, and Oregon), the decisions of the independent
reviews are binding on the HMO or insurer. Id. at 25.


195. Pegram v. Herdrich, 530 U.S. 211, 219-20 (2000); Korobkin, supra note 18, at 462-64; see also text accompanying notes 18-20.

part that "[i]n making determinations under this section, a qualified external review entity
and an independent medical reviewer shall . . . consider the claim under review without
deference to the determinations made by the plan or issuer").

197. E.g., Judge Joyce Krutick Craig, Managed Care Grievance Procedures: The
Dilemma and the Cure, 21 J. NAT'L ASS'N ADMIN. L. JUDGES 336, 393-98 (2001)
discussing patients' rights legislation from the 103rd to the 106th Congresses).

198. TRUDY LIEBERMAN ET AL., HENRY J. KAISER FAMILY FOUND. & CONSUMERS
UNION, A CONSUMER GUIDE TO HANDLING DISPUTES WITH YOUR EMPLOYER OR
hmo-review/ExtReview.pdf.

199. Craig, supra note 197, at 398.

200. Such changes may be done by amending or enacting new Department of Labor
regulations, see 29 U.S.C. § 1135 (2000), and do not require congressional action or
statutory amendment.

201. See discussion supra Part III.A, notes 188-189 and accompanying text.
due to two very important shortcomings in state legislation. First, state laws do not reach self-insured health plans.\textsuperscript{202} This means that a state law creating a participant's right to independent review, which "relates to" an ERISA plan, cannot be imposed upon a self-insured health plan because ERISA's savings clause does not apply to such plans.\textsuperscript{203} Approximately forty-seven percent of all employees with group health coverage are enrollees of a self-insured employer health plan.\textsuperscript{204} For these people to benefit from independent review, a federal law mandating such reviews must be enacted.

A second problem with state-mandated IMR is the lack of uniformity in notice requirements.\textsuperscript{205} A lack of meaningful notice may be linked to the low numbers of health plan participants and beneficiaries who actually exercise their IMR right.\textsuperscript{206} A majority of states that mandate an IMR require that a health plan provide its enrollees with notice of their rights to IMR in the enrollment materials and handbooks.\textsuperscript{207} But, there are no guarantees that consumers read these materials.\textsuperscript{208} All states require that notice of the right to IMR be provided to insureds in a letter denying participants and beneficiaries request for coverage, although many states do not require such notice until the final letter of denial after the final stage of the internal appeal.\textsuperscript{209} A federal law could bring

\begin{itemize}
\item \textsuperscript{202} E.g., Corporate Health Ins., Inc. v. Texas Dep't of Ins., 314 F.3d 784, 786 (2002) ("[S]elf-funded ERISA plans are not covered by ERISA's savings clause . . . ").
\item \textsuperscript{203} Id.
\item \textsuperscript{204} POLLITZ ET AL., supra note 103, at v.
\item \textsuperscript{205} Id. at 10.
\item \textsuperscript{206} Id. at 8, 10. The number of IMR cases in states providing a right to independent review is "strikingly low" compared to the number of insured. \textit{Id.} at 3. A lengthy and often difficult internal appeals process is also cited as hindering participation in IMRs, as most states require a participant to exhaust their plan's internal appeals process before exercising their right to IMR. \textit{Id.} at 5, 7.
\item \textsuperscript{207} E.g., D.C. CODE ANN. § 44-301.03(c) (2001) (providing that at the time of enrollment, the insurer must provide to the enrollee written notice of the components of the grievance system, which includes a right to contact the Director of the District of Columbia's Department of Health if the issuer's internal grievance system produces an unsatisfactory result). Every state with IMR laws except Georgia and Kansas require notice in either a health plan's enrollment information or member handbook. POLLITZ ET AL., supra note 103, at 10 exhibit 5. For a discussion of the different notice requirements within each state that provides for IMR, see id.
\item \textsuperscript{208} POLLITZ ET AL., supra note 103, at 10.
\item \textsuperscript{209} E.g., MD. CODE ANN., INS. § 15-10D-02(a)-(f) (2002 & Supp. 2004). Arkansas, Colorado, Delaware, the District of Columbia, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Minnesota, Missouri, Montana, New Hampshire, New Mexico, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Utah, Vermont, Virginia, Washington, and West Virginia also have similar laws. POLLITZ ET AL., supra note 103, at 10, exhibit 5 (discussing how states that mandate a right to IMR also require notice of a right to IMR).
\end{itemize}
uniformity to this notice scheme and would assure that participants and beneficiaries receive the information necessary to fully exercise their rights to IMR. 210

Recent versions of federal legislation addressing the issue of patients' rights have incorporated independent external review mandates. 211 For example, the IMR provided for in the PBRA 2004 resembles the Illinois law which the court upheld in Rush Prudential. 212 Although the PBRA 2004 does provide for an external appeal mechanism, the bill's inclusion of a new statutory cause of action for compensatory relief keeps the bill mired in congressional conflict. 213 It is therefore unlikely that the bill will pass in its current form. 214 Therefore, in order to give health plan participants and beneficiaries meaningful and immediate protection, Congress should rework the PBRA 2004 to exclude provisions enacting additional civil remedies, and focus on providing participants and beneficiaries with a fair and expedient appeals procedure via IMR.

210. E.g., H.R. 4628, 108th Cong. § 121(a)-(c) (2004). The proposed Patients' Bill of Rights, House Bill 4628, sets forth uniform notice requirements, providing that enrollees must be provided notice of their right to an external appeal: (1) at the initial enrollment period and (2) again annually, and (3) upon request for such information. Id. § 121(a)-(b). In addition, enrollees can request information about the success rate of external appeals under their plan. Id. § 121(c).

211. Leatrice Berman-Sandler, Independent Medical Review: Expanding Legal Remedies To Achieve Managed Care Accountability, 13 ANNALS HEALTH L. 233, 293-94 (2004).

212. Compare 215 ILL. COMP. STAT. ANN. 125/4-10 (West 2000) (providing that each HMO shall provide an independent review procedure to be conducted by a physician jointly selected by the patient, the primary care physician and the HMO, and making the coverage decision of the review binding on the HMO), with H.R. 4628, 108th Cong. § 104 (2004) (mandating that group health plans and health insurance issuers offering health insurance coverage provide their participants and beneficiaries with access to an independent medical review to appeal adverse benefit determinations based on the medical necessity of a service, experimental nature of a treatment, and other medically reviewable decisions).

213. See Welsh, supra note 155 (stating that Democrats and Republicans cannot agree on issues such as limits on money damages and whether plaintiffs may sue their HMO in state courts). Democrats advocate a cause of action that would allow plaintiffs to sue their HMOs in state courts, which are known to award higher damages than federal courts. Id. Republicans seek to limit money damages and confine the lawsuits to federal courts. Id.; see also Editorial, HMOs Win, Patients Lose and Congress Stays in Coma, USA TODAY, June 22, 2004, at 12A (citing disagreement over whether to limit damage awards and whether lawsuits should be heard in state or federal court as forestalling any congressional action on a patients' bill of rights).

214. Welsh, supra note 155 (quoting a spokesman for Senate Majority Leader Bill Frist (R-Tenn.) as saying action on House Bill 4628 was unlikely to pass in the 108th Congress).
IV. CONCLUSION

Immediate measures must be taken to protect health plan participants and beneficiaries from the potentially life-threatening decisions of their HMOs.\textsuperscript{215} The Supreme Court, on numerous occasions and most recently in \textit{Davila}, has expressly invited Congress to take action on this issue.\textsuperscript{216} Almost all of the states have enacted laws implementing independent medical review procedures consistent with the guidelines of \textit{Rush Prudential}, but federal regulation is needed. It is now Congress' turn to be a pioneer—to enact legislation that will fill the regulatory vacuum, and to do so without conflicting with ERISA's purpose and scope. By enacting a federal Patients' Bill of Rights that gives patients a right to external appeal procedures, Congress will be protecting participants and beneficiaries' interests in their own well-being against the competing interests of the health insurance industry of cost-containment and profit. This option, because it does not conflict with ERISA's remedial scheme, does not represent a major departure from ERISA jurisprudence. Additionally, this option will eliminate much of the opposition for a patients' bill of rights, as many oppose not the independent review, but the additional remedies.

\textsuperscript{215} DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442, 467 (3d Cir. 2003) (Berker, J., concurring) ("[T]he vital thing... is that either Congress or the Court act quickly, because the current situation is plainly untenable.").

\textsuperscript{216} Aetna Health Inc. v. Davila, 124 S.Ct. 2488, 2503 (2004) (Ginsburg, J., concurring) ("I also join the rising judicial chorus urging that Congress... revisit what is an unjust and increasingly tangled ERISA regime.").