I. Introduction

On June 21, 2004, the Supreme Court held in *Aetna Health Inc. v. Davila* that the Employee Retirement Income Security Act of 1974 (ERISA) preempted two Texas patients’ state tort law claims against their respective Health Maintenance Organizations (HMOs) for injuries allegedly caused by the HMOs’ failure to exercise reasonable care in making utilization review decisions. This decision effectively shields HMOs from most (or all) claims by patients seeking damages for injuries suffered as a result of negligent utilization review. The same day the Supreme Court decided *Davila*, U.S. Representative John Dingell (D-MI), then ranking Democrat on the House Committee on Energy and Commerce, announced that he would introduce a patients’ bill of rights in the House, stating that “HMOs, foreign diplomats and the mentally insane are the only people in this country who are exempt from the consequences of their decisions.”

His bill, which would have given ERISA-regulated plan beneficiaries the right to sue their HMO without limitations on damages, never became law. However, Rep. Dingell’s words represented, and still represent, the feelings of many legislators, judges, and commentators that the Court’s current ERISA jurisprudence unjustly denies average Americans who suffer injuries as a result of a wrongful denial of coverage. More than ten years before the *Davila* decision, one U.S. Senator described the effects of ERISA during a committee debate in the following terms:

Under current law, states can do nothing to ensure that insurance companies act fairly. When an insurance company denies a claim, an individual has little hope of finding an attorney to take his or her case. For the few who do succeed in retaining an attorney, all they can hope for is that after two or three years of court action their claim will be paid, but with no damages. The Court’s unanimous decision in *Davila* to close the door to aggrieved ERISA-regulated plan beneficiaries seeking “make-whole” relief from their HMO makes this assessment of ERISA even more accurate today than when first made.

Under the Court’s current interpretation of ERISA, an employee participating in an ERISA-regulated plan can sue the plan to recover only wrongfully denied benefits, and not a penny more. Under ERISA, the employee cannot recover damages for injuries resulting from her HMO’s negligent denial of coverage. Moreover, after *Davila*, it is clear that ERISA preempts any state law claim that the employee could raise against the HMO to recover for her injuries. This leaves the employee with no option but to raise a claim under ERISA’s civil enforcement provisions and to hope to at least receive denied benefits. As Justice Ginsburg expressed in her concurrent opinion in *Davila*, the Court’s current ERISA jurisprudence leaves a “regulatory vacuum” where “virtually all state law remedies are preempted but very few federal substitutes are provided.”

Some commentators see the *Davila* decision as the Court’s final statement to Congress that addressing the “regulatory vacuum” left by ERISA is the responsibility of the legislature, not the courts. Others, however, express hope that the Court, as Justice Ginsburg anticipates in her concurring opinion, will eventually revise the current interpretation of ERISA’s remedial scheme to allow aggrieved patients to obtain make-whole relief from their HMO. This article seeks to assess the effects of the *Davila* decision on the ability of ERISA-plan participants and beneficiaries to obtain relief for a wrongful denial of benefits by their HMO. Part II provides an introduction to the relevant ERISA provisions and how the Court has interpreted them. Part III analyzes the Court’s holding in *Davila* and discusses the legal and socioeconomic effects of the decision. This article concludes that the *Davila* decision closed the door on plan participants and beneficiaries seeking to recover damages from their HMO for injuries caused by the HMO’s negligent denial of benefits. Based on this conclusion, Part IV calls on Congress to amend ERISA so as to allow the states to narrow the regulatory gap left by the Court’s current ERISA jurisprudence through patients’ rights legislation.

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II. ERISA Background

Congress enacted ERISA to “protect . . . 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.” Congress was responding to long-ignored claims by American workers that their employers were recklessly underfunding their pension plans and creating unnecessary obstacles to full benefits eligibility. Although Congress enacted ERISA primarily to protect private employee pension plans and creating unnecessary obstacles to their beneficiaries were free to obtain remedies under state law, even when this exclusive “occupation” leaves a “regulatory vacuum.” When this happens, the federal statute invalidates even state laws that are consistent with its provisions. The Court explained in Davila that Section 502(a) of ERISA falls within this category of federal legislation, and therefore, completely preempts even state laws attempting to provide only additional remedies not available under ERISA. The Court noted that this complete preemption arises from Congress’s clear intent to make ERISA’s “comprehensive civil enforcement scheme” exclusive. The Court reasoned that “[t]he policy choices reflected in the inclusion of certain remedies and the exclusion of others . . . would be completely undermined if ERISA-regulated plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.”

Among the civil actions that ERISA-regulated plan participants and beneficiaries can bring under Section 502(a) is an action to hold ERISA-regulated plan fiduciaries liable for a breach of their fiduciary duties to the plan. The Court, however, has held that HMOs do not act as fiduciaries for purposes of ERISA when they make mixed eligibility and treatment decisions, thus limiting the scope of this cause of action.

A. ERISA Civil Enforcement Provisions and Complete Preemption

Section 502(a) allows an ERISA-plan participant or beneficiary to bring a civil action in federal court “to recover benefits due to him under the terms of his plan, or to enforce . . . or . . . clarify his rights to future benefits under the terms of the plan.” A participant or beneficiary can also bring a civil action “to enjoin any act or practice which violates any provision of [ERISA] or the terms of the plan, or to obtain other appropriate equitable relief.” The Court has viewed section 502(a) as providing for ERISA-regulated plan participants and beneficiaries a total of “six carefully integrated civil enforcement provisions,” which “represent a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans.”

Section 502(a) preempts any state law that “duplicates, supplements, or supplants” its civil enforcement provisions. This section derives its preemptive power from the Supremacy Clause of the Constitution, which resolves conflicts between state and federal laws in favor of the later. When federal legislation is substantially broad in one particular area, it is said that such legislation “occupies the field” in question to the exclusion of state laws, even when this exclusive “occupation” leaves a “regulatory vacuum.” When this happens, the federal statute invalidates even state laws that are consistent with its provisions. The Court explained in Davila that Section 502(a) of ERISA falls within this category of federal legislation, and therefore, completely preempts even state laws attempting to provide only additional remedies not available under ERISA. The Court noted that this complete preemption arises from Congress’s clear intent to make ERISA’s “comprehensive civil enforcement scheme” exclusive. The Court reasoned that “[t]he policy choices reflected in the inclusion of certain remedies and the exclusion of others . . . would be completely undermined if ERISA-regulated plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.”

Section 502(a) preemption automatically removes to federal court any cause of action that could have been brought under any of its provisions. The Court has explained that section 502(a)’s preemptive force “converts [even] an ordinary common law complaint into one stating a federal claim.” Justice Thomas, writing for the Court in Davila, summarized Section 502(a)’s preemptive effect in the following: “if an individual, at some point in time, could have brought his claim under ERISA Section 502(a)(1)(B), and where
there is no other independent legal duty that is implicated by a defendant’s actions, then the individual’s cause of action is completely preempted.”

B. Section 514 Preemption and the “Savings” and “Deemer” Clauses

In addition to Section 502(a), ERISA preemption finds support in Section 514(a), which provides that “the provisions of ERISA shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan.” Before New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., the Court interpreted the “relate to” language of section 514 very broadly, so that a state law was found to “relate to” an employee benefit plan “if it ha[d] a connection with or reference to such a plan.” Following this approach, the Court found ERISA preemption even of state laws that “merely exert[ed] some effect, however indirect, on employee benefit plans.” In Travelers, however, the Court realized that a textualist interpretation of Section 514(a)’s “relate to” did not reflect legislative intent because “if ‘relate to’ were taken to extend to the furthest stretch of indeterminacy, then for all practical purposes pre-emption would never run its course.” The Court thus decided to look beyond the language of Section 514(a) to interpret this section in light of the congressional objective of preventing a “multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.” Although the Travelers Court did not elaborate a clear rule to determine what state laws “relate to” employee benefit plans for ERISA purposes, it observed that in prior cases “ERISA pre-empted state laws that mandated employee benefit structures or their administration” and “laws providing alternative enforcement mechanisms.”

In the “savings clause,” Congress provided an exception to Section 514(a) preemption for state laws that regulate insurance. Congress did so in part because insurance had historically been, and still remains, an area subject to state regulation, and in part to preserve the complex systems of insurance regulation the states had in place. In Kentucky Ass’n of Health Plans, Inc. v. Miller, the Court developed a two-prong test to determine whether a state law regulates insurance for purposes of ERISA Section 514. First, the Court asks whether the state law in question is “specifically directed toward entities engaged in insurance.” Second, the Court determines whether such law “substantially affects the risk pooling arrangement between the insurer and the insured.”

Although Congress was willing to “save” a state law that regulates insurance from ERISA preemption, it felt that the scope of state insurance regulation had to be curtailed in some way in order to prevent states from supplanting ERISA regulation of employee welfare plans with state regulation. Congress thus added the “deemer clause” in Section 514, which provides that no “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 [or] insurance contracts . . . .” In Metro. Life Ins. Co. v. Massachusetts the Court interpreted the “deemer clause” as effectively removing employer self-funded welfare plans from the scope of the “savings clause” and placing them beyond state regulation and within ERISA.

C. Pegram v. Herdrich and Fiduciary Acts Under ERISA

ERISA Section 409 provides in part that “any person who is a fiduciary with respect to an [employee benefits] plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by [ERISA] shall be personally liable to make good to such plan any losses . . . resulting from each such breach.” In Pegram, the Court faced the issue of whether a treatment decision made by an HMO physician constituted a fiduciary act under ERISA, thus subjecting the HMO to potential liability under ERISA Section 409. Cynthia Herdrich, an ERISA plan beneficiary, suffered injuries when her treating physician, Dr. Lori Pegram, an HMO employee, required her to wait eight days to have an abdominal ultrasound performed at a facility staffed by the HMO located 50 miles away. While waiting, Herdrich’s appendix burst, causing peritonitis. She brought suit against Dr. Pegram and the HMO, claiming medical malpractice and fraud. Defendants removed the case to federal court under ERISA. Herdrich then amended her complaint to include a claim for breach of fiduciary duty under ERISA Section 409.8 The Court declared that the “threshold question” in analyzing claims for breach of fiduciary duty under ERISA is “not whether the actions of some person employed to provide services under a plan adversely affected a plan beneficiary’s interest, but whether that person was acting as a fiduciary, in that it was performing a fiduciary function to complaint.” The Court held that while pure eligibility decisions (decisions regarding coverage of medical treatment under an employee welfare plan) are strictly administrative and thus fiduciary in nature, mixed treatment and eligibility decisions do not qualify as fiduciary decisions for purposes of ERISA. The Court argued that as a practical matter, it is almost impossible to separate the eligibility and treatment aspects of a mixed eligibility-treatment decision. The Court also feared that ERISA-regulated
plan participants and beneficiaries may disguise medical malpractice claims as claims for breach of fiduciary duty under ERISA to reach the HMO in addition to the physician.\textsuperscript{72} Allowing mixed eligibility-treatment decisions would therefore mix state malpractice claims and federal ERISA actions, creating uncertainty and confusion in the law.\textsuperscript{73} The Court found that Dr. Pegram’s decision to make Herdrich wait eight days for her ultrasound was a mixed decision, not made in a fiduciary capacity.\textsuperscript{74} Therefore, the Court held that Herdrich could not bring a breach of fiduciary duty claim against the HMO under ERISA.\textsuperscript{75}

III. The Davila Decision

In Davila the Supreme Court consolidated two cases brought by ERISA-regulated plan participants/beneficiaries against their respective HMO under the Texas Health Care Liability Act (THCLA).\textsuperscript{76} THCLA, which was part of the first state patients’ bill of rights in American history, was intended to protect beneficiaries of managed care organizations (MCOs), including HMOs, from wrongful denials of benefits.\textsuperscript{77} THCLA required HMOs and health insurance carriers “to exercise ordinary care when making health care treatment decisions,” and subjected them to liability “for damages for harm to an insured or enrollee proximately caused by [the HMO’s or insurance carrier’s] failure to exercise such ordinary care.”\textsuperscript{78} In both cases the plaintiffs sought to recover damages for injuries allegedly resulting from their HMO’s negligent denial of coverage.\textsuperscript{79}

A. Factual Background

Juan Davila, an ERISA-regulated plan participant, suffered from arthritis. His physician prescribed Vioxx to treat his arthritis pain, but Aetna Health Inc. (Aetna), which administered Davila’s health benefits plan, refused to pay for the drug.\textsuperscript{80} Aetna based its decision on the grounds that Davila’s plan provided that Aetna would pay for Vioxx only if no other equivalent drug in Aetna’s formulary was suited for treating a participant’s condition.\textsuperscript{81} Davila then began taking the genetic drug Naprosyn, which Aetna covered. However, this drug caused him to experience internal bleeding and he was rushed to the hospital, where he spent days in critical care.\textsuperscript{82} As a result of his reaction to Naprosyn, Davila became incapable of receiving any medication via his digestive tract.\textsuperscript{83}

A related case involved Rudy Calad, a beneficiary of an ERISA-regulated plan administered by CIGNA.\textsuperscript{84} After Calad underwent a complicated hysterectomy, a CIGNA discharge nurse certified her stay in the hospital for only one day following surgery.\textsuperscript{85} The CIGNA discharge nurse decided that only a one-day stay was “medically necessary” despite Calad’s treating physician’s recommendations that she remain in the hospital for an extended period.\textsuperscript{86} Following her discharge, Calad experienced post surgery complications and returned to the hospital.\textsuperscript{87}

B. Procedural Background

Davila and Calad brought separate suits against their respective HMOs in Texas State Court, claiming that the HMOs had violated their “duty to exercise ordinary care when making health care treatment decisions” under THCLA for the denied coverage for Davila’s drug and Calad’s extended hospital stay.\textsuperscript{88} Defendants removed both cases to federal district courts on the theory that petitioners’ causes of actions were preempted under ERISA Section 502(a).\textsuperscript{89} The district courts agreed with the defendant’s argument, and refused to remand the cases to state court.\textsuperscript{90} Both Davila and Calad failed to amend their respective complaints to state claims under ERISA and the district courts dismissed their complaints with prejudice.\textsuperscript{91}

Davila and Calad appealed the decisions of the district court, and the U.S. Court of Appeals for the Fifth Circuit consolidated the cases along with others raising similar issues.\textsuperscript{92} The Fifth Circuit reasoned that ERISA completely preempts state law causes of action that “duplicat[e] or fall[i] within the scope of an ERISA § 502(a) remedy.”\textsuperscript{93} The panel further observed that only two provisions of ERISA Section 502(a) might preempt the claims brought by Davila and Calad: § 502(a)(1)(B), which provides a cause of action for the recovery of wrongfully denied benefits, and § 502(a)(2), which allows suit against a plan fiduciary for breaches of fiduciary duty to the plan.\textsuperscript{94} Relying on the Supreme Court analysis in Pegram stating that mixed eligibility-treatment decisions are not fiduciary decisions under ERISA, the panel found that the HMOs’ decisions were of the mixed type, and therefore neither Davila nor Calad could have brought their claims under Section 502(a)(2).\textsuperscript{95} The panel also determined that neither plaintiff could have brought claims under Section 502(a)(1)(B) because their THCLA claims were basically tort claims while the remedies that Section 502(a)(1)(B) provides are contractual in nature.\textsuperscript{96} The panel reasoned that Davila and Calad were not trying to obtain reimbursement for benefits denied them, but instead were seeking tort damages based on “an external, statutorily imposed duty of ‘ordinary care.’”\textsuperscript{97}

The Supreme Court granted certiorari on November 3, 2003.\textsuperscript{98} At the time, a circuit split had become apparent. On one hand, the Eleventh Circuit and the Second Circuit held in Land v. CIGNA Healthcare of Florida\textsuperscript{99} and Cicco v. Does\textsuperscript{100} respectively that an HMO’s decision to deny coverage for a particular type of medical treatment based on a finding by the HMO that such treatment was not medically necessary constituted a mixed eligibility-treatment decision, and therefore, was not subject to Section 502(a) preemption.\textsuperscript{101} On the other hand, the Third Circuit in DiFelice v. Aetna U.S. Healthcare\textsuperscript{102} found complete preemption in the same kind of scenario.\textsuperscript{103}

C. The Supreme Court Decision

The Court found that ERISA preempted Davila and Calad’s THCLA claims and therefore reversed the decision of the Fifth Circuit.\textsuperscript{104} The Court discussed ERISA’s role as a comprehensive federal statute intended to “provide a uniform regulatory regime over employee benefit plans.”\textsuperscript{105} The Court emphasized that Congress designed ERISA so as to ensure that the regulation of employee benefit plans would be a matter “exclusively of federal concern.”\textsuperscript{106} The Court considered the Fifth Circuit’s reliance on Rush Prudential HMO, Inc. v. Moran\textsuperscript{107} and its conclusion that ERISA preempted only those causes of action that “duplicat[e] or fall[i] within the scope of an ERISA § 502(a) remedy.”\textsuperscript{108} It rejected the Fifth Circuit’s formulation of the holding in Rush Prudential, observing that “nowhere in Rush Prudential did we suggest that the pre-emptive force of ERISA 502(a) is limited to the situation in which a state cause of action precisely duplicates a cause of action under ERISA 502(a).”\textsuperscript{109} The Court instead set forth the rule that “any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted.”\textsuperscript{110} In order for Davila and Calad’s causes of action to escape
ERISA preemption, they must allege a violation of a legal duty arising independently of ERISA.111

The Court rejected the Court of Appeals’ reasoning that Davila and Calad’s claims did not fall within the scope of ERISA Section 502(a)(1)(B) because they sought tort damages, so their claims did not duplicate the contractual remedies available under that section.112 The Court viewed as immaterial the distinction between tort damages under THCLA and contractual remedies under ERISA on which the Fifth Circuit relied.113 The Court reasoned that determining which claims ERISA preempts on the basis of this distinction would “elevate form over substance and allow parties to evade” the pre-emptive scope of ERISA simply “by relabeling their contract claims as claims for tortious breach of contract.”114

The Court found that the duty that THCLA imposed upon the HMOs was not independent of ERISA because the HMOs would have been liable under THCLA only due to the fact that the HMOs administered ERISA-regulated plans.115 Because “interpret[ing] the terms of respondents’ benefit plans form[ed] an essential part of [Davila and Calad’s] THCLA claim,” their claims depended on the status of the HMOs as administrators of ERISA plans and therefore did not arise independently of ERISA.116 The Court concluded that Davila and Calad’s THCLA claims sought “to rectify a wrongful denial of benefits promised under ERISA-regulated plans, and [did] not attempt to remedy any violation of a legal duty independent of ERISA.”117 The Court held that Davila and Calad’s claims fell “within the scope of ERISA § 502(a)(1)(B) . . . and are therefore completely pre-empted by ERISA § 502 and removable to federal district court.”118

The Court also found that the HMOs’ decisions in these cases were pure-eligibility decisions, and therefore the HMOs were acting as fiduciaries when they made these decisions.119 The Court reiterated its holding in Pegram that mixed eligibility-treatment decisions do not constitute fiduciary decisions for purposes of ERISA.120 The Court, however, narrowed its Pegram decision by suggesting that Pegram applied only to situations in which “the underlying negligence also plausibly constitutes medical malpractice by a party who can be deemed to be a treating physician or such a physician’s employer.”121

The Court distinguished the decisions made by the HMO in Pegram, where through its physician-employee the HMO decided both what treatment to provide for the patient and whether such treatment was covered, from the decisions made by the Davila HMOs, which involved a determination of medical necessity for the purpose of deciding whether the treatment or procedure at issue was covered under the plan.122 Therefore, the Court concluded, Davila and Calad could have brought claims under ERISA Sections 502(a) and 409(a) against the HMO for breach of fiduciary duty, thus ERISA preempted their THCLA claims.123

D. Ginsburg’s Concurrence

Justice Ginsburg’s concurrence, which Justice Breyer joined, was concerned primarily with adding yet another voice to “the rising judicial chorus urging that Congress and [this] Court revisit what is an unjust and increasingly tangled ERISA regime.”124 Although she explained that she joined the majority opinion because it was consistent with the Court’s prior ERISA cases, Justice Ginsburg expressed concern about the “regulatory vacuum” left by ERISA.125 She discussed very briefly three cases where the Court limited the amount of damages available to aggrieved ERISA-regulated plan beneficiaries.126 She mentioned Massachusetts Mutual Life Insurance Co. v. Russell,127 where the Court held that an ERISA-regulated plan beneficiary could not recover extra-contractual or punitive damages in an action for breach of fiduciary duty under ERISA Section 409(a), and expressed reluctance about allowing extra-contractual or punitive damages under other sections of ERISA.128 The second case she discussed was Mertens v. Hewitt Associates,129 in which the Court held that “appropriate equitable relief” in ERISA Section 502(a)(3) does not include money damages.130 The third case was Great-West Life & Annuity Insurance Co. v. Knudson,131 where the Court reiterated that Section 502(a)(3) does not allow money damages as “appropriate equitable relief.”132 After reviewing the above cases, Justice Ginsburg extended an invitation to the Court to reconsider allowing extra-contractual damages under ERISA, stating that “[a]s the array of lower court cases and opinions documents . . . fresh consideration of the availability of consequential damages under § 502(a)(3) is plainly in order.”133 She even provided a specific example of a situation where consequential damages may be allowed under ERISA.134 She suggested that although the Court’s current interpretation of ERISA Section 502(a)(3) does not allow consequential damages against a non-fiduciary, this section may be interpreted as allowing “at least some forms of ‘make-whole’ relief against a breach of fiduciary in light of the general availability of such relief in equity at the time” ERISA was enacted.135

E. The Effects of the Davila Decision

The effects of Davila go far beyond the holding in the case. At the very least there is a consensus among commentators that Davila closed all the doors to ERISA-regulated plan beneficiaries seeking money damages under state law for injuries resulting from a wrongful denial of benefits by their HMO.136 This consensus is well-founded. Courts interpreting ERISA preemption after Davila have consistently found in favor of preemption.137 Only
months after the Supreme Court issued its decision in Davila, the Fourth Circuit found ERISA preemption of a claim brought by a plan beneficiary against her HMO alleging medical malpractice and wrongful death. In Kathy v. Mansheim, a husband accused his wife’s HMO of committing medical malpractice when it failed to approve an experimental bone marrow transplant that his wife’s treating physician had recommended. The wife died of non-Hodgkin’s lymphoma. Relying on Davila, the Court of Appeals held that the claim did not arise independently of the ERISA-regulated plan and was therefore preempted.

The Third Circuit also relied on Davila to hold in favor of ERISA preemption of a claim based on Pennsylvania’s “bad faith” statute. In Barber v. Unum Life Insurance Co., an ERISA-regulated plan participant sought to recover punitive damages from his HMO, alleging that the HMO terminated his disability benefits in violation of Pennsylvania’s “bad faith” statute. The Court of Appeals, invoking the Supreme Court reasoning in Davila, dismissed the State’s “bad faith” claim on the basis that it allowed damages beyond those available under ERISA Section 502(a)’s exclusive remedial scheme.

After Davila, the Eleventh Circuit revisited Land v. CIGNA Healthcare of Florida on remand. In Land, the plaintiff, an ERISA-regulated plan participant, sued the HMO alleging negligence in the treatment of a hand infection which resulted in the amputation of a finger. Before Davila, the Eleventh Circuit decided the case against ERISA preemption, holding that the claim arose out of a mixed eligibility-treatment decision by the HMO. On remand from the Supreme Court after Davila, however, the Eleventh Circuit found that the claim sought only “to remedy the denial of benefits under an ERISA-regulated benefit plan,” and held in favor of preemption.

The Fifth Circuit also had the opportunity to address ERISA preemption after Davila. In Mayeaux v. Louisiana Health Service & Indemnity Co., a patient and her treating physician sued the patient’s insurer under state tort law to recover for the denial of coverage for an experimental treatment. The court rejected the plaintiffs’ argument that the HMO’s decision was a mixed eligibility-treatment decision. Relying on Davila, the court explained that the narrow exception that the Supreme Court carved out for mixed decisions in Pegram applied only in situations where the treating physician performed a dual role as health provider and plan administrator. The court held in favor of preemption.

The Tenth Circuit has also relied on Davila to find ERISA preemption of state law claims seeking damages for injuries resulting from a wrongful denial of benefits. In Lind v. Aetna Health, Inc., an HMO utilization review doctor decided to discontinue coverage of a drug for multiple sclerosis before the patient first tried a “step drug,” despite the vociferous protest from the treating physician. The patient brought, among others, a claim of medical negligence based on a theory of respondeat superior against the HMO, and sought punitive damages. The plaintiff argued that the claim of respondeat superior medical malpractice fell outside the scope of Davila, because a doctor employed by Aetna “made the determination that Ritalin rather than Provigil was the appropriate drug to treat [plaintiff’s multiple sclerosis]” and that “Aetna then imposed this determination upon [plaintiff’s] treating physician.” The court rejected this argument, explaining that the Aetna doctor was not providing treatment for the plaintiff and there was “no agency relationship between [the treating physician]—an outside provider—and Aetna for the purposes of prescribing medication.” The court found that plaintiff’s “medical negligence claim is unavoidably linked to, and is therefore preempted by, ERISA.”

The Seventh Circuit has also joined those jurisdictions relying on Davila to find ERISA preemption of state law causes of action for damages against HMOs. In McDonald v. Household Int’l, Inc., an HMO administering an ERISA plan failed to properly activate an employee’s health insurance. Unable to afford his blood pressure medication, he did not take the drugs he needed and, as a result, suffered a stroke. The employee brought a number of state law claims against the HMO, alleging that it “committed acts of gross negligence, willful or wanton misconduct, or intentional wrongs that led to [the employee’s] lack of health coverage and ultimately to the stroke.” The court found that the facts of this case were significantly similar to those of Davila and held that ERISA preempted the employee’s claims.

As the above cases indicate, commentators are right to conclude that Davila put a definite stop to all attempts by ERISA-regulated plan beneficiaries to obtain “make-whole” relief under state law for injuries caused by their HMO’s negligence, and in some cases, one may argue, intentional denial of benefits.
HMO wrongfully denies benefits can pay out of pocket and then sue the HMO under ERISA to recover for the denied benefits does not constitute a viable alternative for the average American.\(^7\) The average American employee most likely does not have enough out-of-pocket money to pay for medical expenses when faced with a wrongful denial of benefits. Although Justice Ginsburg’s concurrent opinion leaves open the possibility of a turnaround in the Court’s approach to ERISA’s remedial scheme, and suggests allowing some form of make-whole relief under ERISA Section 502(a), the fact that only Justice Breyer joined Justice Ginsburg’s opinion makes this possibility look distant at best.\(^8\)

The Supreme Court’s current ERISA jurisprudence not only leaves a wide gap in the regulation of HMOs, but actually creates incentives for HMOs to defraud ERISA-regulated plan beneficiaries by intentionally denying due benefits, or at least to act with less than ordinary care in making utilization review decisions.\(^9\) ERISA preemption provides HMOs with broad immunity to state law causes of action brought by ERISA-regulated plan participants attempting to obtain damages for injuries resulting from a wrongful denial of benefits.\(^10\) All that these aggrieved ERISA-regulated plan participants can do is sue the HMO under ERISA and obtain an injunction against the HMO or recover the cost of wrongfully denied benefits.\(^11\) Thus, because the only risk of refusing to pay for some medical treatment or procedure for an ERISA-regulated plan participant is to have to eventually pay for such treatment or procedure, it makes good business sense for HMOs to at the very least, err on the side of denying benefits covered under the plan when making utilization review decisions.\(^12\) Considering the hassles and high costs of litigation, chances are that the sick or recovering patient will not even sue.\(^13\)

Another potential effect of the Davila decision is to move medical treatment decision-making from the treating physician to the HMO.\(^14\) While affirming its decision in Pegram that mixed treatment-eligibility decisions made by the treating physician are not fiduciary in nature and, therefore, fall outside the scope of ERISA, the Davila Court held that when ERISA-regulated plan administrators make “medical necessity” decisions in order to determine eligibility, they act as fiduciaries for purposes of ERISA.\(^15\) Thus, “a wrongful decision to deny care is now significantly less costly when made by a plan administrator rather than a treating physician.”\(^16\) This “liability imbalance,” coupled with the HMOs’ sticks and carrots directed at physicians to discourage over-utilization,\(^17\) may encourage physicians to leave certain medical decisions, particularly treatment decisions, in the hands of the HMO by recommending every possible “adequate” treatment and letting the HMO decide which one is “covered” under the plan.\(^18\)

These incentives for the HMO to disregard patients’ rights, and for the treating physician to “delegate” treatment decisions to the HMO, operate, of course, to the detriment of patients. In the best scenario, patients receive lesser-quality health care in the form of less-than-optimal treatment.\(^19\) In the worst scenario, patients find themselves in a situation like that of the patients in Davila, in which most needed treatment is wrongfully denied and no alternative is provided, or the alternative treatment results in severe injuries to the patient.\(^20\) Patients who find themselves in the second type of situation often do not have the money to pay for the needed treatment or procedure out of pocket. In this type of situation, therefore, a wrongful denial of coverage by the HMO constitutes in practice a denial of treatment.

**IV. Recommendations**

The Court’s unanimous decision in Davila should send a strong message to Congress that the courts are not up to the job of fixing the regulatory gap left by ERISA preemption any time in the near future.\(^21\) It is now time for Congress to hear “the rising judicial chorus urging that Congress and [the] Court revisit what is an unjust and increasingly tangled ERISA regime.”\(^22\) Congress should undertake the job of amending ERISA to eliminate ERISA preemption of state law actions brought patients against their HMOs to recover consequential damages for injuries caused by negligent denials of benefits.

On various occasions, Congress has unsuccessfully attempted to pass a patients’ bill of rights.\(^23\) In 2001, both the Senate and the House passed different versions of a patients’ bill of rights.\(^24\) The Senate’s version of the bill called for “extensive new opportunities to challenge decisions by health maintenance organizations and insurers—including a two-tiered review process—and, if a patient remains unsatisfied, a right to sue insurers and HMOs over decisions that lead to injury or death.”\(^25\) The Congressional effort, however, came to an end in the midst of confrontations between Congress and the White House over “whether federal rules or stronger state rules would govern patients’ appeals.”\(^26\) The bill was reintroduced in 2004 by Senator Barbara A. Boxer (D-CA), but died after the Senate Committee on Health, Education, Labor, and Pensions failed to take action on it.\(^27\) Since the Court issued its decision in Davila, Representative John Dingell has twice introduced legislation giving patients the right to sue their insurers and HMOs, but both bills failed to attract much legislative attention.\(^28\) Some commentators have expressed hope that after the Democratic takeover of both the House and the Senate in 2006, Congress will
attempt to pass patients’ rights legislation.\textsuperscript{186}

Whether having a federal comprehensive patients’ bill of rights is a good idea is beyond the scope of this article. Patients’ rights legislation, such as THCLA, has pros and cons.\textsuperscript{187} While it allows patients to recover consequential damages from their HMOs for breach of a duty to exercise ordinary care in making treatment decisions might encourage responsible utilization review and promote equity in plan coverage by protecting vulnerable patients, such legislation may also result in increased risks for HMOs and higher health care prices.\textsuperscript{188} The ultimate effects of patients’ rights laws are largely unknown.\textsuperscript{189} Fortunately, “the federalist structure of the American government is well-suited to handle such issues.”\textsuperscript{190} As Justice Brandeis put it in his famous dissent in \textit{New State Ice Co. v. Liebmann},\textsuperscript{191} “It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”\textsuperscript{192} But the unhappy incident of ERISA preemption is that states cannot serve as laboratories for patients’ rights laws.\textsuperscript{193} The Court in \textit{Davila} closed the door to such experimentation.\textsuperscript{194} As one commentator eloquently put it:

The \textit{Davila}/\textit{Calad} holding precludes a federalist experiment on remedies against HMOs. States may not test and compare the benefits and disadvantages of tort liability statutes or other types of remedies. States must accept the ERISA Section 502 remedies as exclusive. \textit{Davila}/\textit{Calad} undercuts one of the significant strengths of the American form of government—a strength that is well-designed to address the very problems that motivated ERISA’s passage.\textsuperscript{195}

Congress should take action to amend ERISA to allow the laboratory of the states to test the efficacy of patients’ rights laws.

\section*{V. Conclusion}

The Supreme Court’s decision in \textit{Davila} closed the door on patients seeking state tort law damages from their HMO for injuries suffered as a result of a wrongful denial of benefits by the HMO.\textsuperscript{196} After \textit{Davila}, it is clear that ERISA preempts state laws designed to protect patients from intentional or negligent denials of benefits by their HMOs and leaves patients without the possibility of obtaining “make-whole” relief for injuries suffered as a result of such denials.\textsuperscript{197} The unanimity of the decision suggests that the Court is unlikely to change the course of its ERISA jurisprudence anytime soon.\textsuperscript{198} For these reasons, Congress should take action to amend ERISA to correct the regulatory gap left by the Court’s interpretation of ERISA preemption.

3 See \textit{Davila}, 124 S. Ct. at 2502 (holding that the Texas patients’ causes of action sought “to remedy only the denial of benefits under ERISA-regulated benefit plans,” and therefore “fall within the scope of, and are completely preempted by, ERISA § 502(a)(1)(B))”.
4 See id. at 2491 (“Any state-law cause of action that duplicates, supplements, or supplants ERISA’s civil enforcement remedy conflicts with the clear congressional intent to make that remedy exclusive, and is therefore preempted.”); see also Theodore W. Ruger, \textit{The United States Supreme Court and Health Law: The Year in Review}, 32 J. L. Med. & Ethics 528, 529 (2004) (noting that a patient “who suffers grievous harm as a direct result of an improper denial of treatment may recover ex post only the value of that

treatment, and nothing for the injuries that were a foreseeable consequence of such denial”).
5 Emily Heil, \textit{Dingell Introduces Patients’ Rights Bill, but Frist Has Doubts}, \textit{Congress Daily}, June 22, 2004, 2004 WLN 17661710 (Representative Dingell urged Congress to pass patients’ rights legislation to counter the effects of the Court’s decision in \textit{Davila}, stating “I know we need to do our job and legislate to clear the air, otherwise the Supreme Court will have to act over and over again.”).
6 See Laura B. Benko, \textit{New Call for Patients’ Bill of Rights: Does Worry Limiting HMO Suits Will Boost Medical Malpractice Filings}, \textit{Mon. Healthcare}, June 28, 2004, at 12; Heil, supra note 5 (noting that the bill would have ensured patients access to care that their doctor considered medically necessary, and would have granted patients the right to a “fair, independent review process” in cases where the HMO denies a particular treatment); see also Elizabeth Barnardi, \textit{What Lies Ahead for ERISA’s Preemption Doctrine After a Judicial Call to Action is Issued in Aetna Health Inc., 43 Hous. L. Rev. 125, 153 (2006) (“Dingell’s 2004 bill failed to take shape in the House, so he once again reintroduced the bill as the Patients’ Bill of Rights Act of 2005 in May 2005. To date, this bill has also failed to gain any steam in the House.”).
7 See \textit{Davila}, 124 S. Ct. at 2502 (Ginsburg, J., concurring) observing that the Court’s broad interpretation of ERISA preemption and narrow construction of the “equitable relief” available under ERISA § 502(a)(3) has created a “regulatory vacuum” where “virtually all state law remedies are preempted but very few federal substitutes are provided,” and joining “the rising judicial chorus urging that Congress and [the Supreme Court] revisit what is an unjust and increasingly tangled ERISA regime.”); \textit{DiFelicic v. Aetna U.S. Healthcare}, 346 F. 3d 442, 453-54 (3d Cir. 2003) (“Existing ERISA jurisprudence creates a monetary incentive for HMOs to mistreat those beneficiaries, who are often in the throes of medical crises and entirely unable to assert what meager rights they possess.”); Heil, supra note 5; Barnardi, supra note 6, at 150-53 (outlining the history of congressional attempts to pass a comprehensive patients’ bill of rights, partly as an effort to fix the “regulatory vacuum” left by the Court’s current ERISA jurisprudence); see generally \textit{Leading Cases: C. ERISA, 118 Harv. L. Rev. 456, 462-63 (Nov. 2004)} (“\textit{Davila}, coupled with \textit{ERISA’s limited remedial scheme, leads to a troubling incentive structure in managed care utilization review [that] encourages HMOs to take decisions about ‘medical necessity’ out of the hands of physicians and place them into the hands of administrators. . . . Taken to an extreme, this incentive structure may even lead HMOs to ‘instruct their doctors to recommend every possible treatment and leave the real decision to HMO administrators.’ Such an outcome, minimizing the policing of managed care and increasing the risk to patients, is unacceptable.”); Leonard A. Nelson, \textit{Recent Developments in Health Care Law: Aetna v. Davila/Cigna v. Calad: A Missed Opportunity}, 31 WM. MITCHELL L. REV. 843, 845 (2005) (“This case [\textit{Davila}] had huge national importance, and the issue deserved better and more careful analysis than it was given by the Court”); Michael E. Nitzman, \textit{Kentucky Ass’n of Health Plans, and Davila: The (R)evolution of ERISA Preemption}, 18 St. Thomas L. Rev. 139, 140 (Fall, 2005) (asserting that the Supreme Court’s ERISA preemption as “the bane of patients and the savior of insurers”).
10 See \textit{Knudson}, 534 U.S. at 221; \textit{Mertens}, 508 U.S. at 255; Russell, 473 U.S. at 148.
11 See \textit{Davila}, 124 S. Ct. at 2491 (“Any state-law cause of action that duplicates, supplements, or supplants ERISA’s civil enforcement remedy conflicts with the clear congressional intent to make that remedy exclusive,}
and is therefore preempted."); *Leading Case: C. ERISA, supra note 7, at 456-57 (Davila "closed the door on state legislation granting patients a right to sue their HMOs for negligent utilization review."); Edward F. McDuffie, 2003-2004 Survey of New York Law: Health Law, 55 SYRACUSE L. REV. 1107, 1127 (2005) (noting that Davila made it clear that ERISA does not allow private lawsuits by patients based on state law malpractice or negligence causes of action).

12 See Nitardy, supra note 7, at 145-46 (explaining that ERISA preemption forces the claimant to bring suit only under ERISA whether or not preemption is complete or conflict-based). See also discussion infra Part II (B) (1) and (2) (discussing and comparing ERISA “complete” and “conflict” preemption).

13 See Davila, 124 S. Ct. at 2503 (Ginsburg, J., concurring).

14 See Ruger, supra note 4, at 530 (“By shifting the equilibrium point of managed care regulation from a shared federal-state enterprise to one that is (in this area, at least) exclusively federal, the Court has put more immediate pressure on federal government actors to come forward with concrete solutions to public concerns about managed care decision-making”); Barnidge, supra note 6, at 149-50 (“The Davila decision has now made the issue of “fixing” the ERISA preemption doctrine a congressional one, instead of a judicial one.”). Barnidge argues that the Justices found themselves with their hands tied behind their backs in Davila: “[It] is apparent that the Court finally felt bound by the constraining language of the ERISA statute. There was no longer a set of facts present that would allow ‘wiggle room’ or a loophole for the Court to maneuver through in order to provide some form of relief. At oral argument, Justice Breyer stated that the denial in treatment by the HMOs ‘seems to be the thing that ERISA forbids. I don’t see how to get around it.’”; id. at 148.

15 See Davila, 124 S. Ct. at 2503 (Ginsburg, J., concurring) (proposing that “fresh consideration of the availability of consequential damages under § 502(a) (3) of ERISA is plainly in order”, and suggesting that ERISA § 502(a)(3) may “allow at least some forms of ‘make-whole’ relief against a breaching fiduciary in light of the general availability of such a relief in equity at the time of the divided bench.”) (emphasis in the original). See generally Charlotte Johnson, Justice Ginsburg’s Fiduciary Loophole: A Viable Achilles’ Heel to HMOs’ Impenetrable, 2006 B.Y.U.L. REV. 1589 (2006) (arguing that § 502(a)(3) of ERISA allows ERISA-regulated plan beneficiaries to sue their HMO for consequential damages on a theory of breach of fiduciary duty to the ERISA plan).


18 See Stempel & Magdenko, supra note 17, at 697 (noting that the preemption clause, which extended regulation to all employee benefits plans, “was adopted without the thorough investigation, spirited debate, and careful study that otherwise characterizes Congress’ work in drafting the statute because the final preemption language was added only ten days before Congress approved the final bill”). See also Kathy L. Cerninara, Protecting Participants in and Beneficiaries of ERISA-Governed Managed Health Care Plans, 29 U. MICH. L. REV. 317, 326 (1999); Robert L. Aldisert, Blind Faith Congours Bad Faith: Only Congress Can Save Us After Pilot Life Ins. Co. v. Dedeaux, 21 L.OY. L.A. L. REV. 1343, 1350 (1988).

19 See Cerninara, supra note 18, at 326; Aldisert, supra note 18, at 1350.

20 29 U.S.C. 1002(1).


22 See Stempel & Magdenko, supra note 18, at 698; Aldisert, supra note 18, at 1355 (discussing background of section 514).

23 See 29 U.S.C. 1144(a); Nitardy, supra note 7, at 142 (“One stated purpose of ERISA was to create a single uniform body of law to cover the area of pension and welfare benefits. This was so that fifty different regulatory schemes will not challenge ERISA for its regulatory power, and also so that employers would not be excessively burdened by the added cost of keeping up with 50 different regulatory schemes. To make that exclusive control more apparent, Congress enacted an express preemption provision.”).

24 See ERISA § 29 U.S.C. 1144(a).


27 Id.; Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 733 (1985) (referring to ERISA Section 514(a)(2) (B) as the “deemer clause”).

28 See discussion supra Part II(C).

29 See id.


32 See Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987); see also Nelson, supra note 7, at 871 (noting that Section 502(a) actually contains nine enforcement provisions, and explaining that the Court probably referred only to those provisions that allow for enforcement by private parties when it spoke of six enforcement provisions).

33 See Pilot Life Ins. Co., 481 U.S. at 54.

34 See Davila, 124 S. Ct. at 2491.

35 See U.S. CONST. ART. VI; Nitardy, supra note 7, at 147-48 (“ERISA receives its power to preempt state laws and other contrary causes of action from the powers imbued to it by Congress and the Supremacy Clause of the Constitution. When Congress acts within an area assigned to it, Article VI provides Congress with the necessary power to trump other state laws attempting to work in or along side the area in which Congress explicitly controls.”).

36 Nitardy, supra note 7, at 148.

37 Id.

38 See Davila, 124 S. Ct. at 2494-96.

39 See id. at 2495 (quoting Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987)); Stempel & Magdenko, supra note 16, at 699 (explaining that complete preemption was first found in ERISA Section 502(a)).

40 See Davila, 124 S. Ct. at 2495 (quoting Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987)).

41 See id. at 2496. See also Karen A. Jordan, The Complete Preemption Dilemma: A Legal Process Perspective, 31 WAKE FOREST L. REV. 927, 956 (1996) (“[R]emoval pursuant to the doctrine of complete preemption in ERISA cases hinges on whether the claim is within the scope of 502(a).”); Barnidge, supra note 6, at 133-34 (“only section 502(a) serves to automatically remove a case brought under its parameters”).


43 See Davila, 124 S. Ct. at 2496 (explaining further that “if an individual brings suit complaining of a denial of coverage for medical care, where the individual is entitled to such coverage only because of the terms
of an ERISA-regulated plan, and where no legal duty (state or federal) independent of ERISA or the plan terms is violated, then the suit falls ‘within the scope of ERISA’.

44 See 29 U.S.C. 1144(a).
47 Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983); Aldisert, supra note 18, at 1360; Barnidge, supra note 6, at 134 (“Originally, the Court applied a textualist interpretation to section 514, which resulted in ‘a staggering broad preemptive scope.’”).
49 See id. at 657 (noting that the objective of Section 514(a) “was described in the House of Representatives by a sponsor of the Act, Representative Charles Dent (R-PA), as being ‘to eliminate the threat of conflicting and inconsistent State and local regulation’”); Jordan, supra note 7, at 63-64 (“[I]n more recent years, the Court has also more clearly defined limitations on the broad scope of ERISA preemption. The Court has determined that the analysis should be guided by the objectives of ERISA and should involve consideration of the nature and purpose, as well as the effect, of the state law at issue.”).
52 See Nitardy, supra note 7, at 147 (“The Savings Clause was inserted into the express provision language in order to leave for the states areas that have historically remained under their purview.”); Russell Korobkin, The Failed Jurisprudence of Managed Care, and How to Fix It: Reinterpreting ERISA Preemption, 51 UCLA L. Rev. 457, 467 (2003) (“The clear intent of the ‘savings clause’ is to prevent the reference to clause from being read so broadly as to supersede the myriad, complicated, and historically rooted regulation of the business of insurance by state legislators and regulators.”).
54 Id. at 341-342.
55 Id.
56 Id.
57 See 29 U.S.C. 1144(b)(2)(B); Nitardy, supra note 7, at 147.
60 See 29 U.S.C. 1144(b)(2)(B); Metro. Life Ins. Co., 471 U.S. at 746-47 (“We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the ‘deemer clause,’ a distinction Congress is aware of and one it has chosen not to alter.”).
63 Pegram, 530 U.S. at 214.
64 Id. at 215.
65 Id.
66 Id.
67 Id. at 215-16.
68 Id. at 216.
69 Id. at 226.
70 Id. at 228-29 (“What we will call pure ‘eligibility decisions’ turn on the plan’s coverage of a particular condition or medical procedure for its treatment. ‘Treatment decisions,’ by contrast, are choices about how to go about diagnosing and treating a patient’s condition; given a patient’s constellation of symptoms, what is the appropriate medical response?”).
71 Id. (“In practical terms, these eligibility decisions cannot be untangled from physicians’ judgments about reasonable medical treatment.”).
72 Id. at 235-36.
73 Id. at 235-37 (“Thus, for all practical purposes, every claim of fiduciary breach by an HMO physician making a mixed decision would boil down to a malpractice claim, and the fiduciary standard would be nothing but the malpractice standard traditionally applied in actions against physicians.”).
74 Id. at 237.
75 Id.
77 See Nelson, supra note 7, at 852 (explaining that THCLA was a legislative response to long-ignored claims by consumer advocate groups that managed care organizations were relying on the fact that the intricate and detailed language of the plans they covered made it difficult for lay persons to understand their benefits under the plans to wrongfully deny such benefits). Nelson provides an excellent analysis of the benefits and risks of having a piece of legislation like THCLA. Id. at 878-80.
78 THCLA, TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a).
80 Davila, 124 S. Ct. at 2493-94.
81 See generally, Davila, 124 S. Ct. 2488.
83 Id. at 7.
84 Davila, 124 S. Ct. at 2493-94 (describing the employee benefit plan arrangements as follows: “Under Davila’s plan . . . Aetna reviews requests for coverage and pays providers, such as doctors, hospitals, and nursing homes, which performed covered services for members; under Calad’s plan sponsor’s agreement, CIGNA is responsible for plan benefits and coverage decisions”).
85 Id. at 2493-94; Brief for Respondents at 5, Aetna Health Inc. v. Davila, 124 S. Ct. 2488 (2004) (Nos. 02-1845, 03-83).
86 Davila, 124 S. Ct. at 2493-94.
87 Id.
88 Id. at 2493.
89 Id.
90 Id.
91 Id.
92 Id. at 2493-94.
93 Id. at 2494.
94 Id.
95 Id.
96 Id.
97 Id.
99 Land v. CIGNA Healthcare of Fla., 339 F.3d 1286 (11th Cir. 2003).
100 Ciclo v. Does, 321 F.3d. 83 (2d Cir. 2003).
101 See Nelson, supra note 7, at 860.
102 DiFelice, 346 F.3d 442.
103 See id. at 449; Nelson, supra note 7, at 860.
104 See Davila, 124 S. Ct. at 2502.
105 Id. at 2495; see Nelson, supra note 7, at 883 (attacking the proposition that ERISA is a comprehensive statute). Nelson argues that ERISA may be referred to as a comprehensive statute with respect to its regulation of pension plans, but the same cannot be said regarding
its welfare plan provisions. He explains that while ERISA “regulate[s] the procedural standards and content of pension plans,” it does not regulate the content of welfare plans.

106 Id.


108 See Davila, 124 S. Ct. at 2494.

109 Id. at 2499.

110 Id. at 2495.

111 Id. at 2498-99.

112 Id.

113 See Davila, 124 S. Ct. at 2499.

114 Id.

115 Id. at 2497-98.

116 Id.

117 Id. at 2498.

118 Id.

119 See Davila, 124 S. Ct. at 2501-02.

120 Id. at 2501 (“Congress did not intend [the defendant HMO] or any other HMO to be treated as a beneficiary to the extent that it makes mixed eligibility decisions acting through its physicians.”).

121 Id. at 2502 (citing Cicco 321 F.3d at 109 (Calabresi, J., dissenting in part)).

122 Id. at 2501-02.

123 Id.


125 Id.

126 Id.


128 See Davila, 124 S. Ct. at 2503; Russell, 473 U.S. at 148.


130 See Davila, 124 S. Ct. at 2503 (quoting Mertens v. Hewitt Assoc., 508 U.S. 248, 256 (1993) (noting that the Mertens Court “held that § 502(a)(3)’s term ‘equitable relief’ . . . refer[s] to those categories of relief that were typically available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)” (emphasis in original))).

131 534 U.S. 204 (2002).

132 See Davila, 124 S. Ct. at 2503; Knudson, 534 U.S. at 221. See also Johnson, supra note 15, at 1624 (“All that remains of ‘typically equitable’ remedies after Great-West is (1) injunction, for which Congress did not need to provide ‘other equitable relief’ in section 502(a)(3), having already expressly authorized injunction earlier in the same sentence; and (2) restitution for cases that might have been brought as constructive trust actions before fusion.”).

133 See Davila, 124 S. Ct. at 2503-04.

134 Id.

135 Id. emphasis in original.

136 See, e.g. Cameron Krier, One Step Forward, Two Steps Back: The Impact of Aetna Health Inc. v. Davila on ERISA and Patient’s Rights, 38 Tex. Tech. L. Rev. 127, 129, 148 (2005) (declaring that “Davila left millions of Americans without the ability to obtain fair compensation and access to state courts” because “[t]he Supreme Court essentially slams state courthouse doors to millions of Americans seeking relief against their HMOs.”); Nelson, supra note 7, at 870 (“Davila/Calads primary effect is the determination that ERISA preempts and thus invalidates state laws that purport to impose tort liability against HMOs.”); Donald T. Bogan, ERISA: State Regulation of Insured Plans After Davila, 38 J. MARSHALL L. REV. 693, 693 (2005) (“Aetna Health, Inc. v. Davila . . . establishes that ERISA prohibits plan participants from pursuing extra-contractual damages under state law in actions arising from abusive claims settlement practices committed by ERISA plan insurers.”); Elizabeth Khoury, HMO Liability After Aetna Health Inc. v. Davila: Are Patients’ Rights at Risk?, 91 IOWA L. REV. 1621, 1642 (2006) (noting that after Davila, “in the event a patient wanted to dispute a denial of medical coverage, section 502 would be the only source of relief. State tort claims against HMOs [are] preempted”); McArdle, supra note 11, at 1121 (“In Aetna Health Inc. v. Davila, the Supreme Court dealt a severe blow to the ability of patients to bring damages lawsuits against HMOs and other managed care health insurers based on state law causes of action.”); Barnidge, supra note 6, at 126 (“In short, the Court’s decision effectively shuts the door on the majority of patients’ compensation claims for injuries sustained as a result of a denial of coverage or benefits by their Health Maintenance Organization (HMO).”).


138 See Kathy 124 Fed. Appx. at 757.

139 Id. at 757.

140 Id.

141 Id. at 757-58.

142 See Barber, 383 F.3d at 136.

143 Id.

144 Id.

145 Id.

146 See Land, 381 F.3d at 1276.

147 Id.

148 Id.

149 376 F.3d at 431-32.

150 Id.

151 Id.

152 Id. at 432.

153 Lind, 466 F.3d at 1201.

154 Id. at 1197-98.

155 Id.

156 Id. at 1199.

157 Id.

158 Lind, 466 F.3d at 1199.

159 425 F.3d 424.

160 Id.

161 Id. at 426.

162 Id. at 429.

163 See text accompanying note 137; discussion supra Part III (E) (discussing a number of federal circuit court cases decided after Davila).

164 See Davila, 124 S. Ct. at 2497 (“Upon the denial of benefits, respondents [Davila and Calad] could have paid for the treatment themselves and then sought a preliminary injunction.”).

165 See Barnidge, supra note 6, at 149 (referring to Justice Ginsburg’s prediction that one day the Court may confirm that “Congress . . . intended ERISA to relocate the core principles of trust remedy law, including the make-whole standard of relief” as a “bold statement” given that only one member of the Court joined her concurrence, but observing that Justice Ginsburg’s prediction may become a reality if Congress refuses to act to correct the problems of ERISA); McDonald, 425 F.3d at 430 (commenting to the plaintiffs in the case that on remand “they may wish to take note of Justice Ginsburg’s comment in her concurring opinion in Davila, in which she drew attention to the Government’s suggestion that ERISA “as currently written and interpreted, may allow at least some forms of ‘make-whole’ relief against a breaching fiduciary in light of the general availability of such relief in equity at the time of the divided bench.”).

166 See Johnson, supra note 15, at 1623 (“Including a cause of action in ERISA for breach of fiduciary duty that preempts state law claims yet denies individual compensatory relief creates a vehicle for HMOs to defraud.”); Khoury supra note 136, at 1643-44 (proposing that under the Court’s interpretation of ERISA, “the benefits are shifted to the HMOs and the burdens to patients. In fact, because HMOs need not fear tort damages for wrongful denials of care, HMOs might have more of an incentive to provide less coverage for care”).

167 See Krier, supra note 136, at 129; Nelson, supra note 7, at 870; Donald T. Bogan, ERISA: State Regulation of Insured Plans After Davila, 38 J. MARSHALL L. REV. 693, 693 (2005); Khoury supra note 136, at 1642; McArdle, supra note 11, at 1121; Barnidge, supra note 6, at 126.

168 The ERISA Preemption Amendments of 1991: Hearing on S. 794 Before the Subcomm. on Labor of the Comm. on Labor and Human Resources, 102nd Cong. 2 (1991) (opening statement of Senator Howard M. Metzenbaum, Chairman of the Subcommittee) (stating that “all [ERISA plaintiffs] can hope for is that after two or three years of court action their claim will be paid, but with no damages.”); Johnson, supra note 15, at 1623.
(“[W]ith only ‘equitable remedies under ERISA, as interpreted by the courts, the most that could happen is the HMO would be forced to cover only the medical treatment in question and not any resulting harm from the HMO’s decision to deny the physician’s prescribed medical treatment.”).

169 See Johnson, supra note 15, at 1623; but see Ruger supra note 4, at 530 (noting that “even if a plan faced full after-the-fact liability for every denial of care, a rational plan administrator might still deny care and pay later to capture the time value of the money otherwise spent on benefits”). However, Ruger expresses some preoccupation that the incentives for the HMO to defraud patients are overstated. He points out that “market pressures and the threat of consumer revulsion place some practical limits on a plan’s ability to deny care.”

170 See id. (“Participants in the midst of medical crises are generally in no position to appeal their beneficiary rights.”).

171 See Krier supra note 136, at 148-49.

172 See Davila, 124 S. Ct. at 2500-01.

173 See Krier supra note 136, at 148-49; Ruger supra note 4, at 530.

174 See Nelson supra note 7, at 848-49.

175 See Krier supra note 136, at 148-49 (“Davila may force physicians to make a difficult choice between maximizing traditional clinical autonomy and slightly reducing malpractice risk by relinquishing control over certain decisions to plan administrators.”); Ruger supra note 4, at 530; David L. Trueman, Will the Supreme Court Finally Eliminate ERISA Preemption?, 13 ANN. HEALTH L. 427, 445 (2004) (arguing that, as things stand today, “if the physician recommends treatment and the HMO denies coverage, the patient has no recovery. [T]herefore, the Corcoran decision allows the HMO to escape liability if the HMO tells the physicians to recommend every possible, but leaves the real decision to the HMO administrator”).

176 See Khoury supra note 136, at 1643-44; L. Darnell Weeden, ERISA’s Preemption Ruling Prevents a Patient from Suing an HMO Under State Malpractice Law: After Aetna Health, Inc. v. Davila Who Will Grant the Working Middle Class a Meaningful Right to be Heard?, 7 U. PA. J. LAB. & EMP. L. 715, 741 (2005) (encouraging recognition that through the utilization review process HMOs “use an incidental or ministerial coverage question to undermine the quality of medical treatment decisions made by [the treating physician]”).

177 See Brief for Respondents at 6-7, Aetna Health Inc. v. Davila, 124 S. Ct. 2488 (2004) (Nos. 02-1845, 03-83); Davila, 124 S. Ct. at 2493-94.

178 See Barnidge, supra note 6, 150.

179 See Davila, 124 S. Ct. at 2503 (Ginsburg, J., concurring) (quoting DiFelice v. Aetna U.S. Healthcare, 346 F. 3d 442, 453-54 (3d Cir. 2003 (Becker, Circuit Judge, concurring))

180 See Barnidge, supra note 6, at 150-53 (providing a brief chronology of Congress’ efforts to pass a patients’ bill of rights).


183 See Barnidge, supra note 6, at 152 (“Senator Edward M. Kennedy of Massachusetts placed the blame solely on the White House stating that ‘if they had been willing to hold the HMOs and the insurance industry accountable, we could have gotten legislation.’” The White House fired back with its own criticism, quipping that “it appears some are still not able to break loose from the grip of powerful personal injury trial lawyers.”).

184 See Sen. Boxer Introduces Patients’ Bill of Rights, STATES NEWS SERVICE, Feb. 17, 2004; Barnidge, supra note 6, at 152.

185 See Stephen Taub, Senate Revives Patient-Rights Bill: Federal Laws Must Be Enacted for Patients to Be Able to Sue Their HMOs in State Courts, CFO.COM, June 24, 2004; Barnidge, supra note 6, at 152-53.

186 See Lydell C. Bridgeford, Democrats to re-evaluate health care, EMPLOYEE BENEFIT NEWS, February 1, 2007.

187 See Nelson, supra note 7, at 878-80 (providing an excellent analysis of the pros and cons of patients’ rights legislation).

188 See id. (concluding that “THCIA could have the undesired effect of actually shrinking the social safety net”).

189 See id. at 881 (“In the abstract then, the reasons for allowing tort liability against HMOs are countered by equally weighty reasons for disallowing such liability. Whether, in practice, the policy considerations would remain in balance, or whether one set of principles would be seen to predominate over the other cannot be known except through experience.”).