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**AETNA V. DAVILA: FROM PATIENT-CENTERED CARE TO PLAN-CENTERED CARE, A SIGNPOST OR THE END OF THE ROAD?**

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I. INTRODUCTION

The tragic events set forth in [plaintiff’s] [c]omplaint cry out for relief . . . . Under traditional notions of justice, the harms alleged—if true—should entitle [plaintiff] to some legal remedy . . . . Nevertheless, this court had no choice but to pluck [plaintiff’s] case out of the state court in which she sought redress . . . . and then, at the behest of [defendant Managed Care Organization (MCO)], to slam the courthouse doors in her face and leave her without any remedy.<sup>1</sup>

Judge William Young’s words forcefully express his frustration at Managed Care Organizations’ (MCOs’) ability to use the Employee Retirement Income Security Act of 1974 (ERISA) to shield themselves from liability for consequences of wrongful benefit denials.<sup>2</sup> Seven years later, the Supreme Court decision *Aetna Health, Inc. v. Davila*<sup>3</sup> virtually guarantees the frustration will only continue.

This comment establishes *Davila* as an exclamation point in the ongoing medical debate surrounding eroding patient-centered care. In the background section, I shall first define the concept of patient-centered care, explain how it changed during the last thirty years, discuss treatment denial and associated issues, explore how MCOs define medical necessity and note problems with this definition. I shall also explain and compare liability under ERISA to liability under state “right to sue” statutes; illustrate how, leading up to the *Davila* decision, some federal court results made it look as though ERISA preemption might be considered as less than absolute; and finally, provide *Davila*’s facts, procedure, and the Fifth Circuit Court of Appeals’ analysis.

The analysis section acknowledges that, due to ERISA’s language and previous Court interpretations, the Court could not have decided *Davila* differently. It explains and rebuts the Court’s analy-

<sup>1</sup> *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 53 (D. Mass. 1997), *quoted and discussed in* PETER D. JACOBSON, STRANGERS IN THE NIGHT: LAW AND MEDICINE IN THE MANAGED CARE ERA 152 (2002).

<sup>2</sup> Throughout this discussion, health maintenance organizations, preferred provider organizations, and other managed care organizations will all be subsumed by the more generic term: managed care organization (MCO).

<sup>3</sup> *Aetna Health, Inc. v. Davila*, 542 U.S. 200 (2004) [hereinafter *Davila*].

sis and details post-decision reactions. The analysis presents corporate economic concerns, corporate defense of internal appeals processes, and problems with these approaches. The analysis next details consequences of the *Davila* ruling as it affects different groups, and illustrates that often a benefit decision becomes a treatment decision. Finally, it explores a potential judicial avenue for expanding relief under ERISA.

In the conclusion, the author agrees with the concurrence's vigorous charge to Congress, that it is Congress who must solve the problem of the regulatory vacuum in ERISA's current "unjust and increasingly tangled . . . regime."<sup>4</sup> Lastly, the author suggests a legislative solution which makes concessions to each side in the debate, while providing needed relief to patients for their consequential economic damages caused by treatment denial.

#### A. Background: What is at Stake?

While medical care was once criticized for providing procedures and tests in excess of those actually needed for proper patient care, the pendulum may now be swinging in the opposite direction: toward less medical intervention and a less patient-centered ethic.<sup>5</sup> These changes in managed care and medical expenses affect a very large segment of the American population. At least 170 million Americans receive health care benefits through "HMOs (health maintenance organizations), PPOs (preferred provider organizations), and other managed care providers."<sup>6</sup> Around 160 million Americans under the age of 65 receive their health insurance as a benefit of employment or pension;<sup>7</sup> thus ERISA dictates their remedies as against their MCOs.<sup>8</sup> Half of all American personal bankruptcies are estimated to be due, at least in part, to medical

<sup>4</sup> *Id.* at 222–23 (Ginsburg, J., concurring and quoting *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 453 (3d Cir. 2003) (Becker, J., concurring)).

<sup>5</sup> Robert A. Clifford, *High Court to Review Patients' Right to Sue*, CHI. LAW., Feb. 2004 (noting that as MCOs make more decisions regarding benefits and care they "often err on the side of refusing to cover medical tests or procedures, then count on the protection of ERISA to shield them from liability."); WEBSTERS THIRD NEW INTERNATIONAL DICTIONARY UNABRIDGED 780 (3d ed. 1986) (defining ethics as "the principles of conduct governing an individual or group or profession").

<sup>6</sup> NAT'L CONF. OF ST. LEGISLATURES, HEALTH CARE PROGRAM, MANAGED CARE & INSURER LIABILITY, <http://www.ncsl.org/programs/health/libable.htm> (last visited Oct. 9, 2005).

<sup>7</sup> KAISER FAM. FOUND., EMPLOYER HEALTH BENEFITS: 2005 SUMMARY OF FINDINGS (2005), available at <http://www.kff.org/insurance/index.cfm> (last visited Oct. 6, 2005).

<sup>8</sup> Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. §§ 1001-1461 (1996).

expenses.<sup>9</sup> At the time of the *Davila* decision ten states had enacted “right to sue” laws.<sup>10</sup>

Two basic questions underlie this comment. First, when care-denial creates consequential damages for a patient, who should bear the new financial burden: the MCO that denied treatment, the independent physician who advocated for the treatment, or the patient? Second, how does ERISA work in the context of alleged wrongful treatment denials? Under the Supreme Court’s decision in *Davila*, this burden falls squarely on the patient, and the Court’s reading of ERISA immunizes the MCO from the negative consequences of the care-denial decision.<sup>11</sup> In the typical deterrence scenario, upon which most of United States torts law is based, negative behavior is considered to be best controlled and deterred by placing negative consequences on the actor. Malpractice suits generally serve as a deterrent against medical malpractice and negligence. However, under ERISA’s preemption provision<sup>12</sup> and its judicial interpretation in *Davila*,<sup>13</sup> MCOs are not liable for consequential damages to compensate for a patient’s injury or declining health caused by denied medical care. Thus, due to ERISA preemption, the deterrence on benefit plans for malpractice and negligence is missing.<sup>14</sup> Before exploring how *Davila* approved financially burdening the patient, it is useful to examine what is meant by patient-centered care and to describe this model’s erosion.

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<sup>9</sup> See David U. Himmelstein et al., *MarketWatch: Illness And Injury As Contributors to Bankruptcy*, HEALTH AFF. — WEB EXCLUSIVE, Feb. 2, 2005, at W5-63, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.63v1> (last visited Oct. 6, 2005); *infra* note 231 and accompanying text.

<sup>10</sup> NAT’L CONF. OF ST. LEGISLATURES, *supra* note 6. Those laws were: ARIZ. REV. STAT. ANN. § 20-3153 (2002); CAL. CIV. CODE § 3428 (West 2003); GA. CODE ANN. § 51-1-48 (1999); ME. REV. STAT. ANN. tit. 24-A, § 4313 (2002); N.C. GEN. STAT. § 90-21.51 (2005); N.J. STAT. ANN. § 2A:53A-33 (West 2002); OKLA. STAT. ANN. tit. 36, § 6593 (West 2003) (employing language nearly identical to California’s statute); TEX. CIV. PRAC. & REM. CODE ANN. § 88.002 (Vernon 2003) (codifying the Health Care Liability Act); WASH. REV. CODE ANN. § 48.43.545 (West 2003); W. VA. CODE ANN. § 33-25C-7 (LexisNexis 2003).

<sup>11</sup> *Aetna Health, Inc. v. Davila*, 542 U.S. 200 (2004).

<sup>12</sup> See *infra* notes 83–87 and associated text (explaining ERISA’s preemption provision).

<sup>13</sup> *Davila*, 542 U.S. 200, 213–18 (2004).

<sup>14</sup> See Theodore W. Ruger, *The Supreme Court Federalizes Managed Care Liability*, 32 J.L. MED. & ETHICS 528, 529 (2004) (characterizing the current ERISA law’s enforcement scheme and remedial provisions as “crabbed” and “penurious” and noting both “[fail] to serve the baseline goals of compensation and deterrence that undergird remedial law in tort and contract.”).

## 1. *Patient-Centered Care*

Patient-centered care refers to a particular model for delivering health-care services. While no universal medical definition of patient-centered care exists, the various definitions held by physicians, nurses, and the health care systems share the feature of placing the patient's needs first. Some have characterized the patient-centered care ethic among physicians as "doing everything for the patient regardless of cost or degree of effectiveness."<sup>15</sup> The nursing model for patient-centered care conceptualizes the patient as a wheel's hub, and the various health-care providers as the spokes. Under the nursing model, the care providers work collaboratively, making decisions and delivering treatments with the patient's interests serving as the primary, guiding focus.<sup>16</sup> While giving the patient's needs primary consideration remains common to all three perspectives, two scholars<sup>17</sup> offer an extremely detailed description for comprehensive patient-centered care from a systems perspective. Their description demonstrates key components such as relationship, promptness, comprehensive knowledge about the patient, time use during the medical appointment, collaborative consideration of solutions of varying lengths, and collaborative cost evaluation:

In an ideal world, if a patient had a health issue or concern, he would go to an appropriate health care provider with whom he had a pre-existing and long-term relationship for care. He would obtain an appointment with relative promptness, and the provider would see him on time. The patient's health care provider would already have knowledge of the lifestyle and history of the patient from her prior experience with him, as well as knowledge of his baseline physiological and psychological functioning. She would use this knowledge to contextualize the new symptoms or concerns. She would also take the time to discuss what the new problem might be and how best to approach it, both in terms of a short-term solution or cure and, where relevant, a long-term approach to preventing the problem in the future or appropriately managing its effects. If the provider recommended further action, both she and

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<sup>15</sup> Lauren Randel, et al., *How Managed Care Can Be Ethical: When Managed Care Problems are Recast as Ethical Dilemmas, Can Solutions Be Far Behind?*, HEALTH AFF., July–Aug. 2001, at 43 (exploring new ways to understand problems with managed care as we have moved from fee-for-service patient-centered care to managed care which focuses more on populations than on individuals).

<sup>16</sup> F. Ronald Feinstein, *Access to Health Care: It's Not Rocket Science—It's Tougher*, 22 J. LEGAL MED. 235, 243 (2001) (describing patient-centered care as one way to increase the value of health care services).

<sup>17</sup> Laura D. Hermer & William J. Winslade, *Access To Health Care in Texas: A Patient-Centered Perspective*, 35 TEX. TECH L. REV. 33, 36 (2004) (introducing their section on patient-centered care).

the patient would include issues of cost and relative effectiveness in their considerations.<sup>18</sup>

Further in the description, the authors illustrate the importance of open communication, long-term treatment relationships, patient responsibilities, and appropriate roles for payors and legislators:

The health care provider would put the patient's needs—both medical and personal—first in this encounter. Not only would she spend as much or as little time as necessary interacting with the patient and discussing issues and concerns with him, but she would also avoid spending extra time and money chasing down unlikely causes of ailments because of malpractice fears or a desire to maximize revenues from the patient. The patient, for his part, would maintain a close and long-term treatment relationship with the physician. He would forthrightly communicate his symptoms, questions, disagreements, and concerns and openly discuss them. He would also, when in agreement with his health care provider's recommendations, do his best to heed his provider's advice about general and long-term health. Third party payors such as the federal and state government and private insurers would keep their interference in the physician and patient relationship to a minimum and would pay legitimate claims in a timely fashion. Legislation directly affecting the provider and patient relationship would be largely unnecessary, save those laws relating to licensure and screening out unscrupulous providers.<sup>19</sup>

## 2. *As Managed Care Grew, the Health Care Delivery Model Became Less Patient-Centered*

Before managed care, medical services were delivered under a fee-for-service system (FFS) where patients either paid for care themselves or through an employer's third-party commercial indemnity insurer.<sup>20</sup> Under FFS, the entities operated separately; the physician decided upon care and treatment, the insurer paid for the service, and the insurer had minimal oversight in the treatment decision.<sup>21</sup> A patient dissatisfied with the insurance carrier brought a breach of contract action and, if dissatisfied with the physician, a

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<sup>18</sup> *Id.*

<sup>19</sup> *Id.*

<sup>20</sup> JACOBSON, *supra* note 1, at 7 (describing hallmarks of fee-for-service medicine).

<sup>21</sup> *Id.*; see also Edward B. Hirshfeld & Gail H. Thomason, *Symposium: On Physician Decision-Making and Managed Care: Medical Necessity Determinations: The Need for a New Legal Structure*, 6 HEALTH MATRIX 3, 3-4 (1996) (explaining that a treatment decision (or medical decision) concerns the treatment that the physician's judgment determines is best for the patient, while a coverage decision (also called an eligibility decision) concerns the health plan's decision about what treatment the health plan will finance; these two decisions are largely separate, but merge when a coverage decision's calculus must include whether the treatment was "reasonable and necessary" for the patient).

medical malpractice action.<sup>22</sup> The third-party insurer paid for the care while the patient, physician, and payor were not pressured to consider or control cost.<sup>23</sup>

However, the last twenty years produced a model organized, financed, and delivered differently.<sup>24</sup> “Health care has shifted away from a system in which individual physicians provide care for individual patients and toward a system characterized by large patient populations within integrated delivery systems.”<sup>25</sup>

Generically, we call this health care delivery system “managed care.” Cost containment largely motivated the change in delivery systems.<sup>26</sup> Managed care combines the financing and medical functions into one entity<sup>27</sup> and attempts to lower costs through limiting the amount of care while preserving the care’s quality.<sup>28</sup> Managed care employs a variety of techniques to achieve that goal.<sup>29</sup> These include utilization review, capitated funding,<sup>30</sup> limited choice of physicians, limited number of treatments, exclusive contracts with physician groups, and physician bonuses based upon not exceeding a certain health-care resource limit.<sup>31</sup>

This shift from FFS to MCO impacts physician autonomy and patient service access.<sup>32</sup> Further, the shift changed the primary focus for care-delivery decisions and caused new conflicts. For the physician, FFS provided autonomy, while managed care reduces physician autonomy to achieve cost-control.<sup>33</sup> The locus of the care-delivery decision shifted from the patient-physician relationship, which places primary consideration on individual patient needs, to

<sup>22</sup> JACOBSON, *supra* note 1, at 7–8; *see also* Hirshfeld & Thomason, *supra* note 21, at 15.

<sup>23</sup> JACOBSON, *supra* note 1, at 8 (noting that economists call such a situation a “moral hazard”: people change their behavior when insurance protects them from the consequences of their actions).

<sup>24</sup> *Id.* at 7 (characterizing the transformation as “radical”).

<sup>25</sup> *Id.*

<sup>26</sup> *Id.* at 8.

<sup>27</sup> *Id.* Under this system the patient pays a monthly fee for a managed care plan to cover and provide a defined benefit set. *Id.* The patient then might have a co-payment for a physician visit or medical service. *Id.*

<sup>28</sup> JACOBSON, *supra* note 1, at 8.

<sup>29</sup> *Id.*

<sup>30</sup> *Id.* (defining capitated funding arrangements as paying physicians a set monthly fee per patient for which the physician provides medical care).

<sup>31</sup> *Id.*

<sup>32</sup> *Id.* at 9.

<sup>33</sup> JACOBSON, *supra* note 1, at 9.

managed-care resource control and cost reduction.<sup>34</sup> For the patient, FFS gave almost unlimited access to health care services, while under managed care the patient may have less access to services and more difficulty “maneuvering through the system.”<sup>35</sup>

New conflicts emerged under the new model. The first new conflict is between the individual and the group.<sup>36</sup> Under managed care, the physician may encounter conflict between the patient’s best welfare and the incentive to more conservatively use medical procedures and tests.<sup>37</sup> Second, legal standards for medical malpractice conflict with managed care practice patterns (such as seeing more patients and providing fewer services) because legal standards for medical malpractice are geared more to FFS standards of care than to managed-care standards of care.<sup>38</sup> Third, managed care

<sup>34</sup> *Id.* at 9–10 (detailing the shift in traditional medical ethics as managed care emerged, and quoting E. Haavi Morreim’s observation about the attendant changes: “Cost is now highly relevant and patients’ benefit is no longer the sole objective.” E. HAAVI MORREIM, *HOLDING HEALTH CARE ACCOUNTABLE: LAW AND THE NEW MEDICAL MARKETPLACE* 29 (2001)); see also Hirshfeld & Thomason, *supra* note 21 (explaining that, in the absence of an appreciable risk that the treatment would harm the patient, physicians traditionally chose to treat, whereas managed care seeks to move the bias toward withholding treatment absent “a strong showing of necessity”).

<sup>35</sup> JACOBSON, *supra* note 1, at 9.

<sup>36</sup> Hirshfeld & Thomason, *supra* note 21, at 23–25, 29 (explaining that in the managed-care context, weighing a particular treatment’s benefits and costs pits individual needs against group needs; illustrating this point by comparing the benefits of earlier breast cancer detection by mammography (e.g., dramatically increased detection and survival of women without known risk factors) with the expense of providing mammography to low-risk women; and further illustrating this point with an example from radiography by comparing the cost of routinely using a much more expensive contrast agent with the benefits of decreased risk of death to the few patients who have an undetected, yet deadly, allergy to a less expensive contrast agent).

<sup>37</sup> JACOBSON, *supra* note 1, at 9 (pointing out that physicians are put in an untenable situation: They must satisfy patients’ expectations for fee-for-service care levels while operating under the managed care environment’s economic constraints); *id.* at 139 (also noting that when utilization review decisions are more focused on economics, the patient’s individual needs may be subordinated to cost-containment objectives); see also Elaine Blume, *Hippocratic Oath Versus Managed Care: Physicians Caught in Ethical Squeeze*, 89 J. NAT’L CANCER INST. 543–44 (1997) (discussing the conflicts between the physician’s patient-centered ethic and managed-care demands, noting that factors influencing physicians under managed-care often have little to do with the patient’s best interest, and quoting AMA General Counsel Kirk B. Johnson: “The gray areas of medicine are less often coming down in the patient’s favor. Financial incentives to limit care are working. Doctors’ professional values are challenged.”); Hirshfeld & Thomason, *supra* note 21, at 17 (stating that this conflict was always present but became a more serious issue when health care costs escalated beyond Americans’ comfort levels and began using a larger share of national resources).

<sup>38</sup> JACOBSON, *supra* note 1, at 9; see also Maxwell J. Mehlman, *Symposium: Physician Decision-Making and Managed Care*, 6 HEALTH MATRIX 1, 1–2 (1996) (discussing the shift of control over treatment that accompanies managed care, and pointing out while the law accepts



created a new entity, the health-plan administrator, who must both perform “resource allocation” (balancing spending money on a particular patient against how this expenditure affects available resources for the rest of their enrolled patients) and meet shareholder expectations.<sup>39</sup> Hermer and Winslade list several changes affecting patients and patient care that result in part from the decline in patient-centered care.<sup>40</sup>

Despite the criticisms of MCOs for moving the focus away from the patient-physician relationship, MCOs *have* been very successful in improving access to care and containing costs.<sup>41</sup> However, these successes are measured at large-population levels, and due to a number of factors, do not necessarily reflect individual patient welfare.<sup>42</sup> Thus, the damage to the individual caused by problematic MCO decisions should not be ignored just because MCOs, in the aggregate, achieve cost containment and increased access.<sup>43</sup>

Current malpractice law does not reflect the changes in our health care delivery system. Under the FFS model, physicians’ primary care-provider role necessitated legal and moral accountability.<sup>44</sup> The law correspondingly developed to enforce physician liability and to protect the patient’s interests.<sup>45</sup> With the advent of MCOs, the law did change to allow MCOs to participate in medical decisions and to ration care, yet the law limits MCO liability for harm caused by care denial.<sup>46</sup> While the law limits accountability for MCOs in the denied-care arena, the law does not support physi-

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diminished patient choice as a consequence of the patient-payor contract, the law continues to require the physician to meet the “traditional, patient-centered standard of care”).

<sup>39</sup> JACOBSON, *supra* note 1, at 9.

<sup>40</sup> Hermer & Winslade, *supra* note 17, at 38–39 (illustrating the erosion by changes such as the following: patients treat illness as an isolated incident, the health care system focuses on illness as a discrete event, patients seek medical solutions to problems which lifestyle choices can fix, prevention receives diminished attention, and waiting times that lead patients to miss work or forgo treatment).

<sup>41</sup> *Id.* at 37.

<sup>42</sup> Hirshfeld & Thomason, *supra* note 21, at 35–37 (arguing that these studies may not reflect individual patient welfare because, among other things, they don’t report “near misses” where the patient had to go outside the MCO to get the needed care; the incidents where patients *are* harmed may be too few to statistically affect aggregate outcomes; the MCO plans use different criteria for defining medical necessity; and studies may not take into account the different incentives plans used to encourage physicians to withhold care).

<sup>43</sup> *Id.* at 41.

<sup>44</sup> *Id.* at 40.

<sup>45</sup> *Id.*

<sup>46</sup> *Id.* at 41.

cian activities that ration care.<sup>47</sup> Instead, “physicians remain ultimately liable for the medical decisions made in the care of patients, and they are *required to place the interest of the patient above all other considerations.*”<sup>48</sup> (Emphasis added.) Hirschfeld and Thomason argue this liability division puts patients at risk, removes physician legal rights that physicians need to offset MCO’s economic leverage, and makes it inevitable that some patients will be harmed.<sup>49</sup> Additionally, commentators recognize that separating the MCO’s authority from its legal responsibility is unethical.<sup>50</sup>

### 3. *Treatment Denial*

While MCOs have controlled costs, the danger to patients arises from unfair administration, where cost containment can lead to limits on access to hospital and specialty care, limits on pharmaceutical choices, diagnostic delays, and care denials.<sup>51</sup> Mr. Davila faced a limit on pharmaceutical choice.<sup>52</sup> MCOs typically deny care for one or more of the following three reasons: first, the item/treatment is not a covered benefit and not thought to be medically necessary for this patient; second, the patient failed to go through the proper process<sup>53</sup> for item/treatment to be provided/covered; third, the item/treatment is on the patient’s plan, yet not thought to be medically necessary for this patient.

**Defining medical necessity.** MCOs define medical necessity as medical care that will measurably improve a patient’s outcome and define the optimal amount of care as the minimum amount of health care necessary to resolve a health problem.<sup>54</sup> The underlying

<sup>47</sup> Hirshfeld & Thomason, *supra* note 21, at 41.

<sup>48</sup> *Id.*

<sup>49</sup> *Id.* at 42.

<sup>50</sup> Harold J. Bursztajn & Archie Brodsky, *Responsibility Without Scapegoating*, HEALTH DECISIONS, A PUBLICATION OF THE VERMONT ETHICS NETWORK, May 1997, available at <http://www.forensic-psych.com/articles/artScapegoat.html> (last visited Nov. 13, 2005) (proposing that the physician, patient, and MCO each have responsibilities flowing from their authority, and that imposing responsibility without authority is unethical, opportunistic, and leads to the erosion of professional standards).

<sup>51</sup> JACOBSON, *supra* note 1, at 127 (discussing the advantages and disadvantages of managed care).

<sup>52</sup> See *infra* notes 134–35 and accompanying text.

<sup>53</sup> See Peter D. Fox, *Prescription Drug Benefits: Cost Management Issues for Medicare*, 25 HEALTH CARE FINANCING REV. 7, 16–18 (2004) (noting that the authorization process may be prior, concurrent, or retrospective).

<sup>54</sup> PETER R. KONGSTVEDT, THE MANAGED CARE HANDBOOK 180 (Peter R. Kongstvedt ed., 1993) noted in Hirshfeld & Thomason, *supra* note 21, at 21. However, The American Medical Association defines medical necessity more broadly:

rationale for this definition is that if the care will not measurably help the patient, then providing the care harms the patient by exposing him to potential negative treatment side effects.<sup>55</sup> MCOs define medical necessity determination as a process that protects patients from these potential negative effects.<sup>56</sup>

The problems with this definition and rationale stem from inherent difficulties in attempting to define what care is unnecessary. For example, investigations into the medical necessity determination make several fairly narrow inferences.<sup>57</sup> Trying to further verify what constitutes unnecessary care, later studies compared the medical records of patients getting specific treatments against a symptom list thought to indicate when those specific treatments were actually warranted.<sup>58</sup> Because some of the patients getting the specific treatments did not have the listed symptoms, their care was deemed unnecessary.<sup>59</sup>

Such investigations led the current movement of developing practice guidelines that physicians use to deliver effective care and eliminate unnecessary care.<sup>60</sup> Practice guidelines are usually created by sophisticated evidence-based medicine which meta-analyzes physician practice and research studies. However, a practice guideline is created to help physicians treat *populations* and cannot ever

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Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) Clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.

AM. MED. ASS'N, H-320.953 Definitions of "Screening" and "Medical Necessity", [http://www.amaassn.org/apps/pf\\_new/pf\\_online?f\\_n=browse&doc=policyfiles/HnE/H-320.953.HTM](http://www.amaassn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/H-320.953.HTM) (last visited Feb. 27, 2006).

<sup>55</sup> *Id.* at 21–22 (commenting that the way MCOs define necessity “is based upon fiction”).

<sup>56</sup> *Id.* at 22.

<sup>57</sup> First, investigators assumed that if two populations receiving medical services at different rates had no difference in health, then some of the care received by the group getting more care was excessive and unnecessary. Second, they inferred the difference in care volume between the populations was significant. *Id.* at 18.

<sup>58</sup> Constance M. Winslow et al., *The Appropriateness of Performing Coronary Artery Bypass Surgery*, 260 JAMA 505, 507 (1988); Thomas B. Graboy et al., *Results of a Second Opinion Program for Coronary Artery Bypass Graft Surgery*, 258 JAMA 1611, 1614 (1987), as cited by Hirshfeld & Thomason, *supra* note 21, at n. 57, as examples of studies finding that unnecessary procedures were performed.

<sup>59</sup> *Id.*

<sup>60</sup> Hirshfeld & Thomason, *supra* note 21, at 19–20 (noting that practice guidelines are supposed to be easy to disseminate and use).

completely account for individual variability in illness and treatment response. Nor can individual variability be fully accounted for in the medical necessity investigations described above.<sup>61</sup> Because individual variability exists, an individual can still be harmed by care provision or care denial, regardless of whether the care has been defined by the MCO as necessary or unnecessary.

**Damage from treatment denial constitutes a spectrum.** There is a range of potential damages a patient may suffer from treatment denial. That range can be divided into four levels for illustrative purposes. In the first and least severe level, treatment denial may result in a patient requiring costlier care. However, if he remains physically able to work, retains his insurance (or secures new insurance), and insurance covers the more expensive care, then the patient's economic impact may be minimal.

In the second level, if he is damaged so that he cannot continue to work, he will at minimum suffer reduced income. However, he might, if financially able, maintain his health care benefits through COBRA.<sup>62</sup> Because the patient/employee now pays the entire premium, his monthly cost becomes many times greater.

In the third level, if the patient cannot afford COBRA, he must rely on Medicaid care provided through his state. However, eligibility for these programs is much more limited than is commonly assumed.<sup>63</sup> In Texas for example, an individual is not eligible for Medicaid benefits unless he has dependent children *and* a family income at or below 17% of the family poverty level, *or* receives supplemental social security.<sup>64</sup> Thus, “[n]on-elderly, nonpregnant, childless adults . . . are not eligible for Medicaid in Texas, regardless of their degree of impoverishment or medical need.”<sup>65</sup>

In the fourth level, a patient who loses insurance, is not eligible for Medicaid, and cannot afford to pay privately will probably seek

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<sup>61</sup> *Id.* at 20–21.

<sup>62</sup> COBRA stands for Consolidated Omnibus Budget Reconciliation Act. 26 U.S.C. § 4980. It was enacted in 1958 to allow employees to continue their health benefits post-employment if the employee takes over the full cost of the premiums and associated fees.

<sup>63</sup> See Catherine Hoffman et al., *Holes in the Health Insurance System: Who Lacks Coverage and Why*, 32 J.L. MED. & ETHICS 390, 392 (2004) (stating that single adults as well as childless couples do not generally qualify for Medicaid unless they are pregnant or disabled, *regardless of how poor they are*) (emphasis added).

<sup>64</sup> Hermer & Winslade, *supra* note 17, at 53–54.

<sup>65</sup> *Id.* at 54, *citing* Anne Dunkelberg, MEDICAID AND STATE BUDGETS: A CASE STUDY OF TEXAS 15-16 (2002), available at <http://www.kff.org> (last visited Nov. 11, 2005).

his care in the emergency room.<sup>66</sup> This combination results in both a drastic cost increase and cost shift, due to a number of factors. First, a physician consultation in the emergency room is much more expensive than a physician consultation in an outpatient context.<sup>67</sup> Additionally, if the patient has been out of the stream of regular medical care (because he lacks insurance or Medicaid services) his medical condition at this point is likely to be either more complicated or deteriorated.<sup>68</sup> Finally, care previously compensated under the employee-sponsored health care plan is now paid for either by the patient (if he can afford it), by the hospital, by the state, by the public health-care system, or by the local municipalities and taxpayers.

Thus it often falls on the state to fund care for patients who are damaged by treatment denials, who have lost their insurance, and yet are not Medicaid eligible.<sup>69</sup> However, even when the federal government finances health care through safety nets such as Medi-

<sup>66</sup> PETER J. CUNNINGHAM & JESSICA H. MAY, CTR. FOR STUDYING HEALTH CARE CHANGE, ISSUE BRIEF NO. 70: INSURED AMERICANS DRIVE SURGE IN EMERGENCY DEPARTMENT VISITS (2003), <http://www.hschange.org/CONTENT/613> (last visited Oct. 28, 2005) (noting uninsured patients rely on emergency departments for one-fourth of their ambulatory care visits, the uninsured use emergency departments for usual care, and emergency departments are one of the few remaining primary care options for the uninsured).

Note also that receiving non-emergency care in the emergency department is a best-case scenario for patients described by the fourth level. Since the advent of the 1985 Emergency Medical Treatment and Active Labor Act (EMTALA), emergency departments are obligated to render appropriate medical screening, but if no emergency condition is present they are not obligated to treat the patient. 42 U.S.C. § 1395dd(a) (1985).

<sup>67</sup> Because emergency rooms must prepare for any eventuality, they are staffed and credentialed at a higher level than a primary care office. Additionally, emergency rooms require medications, supplies, and equipment not needed in non-emergent care. These elements, while costly in their own right, also add additional overhead and insurance expenses. For these reasons, the care rendered during a thirty minute ambulatory care consultation in an emergency room is much more expensive than is the same interaction in a primary care office. See Paul A. Taheri et al., *The Cost of Trauma Center Readiness*, 187 AM. J. OF SURGERY 7, 7–8 (2004) (explaining the multiple clinical and equipment requirements for staffing a trauma department, and noting that the full cost of this “readiness” is often not recaptured, even if billed); but see Johnathan Showstack, *The Costs of Providing Nonurgent Care in Emergency Departments*, 45 ANNALS OF EMERGENCY MED. 493, 493–94 (noting that studies to determine the true cost of non-emergent care provided by emergency rooms have produced conflicting results, due in part to varied procedures between hospitals regarding such topics as: defining varied and fixed costs, allocating costs among departments, and the degree to which they are willing to adjust their semi-variable costs).

<sup>68</sup> See generally James Hadley, *Sicker and Poorer—the Consequences of Being Uninsured*, 60 MED. CARE RES. & REV. 76S (2003).

<sup>69</sup> For example, state and local funds financed 38% of uncompensated care costs for National Association of Public Hospitals and Health Systems member hospitals in 2001. I. SINGER ET AL., NAT’L ASSOC. OF PUB. HOSPITALS & HEALTH SYSTEMS, AMERICA’S SAFETY NET HOSPITALS AND HEALTH SYSTEMS, 2001: RESULTS OF THE 2001 ANNUAL NAPH MEMBER SURVEY 6,

caid, the financing is actually shared among various levels of government in a fragmented and varying manner.<sup>70</sup> This loose amalgam often precludes access to a defined benefit package and does not guarantee provider reimbursement for treating the uninsured.<sup>71</sup> This cost shift negatively impacts the local health-care economy, health-care workers, and health-care consumers.<sup>72</sup> It would seem that concern about preventing both the cost shift and negative impact upon the localities' health care economy, health care workers, and health-care consumers gives states a legitimate interest in defining and enforcing the benefits and remedies between a patient and his employee-sponsored health-care plan.

**B. Holding MCOs Accountable for Denying Treatment; Contrasting Liability Under ERISA and State Law**

This section examines ERISA's foundation, purpose, and effect, and then contrasts ERISA with a state-law liability statute, the THLCA.<sup>73</sup>

fig. 7 (2003), noted in Bruce Siegal et al., *Health Reform and the Safety Net: Big Opportunities; Major Risks*, 32 J.L. & MED. ETHICS 426, 427 n.32 (2004).

<sup>70</sup> See INST. OF MED., AMERICA'S HEALTH CARE SAFETY NET: INTACT BUT ENDANGERED 4, 7 (2000) (describing the health system safety net as a patchwork of institutions with high local variability).

<sup>71</sup> *Id.* at 24 (stating that many safety-net treatment providers (such as private physicians, academic medical centers, and charity hospitals) are not reimbursed for treating the uninsured).

<sup>72</sup> See Patricia Hopperdietzel, *The Uninsured in Texas: Texas State House Bill 3122; A Beginning*, 15, 22-23 (Spring 2004) (unpublished manuscript, on file with author). Cascading effects result when hospitals assume losses from patients who cannot pay; the hospitals pass these losses on to other consumers who can pay, or reduce operating costs; operating-cost reduction usually causes smaller wages and employee benefits, reduced staff size, and may even lead to the hospital employee becoming unemployed and losing their health insurance benefits; hospitals may need to increase the price of their services to offset their loss from non-paying patients; and as the price of care rises, insurance premiums paid by health consumers rise as well. *Id.*

In 2004, the State of Maine estimated that 16% of premium costs were attributed to shifting bad debt and charity costs to private payers. DIRIGO HEALTH, HELP IS ON THE WAY!, [http://www.maine.gov/governor/baldacci/healthpolicy/dirigo\\_brochure1\\_web.pdf](http://www.maine.gov/governor/baldacci/healthpolicy/dirigo_brochure1_web.pdf) (last visited May 13, 2004), as cited by Hopperdietzel, at 22. A visit to this site on Feb. 16, 2004 revealed that bad debt and charity cost Maine \$275 million in 2001.

Texas physicians wrote off bad debt in excess of one billion dollars in 1998. *Stripped Down Tax Bill Goes to Senate*, 6 TEX. MED. ASS'N EVPGRAM, <http://www.texmed.org/avantgo/evpgram.htm> (last visited Nov. 11, 2005), noted in Hopperdietzel, at 22.

Private hospital bad debt reports for Texas in 1998 were two billion dollars. CHARITY CHARGES AND SELECTED FINANCIAL DATA FOR TEXAS ACUTE CARE HOSPITALS, available at <http://www.tdh.state.tx.us/dpa/survey/CHAR2001.PDF>, reported in Hopperdietzel.

<sup>73</sup> Texas Health Care Liability Act, TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-88.003 [Supp. Pamphlet].

ERISA's regulation of health care insurance and delivery began thirty years ago.<sup>74</sup> ERISA was prompted by concern about employer-sponsored pension plans,<sup>75</sup> but now also covers employer-sponsored health-care benefit plans. Commentators argue that including health-care benefits under ERISA was not a primary congressional purpose, but rather an afterthought.<sup>76</sup> However, ERISA *has* encouraged employers, especially those with employees in several states, to provide health benefits. The federal government also encourages employers to provide health-care benefits to their employees by giving tax incentives to the employers: employers may exclude their contribution toward employee health benefits from normal payroll taxes. Before ERISA, states widely regulated health care.<sup>77</sup> Post-ERISA, state regulation became narrower.

The Supreme Court has interpreted the ERISA preemption provision's<sup>78</sup> purpose as insuring "that the administrative practices concerning employee benefit plans will be governed by a uniform body of benefit law, in order to minimize employers' administrative and financial burden of complying with conflicting directives among states or between states and the Federal Government."<sup>79</sup>

<sup>74</sup> 29 U.S.C. § 1001 (2005).

<sup>75</sup> JACOBSON, *supra* note 1, at 132 (noting that due to pension plan abuses and loss of employee benefits, ERISA sought to move regulation of the programs from the states to the federal government and establish uniform national standards to both protect employees and encourage employers to offer the benefits).

<sup>76</sup> Congress did not evaluate the consequences of using the same statute to regulate both health and pension plans, furthermore, specific pension plan requirements are not generally applicable to health care. *Id.* In stating the problems prompting the bill, Congress never identified health benefit problems. *Id.* Therefore, ERISA lacks an adequate framework for governing health benefits. *Id.*; see also David G. Savage, *High Court Limits Right to Sue HMOs: A 30-year-old Law Blocks State Suits Against Insurers, Justices Say. The 9-0 Ruling Affects 130 Million in the U.S. and Reignites Calls For a Patients Bill of Rights*, L.A. TIMES, June 22, 2004, at A1 (commenting that ERISA was originally hailed by pension reformers, but as applied to medical benefits has had "unintended and unforeseen consequences").

<sup>77</sup> See Lorraine Schmall & Brenda Stephens, *ERISA Preemption: A Move Towards Defederalizing Claims for Patients' Rights*, 42 BRANDEIS L. J. 529, 532-33 (2004) (listing state regulations which follow health care history; starting with laws creating contract rules and defining duties, continuing through current state laws mandating independent benefit-denial reviews, increasing suit grounds, capping premium rates, and creating disincentives for denying coverage to sick people).

<sup>78</sup> 29 U.S.C. § 144 (2005).

<sup>79</sup> *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 2211, 2216 (1987) (determining that preemption provision insures a single set of regulations governs benefit plan's administration. Varied and conflicting state law regulations would make providing benefit plans more difficult and inefficient, and the Court worried employers would react by offering fewer benefits); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990) (stating § 1144(a) ensures a uniform body of law to minimize administrative and financial burdens of complying with conflicting state rules); *but see* New York State Conference of Blue Cross & Blue

Concern about the impact of expensive and conflicting state regulation on American industry's global competitiveness motivated Congress to create a uniform structure for employee benefit plans offered by companies participating in interstate commerce.<sup>80</sup> However, some members of Congress involved in the *Davila* case take a more restricted view of preemption and of ERISA's purpose.<sup>81</sup> They argue that "Congress was predominantly focused on establishing minimum standards to protect pension promises made to millions of workers and their families, Congress did not intend for [the law's] pension standards to be interpreted by the courts as preempting state health care laws."<sup>82</sup>

ERISA's preemptive effect over state law relating to employee benefit plans arises from three provisions. First, the superseding clause<sup>83</sup> states ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ."<sup>84</sup> Then, the "savings" clause leaves laws regulating insurance, banking, and securities to the states.<sup>85</sup> However, the "deemer"<sup>86</sup> clause announces that employee benefit plans are not considered to fall under state laws that regulate insurance.<sup>87</sup>

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Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 661 (1995) (stating nothing in ERISA's language or its passage's context indicate Congress chose to displace general health care regulation, which historically has been a matter of local concern).

<sup>80</sup> BRYAN A. LIANG, HEALTH LAW & POLICY: A SURVIVAL GUIDE TO MEDICOLEGAL ISSUES FOR PRACTITIONERS 76 (2000) (introducing the topic of federal regulation of insurance).

<sup>81</sup> John A. MacDonald, *Patients' Rights to Sue at Stake*, HARTFORD COURANT, Mar. 21, 2004, at A1.

<sup>82</sup> *Id.*

<sup>83</sup> 29 U.S.C. § 1144(a) (2005).

<sup>84</sup> See HEALTH CARE CORPORATE LAW: FORMATION AND REGULATION 8-29 (Mark A. Hall ed., 1993) (noting that because of the United States Constitution's Supremacy Clause, federal statutes already preempt conflicting state and local law and that Congress went much further by specifically including this language in ERISA).

<sup>85</sup> 29 U.S.C. § 1144(b)(2)(A) (2005).

<sup>86</sup> Called the "deemer" clause due to the section's language:

Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

<sup>87</sup> 29 U.S.C. § 1144(b)(2)(B) (2005). This section essentially means that employer-sponsored benefit plans cannot be defined by the state as insurance in an effort to avoid ERISA's federal regulation/preemption.

<sup>87</sup> 29 U.S.C. § 1144 (2005).



In contrast to the liability protection ERISA affords MCOs, Texas<sup>88</sup> and thirteen other states currently have laws allowing patients to sue their MCOs for wrongful treatment denial.<sup>89</sup> The 1997 THCLA provides patients a right to seek damages from their MCO, stating an MCO “has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured . . . proximately caused by [the MCO’s] failure to exercise such ordinary care.”<sup>90</sup> The THLCA passed during George W. Bush’s first gubernatorial term.<sup>91</sup> While governor, and later as president, Bush variously opposed *and* took credit for THLCA.<sup>92</sup>

### C. The Federal Judicial Environment Pre-Davila

The Supreme Court’s position on preemption began strongly, but in the last decade some federal and state cases seemed to indicate the Court might view ERISA preemption as less than absolute.<sup>93</sup> We focus here on three selected Supreme Court cases and two selected federal cases.<sup>94</sup> These cases suggested the federal judiciary, pre-Davila, viewed ERISA preemption less strictly.<sup>95</sup>

<sup>88</sup> Texas Health Care Liability Act, TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-88.003 [Supp. Pamphlet].

<sup>89</sup> Clifford, *supra* note 5.

<sup>90</sup> Texas Health Care Liability Act §§ 88.001-88.003, *see supra* note 73.

<sup>91</sup> Bush was originally opposed to the bill. Editorial, *Only Congress Can Fill HMO Abuse Prescription*, PALM BEACH POST, June 24, 2004, at A16.

<sup>92</sup> Bush vetoed the bill in 1995. *Id.* In 1997 THLCA passed without Bush’s signature. *Id.* He took credit for the bill during his 2000 presidential campaign. *Id.*; *see also* Patty Reinert, *Court Ruling Favors HMOs; Patients Can’t Seek Damages At State Court Level*, HOUS. CHRON., June 22, 2004, at A1 (stating Bush “bragged about the 1997 Texas law, the first in country to allow patients to sue in state courts, where they could collect damages for lost wages, pain and suffering.”); Savage, *supra* note 76, at A1 (quoting Bush, in an October 2000 presidential debate, as he referred to the THCLA, “That’s what I’ve done in Texas, and that’s the kind of leadership style I’ll bring to Washington.”); Linda Greenhouse, *Justices Hear Arguments About H.M.O. Malpractice Lawsuits*, N.Y. TIMES, June 22, 2004, at A1.

During the campaign Bush pledged to push for similar patient rights nationally. Reinert, *supra* note 92, at A1. (quoting Bush at an October 2000 presidential debate, “If I’m president, people will be able to take their HMO insurance company to court”); Charles Lane, *Justices Limit Suits Against HMOs: State Patients’ Rights Laws Struck Down*, WASH. POST, June 22, 2004, at A1 (reporting same).

<sup>93</sup> Schmall & Stephens, *supra* note 77, at 558 (outlining and discussing the evolution of the Court’s stance in the section entitled *Supreme Court Evolves from Complete Preemption to Maybe, Maybe Not*).

<sup>94</sup> N.Y. State Conference of Blue Cross & Blue Shield v. Travelers Ins. Co., 514 U.S. 645 (1995); Pegram v. Herdrich, 530 U.S. 211 (2000); Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002); Roark v. Humana, 307 F.3d 298 (5th Cir. 2002); Cicio v. Vytra Healthcare, 321 F.3d 83 (2nd Cir. 2003).

<sup>95</sup> *Id.*

First, in their unanimous 1995 decision *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*<sup>96</sup> the Court noted, “nothing in the language of the act [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern.”<sup>97</sup>

Second, in 2000, the Court in *Pegram v. Herdrich* held that only claims based on “pure eligibility decisions”<sup>98</sup> are preempted.<sup>99</sup> The *Pegram* ruling implied that when an HMO-employed treating physician simultaneously makes a treatment decision and an eligibility decision the result is considered a “mixed”<sup>100</sup> decision.<sup>101</sup> Such mixed decisions can properly be litigated in state court because they are not fiduciary acts.<sup>102</sup> In state court the plaintiff can sue for consequential damages. The Court also implied support for stronger state regulation in the health care area.<sup>103</sup> Later state-court case outcomes were based on these implications.<sup>104</sup>

One scholar commented that, in 1997, it seemed “even an ardent textualist like Justice Scalia” may support judicial efforts to rein in the preemptive provision’s interpretation.<sup>105</sup> However, in *Davila*,

<sup>96</sup> *Blue Cross & Blue Shield*, 514 U.S. 645 (1995).

<sup>97</sup> *Id.* at 661.

<sup>98</sup> A pure eligibility decision is one relating exclusively to plan benefits. See Hirshfeld, *supra* note 21 (explaining the difference between a treatment decision and a coverage decision).

<sup>99</sup> *Pegram v. Herdrich*, 530 U.S. 211, 228 (2000).

<sup>100</sup> A “mixed” decision involves considering patient’s medical status and prognosis to decide if he will receive a particular benefit. See *id.*

<sup>101</sup> *Pegram*, 530 U.S. at 230–31.

<sup>102</sup> *Id.* at 234.

<sup>103</sup> *Id.* at 237 (stating “in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose”).

<sup>104</sup> See *Miller v. HealthAmerica Pa. Inc.*, 50 Pa. D. & C.4th 1, 26 (2000) (discussing *Pegram*, the court stated, “[t]he logical conclusion, then, is that the U.S. Supreme Court does not intend such ‘mixed’ claims against an HMO to be preempted by ERISA.”); see *Villazon v. Prudential Health Care Plan*, 843 So. 2d 842, 850 (Fla. 2003) (noting while discussing the plaintiff’s claim, “*Pegram* instructs that an HMO’s mixed eligibility and treatment decision implicates a state law claim for medical malpractice, not an ERISA cause of action for fiduciary breach. Thus, if [plaintiff’s] third party claim against U.S. Healthcare arose out of a mixed decision, it is, according to *Pegram*, subject to state medical malpractice law, which is what [plaintiff] asserted.”); see *Pappas v. Asbel*, 564 Pa. 407, 420 (2001) (characterizing the HMO physician’s decision as “a mixed eligibility and treatment decision, the adverse consequences of which, if any, are properly redressed, as *Pegram* teaches, through state medical malpractice law”).

<sup>105</sup> Justice Scalia has endorsed the Court’s efforts to narrow ERISA’s preemptive scope beyond what its plain meaning might suggest, stating that the “statutory text provides an illusory [preemption] test, unless the Court is willing to decree a degree of preemption that no sensible person could have intended.” Theodore W. Ruger, *The United State’s Su-*

the court narrowed this implication considerably by stating that *Pegram* “cannot be read so broadly.”<sup>106</sup>

Third, in 2002 in *Rush Prudential HMO, Inc. v Moran*<sup>107</sup> the Court held five to four that when a dispute arises over a medical treatment or a drug benefit, MCOs can be forced to comply with a state law that gives patients a right to an independent review by outside doctors.<sup>108</sup> At issue was an Illinois statute entitling plan participants to independent review on procedures that their MCO deemed medically unnecessary.<sup>109</sup> The *Rush* Court reasoned an independent review by outside doctors to resolve a dispute over medical treatment or drug benefit is more like insurance regulation, and insurance regulation traditionally has been a state domain.<sup>110</sup> Several federal circuits later cited *Moran* when advocating using state law to resolve disputes about medical necessity.<sup>111</sup>

Fourth, in *Roark v. Humana*<sup>112</sup> the Fifth Circuit Court of Appeals in New Orleans held that ERISA 502(a)(2) (the preemption provision) did not completely preempt the plaintiffs’ state-law claims of malpractice against the plaintiffs’ MCOs.<sup>113</sup> The cases were remanded to state court. The Fifth Circuit Court of Appeals based its holding on the United States Supreme Court’s *Pegram* decision; only claims based on pure eligibility decisions are preempted by ERISA. The Fifth Circuit also cited to *Pegram* dicta: “ERISA should not be interpreted to preempt state malpractice laws or create a federal common law of medical malpractice.”<sup>114</sup>

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*preme Court and Health Law: The Year in Review*, 32 J.L. MED. ETHICS 528, 529 (2004) (citing Cal. Div. Of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc., 519 U.S. 316, 335 (1997) (Scalia, J., concurring)).

<sup>106</sup> *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 218 (2004).

<sup>107</sup> *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002).

<sup>108</sup> *Id.* at 386–87.

<sup>109</sup> *Id.* at 361.

<sup>110</sup> *Id.* at 387.

<sup>111</sup> *Roark v. Humana, Inc.*, 307 F.3d 298, 310 (5th Cir. 2002); *Corp. Health Ins., Inc. v. Tex. Dep’t of Ins.*, 314 F.3d 784, 785 (5th Cir. 2002); *Cicio v. Does*, 321 F.3d 83, 99 (2nd Cir. 2003) (vacated and remanded by *Vytra Healthcare v. Cicio*, 124 S.Ct. 2902 in light of *Davila*).

<sup>112</sup> *Roark*, 307 F.3d 298 (2002).

<sup>113</sup> The *Roark* case consolidated Mr. Davila and Mrs. Calad’s suits along with those of two other plaintiffs. *Id.* at 302.

<sup>114</sup> *Id.* at 311 (citing *Pegram*, 530 U.S. at 236–37).

Finally, in *Cicio*<sup>115</sup> the Second Circuit Court of Appeals relied on the “mixed eligibility” category from *Pegram*<sup>116</sup> and held that an HMO whose medical director’s refusal to authorize a medical procedure in a timely manner is subject to state-law claims.<sup>117</sup>

As of March 2004 the federal circuits were split.<sup>118</sup> The 2nd, 5th, and 11th circuits held ERISA did not preempt state law claims against MCOs for negligence or medical malpractice, while the 1st, 3rd, and 4th, circuits ruled otherwise.<sup>119</sup>

## II. THE DAVILA CASE

### A. Facts

*Davila* was a combination of two cases.<sup>120</sup> Plaintiffs in each case sued their MCOs under the THCLA<sup>121</sup> for deciding not to cover treatment that the plaintiffs’ personal physicians recommended.<sup>122</sup>

<sup>115</sup> *Cicio v. Does*, 321 F.3d 83, 105–06 (2nd Cir. 2003).

<sup>116</sup> See *Pegram v. Herdrich*, 530 U.S. 211, 252 (2000). This was a “mixed” decision under the *Pegram* analysis as follows: Disallowing the treatment because it was considered experimental by the decision maker was a benefits decision (pertaining to whether the plan provided for experimental treatment); disallowing the treatment as not medically necessary was a treatment decision (because it was based upon the patient’s medical condition and whether the decision-maker thought the patient could benefit from the requested treatment). *Id.*

<sup>117</sup> In *Cicio*, the plaintiff’s spouse suffered from multiple myeloma, a particular form of blood cancer. His treating physician requested that the patient’s MCO approve a particular combination of chemotherapy and stem cell transplant that the physician judged (taking into account the patient’s symptoms and response to previous treatment) to be especially needed and time-urgent. Denying the suggested treatment, the MCO offered an alternate treatment, but by the time the MCO processed the request (three weeks), the patient was past the point that he could benefit from the alternate treatment and died. However, after *Davila*, the U.S. Supreme Court granted certiorari, vacated the judgment and remanded the case to the Second Circuit to consider in light of *Davila*. *Cicio*, 321 U.S. at 87–88.

<sup>118</sup> Marcia Coyle, *HMO Liability: U.S. Supreme Court Hears Arguments This Month on ‘Key Issue’ of Health Plan Responsibility Under State Laws*, PALM BEACH DAILY BUS. REV., Mar. 4, 2004 at 9.

<sup>119</sup> Cases holding ERISA did not preempt state law claims against MCOs for negligence or medical malpractice were: *Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003); *Roark v. Humana*, 307 F.3d 298 (5th Cir. 2002); and *Land v. CIGNA Healthcare*, 339 F.3d 1286 (11th Cir. 2003). Cases holding ERISA did preempt state law claims were: *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49 (D. Mass. 1997); *DiFelice v. Aetna U.S. Health Care*, 346 F.3d 442 (3d Cir. 2003); and *Marks v. Watters*, 322 F.3d 316 (4th Cir. 2003).

<sup>120</sup> The U.S. Supreme Court combined *Davila*’s and *Calad*’s cases on certiorari. *Aetna Health, Inc. v. Davila*, 542 U.S. 200 (2004); see *Procedure* discussion *infra*.

<sup>121</sup> See *Roark v. Humana, Inc.*, 307 F.3d 298, 302–03 (5th Cir. 2002).

<sup>122</sup> *Id.*

Both plaintiffs alleged that refusing to cover the recommended treatment breached the MCO's THCLA duty of care.<sup>123</sup>

In *Calad*, the plaintiff had health care benefits through CIGNA. During the plaintiff's recovery from surgery,<sup>124</sup> her MCO physician recommended her hospital stay be extended.<sup>125</sup> A CIGNA discharge nurse determined that the extension was unnecessary and discharged Ms. Calad from the hospital after one day.<sup>126</sup> Once home, Ms. Calad suffered post-surgical complications and required emergency room care.<sup>127</sup>

In *Davila*, the plaintiff suffered simultaneously from post-polio syndrome, diabetes, gastric ulcer disease, and arthritis.<sup>128</sup> Juan Davila had Aetna HMO coverage through his employer's health care benefits plan. Davila's independent physician (not employed by Aetna) prescribed Vioxx,<sup>129</sup> a cox-2 inhibitor anti-inflammatory oral medication,<sup>130</sup> to treat Davila's severe arthritis.<sup>131</sup> Davila's physician chose Vioxx because anti-inflammatories without cox-2 properties are known to aggravate gastric problems.<sup>132</sup> However, Aetna required Davila to first try two less expensive<sup>133</sup> medications before

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<sup>123</sup> *Id.*

<sup>124</sup> Calad's multiple same day surgical procedures included: hysterectomy, rectal repair, bladder repair, and vaginal repair. *Id.* at 303.

<sup>125</sup> *Id.*

<sup>126</sup> *Roark*, 307 F.3d at 303.

<sup>127</sup> *Id.*

<sup>128</sup> *Id.*

<sup>129</sup> Merck & Co., Inc. manufactured Vioxx (generic name rofecoxib). In its information sheet under "Indications and Usage" the top two entries indicate its use for two types of arthritis, with recommended starting dosage of 12.5 and maximum daily dose at 25 milligrams. MERCK & CO., INC., VIOXX PRESCRIBING INFORMATION 9 (2004), available at [http://www.vioxx.com/vioxx/documents/english/vioxx\\_pi.pdf](http://www.vioxx.com/vioxx/documents/english/vioxx_pi.pdf) (last visited Nov. 11, 2005).

This prescription took place well before the Fall 2004 publicized links between Vioxx and heart attack, the ensuing negative press, and subsequent investigation of Merck.

<sup>130</sup> *Id.*

<sup>131</sup> Davila also suffered from post-polio syndrome, diabetes and gastric ulcer disease. *Roark v. Humana, Inc.*, 307 F.3d 298, 303 (5th Cir. 2002).

<sup>132</sup> Conversely, Vioxx, because it is a cox-2 inhibitor, has fewer negative effects on the gastric system. *Id.*

<sup>133</sup> Such a plan is called step therapy and involves starting the patient on less expensive (or in some cases less powerful) medications; monitoring to see how the medication affects symptoms; and if the patient does not improve, continuing on to the more expensive or more powerful treatments. Brenda R. Motheral et al., *Plan-Sponsor Savings and Member Experience With Point-of-Service Prescription Step Therapy*, 10 AM. J. OF MANAGED CARE 457, 457 (2004). The Pharmaceutical Care Management Association, the national association representing America's pharmacy benefit managers (PBMs) who "administer prescription drug plans for more than 200 million Americans with prescription drug coverage provided through the nation's small and large employers, Taft-Hartley union plans, health

Aetna would cover Vioxx.<sup>134</sup> After three weeks on the other medication, Davila sustained bleeding ulcers, severe internal bleeding, and a near heart attack.<sup>135</sup> He was rushed to the emergency room for treatment, spent five days in critical care, and required seven units of blood.<sup>136</sup> Because of his further gastric damage, he can no longer take medication absorbed through the stomach.<sup>137</sup>

## B. Procedure

Both Davila and Calad filed suits in Texas state court under THCLA alleging: 1) their MCOs failed the “duty to exercise ordinary care when making health care treatment decisions,”<sup>138</sup> and 2) this failure led to their injuries.<sup>139</sup> Aetna removed the cases to federal district court on the basis of ERISA preemption.<sup>140</sup> Davila and Calad failed to amend their complaints to include an ERISA claim.<sup>141</sup> The federal district court dismissed Davila and Calad’s claims with prejudice.<sup>142</sup> Davila and Calad’s cases were combined, they appealed the dismissal, and the Fifth Circuit Court of Appeals reversed the federal district court, remanding the case to state court.<sup>143</sup> The Fifth Circuit Court of Appeals held that the THCLA claims were not completely preempted by ERISA section 502(a) because the MCO’s decisions were treatment decisions, rather than eligibility or contract decisions.<sup>144</sup> Under Texas law, treatment decisions

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insurers, state and federal-employee benefit plans and state Medicaid plans” characterize step therapy as a well-established principle and a common-sense approach to using “scarce health care resources most effectively.” Press Release, PHARMACEUTICAL CARE MGMT. ASSOC., *U.S. Supreme Court Ruling Preserves Employers’ Ability to Design Affordable Quality Prescription Drug Plans* (June, 21, 2004) (on file with author).

<sup>134</sup> *Roark*, 307 F.3d at 303.

<sup>135</sup> *Id.*

<sup>136</sup> *Id.*

<sup>137</sup> *Id.*; see also Polly Ross Hughes, *High Court To Consider Texas Law On HMOs*, HOUS. CHRON., Nov. 4, 2004, at A15 (“Davila says he can no longer take pain medications absorbed through the stomach.”).

<sup>138</sup> THCLA § 88.002[a].

<sup>139</sup> *Aetna Health, Inc. v. Davila*, 452 U.S. 200 (2004).

<sup>140</sup> See *supra* notes 83–87 and associated text.

<sup>141</sup> *Roark v. Humana, Inc.*, 307 F.3d 298, 304 (5th Cir. 2002).

<sup>142</sup> *Id.*

<sup>143</sup> *Id.* at 315.

<sup>144</sup> *Id.*

can be challenged in state court.<sup>145</sup> Under federal law, eligibility decisions can be challenged only in federal court.<sup>146</sup>

### C. The Fifth Circuit's Analysis

After stating that ERISA preempts plaintiffs' state-law claims that duplicate or fall under a 502(a) remedy, the Fifth Circuit Court of Appeals made two inquiries.<sup>147</sup> First, it asked whether the claims fall under ERISA 502(a)(1)(B) because the plaintiffs requested recovery for a benefit denial that constituted a breach of contract.<sup>148</sup> The court answered "no" because the plaintiff did not pursue reimbursement for treatment; rather, the plaintiffs sought tort damages caused by breach of a duty of care.<sup>149</sup> Second, the court asked whether the plaintiffs' claims were ERISA 502(a)(2) claims for damages due to breach of a fiduciary duty.<sup>150</sup> The court answered "no" because the decision (not paying for the treatment) was not solely a fiduciary decision, but rather a "mixed" eligibility and treatment decision.<sup>151</sup> The court then stated that it interprets ERISA to not preempt state-law claims regarding decisions that are "mixed" treatment and eligibility. The court then concluded that because the plaintiffs' cause of action does not duplicate a cause of action allowed under ERISA, the cause of action falls outside ERISA and should be allowed to proceed in state court.<sup>152</sup>

## III. ANALYSIS

Even before *Davila*, commentators and judges decried ERISA's constraints and complained about complex legal opinions produced by tortured reasoning.<sup>153</sup> Others criticized the inexplicably absurd distinctions and case outcomes.<sup>154</sup> The court in *Andrews-Clarke v.*

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<sup>145</sup> *Id.*

<sup>146</sup> *Roark*, 307 F.3d at 315.

<sup>147</sup> *Id.*

<sup>148</sup> *Id.*

<sup>149</sup> *Id.*

<sup>150</sup> *Id.*

<sup>151</sup> *Roark*, 307 F.3d at 315.

<sup>152</sup> *Id.*

<sup>153</sup> JACOBSON, *supra* note 1, at 152 (describing the backlash against perceived injustices occurring under ERISA preemption).

<sup>154</sup> *Id.*

*Travelers Ins. Co.* expressed its frustration in the quotation set out in this comment's introduction.<sup>155</sup>

### A. Overview of *Davila* Decision

The *Davila* decision was unanimous, with Justice Clarence Thomas authoring the opinion.<sup>156</sup> Justice Ruth Bader Ginsberg wrote the concurrence, joined by Justice Stephen Breyer.<sup>157</sup> The Court framed the issue as whether patients of ERISA-covered group health plans whose MCOs refuse to pay for physician-recommended treatment may sue the plan under a state law that makes MCOs liable for failing to exercise ordinary care in making and reviewing treatment decisions.<sup>158</sup> The Court held that the patients could not bring their suits under state law because the claims were completely preempted by ERISA.<sup>159</sup> Overall, the Court did not view these patients' allegations as a tort claim, but instead as a claim for denial of promised benefits.<sup>160</sup> The Court pointed out that the ERISA statute is one of the exceptions to the well-pleaded complaint rule.<sup>161</sup> As a result of that exception, even though a state-law cause of action is plead, the claim (through preemption) is considered to be actually based in federal law.<sup>162</sup>

#### 1. *The Court Thinks ERISA's Remedies are the Limit of What Congress Intended*

The Court believes Congress intended ERISA to confer limited liability on MCO benefit plans as a means of assisting employers in providing health insurance coverage.<sup>163</sup> Writing for the Court, Justice Thomas said Congress has already defined what it considers appropriate remedies under ERISA.<sup>164</sup> As part of ERISA's comprehensive structure, Congress provided civil remedies and an "integrated enforcement mechanism."<sup>165</sup> Therefore, the Court says,

<sup>155</sup> *Id.* (quoting *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49 (D.Mass. 1997)).

<sup>156</sup> *Aetna Health, Inc. v. Davila*, 542 U.S. 200 (2004).

<sup>157</sup> *Id.*

<sup>158</sup> *Id.* at 213–14.

<sup>159</sup> *Id.*

<sup>160</sup> *Id.* at 221.

<sup>161</sup> *Davila*, 542 U.S. at 207–08.

<sup>162</sup> *Id.*

<sup>163</sup> *Id.* at 215–16.

<sup>164</sup> *Id.* at 217.

<sup>165</sup> *Id.* at 208.



plaintiffs would have a valid state law claim only if they were alleging that MCOs misinterpreted the plan's provisions and, as a result, failed to approve/pay for a benefit that should have been approved/paid for.<sup>166</sup>

## 2. *The Court Finds the Plaintiffs' Causes of Action are Not Independent of ERISA*

ERISA 502(a) preemption is not implicated if the state law imposes duties and responsibilities arising independently of ERISA and the plan's terms.<sup>167</sup> But in the instant case, the Court considers litigating the benefit decision in state court a duplication, supplementation, or supplantation of the civil remedies ERISA provides, because—in the Court's view—"THCLA liability would exist here only because of petitioner's administration of ERISA-regulated benefits plans."<sup>168</sup> More specifically, the Court states "Petitioner's potential liability under the THCLA in these cases, then, derives entirely from the particular rights and obligations established by the benefit plans."<sup>169</sup> The Court finds the plaintiff's THCLA claims "are not entirely independent of the federally regulated contract itself."<sup>170</sup> Thomas concludes, therefore, ERISA 502(a) preempts the plaintiffs' state causes of action.<sup>171</sup>

### B. Mixed Decisions are Really Treatment Decisions

The Court viewed the MCO's decisions about which the plaintiffs complained as benefit decisions, not as treatment decisions. Under ERISA, benefit decisions are litigated exclusively in federal court.<sup>172</sup> The Court found that the MCO's decision was only an eligibility/plan decision.<sup>173</sup> The Court relied heavily on two factors in making that finding. First, the Court stressed that, because the treating physicians for Davila and Calad were not employed by the HMO, the treating physician *was not* making an eligibility/plan decision.<sup>174</sup> Second, they noted the MCO was not medically "treating"

<sup>166</sup> *Davila*, 542 U.S. at 212–13.

<sup>167</sup> *Id.* at 211–13.

<sup>168</sup> *Id.* at 213.

<sup>169</sup> *Id.*

<sup>170</sup> *Id.*

<sup>171</sup> *Davila*, 542 U.S. at 214.

<sup>172</sup> *Id.* at 208.

<sup>173</sup> *Id.* at 220–21.

<sup>174</sup> *Id.*

the patient; therefore the HMO's decision could only be an eligibility/benefit decision.<sup>175</sup> Because the Court defines the HMOs' decisions in these cases as simply benefit decisions/plan benefits interpretations (for example: "Is treatment X an item covered by this patient's plan?") rather than treatment decisions, the Court finds these decisions may not be addressed by state courts.<sup>176</sup>

Also, the Court closed some doctrinal doors in their treatment of *Pegram*. Even though the facts of *Davila* did not involve a treating physician who is also responsible for making benefit determinations/eligibility decisions, the Court discussed situations where the physician's eligibility decision requires medical decision-making.<sup>177</sup> The Court's discussion shows that it perceives a bright line between medical decisions about treatment and decisions defining a plan's benefits.<sup>178</sup> Further, the Court narrows the implication resulting from *Pegram*.<sup>179</sup> *Pegram* said that a MCO-employed physician who makes a simultaneous benefit decision and treatment decision makes a "mixed" decision and that when this "mixed" decision is made negligently, the plaintiff may have a state-law medical malpractice claim, which ERISA does not preempt.<sup>180</sup> In *Davila* the Court holds that "*Pegram* cannot be read so broadly."<sup>181</sup> Thus, *Davila* seems to move a *Pegram* "mixed" decision into the category of a benefit decision that is preempted by ERISA.

However, "mixed" decisions really *are* treatment decisions.<sup>182</sup> With deference to the Court, it seems disingenuous to characterize "mixed" decisions as only a benefit decision. This is especially true when the decision rests on a "not medically necessary" determination. When an eligibility decision is premised upon medical neces-

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<sup>175</sup> *Id.*

<sup>176</sup> *Davila*, 542 U.S. at 214.

<sup>177</sup> *Id.* at 219.

<sup>178</sup> *Id.* at 220–21. Some commentators note the opposite could plausibly be argued. See Donald P. Carleen, *Employee Benefits Law; ERISA Preemption and Mixed-Eligibility and Treatment Decisions*, N.Y.L.J. (Dec. 17, 2004) (noting the decision-making administrator is likely economically aligned with the HMO and at the same time may have assumed a physician's role).

<sup>179</sup> *Pegram v. Herdrich*, 530 U.S. 211, 229 (2000).

<sup>180</sup> *Id.*

<sup>181</sup> *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 218 (2004).

<sup>182</sup> *Hirshfeld & Thomason, supra* note 21, at 4 (arguing that while treatment decisions and coverage decisions are often independent efforts, these two decisions may merge when health plans make determinations about whether requested services are reasonable and necessary. Furthermore, if coverage is denied and a patient forgoes treatment because he cannot afford treatment without the financial help of the insurance company, then the coverage decision becomes a treatment decision).

sity, a particular patient's medical status and potential treatment response are put in play. We defy logic when we simultaneously 1) use medical facts and patient prognosis (facts central to treatment) as the basis for deciding to grant or deny care, and 2) ignore the very aspect of the analysis that leads to the ultimate decision. Such characterization largely employs form over function by treating the same decision differently based only upon the decision-maker's identity.<sup>183</sup>

### C. A Clear Distinction Between Coverage Denial and Procedure Denial Cannot be Drawn

The Court views coverage denial and procedure denial as separate entities. Justice Thomas said that an HMO's denial of coverage is not the same as denying a procedure because the patient can still pay for the procedure and seek reimbursement under federal law.<sup>184</sup> However, for many reasons, such a distinction cannot be so clearly drawn, and coverage denials often actually constitute procedure denials.

First, the average patient might not be able to afford paying the full cost of prescriptions or procedures.<sup>185</sup> For those patients a denial materially influences whether they get the treatment. Second, due to differing timelines for care and appeal, a patient might be past the point of meaningful treatment by the time he finishes the appeal/ approval process. Similarly, when a patient who pursues a

<sup>183</sup> See Ruger, *supra* note 14, at 530 (commenting that *Davila's* holding reflects "categorical reasoning" which sacrifices a contextual and functional analysis of managed-care decision making while elevating "organizational form" and noting the mixed decision in *Pegram* was made by a treating physician while the mixed decision in *Davila* was made by a plan administrator).

<sup>184</sup> *Davila*, 542 U.S. at 211.

<sup>185</sup> An internet search to determine the price a private consumer would pay for Vioxx in January of 2005 revealed that the daily cost would range from \$1.89 to \$2.61 per 25 milligrams (the daily maximum recommended dose for osteoarthritis). The supplier was Wal-Mart. At this dose the consumer would spend from \$691.77 to \$954.35 annually. The variation in price reflects that Vioxx could be bought from this source in quantities from 30 to 90 and in strengths from 25 milligrams to 50 milligrams. <http://www.destinationrx.com/prescriptions/refine.asp?BrandName=vioxx> (last visited Nov. 11, 2005).

During oral arguments in *Davila*, Justice Scalia disputed that *Davila* was denied care and suggested *Davila* could have paid for Vioxx on his own. John A. MacDonald, *Justices Skeptical of HMO Lawsuits: Case Tests Texas Statute*, HARTFORD COURANT, Mar. 24, 2004, at A2. Mr. Young, counsel for *Davila* and Calad, responded, "Well, the truth is, Your Honor, that neither of these claimants would have needed health insurance if they had the independent means to just whip out a gold card and pay for the drug." Linda Greenhouse, *Justices Hear Arguments About H.M.O. Malpractice Lawsuits*, N.Y. TIMES, Mar. 24, 2004, at A15.

lawsuit, the window for meaningful treatment may close before the lawsuit is completed. Additionally, while it may be expensive to pay for the treatment out of pocket, the cost to pursue a lawsuit may be even greater. Therefore, pursuing an appeal or instituting a lawsuit may materially change whether the patient gets the treatment.<sup>186</sup> Third, although the patient may seek reimbursement for self-funded treatment, he has no guarantee of reimbursement. Thus, if he is not reimbursed, he may not be able to continue the treatment that he originally self-funded.

#### D. Form over function

The Supreme Court criticized the Fifth Circuit as putting form over function; however, the Supreme Court used similar logic when deciding *Davila*. The Supreme Court criticized the Fifth Circuit's rationale,<sup>187</sup> by saying that "distinguishing between preempted and non-preempted claims based on the particular label affixed to them would elevate form over substance and allow parties to evade the preemptive scope of ERISA simply 'by relabeling their contract claims as claims for tortious breach of contract.'"<sup>188</sup> However, the Supreme Court in *Davila* also elevated form over function by the manner in which they discussed and clarified their previous *Pegram* holding.<sup>189</sup>

#### E. The Concurrence

Justice Ruth Bader Ginsburg wrote separately for herself and Justice Stephen Breyer. Justice Ginsburg said that although ERISA, as written, does preempt state laws allowing consumers to sue health plans, Congress should revisit ERISA and give health plan members a better mechanism for relief when care is wrongly denied.<sup>190</sup> Justice Ginsburg wrote that ERISA's limited remedies produced a "regulatory vacuum," and she urged "fresh consideration of the availability of consequential damages under ERISA

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<sup>186</sup> Carleen, *supra* note 178, at 5 (noting that when patients cannot pay out-of-pocket for a treatment, then denials often have the effect of treatment decision, and that a patient likely assumes a denial is "informed and based on a review of all relevant medical information").

<sup>187</sup> See *supra* notes 147–152 and associated text (explaining the Fifth circuit's rationale).

<sup>188</sup> *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 214 (quoting *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 211 (1985)).

<sup>189</sup> See *supra* notes 172–180 and associated text.

<sup>190</sup> *Davila*, 542 U.S. at 222.

§ 502(a)(3).<sup>191</sup> These concerns echo the frustrations of United States Circuit Court judges.<sup>192</sup>

## F. The *Davila* Decision Produced Strong Reactions on Both Sides of the Debate

### 1. Opponents

Opponents of the *Davila* decision include some Congressional Democrats, consumer groups, and the American Medical Association. Some Congressional democrats and consumer groups decry the resulting double standard, lack of remedies, unlawful medical practice, and the negative impact on patient-centered care. Sen. Edward Kennedy (D-Mass.) and Rep. John Dingell (D-Mich.) said Congress would “step in and revive federal patient rights legislation.”<sup>193</sup> Sen. Kennedy, disagreeing with such robust preemption, said Congress did not intend ERISA to “interfere with a patient’s right to quality health care. Whom do you trust to make health care decisions for you—your doctor or an HMO bureaucrat? That’s what this case is all about.”<sup>194</sup> Foundation for Taxpayer and Consumer Rights (FTCR) said the ruling creates a double standard.<sup>195</sup> The double standard results because the only patients who have a legal remedy when harmed by their MCO’s treatment denial are government officials, church workers, or those on public assistance programs — groups whose claims regarding wrongful treatment denial are not subject to ERISA preemption.<sup>196</sup> Consumers Union senior counsel Sally Greenberg said the ruling leaves “a gap in meaningful remedies for patients” and should be a “call to Congress to step in and address the tangled ERISA regime that’s currently preventing patients from holding HMOs accountable when they’re

<sup>191</sup> *Id.* at 222–23.

<sup>192</sup> *Cicio v. Does*, 321 F.3d 83, 106 (2d Cir. 2003) (Calabresi, C.J. dissenting in part); Chief Judge Becker of the Third Circuit: “I write separately to add my voice to the rising judicial chorus urging that Congress and the Supreme Court revisit what is an unjust and increasingly tangled ERISA regime.” *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 453 (3d Cir. 2003) (Becker, C.J., concurring).

<sup>193</sup> HENRY J. KAISER FAM. FOUND., DAILY HEALTH POLICY REPORT, (Mar. 24, 2004), [http://www.kaisernetwork.org/dailyreports/rep\\_index.cfm?DR\\_ID=22847](http://www.kaisernetwork.org/dailyreports/rep_index.cfm?DR_ID=22847) (citing Heil, Congress Daily, Mar. 23, 2004).

<sup>194</sup> HENRY J. KAISER FAM. FOUND., *supra* note 193 (citing Maria Recio, *Justices Show Little Patience for Patients’ Case*, FORT WORTH STAR-TELEGRAM, Mar. 24, 2004).

<sup>195</sup> Gregory Robb & Kristen Gerencher, *High Court Blocks HMO Patient Suits: Unanimous Ruling Says Federal Law Bans Such Litigation*, CBS MarketWatch (June 21, 2004).

<sup>196</sup> *Id.*

wrongfully denied coverage.” She noted substantial progress at the state level because of state-level lawsuits and voiced concern that, as a result of the *Davila* decision, “the HMOs and others may have a green light to deny coverage because they realize now there may not be remedies available.”<sup>197</sup>

American Medical Association (AMA) President John C. Nelson expressed concern that the decision encouraged both decreased accountability and unlicensed medical practice.<sup>198</sup> “The AMA, [representing] about 250,000 U.S. doctors, says the ruling allows HMOs to ‘play doctor’ with treatment decisions.”<sup>199</sup> Nelson predicted a further erosion of patient-centered care as MCOs will have “very little incentive to approve expensive but medically necessary treatments.”<sup>200</sup>

## 2. *Proponents and Rebuttal to Proponents*

Proponents of the *Davila* decision included the Bush White House, benefit plan administrators, HMOs, insurance plans, and employers. The White House praises protecting health care costs.<sup>201</sup> White House press secretary Trent Duffy said President Bush’s position on the *Davila* decision was “compatible” with Bush’s position while Texas Governor.<sup>202</sup> While Bush was governor, the THCLA passed without his signature.<sup>203</sup> Duffy said, “The president’s principles are for allowing patients a fair process for challenging the decision of health insurers without needlessly driving up health care costs.”<sup>204</sup>

However, state-based remedies, such as the THLCA provides, may not necessarily increase health care costs. Interestingly, at least

<sup>197</sup> *Id.*

<sup>198</sup> Janice G. Inman, *Supreme Court Deals Blow to Malpractice Plaintiffs*, MED. MALPRACTICE L. & STRATEGY, July 30, 2004, at 1 (quoting John C. Nelson, AMA President, expressing concern that “By reserving the right to decide what is and what is not medically necessary, managed care plans can now practice medicine without a license, and without the same accountability that physicians face every day. While the AMA appreciates those managed care plans that put patients ahead of profits, today’s Supreme Court action significantly erodes patients’ ability to obtain medically necessary care by placing patients at the mercy of managed care plans that play doctor.”).

<sup>199</sup> Robb & Gerencher, *supra* note 195.

<sup>200</sup> *Id.*

<sup>201</sup> HENRY J. KAISER FAM. FOUND., *supra* note 193.

<sup>202</sup> *Id.*; but see *supra* note 92 (describing Bush’s various stances on MCO liability).

<sup>203</sup> Texas Health Care Liability Act, TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-88.003 [Supp. Pamphlet].

<sup>204</sup> HENRY J. KAISER FAM. FOUND., *supra* note 193.

one study found the impact of state lawsuits on managed care and physician malpractice premiums to be negligible. Mark Hall, Professor of Law and Public Health at Wake Forest University, and Gail Agrawal, Associate Dean and Professor at the University of North Carolina School of Law, surveyed six states representing various tort liability statutes for patient harm caused by managed care organizations.<sup>205</sup> Their findings reveal such statutes result in little or no litigation and the researchers do not view them as creating any fundamentally new type of liability exposure, particularly given the costs and complexities of suing a health plan.<sup>206</sup> Hall and Agrawal conclude, “To date—there is no evidence of the ‘flood of litigation’ that was predicted when states began to enact right-to-sue laws.”<sup>207</sup>

The Pharmaceutical Care Management Association<sup>208</sup> lauded the decision as validating step therapy,<sup>209</sup> criticized Mr. Davila for bypassing “every avenue available to him to resolve this coverage dispute quickly and instead fast-tracked this case to the nearest courtroom,” and stated that they hoped the ruling could help stem the tide of unnecessary litigation. The decision does validate step therapy, the value of which was never in doubt, but — more disturbingly — validates that patients injured while undergoing step therapy have no rights to recover for consequential damages caused by the step therapy. Further, PCMA misses the fact that Davila *was* complying with his MCO and pursuing one of the avenues for resolving the coverage dispute — namely the step therapy process.<sup>210</sup> Finally, the fact that a patient pursues one of the alternative resolution avenues (appealing within the MCO, requesting an external review, or filing a federal lawsuit) does not preclude him from suffering consequential damages and wishing to sue for make-whole relief.

The health care industry sees the *Davila* decision as a victory for consumers. America’s Health Insurance Plans president Karen

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<sup>205</sup> Mark A. Hall & Gail Agrawal, *The Impact of State Managed Care Liability Statutes*, 22 HEALTH AFF. 138, 138–39 (2003).

<sup>206</sup> *Id.*, reported in Clifford, *supra* note 5. See also John A. MacDonald, *Patients’ Rights To Sue At Stake*, HARTFORD COURANT, Mar. 21, 2004, at A1 (reporting that the Harvard Health Policy Review of 2000 estimated additional costs from state-court patient suits ranged from one to eight percent of premiums, but that conclusions are hard to achieve because the figures in these predictions are “almost entirely speculative”).

<sup>207</sup> Hall & Agrawal, *supra* note 205, at 141.

<sup>208</sup> See *supra* note 132 (identifying PCMA).

<sup>209</sup> See *supra* note 132 (defining step therapy).

<sup>210</sup> *Roark v. Humana, Inc.*, 307 F.3d 298, 303 (5th Cir. 2002) (noting Mr. Davila was taking a less expensive drug at the request of his MCO).

Ignagni said that the ruling is a victory for employers and consumers because “[t]here is already far too great a reliance on using the courts to resolve disputes in health care.”<sup>211</sup> She said her group “will continue to support existing alternative approaches for consumers to solve their disputes fairly and quickly, and in ways that promote access, affordability and quality care.”<sup>212</sup> Aetna responded, “By affirming the role of ERISA in employee benefits, the court has helped to assure that millions of working Americans will continue to have access to quality health coverage provided by their employers.”<sup>213</sup>

However, consumers are not necessarily better off because alternative approaches to judicial action are not necessarily quick. Additionally, the alternatives operate in a different time frame from the medical decision-making time frame (as described in section G, immediately below). Although alternative approaches to litigation may keep MCOs’ costs lower (thus promoting affordability), denying treatment hardly promotes access to care. Further, providing MCOs with immunity from compensating patients’ consequential damages might not be the best deterrent for protecting “quality care.”

#### **G. Even Non-Judicial Alternatives for Contesting Treatment Denial Have Time Frames Which Poorly Fit Medical Decision Making**

Miguel Estrada, attorney for Cigna and Aetna, said patients have alternate venues to state court for challenging the HMO administrative decisions related to treatment: 1) Appeal within the HMO, 2) request an external review, or 3) file suit in federal court.<sup>214</sup> However, the alternatives’ time frames poorly fit a medical decision-making time frame. The time frame in which the alternatives and appeals processes operate are very different from the time frame in which clinical care operates. As between the alternatives and appeals processes, or the recovery phase and disease process, it is usually the latter that has the shortest time for meaningful decision-making. The alternatives to state court and the appeals processes often require days or months to pursue and complete. However, the disease or recovery process may require meaningful

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<sup>211</sup> Robb & Gerencher, *supra* note 195.

<sup>212</sup> *Id.*

<sup>213</sup> *Id.*

<sup>214</sup> HENRY J. KAISER FAM. FOUND., *supra* note 193.



decisions be completed within hours or days. The alternatives to state court action may require time that may not be available given the disease's course or recovery process. Thus, the non-judicial alternative's completion may occur well past the end of the time frame for meaningful medical intervention.<sup>215</sup> Calad's case<sup>216</sup> provides an example; by the time the shortest route (internal appeal) could be completed, she would likely be past the window during which her requested intervention (extended inpatient post-operative care) would benefit her. Thus, because of these mismatched time frames, a plaintiff may comply with non-judicial alternatives, yet still suffer consequential damages.

#### H. Denying Treatment May Actually be at Odds With Keeping Health Care Costs Low, Regardless of Whether HMOs Pay Plaintiffs for Consequential Damage

Before the *Davila* decision, the business community argued that state court denial-of-treatment cases seeking consequential damages drive up the cost of co-payments, deductibles, and premiums; and force plans to limit benefits and drug selection. The American Association of Health Plans and the U.S. Chamber of

<sup>215</sup> At the time the decision on whether or not to allow the requested treatment is completed, the patient's status falls somewhere on the following spectrum:

**A-Least affected-** target disease has not progressed or patient's recovery process has been either successfully completed or has not worsened, patient can still benefit from the requested treatment and in either case there are no consequential damages.

**B-Mid range-** target disease has worsened but can be brought back to pre requested-treatment level by now delivering the requested treatment, or recovery process has been compromised by lack of the requested treatment but can be brought back to pre requested-treatment level by delivering the requested treatment and the recovery outcome will not be affected by the treatment delay, and in either case there may or not be consequential damages.

**C-Most affected-** target disease has progressed due to lack of the requested treatment and patient has suffered consequential damages (such as: increased or new symptoms from the target disease, new related disorders, aggravated underlying disorders, inability to now benefit from the requested treatment, treatment delay caused need for more costly or aggressive treatment to address the target disease, lost wages, lost physical function, impaired daily living activities) or patient's recovery process has been compromised and patient has suffered similar consequential damages.

Given the short time frame required for medical decision-making, and the likely status outcomes seen above, it is likely that even when treatment is ultimately approved the patient will have sustained some associated damage. In the case of treatment denial the patient's status has a chance to continue to decline and the associated damage will likely be even greater.

(Examples provided by the author to concretely illustrate the patient-status spectrum.)

<sup>216</sup> Plaintiff requested to stay overnight in the hospital while recuperating from surgery. *Rorark v. Humana, Inc.*, 307 F.3d 298, 302 (5th Cir. 2002).

Commerce filed amicus briefs to that effect.<sup>217</sup> Employers began to question the difference between an employee benefit and health insurance.<sup>218</sup> However, if the major concern actually is keeping costs lower, insurance companies might better meet this goal by approving the requested treatment in the first place. Consider the following scenario and the end result.

If Davila had been allowed the physician-recommended medication, then he would likely not have developed severe internal bleeding, nor suffered near cardiac arrest, nor required emergency room care, nor required intensive care,<sup>219</sup> and he would be able to conservatively manage his arthritis with the physician-recommended medication today.<sup>220</sup> Instead of the cost of daily Vioxx, Aetna faced the greater costs associated with treating his medical emergency, stabilizing him, and now using more-complexly delivered and more-costly pain medications than oral Vioxx.<sup>221</sup> Thus, administering Vioxx from the beginning, according to his physician's recommendation, would have been the less costly treatment scenario for Mr. Davila. Calad's situation is analogous. One additional day in the hospital is less costly than providing emergency care and treating ongoing worsened symptoms.

However, MCOs are probably sensitive to the economic rationale for treatment denial. Even when factoring in the increased treatment costs due to Mr. Davila's now further-compromised health, the MCO saves money in the aggregate by denying treatment that costs more or that is not originally covered by the plan. This is true because more costly treatment is not *always* necessary, despite physician recommendation. Though perhaps doubtful that a plan administrator would openly admit such a strategy, a rational argument exists from an economic standpoint.

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<sup>217</sup> Clifford, *supra* note 5; see also David G. Savage, *ERISA AGAIN: High Court Takes Another Look at Pre-Emption in HMO Disputes*, A.B.A.J., Feb. 2004, at 14 (noting employers fear that the *Rush* holding will force them to provide more costly benefits, and that employers after *Rush* wonder where is the line between employee benefit and health insurance).

<sup>218</sup> *Id.*

<sup>219</sup> See *supra* notes 135–37 and associated text (stating the medical complications which Mr. Davila suffered as a result of taking the less expensive medication).

<sup>220</sup> *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 205 (2004). Because of the damage he suffered he can no longer absorb medication through his stomach. *Id.*

<sup>221</sup> Delivering medication through routes other than gastric uptake is usually more expensive than the cost of an oral medication. Routes of administration other than gastric uptake usually require special formulations of medications; supplies such as syringes and intravenous equipment; and often trained personnel to administer the medication.

MCOs can afford to aggressively deny more costly benefits because ERISA immunizes them legally and financially from their mistakes. If MCOs were instead exposed to liability for consequential damages (as are private physicians and health care plans that provide medical coverage to government officials, church workers, or those on public assistance programs), they would likely respond by more liberally allowing more expensive benefits. They might also implement faster appeals processes so as to minimize the harm a patient suffers from the denial of treatment during the appeals process. However, neither of these changes are likely as long as ERISA provides defendant immunity from the consequential damages of mistakes.

### I. Consequences of the Ruling for Various Concerns

MCOs, physicians and other medical care providers, patients, the health care market, and the legal system will all be affected by the *Davila* ruling. The current MCO appeal processes, ERISA's preemption provision, and the *Davila* decision interact to confer double immunity upon MCOs. Through their patient appeal processes, MCOs already enjoy a level of immunity from providing care that a patient might need. This is so because, in the worst-case scenarios, even the most rapid internal appeals process may take so long that by the time the procedure/treatment is authorized, the patient can no longer benefit from it, freeing the MCO from having to provide or pay for the treatment.<sup>222</sup>

Combining the *Davila* decision with ERISA's preemption provision<sup>223</sup> gives MCOs further latitude to make decisions against the patient's best interest and even against a treating physician's advice.

The current interpretation of both ERISA's language and purpose immunizes MCOs.<sup>224</sup> *Davila* further immunizes MCOs through three principal mechanisms. First, *Davila* affirms that under ERISA, patients are denied consequential damages to compensate for injury or declining health caused by the denied care/

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<sup>222</sup> See *supra* Section III.G. "Even non-judicial alternatives for contesting treatment denial have time frames which poorly fit medical decision making" (discussing the appeals processes and the disparate timing between clinical care decisions and appeals processes).

<sup>223</sup> See *supra* notes 83–87 (discussing ERISA's (29 U.S.C. § 1001) preemption provision and its effect).

<sup>224</sup> See *supra* notes 78–82 and accompanying text (discussing interpretation of ERISA language and purpose).

procedure.<sup>225</sup> Instead, a successful plaintiff's recovery is limited to the following two options: reimbursement for a denied procedure (*if* the plaintiff can prove the procedure was actually covered, the procedure is adjudicated as wrongly denied, and the patient has already personally paid for the procedure); or an injunction against the benefit's/treatment's denial after adjudication that the MCO should have provided the treatment/benefits under the benefit plan. Second, *Davila* sanctions and continues the Court's very narrow definition of a treatment decision.<sup>226</sup> In doing so it continues a trend from previous cases where the majority agrees with this narrow definition, but it encounters opposition from either the dissent or concurrence. Third, the *Davila* Court makes a fairly constrained "proximate cause" analysis.<sup>227</sup> Essentially it says there is no link between treatment denial and patient harm.

Due to the interaction between ERISA preemption and the time delays associated with internal appeals process, MCOs that provide benefits through ERISA essentially enjoy double immunization. In marked contrast, states' "right to sue" laws allow recovery for both consequential and punitive damages when a plaintiff sues her MCO or treatment provider.<sup>228</sup>

Physicians may face more malpractice actions under state law now that the Supreme Court has underscored that make-whole relief will not come from the MCO. Increased suits against physicians could result because consequential injury resulting from the MCO's decision to deny treatment often translates into increased financial burden on the patient. In fact, an estimated one-quarter of all private bankruptcy is due to medical expenses.<sup>229</sup> Thus, patients may

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<sup>225</sup> *Davila*, 542 U.S. at 222 (Ginsburg, J., concurring).

<sup>226</sup> See *supra* Section III.B. "Mixed" decisions are really treatment decisions (comparing the Court's interpretation of treatment decisions, mixed decisions, and eligibility decisions).

<sup>227</sup> *Id.*

<sup>228</sup> See *supra* note 10 (listing the states with "right to sue" laws).

<sup>229</sup> See Himmelstein et al., *supra* note 9, at W5-63. 1,457,572 households filed for bankruptcy in 2001. *Id.* at W5-66. A study performed to estimate the role medical expenses play in bankruptcies lead researchers to estimate that half of all personal bankruptcies are due to medical causes (one quarter due to illness or injury and another quarter caused by uncovered medical bills in excess of \$1,000). *Id.* The half who were bankrupt due to medical causes reported that, in the two years leading up to filing for bankruptcy, medical costs caused them to miss the following: 40.3% lost telephone service, 19.4% went without food, 53.6% missed needed physician or dental visits, 43% could not fill a prescription due to cost. *Id.* at W5-68. Three fourths of the debtors had insurance at the onset of their illness. *Id.* at W5-69. One third of the debtors lost coverage during the illness. *Id.* The researchers estimate that the number of medical bankruptcies increased twenty-threefold between 1981 and 2001. *Id.* at W5-71.

sue their doctors not because they really believe the doctor is at fault (in fact the doctor might be without personal fault), but instead as a means to obtain resources they can use to meet their new financial burden.<sup>230</sup> Additionally, although unintended by our judicial system, juries often sympathize with the plaintiff's plight. To that extent, while not believing the physician truly at fault, a jury may yet rationalize rendering a verdict which causes a faceless malpractice insurance company to help the plaintiff who has little other means to meet her new financial burden.<sup>231</sup>

Provider entities that function as MCO creditors seem to be safe from automatic ERISA preemption of their claims against MCOs. Five months after *Davila*, the Third Circuit interpreted *Davila* in a case where a hospital-creditor sued for improperly-discounted payments by an employee welfare benefit plan.<sup>232</sup> The Third Circuit's decision in *Pascack* shows how ERISA may or may not affect creditor claims. The court held that status as an ERISA-qualified plan does not guarantee the plan's removal of claims to federal court.<sup>233</sup> The MCO and its creditor, Pascack Valley Hospital,<sup>234</sup> had an agreement that if the MCO would pay claims during a prompt-payment period, the hospital would discount the claims.<sup>235</sup> An audit revealed that the MCO took claim discounts to which it was not entitled because the actual payment was made beyond the prompt-payment period.<sup>236</sup> The court reasoned that the record was unclear whether the hospital had standing to bring a claim under 502(a).<sup>237</sup> Had the claim fallen under 502(a) it would have been preempted.<sup>238</sup> Next, the court reasoned that under the well-pleaded complaint rule, a complaint remains in state court so long as the

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<sup>230</sup> *Talk of the Nation: Why So Litigious?*, National Public Radio broadcast, Jan. 12, 2005, available at <http://www.npr.org/templates/story/story.php?storyId=4280703> (last visited Nov. 11, 2005) (discussing plaintiff motives in medical malpractice suits generally; and interviewing Dr. Gerald Hickson, director, Center for Patient and Professional Advocacy at Vanderbilt, who found about 20% of plaintiffs file suit to obtain finances to help deal with long-term medical expenses that resulted from a care-induced injury).

<sup>231</sup> Bursztajn, *supra* note 50.

<sup>232</sup> *Pascack Valley Hosp. v. Local 464A UFCW Welfare Reimbursement Plan*, 388 F.3d 393, 396 (3d Cir. 2004).

<sup>233</sup> *Id.* at 398–99.

<sup>234</sup> *Id.* at 395.

<sup>235</sup> *Id.* at 396.

<sup>236</sup> *Id.* at 397.

<sup>237</sup> *Pascack*, 388 F.3d at 400.

<sup>238</sup> *Id.*

complaint does not affirmatively allege a federal claim.<sup>239</sup> Because the MCO's argument for preemption was only a defense to the claim, and did not appear on the complaint's face, that defense could not support removal.<sup>240</sup>

Patients may react by bringing more federal suits, and they may do so earlier. Given the history of ERISA preemption cases and the Supreme Court's unequivocal ruling in *Davila*, patients dissatisfied with the outcome of alternatives to state law claims may feel the need to bring a federal suit challenging the benefit determination, hoping for a different result. A patient might also wish to avoid the delay of pursuing the alternatives and file a federal suit alternatively to or concurrently with pursuing other means to relief. Patients might bring these suits sooner instead of later, in order to obtain a firm determination of their benefits early in the course of their treatment/disease. An earlier determination would allow them and their physicians to maximize valuable treatment time and to establish early on the medical and financial resources they have with which to fight the disease or treat the condition.<sup>241</sup> These earlier and more numerous suits will require additional MCO resources for defense. Thus, MCOs may face increased business expenses in responding to the increased requests for benefit approval and in defending themselves in more numerous federal suits, regardless of their continued denial of more expensive treatment options.

Perhaps the market will support a second medical insurance tier. Individuals might buy this coverage outside of their employee benefits. It would be designed to cover the more expensive treatments/procedures that one's HMO denies. This could be similar to Medicare part A and B. The advantages are that individuals would now be able to hold an insurance provider liable for treatment denial. The disadvantage is that if individuals could afford this type of insurance in the first place they may already be self-insuring, rather than relying on purchasing volume-discounted insurance from their employers. If such a plan worked we would have at least three classifications of the insured. First, federal employees, government officials, church workers, and those on public assistance programs can sue their MCO for consequential damages. Second, non-

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<sup>239</sup> *Id.* at 398.

<sup>240</sup> *Id.* at 398–99.

<sup>241</sup> Of course, pursuing a federal suit is subject to the same threshold issues of cost, so if a potential plaintiff is already struggling to pay for denied care he may also have difficulty funding a suit to challenge the benefit determination.

federal employees with both levels of insurance who now have coverage at least for procedures their first insurance would not cover. Third, patients with employer-provided MCO insurance, which as now—because of ERISA preemption—provides no consequential damages for wrongfully-denied treatment.

MCOs may make more treatment denials, further eroding patient-centered care. Theodore Ruger notes the imbalanced liability rule coming out of the *Davila* decision (less/no liability for a plan administrator who denies care, than for a plan's treating physician who denies care).<sup>242</sup> He hypothesizes that because of the imbalance, an MCO might “push such mixed decisions upward in their organizational hierarchy away from treating physicians.”<sup>243</sup> Because MCOs have more protection for adverse decisions, adverse decisions may increase.

Such a response has implications for further reducing patient-centered care. The resulting model severely reduces physician autonomy, a crucial aspect of patient-centered care. Decision making moves from medical experts most familiar with the individual (such as an independent physician familiar with the particular patient's medical needs) toward those who are less familiar with the patient's medical needs and who work in a milieu that is more likely disposed to disallow the requested treatment (such as a MCO-employed reviewing physician or MCO-employed charge nurse.) At the furthest level of removal, a trial judge or jury (neither likely to be medically trained or familiar with this particular patient's medical needs) evaluate the treatment decision.

The law might rely more on contract rules (and less on tort rules) to resolve care denial disputes, but such reliance is problematic for several reasons. We should not rely so much on contract rules to legally resolve care-denial disputes because health care delivery is too complex, uncertain, and unpredictable. More importantly, basic features of contract negotiation are absent from the patient-MCO setting. First, customer choice, a factual situation included in most contract disputes, is not present or at most is only very limited in the patient-MCO scenario. Instead, the patient picks from a limited number of plans his employer makes available.<sup>244</sup> Additionally, the patient does not negotiate the terms of his MCO

<sup>242</sup> Ruger, *supra* note 14, at 530.

<sup>243</sup> *Id.*

<sup>244</sup> JACOBSON, *supra* note 1, at 114 (explaining that this problem is exacerbated because the employers often don't have the requisite knowledge to evaluate and monitor medical quality and quantity, and in some cases may not have much bargaining power. Addition-

contract. Regardless of whether the terms are favorable or unfavorable this transaction looks more like a contract of adhesion than an arms length transaction because the patient's only choices are between obtaining insurance through employer assistance, securing insurance on his own at a much greater price, or remaining uninsured.<sup>245</sup> Finally, the parties occupy very unequal positions regarding needed information. While the MCO may know the quantity and quality of the services offered, the average customer does not have the required expertise to judge either of these aspects.<sup>246</sup> Nor may the consumer know what he is actually purchasing.<sup>247</sup>

### J. Exploring Alternative Judicial Avenues for Relief

After *Davila*, are there any alternative judicial avenues for providing additional relief to similarly-situated plaintiffs? The Court seems to suggest that only congressional action will improve relief. However, one commentator has proposed that ERISA's § 502(a)(3) "other appropriate equitable relief" phrase could be utilized.<sup>248</sup> Justice Ginsburg refers to that section,<sup>249</sup> and Michael H. Bernstein notes that in 1993 the Court in *Mertens*,<sup>250</sup> in a five-to-four decision, interpreted "appropriate equitable relief" narrowly.<sup>251</sup> In *Mertens*, Justice Scalia applied a very narrow analysis based on traditional law principles. He said legal relief includes monetary damages, while in sharp contrast, equitable relief includes only "injunction,

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ally, employer and employee interests may diverge with the former valuing saving money and the latter wishing to obtain more thorough coverage.)

Although a realistic counterargument is that because the employer has greater spending power and bargaining power than the individual, the employer probably either negotiated for, or simply receives better terms for the same price than could the individual negotiating one-on-one with the MCO.

<sup>245</sup> A contract of adhesion is essentially a "take it or leave it" proposition. 16 Am.Jur. 2d. Conflict of Law § 91 (2005).

<sup>246</sup> JACOBSON, *supra* note 1, at 113 (adding that it is not practical or efficient for patients to become highly educated about the types of medical care they might need, nor to have the knowledge to judge technical quality, and simplifying such information has the potential of leading to misuses).

<sup>247</sup> Hirshfeld & Thomason, *supra* note 21, at 34–35 (discussing that patients remain unaware of numerous cost control measures and agreements between physicians and MCOs, and lack information comparing different plans' performance).

<sup>248</sup> Michael H. Bernstein, *A New Battleground For Patient Suits Against HMOs?*, 178 N.J.L.J. 1048, (2004).

<sup>249</sup> *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 222–23 (2004).

<sup>250</sup> *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993).

<sup>251</sup> Bernstein, *supra* note 249 (discussing *Mertens*, 508 U.S. at 256).



mandamus and restitution, but not compensatory damages.”<sup>252</sup> After presenting this distinction, Justice Scalia found monetary damages to fall only under legal relief, and not under equitable relief.<sup>253</sup> Thus, the *Mertens* plaintiff’s claims for monetary damages were unavailable under ERISA § 502(a)(3)’s “other appropriate equitable relief.”<sup>254</sup>

However, *Mertens* and *Davila* are factually distinguishable. *Mertens* concerned a non-fiduciary who knowingly facilitated a fiduciary’s breach of duty,<sup>255</sup> while in *Davila* the plan fiduciary is alleged to have breached its own duty.<sup>256</sup> Because of this distinction, Bernstein notes, the question of “make whole” relief against a plan fiduciary may still be open under ERISA’s section 502(a)(3) “other appropriate equitable relief.”<sup>257</sup>

Nonetheless, Bernstein cautions that two United States Supreme Court cases decided after *Mertens* may ultimately limit this alternative approach.<sup>258</sup> First, the 1996 *Howe* Court’s reasoning on the meaning of “appropriate” said “. . . where Congress elsewhere provided adequate relief for a beneficiary’s injury, there will likely be no need for further equitable relief, in which case such relief normally would not be ‘appropriate.’”<sup>259</sup> Because the Court’s reasoning in *Howe* seemingly turns on whether the relief is “adequate,” it seems that a court so inclined might revisit whether the current relief provided under § 502(a)(1)(B) is truly adequate. But Bernstein indicates that a second case, *Knudson*,<sup>260</sup> makes such reexamination unlikely.<sup>261</sup> In *Knudson* the Court held that ERISA’s § 502(a)(3) for “other appropriate equitable relief” did not include “all relief,” and the Court reasoned that the fact that relief under ERISA

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<sup>252</sup> *Id.*

<sup>253</sup> *Id.*

<sup>254</sup> *Id.*

<sup>255</sup> *Mertens*, 508 U.S. 248.

<sup>256</sup> *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 212–13 (2004).

<sup>257</sup> Bernstein, *supra* note 249 (noting that the court, if so disposed, might apply ERISA’s § 502(a)(3) to claims where an ERISA fiduciary made allegedly wrongful benefit determinations in breach of their ERISA fiduciary duty, and noting that a change in the Court’s composition might prompt this application).

<sup>258</sup> *Id.* (discussing *Varity Corp. v. Howe*, 516 U.S. 489 (1996) and *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002)).

<sup>259</sup> *Id.*, quoting *Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996).

<sup>260</sup> *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002).

<sup>261</sup> Bernstein, *supra* note 249 (arguing the *Knudson* holding effectively closes the door to using § 502(a)(3) as an alternative).

§ 502(a)(1)(B) is limited does not imply that § 502(a)(3) can be used to augment 502(a)(1)(B)'s remedies.<sup>262</sup>

Will the Court's new composition change the direction of the *Davila* ruling or current ERISA jurisprudence? A change is unlikely given that even the concurrence, which seemed not to like the outcome, felt bound by the law's language to make the same ultimate decision as did their peers. Additionally, it seems unlikely that the Court would revisit such a firm decision any time soon.

#### IV. CONCLUSION

Congress needs to amend ERISA to allow relief for consequential damages caused by treatment denials.<sup>263</sup> As the concurrence noted, the Court could not have decided *Davila* differently—due to ERISA's language and the effect of its prior judicial interpretations of ERISA.<sup>264</sup> Additionally, although possible means exist for reconsidering other sections to construe more relief, they are not likely to be used.<sup>265</sup> As discussed above, Congress likely wanted to promote increased access to coverage, though few to no congressional intentions were articulated when setting employer-provided health care benefits under ERISA. Congress also wanted a uniform system to oversee employer-provided health care benefits, but surely their intent was not to provide increased access while ignoring and denying relief to those pushed into further illness and penury.

We need a collaborative Congressional solution to address the “mixed-decision” rationale for denying treatment. Congress should craft legislation which appends to ERISA a judicial solution to handle claims for consequential damages that are based upon alleged treatment denials. This proposed solution would recognize the decisional elements that are medical decisions and would evaluate the medical decisions' quality in light of existing clinical knowledge. Such a solution needs two components to alleviate the typical fears and criticisms aimed at tort actions: namely, that tort actions pro-

<sup>262</sup> *Id.* (characterizing *Knudson's* treatment of § 502(a)(3)).

<sup>263</sup> In fact, one scholar suggests that the most important aspect of the *Davila* decision is providing impetus to congressional action: “To the extent the decision provokes a long-awaited [c]ongressional action in this area, or more substantive federal judicial intervention in managed care decisions, its catalyzing force will be vastly greater than its immediate ruling on ERISA's remedial exclusivity.” Ruger, *supra* note 14, at 528.

<sup>264</sup> See *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 222 (2004) (Ginsburg, J., concurring).

<sup>265</sup> Bernstein, *supra* note 249.

duce arbitrary decisions that overcompensate the first successful plaintiffs while eviscerating resources needed to help later plaintiffs.

First, the solution should take away the current blanket preemption over mixed decisions, yet give back a prohibition on punitive damages. Second, disputes should be heard before a separate judicial body (without a jury) that is equipped to understand the intricacies that medical decision-making involves. (This special expertise element would be similar to that existing in the current patent bar.) Additionally, this should be a federal judicial body to prevent forum shopping.

Such a solution accomplishes three important goals and extends a benefit to each party in the debate. First, by removing punitive damages it recognizes that by and large, when viewing their performance on behalf of populations, the employer-sponsored MCOs do a good job providing access and containing costs. Second, the solution provides a mechanism to protect the patient from further medical harm and financial ruin for the few, but personally devastating, decisions that are out of step with current standards of clinical care. Finally, the solution provides a forum in which citizens whose states have authorized MCO liability for consequential damages may seek relief.

**Summation.** Regardless of the semantics employed to describe “decisions,” current ERISA preemption, as interpreted through *Davila*, allows MCOs immunity for treatment decisions that contravene the treating physician’s considered medical opinion. These “benefit” decisions often become treatment decisions. Additionally, patients often end up following the MCO decision either due to their inability to pay out-of-pocket for the treatment, or because the MCO appeal process’s lag time renders the original physician-recommended treatment medically meaningless.

As noted above, the Court could not have decided *Davila* differently, and other ERISA sections are not likely to be used by the court to find more room for consequential damage relief. Further, the concurrence and commentators note there is strong negative reaction to the current state of affairs in which patients who get their health care benefits from a plan falling under ERISA are left without relief from consequential damages that arise from treatment denial. The Court signaled Congress to take up this problem and provide needed relief. A Congressional solution as outlined above would balance the interests of the parties and provide a limited and uniform forum to compensate individuals for their consequential damages when harmed by treatment denial.

