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AETNA V. DAVILA/CIGNA V. CALAD: A MISSED OPPORTUNITY

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On June 21, 2004, the United States Supreme Court decided the health law "case of the year" in the two consolidated cases of *Aetna Health, Inc. v. Davila* and *CIGNA HealthCare of Texas, Inc. v. Calad*.[1] The Court held that section 502(a) of the Employee Retirement Income Security Act of 1974[2] (ERISA) "completely pre-empt[s]" and thus invalidates the tort liability provisions of the Texas Health Care Liability Act[3] (THCLA).[4] The case could potentially affect the rights of millions of Americans in a matter of vital concern—whether they will receive the health insurance coverage promised them if they become unable to pay for medical bills out of their own resources. The Court justified its decision as effecting "clear congressional intent."[5]

In reality, congressional intent was anything but clear.[6] The Court's decision was inconsistent with long-established and logically valid interpretations of procedural statutes, as well as the wording, structure, and underlying policies of ERISA.[7] The decision was also inconsistent with constitutional principles that should inform all jurisprudence. Instead, it was based on Supreme Court precedent that the Court itself had already partially disavowed as "not [giving]

1. 124 S. Ct. 2488 (2004) [hereinafter *Davila/Calad*].

2. 29 U.S.C. § 1132(a) (2000). ERISA is codified as Chapter 18 of the United States Labor Code, 29 U.S.C. §§ 1001-461 (2000).

3. TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-.003 (Vernon 1997 & Supp. 2004).

4. *Davila/Calad*, 124 S. Ct. at 2502.

5. At nine distinct places in the opinion, the *Davila/Calad* Court explicitly said that it was reading congressional intent. *See id.* at 2491, 2495, 2498 n.4, 2499-500, 2503. Five times the Court said that the intent was "clear" or that evidence of intent was "strong." *See id.* at 2491, 2495, 2497, 2498 n.4, 2500.

6. *See infra* Part III.B.4.

7. *See infra* Part III.

much help [in] drawing the line."[8]

This article does not suggest that the *Davila/Calad* holding was unexpected or completely incongruent with earlier Supreme Court decisions. To the contrary, if the Court had decided the case differently, it would have had to break with its own precedent. This article argues that the Court should have done just that—that the correct decision would have favored more fundamental considerations than the mere desire to remain superficially consistent with its previous holdings and rationales.

The Court missed an opportunity to correct what has been called "an unjust and increasingly tangled ERISA regime."[9] This case had huge national importance, and the issue deserved better and more careful analysis than it was given by the Court.

I. THE SETTING FOR THE CASE

A. ERISA

The purpose of ERISA is to broaden and strengthen the social safety net by encouraging employers, primarily through federal income tax preferences, to provide certain non-salary benefits to employees.[10] These benefits are intended to protect employees and their families from impoverishment as a result of retirement, illness, disability, or death. ERISA also requires those who provide and administer the benefits to satisfy basic standards of equity disclosure, integrity, and financial soundness.[11]

Because the principal incentive to employers for the provision of non-salary benefits is the reduction of income taxes, ERISA is intimately correlated with the Internal Revenue Code.[12] The Departments of Labor and Treasury are instructed to coordinate

8. N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins., 514 U.S. 645, 655 (1995) (discussing prior attempts to construe preemption by ERISA).

9. *Davila/Calad*, 124 S. Ct. at 2503 (Ginsburg, J., concurring) (quoting DeFelice v. Aetna United States Healthcare, 346 F.3d 442, 453 (3d Cir. 2003) (Becker, J. concurring)).

10. *See* Parker v. BankAmerica Corp., 50 F.3d 757, 765 (9th Cir. 1995) (warding off economic hardship relating to joblessness and rewarding employees for past service to companies); Altemose Constr. Co. v. Bldg. & Constr. Trades Council, 443 F. Supp. 492, 506 (E.D. Pa. 1977) (protecting the employees' right to receive benefits).

11. *See* ERISA § 502(a), 29 U.S.C. § 1001 (2000).

12. *See* 26 U.S.C. §§ 401-20 (2000).

their implementing rules and regulations.[13] Some employee benefit arrangements qualify for favorable treatment as a result of Congress' desire to contribute to the social safety net. Other arrangements are deemed less preferable and do not qualify for favorable tax treatment.

The term "plan" is a key concept in ERISA. A "plan" is "any plan, fund, or program . . . established or maintained by an employer or by an employee organization [*e.g.*, a union]," which has the purpose of providing certain types of non-salary benefits for employees.[14] ERISA covers two types of plans: "pension plans" (also called "employee pension benefit plans") and "welfare plans" (also called "employee welfare benefit plans"). Pension plans provide retirement or post-employment income to employees. As the very name Employee Retirement Income Security Act suggests, the primary focus is on pension plans. ERISA imposes a variety of substantive requirements of the statute upon pension plans relating to participation, funding, and vesting.[15] By contrast, ERISA "does not regulate the substantive content of welfare plans."[16]

One type of welfare plan is a plan that provides "through the purchase of insurance . . . medical, surgical, or hospital care or benefits."[17] These medical plans are the principal subject of this article.

B. Managed Care and Health Maintenance Organizations

For many years, national health care costs have risen substantially faster than the rate of inflation.[18] Although the causes are numerous, one factor undoubtedly has been the third-party payment system. The vast majority of health care costs are not paid by the patients.[19] Instead, the costs are typically paid by a third-party directly, such as a governmental entity or a health insurance

13. ERISA § 3004, 29 U.S.C. § 1204.
14. ERISA § 3(1)-(3), 29 U.S.C. § 1002(1)-(3).
15. ERISA §§ 201-308, 29 U.S.C. §§ 1051-86.
16. *See* Metro. Life Ins. v. Massachusetts, 471 U.S. 724, 732 (1985).
17. ERISA § 3(1), 29 U.S.C. § 1002(1).
18. *See Consumer Price Index: September 2004*, NEWS, U.S. DEP'T OF LABOR NEWS (Bureau of Labor Statistics, Washington D.C.) (Oct. 19, 2004), *available at* http://www.bls.gov/news.release/archives/cpi_10192004.pdf; *see also* JANET LUNDY ET AL., TRENDS AND INDICATORS IN THE CHANGING HEALTH CARE MARKETPLACE, 2004 Update exhibit 1.3 (Henry J. Kaiser Family Foundation 2004), *available at* http://www.kff.org/insurance/7031/index.cfm.
19. *See* LUNDY, *supra* note 18, at exhibit 1.8.

company. Thus, a patient receives the full benefits of the care but pays only a portion of its cost. Arguably, this disassociation between costs and benefits can lead to over utilization of medical services and a misallocation of economic resources.[20]

Care providers themselves could limit the provision of health care services, but they too may operate under distorted incentives. For example, a physician may be faced with a choice of two medications to prescribe to a patient. One medication might be slightly more efficacious but considerably more expensive than the other. If the physician knows that the patient will be paying for the medication out of his own pocket, he may give the patient a detailed comparison of the two alternatives. On the other hand, if the physician knows that a third-party will bear the entire cost, he will have little reason to discuss the less expensive possibility.

In a variation of this situation, the patient and the physician might be faced with a choice of medical treatments, and the treatment decision could affect the physician's own interests. For example, an issue might arise as to whether the patient should spend one or two days in the hospital following surgery. It might be slightly preferable, medically, for the patient to spend two days in the hospital, but the financial cost of the additional day could be significant. If fully informed of the consequences, the patient, if paying for the care himself, might reasonably elect to spend only one day in the hospital after the surgery. However, if the patient spends an extra day in the hospital, the physician will be paid for that additional day of care. Ethically, the physician is bound to advise the patient solely according to the patient's welfare.[21] Nevertheless, physicians have human frailties and may consciously or unconsciously steer the patient toward the alternative that best suits the doctor's personal interests. Such propensities may be accentuated if the doctor understands that a third party, rather than the patient, will pay for the hospitalization.

20. *See* Holman W. Jenkins, Jr., *Was Withdrawing Vioxx the 'Right Thing to Do'?*, WALL ST. J., Nov. 10, 2004, at A17 (deciding whether to take one drug or medical treatment over another may depend on whether a third party is paying).

21. *See* AM. MED. ASS'N, PRINCIPLES OF MED. ETHICS No. VIII, *available at* http://www.ama-assn.org/ama/pub/category/2512.html (last visited Mar. 1, 2005) (defining standards of conduct for honorable physician behavior including "responsibility to the patient as paramount"); AM. MED. ASS'N, CODE OF MED. ETHICS E-8.054, E-10.015, *available at* http://www/ama-assn.org/ama/noindex/category/11760.html (last visited Mar. 3, 2005) (regarding ethical conduct within the patient-physician relationship as to financial incentives).

As a remedy, the concept of managed care was developed in the early 1970s. The American Medical Association (AMA) has defined "managed care" as "those processes or techniques used by any entity that delivers, administers, and/or assumes risks for health care services in order to control or influence the quality, accessibility, utilization, or costs and prices or outcomes of such services provided to a defined enrollee population."[22]

One of the ideas behind managed care is that health care providers and recipients should not make all decisions regarding the provision of health care services. Third-party payers should also have a say.[23] Under the managed care scenario, health care decisions are to be guided by objective standards of medical efficacy and cost.[24] A managed care organization (MCO), which may be the payer or act on behalf of the payer, will apply these standards to specific situations to determine which procedures are medically efficacious and cost-effective. Only procedures that meet the criteria of efficacy and economy qualify for payment. Furthermore, health care providers may be given economic incentives to reduce cost in their treatment decisions.[25]

Part of the savings from managed care comes from the management of health care services, with a focus on costs as well as medical efficacy. Another aspect of the savings—in many instances more pronounced than savings from the actual care management—comes from the economic influence MCOs can exert over health care providers. MCOs contract with physicians, hospitals, and other providers, under which those providers agree to provide health care services to the beneficiaries of the MCOs at

22. AM. MED. ASS'N, HEALTH AND ETHICS POLICIES OF THE AM. MED. ASS'N HOUSE OF DELEGATES H-285.998, *available at* http://www.ama-assn.org/ama/noindex/category/ 11760.html (last visited Mar. 1, 2005).

23. *See* National Conference of State Legislatures, *Managed Care*, *at* http://www.ncsl.org/programs/health/managed.htm (last visited Mar. 1, 2005).

24. AM. MED. ASS'N, COUNCIL ON MEDICAL SERVICES REPORT 5 (Dec. 2001), *at* http://www.ama-assn.org/ama/pub/category/7008.html; *see also* AM. MED. ASS'N, HEALTH AND ETHICS POLICIES OF THE AM. MED. ASS'N HOUSE OF DELEGATES H-285.920, *available at* http://www.ama-assn.org/ama/noindex/category/ 11760.html (last visited Mar. 1, 2005) (setting forth criteria, acceptable to the medical profession, for the development and use of level of care guidelines). There is intense debate between the managed care industry and the medical profession as to whether the guidelines meet these standards.

25. *See* National Conference of State Legislatures, *What Legislators Need to Know About Managed Care: Executive Summary*, *at* http://www.ncsl.org/public/catalog /6642ex.htm (last visited Mar. 1, 2005) [hereinafter *Executive Summary*].

rates substantially reduced from those charged to nonbeneficiaries. In exchange, the MCOs provide economic inducements to beneficiaries to utilize the providers' services.[26] The contracts between the MCOs and the care providers are sometimes called "provider panel contracts." The providers are deemed to belong to the managed care organization's "provider panel." Such arrangements are feasible only if large numbers of potential patients subscribe to the managed care organization's health care plan.

Managed care has several drawbacks. First, the process interposes a potentially disruptive third party, the MCO, into what should ideally be a private and intimate relationship between patient and physician.[27] Another drawback is that the bureaucratic procedures and personnel imposed by managed care are sources of significant inefficiency. A third drawback arises in situations where optimal medical care is substantially more expensive than suboptimal care. MCOs have their own, frequently disparaged, economic incentives that may sacrifice patient welfare to cost considerations. Today, more than 200 million Americans are covered by private or government-sponsored managed care plans.[28]

A health maintenance organization (HMO) is one type of MCO. The Federal Health Maintenance Act, defines an HMO as an entity, organized under state law, that, inter alia, provides basic health services for a predetermined periodic fee.[29] That fee "is fixed without regard to the frequency, extent, or kind of service (within the basic health services) actually furnished."[30] HMOs are seen as alternatives to the more traditional fee-for-service health care plans where payments are made for each service rendered. As with all MCOs, HMOs employ economic incentives to reduce

26. *See* AM. MED. ASS'N, PRINCIPLES OF MANAGED CARE 2 (5th ed. 2004), *available at* http://www.ama-assn.org/ama1/pub/upload/mm/363/principlesmanagecare.pdf.

27. *See* AM. MED. ASS'N, CODE OF MEDICAL ETHICS E-9.123; E-10.01(4), E-10.015, *available at* http://www.ama-assn.org/ama/noindex/category/11760.html (last visited Mar. 1, 2005).

28. *See* America's Health Insurance Plans, About AHIP, *at* http://www.ahip.org/ (last visited Mar. 1, 2005) (representing nearly 1300 companies that provide health insurance coverage). An ERISA plan that uses an MCO to provide or administer benefits is sometimes called a "managed care plan." *See Executive Summary, supra* note 25.

29. 42 U.S.C. §§ 300e(a), (b)(1) (2000).

30. *Id.* at (b)(1).

overall health care expenditures.[31]

In non-emergency situations, HMOs generally require prospective "utilization review" before providing coverage.[32] HMOs make their utilization review decisions by interpreting the documents that define their coverage.[33] Such documents regulate the scope of coverage through specific exclusions and a general contract term requiring that services and other benefits be "medically necessary."[34] Participants (also called "members" or "beneficiaries") may appeal adverse coverage determinations through administrative procedures provided by the HMO or, in most states, by statutorily mandated external reviews.[35] HMO participants are also free to obtain whatever health care they choose, so long as they are willing and able to pay for such care.[36]

HMOs provide various mechanisms to challenge prospective benefit denials. In the simplest situation, a physician may telephone or write to an HMO utilization reviewer to explain why the denial was improper.[37] Although third-party health care payers pay physicians for the provision of medical services, neither HMOs nor the patients will, as a general rule, pay extra for ancillary efforts such as writing letters or making telephone calls to HMO

31. *Executive Summary*, *supra* note 25.

32. *Id.*

33. *See generally* AM. MED. ASS'N, MODEL MANAGED CARE CONTRACT (3d ed. 2002), *available at* http://www.ama-assn.org/ama/pub/category/9559.html [hereinafter AMA, MODEL MANAGED CARE CONTRACT] (last visited Mar. 1, 2005).

34. *Id.* at 39-40. The American Medical Association defines "medical necessity" as

> [h]ealth 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.

Id.; *see also* AMA Policy H-320.953(3), *available at* http://www.ama-assn.org/ama/noindex/category/11760.html (last visited Mar. 1, 2005). While some MCOs have moved toward the AMA definition, it is not industry standard. Many MCOs emphasize cost containment as an element of the medical necessity determination.

35. AMA, MODEL MANAGED CARE CONTRACT, *supra* note 33, at 40.

36. *See Executive Summary*, *supra* note 25.

37. The AMA believes that physicians have an ethical duty to advocate for their patients with HMOs to secure necessary medical care. AMA CODE OF MEDICAL ETHICS §§ E-8.13, E-8.135, *available at* http://www.ama-assn.org/ama/noindex/category/ 11760.html (last visited Mar. 1, 2005).

administrators.[38] Time and effort spent by a physician or his office staff to override an HMO coverage decision will generally go uncompensated.[39]

Because HMOs transfer costs of ongoing medical expenditures from individual members to a large institution by means of a fixed fee, they are sometimes considered insurance companies.[40] However, they also decide what medical care is necessary in specific circumstances and provide care through their panel of physicians and other medical care givers.[41] Therefore, they may also be deemed, themselves, providers of medical treatment.[42]

Supporters claim that because HMOs have an incentive to minimize the medical procedures utilized, HMOs reduce waste and encourage preventive care.[43] Detractors counter that the principal effect is merely to reduce the amount of care received, with little regard for what may be medically necessary.[44] HMO incentives have been waggishly critiqued in the following terms:

> From a short-term financial standpoint—which we do not suggest is the only standpoint that an HMO is likely to have—the HMO's incentive is to keep you healthy if it can

38. AMA COUNCIL ON MEDICAL SERVICE REPORT, PAYMENT FOR MANAGED CARE ADMINISTRATIVE SERVICES 266 (Dec. 1997).

39. Even if the patient wanted to pay the physician for advocating on his behalf, he probably could not do so. As noted *supra*, the federal HMO law specifies that, for basic health services the premium is a fixed sum, regardless of the extent of basic health services provided. 42 U.S.C. § 300e(b)(1). Arguably, provider panel contracts could define physician advocacy efforts as something other than "basic health services" for these purposes. In practice, they do not. Standard HMO contracts prohibit physicians from receiving any payments from patients (through what is known as "balance billing"), except under narrowly defined circumstances. AMA, MODEL MANAGED CARE CONTRACT, *supra* note 33, § 3.10; *see also* Kartell v. Blue Shield of Mass., Inc., 749 F.2d 922, 923 (1st Cir. 1984) (upholding a "ban on balance billing" practice if doctors do not make additional charges).

40. Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 366-67 (2002).

41. *Id.*

42. *Id.*

43. Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic, 65 F.3d 1406, 1409 (7th Cir. 1995); *see* America's Health Insurance Plans, *Health Care Quality: Utilization of Health Services, at* http://www.ahip.org/content/default.aspx?bc= 41|331|360 (last visited Mar. 1, 2005).

44. *Blue Cross & Blue Shield United of Wis.*, 65 F.3d at 1409. HMO travails are a popular Hollywood staple. For example, the movies JOHN Q (New Line Productions, Inc. 2002) (starring Denzel Washington), AS GOOD AS IT GETS (Columbia/TriStar Studios 1997) (starring Helen Hunt), and THE RAINMAKER (Paramont Studio 1997) (starring Matt Damon) all addressed heroic efforts by ordinary citizens to secure payment from the evil HMO for their critically ill children.

> but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible. HMOs compensate for these perceived drawbacks by charging a lower price than fee-for-service plans.[45]

C. The Patients' Bill of Rights and the Texas Health Care Liability Act

As observed in Part I.A, ERISA does not substantively regulate welfare plans. Yet the very nature of the HMO calls for government regulation. Insurance policies are written in legally dense terms, prepared solely by HMO attorneys. Huge disparities in size and sophistication separate an HMO and its individual members. At the very moment when plan beneficiaries are most in need of the protection promised by their health insurance companies, they may be least able to advocate for their rights. The fundamental issue as to what medical services should be covered in a specific situation is, at least in the details, beyond a lay person's capacity to determine. The potential for deception, overreaching, or other forms of heavy-handedness by MCOs is rife.

In response to the regulatory vacuum, consumer advocates have called for a "patients' bill of rights."[46] The concept, in essence, describes laws that would protect beneficiaries of MCOs from wrongful benefit denials by HMOs. At the federal level, it refers to an amendment to ERISA that would provide tort damages for such denials. Although bills to this effect have been introduced in both houses of Congress and have been the subject of nationally televised debate during the past two presidential elections,[47] no such legislation has been passed.[48]

Patients' rights advocates have been more successful at the state level. The first state patients' bill of rights, known as Senate Bill 386 (S.B. 386), was passed in Texas and took effect May 22, 1997.[49] S.B. 386 included THCLA, which imposes tort liability on MCOs (including HMOs) that fail to exercise ordinary care when

45. *Blue Cross & Blue Shield United of Wis.*, 65 F.3d at 1410.

46. *See* Sydney A. Halpern, *Medical Authority & the Culture of Rights*, 29 J. HEALTH POL. POL'Y & L. 835, 847 (Aug. - Oct. 2004).

47. Commission on Presidential Debates, Debate Transcripts, *available at* http:// www.debates.org/pages/debtrans.html (last visited Mar. 1, 2005).

48. *See* Sylvia A. Law, *Do We Still Need a Federal Patients' Bill of Rights?*, 3 YALE J. HEALTH POL'Y, L. & ETHICS 1, 27-31 (2002) (discussing the political battle over a patients' bill of rights).

49. S.B. 386, 1997 Leg., 75th Sess. (Tex. 1997).

making health care treatment decisions.[50]

THCLA section 88.002 states:

> A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care. [This creates] no obligation on the part of the . . . health maintenance organization . . . to provide to an insured or enrollee treatment which is not covered by the health care plan . . . .[51]

THCLA section 88.001 states:

> (5) Health care treatment decision' means a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees.
>
> . . . .
>
> (8) 'Managed care entity' means any entity which delivers, administers, or assumes risk for health care services with systems or techniques to control or influence the quality, accessibility, utilization, or costs and prices of such services to a defined enrollee population, but does not include an employer purchasing coverage . . . on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer . . . .
>
> . . . .
>
> (10) 'Ordinary care' means, in the case of a . . . health maintenance organization . . . that degree of care that a . . . health maintenance organization . . . of ordinary prudence would use under the same or similar circumstances.[52]

Almost immediately after its passage, Aetna Insurance Company, one of the largest insurance companies in the United States, sued to have S.B. 386 declared invalid as being in conflict

50. *Id.*

51. TEX. CIV. PRAC. & REM. CODE ANN. § 88.002 (Vernon 1997).

52. *Id.* at § 88.001. The THCLA definition of "managed care entity" closely tracks the AMA definition of "managed care." *See supra* note 22 and accompanying text.

with ERISA and with the Federal Employees Health Benefit Act.[53] For the most part, the Fifth Circuit ruled against Aetna and upheld S.B. 386.[54] It specifically upheld the tort liability provisions, by holding, in essence, that those provisions regulated health care and so they did not impinge on the federal regulation of employee benefit plans.[55]

Despite the favorable ruling from the Fifth Circuit, the victory for THCLA was incomplete. The United States Supreme Court had not examined THCLA. Until *Davila/Calad*, whether state laws that impose such tort liability on HMOs could withstand a Supreme Court challenge remained an open question.[56]

II. THE *DAVILA/CALAD* CASE

A. *Underlying Facts*

1. Davila

Juan Davila was a post-polio patient suffering from diabetes and arthritis.[57] He received Aetna HMO coverage through his employer's health plan.[58] Aetna administered the plan by, inter alia, determining coverage, and it funded the plan by paying for benefits from its own assets.[59]

As part of its benefit structure, Aetna established a formulary to govern the use of prescription drugs.[60] Under the formulary, Aetna unconditionally approved certain drugs, without a pre-certification requirement, so long as it deemed them medically

53. Corp. Health Ins., Inc. v. Tex. Dep't of Ins., 215 F.3d 526 (5th Cir. 2000), *reh'g denied*, 220 F.3d 641 (2000), *vacated in part on other grounds*, *sub nom.* Montemayor v. Corp. Health Ins., 536 U.S. 935 (2002); *see also* 29 U.S.C. §§ 1001-461 (ERISA); 5 U.S.C. §§ 8901-13 (Federal Employees Health Benefit Act).

54. 215 F.3d at 526.

55. *Id.* at 534.

56. When *Davila/Calad* was decided, fourteen states had laws imposing tort liability against HMOs for incorrect decisions as to proper health care treatment. *See* NAT'L CONFERENCE OF STATE LEGISLATURES, *Managed Care Insurer Liability*, *at* http://www.ncsl.org/programs/health/liable.htm (last visited Mar. 1, 2005).

57. Roark v. Humana, Inc., 307 F.3d 298, 303 (5th Cir. 2002), *rev'd sub nom.* Aetna Health Inc. v. Davila, 124 S. Ct. 2488 (2004).

58. *Id.*

59. *See* Brief for Petitioner Aetna Health, Inc., at 6, Aetna Health, Inc. v. Davila, 124 S. Ct. 2488 (2004) (No. 02-1845) (Dec. 18, 2003), *available at* 2003 WL 23010751 [hereinafter *Aetna Brief*].

60. *Id.* at 8.

necessary.[61] Other medications, however, which were more expensive, required a "step-therapy program."[62]

Under the formulary's step-therapy program, the patient would first have to try alternative, less expensive medications unconditionally listed in the formulary.[63] The patient would have to demonstrate that those less expensive medications were ineffective or caused intolerable side effects before Aetna would pay for the more expensive medication.[64] However, the patient's physician could explain to Aetna why the unconditionally approved drugs might be inappropriate for a particular patient, because of an allergy or other contraindication.[65] If Aetna accepted that explanation, it would allow the patient to bypass the step-therapy program and move immediately to a more expensive drug.[66]

Davila's primary care physician, who served on Aetna's provider panel (and was therefore paid by Aetna), prescribed Vioxx for Davila's arthritic pain.[67] Vioxx, an anti-inflammatory drug known as a Cox 2 inhibitor, was at the time commonly prescribed for treatment of chronic pain. Some studies had shown that Cox 2 inhibitors have a lower rate of gastrointestinal toxicity (e.g., bleeding, ulceration, perforation of the stomach) than do similar but older drugs,[68] including drugs known as Cox 1 inhibitors.[69] Aetna's formulary listed fifteen other drugs for

61. *Id.*

62. *Id.*

63. *Id.*

64. Roark v. Humana, Inc., 307 F.3d 298, 303 (5th Cir. 2002), *reversed sub nom.* Aetna Health Inc. v. Davila, 124 S. Ct. 2488 (2004).

65. *See Aetna Brief*, *supra* note 59, at 9. A physician who feels that an HMO's step-therapy program should be bypassed for a specific patient will generally be uncompensated for the effort required to communicate this recommendation to the HMO. *See supra* note 35 and accompanying text.

66. *Aetna Brief*, *supra* note 59, at 9. Step-therapy programs and drug formularies are standard features of HMO plans. They are designed to steer beneficiaries toward less expensive medications, which the HMO deems to be clinical near-equivalents of the more costly drugs. *See* Associates & Wilson, *Prescription Drug Benefit Management: Improving Quality, Promoting Better Access, and Reducing Costs*, America's Health Insurance Plans, *at* http://ahip.org/content/fileviewer.aspx?docid=170&linkid=1295 (Oct. 2003).

67. *Aetna Brief*, *supra* note 59, at 8.

68. PHYSICIANS DESK REFERENCE 2048 (Thompson eds., 58th ed. 2004).

69. Prescription of Vioxx has since been generally shown to be clinically unwarranted, due to side effects previously not fully recognized and also due to the availability of efficacious alternative medications. Its manufacturer has withdrawn the drug from further distribution. *Merck Halts Vioxx Sales on Health Threats*, Associated Press Release (Sept. 30, 2004); U.S. Food and Drug Administration, Center for Drug Evaluation and Research, *Vioxx (rofecoxib)*

treatment of chronic arthritis, which it had unconditionally approved. Vioxx, being more expensive, would not be covered unless Davila had first tried two of the unconditionally approved drugs and found them unsuitable.[70]

Davila's physician did not explain to Aetna why it should bypass the step-therapy program, and so Aetna refused to pay for the Vioxx[71] despite what the complaint alleged to be the physician's "protests."[72] Consequently, as an alternative to the Vioxx, Davila's physician prescribed Naprosyn, a Cox 1 inhibitor[73] listed as unconditionally approved on the drug formulary.[74]

After three weeks on the Naprosyn, Davila was rushed to the emergency room.[75] Emergency room doctors reported that Davila was suffering from ulcers, which were bleeding internally and had nearly led to a heart attack.[76] The hospital gave Davila seven units of blood and kept him in critical care for five days.[77] Subsequently, he was unable to take any pain medication that would be absorbed through the stomach.[78] Davila attributed his bleeding to his use of Naprosyn.[79]

2. Calad

Through her husband's employer, Ruby Calad became a beneficiary of CIGNA HealthCare of Texas, Inc. (CIGNA), a Texas HMO.[80] Calad underwent a hysterectomy with rectal, bladder, and vaginal repair.[81] A physician on CIGNA's provider panel performed the surgery.[82]

Questions and Answers, at http://www.fda.gov/cder/drug/infopage/vioxx/vioxxQA.htm (last visited Mar. 2, 2005).

70. *Aetna Brief, supra* note 59, at 9.

71. *Id.*

72. Plaintiff's Original Petition ¶ 13, Aetna Health Inc. v. Davila (on file with author).

73. PHYSICIANS DESK REFERENCE, *supra* note 68.

74. Vioxx and Naprosyn are known as nonsteroidal anti-inflammatory drugs (NSAIDs). The most famous and widely used NSAID is common aspirin.

75. Roark v. Humana, Inc., 307 F.3d 298, 303 (5th Cir. 2002), *rev'd sub nom.* Aetna Health Inc. v. Davila, 124 S. Ct. 2488 (2004).

76. *Id.*

77. *Id.*

78. *Id.*

79. *Id.*

80. *Id.* at 302.

81. *Id.*

82. *See* Brief for Petitioner CIGNA Healthcare of Texas, Inc. at 3, Aetna Health Inc. v. Davila, 124 S. Ct. 2488 (2004) (No. 03-83) (Dec. 18, 2003), *available*

The contract between CIGNA and Calad's husband's employer provided that CIGNA would, with certain exceptions, pay its beneficiaries' medically necessary health care expenses.[83] Under its standard guidelines, CIGNA generally deems a one-day stay in the hospital sufficient after a hysterectomy and ordinarily refuses to pay hospital benefits beyond that day.[84]

In this instance, Calad's surgeon recommended a longer stay than one-day.[85] CIGNA's hospital discharge nurse, however, reviewed the file and determined that the standard one-day hospital stay was medically sufficient.[86] Based on her determination, CIGNA refused to authorize payment beyond one day.[87]

Either because she was unable or unwilling to pay for the additional care out of her own pocket (or perhaps did not fully understand the situation or appreciate the medical consequences), Calad had herself discharged from the hospital after the one day that CIGNA had authorized.[88] Subsequently, however, she suffered complications from the surgery. A few days later she returned to the emergency room for further treatment. She attributed the complications to her early release from the hospital.[89]

B. Lower Court Proceedings

Davila and Calad sued separately in Texas state court,[90] alleging violations of THCLA. Davila claimed that Aetna had failed to exercise ordinary care when it refused to pay for his Vioxx, and Calad claimed that CIGNA had failed to exercise ordinary care when it refused to pay for her extended hospital stay.[91] The HMOs removed their respective cases to federal district court pursuant to 28 U.S.C. § 1441(a) based on federal question jurisdiction.[92] Davila and Calad moved to remand, and the HMOs opposed their motions on the grounds that ERISA section 502(a) completely

at 2003 WL 23010752.

83. *Id.*
84. *Id.* at 3-4.
85. *Id.*
86. *Id.*
87. *Id.*
88. *Id.*
89. *Id.*
90. *Id.* Davila and Calad used the same lawyer.
91. *Id.*
92. 28 U.S.C. § 1331 (2000).

preempted THCLA.[93] The district courts agreed, determining that the only cause of action available was under ERISA, and denied the motions to remand.[94] Both Davila and Calad refused to amend their pleadings to bring explicit ERISA claims, and the district courts dismissed the cases with prejudice under Federal Rule of Civil Procedure 12(b)(6).[95]

Davila and Calad appealed to the United States Court of Appeals for the Fifth Circuit, which consolidated their cases and joined them with two other similar suits.[96] While the procedural postures of the two other lawsuits were slightly different from the Davila and Calad cases,[97] all of the cases raised the same ultimate legal issue—whether ERISA section 502(a) preempted THCLA claims against employer-sponsored HMOs.[98]

The *Roark* decision observed that ERISA section 502(a) lists various remedies established by Congress to rectify ERISA violations. The court noted that in prior cases it had deemed some claims related to ERISA plans to be "completely preempted."[99] If state causes of action "duplicate[] or fall[] within the scope of an ERISA section 502(a) remedy," they are completely preempted and removable to federal court.[100] Otherwise, they are not completely preempted and not removable to federal court.[101] The question was whether the *Davila/Calad* lawsuits sought to duplicate or fall within the scope of the ERISA section 502(a) remedies.

After examining the causes of action available under section 502(a), the court determined that most of the section 502(a)

93. *See* Brief for Petitioner CIGNA Healthcare of Texas, Inc. at 3, Aetna Health Inc. v. Davila, 124 S. Ct. 2488 (2004) (No. 03-83) (Dec. 18, 2003), *available at* 2003 WL 23010752.

94. *Id.*

95. Roark v. Humana, Inc., 307 F.3d 298, 302-03 (5th Cir. 2002), *rev'd sub nom.* Aetna Health Inc. v. Davila, 124 S. Ct. 2488 (2004).

96. The two other suits were also brought by the same lawyer for the plaintiffs. The Fifth Circuit decision for the consolidated cases is published as *Roark v. Humana, Inc.*, 307 F.3d 298 (5th Cir. 2002). Roark is the plaintiff's name in one of the companion lawsuits and Humana was the HMO sued in that case.

97. For example, in one of the companion suits the district court judge had granted the motion to remand, finding the THCLA claim not preempted

98. The other two cases ultimately settled and were not argued before the United States Supreme Court. *Roark v. Humana, Inc.*, 307 F.3d 298 (5th Cir. 2002), *cert. dismissed,* 539 U.S. 986 (2003).

99. *See Roark*, 307 F.3d at 309.

100. *Id.* at *305* (internal quotation marks and citations omitted).

101. *Id.*

remedies were clearly inapplicable.[102] Arguably, though, the *Davila/Calad* claims might fall under either of two provisions of section 502(a): section 502(a)(1)(B), which provides a cause of action for the recovery of wrongfully denied benefits, or section 502(a)(2), which allows suit against a plan fiduciary for breaches of fiduciary duty to the plan.[103]

Analyzing section 502(a)(2), the court determined that the decisions for which the HMOs were being sued were "mixed eligibility and treatment decisions," as described in *Pegram v. Herdrich*[104] and, hence, were not fiduciary in nature.[105] Thus, section 502(a)(2) was inapplicable.[106] The court next found that Davila's and Calad's claims did not fall within the scope of section 502(a)(1)(B) either. The court noted that Section 502(a)(1)(B) creates a cause of action for reimbursement of wrongfully denied benefits—essentially, a claim for breach of contract.[107] Davila and Calad, however, were seeking tort damages, arising from "an external, statutorily imposed duty of 'ordinary care.'"[108]

The Fifth Circuit concluded that because the THCLA cause of action was different from the causes of action listed in section 502(a) it was not completely preempted. Accordingly, Davila and Calad had brought valid suits under a state law, and there was no reason to dismiss those suits for failure to state a cause of action or to infer that a THCLA claim was one that could only be brought under a federal statute, ERISA. Therefore, because the court did not have federal question jurisdiction, the trial courts should have granted the motions to remand.[109] The court reversed the *Davila* and *Calad* cases on that basis.[110]

102. *Id.*
103. *Id.* at 305-06.
104. 530 U.S. 211, 229 (2000).
105. *Pegram* held that a decision by a physician acting on behalf of an HMO as to the proper course of medical treatment for a plan beneficiary was not fiduciary in nature, within the meaning of ERISA section 502(a)(2). *Id.* The Court characterized the physician's decision as to how the patient should be treated for appendicitis as one of "mixed eligibility and treatment," because the patient's eligibility for benefits from the HMO depended on that treatment decision. *Id. Pegram* concerned liability under ERISA itself (holding that there was no such liability) and did not address preemption of state law. *Id.*
106. *Roark*, 307 F.3d at 308.
107. *Id.* at 309.
108. *Id.*
109. *Id.* at 315.
110. The Fifth Circuit affirmed the lower court decisions in the companion suits, which were in a different procedural posture from the Davila and Calad

C. Conflict in the Courts

Aetna and CIGNA both petitioned the Supreme Court for *certiorari*. The Fifth Circuit had relied heavily on the *Pegram* rationale, and judicial decisions before *Pegram* became arguably irrelevant to a current understanding of the law. Thus, one might have expected a passage of several years before the lower courts could develop an analysis of "mixed eligibility and treatment decisions." This was not so.

The question of HMO tort liability for medical necessity decisions was too important to remain on the back burner. By 2003, when the Supreme Court addressed the writ of certiorari petitions, a clear split had already developed in the lower court decisions. *Land v. CIGNA Healthcare of Florida*,[111] *Cicio v. Does*,[112] and *Pappas v. Asbel*[113] all held that ERISA does not completely preempt state laws of negligence against HMOs who withhold payment of health care benefits because they have determined that proposed treatment is medically unnecessary—a "mixed eligibility and treatment decision" under *Pegram*.[114] On the other hand, *DiFelice v. Aetna U.S. Healthcare*[115] held in favor of complete ERISA preemption of state law.[116] Unlike the *Davila/Calad* suit, all of those cases considered common law negligence, rather than a statute specifically tailored to the health insurance industry, such as THCLA. The Court granted *certiorari* to CIGNA and Aetna on November 3, 2003.[117]

cases. In the *Roark* case itself, the panel held that ERISA did preempt THCLA, stating that it might have decided against preemption "[i]f we were writing on a clean slate." *Id.* at 313. However, it felt procedurally bound by what it deemed a "factually indistinguishable" precedent, *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992). *Id.* The panel intimated that an *en banc* court might decide this issue differently. *Id.* However, a later request for *en banc* hearing was denied. *Roark v. Humana, Inc.*, Nos. 01-10831, 01-10891, 01-10905, 2003 WL 21018397 (5th Cir. Apr. 15, 2003). As observed *supra*, note 98, both companion cases then settled.

111. 339 F.3d 1286 (11th Cir. 2003).

112. 321 F.3d 83 (2d Cir. 2003).

113. 768 A.2d 1089 (Pa. 2001).

114. 530 U.S. 211 (2000).

115. 346 F.3d 442 (3d Cir. 2003).

116. *Id.* at 449.

117. CIGNA HealthCare of Tex., Inc. v. Calad, *cert. granted*, 124 S. Ct. 463 (2003); Aetna Health Inc. v. Davila, *cert. granted*, 124 S. Ct. 462 (2003).

D. Supreme Court Decision

The Supreme Court, after first recounting the underlying facts of the *Davila/Calad* case and the Fifth Circuit decision, explained the general nature of the complete preemption doctrine. Under 28 U.S.C. § 1441(a), a civil action filed in a state court can be removed to a federal court if the plaintiff could have filed in federal court initially and the federal court would have had proper subject matter jurisdiction. One such category of suit is a "federal question" case: a case "arising under the Constitution, laws, or treaties of the United States."[118] The issue in *Davila/Calad* was whether those actions had arisen under the laws of the United States, notwithstanding that the complaints on their face purported to be based solely on violations of THCLA and never mentioned ERISA or any other federal law.

Under the "well-pleaded complaint" rule, the determination of federal question jurisdiction comes from the plaintiff's statement of his own claim. If the plaintiff asserts a cause of action necessarily based on a federal law, then the federal courts could have had jurisdiction over the case and the suit can be removed from state to federal court. If the claim is not based on federal law, however, it is not removable.[119] The well-pleaded complaint rule applies even if it is certain that the defendant will argue federal law to defend against the claim. In fact, it applies even if the complaint explicitly anticipates, on its face, that a federal law will be raised in defense and it then cites to that law.[120] As long as the complaint raises solely state law claims it is not removable.[121]

An exception arises, however, if a federal statute "wholly displaces the state-law cause of action through complete pre-emption."[122] This occurs when Congress intends that federal law is to regulate all aspects of a particular area of law. In such instances, federal law preempts state law, and even if the claim is couched solely in terms of a state law claim, the claim is deemed to be based on federal law.[123] When a claim is made in a completely preempted area of law it is removable to the federal courts. ERISA, the Court

118. 28 U.S.C. § 1331 (2000).
119. *Davila/Calad*, 124 S. Ct. 2488, 2494 (2004).
120. Caterpillar Inc. v. Williams, 482 U.S. 386 (1987).
121. *Davila/Calad*, 124 S. Ct. at 2494.
122. *Id.* at 2494-95 (quoting Beneficial Nat'l Bank v. Anderson, 539 U.S. 1, 8 (2003)).
123. *Id.* at 2495.

held, is one of those statutes giving rise to complete preemption.[124]

The Court cited three factors to justify its conclusion that ERISA completely preempts state law. First, ERISA sets out substantive regulatory requirements for employee benefit plans, which establish a "uniform regulatory regime," including a detailed catalogue of remedies and sanctions for violations of the statute.[125] Thus, "[t]he policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under the state law that Congress rejected in ERISA."[126] Second, ERISA section 514[127] includes expansive pre-emption provisions. These ensure that employee benefit plan regulation is to be exclusively a federal concern.[128] Third, *Metropolitan Life Insurance Co. v. Taylor*[129] had found the language of ERISA to be similar to the language of section 301 of the Labor Management Relations Act of 1947 (LMRA).[130] *Avco Corp. v. Aero Lodge No. 735, International Association of Machinists*[131] held that LMRA section 301 converts state causes of action into federal ones to determine the propriety of removal[132] and therefore ERISA section 502(a)(1)(B) should be given the same weight.[133] Thus, the ERISA civil enforcement mechanism should be deemed a provision with "such extraordinary pre-emptive power" that, for purposes of the well-pleaded complaint rule, it converts an ordinary state law complaint into a federal claim.[134]

Next, the Court held that because ERISA section 502(a)(1)(B) sets forth remedies for denial of coverage promised under an employee benefit plan, a suit complaining of a benefit denial is limited to ERISA remedies unless the benefit denial gives rise to a violation of law independent of ERISA and of the plan terms.[135] In *Davila/Calad*, the only complaints were that the HMOs denied the

124. *Id.*
125. *Id.*
126. *Id.* (quoting Pilot Life Ins. Co. v. Dedeaux, 418 U.S. 41, 42 (1987)).
127. 29 U.S.C. § 1144 (2000).
128. *Davila/Calad*, 124 S. Ct. at 2495-96.
129. 481 U.S. 58 (1987).
130. *Id.* at 65-66; *see* 29 U.S.C. § 185 (2000).
131. 390 U.S. 557 (1968).
132. *Id.* at 560.
133. *Davila/Calad*, 124 S. Ct. at 2496.
134. *Id.*
135. *Id.*

coverage promised under the terms of ERISA-regulated employee benefit plans. Davila and Calad premised their cases under THCLA, but their THCLA claims derived from the rights and obligations established by the benefit plans, which were federally regulated contracts.[136] Hence, regardless of their characterization, Davila's and Calad's claims fell within the scope of ERISA section 502(a)(1)(B) and were completely preempted and removable to federal court.[137]

The Court then disposed of the argument, made in the Fifth Circuit and in several other lower courts,[138] that mixed eligibility and treatment decisions, as described in *Pegram*, should fall outside ERISA's preemptive scope. *Pegram*, it said, should be limited to situations where the person making the coverage decisions is also the claimant's treating physician.[139] Here, there was no such relationship between Davila, Calad, and their respective HMOs. The decisions in this case were "pure eligibility decisions," and thus, *Pegram* was not implicated.[140]

Accordingly, the Court reversed the Fifth Circuit's judgment and remanded for further proceedings consistent with its findings of complete pre-emption under ERISA section 502(a)(1)(B) and valid removability to the federal courts.[141] While not explicitly stated, the clear inference was that the courts were to dismiss the complaints because Davila and Calad had announced that they would not amend their complaints to allege ERISA-based claims.[142]

While the decision was unanimous, Justice Ginsburg, joined by Justice Breyer, filed a concurring opinion.[143] She noted that the Court's decisions in this area had "yielded a host of situations in which persons adversely affected by ERISA-proscribed wrongdoing cannot gain make-whole relief."[144] A "gaping wound" was caused by "the breadth of preemption and limited remedies under ERISA, as interpreted by this Court."[145] She therefore joined a "rising judicial chorus urging that Congress and this Court revisit what is an unjust

136. *Id.* at 2496-97.
137. *Id.* at 2498.
138. *See supra* Part II.C.
139. *Davila/Calad*, 124 S. Ct. at 2501.
140. *Id.* at 2502.
141. *Id.*
142. That is, in fact, what subsequently happened. *See* Calad v. CIGNA Healthcare of Tex., Inc., 388 F.3d 167 (5th Cir. 2004).
143. *Davila/Calad*, 124 S. Ct. at 2503-04.
144. *Id.* at 2503.
145. *Id.*

and increasingly tangled ERISA regime."[146]

III. ANALYSIS

The Supreme Court decision set forth two principal, intertwined holdings. First, the Court directly mandated that lawsuits by beneficiaries of most employer-sponsored health plans against their health insurance companies[147] should be deemed to raise a federal question and therefore be removable to the federal courts even if they were purportedly based on state law.[148] This holding concerns an area of federal civil procedure and has only a limited impact.

The second, more consequential holding is that state laws that impose tort liability on ERISA-covered MCOs for wrongful denial of medical benefits are invalid.[149] This holding, because of its substantive character, is further reaching than the procedural one. Both holdings are questionable readings of the controlling statutes and of the relevant policy considerations.

As Justice Ginsburg intimated, few, if any, areas of law are more tangled than that of ERISA preemption.[150] The Supreme Court has written extensively on this narrow issue and has repeatedly revised its holdings.[151] To explore the topic's intricacies,

146. *Id.* (quoting DiFelice v. Aetna United States Healthcare, 346 F.3d 442, 453 (3d Cir. 2003) (Becker, J., concurring)).

147. In 2003, approximately 159-million Americans were insured under employer-sponsored health plans. *See Employer-Sponsored Health Insurance: Trends in Cost and Access*, RESEARCH IN ACTION (Agency for Healthcare Research & Quality, Rockville, Md.), at 1, 2 (Sept. 2004), *available at* http://www.ahrq.gov/research/empspria/ empspria.pdf. Not all of these are covered by ERISA, as ERISA does not apply to plans maintained by governmental entities or certain churches. 29 U.S.C. § 1003(b) (2000).

148. *Davila/Calad*, 124 S. Ct. at 2495.

149. The *Davila/Calad* suit was brought against two HMOs for denial of allegedly necessary medical services. The *Davila/Calad* holding is broad enough to immunize any employer sponsored health plan against tort liability for denial of promised benefits. As a practical matter, tort claims, were they allowed, would almost always be confined to HMOs on account of medical necessity denials. This is because the practice of prospective utilization review is largely confined to HMOs, and that practice is what generally gives rise to tort claims in the managed care context. *See supra* Part I.B. However, managed care plans other than HMOs also engage in utilization review, and such review could, on occasion, give rise to a tort claim. *See* Rubin-Schneiderman v. Merit Behavioral Care Corp., No. 00 Civ. 8101, 2003 U.S. Dist. LEXIS 14811 (S.D.N.Y. Aug. 27, 2003) (tort claim made against preferred provider organization, another type of managed care entity).

150. *Davila/Calad*, 124 S. Ct. at 2503 (Ginsburg, J., concurring).

151. At least twenty Supreme Court decisions, not counting *Davila/Calad*, have

the analysis of *Davila/Calad* must follow a twisted and somewhat tortuous path. The basic points are: (1) the *Davila/Calad* decision is inconsistent with a specific statutory provision, ERISA section 514(b); (2) the decision is inconsistent with several considerations of public policy, as enunciated in numerous Supreme Court decisions and in ERISA itself; and (3) the rationales that support the Court's holding are flimsy.

A. The Procedural Holding: Removal Jurisdiction Through Recharacterization of State Law Claims

With minor exceptions, federal courts only have such jurisdiction as is granted by specific Congressional enactments.[152] The underlying jurisdictional law cited in *Davila/Calad* was 28 U.S.C. § 1331, the federal question statute, which provides that "[t]he district courts shall have original jurisdiction of all civil actions arising under the . . . laws . . . of the United States."[153]

Consistent with the constitutional doctrine that national governmental powers are limited in nature,[154] federal jurisdictional statutes, including the federal question statute, are construed against the exercise of federal court jurisdiction.[155] One aspect of this doctrine of strict statutory construction is the well-pleaded complaint rule, which was first recognized in *Louisville & Nashville Railroad v. Mottley*.[156] In that case, the complaint alleged a claim

decided the appropriate scope of ERISA preemption, under varying circumstances. *See KAHP*, 538 U.S. 329 (2003); Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002); Egelhoff v. Egelhoff, 532 U.S. 141 (2001); UNUM Life Ins. Co. of Am. v. Ward, 526 U.S. 358 (1999); Boggs v. Boggs, 520 U.S. 833 (1997); De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806 (1997); Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., 519 U.S. 316 (1997); N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins., 514 U.S. 645 (1995); John Hancock Mut. Life Ins. Co. v. Harris Trust and Sav. Bank, 510 U.S. 86 (1993); District of Columbia v. Greater Wash. Bd. of Trade, 506 U.S. 125 (1992); Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1990); FMC Corp. v. Holliday, 498 U.S. 52 (1990); Massachusetts v. Morash, 490 U.S. 107 (1989); Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825 (1988); Fort Halifax Packing Co. v. Coyne, 482 U.S. 1 (1987); Metro. Life Ins. Co. v. Taylor, 481 U.S. 58 (1987); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987); Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985); Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983); Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504 (1981).

152. U.S. CONST. art. III, § 2, cl. 2.

153. 28 U.S.C. § 1331 (2000).

154. United States v. Morrison, 529 U.S. 598, 617 (2000).

155. Kresberg v. Int'l Paper Co., 149 F.2d 911, 913 (2d Cir. 1945), *cert. denied*, 326 U.S. 764 (1945).

156. 211 U.S. 149 (1908).

based on state law.[157] It further alleged that the defense would be based on a federal law, which in turn was alleged to be invalid under the United States Constitution.[158] The Supreme Court held that such pleading did not give rise to federal question jurisdiction because the complaint would have been sufficient if it had merely asserted the state law claim without anticipating the federal defense.[159] The nature of the underlying claim and not the defenses defined the legal issues for purposes of jurisdiction.[160]

The well-pleaded complaint rule has been defined as follows: "a case will be said to 'arise under' federal law only if the presence of the federal issue or issues can be ascertained from the plaintiff's well-pleaded complaint, that is, a complaint that does not anticipate possible federal defenses that the defendant might raise."[161] *Caterpillar, Inc. v. Williams,*[162] a suit by a union employee against an employer, found the state law not to be preempted and gave the following rationale for the rule:

> [T]he presence of a federal question . . . in a defensive argument does not overcome the paramount policies embodied in the well-pleaded complaint rule—that the plaintiff is the master of the complaint, that a federal question must appear on the face of the complaint, and that the plaintiff may, by eschewing claims based on federal law, choose to have the cause heard in state court.[163]

A preemption defense, based on the invalidity of the state law that underlies a claim, is deemed affirmative in nature.[164] It must be specifically raised in the defensive pleadings, and ordinarily it will not, by itself, justify removal jurisdiction.[165]

The well-pleaded complaint rule is also justified on the grounds of consistency. While the plaintiff can choose between a federal or a state forum, that choice is determined according to the

157. *Id.*
158. *Id.* at 150-52.
159. *Id.* at 153-54.
160. *Id.*
161. 15 JAMES WM. MOORE & DANIEL R. COQUILLETTE, MOORE'S FEDERAL PRACTICE § 103.40 (3d ed. 1997).
162. 482 U.S. 386 (1987).
163. *Id.* at 398-99.
164. 5 CHARLES A. WRIGHT & ARTHUR R. MILLER, FEDERAL PRACTICE AND PROCEDURE § 1271 n.56 (3d ed. 1992).
165. *Id.*

nature of the claim, rather than the vagaries of the pleadings.[166] Furthermore, it is straightforward and relatively easy to apply. Certainly, it has attained a historical validity and has become generally appreciated as a desirable aspect of federalism.[167]

In addition to statutes that allow plaintiffs to obtain original federal court jurisdiction, the removal laws allow defendants to have cases transferred from state to federal courts. The provisions purportedly justifying removal in the *Davila/Calad* case were 28 U.S.C. § 1441(a) and (b), which state as follows:

> § 1441. Actions removable generally
>
> (a) Except as otherwise expressly provided by Act of Congress, any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending. For purposes of removal under this chapter, the citizenship of defendants sued under fictitious names shall be disregarded.
>
> (b) Any civil action of which the district courts have original jurisdiction founded on a claim or right arising under the Constitution, treaties or laws of the United States shall be removable without regard to the citizenship or residence of the parties. Any other such action shall be removable only if none of the parties in interest properly joined and served as defendants is a citizen of the State in which such action is brought.[168]

Removal jurisdiction is generally disfavored,[169] and uncertainties in the application of these statutes are resolved in support of remand.[170] This construction mirrors that of the statutes giving rise to original federal jurisdiction. It follows the

166. 13 CHARLES A. WRIGHT & ARTHUR R. MILLER, FEDERAL PRACTICE AND PROCEDURE § 3522 (2d ed. 1987).

167. The well-pleaded complaint rule has nevertheless been criticized as a doctrine that "makes no sense." 15 MOORE, *supra* note 161, § 103.41.

168. 28 U.S.C. § 1441 (a),(b) (2000).

169. 16 MOORE, *supra* note 161, §107.06.

170. Removal from the state to the federal courts is accomplished by the defendant's filing of a notice of removal with the clerk of the state court. Removal is non-discretionary. 28 U.S.C. § 1446. To undo the removal, the plaintiff moves for remandment with the federal court, which then considers whether it has the necessary jurisdiction. The court may also remand *sua sponte*, if it determines that it lacks jurisdiction. 28 U.S.C. § 1447.

constitutional precepts that the federal government was created with limited powers and that the federal courts should have only such jurisdiction as Congress granted them.[171]

Apart from these constitutional considerations, strict construction of the removal statute is justified by concerns of judicial efficiency. An order denying a motion to remand, being interlocutory, is ordinarily not appealable until after the entry of final judgment.[172] If, following denial of remand, the court of appeals determines that the case should have been remanded for lack of federal court jurisdiction, the judgment on the merits must also be vacated.[173] If the remand order was incorrect, then the defendant may have lost the right to litigate in federal court,[174] but the ultimate state court judgment will not suffer from a lack of subject matter jurisdiction.[175] Thus, an improper remand is less wasteful of judicial resources than an improper denial of a request for a remand.

Furthermore, because original jurisdiction statutes and removal jurisdiction statutes are both construed against federal court jurisdiction, they are easy to apply and understand. The federal courts do not need to reconcile competing policy considerations because the considerations are identical under both statutes. Until the Supreme Court created an exception to these jurisdictional rules, the rules gave a consistent result across all actions.

If exception is to be made, as *Davila/Calad* itself suggests, the exception should be based on a "clear" and not a speculative reading of congressional intent.[176] Or, as Justice Frankfurter said:

> Federal legislation . . . cannot therefore be construed without regard to the implications of our dual system of government . . . . [I]t is not to be assumed as a matter of course that when Congress adopts a new scheme for federal . . . regulation, it deals with all situations falling within the general mischief which gave rise to the legislation . . . . [W]hen the Federal Government takes over . . . and thereby radically readjusts the balance of state and national authority, those charged with the duty

171. 16 MOORE, *supra* note 161, §107.05.
172. 28 U.S.C. § 1291.
173. Firestone Tire & Rubber Co. v. Risjord, 449 U.S. 368, 379-80 (1981).
174. An order of remand is generally not appealable. 28 U.S.C. § 1447(d).
175. 16 MOORE, *supra* note 161, §107.05.
176. 124 S. Ct. at 2494-95.

of legislating [must be] reasonably explicit.[177]

The strength of the Supremacy Clause is not undermined by this analysis.[178] In deciding whether a case is decided by a state or a federal court, a rule established by state law must give way to a conflicting rule established by federal law.[179] The only issue addressed by the well-pleaded complaint rule, and by the rules of construction applicable to the federal question and removal statutes, is who should make these decisions—a state court or a federal one.

The *Davila/Calad* case espoused a radical exception to these restricted views of federal court jurisdiction, holding that the *Davila/Calad* claims fell within *Avco*'s "complete preemption" doctrine.[180] In a suit by a beneficiary against an employer-sponsored health insurance plan, the court, not the plaintiff, should be the master of the complaint. The benefits of orderliness, judicial efficiency, and ease of understanding should not be determinative. Federalist concerns are trumped because ERISA, supposedly, shows that Congress intended an exception to the traditional rules of pleading and the construction of jurisdictional statutes.

ERISA section 502(a)(1)(B),[181] which the Court interpreted as creating an exception to the well-pleaded complaint rule, is as follows:

> A civil action may be brought—(1) by a participant or beneficiary— . . . (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.[182]

This statute says nothing about jurisdiction or about re-characterization of pleadings. ERISA section 502(e)(1),[183] however, speaks directly to jurisdiction. ERISA section 502(e)(1) says (in

177. Felix Frankfurter, *Some Reflections on the Reading of Statutes*, 47 COLUM. L. REV. 527, 540 (1947).

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

179. *Id.*

180. Avco Corp. v. Aero Lodge No. 735, 390 U.S. 557, 560-61 (1968). *Avco* was based on LMRA §301. It held that any suit brought to enforce a collective bargaining agreement is inherently federal in character, even if the complaint purports to be based solely on state law. *Id.* The case did not use the expression "complete preemption."

181. ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) (2000).

182. *Id.*

183. ERISA § 502(e)(1), 29 U.S.C. § 1132(e)(1).

relevant part):

> Except for actions under subsection (a)(1)(B) of this section [viz., ERISA section 502(a)(1)(B)], the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter . . . . State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) . . . .[184]

Therefore, Congress specifically said that the state and federal courts would have concurrent jurisdiction over suits brought under ERISA section 502(a)(1)(B).[185] Congress did not say whether state law causes of action against HMOs should be recharacterized as federal pleadings. The statute does suggest, however, that Congress was not concerned with preventing state courts from hearing lawsuits by plan beneficiaries against employer sponsored health plans. The inferences from ERISA section 502(e)(1) and the pertinent policy considerations imply that Congressional intent regarding federal court jurisdiction was not the clear mandate the Court invoked.

In fact, the main challenge to the procedural holding does not lie in either the implications to be drawn from ERISA section 502(e)(1) or in the general policy considerations applicable to federal question jurisdiction. Rather, the main challenge to the procedural holding lies in the specific language of ERISA section 514,[186] which explicitly defines the intended scope of ERISA preemption. Here, the procedural issues become intertwined with the substance of the statute, and so the analysis moves to the substantive holding. A later section discusses how that decision impacts the jurisdictional holding.[187]

B. The Substantive Holding: Invalidity of the Tort Liability Provisions of the Texas Health Care Liability Act

The main impact of the *Davila/Calad* case is not its jurisdictional holding. Far and away, *Davila/Calad*'s primary effect is the determination that ERISA preempts and thus invalidates state laws that purport to impose tort liability against HMOs. On this,

184. *Id.*
185. *Id.*; ERISA § 502(a)(1)(B), 29 U.S.C. § 1132 (a)(1)(B) (2000).
186. ERISA § 514, 29 U.S.C. § 1144.
187. *See infra* Part III.B.1.c.

the primary aspect of the case, the Court's reasoning was significantly wanting.

1. ERISA Section 514

a. Background

On the substantive issue, the *Davila/Calad* Court stated that "'[t]he six carefully integrated civil enforcement provisions found in §502(a) of the [ERISA] statute . . . provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.'"[188] In addition, the Court held that "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." [189]

As can be readily seen by cursory inspection, there are nine, not six, civil enforcement provisions in ERISA section 502(a).[190] It is possible, though, that the Court was referring to provisions 1, 2, 3, 4, 8, and 9,[191] which allow enforcement by private persons, as "the six carefully integrated civil enforcement provisions."[192] Regardless of how one does the counting, if ERISA section 502(a) were viewed in a vacuum, an inference of implied preemption of all state remedies would be reasonable. Whether the evidence for such inference is "strong" and whether the Congressional intent is "clear," as the Court maintains, are questionable points, but, hyperbole aside, the conclusion is certainly defendable. *Expressio unius est exclusio alterius* (the expression of one thing is the exclusion of another) is an accepted and justifiable rule of statutory construction.[193]

The primary determinant of Congressional intent must be the statutory language itself, viewed in its entirety.[194] No section of the

188. *Davila/Calad*, 124 S. Ct. at 2495 (quoting Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987)).

189. *Id.* ERISA § 502(a) is attached to this article as Exhibit A.

190. ERISA §§ 502(a)(1)-(9), 29 U.S.C. §§ 1132 (a)(1)-(9).

191. ERISA §§ 502(a)(1)-(4), (8), (9), 29 U.S.C. §§ 1132 (a)(1)-(4), (8), (9).

192. *Davila/Calad*, 124 S. Ct. at 2495 (quoting Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987)).

193. *See* Swierkiewicz v. Sorema N.A., 534 U.S. 506, 513 (2002) (citing Leatherman v. Tarrant County Narcotics Intelligence and Coordination Unit, 507 U.S. 163, 168 (1993)).

194. Negonsott v. Samuels, 507 U.S. 99, 104 (1993).

statute should be viewed in isolation, but all relevant provisions must be considered.[195] Thus, section 502(a) should not be read in isolation from other sections of ERISA.

Congress specifically spoke to which state laws are to be preempted and which are not. The Court did not have to infer anything, and it did not have to decide whether evidence was strong or whether the implied legislative intent was clear. Nothing was left for deep legal analysis, except how to interpret the words Congress had written. While such interpretation has turned out to be difficult, that should have been the starting point (and, in fact, the ending point as well). The applicable provisions are located in ERISA sections 514(a) and (b).[196]

Section 514(a) declares that ERISA is to supersede state laws which "relate to" employee benefit plans (with the exception of those plans described in ERISA section 4(b), which are relatively few in number and are irrelevant to the present discussion).[197] On its face, this appears to be broad language. However, section 514(b)(2)(A), the key provision for purposes of this article, states in relevant part that, with one exception, "nothing in this title [ERISA] shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . . ."[198] Section 514(b)(2)(A) is sometimes called "the insurance savings clause" or simply the "savings clause."[199] Section 514(b)(2)(A) is an exception to section 514(a). It says that some state regulations, even if they relate to employee benefit plans, are not to be preempted.[200] Section 514(b)(2)(B), called the "deemer clause,"[201] is the one exception to (or at least a limitation on) section 514(b)(2)(A).[202]

Although the preemptive force of ERISA seems to be a narrow, technical issue, the Supreme Court has devoted enormous effort to

195. United States Nat'l. Bank of Or. v. Indep. Ins. Agents of Am., Inc., 508 U.S. 439, 454-55 (1993); Commissioner v. Engle, 464 U.S. 206, 223 (1984).

196. ERISA §§ 514(a), (b), 29 U.S.C. §§ 1144(a), (b). The relevant portions of ERISA § 514 are attached to this article as Exhibit B.

197. ERISA § 514(a), 29 U.S.C. § 1144(a).

198. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).

199. *Id.*

200. *See id.*

201. *See* Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 733 (1985) (coining the term "deemer clause").

202. Thus, state laws are valid, except as they relate to ERISA plans, except as they are saved, except as the "deemer clause" applies. The deemer clause, then, is an exception to an exception to an exception. Each step of this analysis is technical and complicated.

construing ERISA section 514.[203] Older cases interpreting this language gave an expansive reading to section 514(a) and, conversely, a narrow reading to the Insurance Savings Clause.[204] Starting with its decision in *Travelers*,[205] however, the Court has adopted a much more restrictive reading of section 514(a).[206] Recognizing that a literal, dictionary interpretation of the "relate to" language of section 514(a) can lead to absurd results, the Court inferred certain limitations to section 514(a), particularly in areas of the law that may have only an indirect effect on the regulation of employee benefit plans. Furthermore, in areas "traditionally occupied by the States" there is a "starting presumption that Congress does not intend to supplant state law."[207] Concomitantly, with its contraction of section 514(a), the Court has expanded the scope of the Insurance Savings Clause.[208]

b. Application to the Substantive Holding

THCLA singles out MCOs, including HMOs, for tort liability. The Court in *Shaw v. Delta Air Lines, Inc.*[209] held that any state law having a connection with or making a reference to covered employee benefit plans falls within section 514(a).[210] While later Court decisions have refined and clarified the *Shaw* holding,[211] the case has never been overturned. In light of the directness of the connection between THCLA and ERISA-covered health plans, it would be reasonable to argue that THCLA sections 88.001-88.003, in the context of *Davila/Calad,* "relate to" an employer-sponsored benefit plan.[212]

203. *See supra* note 151.

204. *See* Shaw v. Delta Airlines Inc., 463 U.S. 85 (1983); Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985); Pilot Life Ins. Co. v Dedeaux, 481 U.S. 41, 46 (1987).

205. N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins., 514 U.S. 645, 661-62 (1995).

206. *See, e.g.*, De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806 (1997); California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc., 519 U.S. 316 (1997).

207. *Travelers*, 514 U.S. at 654-55.

208. *See, e.g.*, Ky. Assoc. of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003) [hereinafter *KAHP*]; Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002); UNUM Life Ins. Co. of Am. v. Ward, 526 U.S. 358 (1999).

209. 463 U.S. 85 (1983).

210. *Id.* at 100.

211. *See, e.g.*, *Travelers*, 514 U.S. at 645.

212. TEX. CIV. PRAC. & REM. CODE §§ 88.001-.003 (West 2004). In anticipation of its later holding in *Roark v. Humana*, 307 F.3d 298 (5th Cir. 2002), the Fifth

The catch, however, is that the insurance savings clause establishes specific exceptions to the general preemption rule of ERISA section 514(a).[213] A state law "which regulates insurance" is not to be preempted.[214] The Court has grappled at length with the term "regulates insurance." Both of those words are technical in nature, and so the Court has developed (and then repeatedly modified) various formulas to define those terms within the context of the insurance savings clause. Thus, it requires some analysis to determine whether THCLA sections 88.001-88.003 fall within that clause, and it requires even more analysis to consider what effect, if any, the deemer clause should have on the final result.[215]

The two most recent Supreme Court interpretations of the insurance savings clause strongly suggest that the tort liability provisions of THCLA should have been saved from preemption.[216] In *KAHP*, the Court held that a state law regulates insurance if (1) it is specifically directed toward entities engaged in insurance and (2) it "substantially affect[s] the risk pooling arrangement between the insurer and the insured."[217] THCLA section 88.002(a) imposes liability against "[a] health insurance carrier, health maintenance organization, or other managed care entity."[218] In *Rush Prudential*, the Court held that an HMO is an insurer for insurance savings clause purposes.[219] Therefore, THCLA should satisfy the first *KAHP* requirement. THCLA almost certainly meets the second

Circuit in *Corporate Health Insurance, Inc. v. Texas Department of Insurance*, 215 F.3d 526, 534 (2000), *rehearing denied*, 220 F.3d 641 (2000), *vacated in part on other grounds*, *sub nom., Montemayor v. Corporate Health Insurance,* 536 U.S. 935 (2002), found that THCLA was primarily directed toward health care treatment decisions and only incidentally directed toward administration of insurance coverage. Corporate Health Ins., Inc. v. Tex. Dep't of Ins., 215 F.3d 526, 534 (5th Cir. 2000), *rehearing and rehearing en banc denied*, 220 F.3d 641 (5th Cir. 2000), *vacated in part on other grounds*, *sub nom.,* Montemayor v. Corporate Health Ins., 536 U.S. 935 (2002). Thus, it held, THCLA was not related to ERISA-covered plans for purposes of ERISA § 514(a). If THCLA were deemed not even to "relate to" an ERISA-covered plan, of course, that would be all the more reason to find it was not completely preempted. *Id.*

213. ERISA § 514(a), 29 U.S.C. § 1144(a) (2000).

214. This disregards the "deemer clause." *See supra* notes 202-03 and accompanying text regarding the deemer clause.

215. TEX. CIV. PRAC. & REM. CODE §§ 88.001-.003 (West 2004); *see supra* note 203.

216. *See KAHP,* 538 U.S. at 329; *Rush Prudential HMO*, 536 U.S. at 363-64.

217. *KAHP*, 538 U.S. at 338.

218. TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (Vernon 1997).

219. *Rush Prudential HMO*, 536 U.S. at 366-67.

KAHP requirement as well because THCLA mandates that managed care entities, rather than insureds, must incur the tort damages that ensue from insurers' failure to exercise ordinary care when making health care treatment decisions.[220] Because the statute shifts this risk between the parties, THCLA should fall within the *KAHP* criteria for the insurance savings clause.

If the plans are underwritten by an employer rather than an insurance carrier, the deemer clause is construed to exempt health insurance plans from the insurance savings clause.[221] In such situations, an insurance company may provide administrative services for the plan, but benefit payments come from the employer's resources. If the health insurance plan is funded by an insurance company, then the deemer clause does not apply.[222]

Davila/Calad was decided under the four corners of the pleadings, and neither the Calad complaint nor the Davila complaint alleged whether it was the employer or the insurance company who funded the health plan. Because such allegation is extraneous to a cause of action under THCLA (and, in general, the funding source would probably not even be known to a plaintiff at the time of filing a complaint), there would be no basis for assuming employer funding. In any event, Aetna, in its Supreme Court brief, stated that it had funded Mr. Davila's health insurance policy.[223] Accordingly, the deemer clause did not apply in this lawsuit, and the insurance savings clause should have saved the claim from preemption, complete or otherwise.

c. Reconsideration of the Procedural Holding

As previously suggested, the main argument against the Court's procedural holding comes from the specific language of ERISA section 514.[224] Whether the insurance savings clause is read broadly or narrowly, and regardless of the scope of the deemer clause, the insurance savings clause must mean something. Congress has made the announcement explicitly: if a state law

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

221. Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 746-47 (1985).

222. *See id.*

223. Brief for Petitioner Aetna Health Inc. at 6-7, Aetna Health Inc. v. Davila, 124 S. Ct. 2488 (2004) (No. 02-1845). The CIGNA brief did not indicate who funded the Calad plan benefits. *See* Brief for Petitioner CIGNA Healthcare of Texas, Aetna Health Inc. v. Davila, 124 S. Ct. 2488 (2004) (No. 03-83).

224. *See supra* note 195-99 and accompanying text.

regulates insurance (however that term is defined), then, subject to the limitations of the deemer clause, ERISA does not invalidate it.[225]

This point, by itself, should dispose of the *Davila/Calad* procedural holding. The Court found that Congress intended so thoroughly to occupy the area of law covered by a beneficiary's right to seek redress against an employer-sponsored health insurance plan that no state law in this area could possibly stand. Nothing in the language of the insurance savings clause, however, remotely suggests that Congress intended to exclude any category of state laws that regulate insurance from its ambit, even if those laws might expand on the remedies specified under section 502(a).[226] To say, as the Court did, that no state remedial statute could possibly be saved is simply to discard the language of the insurance savings clause.

d. The Davila/Calad *Rationale*

The *Davila/Calad* decision never determined whether THCLA was a law that regulates insurance. The Court simply concluded that the insurance savings clause argument "is unavailing."[227] The Court cited two previous decisions for the proposition that Congress intended the ERISA section 502(a)[228] remedies to be exclusive.[229] Citing *Pilot Life Insurance Co v. Dedeaux*, the Court stated that "the policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA."[230]

The Court refused to acknowledge that Congress had not rejected all state law remedies under ERISA, as it had specifically saved state laws that regulate insurance. Similarly, the Court did not explain why validation of state insurance laws which allow tort liability for negligent denial of plan benefits would "completely undermine" the federal scheme. Rather than establish a principled basis for discarding the insurance savings clause, the Court relied

225. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (2000).
226. ERISA § 502(a), 29 U.S.C. § 1132.
227. *Davila/Calad*, 124 S. Ct. at 2500.
228. ERISA § 502(a), 29 U.S.C. § 1132.
229. *Id.*
230. *Id.* at 2495 (citing Pilot Life Ins. Co. v. Dedeaux, 418 U.S. 41, 54 (1987)).

on circular reasoning.[231] Specific statutory language was not to be the indicium of Congressional intent in this case because earlier decisions had stated that such language would not be determinative.

In other interpretations of ERISA's preemption effects, the Court has repeatedly reconsidered, and at times rightly rejected, the language and rationale of prior opinions.[232] This area of the law is so important that the Court subordinated stare decisis to the public need for a fair and understandable reading of the ERISA statute. In *Davila/Calad*, though, the Court defeated a specific Congressional directive. Although the Court ruled consistently with some of its earlier decisions, it undermined much of its own progress.

2. Policy Considerations

The *Davila/Calad* holding precluded all but the ERISA-prescribed remedies for the vast majority of employee benefit plans. Rejection of specific statutory language is reason enough to question the decision. However, while statutory language is generally the *sine qua non* of Congressional intent,[233] legislative construction may also be guided by the overall structure and objects of the law.[234] It is worthwhile, therefore, to consider the practical consequences of the substantive *Davila/Calad* holding. These consequences should be examined in light of the declared Congressional policies that motivated ERISA and of the policy considerations that the Court itself articulated.

a. Strengthening and Broadening the Social Safety Net

The "Congressional findings and declaration of policy" set forth in ERISA section 2, indicate concerns for "disclosure" of

231. *See id.*

232. *See* De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806, 814 (1997); Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc., 519 U.S. 316, 334 (1997); N.Y. State Conference of Blue Cross & Blue Shield v. Travelers Ins., 514 U.S. 645, 649 (1995) (reconsidering the meaning of "relate to" in ERISA §§ 514(a) and (b)); *KAHP*, 538 U.S. at 335; UNUM Life Ins. Co. of Am. v. Ward, 526 U.S. 358, 364 (1999) (reformulating the scope of the insurance savings clause).

233. *See* Negonsott v. Samuels, 507 U.S. 99, 104 (1993) (citing Griffin v. Oceanic Contractors, Inc., 458 U.S. 564, 570 (1982)).

234. *Travelers,* 514 U.S. at 655; United States Nat'l. Bank of Or. v. Indep. Ins. Agents of Am., Inc., 508 U.S. 439, 454-55 (1993).

expected benefits to employees, "minimum standards . . . assuring the equitable character of such plans," and "responsibility" to the beneficiaries of those charged with administering employee benefit plans.[235] Consistent with ERISA's primary focus on retirement income security, section 2 speaks most directly to pension plans. Nevertheless, it is certainly reasonable to expect that Congress, by including welfare plans within ERISA's coverage, wished to enhance the principles of disclosure, equity, and administrative responsibility for employer sponsored health insurance plans. THCLA is a reasonable means for accomplishing those objectives.

THCLA section 88.002(d) specifies that it will not impose tort liability on managed care plans for failure to provide treatment that is not covered by the health care plan.[236] Thus, managed care plans have an incentive to disclose the treatment they will or will not cover. For example, CIGNA could have posted a statement on its web site that it will generally refuse to pay for more than one day's hospital stay following a hysterectomy, and Aetna could likewise have posted the details of its prescription drug formulary and step-therapy program. The HMOs could have also posted a general statement that their internal determinations of appropriate medical treatment could in some cases lead to a lower standard of health care than might be recommended by the members' treating physicians. If these coverage restrictions were clearly disclosed to the employer and the plan beneficiaries before they purchased health insurance, the HMOs would have had a clear defense to the THCLA claims under the *Davila* and *Calad* scenarios.

Likewise, THCLA promotes equity in plan coverage decisions by providing that a managed care plan which fails to exercise ordinary care when making health care treatment decisions will pay the resulting damages to those plan beneficiaries harmed by such failure.[237] THCLA also promotes responsibility in health insurance plan administrators. ERISA section 502(a)[238] remedies for wrongful coverage denials in the *Davila* and *Calad* situations are essentially non-existent. Under those remedies, CIGNA could be required to pay Calad the cost of an extra day's stay in the hospital, and Aetna could be required to pay Davila the cost of a few weeks' supply of Vioxx. These contract remedies, of course, bear almost no

235. ERISA § 2, 29 U.S.C. § 1001 (a)-(b) (2000).
236. TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(d) (Vernon 1997).
237. *Id.* § 88.002(a).
238. ERISA § 502(a), 29 U.S.C. § 1132(a).

relationship to the personal injuries suffered.[239]

In a more general sense, THCLA might broaden and strengthen the social safety net. It would encourage HMOs to be more cognizant of those members, such as Davila and Calad, who might not meet standard patient profiles. It would make it more likely that medically vulnerable persons are given care that is suitable for their needs. It would also ensure that when people are injured because of negligent medical necessity decisions, the burdens arising from those injuries can be spread among a broad population base.

The arguments for extra-contractual remedies against health insurers are similar to but, perhaps, stronger than the arguments for extra-contractual remedies against any insurer in the non-HMO context. Ordinarily, a dispute between an insured and an insurer takes the form of an argument over money after the fact, with no consequences other than who should have the money. The loss, whatever it may be, is relatively fixed.[240] With an HMO, the dispute is generally over prospective care. The potential consequences to the insured are partly financial but may also include injury to health, or even to life, resulting from a deprivation of necessary medical care.

At the same time, though, substantial arguments can be made against the imposition of tort liability for an improper denial of health insurance coverage. THCLA seeks to impose an objective "ordinary care" or "ordinary prudence" standard of liability.[241] On its face, this seems reasonable enough. In practice, however, the application of the law to a specific fact situation will depend on the judicial process. While that process may support goals of social equity, it will also engender significant monetary and other costs for those involved. Tort litigation is a spectacularly expensive and inefficient undertaking, and it might be worthwhile for the health care system to suffer a modest level of inequity if doing so would avoid those costs.

Reasonable doubts could be raised about the inherent fairness

239. Presumably, although not necessarily, CIGNA and Aetna had to bear most or all of the medical bills resulting from their alleged failure to exercise reasonable care. The injuries suffered by Davila and Calad, however, went far beyond the cost of their medical treatment. *See Davila/Calad*, 124 S. Ct. at 2493.

240. 16A JOHN A. APPLEMAN & JEAN APPLEMAN, INSURANCE LAW AND PRACTICE § 8878 (1981) (pointing out that any delay in receipt of insurance proceeds is likely to cause some accretion of the loss).

241. *See supra* Part I.C.

of a jury verdict in a case brought against a health insurance company by those who have suffered serious medical injuries. In the Davila and Calad situations, the members' physicians recommended treatments based primarily on their patients' welfare. There is no simple way to ascertain the regard they had for the financial burdens associated with their recommendations. The HMOs, on the other hand, gave substantial weight to the costs of the proposed treatments. They may have determined that the physicians' recommendations were medically desirable but not strictly medically necessary. From the position of society as a whole, this is a reasonable way of allocating medical resources. Viewing the matter with hindsight, however, a jury might be disinclined to defer to the HMOs' judgments. The situation invites a prejudicial verdict. Plan sponsors might be unwilling to bear these uncertainties and might decline to provide their employees with health insurance. Thus, THCLA could have the undesired effect of actually shrinking the social safety net.

Also, in most circumstances patients could pay for the medical care the HMO denied them and then sue for reimbursement of the costs under ERISA.[242] Mrs. Calad's physician should have explained to her the basis for his recommendation that she spend an extra day in the hospital, and Mr. Davila's physician should have explained to him why he thought Vioxx was a more appropriate medication than Naprosyn.[243] Unless the patients were completely devoid of financial resources, they could have followed their physicians' advice, paid for the medical care out of their own pockets, and then sued for the wrongfully denied coverage.[244] While patients who buy insurance coverage to protect against medical bills may feel imposed upon when their reasonable payment requests are denied, it is not irrational to expect them to mitigate their damages. Thus, the injuries of Calad and Davila may

242. ERISA § 502(g)(1), 29 U.S.C. § 1132(g)(1) (providing for the recovery of attorneys' fees in such a suit, within the court's discretion).

243. Under the AMA *Code of Medical Ethics*, physicians are required to inform their patients of the benefits, risks, and costs of appropriate treatment alternatives. AM. MED. ASS'N, CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, E-10.01, (issued June 1992, updated 1993), *at* http://www.ama-assn.org/ama/noindex /category/11760.html.

244. One study found that among elderly patients with osteoarthritis, the strongest predictor of Cox-2 inhibitor drug usage was the patient's insurance coverage rather than clinical criteria. Jalpa A. Doshi et al., *The Impact of Drug Coverage on COX-2 Inhibitor Use in Medicare,* HEALTH AFFAIRS (2004), *at* http://content.healthaffairs.org/cgi/reprint/ hlthaff.w4.94v1?ck=nck.

have resulted partly from their personal decisions as well as from the HMOs' decisions.

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

The federalist structure of American government is well-suited to handle such issues. If there is no consensus on a problem of legal economics, the matter can be left to the states. One state may try one solution, and another state may try a different solution. Each state's government represents and is responsible to its own citizens.[245]

With experience, a consensus may emerge as to what is the most desirable solution to a social problem, and most, or even all, states may adopt that consensus solution. Alternatively, what may be found desirable in one state might be rejected in another, and the state laws may disagree. If there is such disagreement, each state will have chosen the laws that it deems, rightly or wrongly, best suited for its own governance. As the oft-quoted dissent in *New State Ice Co. v. Liebmann*[246] puts the matter: "It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country."[247]

As a general matter, there is little uniformity among state insurance laws about the scope of the insured's remedies in the non-HMO context for wrongful coverage denials. Some states simply allow ordinary contract damages,[248] others allow an element of punitive damages,[249] and others have other remedies.[250] Congress was undoubtedly aware of this variation among state insurance laws when it enacted ERISA. Through the insurance savings clause, it endorsed their application of state insurance laws to plans covered under ERISA.

The *Davila/Calad* holding precludes a federalist experiment

245. Printz v. United States, 521 U.S. 898, 920 (1997).
246. 285 U.S. 262 (1932).
247. *Id.* at 311. (Brandeis, J., dissenting).
248. APPLEMAN & APPLEMAN, *supra* note 240, § 8878.15.
249. *Id.* § 8878.65.
250. *Id.* §§ 8878.35 (consequential damages), 8878.55 (damages for mental and emotional distress).

on remedies against HMOs. States may not test and compare the benefits and disadvantages of tort liability statutes or other types of remedies. States must accept the ERISA section 502 remedies as exclusive. *Davila/Calad* undercuts one of the significant strengths of the American form of government—a strength that is well-designed to address the very problems that motivated ERISA's passage.

b. National Uniformity

Congress, by enacting ERISA, federalized the law applying to employee benefit plans to in order to reduce or eliminate some of the disuniformities that would otherwise force national plans entering into local markets to purchase insurance.[251] Thus, if a nationwide employer with employees in a state with a THCLA-type statute wished to establish an HMO for its employees, the employer would have to provide a somewhat different mix of benefits to its employees on a state by state basis. Specifically, employees in states with THCLA-type laws would be entitled to tort remedies for breach of promised health care benefits, whereas employees in states without such laws would not have these rights. Employers might find the inability to provide a uniform benefits package to be a disincentive to the creation of the welfare plan. It might therefore be argued that enforcement of THCLA would undercut a principal purpose of ERISA—encouragement of employer-sponsored benefit plans.

The problem with this argument is that it simply reads the insurance savings clause out of ERISA. In *Metropolitan Life Insurance Co. v. Massachusetts*,[252] the Court stated:

> We also are aware that [Metropolitan Life's] construction of the statute would eliminate some of the disuniformities currently facing national plans that enter into local markets to purchase insurance. Such disuniformities, however, are the inevitable result of the congressional decision to "save" local insurance regulation. Arguments as to the wisdom of these policy choices must be directed at Congress.[253]

The Supreme Court has repeatedly employed the insurance

251. N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins., 514 U.S. 645, 656-58 (1995).

252. 471 U.S. 724 (1985).

253. *Id.* at 747.

savings clause to enforce state laws that effectively require nationwide employers to provide non-uniform national benefits.[254] Logically, the advantages of national uniformity should yield to the force of the insurance savings clause when it comes to remedial measures, just as the advantages of national uniformity have yielded to the insurance savings clause in other areas of insurance regulation.

c. Upsetting the Regulatory Applecart

The *Davila/Calad* opinion observes:

> Congress enacted ERISA to protect . . . the interests of participants in employee benefit plans and their beneficiaries by setting out substantive regulatory requirements for employee benefit plans and to provid[e] for appropriate remedies, sanctions, and ready access to the Federal courts. The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans. To this end, ERISA includes expansive pre-emption provisions . . . .[255]

From this premise, the opinion concludes that the section 502 remedies are part of a "uniform regulatory regime," and are "essential to accomplish Congress' purpose of creating a comprehensive statute for the regulation of employee benefit plans."[256]

The problem with this argument is that it may hold true for pension plans, but it does not apply to welfare plans. ERISA regulates the procedural standards and content of pension plans closely. While ERISA provides similar procedural safeguards for welfare plans, it does not regulate their substantive content at all.[257] As applied to welfare plans, then, ERISA cannot be fairly deemed "a comprehensive statute despite the Court's assertions."[258]

The insurance savings clause provides a mechanism for filling

254. *E.g., id.* (mental health benefits); *KAHP*, 538 U.S. at 341-42 (access to any qualified provider willing to enter into the insurance carrier's provider panel contract); Rush Prudential HMO Inc. v. Moran, 536 U.S. 355 (2002) (acceptance of medical necessity determinations by an independent physician—one not on the HMO panel of physicians).

255. 124 S. Ct. at 2495 (inner quotation marks and statutory citations omitted).

256. *Id.*

257. *See* Metro. Life Ins. Co. v. Massachusetts., 471 U.S. 724, 732 (1985).

258. *See Davila/Calad*, 124 S. Ct. at 2495.

the regulatory gap ERISA has left uncovered—state insurance laws. Such laws have been commonplace since well before the enactment of ERISA.[259] Thus, the fairest reading of ERISA, both from the language of the statute and the historical perspective, is that employer-sponsored health insurance policies were to be regulated by a conjunction of state and federal laws. From this viewpoint, a rule that invalidates those state remedial laws which regulate the insurance industry has the effect of upsetting the overall regulatory scheme.[260] The Court's conclusion, that "the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA," does not stand up.[261]

3. Comparison of the Language of ERISA with the Language of LMRA

Davila/Calad emphasized "the similarity of the language used in [LMRA] and ERISA" to justify the *Avco* complete preemption doctrine in the ERISA section 502(a) context.[262] The Court cited *Metropolitan Life Insurance Co. v. Taylor*[263] to support its statement. *Taylor*, in turn, said that the "closely parallel" language was to be found in ERISA section 502(f) and LMRA section 301(a).[264]

ERISA section 502(f) states that "[t]he district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section [ERISA section 502(a)] in any action."[265]

LMRA section 301(a) states:

> (a) Venue, amount, and citizenship. Suits for violation of contracts between an employer and a labor organization representing employees in an industry affecting commerce as defined in this chapter, or between any such labor organizations, may be brought in any district court of the United States having jurisdiction of the parties,

259. Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 742 (1985).
260. *Id.* at 750.
261. *Davila/Calad*, 124 S. Ct. at 2495 (quoting Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987)).
262. Avco Corp. v. Aero Lodge No. 735, Int'l Assoc. of Machinists & Aerospace Workers, 390 U.S. 557 (1968).
263. *Davila/Calad*, 124 S. Ct at 2495.
264. Metro. Life Ins. Co. v. Taylor, 481 U.S. 58, 59 (1987).
265. ERISA § 502(f), 29 U.S.C. §1132(f) (2000).

> without respect to the amount in controversy or without regard to the citizenship of the parties.[266]

There is nothing remarkable about the language of either statute. They are both simple affirmations that the district courts of the United States are to have non-exclusive jurisdiction over certain controversies, based on ERISA and LMRA, respectively. There is no particular or distinctive "similarity" or "closely parallel" language between these two provisions.

4. What Went Wrong: Pilot Life *and* Taylor

The problem, which has come to a boil in *Davila/Calad*, began with the murky language of ERISA itself. First, the title refers to retirement income, while the case itself had nothing to do with retirement or income. Clearly, the statute covers more than the title suggests. While the misnomer does not diminish the force of the law,[267] it does demonstrate that Congressional thinking was focused outside the realm of welfare benefits.

Second, the unvarnished language of the primary provision on preemption, ERISA section 514(a), is self-contradictory. According to section 514(a), state laws "insofar as they may now or hereafter relate to any employee benefit plan" are to be preempted.[268] As the Supreme Court ultimately observed, everything in some degree relates to everything else, so all state laws relate to employee benefit plans in some measure. Clearly, Congress was not suggesting a wholesale overthrow of state law. To imply some limitation on the literal language of the statute and give it sense the Court's current holdings read the quoted language as though the word "reasonably" was before the word "relate."[269] The problem, though, is that it took time for the Court to wrestle with the section 514(a) language in various contexts, before it ultimately concluded a dictionary meaning was not appropriate. While the jurisprudential transformation was taking place, older precedents, based at least in part on discarded analysis, were left standing.

266. 29 U.S.C. § 185(a) (2000).

267. In cases of doubt, the title of a statute can shed light on its meaning. Almondarez-Torres v. United States, 523 U.S. 224, 234 (1998).

268. ERISA § 514(a), 24 U.S.C. § 1144(a).

269. De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806 (1997); Cal. Div. of Labor Standards Enforcement v. Dillingham Const., N.A., Inc., 519 U.S. 316 (1997); N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins., 514 U.S. 645 (1995).

The language of the other key preemption provision, the insurance savings clause, is also a factor. In *Metropolitan Life Insurance Co. v. Massachusetts,*[270] the Court observed that "the saving clause appears broadly to preserve the States' lawmaking power over much of the same regulation [that Congress had preempted with section 514(a)]. While Congress occasionally decides to return to the States what it has previously taken away, it does not normally do both at the same time."[271] Thus, the Court simultaneously had to reconcile the imprecise wording of section 514(a) with the equally imprecise language of the insurance savings clause. As indicated above,[272] the struggle to hit this moving target led to varying formulations of the insurance savings clause.

As a way out of this morass, the Court turned to the legislative history of ERISA. Here, too, it initially found little assistance. In *Metropolitan Life Insurance Co. v. Massachusetts* it noted:

> There is no discussion in that history of the relationship between the general pre-emption clause [section 514(a)] and the saving clause, and indeed very little discussion of the saving clause at all . . . . [There is no] indication in the legislative history that Congress . . . was aware that the saving clause was in conflict with the general pre-emption provision.[273]

Although the legislative history seemed so unclear in 1985, when *Metropolitan Life Insurance Co. v. Massachusetts* was decided, it suddenly became transparent to the Court in 1987, when it decided two companion cases, *Pilot Life Insurance Co. v. Dedeaux*,[274] and *Metropolitan Life Insurance Co. v. Taylor.*[275] *Pilot Life* arose out of a disability insurance claim.[276] Mr. Dedeaux had injured his back and claimed long term disability benefits under an employer purchased insurance policy with Pilot Life.[277] Pilot Life originally allowed the claim, but it then repeatedly terminated and reinstated the benefits.[278] Eventually, Dedeaux brought a diversity action against Pilot Life in federal court, alleging three counts, all based solely on

270. 471 U.S. 724 (1985).
271. *Id.* at 740.
272. *See infra* Part III.B.1.a.
273. 421 U.S. at 745.
274. 481 U.S. 41 (1987).
275. 481 U.S. 58 (1987).
276. *Pilot Life Ins. Co.*, 481 U.S. at 41.
277. *Id.* at 43.
278. *Id.*

state law: tortious breach of contract, breach of fiduciary duties, and fraud in the inducement.[279] He sought, inter alia, punitive damages and damages for mental and emotional distress.[280] He did not raise any ERISA claims.[281] The trial court granted summary judgment to Pilot Life, finding that all of Dedeaux's claims had been preempted.[282] The Court of Appeals reversed the district court, but the Supreme Court granted *certiorari* and reversed the Court of Appeals.[283]

Pilot Life observed that "the express pre-emption provisions of ERISA are deliberately expansive and designed to establish pension plan regulation as exclusively a federal concern."[284] The Court went on to quote Congressional sponsors of ERISA, to the effect that the law is "intended to preempt the field for Federal regulations."[285] It then held, based on the "expansive sweep of the pre-emption clause," that Dedeaux's suit came within the "relate to" language of section 514(a).[286]

Next, *Pilot Life* turned to the insurance savings clause. It looked at several criteria for interpreting that clause, including a "common-sense view" of the statutory language, and it found that the laws asserted in the complaint did not regulate insurance.[287] Thus, the suit was not saved from preemption.[288]

Then, the Court went on to say that any state law that purports to establish a remedy other than as set forth in ERISA section 502(a) would have to be preempted. It based this conclusion partly on its determination that section 502(a) was intended to be "a comprehensive civil enforcement scheme,"[289] and partly on the following language from the Congressional Conference Report on ERISA:

> Under the conference agreement, civil actions may be brought by a participant or beneficiary to recover benefits due under the plan, to clarify rights to receive future benefits under the plan, and for relief from breach of

279. *Id.*
280. *Id.* at 43-44.
281. *Id.* at 44.
282. *Id.*
283. *Id.*
284. *Id.* at 45-46 (inner quotation marks omitted).
285. *Id.* at 46 (inner quotation marks omitted).
286. *Id.* at 47.
287. *Id.* at 50-51.
288. *Id.* at 48-50.
289. *Id.* at 54.

> fiduciary responsibility . . .. [W]ith respect to suits to enforce benefit rights under the plan or to recover benefits under the plan which do not involve application of the title I provisions, they may be brought not only in U.S. district courts but also in State courts of competent jurisdiction. *All such actions in Federal or State courts are to be regarded as arising under the laws of the United States in similar fashion to those brought under section 301 of the Labor-Management Relations Act of 1947.*[290]

The Court also quoted a similar comment by Senator Williams, plus other, less pointed observations in the legislative record concerning the desirability of having questions concerning employee benefit plans be resolved without recourse to state law.[291] None of these legislative record quotations referred to the insurance savings clause.

It is unclear from *Pilot Life* whether the Court intended to say that a state law that falls squarely within the insurance savings clause should be preempted notwithstanding the language of the Insurance Savings Clause or whether the Court was merely supporting a conclusion that the insurance savings clause should be read narrowly. What the Court did say was that it divined a "clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive."[292] No mention was made that, when Congress was discussing preemption issues, it had not focused on the effect of the insurance savings clause. More significantly, no mention was made that the *Pilot Life* Court's reasoning required that a Congressional report be accorded more force than the statutory language itself.

Taylor relied heavily on the *Pilot Life* rationale.[293] It, too, was a claim for disability insurance benefits, although it also alleged claims unrelated to an employee benefit plan.[294] It asserted only state law causes of action.[295] Unlike *Pilot Life* (but like *Davila/Calad*), the case was brought in state court.[296] The defendants removed the case to federal court, and the district court

290. *Id.* at 55 (quoting H. R. Conf. Rep. No. 93-1280 at 327 (1974) (emphasis in Court opinion but not in original document)).
291. *Id.* at 56.
292. *Id.* at 57.
293. Metro. Life Ins. Co. v. Taylor, 481 U.S. 58, 62-65 (1987).
294. *Id.*
295. *Id.* at 60.
296. *Id.* at 61.

granted them summary judgment on the merits.[297] The court of appeals reversed the district court on the grounds that it lacked removal jurisdiction, and the Supreme Court granted *certiorari*.[298] The Supreme Court then reversed, quoting the same language of the Congressional Conference Report that *Pilot Life* had quoted.[299]

The *Taylor* court noted that "[i]n the absence of explicit direction from Congress, this question would be a close one."[300] However, the Conference Report, along with the supposedly "closely parallel" language of ERISA section 502(f) and LMRA section 301(a),[301] was determinative.

Neither *Pilot Life* nor *Taylor* addressed a law, like THCLA, that fell specifically within the insurance savings clause. The *Davila/Calad* decision could have distinguished these two earlier holdings on that basis. Considering the sweeping language of *Pilot Life* and *Taylor*, though, the better course would probably have been a complete disavowal of the errant language (and, perhaps in the case of *Taylor*, the actual holding). If *Pilot Life* and *Taylor* are to be read, as *Davila/Calad* ultimately did, as holding that language in the legislative record should be given more force than the language of the insurance savings clause, then those holdings were in error.

The Court has often observed that reliance on legislative history to divine congressional intent is "a step to be taken cautiously,"[302] which, as often as not, "muddies the waters."[303] Individual members of the Court have expressed differing views regarding the role that legislative history should play in statutory interpretation. Justice Rehnquist has opined that "the legislative history of a statute is a useful guide to the intent of Congress,"[304] whereas Justice Scalia has found legislative history to be "unreliable . . . as a genuine indicator of congressional intent."[305] At minimum, though, the courts should not base their decisions solely on legislative history, without "[a] statutory reference point."[306]

Here, there was no such reference point. The insurance

297. *Id.* at 61-62.
298. *Id.* at 62.
299. *Id.* at 65-66.
300. *Id.* at 64.
301. *See* analysis *supra* Part III.B.3.
302. Piper v. Chris-Craft Indus., 430 U.S. 1, 26 (1977).
303. United States v. Gonzales, 520 U.S. 1, 6 (1997).
304. County of Washington v. Gunther, 452 U.S. 161, 182 (1981) (dissenting).
305. Wis. Public Intervenor v. Mortier, 501 U.S. 597, 617 (1991) (concurring).
306. Shannon v. United States, 512 U.S. 573, 584 (1994).

savings clause—"nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance"—is unambiguous.[307] It makes no exception for private enforcement actions, and nothing in the quotations on which *Pilot Life* and *Taylor* relied suggests statutory language that might reasonably give rise to such an exception.

In all likelihood, the congressional statements, including those in the Conference Report, suggesting a parallel between LMRA preemption and ERISA preemption, were geared toward the preemption of laws that might affect pension plans, rather than those laws that might affect welfare plans.[308] As *Metropolitan Life Insurance Co. v. Massachusetts* noted, Congress, during its debates, gave little regard to the insurance savings clause.[309] To find, then, that Congress intended to limit its scope in the area of private enforcement actions is an unfounded stretch.

But even if the authors of the Conference Report and the various other Congressmen quoted in *Metropolitan Life* and in *Taylor* were thinking squarely about the effect of the Insurance Savings Clause on welfare plans, it should not matter. Congress votes on legislation as written, not on the wording of debates or of explanatory reports.[310] "It is the function of the courts, and not the Legislature . . . to say what an enacted statute means."[311]

In other situations, the Court has found language similar to that of the insurance savings clause to be sufficiently clear as to foreclose consideration of the legislative record. In *Norfolk & Western Railway Co. v. Brotherhood of Railway Carmen*,[312] the statute provided that a railroad carrier "is exempt from the antitrust laws and from all other law, including State and municipal law, as necessary [to let the carrier carry out certain defined functions]."[313] The Court noted that the language was "clear, broad, and unqualified" and refused to consider whether the Congressional record might suggest that Congress intended the exemption

307. ERISA § 514(b)(2)(A), 24 U.S.C. § 1144(b)(2)(A) (1998).

308. The Court has itself observed that statements made during the legislative process, "unless very precisely directed to the intended meaning of particular words in a statute, can seldom be expected to be as precise as the enacted language itself." Regan v. Wald, 468 U.S. 222, 237 (1984).

309. 471 U.S. 724, 745 (1985).

310. Am. Hosp. Assoc. v. NLRB, 499 U.S. 606, 616 (1991).

311. NLRB v. Health Care & Retirement Corp. of Am., 511 U.S. 571, 582 (1994).

312. 499 U.S. 117 (1991).

313. *Id.* at 119 (citing 49 U.S.C. § 11341(a)).

applied only to certain classes of laws and not others.[314]

Similarly, in *United States v. Gonzales*,[315] the Court considered a section of the criminal code that says that if a person is sentenced to prison for drug trafficking while using or carrying a firearm the "term of imprisonment imposed on a person under this subsection [shall not] run concurrently with any other term of imprisonment."[316] The Court found the phrase "any other term of imprisonment" to be unambiguous and not reasonably susceptible to meaning only federal prison sentences.[317] It therefore found no reason to resort to legislative history, even if that history might suggest otherwise.[318]

The insurance savings clause is equally comprehensive and unsusceptible to inferred exceptions. *Pilot Life* and *Taylor* should not have considered legislative history which undid the unambiguous statutory language. Moreover, if the standard needed to justify complete preemption was a finding of "clear" legislative intent, *Pilot Life* and *Taylor* were even more egregious. Unfortunately, the *Davila/Calad* Court missed the opportunity to acknowledge the slender foundations that underlay complete preemption and disavow the language or, if necessary, the holdings of those cases.[319]

IV. THE LOWER COURTS' RATIONALES — EFFORTS BY THE RISING JUDICIAL CHORUS TO FIND AN EXCEPTION FOR MIXED ELIGIBILITY AND TREATMENT DECISIONS

As observed at Part II.C, three circuits of the United States Court of Appeals (the Second, Fifth, and Eleventh) and one state supreme court (Pennsylvania) attempted to find tort liability for

314. *Id.* at 128.
315. 520 U.S. 1 (1997).
316. 18 U.S.C. § 924(c)(1)(D)(ii) (2000).
317. *Gonzales*, 520 U.S. at 5.
318. *Id.* at 6.
319. *Davila/Calad* also cited Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002) for the proposition that Congress intended to create an exclusive remedy in ERISA § 502(a). *Davila/Calad*, 124 S. Ct. at 2500. *Rush Prudential*, however, held that a state law requiring external review of medical necessity decisions did not create a remedy of the sort prohibited under *Pilot Life* and *Taylor*. *Rush Prudential HMO, Inc.*, 536 U.S. at 373-74 (2002). In dictum, it said that if it had to address such a law, *Pilot Life* and *Taylor* would require that it be preempted. *Id.* at 375-79. Even in dictum, *Rush Prudential* did not add to the force of the arguments that underlay *Pilot Life* and *Taylor*; it merely repeated them. *Id.*

"mixed eligibility and treatment decisions."[320] The reason for such approach is not hard to surmise. The lower courts were dissatisfied with a jurisprudence that left such a large gap in the regulatory structure of employer sponsored health insurance plans. No matter how dissatisfied the lower courts may have been with that jurisprudence, however, it was outside their purview to rewrite the Supreme Court's interpretation on a matter of federal law. Therefore, they looked for an alternative way to reach the desired result.

That alternative seemed to be the Court's pronouncement in *Pegram v. Herdrich*[321] that HMO coverage decisions involving issues of mixed eligibility and treatment fell outside ERISA's fiduciary liability requirements.[322] Such decisions, under this reading, would not be deemed to "relate to" the employee benefit plan itself and, if the Court concurred, would never impinge upon either the general preemption requirement of section 514(a)[323] or the complete preemption doctrine of *Pilot Life* and *Taylor*. The Fifth Circuit did not attempt to invoke the insurance savings clause argument, because to do so would have violated its obligation to adhere to binding Supreme Court rulings.[324] The other circuits and the Supreme Court of Pennsylvania could not even have considered the insurance savings clause, as they did not have before them a state law that might have come within its scope. Even those judges who felt unable to stretch the *Pegram* dictum sufficiently far as to allow recovery of tort damages acknowledged the need to change the law.[325] Ultimately, the Supreme Court denied the attempt to fit *Davila/Calad* within this concept, as it would have required an essentially new reading of ERISA, not mandated by the statutory language itself.[326] Justices Ginsburg and Breyer, however, joined "the rising judicial chorus" of dissatisfaction with the result.[327]

320. *See infra* Part II.C.
321. 530 U.S. 211 (2000).
322. *Id.* at 229-30.
323. *Id.* at 231.
324. *See generally* Roark v. Humana, Inc., 307 F.3d 298 (5th Cir. 2002) (consolidated with Aetna Health, Inc. v. Davila and CIGNA HealthCare of Tex., Inc. v. Calad).
325. *E.g.*, DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442, 453-61 (3d Cir. 2003) (Becker, J., concurring); Cicio v. Does, 321 F.3d 83, 106 (2d Cir. 2003) (Calabresi, J., dissenting in part).
326. 124 S. Ct. at 2500-02.
327. *Id.* at 2503.

V. CONCLUSION

The Supreme Court's doctrine of complete ERISA preemption is unsatisfactory, but not because the damages of those who have been injured by HMOs' medical necessity decisions must sometimes go uncompensated. Complete ERISA preemption is unsatisfactory because it usurps constitutionally allocated powers of co-equal branches of government. It limits state judiciaries' authority to determine whether ERISA preempts their own state's laws. It encroaches on Congress's prerogative to determine the jurisdiction of the federal courts. Most importantly, it deprives state legislatures of their right to enact legislation to rectify the economic imbalance between HMOs and their members.

Whether HMOs should bear tort liability for negligent medical necessity decisions is a subject for debate, well suited for resolution by varying state laws. ERISA, through its specific language and by its overall structure, anticipates such resolution. To return to Justice Brandeis —

> There must be power in the states and the nation to remould [sic], through experimentation, our economic practices and institutions to met changing social and economic needs . . .. To stay experimentation in things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the nation.[328]

The Supreme Court, largely by reasons of historical accident, has failed to give a fair reading to the wording or to the objects and purposes of ERISA. The issue of tort liability against HMOs has been taken from its proper forum, the state legislatures, and any reform must come through Congress—decidedly the wrong forum.

328. New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932).

EXHIBIT A

ERISA §502(a)

Civil Enforcement

(a) Persons empowered to bring a civil action. A civil action may be brought—

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

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409 [29 U.S.C.S. § 1109];

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

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 105I [29 U.S.C.S. § 1025I];

(5) except as otherwise provided in subsection (b), by the Secretary (A) to enjoin any act or practice which violates any provision of this title, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this title;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), (6), or (7) of subsection I or under subsection (i) or (l);

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 609(a)(2)(A) [29 U.S.C.S. § 1169(a)(2)(A)]);

(8) by the Secretary, or by an employer or other person referred to in section 101(f)(1) [29 U.S.C.S. § 1021(f)(1)], (A) to enjoin any act or practice which violates subsection (f) of section 101 [29 U.S.C.S. § 1021(f)], or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such

subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title [subtitle] or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

EXHIBIT B

Excerpts from ERISA §514(a) and (b)

Effect on Other Laws

(a) Supersedure. Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) [29 U.S.C.S. § 1003(a)] and not exempt under section 4(b) [29 U.S.C.S. § 1003(b)].

(b) Construction and application.

(2) (A) Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 4(a) [29 U.S.C.S. § 1003(a)], which is not exempt under section 4(b) [29 U.S.C.S. § 1003(b)] (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.