

The Aetna v. Davila Decision:

IMPLICATIONS FOR HMOs, CONSUMERS, AND STATES

By Christine Naglieri

I. Introduction

FOR THE FOURTH TIME IN FOUR YEARS, the United States Supreme Court analyzed the extent to which the Employment Retirement Income Security Act of 1974 (ERISA) preempts state laws regulating health insurance.¹ On June 21, 2004, in a unanimous decision, the Supreme Court issued its opinion in the consolidated cases of *Aetna Health Inc. v. Davila* and *CIGNA HealthCare of Texas, Inc. v. Calad* (collectively, “*Aetna*”). The Court held that ERISA completely preempts state law claims of wrongful denial of healthcare benefits by ERISA-governed employee health plans.²

The *Aetna* decision has important implications for HMOs, consumers, and states that may not be obvious from the Court’s opinion. Despite being a positive development for HMOs, the decision does not foreclose plaintiffs from suing HMOs, and it does not destroy states’ authority to draft healthcare regulation. In fact, plaintiffs may still sue HMOs under various liability theories, and have several alternatives to bringing a benefits claim in federal court under ERISA. Also, state laws permitting patients to sue HMOs for medical malpractice are not entirely preempted after *Aetna*.

The *Aetna* decision sets forth ERISA standards and clarifies preceding ERISA jurisprudence for the healthcare community. *Aetna* also has significant implications for the healthcare industry, leaves doctrinal questions unanswered, and sets the stage for future ERISA litigation.

II. ERISA Preemption and Jurisprudence

A. What is ERISA?

ERISA is federal legislation that sets minimum standards for most voluntarily established employee health and pension plans. Congress enacted ERISA in order to promote commerce and protect employees by federalizing employee retirement programs.³ Specifically, Congress sought a balance between ensuring fair and prompt enforcement of rights under a health or pension plan and encouraging the creation of such plans.

ERISA (1) requires that health and pension plans provide participants with plan information, (2) establishes fiduciary responsibilities for those who manage and control plan assets, (3) establishes a grievance and appeals process for participants to petition for the proper benefits, and (4) gives participants a

right to sue for benefits and breach of fiduciary duty. ERISA does not cover all group health plans. Examples of those plans not covered by ERISA are: plans established or maintained by government entities or churches for their employees; plans maintained solely to comply with applicable workers compensation, unemployment, or disability laws; and plans maintained outside of the United States primarily for the benefit of nonresident aliens or unfunded excess benefit plans.

B. ERISA Preemption

In *Aetna*, the Court explicitly states Congress’ purpose and intent in enacting ERISA legislation and creating ERISA’s preemptive provisions.

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 preemption provisions . . . which are intended to ensure that employee benefit plan regulation would be exclusively a federal concern.⁴

ERISA's broad preemption clause supersedes "any and all State law insofar as they may now or hereafter relate to any employee benefit plan."⁵ This preemption provision determines when federal courts have subject matter jurisdiction over certain state law claims brought by employee health plan beneficiaries in state court.

The preemption provision is divided into two sections, §502(a) and §514(a).⁶ ERISA §502(a) provides for "complete" preemption, and allows ERISA participants or beneficiaries to bring causes of actions against ERISA plans. ERISA §514(a) applies to state laws that are "conflict" preempted, and provides that "ERISA supersedes any and all States laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title."⁷

III. The Davila Decision

A. Juan Davila and Ruby Calad

The facts of *Aetna* focus on two Texas plaintiffs, Juan Davila ("Davila") and Ruby Calad ("Calad"), who brought separate cases against their HMOs in the U.S. District Court for the Northern District of Texas. Both Davila and Calad alleged that their HMOs' denial of benefits constituted a failure "to exercise ordinary care" required under the Texas Health Care Liability Act ("THCLA"),⁸ and that this failure proximately caused their injuries. They also alleged that the HMOs' systems made substandard care more likely, and the HMOs acted negligently in making decisions of medical necessity.

The first plaintiff, Davila, suffers from long-term effects of polio. He is a participant in Aetna, the HMO that provides coverage for his employer's health plan. Davila's physician prescribed Vioxx, an anti-inflammatory medication, for his arthritis and inflammation based on studies showing that Vioxx causes fewer gastrointestinal problems than other pain medications on Aetna's formulary. Aetna refused to cover the Vioxx prescription, instead covering a drug called Naprosyn. Aetna insisted that Davila first try two less expensive medications, and would only cover Vioxx if Davila had an adverse reaction to the less expensive medications.⁹ Davila did not appeal Aetna's decision denying Vioxx.

After taking Naprosyn for three weeks, Davila suffered bleeding stomach ulcers, was hospitalized for five days, required transfusion of seven units of blood, and nearly suffered a heart attack. Currently, he can no longer take pain medication that is absorbed through the stomach. Davila alleged that Aetna's adherence to its policies on the use of Vioxx constituted a violation of the THCLA, and Aetna was liable for

punitive damages because it knew its policy involved a risk of serious injury or death.

The second plaintiff, Calad, is a beneficiary of CIGNA Healthcare of Texas, a Texas HMO, through her husband's employer. She underwent a hysterectomy performed by a CIGNA physician and was discharged from the hospital earlier than the physician recommended. CIGNA stated that Calad did not meet the plan's criteria for approving a longer hospital stay, that the standard one-day hospital stay was sufficient, and that it would not pay for additional inpatient treatment. Similar to Davila, Calad did not appeal the CIGNA decision. She left the hospital and returned a few days later for additional treatment after becoming seriously ill. Calad alleged that CIGNA's conduct violated the THCLA since her illness was a result of CIGNA's decision to deny her a longer initial hospital stay.

B. The Arguments

When the consolidated case was filed in district court, Aetna and CIGNA requested to remove the case to federal court. The HMOs argued that because the plaintiffs' health coverage existed under employer-sponsored ERISA plans, the case was completely preempted by ERISA and could only be litigated in federal court. In addition, the HMOs argued that Davila and Calad could have sought alternative remedies, such as paying for treatment and seeking reimbursement or obtaining a preliminary injunction.

Davila and Calad argued against the case being removed to federal court because they would have to argue their case under federal law.¹⁰ They claimed that the HMOs violated legal duties that arise independently of ERISA and the terms of the employee benefit plans. In particular, they argued that the duty of "ordinary care" imposed by the THCLA was an independent legal duty that should allow the case to proceed in state court. This duty arose independently of any duty imposed by ERISA and the plan terms, and any civil action to enforce this duty was not within the scope of ERISA civil enforcement.

C. The Supreme Court's Ruling

The U.S. Supreme Court unanimously held that states may not provide ERISA health plan beneficiaries or participants with non-equitable remedies under state law claims for erroneous plan benefit determinations. In particular, the Court concluded that state law causes of action under the THCLA were completely preempted and thus, removable to federal court under ERISA.

Writing for the court, Justice Clarence Thomas explained that ERISA's purpose is to "provide a uniform regulatory regime" with broad preemption provisions that are "intended to ensure that employee benefit plan regulation" is "exclusively a federal concern."¹¹ Justice Thomas further added that ERISA §502(a) is "essential to accomplish Congress' purpose of creating a com-

prehensive statute for the regulation of employee benefit plans.” In quoting *Pilot Life Ins. Co. v. Dedeaux*,¹² he stated:

[T]he detailed provisions of §502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. 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.¹³

IV. Implications for the Healthcare Industry

The Supreme Court’s ruling in *Aetna* displays an aggressive protection of federal interests under ERISA and has significant implications for HMOs, consumers, and states. In particular, the decision presents several issues: (1) what options are left for consumers who are faced with a denial of benefits, (2) whether HMOs remain liable for consumer grievances, and (3) whether state laws that provide remedies for citizens who receive medical treatment below state standards are valid. Although the Court’s central holding may seem clear, its implications for the healthcare industry are not so obvious.

A. Implications for HMOs

The Supreme Court’s decision is a positive development for HMOs and provides new guidelines for ERISA civil enforcement. The decision quickly reverses a decade of deci-

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sions promoting a decline in ERISA preemption.

1. A POSITIVE DEVELOPMENT FOR HMOs

Following the decision in *Aetna*, an HMO should not be subject to a state tort claim for a benefit denial unless the plan actually employs the treating physician. HMOs contracting with treating physicians who do not make benefits determina-

tions, and whose medical directors are not treating physicians, may obtain removal to federal court and subsequent dismissal of state law claims. Therefore, HMOs will routinely be allowed to remove benefit litigation to federal court.

In *Aetna*, the Supreme Court ruled that HMOs act as ERISA fiduciaries when they make eligibility determinations. Thus, the Court’s holding limits an HMO’s liability because an ERISA fiduciary owes his duty to the ERISA plan as a whole, not to individual ERISA beneficiaries.¹⁴ As long as HMO administrative personnel act in accordance with ERISA plan terms in a manner that serves the interests of the plan, they should not be liable for harm caused by denials of coverage for treatment.

2. EFFECTS OF A CONTRARY DECISION

In *Aetna*, the Supreme Court could have allowed the plaintiffs to bring their claims under state law. Such a decision, however, would be contrary to legislative intent under ERISA. Congress intended for ERISA to provide uniform regulation of group health plans and to avoid a patchwork of state remedies that would expand liability. If the Court held for the plaintiffs, a claim of fiduciary breach by an HMO physician making a mixed decision could be categorized as a malpractice claim. As a result, ERISA’s fiduciary standard would amount to nothing more than the malpractice standard traditionally applied in actions against physicians.

3. ARE HMOs LIABLE AFTER AETNA?

After *Aetna*, if a plaintiff is successful in bringing an ERISA claim against an HMO, the HMO may be subject to a variety of civil penalties. Under ERISA’s “carefully integrated civil enforcement provisions,” a plaintiff may recover damages for the cost of the benefit and reasonable attorneys’ fees. In addition, ERISA authorizes lawsuits against HMOs for breach of fiduciary duty, disgorgement of profits, imposition of constructive trust on ill-gotten profits, interest on delayed benefit payments, restitution, and injunctions.

Although a treating physician may not be an employee of an HMO, plaintiffs may attempt to pursue vicarious liability theories against an HMO such as agency and ostensible agency. An HMO may also be liable for a physician’s conduct under a respondent superior theory or for negligently selecting and/or retaining the physician on staff. Accordingly, counsel for HMOs should be sure that their clients implement appropriate policies and procedures for making benefit determinations and follow efficient credentialing and peer review procedures.

ERISA regulations also expressly provide that state independent review laws are not preempted.¹⁵ State independent review laws are binding on an HMO, and a plaintiff can file suit against an HMO for violation of such laws. In addition, plaintiffs may bring suits alleging that an HMO acted in bad faith. For example, a plaintiff may bring a bad faith cause of action

when an HMO discriminates between ERISA and non-ERISA members in examining claims.

In *Aetna*, the Supreme Court pointed out that a cause of action will be deemed “independent” of ERISA only if it is “entirely independent of the federally regulated contract itself.”¹⁶ Thus, duties outside of ERISA may be imposed on an HMO that are not “related to” an ERISA plan. Nevertheless, the Court did not give much guidance on what is “independent” of ERISA, and has left this issue open for future ERISA litigation.

B. Implications for Consumers

If the *Aetna* decision is a positive result for HMOs, what are the anticipated effects on consumers? After *Aetna*, consumers can still bring suit against their HMOs, and have alternatives to ERISA litigation.

1. CAN CONSUMERS SUE HMOs AFTER AETNA?

The Supreme Court decision does not mean that consumers can't sue their HMOs. Instead, it is about whether a state law that requires HMOs to exercise a duty of care is preempted by ERISA. If a state law is preempted by ERISA, consumers can

“[A]fter *Aetna*, alternatives to suits against HMOs for denial of benefits or services will become more important than ever for consumers.”

still recover the value of benefits denied to them, and may be able to sue their HMOs in certain factual situations.¹⁷

Consumers can still sue non-ERISA plans, such as government or church plans. The decision does not apply to Medicaid managed care products, Medicare HMOs, Medigap policies, health benefits plans for federal employees, or discount health plans. Also, medical malpractice claims against staff-model HMOs based upon an agency theory would not be preempted by ERISA because it would not be an eligibility claim, but a negligent hiring or supervision claim. In addition, vicarious liability claims against HMOs and insurers may survive the decision.

After *Aetna*, consumers, under certain circumstances, may bring claims against ERISA-governed health plans in state court. The Supreme Court stated that consumers may sue in state court when the facts of their case resemble the facts of *Pegram v. Herdrich*.¹⁸ In *Pegram*, the plaintiff's treating physician was administering the plan benefits, and the Supreme Court explained that “the physician's eligibility decision and the treatment of the decision were inextricably mixed.”¹⁹

The *Aetna* Court held that treating physicians or their employers are not acting as fiduciaries when making mixed treatment and eligibility decisions; HMOs, insurers, and plan administrators are acting as fiduciaries and are covered and protected by ERISA when making benefit determinations. The Court did not consider under what conditions HMOs directly employing treating physicians are liable to ERISA beneficiaries for physician conduct. This is because the coverage decisions in Davila and Calad's cases were not made by treating physicians. Thus, whether ERISA preempts such claims is unclear and is another question left open for future ERISA litigation.

2. CONSUMER ALTERNATIVES TO ERISA

In its opinion, the Supreme Court points out that Davila and Calad could have pursued alternative remedies upon their denial of benefits.

It is clear, then, that respondents complain only about denials of coverage promised under the terms of ERISA-regulated employee benefit plans. Upon the denial of benefits, respondents could have paid for the treatment themselves and then sought reimbursement through a §502(a)(1)(B) action, or sought a preliminary injunction . . .²⁰

Consumers claiming wrongful denial of ERISA benefits have alternatives to bringing an ERISA claim against their HMO. For instance, a consumer may pay for denied benefits out of pocket and seek reimbursement under the HMO's internal appeals process, required by ERISA. If this appeal is denied, consumers may then sue under ERISA.

If consumers cannot pay for their benefits out of pocket, and the benefits are needed urgently, they can seek an injunction or seek a temporary restraining order from a state or federal court against the HMO. This would force the HMO to make a decision or to cover the service for that period of time. If the HMO is recommending discharge or will not keep the patient in the hospital without coverage, consumers may also ask a state court for an injunction. However, this approach requires that both the consumer come up with the money and the provider give the services without insurance approval or authorization. If the HMO alone is the problem, consumers may first complain to a hospital administrator or compliance officer.

Some of these alternatives could have been used by Davila and Calad. Davila could have purchased Vioxx and then sued Aetna for the cost, or sought a declaratory judgment requiring Aetna to pay for Vioxx. Similarly, Calad could have stayed in the hospital, paid the hospital bill, and then sued CIGNA. In addition, Davila and Calad could have appealed their denial of benefits through their HMOs' appeals process, or instead sued a doctor or hospital. HMO internal grievance processes were available to both plaintiffs.

In Calad's case, however, by the time the HMO heard the appeal, she would have been out of the hospital. Calad needed the decision immediately and an appeal would have been futile. Nevertheless, she could have asked for an injunction. Consumers may go to state or federal court to ask for an injunction and request the court to hear their complaint immediately. They may represent themselves or have counsel present, and if the situation is urgent, the court will hear their request the same day. However, this assumes that consumers are aware of injunctions and if they cannot represent themselves, can afford counsel to represent them. This may not be a realistic option for most consumers.

The Supreme Court's ruling in *Aetna* means that there are fewer options for consumers who seek to recover from a denial of benefits and do not obtain the benefits on their own. Thus, after *Aetna*, alternatives to suits against HMOs for denial of benefits or services will become more important than ever for consumers.

3. CONSUMER RELIEF UNDER ERISA

Although consumers may perceive their grievances as unremedied, the *Aetna* decision may create greater relief under future ERISA enforcement. In her concurring opinion, Justice Ginsburg recommends that a form of "make whole" relief might be appropriate equitable relief under ERISA. She suggests that the Court's broad interpretation of ERISA's preemptive provisions, along with its construction of equitable relief under §502(a)(3), creates a "regulatory vacuum" in which a majority of state law remedies will be preempted, but few federal substitutes will be available for plaintiffs. She urges the judicial and legislative branches to "revisit what is an unjust and increasingly tangled ERISA regime" and assist those "persons adversely affected by ERISA-proscribed wrongdoing."²¹

The Supreme Court notes that Davila and Calad failed to amend their complaints to bring a claim under §502(a), and therefore waived the opportunity for the Court to address the "make-whole" issue. Justice Ginsburg's appeal for such relief may suggest that plaintiffs should consider pursuing an action under §502(a)(3) for monetary damages resulting from harm caused by erroneous medical necessity decisions made by HMOs. Whether such a difficult case would be fruitful may be the next step in ERISA preemption analysis.

C. Implications for States

A state's role is to protect the health, safety, and welfare of its citizens. The regulation of healthcare is an integral part of that role. One implication of the *Aetna* decision is the erosion of states' authority through invalidation of state laws providing remedies for citizens who receive medical treatment below state standards. However, are state statutes concerning HMO liability actually invalidated as a result of *Aetna*?

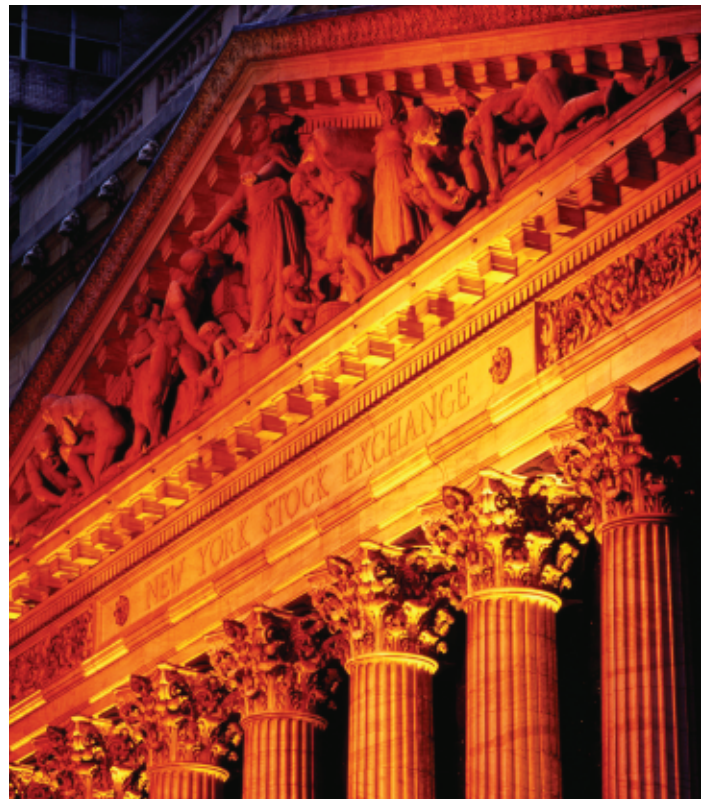
State laws concerning HMO liability may be invalid with respect to liability for denials of benefits. However, the *Aetna*

decision does not mean that all state laws are preempted. For example, the THCLA is not entirely invalidated. Only those portions of the THCLA with remedies "in addition to" ERISA's remedies are preempted, and those portions of the THCLA that do not relate to civil cases are not preempted. Furthermore, the THCLA still protects consumers with non-ERISA HMO plans.

State independent right to review laws are also not preempted by ERISA.²² Forty-three states and the District of Columbia have right to review laws which enable consumers to challenge coverage decisions.

1. "INDEPENDENT" OF ERISA

The THCLA requires the interpretation of plan benefit terms in order to determine liability under its provisions. Thus, the legal duties imposed by the THCLA do not arise independently of ERISA or the terms of the HMO plan, and the Court did not need to consider what might constitute an "independent duty" owed by an HMO to an individual ERISA beneficiary.



States may attempt to enact managed care liability laws, which would create an independent legal duty, in order to permit actions against HMOs based on an alleged breach of those duties. However, it is difficult to ascertain what those duties might be. Arguably, any state cause of action by an ERISA beneficiary against an HMO that is acting as a fiduciary either seeks remedies alternative to ERISA's exclusive remedies under §502(a), and/or "relates to" an ERISA plan under §514. Thus, it is uncertain how the *Aetna* ruling will play out in future ERISA cases.

2. STATE INSURANCE LAWS

The *Aetna* decision also raises the issue of whether state insurance laws that create liability for bad faith are affected by ERISA's enforcement provisions. The Court addressed this issue when it reaffirmed its holding in *Pilot Life Ins. Co. v. Dedeaux*.²³ The Court reiterated that *Pilot Life* requires preemption of even saved state insurance laws if such laws would provide "a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme."²⁴ Therefore, even where state statutes meet ERISA's test under the savings clause,²⁵ if the statutes replace ERISA remedies, they are preempted. Consequently, it appears that states must create laws that do not replace the ERISA remedial scheme in order to provide remedies for citizens.

V. Conclusion

The *Aetna* decision has many anticipated implications for HMOs, consumers, and states. While the decision is a positive development for HMOs, it does not entirely foreclose consumers from gaining relief under ERISA and does not erode states' authority in healthcare regulation. Although seemingly supported by the decision, HMOs may still be liable for their conduct and for the conduct of physicians, and remain subject to ERISA's exclusive remedies. HMOs also face the prospect of litigation on issues such as what is appropriate make-whole

relief for plaintiffs, and what constitutes a violation of federal or state legal duties independent of ERISA and benefit plan terms.

The decision does not preclude consumers from having their potential grievances remedied. Consumers may still sue non-ERISA HMOs and government-sponsored plans, and medical malpractice claims against doctors and hospitals remain as options. Consumers also have alternatives to ERISA litigation such as appeals processes and court-ordered injunctions.

The *Aetna* decision does not erode state authority in healthcare regulation. Only those provisions that are "in addition" to ERISA's remedial provisions are preempted. After *Aetna*, states must create laws that constitute an independent legal duty of ERISA in order to avoid preemption. However, creation of an independent duty may be a difficult task because what is "independent" of ERISA enforcement remains unanswered.

Given its many unresolved issues and open-questions, *Aetna* will likely become another decision in a long line of court decisions on the role of ERISA in an increasingly complex healthcare setting.²⁶

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Christine Naglieri is a third-year JD candidate at American University Washington College of Law, where she is a Student Articles Editor of the Business Law Brief and Co-Chair of the Student Health Law Association. Ms. Naglieri has an undergraduate degree in Health and Society from the University of Rochester in Rochester, N.Y.

ENDNOTES: Christine Naglieri

¹ Kentucky Assn. of Health Plans, Inc., et al. v. Miller, 123 S.Ct. 1471 (2003) (upholding a Kentucky "any willing provider" law); Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002) (upholding an Illinois external review law); Pegram v. Herdrich, 530 U.S. 211 (2000) (holding that HMOs could not be sued over the use of physician financial incentives to limit care).

² *Aetna Health, Inc. v. Davila*, 124 S.Ct. 2488 (2004).

³ Commerce is promoted by allowing companies to operate on a national basis and not have to worry about each individual state law that regulates employee benefits. Health coverage is considered an employee benefit.

⁴ *Aetna Health, Inc.*, 124 S.Ct. at 2495. (citing *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981)).

⁵ 29 U.S.C.A. § 1144(a) (2000).

⁶ 29 U.S.C. § 1132(a) (2000); 29 U.S.C. § 1144(a).

⁷ 29 U.S.C. § 1144(a).

⁸ Tex. Civ. Prac. & Rem. Code §§ 88.001-88.003. The THCLA is a Texas state law that allows Texas patients to sue their HMOs directly for medical malpractice. It expressly provides that an HMO can be sued in state court for breaching its "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." Ten states have enacted legislation similar to the THCLA. They are: Georgia, California, Washington, Arizona, Maine, Oklahoma, West Virginia, Oregon, New Jersey and North Carolina.

⁹ *Aetna* covered Naprosyn as part of a step program in which patients receive less expensive medication before trying more expensive forms of similar medications.

¹⁰ Under ERISA, there would be nothing for *Davila* and *Calad* to recover because they were asking only for monetary damages for pain and suffering and ERISA does not provide monetary relief.

¹¹ *Aetna Health, Inc.*, 124 S.Ct. at 2495 (citing *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981)).

¹² 481 U.S. 41 (1987).

¹³ *Aetna Health, Inc.*, 124 S.Ct. at 2495.

¹⁴ *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 141-143, 140-148 (1985).

¹⁷ See 29 CFR § 2560.503-1 (k)(2)(i); See also, *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) (holding that an Illinois statute providing for outside review of plan coverage determinations did not conflict with ERISA).

¹⁸ *Aetna Health Inc.*, 124 S.Ct. at 2497.

¹⁹ The major advantage to bringing a state law tort cause of action rather than an ERISA claim against an HMO is the broader spectrum of relief available under state tort law. In a state tort law cause of action against an HMO, a successful plaintiff can recover monetary damages which are unavailable under ERISA. For example, a plaintiff may seek compensatory damages for past and future physical, mental, and emotional pain and suffering, as well as medical expenses and lost wages. In contrast, ERISA does not permit individual claims for compensatory or punitive damages.

²⁰ 530 U.S. 211 (2000).

²¹ *Aetna Health Inc.*, 124 S.Ct. at 2501, quoting *Pegram*, 530 U.S. at 228.

²² *Id.* at 2497.

²³ *Id.* at 2503.

²⁴ The *Aetna* opinion does not affect the Supreme Court's holding in *Rush Prudential v. Moran*, 536 U.S. 355 (2002) (holding that state external review laws are saved from ERISA preemption, as "garden variety insurance regulation").

²⁵ 481 U.S. 41 (1987) (holding that all state insurance remedies that are in addition to ERISA's remedies are preempted, even for non-compliance with saved insurance laws).

²⁶ *Aetna Health Inc.*, 124 S.Ct. at 2489.

²⁷ *Id.*

²⁸ After the Supreme Court issued its decision, a group of more than 50 House Democrats, led by representative John Dingell (D-MI), the ranking member of the House Committee on Energy and Commerce, introduced H.R. 4628, legislation proposing a wide range of health plan mandates and a major expansion of liability for health plans, insurers, and employers. The bill, based on a "Patients' Bill of Rights," guarantees patients certain rights under their health plans such as the right to appeal claim denials to an independent board of review, the right to sue HMOs for damages if claim denials result in injury to the patient, and final medical necessity determinations made by doctors, not insurance administrators. See Press Release, Dingell to Introduce Patients' Rights Bill After Supreme Court Sides with HMOs (June 21, 2004), at www.house.gov/commerce_democrats/press/108nr38.htm.