

**THE UNITED STATES SUPREME COURT'S DECISION IN *DAVILA* PROVIDES
MUCH NEEDED CLARITY ON THE SCOPE OF ERISA PREEMPTION OF
MANAGED CARE DECISIONS**

BY CIARA RYAN FROST and
JOAN E. BRADY of
KERNS, PITROF, FROST & PEARLMAN, LLC

For years, litigants have debated the scope of ERISA preemption of state laws and state law claims concerning the management of care under ERISA-governed health benefit plans. On June 21, 2004, the U.S. Supreme Court provided some much needed clarity on the scope of ERISA preemption of state law claims concerning managed care practices in its decision in *Aetna Health, Inc. v. Juan Davila*, No. 02-1845 (U.S. June 21, 2004).

As discussed below, *Davila* is a victory for the managed care industry because it broadly interprets ERISA preemption in the context of managed care decisions. *Davila makes it clear that lawsuits alleging wrongful denials of health benefits by employee benefit plan administrators who do not also serve as the plan participant's physician or the physician's employer concern pure benefits determinations and, consequently, are preempted by ERISA. Significantly, the Davila ruling applies regardless of whether the benefit determination involved some medical judgment and regardless of how such lawsuits are pled (e.g. in contract, in tort or under state statute). However, while not addressing the issue, the Davila decision implies that, in the future, the U.S. Supreme Court might be inclined to more broadly interpret the "make-whole relief" available under ERISA's remedial provisions to afford more expansive relief to ERISA plan participants. (See footnote no. 7 of the majority opinion and the concurring opinion).*

Before discussing *Davila* in detail, this article provides a brief overview of the Employment Retirement Income Security Act of 1974, 29 U.S.C. §§1001 et seq. ("ERISA") and ERISA preemption, as a basic understanding of ERISA preemption is beneficial in appreciating the impact of the *Davila* decision.

I. ERISA Preemption and its Significance

ERISA is a federal statute enacted to provide uniform standards for the administration of employee benefit plans. ERISA's reach is broad: it governs most employee benefit plans sponsored by private employers.¹ An estimated 160 million Americans are enrolled in ERISA-governed employee benefit plans. Lawsuits challenging the misadministration of health benefits under ERISA-governed plans may only be brought in federal court. Indeed, ERISA preempts or supersedes state laws and state law causes of action relating to the *administration of healthcare benefits* under ERISA governed plans. ERISA does not preempt state laws or state law causes of action relating to the *quality of healthcare* (e.g. medical malpractice), because the quality of healthcare is an area reserved for state law regulation. The integration of the financing and delivery of healthcare under managed care has made it more difficult for some to differentiate

¹ ERISA does not govern health plans sponsored by churches or government entities. Nor does it govern individual health plans.

between benefits decisions (subject to ERISA) and healthcare treatment decisions (not subject to ERISA).

ERISA preemption is significant because ERISA's civil enforcement provisions do not provide the broad range of remedies typically available under state law. As historically interpreted, ERISA has effectively restricted the remedies available to plan participants and beneficiaries² to: (1) benefits due under the employee benefit plan; (2) equitable relief to enforce the plan terms (e.g. a declaration that particular benefits are covered under the plan or an injunction prohibiting the plan from denying benefits for particular treatment); and (3) plaintiffs' attorneys fees and costs (which awards are available at the court's discretion.) 29 U.S.C. sec. 1132 (a) (1) (b). To date, *courts have consistently held that extra-contractual (including punitive) damages are not available to claimants alleging violations of ERISA plans.* This position has been controversial as ERISA plan participants have essentially had no remedy for emotional distress, bodily injury and other extra-contractual damages caused by denials of benefits under their plans. Since Congress has not taken action to correct this perceived remedial vacuum by amending ERISA, some states, led by Texas, have passed legislation designed to circumvent ERISA by creating independent state law causes of action for denials of health care benefits which adversely impact health care. As discussed below, the U.S. Supreme Court's decision in *Davila* makes it clear that ERISA still preempts claims brought under such state statutes to the extent they challenge benefit determinations which could and should be redressed under ERISA.

ERISA plan participants and their attorneys have also attempted to circumvent ERISA by characterizing their causes of action as relating to the *quality* of care, as opposed to the *quantity* of care, received under an ERISA plan. For example, participants have argued that health plan administrators exercise medical judgment in making certain benefit determinations (particularly those based upon "medical necessity"). Some courts have been persuaded by such efforts and have held that ERISA does not preempt lawsuits challenging the management of care (e.g. utilization review and case management decisions) under ERISA plans which involves medical judgment or is perceived to have adversely impacted treatment. Other courts have disagreed and have held that benefit determinations involving medical judgment are still benefit decisions preempted by ERISA. The United States Supreme Court's decision in *Herdrich v. Pegasus* in 2000, which held that "mixed eligibility and treatment" decisions are not fiduciary acts subject to ERISA preemption, only intensified the debate over when lawsuits challenging managed care activities are preempted by ERISA. Indeed, after *Pegasus*, lower courts issued conflicting decisions on this significant issue. Fortunately, the U.S. Supreme Court's decision in *Davila* should put this longstanding debate largely to rest.

II. *Davila*

The U.S. Supreme Court's unanimous ruling in *Davila* is instructive on the liability exposures faced by health insurers and managed care organizations across the country. The ruling makes it clear that, *where an ERISA plan participant challenges a benefit decision made by a party other than the participant's physician or the physician's employer, ERISA and its limited remedies apply, regardless of whether or not the benefit decision required the exercise of medical judgment by the plan administrator and regardless of how the participant fashions his/her claim*

² This article jointly refers to ERISA plan participants and beneficiaries as "participants".

(e.g. in contract, in tort or under a state statute purporting to impose an independent duty on ERISA plan fiduciaries). However, the concurring opinion in *Davila* hints that expanded ERISA remedies may be available in the future as the Court might be willing to more liberally construe what constitutes “make-whole relief” available under ERISA §503(a)(3) and/or Congress may amend ERISA to provide a remedy for additional compensatory damages.

A. Lower Court Rulings in *Davila*

Davila involves the consolidated appeals of two cases brought by Juan Davila and Ruby Calad. Davila and Calad were both ERISA participants who sued their health plan administrators (Aetna and CIGNA respectively) in Texas State Court, seeking to hold them liable for injuries allegedly sustained as a result of the plans’ refusal to preauthorize benefits for treatment recommended by the participants’ physicians.³ Davila and Calad argued that the plan administrators’ benefit denials breached their duty of care under the Texas Health Care Liability Act (“THCLA”), Tex. Civ. Prac. & Rem. Code Ann. §§88.001 et seq. The THCLA allows patients to sue their health plan administrators for any failure to use “ordinary care” in making “health care treatment decisions” (which are broadly defined to include health benefit decisions) that proximately cause them injury.

Aetna and CIGNA removed the *Davila* and *Calad* cases to federal court on ERISA preemption grounds. Davila and Calad sought to have their cases remanded to state court, arguing that ERISA did not preempt their claims. The U.S. District Court for the Northern District of Texas denied the motion to remand. However, the Fifth Circuit Court of Appeals reversed, finding that ERISA did not preempt either action. *Roark v. Humana*, 307 F.3d 298 (2002).

The Fifth Circuit recognized that ERISA §502(a)(1)(B), which provides a cause of action for recovery of wrongfully denied benefits, completely preempts any state law claim that could have been brought under §502(a)(1)(B), unless the defendant’s actions violate an independent legal duty. However, it concluded that Davila’s and Calad’s claims were not preempted by §502(a)(1)(B) because: (1) Davila’s and Calad’s claims sounded in tort and did not seek to recover benefits; and (2) Aetna and CIGNA’s actions violated duties imposed by the THCLA, which duties the Fifth Circuit deemed independent of ERISA and the terms of their employee benefit plans. Citing the U.S. Supreme Court’s decision in *Pegram v. Herdrich*, 530 U. S. 211(2000), the Fifth Circuit also concluded that the plaintiffs’ claims were not preempted by ERISA §502(a)(2), which provides a cause of action against ERISA fiduciaries for breach of fiduciary duty. The Fifth Circuit based this conclusion on its finding that Aetna and CIGNA were not acting as ERISA plan fiduciaries when they denied the plaintiffs’ medical benefits, because they made “mixed eligibility and treatment decisions.”

³ Davila’s physician prescribed Vioxx for arthritic pain. Davila’s employer-sponsored health plan required arthritic pain to first be treated with less expensive pain relievers, and provided benefits for Vioxx only if the participant suffered a detrimental reaction to, or failed to respond to, the less expensive drugs. The cheaper medication allegedly caused severe internal bleeding in Davila and a near heart attack.

Following a hysterectomy, Ruby Calad’s surgeon recommended an extended hospital stay. Calad’s health plan only approved benefits for the standard one-day hospital stay. Following discharge, Calad experienced complications that required her to return to the emergency room.

B. The U.S. Supreme Court's Decision in *Davila*

Aetna and CIGNA petitioned the U.S. Supreme Court for leave to appeal. On November 10, 2003, the U.S. Supreme Court agreed to hear Aetna's and CIGNA's appeals of *Davila* and *Calad* to determine whether ERISA plan participants can file suit against their health plan administrators in state court seeking consequential and punitive damages under state tort law.

On June 21, 2004, the U.S. Supreme Court issued its unanimous ruling, finding the claims of respondents, Davila and Calad, to be completely preempted under ERISA §502(a)(1)(B) and, hence, removable from state to federal court where recovery is limited to the remedies available under ERISA. Davila, page 2.

1. The Court Broadly Construed ERISA Preemption Under §502(a)(1)(B)

At the outset of its opinion, the Supreme Court described the rationale underlying ERISA's deliberately expansive preemption provisions and then stated: "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 preempted." *Davila* at page 6. Next, the Court addressed the issue of whether ERISA §502(a)(1)(b) preempts plaintiffs' state law claims, noting that, when a denial of coverage to an ERISA participant is at issue, and no legal duty independent of ERISA or the plan terms is violated, the lawsuit falls within the scope of ERISA §502(a)(1)(B). *Davila*, page 8. The Court then held that the Fifth Circuit's ruling that §502(a)(1)(B) did not preempt respondents' claims was erroneous for several reasons. First, the Court disagreed with the Fifth Circuit's finding that respondents' causes of action were not for benefit denials enforceable under §502(a)(1)(B). The Court stated:

... 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 ...

Davila, page 9. Second, the Court rejected respondents' arguments that the petitioners, Aetna and CIGNA, violated legal duties that arose independently of ERISA and the terms of their health plans, stating:

The duties imposed by the THCLA in the context of these cases, however, do not arise independently of ERISA or the plan terms. The THCLA does impose a duty on managed care entities to "exercise ordinary care when making health care treatment decisions," and makes them liable for damages proximately caused by failures to abide by that duty. §88.002(a). However, if a managed care entity correctly concluded that, under the terms of the relevant plan, a particular treatment was not covered, the managed care entity's denial of coverage would not be a proximate cause of any injuries arising from the denial. Rather, the failure of

the plan itself to cover the requested treatment would be the proximate cause. More significantly, the THCLA clearly states that “[t]he standards in Subsections (a) and (b) create no obligation on the part of the health insurance carrier, health maintenance organization, or other managed care entity to provide to an insured or enrollee treatment which is not covered by the health care plan of the entity.” §88.002(d). Hence, a managed care entity could not be subject to liability under the THCLA if it denied coverage for any treatment not covered by the health care plan that it was administering.

Thus, interpretation of the terms of respondents’ benefit plans forms an essential part of their THCLA claim, and THCLA liability would exist here only because of petitioners’ administration of ERISA-regulated benefit plans. Petitioners’ potential liability under the THCLA in these cases, then, derives entirely from the particular rights and obligations established by the benefit plans. (Emphasis supplied)

Davila, pages 10-11. For these reasons, the Court held that plaintiffs’ claims were preempted by ERISA.

2. The Court Corrects Lower Court Misinterpretations of Its Earlier ERISA Preemption Rulings

Significantly, the Court took pains to point out that the Fifth Circuit had misconstrued its holding in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002). Contrary to the Fifth Circuit’s interpretation of *Rush Prudential*, the Court noted: “[n]owhere in *Rush Prudential*” did it suggest that ERISA only preempts a state cause of action that “precisely duplicates a cause of action under ERISA §502(a).” *Davila*, page 14. It elaborated: “Congress’ intent to make the ERISA civil enforcement mechanism exclusive would be undermined if state causes of action that supplement the ERISA §502(a) remedies were permitted, even if the elements of the state cause of action did not precisely duplicate the elements of an ERISA claim.”

Next, although the Court stated that it need not address the issue of whether respondents’ claims were preempted by ERISA §502(a)(2), which provides a cause of action for breach of fiduciary duty, because the petitioners did not argue that §502(a)(2) preemption applied, it pointed out that the Fifth Circuit misconstrued its decision in *Pegram v. Herdrich*, 530 U.S. 211 (2000). Specifically, the Court deemed misplaced the Fifth Circuit’s reliance on *Pegram* to find that respondents’ challenged actions were not fiduciary acts governed by ERISA because they were “mixed eligibility and treatment decisions.” The Court distinguished *Pegram* from *Davila* in one significant respect: in *Pegram*, the plaintiff’s treating physician was also the person in charge of administering plaintiff’s benefits. The Court stated:

Since administrators making benefit determinations, even determinations based extensively on medical judgments, are

ordinarily acting as plan fiduciaries, *it was essential to Pegram's conclusion that the decisions challenged there were truly "mixed eligibility and treatment decisions,"* 530 U.S. at 229, *i.e. medical necessity decisions made by the plaintiff's treating physician qua treating physician and qua benefit administrator.* [Emphasis added]

Davila, page 19.

Because the health plan administrators in *Davila* were neither the respondents' treating physicians nor the employers of the treating physicians, the Court held that their "coverage decisions are purely eligibility decisions and *Pegram* is not implicated." *Davila* at page 19. Citing the dissent in *Vytra Healthcare v. Cicio*, 321 F.3d at 109 (2nd Cir. 2003), the Court stated:

Put another way, the reasoning of *Pegram* "only make[s] sense where the underlying negligence also plausibly constitutes medical maltreatment by a party who can be deemed to be a treating physician or such a physician's employer." ... Petitioners' coverage decisions, then, are pure eligibility decisions, and *Pegram* is not implicated.⁴

C. Noteworthy Comments By Two Supreme Court Judges On The Need To Revisit The Court's Previous "Cramped Construction" Of The "Make Whole Relief" Available Under ERISA

Significantly, the majority opinion in *Davila* notes in *dicta* that "some individuals in respondents' positions could possibly receive some form of 'make-whole' relief under ERISA §502(a)(3)." *Davila*, footnote 7. The Court did not address whether "make whole relief" was appropriate in *Davila* because the respondents did not seek such relief. However, the concurring opinion authored by Justice Ginsburg and (joined in by Justice Breyer) joins "the rising judicial chorus urging that Congress and [the U.S. Supreme] Court revisit what is an unjust and increasingly tangled ERISA regime." *Davila*, Ginsburg concurring opinion, page 1, citing *DiFelice v. AETNA U.S. Healthcare*, 346 F.3d 442, 453 (3rd Cir. 2003)(Becker, J. concurring). Justice Ginsburg's concurring opinion notes that the Court's broad interpretation of ERISA's preemptive force, coupled with its "cramped construction of the 'equitable relief' allowable under §502(a)(3)," has created a "regulatory vacuum" in which participants "adversely affected by ERISA – proscribed wrongdoing cannot gain make – whole relief." *Davila*, concurring opinion at page 2. *Justice Ginsburg opines that "... fresh consideration of the availability of consequential damages under §502(a)(3) is plainly in order," and concludes that Congress or the United States Supreme Court will one day confirm that "Congress ... intended ERISA to replicate the core principles of trust remedy law, including the make-whole standard of relief."* *Davila*, concurring opinion at page 3.

⁴ After issuing its decision in *Davila*, the Court vacated and remanded the Second Circuit's decision in *Vytra Healthcare v. Cicio* and the Eleventh Circuit's decision in *CIGNA Healthcare of Florida v. Land*. In each of these decisions, the Circuit Court had erroneously characterized utilization review decisions by health insurers as "mixed eligibility and treatment decisions".

Thus, the Supreme Court left open the possibility that, in the future, ERISA may be construed to provide consequential damages for bodily injury and emotional distress to aggrieved participants.

D. Likely Impact of *Davila*

The U.S. Supreme Court's decision in *Davila* should quell the debate over whether and when ERISA preempts lawsuits challenging utilization review and similar managed care decisions by parties other than the treating physicians or their employers under ERISA-governed plans. As a result of *Davila*, challenges to all such decisions under ERISA-governed plans should be prosecuted in federal court under ERISA's exclusive enforcement scheme, unless the participant asserts the breach of an independent duty separate and apart from ERISA and the plan. The Court's broad interpretation of ERISA's preemptive power, combined with its suggestion that, in the future, Congress or the courts may clarify that ERISA §502(a)(3) provides "make whole relief" in the form of consequential damages, will likely lead to an increase in the frequency and severity of ERISA claims. However, comments made at the oral arguments in *Davila* suggest that, while make whole relief available under §502(a)(3) may include some compensatory damages, it would not include punitive damages. Therefore, unless Congress amends ERISA to provide for awards of punitive damages, punitive damages are unlikely to be available under ERISA §502(a)(3).