The *Davila* Legacy

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This article examines the impact, one year later, of the United States Supreme Court's ERISA preemption decision in *Aetna Health Inc. v. Juan Davila*, 542 U.S. 200, 124 S. Ct. 2488 (2004).

The Supreme Court's Holding in *Davila*

In *Davila*, the Supreme Court tackled the decisive issue of when the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 et seq. ("ERISA") completely preempts state laws or state court litigation concerning benefit decisions made in the context of managed care. ERISA preemption of managed care decisions is controversial because prospective benefit denials under ERISA-governed plans can lead to bodily injury and emotional distress, and courts have historically interpreted ERISA as *not* affording recovery of such extra-contractual damages.[1]

Prior to *Davila*, ERISA plan participants/beneficiaries who received adverse benefit determinations often attempted to avoid ERISA preemption and recover extra-contractual damages in state court proceedings by characterizing their causes of action as relating to the *quality* of health care (an area reserved for state regulation), as opposed to the administration of health care benefits (an area governed by ERISA). Lower courts were deeply divided on the circumstances in which ERISA preempted litigation over managed care decisions. The *Davila* ruling quelled this debate: it clarified that, *where an ERISA plan participant/beneficiary challenges a benefit decision made by a non-treater, ERISA and its limited remedies apply, even if the benefit decision required the exercise of medical judgment by the plan administrator, and even where the claim is brought as a tort or under a state statute purporting to impose an independent duty on ERISA plan fiduciaries.*

However, comments in Davila by a few of the Justices appear to invite claimants to shift their focus from circumventing ERISA preemption to attempting to obtain broader remedies, including

[1] ERISA remedies are narrower than those available under many state laws. ERISA plan participants/beneficiaries who sue for wrongful denial of, or failure to preauthorize, healthcare benefits have only been able to recover benefits due under their plan, equitable relief to enforce the plan (e.g. a declaration that particular benefits are covered), and plaintiffs' attorneys' fees. 29 U.S.C. sec. 1132 (a)(1)(b).

extra-contractual relief, under ERISA.[2] Justice Ginsburg predicted that, one day, the Supreme Court or Congress will confirm Congress' intent that ERISA provide make-whole relief.

Post *Davila* Courts Have Consistently Held That ERISA Preempts Denial of Benefits Cases Cloaked in Medical Malpractice Clothing

Since Davila, as expected, more courts are rejecting plaintiffs' attempts to circumvent ERISA preemption by cloaking denial of benefits cases in medical malpractice clothing, except in situations where the treater also made the benefit decision.[3] For example, see *Land v. CIGNA Healthcare of Florida*, 381 F. 3d 1274 (2004), a "medical malpractice" lawsuit stemming from a CIGNA approval nurse's authorization of outpatient care, instead of the prescribed inpatient care, for the plaintiff's hand infection. After the plaintiff's condition worsened, requiring several surgeries and amputation of his middle finder, he sued CIGNA, alleging it was negligent in the care and treatment of his infection. The Eleventh Circuit Court of Appeals concurred that ERISA completely preempted the case because the plaintiff really sought to redress CIGNA's denial of benefits under his ERISA-regulated benefit plan. See also, *Rubin-Schneiderman v. Merit Behavioral Care Corporation*, 121 Fed. App. 414, 2005 WL 229862 (2d Cir. 2005) in which the Second Circuit Court of Appeals found that "claims [against a utilization review service provider] for negligence in improperly failing to approve [psychiatric inpatient treatment] more closely resemble claims for denial of a plan benefit than for medical malpractice."

The *Smelik v. Humana* Verdict Demonstrates How Plaintiffs Can Still Circumvent ERISA Preemption After *Davila*

Despite Davila, claimants can still circumvent ERISA preemption by fashioning independent state law claims against health insurers and other managed care organizations, sounding in medical negligence or other theories distinct from denial of insurance benefits.

The recent $4.2 million Texas state court verdict against Humana Health Plan in *Smelik v. Humana* is a case in point. In that case, the plaintiffs succeeded in holding Humana, along with the treating physician defendants, liable for the wrongful death of Joan Smelik, a 66 year old woman who died of after her treating physicians apparently failed to diagnose and appropriately treat her chronic kidney disease. Ms. Smelik received her medical insurance through an ERISA governed employee benefits plan which was administered by Humana. The treating physicians were independent contractors who participated in Humana's provider network.

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[2] Specifically, a footnote in the majority opinion in *Davila* states: "some individuals in respondents' positions could possibly receive some form of 'make-whole' relief under ERISA § 502(a)(3)." *Davila*, footnote 7. Likewise, in her concurring opinion, Justice Ginsburg (joined by Justice Breyer) states "fresh consideration of the availability of consequential damages under § 502(a)(3) is plainly in order." ERISA Section 502(a)(3) allows "a participant, beneficiary or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter 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 subchapter or the terms of this plan."

[3] Where the treating physician (or his/her employer) made the benefit decision, courts are likely to find it to be a "mixed eligibility and treatment" decision not preempted by ERISA.

Humana denied any responsibility for Ms. Smelik's death, arguing that it approved every referral request and paid every medical bill submitted on behalf of Ms. Smelik.[4] The plaintiffs' argued that Humana was required to do much more than that because of promises it made to manage the care provided to Ms. Smelik by its network physicians. For example, according to the plaintiffs' Second Amended Complaint, in its Member Handbook, Humana promised to "work with" members' physicians, to "review" their health services, and to "assess whether the treatment provided is appropriate." The plaintiffs further argued that Humana was grossly negligent because, despite its awareness of Ms. Smelik's chronic kidney condition, Humana: failed to refer her to a kidney specialist or to a disease management program; approved benefits for a drug that was contraindicated and toxic to those suffering from kidney disease; and otherwise failed to assess the quality of health care provided by the treating physicians.

Thus, Humana was held responsible for the substandard medical treatment provided to Ms. Smelik due to Humana's failure to fulfill promises Humana made in its Member Handbook. While some commentators have hailed *Smelik* as potentially groundbreaking for ERISA plan participants, the theories on which the plaintiffs prevailed in *Smelik* should only apply where (1) medical negligence occurred and, (2) the health insurer or managed care organization assumed a duty to ensure the propriety of the care rendered to its members.

While Some Courts Are Poised to Consider Whether ERISA §502(a)(3) Affords Extra-Contractual Relief, Congressional Action Will Probably Be Required To Redress ERISA's Perceived Remedial Vacuum

While the scope of Section 502(a)(3) ERISA remedies is currently being tested (e.g. see Rubin-Schneiderman v. Merit Behavioral Care Corporation, 121 Fed.App. 414, 2005 WL 229862 (2nd Cir. 2005))*, a review of the United States Supreme Court's previous rulings on the scope of ERISA remedies suggests that Congress will have to amend ERISA before the courts will permit recovery of extra-contractual damages thereunder. See Mertens v. Hewitt Associates*, 508 U.S. 248, 249-50 (1993), in which the majority held that the remedies available under ERISA are limited to typical equitable remedies, such as injunctions, mandamus and restitution, and do not include compensatory damages. However, Justice White dissented (joined by Rehnquist, O'Connor and Stevens), stating that the text of ERISA "…would permit a court to award compensatory monetary relief where necessary to make an ERISA beneficiary whole."

Conclusion

While *Davila* has made it considerably more difficult for plaintiffs to circumvent ERISA preemption of benefit disputes, until Congress or the Supreme Court remedies the perceived ERISA remedial vacuum, we expect aggrieved ERISA plan participants/beneficiaries to continue to attempt to sidestep ERISA preemption by fashioning creative claims which do not depend upon a denial of benefits. In light of *Smelik v. Humana,* plaintiffs' attorneys will probably be more focused on proving negligence by health plans who assume heightened duties in marketing

[4] This may explain why the court did not submit the Smelik's alternative cause of action under ERISA Section 502(a)(1)(B) to the jury. (The Texas state court had concurrent jurisdiction over this count.) Significantly, the plaintiffs alleged that their claim for ERISA benefits did <u>not</u> extend to the utilization management, concurrent review, medical case management and quality assurance services Humana promised, but failed, to perform.

materials. In the meantime, health insurers and managed care organizations should scrutinize their member handbooks and marketing materials and make sure their policies and practices on concurrent review, case management and quality assurance comply with any promises made therein.