AETNA HEALTH V. DAVILA: ARE WE DONE YET?

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On June 21, 2004, the United States Supreme Court handed down its toughest decision yet on the issue of whether beneficiaries of employer-sponsored health plans may sue for damages under state law for injuries allegedly sustained as a result of the plan's coverage decisions. Writing for a unanimous court, Justice Clarence Thomas held that the Employee Retirement Income Security Act (ERISA) provides the exclusive remedy in these circumstances, preempting state laws that purport to duplicate, supplement or supplant the remedies available under ERISA. Aetna Health, Inc. v. Davila, 124 S. Ct. 2488 (2004). Davila is the capstone of a series of cases in which the Supreme Court addressed the availability of state tort remedies in cases involving "mixed" coverage and treatment decisions. Does Davila represent the final nail in the coffin for these types of claims? Yes and no.

Davila itself was a conglomeration of two cases involving individuals who sued their respective health maintenance organizations (HMOs) for alleged failure to exercise ordinary care in the handling of coverage decisions. The individuals alleged that the conduct of the HMOs violated the duties imposed by the Texas Health Care Liability Act (THCLA), Tex. Civ. Proc. & Rem. Code Ann. §§88.001-88.003 (2004 Supp. Pamphlet). In the first case, Juan Davila allegedly suffered injuries due to Aetna's decision not to cover the prescription arthritis drug Vioxx. In order to obtain approval for this expensive drug, Aetna required its plan participants first to try two less expensive medications. After three weeks of taking the less expensive drug Naprosyn, Davila suffered a severe reaction requiring extensive treatment and hospitalization.

In the second case, Ruby Calad was discharged from the hospital one day after undergoing a hysterectomy. She experienced post-surgical complications, allegedly because a CIGNA discharge nurse determined that she did not meet the plan's criteria for an extended hospital stay recommended by her physician. In both cases, plaintiffs had health insurance coverage through an employer-sponsored plan governed by ERISA.

Both plaintiffs brought suit in Texas state court under §88.002(a) of the THCLA, based on the health plans' alleged breaches of their "duty to exercise ordinary care when making health care treatment decisions." The health plans removed the claims to the federal court on the grounds that §502(a) of ERISA, 29 U.S.C. §1132(a), completely preempted these state law claims. The respective district courts agreed, denied plaintiffs' motions to remand and dismissed their claims after plaintiffs refused to amend their complaints to state causes of action under ERISA.

In a case involving similar claims by other individuals, Roark v. Humana, Inc., 307 F.3d 298 (5th Cir. 2002), the Fifth Circuit Court of Appeals reversed. Citing the "mixed eligibility and treatment decision" rationale addressed in Pegram v. Herdrich, 530 U.S. 211, 120 S. Ct. 2143, 147 L.Ed.2d 164 (2000), the Fifth Circuit reasoned that since the plaintiffs were not seeking reimbursements for benefits denied them but rather tort damages arising from an external statutory duty of care, these claims did not fall within ERISA's preemptive reach. Also relying on Rush Prudential HMO v. Moran, 536 U.S. 355, 122 S. Ct. 1251, 153 L.Ed.2d 375 (2002), the

Fifth Circuit derived the principle that where the state law remedy did not duplicate the remedies provided under ERISA, the state law remedies were not preempted.

In reversing the Fifth Circuit's decision, the Supreme Court seemingly went out of its way to reject each and every reason advanced by the Court of Appeals. Plowing familiar ground, the court first noted that the purpose of ERISA was to provide a uniform regulatory regime over employee benefit plans. To this end, ERISA's expansive preemptive provisions, 29 U.S.C. §1144, are deliberately designed to ensure that employee benefit plan regulation remains exclusively a federal concern. Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 523, 101 S. Ct. 1895, 68 L.Ed.2d 402 (1981). Quoting extensively from its seminal case of Pilot Life Insurance Company v. Dedeaux, 481 U.S. 41, 107 S. Ct. 1549, 95 L.Ed.2d 39 (1987), the court reiterated that Congress' inclusion, in ERISA, of some remedies and the exclusion of others represented "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." That policy, the Pilot Life court said, would be completely undermined if ERISA plan participants and beneficiaries could obtain state law remedies that Congress rejected in ERISA. In language destined to be quoted time and time again, the Davila court concluded:

> Therefore, 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.

Turning to the question of whether plaintiff's claims under the THCLA fell within the scope of ERISA's civil enforcement provision, the court looked first to the civil enforcement provisions themselves. Under §502(a)(1)(B) of ERISA, a participant or beneficiary who believes that benefits promised to him under the terms of the plan have not been provided can bring suit seeking those benefits. Thus, if an individual brings suit complaining of a denial of coverage for medical care, where the individual is entitled to such coverage only because of the terms of an ERISA regulated employee benefit plan, and no independent legal duty is violated, the suit falls within the scope of §502(a)(1)(B):

> In other words, if an individual, at some point, could have brought his claim under ERISA §502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant's actions, then the individual's cause of action is completely preempted by ERISA §502(a)(1)(B).

The Court had little difficulty in finding that, at their core, plaintiff's complaints in the case before it were only about denials of coverage under the terms of their ERISA regulated plans.

As if to drive home the point, the court chose to address plaintiff's argument, raised for the first time in their Supreme Court brief, that the THCLA is saved from preemption as a law that "regulates insurance." Again, citing its statement of Congressional policy in Pilot Life, the Court concluded that, under ordinary principles of conflict preemption, "a state law that can arguably

be characterized as 'regulating insurance' will be preempted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme."

Finally, the Court rejected plaintiffs' reliance on its earlier decision in Pegram to the effect that ERISA does not completely preempt suits arising out of what have come to be known as "mixed" eligibility and treatment decisions. The Court stated that Pegram could not be read so broadly. In a rare reference to a dissenting opinion of a lower court judge, the Court observed that 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.

quoting Cicio v. Does, 321 F.3d 83, 109 (2d Cir. 2003) (Calabresi, J., dissenting in part). Simply put, unless the coverage decisionmaker is also a treatment provider, or the employer of a treatment provider, ERISA limits the claims that can be brought to those expressly provided in §502(a).

In a concurring opinion joined by Justice Breyer, Justice Ruth Bader Ginsburg gave authoritative voice to "the rising judicial chorus urging that Congress and [the] Court revisit what is an unjust and increasingly tangled ERISA regime." Quoting, DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442, 453 (3d Cir. 2003) (Becker, J., concurring). Justice Ginsburg noted that the broad construction of ERISA's preemptive provisions, coupled with the "cramped" construction of the equitable relief allowable under §502(a)(3) has created a "regulatory vacuum," in which virtually all state law remedies are preempted but few federal substitutes are provided. Justice Ginsburg argued that "fresh consideration of the availability of consequential damages under §502(a)(3) is plainly in order."

The U.S. Solicitor General appeared to share Justice Ginburg's beliefs. In an Amicus brief, the government suggested that §502(a)(3) as currently written, may allow some forms of make-whole relief against fiduciary breaches. Virtually inviting such claims in the future, Justice Ginsburg stated that the "government's suggestion may indicate an effective remedy others similarly circumstanced might fruitfully pursue."

What's left after Davila? Not much in terms of state law claims against ERISA governed managed care plans for injuries allegedly caused by their coverage decisions. Unless the coverage decisionmaker can fairly be classified as a treating physician or the employer of a treating physician, participants and beneficiaries of ERISA plans will be limited to those remedies available under §502(a) of ERISA. The debate over quality versus quantity of care, e.g. DiFelice, supra, appears to have been rendered academic. The decision appears to insulate all but staff-model HMO's, whose coverage and treatment decisions are intertwined, from state tort and bad faith claims arising out of coverage decisions.

The Davila decision also appears to foreclose state law claims for bad faith and the like against other types of employee welfare benefit plans, for example group life and disability plans typically provided through the purchase of a group insurance product. Indeed, on September 7,

2004, the Third Circuit held that ERISA preempts claims under Pennsylvania's bad faith statute, 42 Pa.C.S. §8371, reversing a minor judicial rebellion, Barber v. UNUM Life Insurance Company of America, 2004 WL 1964500 (3d Cir. 2004).

Of course, claims against non-ERISA benefit plans are not directly affected by the decision. These include most, but not all, individual insurance policies, governmental plans and church plans that do not elect to be governed by ERISA. With respect to ERISA plans, however, the decision leaves very little room for enterprising plaintiff lawyers to argue their way out of ERISA.

What's next? No doubt plaintiffs will enthusiastically accept Judge Ginsburg's invitation to push the boundaries of equitable relief available under §502(a)(3) of ERISA. These plaintiffs may receive a warmer than expected reception from judges who may have felt hamstrung by ERISA's limited remedial provisions. Unfortunately, this is an area in which the maxim that bad cases make bad law may be proven all too true.

Although Judge Ginsburg invites Congress to intervene, that seems unlikely in today's political climate. Employers are justifiably concerned about the rising cost of health care coverage for their employees, and it seems unlikely that a Congress willing to debate caps on medical malpractice damages would be inclined to open the floodgates of litigation against third party payors.

On the other hand, it is doubtful that health plans will view Davila as a *carte blanche* to deny coverage. Health insurers are already subject to intense regulation at the state level, and federal regulations spell out exactly what health plans must do in terms of reviewing claim denials. Market forces have largely dictated less aggressive claims handling by managed care organizations, a trend that is likely to continue notwithstanding the Davila decision.

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