Aetna v. Davila

A New Look at ERISA Preemption of Medical Malpractice Claims

By Michael Kolosky

In the summer of 2004, the U.S. Supreme Court released a groundbreaking decision, *Aetna v. Davila*,[1] addressing federal preemption of state law claims against health maintenance organizations (HMOs). Specifically, the Court held that the Employee Retirement Income Security Act (ERISA)[2] completely preempts state law medical malpractice claims challenging health benefits decisions made by HMOs. In doing so, *Davila* marked a turnaround in recent Supreme Court decisions that seemed to have eroded ERISA's preemptive effect. It also resolved a split among the circuit courts as to whether health plan members can sue their HMOs for making negligent medical decisions.

This article discusses the facts behind *Davila*, explores the legal landscape leading up to the decision, and considers the lessons to be learned. It attempts to be accessible to readers unfamiliar with ERISA case law but interested in the wide-ranging policy impact of these issues. Nevertheless, it also offers a discussion of other relevant ERISA decisions to provide a fuller analysis for practitioners in this area.

Background

ERISA is a comprehensive federal law designed to protect the rights of benefit plan participants and to ensure uniformity in the interpretation of employee benefit plans. ERISA "works" by preempting state law causes of action challenging benefit decisions made by insurers and other plan administrators. Instead of bringing claims under state law, plan participants must enforce their rights to benefits under the federal ERISA statute, which provides various remedies designed to protect the participant's claim to benefits. However, the chief criticism of ERISA is not so much the nature of the remedies provided as much as the type of relief that is unavailable under the statute. Compensatory and consequential relief are not available under ERISA, much less awards of punitive damages. Instead, ERISA section 502 strictly limits recovery to the benefits due under the plan or injunctive relief to secure the same. Other than possibly recovering attorneys' fees, the consequential damages caused by ERISA violations—including wrongful benefit denials—are simply not recoverable.

In response to this perceived hole in ERISA's regulatory scheme, the Texas legislature enacted a state law known as the Texas Health Care Liability Act (THCLA). The THCLA was designed to allow participants and beneficiaries to sue their HMOs and other managed care entities based on (1) the quality of the medical treatment that they receive under the terms of their benefit plans or (2) a decision not to pay for requested treatment that results in harm to the patient. The THCLA sought to achieve this by imposing a duty on HMOs to exercise ordinary care in making health care treatment decisions and making them liable for any damages proximately caused by their failure to do so.

The *Davila* case grew out of this context. In particular, the case came to the Supreme Court after two ERISA plan participants attempted to sue their respective HMOs under the THCLA for denying payment authorization for requested benefits. The following section briefly summarizes the facts relating to each of their cases.

Juan Davila. Davila was a Texas resident who received health insurance benefits through a plan sponsored by his employer and insured by Aetna Health, Inc. Under this arrangement, Aetna reviewed claims for medical services to determine whether they were covered under the terms of the plan. Aetna also paid treating providers to supply services to members in accordance with the plan's terms.

When Davila visited his doctor with complaints of joint pain following treatment for polio, his doctor decided to prescribe Vioxx,

Volume 34 • Number 3 • Spring 2005 • American Bar Association • The Brief

a brand name prescription medication used to treat arthritis. Before writing the prescription, Davila's doctor contacted Aetna to determine if it would pay for Vioxx under the terms of Davila's health plan. Aetna reviewed the claim and informed Davila's physician that Vioxx was listed conditionally on Aetna's formulary—its list of covered drugs. Aetna explained that the plan would pay for Vioxx if Davila had already tried at least two of the 15 alternative "unconditional" drugs on the formulary or if Davila could demonstrate that he was unable to take an alternative medication due to an allergy or other clinical reasons. Aetna also noted that Davila could challenge the decision either by filing an appeal with Aetna or with an independent review organization.

Davila did not appeal Aetna's decision or submit any information suggesting that Vioxx was preferable to the formulary alternatives. Instead, Davila's physician simply prescribed one of the 15 other arthritis medications on Aetna's formulary. Several weeks after taking the formulary medication, Davila was hospitalized as the result of severe internal bleeding, spent five days in the critical care unit, and was later readmitted to the hospital for further treatment. He subsequently filed a complaint against Aetna under the THCLA alleging that Aetna failed to exercise ordinary care in making health care treatment decisions on his behalf. Specifically, Davila alleged that Aetna had directly influenced and controlled the course of his medical treatment and violated the duty of ordinary care by insisting that he take a formulary alternative instead of Vioxx.

Aetna removed the plaintiff's suit to federal district court on the ground that his claims were completely preempted by ERISA. Aetna argued that Davila's state law causes of action were more appropriately characterized as seeking benefits due under the terms of the plan rather than challenging a medical decision by the HMO. Aetna argued that each of the plaintiff's state law claims must be dismissed because ERISA provided Davila an exclusive remedy for enforcing the plan's terms.

The district court agreed. After refusing to allow Davila to replead his claim under ERISA, the lawsuit was dismissed with prejudice. Davila appealed to the Fifth Circuit Court of Appeals.

Mary Calad. Calad was enrolled as a beneficiary under the health plan provided by her husband's employer. Like Davila, Calad's health benefits were administered by a Texas HMO, CIGNA HealthCare of Texas, Inc. CIGNA administered the benefits available under Calad's plan and determined whether requested services were covered under its terms.

Calad had received payment authorization from CIGNA to undergo a complex surgical procedure. Despite her request for an extended recovery period, however, CIGNA only authorized payment for Calad to have a one-day postsurgical stay at the hospital. After the surgery, Calad's physician again requested CIGNA to pay for additional inpatient days so that Calad could recover in an inpatient setting. CIGNA again denied the request, finding that the additional stay was not medically necessary. Like Davila, neither Calad nor her doctor challenged CIGNA's decision to deny payment. After one day of postoperative rehabilitation, Calad was discharged by her doctor. Shortly after discharge, she suffered surgical complications that required her to be readmitted to the hospital.

Calad subsequently filed a lawsuit against CIGNA in Texas state court, alleging that CIGNA violated the THCLA by failing to exercise ordinary care in making medical decisions that affected her treatment. CIGNA filed a motion to remove the action to federal court, claiming that Calad's sole avenue for relief was to bring a claim under ERISA. Calad rejected CIGNA's argument and insisted on pursuing her state law causes of action. The district court, however, agreed with CIGNA and dismissed Calad's claim on the ground that it was preempted by ERISA. Calad then appealed to the Fifth Circuit.

The Fifth Circuit appeal. The Fifth Circuit consolidated Davila's and Calad's appeals with two others presenting substantially the same issue.[3] The Fifth Circuit began its analysis by recognizing that federal law completely preempts any state cause of action that duplicates or otherwise falls within the scope of ERISA's enforcement provision, section 502(a). The court then considered whether the appellants' THCLA causes of action sought benefits due under the plan or whether they alleged a breach of fiduciary duty toward plan members. If the appellants' THCLA claims fell into either category, they would be completely preempted by ERISA's enforcement provision, which provides the exclusive remedy for members seeking to recover under these theories.

Regarding a breach of fiduciary duty, the court looked at the nature of the action that the appellants had challenged: the denial of health benefits based on a finding that the requested service was not medically necessary. Relying on the Supreme Court's decision in *Pegram v. Herdrich*,[4] the court held that HMO personnel do not act in a fiduciary capacity when denying claims based on "mixed eligibility and treatment decisions."[5] Accordingly, the court found that the appellants' claims could not be properly characterized as a breach of fiduciary duty claim under ERISA because the appellants were not challenging a fiduciary act.

Looking to the nature of the relief sought by the plaintiffs, the court held that the plaintiffs were not seeking to recover the value of benefits allegedly due, that is,

Davila's Vioxx and Calad's additional hospital stay. Instead, the Fifth Circuit found that the plaintiffs sought to recover tort-like damages for the harm that they allegedly suffered when their respective HMOs denied payment for the benefits sought. Because the plaintiffs sought relief unavailable under ERISA based on alleged violations of statutorily imposed duties external to federal law, the court held that the plaintiffs' claims did not duplicate ERISA's enforcement provisions under the Supreme Court's reasoning in *Rush Prudential HMO, Inc. v. Moran*.[6] Accordingly, the Fifth Circuit found that the plaintiffs' claims were not preempted by ERISA section 502(a)(1)(B).

Aetna and CIGNA appealed to the Supreme Court, questioning whether a claim for consequential, tort-like damages stemming from the wrongful denial of benefits is preempted by section 502(a)(1)(B), which provides a cause of action to recover benefits due under a plan. The issue of whether the plaintiffs' causes of action could be construed as claims for breach of fiduciary duty under section 502(a)(2) was not presented to the Court.

The Supreme Court Decision

In a unanimous opinion written by Justice Clarence Thomas, the Supreme Court reversed the Fifth Circuit's decision and found that the plaintiffs' claims under the THCLA were completely preempted under ERISA. The Court rejected every argument raised by the plaintiffs and established relatively bright-line tests for determining whether a state law cause of action is preempted by ERISA. By doing so, the Court established a turning point in the recent judicial trend toward eroding ERISA's preemptive power. The result was to create a more vibrant federal statutory scheme that applies more clearly and forcefully than ever before to provide participants in employer-sponsored benefit plans with their exclusive remedy to enforce their rights against the plan.

Removal and preemption. The Court began its analysis by considering the relationship between the federal removal statute and the well-pleaded complaint rule. First, the Court noted that the federal removal statute allows a defendant to remove any civil action from state court to federal court provided that federal jurisdiction exists. Accordingly, state law cases are subject to removal if the requirements for diversity are satisfied or if the plaintiff has stated a federal claim.

The Court found that it is generally necessary that the federal cause of action appear in the plaintiff's complaint when removal is based on the existence of a federal claim. This is necessary because the existence of a federal defense to a purely state law claim does not ordinarily confer subject matter jurisdiction on the federal court. This principle is commonly referred to as the "well-pleaded complaint rule." As with virtually any rule, however, there is an exception. If Congress intended federal law to wholly displace and preempt state law with respect to the circumstances and transactions at issue in the complaint, then the state law claim may be removed to federal court. This is the case because the cause of action, despite being pleaded under state law, is in reality based on federal law when a federal statute completely occupies the field being regulated.

The Court confirmed that ERISA is, in fact, one of those federal laws imbued with such preemptive power that it entirely displaces most state attempts to regulate employee benefit plans.[7] The Court found that this extraordinary preemptive power can be found primarily in ERISA sections 502 and 514. The Court was careful to distinguish between the two sections and to explain in detail what each was intended to accomplish. Section 514 contains ERISA's basic preemption provision while section 502 sets forth the statute's exclusive enforcement mechanism. The Court considered these interlocking and interdependent provisions together when determining whether ERISA completely preempted the plaintiffs' THCLA claims.

Section 514 embodies ERISA's preemptive power. Section 514(a) provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan,"[8] subject to limited exceptions. The most notable exception to this wide preemptive range is set forth in the statute's insurance "savings clause."[9] Pursuant to the savings clause, ERISA does not preempt state laws specifically relating to insurance. This limitation recognizes and safeguards the traditional power of the states to regulate the insurance industry[10] by "saving" state insurance laws from preemption under ERISA.

ERISA's enforcement procedures and mechanisms are set forth in section 502. Section 502(a)(1)(B) provides that a participant or beneficiary may bring a civil action "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."[11] The *Davila* Court noted that this rule is "relatively straightforward" in that it basically allows a plan member to bring a lawsuit to protect his or her rights under a benefit plan.

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Volume 34 • Number 3 • Spring 2005 • American Bar Association • The Brief

Section 502 provides contract-like remedies for violations of ERISA. For example, this provision allows a member to seek reimbursement for covered benefits that the member paid for out-of-pocket, to enforce any administrative or other rights described in the plan, and to obtain official explanations regarding his right to future benefits. The provision also allows for the recovery of costs and attorneys' fees, when appropriate.

Section 502 analysis. The Court noted that section 502 "is a distinctive feature of ERISA, and essential to accomplish Congress' purpose of creating a comprehensive statute for the regulation of employee benefits plans."[12] Introducing a theme that would later be echoed more loudly in the concurring opinion of Justice Ruth Bader Ginsburg, the Court relied on its previous decision in *Pilot Life Ins. Co. v. Dedeaux*[13] to point out that the rather limited remedies available under ERISA are the result of a careful congressional balance designed to promote the development and maintenance of employee benefit plans. The Court explained that "[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 state law that Congress rejected in ERISA."[14]

Based on the notion that ERISA's purpose would be thwarted if participants could sue under state law causes of action, the Court confirmed that ERISA preempts any state law cause of action that "duplicates, supplements, or supplants" the enforcement provisions set forth in section 502.[15] Looking at it another way, the Court announced the rule as follows: "[I]f an individual, at some point in time, could have brought his claim under ERISA § 502(a)(1)(B), and where there is no independent legal duty that is implicated by a defendant's actions, then the individual's cause of action is completely pre-empted by ERISA § 502(a)(1)(B)."[16]

In accordance with this rule, the Court then set out to determine whether Davila and Calad could have brought their claims under ERISA at any point in time. The Court conducted its analysis by considering the factual allegations set forth in the plaintiffs' complaints, the causes of action asserted, and the plan documents establishing their relationships with the HMO defendants.

After careful analysis of the complaints, the Court concluded that the only conduct complained of by either plaintiff was the denial of coverage under the terms of an ERISA-qualified health benefits plan. In Davila's case, he argued that he suffered physical and financial harm as the result of Aetna's decision to deny his request for Vioxx. Calad claimed that she was harmed by CIGNA's decision not to authorize payment for a longer hospital stay. Despite the plaintiffs' own characterization of their claims as challenging a medical decision made by an HMO, the Court found—perhaps somewhat narrowly—that the only role that either HMO played was to administer the benefits available under an ERISA plan. In doing so, the Court made clear that a benefit decision remains a benefit decision regardless of whether it involves some level of medical decision making on the part of the HMO. Ultimately, that categorical viewpoint of the Court dictated the outcome of the case.

Having found that the only conduct challenged by the plaintiffs was the defendants' denial of benefits under an ERISA-qualified plan, the Court concluded that the plaintiffs could have, at some point, filed a claim for benefits due under ERISA section 502(a)(1)(B) to challenge the decisions made by the HMOs. Finally accepting the position that the HMO industry had argued for years in other litigation, the Court noted that the plaintiffs could have paid for the denied benefit out of pocket and subsequently sought reimbursement from the plan under ERISA. The Court also pointed out that the plaintiffs could have filed for an injunction under ERISA to prohibit the denial of coverage under the plan, effectively compelling approval of the requested benefit.[17] Having failed to pursue those available remedies, the Court held that the plaintiffs' subsequent state law claims were barred.

The only remaining issue was whether the plaintiffs adequately alleged that the defendants violated a legal duty independent of ERISA. In support of this position, the plaintiffs argued that the Texas legislature enacted the THCLA to "fill a vacuum" in ERISA and was therefore independent of federal law. During oral argument, plaintiffs' counsel pointed out that the THCLA in no way duplicates the regulatory standards governing benefit determinations under ERISA because nothing in ERISA imposes any standards on how HMOs make medical necessity decisions. Counsel argued that the Texas legislature had simply filled that void by imposing the same standard on HMOs as it does on any medical professional when making a medical decision. Because the source of the duty—that is, the THCLA—was outside of the terms of the plan, the plaintiffs argued that their claims were based on a legal duty that is independent of ERISA.

The Court rejected this argument, finding that resolution of the plaintiffs' claims would necessarily require the Court to interpret the provisions of their ERISA-qualified plans. The Court arrived at this conclusion by scrutinizing how the THCLA actually works. First, the Court noted that the THCLA only imposes an obligation to exercise reasonable care when making treatment decisions. For an HMO, this duty becomes relevant when deciding whether a requested treatment is medically necessary under the terms of the

plan. Second, the Court observed that the THCLA did not require HMOs to authorize payment for services that are not covered by the plan. This is relevant because, even under the THCLA, an HMO cannot be liable for denying coverage for medically necessary treatment if the plan did not provide coverage for the type of treatment requested. Accordingly, the Court found that THCLA liability only exists when an HMO incorrectly determines that a requested treatment is not covered under the plan's terms. The Court went so far as to note that if a plan member suffers injury as the result of an HMO correctly deciding that the plan does not provide for coverage of the requested benefit, then the HMO would not be a proper party to the lawsuit. The reasoning for the observation is that the failure of the plan to arrange for coverage of the requested benefit—not the HMO's administration of the plan's terms—would be the proximate cause of the member's injury.[18]

Based on these findings, the Court concluded that "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 petitioner's administration of ERISA-regulated benefit plans."[19] The Court also observed that the plaintiffs "bring suit only to rectify a wrongful denial of benefits promised under ERISA-regulated plans, and do not attempt to remedy any violation of a legal duty independent of ERISA."[20] Accordingly, the Court found the plaintiffs' claims to be within the scope of section 502, authorizing a claim for benefits due under a plan, and therefore completely preempted.

The Court also addressed the Fifth Circuit's reasoning in arriving at a contrary conclusion regarding section 502. The Court stated that the Fifth Circuit erred when it considered the nature of the relief available under the state cause of action to be relevant for purposes of deciding whether the cause of action was preempted. As noted above, the Fifth Circuit had found the fact that the THCLA authorized the recovery of tort-like damages unavailable under section 502 positioned the THCLA outside the scope of ERISA's enforcement provision. The Court found this reasoning to be flawed. Relying on *Allis-Chalmers Corp. v. Lueck*,[21] the Court observed that "distinguishing between preempted and nonpreempted claims based on the particular label affixed to them would 'elevate form over substance'"[22] in that it would allow any party to avoid ERISA simply by recasting their claims in tort.

The Court held that the Fifth Circuit also erred by finding that interpretation of the benefit plans would be unnecessary to resolve the plaintiffs' claims. Readers will recall that the Fifth Circuit had reasoned that the duty imposed by the THCLA was external to the benefit plans and that no interpretation of the plan would be necessary to determine whether the HMO acted in accordance with the statutorily imposed duty of care. The circuit court also found that the plaintiffs' claims were not within the scope of ERISA because they did not duplicate ERISA's enforcement provisions. The Supreme Court found each of these theories problematic. First, the Court had already explained its view that the terms of the plan would be relevant to determining whether the HMO's coverage decision was correct. Second, the Court clarified that *Rush Prudential* does not stand for the proposition that a state cause of action is preempted by section 502 only if it duplicates the remedy available under ERISA. Instead, the Court confirmed that even those state laws that supplement or supplant ERISA's remedial scheme, as Texas had designed the THCLA to do, are also preempted.

Section 514 analysis. Raising the issue for the first time at the Supreme Court, the plaintiffs pointed out that the insurance savings clause set forth in section 514 appeared to apply to the THCLA. Stated simply, the plaintiff's argument was that the THCLA imposed a duty of ordinary care on health insurers when making medical decisions as part of a coverage determination. Because the law only applies to health insurers and similar entities when benefit determinations are being made, the plaintiffs argued that the THCLA falls squarely within the category of a law regulating insurance. Such laws, they argued, are clearly saved from ERISA preemption.[23]

The Court disagreed. Relying on its previous decision in *Pilot Life*, the Court again emphasized that the overriding purpose of ERISA is to create an exclusive enforcement scheme for plaintiffs challenging the administration of benefits under qualified plans. The Court repeated its previous finding that "[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 state law that Congress rejected in ERISA."[24] The Court found the goal of section 502 so singularly overpowering that it overrode the interest in preserving the traditional power of the states to regulate insurance embodied in section 514. Thus, the Court held that "even 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."[25]

The Court Further Addresses Preemption

Having already found the plaintiffs' claims completely preempted, it appeared that the Court's work was done. Instead, the Court took

Volume 34 • Number 3 • Spring 2005 • American Bar Association • The Brief

the opportunity to address an emerging trend in some circuits to allow medical malpractice cases to proceed against HMOs under the Court's reasoning in *Pegram v. Herdrich*.[26] Indeed, to fully appreciate the impact of the Court's ruling in *Davila*, some familiarity with *Pegram* is necessary.

Pegram. Cynthia Herdrich participated in a health benefits plan made available through her husband's employer. Herdrich's benefit plan was made available through a staff model HMO, that is, a physician-owned HMO in which the physician owners provided medical treatment to plan participants. At issue in *Pegram* was whether a treatment decision made by a physician owner of an HMO constituted a fiduciary act for purposes of ERISA.

Herdrich went to her doctor complaining of pain in the midline area of her groin. Six days later, her doctor, Dr. Pegram, discovered an inflamed mass in Herdrich's abdomen. Rather than admitting her at a nearby hospital, Pegram recommended that the plaintiff wait eight days for an ultrasound. Heeding the advice of her physician, Herdrich waited. However, her appendix burst before the ultrasound could be performed. Herdrich sued Pegram and the HMO under state law medical malpractice and fraud theories.

The defendants removed the case to federal district court on the ground that Herdrich's state law fraud claims were preempted by ERISA.[27] The plaintiff eventually recast her fraud claims as a claim for breach of fiduciary duty under ERISA. The plaintiff alleged that the defendant HMO breached its fiduciary duty to act exclusively in the interest of plan participants by creating incentives for its physician owners, such as Pegram, to deny care.

The Court recognized that making a benefit determination under ERISA is in most cases a fiduciary act, as the decision involves the management of plan assets and property. The difficulty in *Pegram* was that the doctor's decision was a benefit determination in some respects and a treatment decision in others. The dual nature of the decision reflected the dual nature of Pegram's role for the plaintiff. Because the doctor was an employee-owner of a staff model HMO, any decision to provide a medical service (an ultrasound) to a patient enrolled in the HMO was also a decision to authorize plan benefits for that patient (payment for the ultrasound). This duality derives from the nature of the staff model HMO's being both a provider of medical treatment and a risk-bearing administrator of plan benefits at the same time. The Court characterized the decisions made by the physician owners of these entities as "mixed eligibility and treatment decisions."[28]

The Court decided that a physician owner-employee of a staff model HMO does not act in the capacity of a plan fiduciary when making mixed eligibility and treatment decisions. It found that Pegram was not acting in her capacity as a manager, administrator, or financial advisor to the plan—a plan fiduciary—when she decided that the plaintiff could wait for an ultrasound, despite the fact that the decision to send the plaintiff to an HMO-owned facility for the ultrasound would conserve the plan's assets. Instead, the Court found that Pegram made that decision in her capacity as the plaintiff's treating physician. The Court arrived at this finding by examining the consequences of concluding otherwise and considering whether such an outcome was consistent with congressional intent. Among a host of other reasons, the Court noted that if mixed eligibility and treatment decisions were treated as being fiduciary actions for purposes of ERISA, then state medical malpractice law would essentially be subsumed and preempted by ERISA claims for breach of fiduciary duty. Finding that Congress did not intend to federalize state malpractice law, the Court determined that mixed eligibility and treatment decisions cannot support a cause of action for breach of fiduciary duty under ERISA.[29]

***Pegram's* progeny.** A number of federal courts interpreted *Pegram* as establishing that ERISA did not preempt medical malpractice claims against a health insurer provided that the claim was based on an allegedly wrongful mixed eligibility and treatment decision.[30] The Second Circuit Court of Appeals was among them, finding in *Cicio v. Does*[31] that some decisions HMOs make about payment of benefits are "inextricably mixed" with medical judgments because they involve elements of both a benefit eligibility decision and an appropriateness of treatment decision. The court held that if the HMO considers the member's "constellation of symptoms" in making a benefit decision, it can be exposed to a medical malpractice claim.[32]

***Davila* and the mixed eligibility and treatment decisions.** Not surprisingly, the plaintiffs in *Davila* also contended that their claims under the THCLA were not preempted by virtue of the *Pegram* doctrine. Particularly, the plaintiffs argued that their claims, which resembled the medical malpractice claims in *Pegram* and *Cicio*, were unrelated to the benefits plan and that ERISA was not intended to preempt state law claims based on the failure of medical professionals to satisfy the applicable standard of care.

The Supreme Court found that *Pegram* cannot be read so broadly as to stand for the proposition that medical malpractice claims against HMOs can never be preempted.[33] Instead, the Court explained that the outcome in *Pegram* was largely due to the fact that the defendant HMO was based on a staff model, rather than the network model defendants in *Davila*. Just as importantly, the Court pointed out that the plaintiffs' allegations in *Davila* were sufficiently distinguishable from those raised by the plaintiff in *Pegram* so as to render their reliance on *Pegram* displaced.

Differentiating staff and network models. As noted above, the

HMO in *Pegram* was designed as a staff model. Under that arrangement, the HMO is owned by a group of physicians. The HMO then hires the physician owners as employees of the HMO. Those physician owners-employees provide treatment to the HMO members. Under this type of arrangement, the HMO is both a payor and provider of health care services to its enrollees. Furthermore, treatment decisions made by this type of staff model physician are, by necessity, also benefit determinations.

The defendants in *Davila*, however, were organized as network model HMOs. Network model HMOs do not provide medical treatment to their members. Instead, the HMO contracts with a network of physicians and other medical professionals who agree to provide services to the HMO's members in exchange for payment of agreed-upon rates. The network physicians are not employees of the HMO. They are paid as independent contractors providing services to the enrolled population. Furthermore, the physicians are usually responsible for submitting information to the HMO to demonstrate that their services are medically necessary before the HMO will authorize payment. Under this arrangement, the HMO acts as a payor of health care services provided by the physician payees. The HMO makes benefit determinations—whether a requested service is covered under the plan—while the physician makes treatment decisions about the care the member should receive.

The distinction between the staff and network models is critical for purposes of the preemption analysis. The Court clarified that its discussion of mixed eligibility and treatment decisions in *Pegram* was limited to the factual circumstances where a staff model physician makes *both* the benefit determination and the treatment decision at the same time. The Court described that decision as being mixed precisely because it was made by one person.

The Court distinguished the nature of such a decision from the type made in a network HMO, where a medical director or other clinical employee evaluates the request for services submitted by the member's physician to determine whether payment for that service is covered under the terms of the plan. In its simplest terms, such a review requires the HMO medical director to evaluate two things. First, there is the question of whether the service is covered under the terms of the plan irrespective of the member's need for that service. For example, if treatment for smoking cessation is excluded under the plan terms, the member's medical need for these services is irrelevant for purposes of the HMO's coverage decision. Under such circumstances, the request would be denied. If, on the other hand, the plan covers the requested service upon a showing of medical necessity—as with Davila's request for Vioxx and Calad's request for the prolonged hospital stay—the medical director then must apply some level of medical judgment to the request for services.

The terms of Davila's plan provided that Vioxx would be paid for if he had tried two other similar medications without success or if Davila's physician provided information showing that Davila was unable to take a Vioxx alternative. Similarly, Calad could have received all the inpatient days her doctor requested provided that the additional days were shown to be medically necessary. In both cases, the defendants concluded that the requested services were not medically necessary and denied payment authorization.

***Davila* rejects the *Pegram* analysis.** Comparing the circumstances in *Pegram* to those in *Davila*, it appears that the Court focused on the actual nature of each HMO's decision and its resultant effect on the plan members in determining whether the plaintiffs' claims were preempted by ERISA. In *Pegram*, Herdrich's doctor decided that it was not medically necessary for her to be immediately admitted to the hospital. Instead, she decided that it would be clinically acceptable for Herdrich to wait 14 days to get an ultrasound at an HMO-owned diagnostic facility. The result of this decision was twofold. First, Herdrich did not receive the plan benefit for payment of the ultrasound because, obviously, no ultrasound was performed. Second, and most importantly, access to the treatment itself was denied. Because her doctor chose not to order Herdrich an immediate ultrasound, Herdrich had no ability to receive the treatment. Without her doctor's order, Herdrich could not go to the hospital and demand that it perform an ultrasound. That is a critical difference between *Pegram* and *Davila*.

In *Davila*, the plaintiffs tried to get their HMOs to pay for care that their treating physicians thought was medically necessary. The HMOs reviewed the requests, determined that the requested services were not medically necessary under the terms of the benefit plans, and decided not to pay for the services. Although the decisions not to pay involved medical decision making, the HMOs in *Davila* did not make any *treatment* decisions, as *Pegram* had done. They only made a decision whether to pay for the services under the terms of the plan. In other words, they made a benefit determination. The HMO did not—through any of its employees or otherwise—decide how to treat the member. That discretion and judgment was left completely to the member's doctor. The members could still receive the services sought despite the HMO's decision if they paid for them in some other way. The crucial difference is that the HMOs' decisions to deny payment in *Davila* were separate and distinct from the treating providers' decisions as to how best treat the patients.

The Court's decision in *Davila* was undoubtedly driven by its recognition that the denial of treatment

by a staff model physician has a substantively different effect on the plan member than does the denial of payment by a network model medical director. In *Pegram*, the relationship between Herdrich and Pegram involved more than the payment of money to cover medical treatments. There was a doctor-patient relationship. In *Davila*, the doctor-patient relationships were independent of the members' relationship with the plan. In that structure, the doctor and the patient can still agree to pursue a course of therapy despite payment being denied by the plan. That option is unavailable in the staff model system.

As the *Davila* defendants pointed out in their reply briefs and during oral argument, the American Medical Association's Code of Ethics generally prohibits a physician from rendering substandard care just because the patient's insurance carrier has denied coverage for the preferred course of therapy. Instead, physicians are obligated to take reasonable measures to mitigate the effect of the denial of coverage. In a situation like Davila's, the prescribing physician is supposed to exhaust all avenues for securing payment for the drug. If unsuccessful, the physician should then discuss the advantage of the recommended drug over a suggested alternative so that the patient can make an informed decision regarding whether the recommended drug should be obtained regardless of the insurer's denial of coverage. Physicians are also supposed to assist patients in securing alternate forms of financial assistance. The doctor may prescribe the alternative drug only if he or she believes that it is just as effective as the denied medication.

Conclusion

The *Davila* decision marks the return of the type of powerful ERISA doctrine that was embodied in the Supreme Court's early preemption cases.[34] By returning to a more categorical approach for determining when state law claims are preempted, the Court made significant headway into clarifying—or, some would say, ignoring—its more recent decisions that cast doubt on the scope of ERISA preemption.[35] In any event, the result is that practitioners now have relatively straightforward and reliable guidelines when evaluating whether a state law claim against an HMO will be preempted by ERISA.

First and foremost, *Davila* teaches us that the touchstone for the preemption inquiry should be whether the state law cause of action constitutes an alternative enforcement mechanism to a claim under ERISA section 502(a). The reason that this analysis should be undertaken first is that it is often outcome determinative. If the state law cause of action provides the plaintiff with an alternative to bringing a claim against the HMO under section 502(a), the cause of action is preempted regardless of whether the state law in conflict is preempted under ERISA section 514. Therefore, one need not engage in the analysis of whether the state law is saved from preemption as a law that regulates insurance and whether, in turn, the plan is deemed to be an insurer. Accordingly, one can essentially dispense with a section 514 analysis when evaluating a claim of this nature.

Davila also clarifies when state law causes of action may actually constitute alternative enforcement mechanisms to ERISA. The Court made clear that state law causes of action are preempted if plan members could have previously brought their claims under section 502(a)(1)(B). As noted above, members may bring section 502(a)(1)(B) claims to recover benefits due to them under the terms of their plans, to enforce their rights under the terms of the plans, or to clarify their rights to future benefits under the terms of their plans. Under *Davila*, the exclusivity of this ERISA cause of action is such that it bars a plan participant from pursuing any other cause of action at a later time if the participant ever could have challenged the complained-of conduct through a section 502(a)(1)(B) claim. Accordingly, claims stemming from the denial of benefits will always be preempted if the members could have challenged the benefit denial under ERISA. The difference in available remedies under ERISA and other state law causes of action are of no consequence in this analysis. The *Davila* Court made clear that it is irrelevant that a state law cause of action provides a remedy that is unavailable under ERISA for purposes of determining whether the cause of action constitutes an alternative enforcement mechanism. In fact, the Court repeated its previous position in *Pilot Life* 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."[36]

Finally, one needs to consider whether the defendant's conduct implicates an independent legal duty. Presumably, a plaintiff may bring a state law cause of action against an HMO provided that the duty sought to be enforced is one that is independent of ERISA. One of the questions remaining after *Davila* will be deciding when a duty is truly independent of the federal scheme, such that it can be enforced under state law without being preempted. *Davila* tells us that legal duties are not independent of ERISA for purposes of this analysis simply because they are embodied in a state law, such as the THCLA. Instead, it is more likely that future courts will conduct an analysis similar to that under section 514 to determine whether enforcement of the duty would require the court to interpret the provisions of an ERISA plan for the purpose of resolving the state law claim. Those claims that require interpretation of plan

provisions may be found to stem from legal duties that overlap with ERISA, whereas those that do not involve interpreting plan terms may be found to be completely independent and therefore enforceable. ■

Notes

1. 124 S. Ct. 2488 (2004). *Davila* was consolidated with *Cigna v. Calad* out of the Fifth Circuit, and both were argued before the Supreme Court on March 23, 2004, and decided on June 21, 2004.

2. 29 U.S.C. §§ 1001–1461 (2004).

3. Roark v. Humana Inc., 307 F.3d 298 (5th Cir. 2002).

4. 530 U.S. 211 (2000).

5. *Roark*, 307 F.3d at 308.

6. 536 U.S. 355 (2002).

7. *Aetna v. Davila*, 124 S. Ct. 2488, 2495 (2004).

8. 29 U.S.C. § 1144(a).

9. *Id.* § 1144(b)(2)(A).

10. Readers familiar with the statutory structure of ERISA would be quick to point out that the savings clause is, in turn, limited by the "deemer" clause. For those less versed in ERISA, ERISA treats employee benefit plans that are actually funded by the employer (self-funded plans) differently from those benefit plans that are insured by an HMO or similar entity pursuant to a contract of insurance purchased by the employer (fully insured plan). The deemer clause essentially provides that employers with self-funded plans are not considered insurers under ERISA. Stated simply, this means that state insurance laws are preempted by ERISA to the extent that they regulate self-funded benefit plans but are not preempted by ERISA to the extent that they regulate fully insured plans. The deemer clause is not relevant to a discussion of *Aetna v. Davila* because the plans at issue in the case were fully insured.

11. 29 U.S.C. § 1132(a)(1)(B).

12. 124 S. Ct. 2488, 2495 (2004).

13. 481 U.S. 41 (1987).

14. 124 S. Ct. at 2495 (quoting *Pilot Life*, 481 U.S. at 54).

15. *Id.*

16. *Id.* at 2496.

17. *Id.* at 2497 (citing Pryzbowski v. U.S. Healthcare, Inc., 245 F.3d 266, 274 (3d Cir. 2001)).

18. *Id.* at 2498 n.3.

19. *Id.* at 2498.

20. *Id.*

21. 471 U.S. 202 (1985).

22. 124 S. Ct. at 2498.

23. The insurance savings clause reads that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A).

24. 124 S. Ct. at 2500 (quoting Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987)).

25. *Id.*

26. 530 U.S. 211 (2000).

27. The defendants did not challenge the propriety of the plaintiff's medical malpractice claim.

28. *See Pegram*, 530 U.S. at 235–37.

29. *Id.*

30. *See* Cicio v. Does, 321 F.3d 83, 100–14 (2d Cir. 2003); Land v. Cigna Healthcare, 339 F.3d 1286, 1292–94 (11th Cir. 2003).

31. 321 F.3d 83 (2d Cir. 2003).

32. *Id.* at 102.

33. 124 S. Ct. 2488, 2501 (2004).

34. *See* Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1990) (holding that ERISA preempts any claim relating to the plan regardless of how the plaintiff characterizes the request for relief); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 52 (1987) (noting that "Congress clearly expressed an intent that the civil enforcement provisions of ERISA § 502(a) be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits"); Metro. Life Ins. Co. v. Taylor, 481 U.S. 58 (1987) (holding that state law causes of action within the scope of section 502(a) are preempted by ERISA and removable to federal court).

35. *See* Ky. Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003) (finding that state law "any willing provider" statutes are saved from preemption); Rush Prudential v. Moran, 536 U.S. 355 (2002) (holding that external review laws are saved from preemption).

36. 124 S. Ct. at 2495.