

## **ERISA Preempts Wrongful Denial of Benefits Causes of Action Involving “Pure Eligibility Decisions”**

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On June 21, 2004, a unanimous Supreme Court of the United States issued an opinion in two consolidated cases, *Aetna Health Inc. v. Davila* and *CIGNA HealthCare of Texas, Inc. v. Calad*, holding that the federal Employee Retirement Income Security Act of 1974 (ERISA) completely preempts state law wrongful denial of benefits causes of action that involve “pure eligibility decisions.”<sup>1</sup> Although ERISA permits patients to sue for reimbursement of the costs associated with wrongfully denied benefits, ERISA does not permit damages for any resulting injuries or death. By striking down the Texas Health Care Liability Act,<sup>2</sup> which passed with overwhelming bipartisan support in 1997, the Supreme Court’s decision eliminates the ability of participants and beneficiaries in Texas and the ten other states<sup>3</sup> that have enacted patients’ rights legislation to sue their managed care organizations for certain wrongful coverage decisions that result in injury or death. Such grievants are now relegated to the Department of Labor’s regulations,<sup>4</sup> which provide a federal administrative route for those deterred from obtaining medical care because of an allegedly wrongful denial of benefits by an ERISA plan. Those finding these administrative remedies inadequate must now turn their attention to Congress and support patient protection legislation that will authorize persons adversely

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<sup>1</sup> *Aetna Health Inc. v. Davila*, No. 02-1845 and No. 03-83, 2004 WL 1373230 (U.S. June 21, 2004).

<sup>2</sup> TEX. CIV. PRAC. & REM. CODE § 88.001 *et seq.*

<sup>3</sup> Arizona, California, Georgia, Maine, New Jersey, North Carolina, Oklahoma, Oregon, Texas, Washington, and West Virginia have enacted legislation permitting individuals to sue their managed care organizations for wrongful coverage decisions that result in personal injury or death.

<sup>4</sup> 29 C.F.R. § 2560.503-1.

affected by ERISA-proscribed wrongdoing to sue managed care organizations for heightened damages.

The consolidated cases involve the claims of Juan Davila and Ruby Calad, a participant and a beneficiary, respectively, in ERISA-regulated employee benefit plans.<sup>5</sup> Davila and Calad's plan sponsors had entered into agreements with Aetna Health Inc. (Aetna) and CIGNA HealthCare of Texas, Inc. (CIGNA), respectively, to administer their employee benefit plans.<sup>6</sup> Under Davila's plan, Aetna reviews requests for coverage from and pays those health providers that provide covered services to members. Under Calad's plan, CIGNA is responsible for plan benefits and coverage decisions.<sup>7</sup>

Davila and Calad alleged that they suffered injuries allegedly arising from Aetna's and CIGNA's decisions not to cover certain treatments and services recommended by the respondents' treating physicians.<sup>8</sup> In Davila's case, Aetna refused to pay for the Vioxx Davila's treating physician prescribed for arthritis pain. Davila did not appeal or contest the decision; instead, he began taking Naprosyn, from which he allegedly suffered a severe reaction that required extensive treatment and hospitalization.<sup>9</sup> In Calad's case, she underwent a hysterectomy with rectal, bladder, and vaginal repair for which her treating physician recommended an extended hospital stay. Because a CIGNA discharge nurse determined that Calad did not meet the plan's criteria for an extended hospital stay, CIGNA denied coverage and Calad went home after one day. Calad experienced post-surgery complications that forced her to return to the hospital through

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<sup>5</sup> *Aetna*, 2004 WL 1373230, at \*4.

<sup>6</sup> *Id.*

<sup>7</sup> *Id.*

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*

the emergency room. Calad alleges that her complications would not have occurred if CIGNA had approved coverage for an extended stay.<sup>10</sup>

Davila and Calad filed separate lawsuits in Texas state court, arguing that Aetna's and CIGNA's refusals to cover the requested services violated their "duty to exercise ordinary care when making health care treatment decisions" and that these refusals "proximately caused" their injuries in violation of the Texas Health Care Liability Act (Act).<sup>11</sup> The Act provides that a health insurance carrier, health maintenance organization, or other managed care entity has a duty to exercise ordinary care when making health care treatment decisions and shall be liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care.<sup>12</sup>

CIGNA and Aetna, respectively, removed the cases to federal district court, arguing that ERISA preempted Davila's and Calad's state law causes of action.<sup>13</sup> The federal district courts agreed to the removal.<sup>14</sup> Because Davila and Calad refused to amend their complaints to state ERISA-specific claims, the federal district courts dismissed their complaints.<sup>15</sup>

Davila and Calad appealed the dismissals to the United States Court of Appeals for the Fifth Circuit, which consolidated their cases with several others that raised similar issues.<sup>16</sup> In its opinion, the Court of Appeals explained that state causes of action that

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<sup>10</sup> *Id.*

<sup>11</sup> *See Calad v. Cigna HealthCare of Texas, Inc.*, No. Civ. 300-CV-2693-H, 2001 WL 705776, at \*1 (N.D. Tex. 2001).

<sup>12</sup> TEX. CIV. PRAC. & REM. CODE § 88.002(a).

<sup>13</sup> *Calad*, 2001 WL 705776, at \*1.

<sup>14</sup> *Id.*

<sup>15</sup> *Id.* at \*6 (stating that "the court notes that Calad has repeatedly made clear that, should the Court deny her motion to remand, she will not amend her pleading to bring an ERISA claim and therefore requests that her claims be dismissed. Accordingly, Plaintiff Calad's claims are hereby DISMISSED WITH PREJUDICE.").

<sup>16</sup> *Roark v. Humana, Inc.*, 307 F.3d 298, 302 (5th Cir. 2002).

duplicate or fall within the scope of a remedy set forth under Section 502(a) of ERISA are completely preempted and, hence, removable to federal court.<sup>17</sup> After examining Davila and Calad’s specific causes of action, the Court of Appeals determined that their claims only had the potential to fit under two provisions set forth in Section 502(a) of ERISA: (1) Section 502(a)(1)(B), which provides a cause of action for the recovery of wrongfully denied benefits; and (2) Section 502(a)(2), which allows suit against a plan fiduciary for breaches of fiduciary duty to the plan.<sup>18</sup> The Court of Appeals then held that Davila and Calad’s tort claims did not fit under Section 502(a)(1)(B) because that provision only creates a cause of action for breach of contract.<sup>19</sup> The Court of Appeals further held that the respondents’ claims were not fiduciary for purposes of Section 502(a)(2) because the decisions for which Aetna and CIGNA were being sued were “mixed eligibility and treatment decisions.”<sup>20</sup> The Court of Appeals concluded that Davila and Calad’s claims were not completely preempted by ERISA.<sup>21</sup>

The Supreme Court of the United States granted certiorari to determine whether ERISA should completely preempt Davila and Calad’s causes of action.<sup>22</sup> Amicus curiae briefs were submitted on behalf of at least fifteen groups and organizations. In its June 21 opinion, the Supreme Court held that:

[R]espondents 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. We hold that

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<sup>17</sup> *Id.* at 305 (citing *Giles v. NYLCare Health Plans, Inc.*, 172 F.3d 332, 337 (5<sup>th</sup> Cir. 1999) (“Section 502, by providing a civil enforcement cause of action, completely preempts any state cause of action seeking the same relief.”)).

<sup>18</sup> *Id.* at 306 (“This leaves only two enforcement provisions of § 502(a)—§ 502(a)(2) and (a)(1)(b) . . .”).

<sup>19</sup> *Id.* at 308-09 (“Section 502(a)(1)(B), we have held, creates a cause of action for breach of contract . . . . By contrast, Calad and Davila assert tort claims . . .”).

<sup>20</sup> *Id.* at 306-07.

<sup>21</sup> *Id.* at 311.

<sup>22</sup> *Aetna Health Inc. v. Davila*, 124 S. Ct. 462 (2003); *CIGNA HealthCare of Texas, Inc. v. Calad*, 124 S. Ct. 463 (2003).

respondents' state causes of action fall "within the scope of" ERISA 502(a)(1)(B) . . . and are therefore completely pre-empted by ERISA § 502 and removable to federal district court.<sup>23</sup>

Writing for the Court, Justice Thomas reasoned that the Court of Appeals' distinction between the respondents' tort claims and the contractual obligations suggested by Section 502 of ERISA "elevated form over substance" and would allow parties to evade ERISA preemption by re-labeling their contract claims as tort claims.<sup>24</sup> Justice Thomas also reasoned that Congress' intent to make ERISA's civil enforcement mechanisms exclusive would be undermined if state law causes of action that supplemented, but did not "precisely duplicate," ERISA's remedies evaded preemption.<sup>25</sup>

Justice Thomas was careful to distinguish the case from the 2000 *Pegram v. Herdrich* decision.<sup>26</sup> In *Pegram*, the plaintiff's treating physician also was responsible for administering the plaintiff's benefits and deciding whether certain treatments were covered.<sup>27</sup> When the plaintiff sued the physician and the physician-owned-and-operated HMO for medical malpractice and for breach of an ERISA fiduciary duty, the *Pegram* court found that the physician's "eligibility decision and the treatment decision were inextricably mixed"<sup>28</sup> and concluded that Congress did not intend the defendant HMO to be treated as a fiduciary under ERISA "to the extent it makes mixed eligibility decisions acting through its physicians."<sup>29</sup>

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<sup>23</sup> *Aetna Health Inc. v. Davila*, No. 02-1845, 2004 WL 1373230, at \*9 (U.S. June 21, 2004).

<sup>24</sup> *Id.*

<sup>25</sup> *Id.* at \*10.

<sup>26</sup> *Pegram v. Herdrich*, 530 U.S. 211 (2000).

<sup>27</sup> *Id.* at 228-29 (noting that "treating and eligibility decisions are made by the same person, the treating physician. . . . In practical terms, these eligibility decisions cannot be untangled from physicians' judgments about reasonable medical treatment, and in the case before us, Dr. Pegram's decision was one of that sort.").

<sup>28</sup> *Id.* at 228.

<sup>29</sup> *Id.* at 231 ("Based on our understanding of the matters just discussed, we think Congress did not intend Carle or any other HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions

Justice Thomas said the medical necessity decisions in *Pegram* were made by the “plaintiff’s treating physician *qua* treating physician and *qua* benefits administrator.” By contrast, the coverage decisions of Aetna and CIGNA, neither of whom are treating physicians nor employers of such physicians, were “pure eligibility decisions.”<sup>30</sup> Read together, the *Aetna* and *Pegram* decisions suggest that whether ERISA will totally preempt a denial of benefits cause of action depends in part on whether the coverage decision is a “pure eligibility decision” or a “mixed eligibility decision.”

Joined by Justice Breyer, Justice Ginsburg issued a short concurring opinion urging Congress to “revisit what is an unjust and increasingly tangled ERISA regime” in light of the number of cases “in which persons adversely affected by ERISA-proscribed wrongdoing cannot gain make-whole relief.”<sup>31</sup> As suggested by Justice Ginsburg, patients’ rights advocates now must turn their attention to Congress, where legislation to authorize lawsuits against HMOs has stalled. Although the Senate passed strong patient protection legislation in 2001, Republican leadership in the House of Representatives and the White House opposed the bill, and it never was signed into law.

The Supreme Court’s decision in *Aetna* is expected to provide plenty of fodder for the presidential campaign. Although Democratic Senator John Kerry voted for legislation in 2001 that would have given patients a broad right to take their health insurers to court, President George W. Bush opposed the same legislation on the grounds that it would drive up health care costs (although Bush did support a scaled-back version

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acting through its physicians. We begin with doubt that Congress would ever have thought of a mixed eligibility decision as fiduciary in nature.”).

<sup>30</sup> *Aetna*, 2004 WL 1373230, at \*12.

<sup>31</sup> *Id.* at \*13.

of the bill).<sup>32</sup> The Bush administration also urged the Supreme Court to bar Davila and Calad's lawsuits.<sup>33</sup>

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<sup>32</sup> On June 29, 2001, Kerry voted for Senate Bill 1052, the Bipartisan Patient Protection Act, which was sponsored by Senator John McCain of Arizona. *See* [http://www.vote-smart.org/issue\\_keyvote\\_member.php?vote\\_id=301](http://www.vote-smart.org/issue_keyvote_member.php?vote_id=301). Interestingly, Bush took credit for the Texas patients' rights law during his 2000 campaign and promised that people will be able to take their HMOs to court. *See* "The Three Faces of Bush on Patients' Rights," at <http://blog.johnkerry.com/blog/archives/001950.html>

<sup>33</sup> *See Brief for the United States as Amicus Curiae Supporting Petitioners*, 2003 WL 23011479 (Dec. 18, 2003).