Supreme Court Finds that HMO Coverage Decisions are Governed by ERISA and Not Subject to Claims Under State Health Care Liability Laws

by Bill Scogland and Galen Mason

At the end of its recent 2003-04 term, the U.S. Supreme Court shed further light on the scope of the preemptive effect of the Employment Retirement Income Security Act of 1974 (ERISA) on state health care liability claims against insurers. In Aetna Health Inc. v. Davila and CIGNA Health Care, Inc. v. Calad, the Supreme Court ruled in a unanimous decision that patients cannot use state health care liability laws to sue the administrators of ERISA-regulated employee benefit plans for claims relating to the denial of coverage of treatment or services. In both cases, an HMO, acting as plan administrator, denied physician-recommended treatment because it determined that the benefit sought was not covered by the plan. In reaching its conclusion, the Court, speaking through Justice Thomas, reasoned that allowing the plaintiff’s state law claims would interfere with Congress’ intent to create a uniform scheme for the regulation of employee benefit plans and therefore the claims were completely preempted by ERISA. The effect of the Court’s decision will likely be to shift the focus of future legal battles over coverage denials by ERISA-regulated employee benefit plans from preemption of state law remedies to the scope of remedies available under ERISA, a federal law which generally limits damages to amounts for benefits found to have been improperly denied.

History

Both Davila and Calad involved employer-provided health plans administered by an HMO. In Davila, the physician recommended Vioxx for arthritis pain. However, Aetna refused to pay for the recommended drug. Davila took a different medication and suffered a severe reaction requiring hospitalization and extensive treatment. In Calad, the physician recommended an extended hospital stay following a scheduled surgery. CIGNA determined that Calad did not meet the plan’s criteria for an extended hospital stay and refused to cover it. Calad suffered post-surgery complications. Both Davila and Calad brought suit under the Texas Health Care Liability Act (THCLA), claiming that the HMOs’ refusal to authorize benefits proximately caused their injuries and therefore constituted a breach of the THCLA duty to exercise reasonable care.

Aetna and CIGNA removed the state actions to federal court on the basis that Davila and Calad’s claims were completely preempted by the civil enforcement provisions found in Section 502 of ERISA. The district courts ruled in favor of the HMOs and because the plaintiffs refused to amend their complaints to bring claims under ERISA, the courts dismissed the cases with prejudice.

Davila and Calad both appealed to the Fifth Circuit Court of Appeals where their cases were consolidated (as Davila) along with several others raising similar issues. The Fifth Circuit ruled for the plaintiffs, holding that their state causes of action were not preempted by ERISA because the actions were:

(i) mixed eligibility and treatment cases not subject to ERISA;
(ii) pleaded in tort rather than ERISA breach of contract language; and
(iii) sought tort damages under an independent statutorily-imposed duty of ordinary care rather than for the collection of benefits.

The Court of Appeals reasoned that complete preemption under ERISA...
is limited to cases in which states duplicate causes of actions available under ERISA and because the Texas health care liability law does not provide an action for collecting benefits, the plaintiffs' claims fell outside of ERISA. The HMOs appealed to the Supreme Court and were granted certiorari.

**Summary of the Decision**

The Supreme Court first notes that the purpose of ERISA is to provide a uniform regulatory scheme over employee benefit plans and that ERISA § 514 specifically includes broad preemption provisions to serve that end. As further evidence of Congress' intent to create a comprehensive statute for the regulation of employee benefit plans, the Court points to the existence of carefully integrated, albeit limited, civil enforcement remedies in ERISA Section 502(a). Although Section 502(a) does not provide all potential remedies, the Court, quoting its previous decision in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 504 (1981), notes that the statute's explicit remedies represent 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. ... [and] provides strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly.’” Therefore, the Court concludes that “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.” In addition, the Court confirmed that causes of action within the

... because plaintiffs’ causes of actions were brought to remedy only the denial of benefits under ERISA-regulated benefit plans, their state law claims ... were completely preempted by ERISA.

scope of ERISA's civil enforcement provisions of § 502(a) are removable to federal court.

The plaintiffs contended that their HMOs' actions violated legal duties that arose under Texas law independently of ERISA or of the terms of the employee benefit plans at issue. Specifically, they claimed that the Texas health care liability law created a duty for managed care entities to exercise ordinary care when making health care treatment decisions. However, the Court concluded that the essential actions complained of were the HMOs' refusal to approve payment for particular treatments because they were not covered by the plaintiffs' respective ERISA-regulated employee benefit plans. Therefore, because plaintiffs' causes of actions were brought to remedy only the denial of benefits under ERISA-regulated benefit plans, their state law claims fall within the scope of ERISA's civil enforcement mechanism and were completely preempted by ERISA.

In permitting the suit to go forward outside of ERISA, the court of appeals had found significance in the fact that the plaintiffs had alleged a tort claim for tort damages rather than a contract claim for contract damages and were not seeking reimbursement for benefits denied. The high court rejected this reasoning as putting form over substance and allowing the evasion of ERISA's preemptive scope by merely re-labeling contract claims as tortious breach of contract claims. Likewise, the mere
fact that a state law authorizes remedies beyond those available under ERISA cannot alter ERISA’s preemptive scope and effect.

The Court also rejected the plaintiffs’ claim, raised for the first time in the Supreme Court, that the Texas statute is a law that regulates insurance and therefore falls within the “business of insurance” exception from ERISA preemption under § 514(b)(2)(A). Following Pilot Life and other precedents, the Court found 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.”

Lastly, the Court distinguished its decision in Pegram v. Hedrich, 530 U.S. 211 (2000), which held that ERISA did not preempt claims that involved mixed eligibility and treatment decisions by an HMO acting through its physicians. In such cases, ERISA does not apply because HMOs are not acting in their fiduciary capacity. The Court emphasized that Pegram only applies in situations where the alleged “negligence plausibly constitutes medical maltreatment by a party who can be deemed to be a treating physician or such physician’s employer.” (citation omitted) This case, by contrast, involved pure eligibility decisions by HMOs acting in their fiduciary capacity, even though those decisions might involve medical judgments. And it did not involve the plaintiffs’ treating physicians or their employers. Thus, the Court appears to have significantly narrowed its holding in Pegram in order to distinguish it from the facts in Davila.

...the decision is likely to shift the focus of future litigation in coverage denial cases from preemption of state remedies to the scope of remedies available under ERISA.

Concurrence
Justice Ginsburg’s concurrence, joined by Justice Breyer, attempts to shift the battle from ERISA preemption to ERISA remedies. She warns that the Court’s strong ERISA preemption doctrine coupled with a “cramped construction” of ERISA’s equitable remedies leaves many plaintiffs without access to make-whole relief. As a result, Justice Ginsburg calls on Congress and/or the Supreme Court “to revisit what is an unjust and increasingly tangled ERISA regime.” She urges both institutions to take steps to broaden ERISA’s equitable relief and specifi-

cally to reconsider the provision of consequential damages under ERISA. She points out that the Government’s amicus brief suggests that the Act as currently written and interpreted leaves room for some type of “make-whole” relief against a breaching fiduciary. She hints that others in plaintiffs’ situation may want to bring claims under ERISA for such relief, which, she notes, is a traditional remedy against fiduciaries under trust law.

Impact of the Decision
Davila represents a significant clarification of the scope of ERISA’s preemptive effect. The case restricts participants contesting coverage decisions under employer-provided health plans to bringing suit under ERISA. Therefore, despite state laws attempting to fill the void, plan participants’ ability to recover compensation for damages that result from the denial of claims is essentially capped. HMO administrators cannot be sued for refusing pay for benefits that the plan has not chosen to provide — despite the fact that not providing certain benefits may proximately cause injury to a plan participant. Certain benefits simply are not covered. At the same time, the Court’s decision leaves the door open to, and Justice Ginsburg’s concurrence explicitly calls for, broader remedies under ERISA itself. Thus, the decision is likely to shift the focus of future litigation in coverage denial cases from preemption of state remedies to the scope of remedies available under ERISA.
The United States Court of Appeals for the Seventh Circuit recently issued one of the first decisions by a federal court of appeals interpreting the HIPAA privacy regulations. In Northwestern Memorial Hospital v. Ashcroft, 362 F.3d 923 (7th Cir. 2004), the Seventh Circuit reviewed a district court order quashing the government’s subpoena to Northwestern Memorial Hospital to produce the medical records of certain patients who had received late term abortions using a medical procedure banned under the Partial-Birth Abortion Ban of 2003 (“the Act”). The documents were subpoenaed in a lawsuit challenging the constitutionality of the Act that was brought by the physician who had performed the procedures. The district court held that the HIPAA statute directed the court to resolve the issue under Illinois state law, because Illinois law governing the production of medical records in litigation is “more stringent” than the HIPAA regulations, and therefore should be applied to prohibit the disclosures. The Seventh Circuit held that the district court erred in holding that the Illinois privilege governing medical records barred disclosure in this case.

The Seventh Circuit began by explaining that the HIPAA privacy regulations allow covered entities to disclose protected health information in judicial and administrative proceedings if the patient is notified, or the party seeking the information makes a reasonable effort to obtain a protective order ensuring the confidentiality of the information. See 45 C.F.R. § 164.512(e). In this case, the government had obtained a protective order, so the records could have been produced under 42 U.S.C. § 1320d-2 Note (c)(2). The Court of Appeals agreed with the district court’s interpretation of the HIPAA regulations, but disagreed that the issue was resolved by either HIPAA or Illinois law.

It reasoned that the Illinois rules created a state evidentiary privilege that does not apply in a federal case challenging the constitutionality of a federal statute. The court explained that the HIPAA regulation governing disclosure merely “create[s] a procedure for obtaining authority to use medical records in litigation. ... We do not think HIPAA is rightly understood as an Act of Congress that creates a privilege.”

Despite its disagreement with the district court’s interpretation of the HIPAA regulations, the Seventh Circuit agreed with the lower court’s conclusion that the subpoena should be quashed. Instead of resolving the issue under HIPAA or Illinois law, however, the court held that burden of compliance with the subpoena would exceed the benefit of production, and thus the subpoena should not be enforced under Fed. R. Civ. P. 45(c)(3)(A)(iv), the federal procedural rule governing third-party subpoenas. In short, the court found that the medical records were unlikely to be of much value to the Government while the potential loss of privacy resulting from the disclosure of the records would be significant.

HIPAA had the district court not found that a provision of the Illinois Code of Civil Procedure governing such disclosures – 735 ILCS 5/8-802 – was “more stringent” than the HIPAA regulations, and therefore should be applied to prohibit the disclosures. The Seventh Circuit held that the district court erred in holding that the Illinois privilege governing medical records barred disclosure in this case.

... the court found that the medical records were unlikely to be of much value to the Government ... while the potential loss of privacy resulting from the disclosure of the records would be significant.
court reasoned, “even if there were no possibility that a patient’s identity might be learned from a redacted medical record, there would be an invasion of privacy.” *id.* at 929, comparing the harm of disclosure to harm that might result from the publication of anonymous, nude pictures of the patient. The court identified the cost of production to be the “potential psychological cost to the hospital’s patients, and a potential cost in lost goodwill to the hospital itself, from the involuntary production of the medical records, even as redacted. ...” *id.* at 930.

At the end of the day, while the Seventh Circuit concluded that neither the HIPAA regulations nor the Illinois Code of Civil Procedure barred production of the records, its conclusion that the subpoena was unenforceable was informed by the privacy policies established by HIPAA and Illinois law, which have created strong expectations about the privacy of medical records among patients, physicians, and hospitals that should not be upset without a compelling reason. •