As One Door Closes, Another Opens:
Medical Malpractice Claims in ERISA Healthcare Benefit Litigation

On Monday, June 21, 2004, the United States Supreme Court handed down its much-anticipated opinion in the case of Aetna Health, Inc. v. Davila, 124 S.Ct. 2488 (2004). In a unanimous decision, the United States Supreme Court reversed the judgment of the United States Court of Appeals for the Fifth Circuit that had permitted plan participants to sue their employer-sponsored healthcare plans for alleged negligent denial of healthcare benefits.

In both cases, the plan participants argued that medical malpractice claims against their Health Maintenance Organizations (“HMOs”) are not completely preempted by the Employee Retirement Income Security Act of 1974 (ERISA) because their benefit determinations were based upon questions of “mixed eligibility and treatment.”

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ERISA Preemption and the Exclusivity of the Federal Scheme

In order to appreciate the significance of the Davila decision, it is first necessary to understand ERISA preemption and its history in the context of healthcare benefit litigation. ERISA issues often present questions of national significance because the vast majority of working Americans and their families are covered by ERISA-regulated health insurance plans sponsored by their employers. Contrary to some popular misconceptions, ERISA is not limited to the regulation of employee pension funds. ERISA is a complex statute that has a widespread effect due to its broad preemption clause, which provides that state laws, “insofar as they may now or hereafter relate to any employee benefit plan,” are preempted. See ERISA §514(a) 29 U.S.C. §1144(a).

Conflict Preemption (also known as “ordinary preemption”) occurs when a state law “relates to” the administration of an employee benefit plan. Boggs v. Boggs, 520 U.S. 833 (1997). Conflict preemption is generally considered an affirmative defense on the merits in any action against an ERISA plan, to the extent that a state law cause of action may relate to a section of ERISA. Under such circumstances, the ERISA statute will take precedence and the state law will be preempted and thus rendered nugatory.

A far more complex question and one that has resulted in a substantial amount of litigation, is the issue of “complete preemption.” ERISA provides only a discrete and limited set of rights and remedies available to ERISA plan participants and beneficiaries for enforcing their rights to benefits under an ERISA plan. ERISA’s civil enforcement scheme is set forth in ERISA §502 (a) (29 U.S.C. §1132(a)). The real workhorse section for participants and beneficiaries seeking to challenge determinations concerning their rights to benefits under an ERISA-regulated plan is ERISA §502(a)(1)(B), which permits an action by a participant or beneficiary to recover benefits or to enforce or clarify benefit rights under the terms of a plan. Complete ERISA preemption occurs when a plaintiff’s state law cause of action against an ERISA plan conflicts with ERISA’s civil enforcement scheme by purporting to add, supplement or provide an alternate enforcement mechanism to those limited enforcement remedies set forth in ERISA §502(a).

The Supreme Court’s interpretation of complete ERISA preemption can be
traced back to two seminal decisions handed down in April 1987. In the first case, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), the Supreme Court held, in a unanimous decision, that state law contract and tort claims filed against an insurer for “bad faith” denial of benefits under an ERISA long-term disability plan are completely preempted by ERISA. The Supreme Court noted that permitting such state law causes of action to proceed would be tantamount to recognizing the legitimacy of alternate enforcement mechanisms for contesting a denial of benefits to those remedies available in ERISA §502(a). The Court stated that Congress clearly intended that the remedies set forth in ERISA §502(a) be exclusive. Therefore, any attempt to enforce a right falling within the scope of ERISA §502(a) via state law must be considered an impermissible alternate enforcement mechanism and consequently be held completely preempted. In so holding, the Supreme Court reasoned 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 were free to obtain remedies under state law that Congress rejected in ERISA.” *Pilot Life*, 481 U.S. at 54.

In the second case, *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987), the Supreme Court held that the preemptive effect of the ERISA civil enforcement scheme is so strong that a defense to a state law claim, arguing that the claim falls within the scope of ERISA §502(a) remedies, is a sufficient basis for removal of that state law claim to federal court notwithstanding the limitations of the “well-pleaded Complaint rule,” which otherwise limits availability of a federal removal jurisdiction. *Taylor*, 481 U.S. at 63–64.

Read together, *Pilot Life* and *Taylor* form the basis for the Supreme Court’s original interpretation of the complete ERISA preemption doctrine. In those cases, the Supreme Court conclusively determined the exclusivity of ERISA’s civil enforcement scheme, noting that this exclusivity was necessary to ensure that ERISA plans, and those who administer them, be “subject to a uniform body of benefits law.” The Court also ruled that state laws that interfere with the ERISA civil enforcement scheme, and in particular, state laws that provide alternate remedies to it, are preempted by both ERISA §514 and §502.

**Conflict Among the Circuits:**

**ERISA Preemption Before Davila**

Although the Supreme Court’s decisions in *Pilot Life* and *Taylor* appeared to decide the question conclusively, opportunistic attacks on the outer limits of ERISA preemption subsequently became part of the regular diet for the federal district courts and courts of appeal.

Although the Supreme Court’s decisions in *Pilot Life* and *Taylor* appeared to indicate a retreat from its initial unequivocal position set forth in *Pilot Life* and *Taylor*. In *New York State Conference of Blue Cross and Blue Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316 (1997), and *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997), the Supreme Court suggested that its initial interpretation of the “relate to” language of ERISA §514(a) is not quite as all-encompassing as originally contemplated. In fact, the Court stated in *Travelers* that “if ‘relate to’ were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes, preemption would never run its course.” *Travelers*, 514 U.S. at 655. This perceived weakening of the Supreme Court’s interpretation of the limits of complete ERISA preemption initiated a new generation of litigation aimed at removing it entirely, so that plan participants could sue their ERISA plans in state court and thereby obtain consequential damages, which are not available under ERISA.

Perhaps no case created more uncertainty concerning the applicability of complete ERISA preemption than the Supreme Court’s decision in *Pegram v.*
Herdrich, 530 U.S. 211 (2000).

Pegram’s effect on subsequent ERISA preemption jurisprudence is remarkable considering that it was not a preemption case. Rather, in a unanimous decision, the United States Supreme Court ruled that a plan subscriber’s ERISA-based breach of fiduciary duty claim could not be sustained. In Pegram, plaintiff Cynthia Herdrich, the patient of defendant Dr. Lori Pegram, alleged that she sustained injuries when Dr. Pegram did not order an immediate abdominal ultrasound when she discovered an inflamed mass in Ms. Herdrich’s abdomen. She directed Ms. Herdrich to have an ultrasound examination at a different location eight days later. Before those eight days passed, Ms. Herdrich’s appendix burst, resulting in peritonitis and injury. Ms. Herdrich’s complaint against Dr. Pegram and the HMO was not just a simple medical malpractice action but also included breach of ERISA fiduciary duty claims because, in the employer-sponsored healthcare plan in which Ms. Herdrich was enrolled, Dr. Pegram was both a physician and owner of the HMO that provided health benefits to the plan’s participants. Since Dr. Pegram’s treatment decisions were also simultaneous eligibility decisions for healthcare benefits, Ms. Herdrich argued that Dr. Pegram’s decisions were those of an ERISA fiduciary and subject to ERISA fiduciary duty liability. The Supreme Court concluded, however, that most decisions made by HMOs acting through their physician employees are not fiduciary acts within the meaning of ERISA. Plaintiff’s ERISA breach of fiduciary duty claim was therefore found to be unsustainable.

In the course of reaching its decision, the Supreme Court discussed the different types of decision-making that occur in an HMO context. These include treatment decisions, eligibility decisions and “mixed eligibility and treatment decisions.” Pegram, 530 U.S. at 228–29. While “pure eligibility decisions” involve “simple yes or no” questions such as whether or not appendicitis is a covered condition, “treatment decisions” involve choices about how to diagnose and treat a particular condition. The Supreme Court found that in Pegram, a “mixed eligibility and treatment decision” was made since the decision involved both questions of treatment as well as eligibility for benefits under the ERISA plan. The Court ruled that such “mixed decisions” by an HMO in an ERISA context are not fiduciary acts within the meaning of ERISA.

The Pegram dicta concerning treatment decisions, eligibility decisions and “mixed eligibility and treatment decisions” spawned a wave of litigation resulting in a profound split among the circuit courts of appeal concerning the limits of ERISA preemption where a participant or beneficiary alleges that a wrongful denial of benefits resulted in injury. While previously, the circuit courts had been fairly universal in their determination that ERISA completely preempts state law challenges to ERISA healthcare plan denials of benefits based upon the argument that a negligent or wrongful denial of benefits resulted in harm to the patient/plan participant or beneficiary, Pegram seemingly opened the door to a more liberal construction. Following Pegram, the Courts of Appeals for the Second, Fifth and Eleventh Circuits issued opinions, ostensibly based upon the Supreme Court’s identification of “mixed eligibility and treatment decisions,” that permitted certain state law medical malpractice causes of actions to proceed against ERISA-regulated HMOs and their administrators for allegedly negligent denials of health care benefits. See Cicio v. Does, 321 F.3d 83 (2nd Cir. 2003), cert. granted, judgment vacated, Vytra Health Care v. Cicio, 124 S.Ct. 2902 (June 28, 2004); Roark v. Humana, Inc., 307 F.3d 298 (5th Cir. 2002), cert. granted, judgment vacated, Aetna Health, Inc. v. Davila, 124 S.Ct. 2488 (2004); Land v. CIGNA HealthCare of Florida, 339 F. 3d 1286 (11th Cir. 2003), cert. granted, judgment reversed, CIGNA HealthCare of Florida v. Land, 124 S.Ct. 2903 (June 30, 2003). The Courts of Appeals for the First, Third, Fourth, Sixth, Eighth, Ninth and Tenth Circuits all issued decisions consistent with pre-Pegram complete preemption jurisprudence, finding that state law medical malpractice claims against ERISA-regulated HMOs are completely preempted by ERISA and subject to dismissal. See Hotz v. Blue Cross and Blue Shield of Mass., Inc., 292 F.3d 57 (1st Cir. 2002); Pryzbowski v. U.S. Healthcare, Inc., 245 F.3d 266 (3rd Cir. 2001); Marks v. Watters, 322 F.3d 316 (4th Cir. 2003); Caffey v. Unum Life Ins.Co., 302 F.3d 576 (6th Cir. 2002); Howard v. Coventry Health Care of Iowa, Inc., 293 F.3d 442 (8th Cir. 2002); Bui v. American Telephone and Telegraph Co., Inc., 310 F.3d 1143 (9th Cir. 2002); Conover v. Aetna U.S. Healthcare, Inc., 320 F.3d 1076 (10th Cir. 2002).

Complete ERISA Preemption Confirmed by the Supreme Court

Given the confusion and great degree of conflict between the U.S. Circuit Courts in the wake of the Pegram deci-
sion, it was only a matter of time before the Supreme Court resolved the conflict and more clearly defined the boundaries of complete ERISA preemption. In *Aetna Health, Inc. v. Davila*, *supra*, the Court finally laid this issue to rest in unequivocal fashion. In the consolidated cases of *Davila v. Aetna Health, Inc.* and *Calad v. CIGNA HealthCare of Texas*, the Fifth Circuit ruled that the Texas Healthcare Liability Act (Tex. Civ. Prac. & Rem. Code Ann. §88.001-88.0003 (2004 Supp. Pamphlet)), which created a statutory cause of action under state law for plan participants and beneficiaries to sue their ERISA-regulated HMOs for wrongful denial of health-care benefits caused by the breach of an ordinary duty of care in rendering such determinations, was not completely preempted by ERISA.

In other words, if an individual, at some point in time, 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 *Davila* decision is notable for its comprehensive discussion of complete ERISA preemption in the context of HMO medical benefit claims, . . . [but] we may not have heard the end of ERISA litigation concerning so-called negligent benefit denials.

Writing for a unanimous Supreme Court, Justice Clarence Thomas noted that ERISA was enacted by Congress to protect the interests of participants in employee benefit plans by setting forth substantive regulatory requirements and to provide appropriate remedies and sanctions, as well as ready access to the federal courts for those participants and their beneficiaries. Justice Thomas noted that ERISA's comprehensive legislative scheme included an integrated civil enforcement mechanism set forth in ERISA §502(a).

Dissipating the recent confusion concerning the scope of complete preemption under ERISA §502, the Court stated that ERISA's civil enforcement mechanism is the exclusive means for plan participants and beneficiaries to vindicate rights under an employee benefit plan. Tracing the court's prior precedent on point, Justice Thomas found that state law tort claims, such as those asserted by the plan participants in the consolidated cases before the Court, were completely preempted by ERISA because they fell within the scope of those areas covered by ERISA's exclusive civil enforcement scheme. The Supreme Court reversed the judgment and remanded both cases back to the Fifth Circuit for further proceedings consistent with this opinion.

The *Davila* decision is notable for its comprehensive discussion of complete ERISA preemption in the context of HMO medical benefit claims. Addressing many of the misconceptions left in the wake of *Pegram*, the Supreme Court set forth a bright-line test for complete ERISA preemption as follows:

In other words, if an individual, at some point in time, 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).

*Davila*, 124 S.Ct. 2488, 2496.

The Court determined that the state law medical malpractice claims asserted by both Mr. Davila and Mrs. Calad were
essentially allegations that the plan failed to authorize money to pay for medical services recommended by their treating physicians. The Supreme Court concluded that anytime a plan administrator makes a discretionary decision concerning whether or not to release plan funds to pay a health benefit claim, such a claim decision is a fiduciary decision under ERISA and therefore can only be challenged through ERISA's exclusive civil enforcement scheme.

Subsequent to the Davila decision, the Second Circuit's decision in Cicio v. Does, supra, and the Eleventh Circuit's decision in Land v. CIGNA HealthCare of Florida, supra, were also vacated and remanded for further consideration in light of Davila.

New Strategies and Defenses after Davila

While the Supreme Court's decision in Davila settles a question that had split the circuit courts of appeals and created a great deal of litigation in both the state and federal courts, two footnotes in the main decision and a strong concurring opinion by Justice Ginsburg (joined by Justice Breyer) suggest that we may not have heard the end of ERISA litigation concerning so-called negligent benefit denials. At footnote seven of the main opinion, Justice Thomas briefly discusses the suggestion of the United States, as amicus, that some form of “make whole” relief might still be available under ERISA §502(a)(3). The Court refused to address this point, however, because the respondent plan participants chose not to pursue any ERISA claims despite having been given the opportunity to amend their pleadings to do so. Similarly, at footnote one of the opinion, Justice Thomas specifically noted that none of the respondents’ causes of action are claimed to fall within ERISA §502(a)(2). In her concurring opinion, Justice Ginsburg observed that a “regulatory vacuum” exists because of the limited remedies available under ERISA's civil enforcement scheme. Although she agreed with the majority opinion vacating the judgment of the Fifth Circuit, Justice Ginsburg also noted that “fresh consideration of the availability of consequential damages under ERISA §502(a)(3) is plainly in order.” Davila, 124 S.Ct. 2488, 2503–04 (Ginsburg, J., concurring).

Given the Supreme Court’s tacit invitation to litigants to focus their attention on the other remedial sections of ERISA §502(a), as opposed to launching collateral attacks on ERISA preemption via various state law theories, it is worth reviewing those sections since they may form the new battleground for ERISA litigation in the healthcare benefits forum.

ERISA §502(a)(3)

ERISA §502(a)(3) states:

(a) Persons empowered to bring a civil action

A civil action may be brought – * * *

(3) by 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 the plan.

(emphasis added)

While ERISA §502(a)(3)(B) appears to offer some sort of equitable “catchall” to provide the “make whole” relief hinted at by Justice Thomas and Justice Ginsburg, this alternative may ultimately prove illusory. In the case of Mertens v. Hewitt Associates, 508 U.S. 248 (1993), a sharply divided Supreme Court held (in a five-four decision) that the words “appropriate equitable relief” as they appear in ERISA §502(a)(3) do not contemplate an award of money damages, consequential damages or punitive damages. Justice Scalia, writing for the majority, concluded that the words “other appropriate equitable relief” referred back to the days of the divided bench, where certain remedies were considered “legal” remedies and others were only available in “equity.” Such equitable relief included injunction, mandamus and restitution but not “compensatory damages.” Mertens, 508 U.S. 248, 256. Finding consequential “money damages” to be the classic form of “legal” relief, the Supreme Court ruled that such damages, not being “equitable” relief, are unavailable under ERISA. Mertens, 508 U.S. at 255. Therefore, plaintiff’s claims seeking money damages against a non-fiduciary...
The intriguing question following Mertens, and especially following Davila, is whether claims for “make whole” relief against a plan fiduciary are equally limited by the Court’s holding in Mertens. The Supreme Court’s analysis of ERISA §502(a)(3) in Mertens is explicitly limited to the “narrow battlefield” of the non-fiduciary’s knowing facilitation of a fiduciary’s breach of duty. It is therefore arguable that the availability of “make whole” relief against a plan fiduciary for breach of his or her own ERISA fiduciary duty is still an open question. This being said, however, it is hard to imagine the circumstance (with the Supreme Court’s composition remaining as currently constituted) where a claim under ERISA §502(a)(3) against a plan fiduciary would result in a different holding. However, given both Justice Thomas’s and Justice Ginsburg’s reference to ERISA §502(a)(3)’s catchall, “other appropriate equitable relief” section, it is possible that the Court might consider the application of this section to challenges against an ERISA fiduciary concerning alleged wrongful benefit determinations made in breach of an ERISA fiduciary duty. Certainly, this possibility may become a reality if the constituency of the Court changes over the next few years.

It may be, however, that ERISA §502(a)(3) will ultimately not provide any real alternative to §502(a)(1)(B) remedies except in the rarest of circumstances. In Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002), the Supreme Court held that ERISA §502(a)(3) equitable “catchall” relief does not include “all relief.” Citing its previous decision in Mertens, supra, the Court noted that ERISA §502(a)(1)(B) already provides a means for plan participants to enforce their rights under an ERISA plan. The fact that the relief available under that section is limited does not imply that ERISA §502(a)(3) is available to provide any other form of relief consistent with ERISA’s purposes but not explicitly provided elsewhere. Knudson, 534 U.S. 204, 221 n.5. Similarly, in Varity Corp. v. Howe, supra, the Supreme Court observed that “...where Congress elsewhere provided adequate relief for a beneficiary’s injury, there will likely be no need for further equitable relief, in which case such relief normally would not be ‘appropriate.’” Varity Corp., 516 U.S. 489, 515.

Given the availability of relief under ERISA §502(a)(1)(B), it may prove quite difficult, if not impossible, for a litigant who fails to pursue those remedies to argue for “appropriate equitable relief” under ERISA §502(a)(3). The simple fact that a litigant failed to timely avail himself of ERISA §502(a)(1)(B) relief would seem to disqualify him from requesting relief under ERISA §502(a)(3) because such relief would not be “appropriate.” See Varity Corp., supra. Nonetheless, ERISA §502(a)(3) is probably the only viable alternate remedial section available under ERISA for plan participants who find ERISA §502(a)(1)(B) remedies to be less than satisfactory.

ERISA §502(a)(2)

In addition to the footnote citing ERISA §502(a)(3), Justice Thomas also notes that the respondents did not pursue remedies under ERISA §502(a)(2). See Davila, 124 S.Ct. 2488, 2494 n.1. ERISA §502(a)(2) permits ERISA plan participants and beneficiaries (as well as the Secretary of Labor or other plan fiduciaries) to sue for relief under ERISA §409. ERISA §409(a) (29 U.S.C. §1109(a)) makes ERISA plan fiduciaries personally liable for breach of their fiduciary duty in carrying out: proper management, administration and investment of plan assets; the maintenance of proper records; the disclosure of specified information and the avoidance of a conflict of interest. ERISA plan fiduciaries will be personally liable “to make good to the plan” any losses sustained by the plan resulting from each such breach, for restitution and for “such other equitable or remedial relief as the Court may deem appropriate,” including removal of the fiduciary. See ERISA §409(a). Although Justice Thomas refers to ERISA §502(a)(2), this section really is not an appropriate vehicle for vindicating a participant’s rights to benefits under an ERISA plan. Unlike ERISA §502(a)(3), ERISA §502(a)(2) is directed to recovering damages that run to the plan, rather than running to the benefit of plan participants. In Massachusetts Mutual Life Ins. Company v. Russell, 473 U.S. 134 (1985), the United States Supreme Court held that ERISA §502(a)(2) is primarily concerned with the possible misuse of plan assets and remedies to protect an ERISA plan, as opposed to the rights of individual beneficiaries. See Russell, 573 U.S. 134, 142. Therefore, ERISA §502(a)(2) seems to be dead
The “Staff Model” Scenario

Non-ERISA Remedies Are Still Available in Limited Circumstances

Although Davila unequivocally limits most claims against ERISA-regulated health benefit plans to those available under §502(a)(1)(B), there are a few potential exceptions that may result in significant non-preempted medical malpractice litigation in state court.

The “Staff Model” Scenario

In Pegram, the Supreme Court observed that where an HMO’s physicians make “mixed eligibility and treatment” decisions, those decisions may be subject to state law medical malpractice claims. Pegram, 530 U.S. 211, 236–37. As the Court noted in Davila, a truly “mixed” decision occurs when the HMO physician, acting as the participant’s treating doctor, makes decisions concerning how to treat his illness or injury that are simultaneous plan eligibility decisions. In a medical malpractice context, a “mixed decision” is one where “the underlying negligence also plausibly constitutes medical malpractice by a party who can be deemed to be a treating physician or such physician’s employer.” Davila, 124 S.Ct. 2488, 2502 (citing Cicio, 321 F.3d at 109 (Calabresi, J., dissenting in part)). Based upon the foregoing analysis, it seems clear that neither Davila nor Pegram precludes state law medical malpractice claims against a “staff model” HMO, such as the HMO involved in Pegram.

In the so-called “staff model,” the HMO directly employs treating physicians on a salaried basis. The HMO’s patients are directly treated by its employee physicians. Consequently, any decision by the HMO’s physicians concerning how to treat a given medical condition (including a decision not to treat) is inescapably a “mixed decision” by the HMO. This is in stark contrast to the more prevalent “individual practice association” (IPA) model, where the HMO contracts with a large number of independent physicians or small groups of physicians who agree to accept some sort of discounted fee-for-service rendered to the HMO’s participants in exchange for access to the HMO’s participants and direct payment of those discounted fees by the HMO (instead of by the patient/participant). See generally Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships, 1984 Duke L.J. 1071, 1073 n.3 (describing HMO arrangements with physicians); see also Cicio, 321 F.2d 83, 87 n.2. Unlike the situation presented in Davila, where the eligibility decisions were made by HMO claim fiduciaries who were not the participant’s treating physicians, the “staff model” scenario does involve the rendering of direct medical treatment by the HMO. Under such circumstances, complete ERISA preemption will likely not apply, and suits against the HMO’s physician employees, and potentially against the HMO as vicariously liable for the malpractice of those employees, may very well be permitted to proceed in state court.

As Justice Calabresi noted in his dissenting opinion in Cicio v. Does, supra, “[t] is, of course, possible that the insurance provider is also the medical care provider. In such cases, in which propriety of treatment and propriety of judgment as to eligibility under an ERISA plan are intertwined, I do not believe that a state law malpractice suit would be preempted. Such a state law action cannot be preempted simply because the treatment decision was made by the same person who made the improper decision as to the scope of coverage under an ERISA plan. The fact that the medical malpractice and the contract misinterpretation involved the exact same error does not make the state tort action in any way dependent on a finding that the ERISA contract has been breached. It therefore would not be barred by ERISA.” Id. at 108 (Calabresi, J., dissenting in part) (emphasis in original). Given the foregoing, medical malpractice claims against “staff model” HMOs and their physician employees will likely not be found preempted by ERISA.

Professional Licensing Grievances Against Plan Medical Directors

Although not mentioned at all in the context of the Davila decision, there have been concerted efforts by aggrieved plan participants to apply indirect pressure on ERISA plan medical directors by subjecting them to state licensing board grievances for allegedly wrongful denials of healthcare benefits. Davila makes it clear that a plan participant or beneficiary’s attempt to sue ERISA plan medical directors for medical malpractice in rendering allegedly wrongful benefit denials is completely preempted. Such decision making constitutes a fiduciary act under ERISA and can only be challenged by an ERISA §502(a)(1)(B) action. See Davila, 124 S.Ct. 2488, 2501–02. However, several courts have held that while ERISA preempts a direct claim by a plan participant or beneficiary against an ERISA plan’s medical director for an allegedly wrongful benefit denial, there is
no ERISA preemption of a state licensing board’s professional grievance proceedings against a medical director concerning such benefit denials where the licensing board finds that the denial was issued without regard to appropriate standards of medical care. See Murphy v. Board of Medical Examiners, 949 P.2d 530 (Ariz. App. 1997); State Board v. Fallon, 41 S.W.3d 474 (Mo. 2001); but see United Healthcare Ins. Co. v. Bruce A. Levy, M.D., 114 F.Supp.2d 559 (N.D. Tex. 2000); see also Corporate Health Ins. Co. Inc. v. Texas Dept’ of Ins., 215 F.3d 526, 534 (5th Cir. 2000), rev’d on other grounds sub nom. Montemayor v. Corporate Health Ins. Co., Inc., 536 U.S. 935 (2002), stating: medical director’s ability to deny health-care benefits while performing his or her duty as a plan fiduciary. Although a medical director’s duty as a plan fiduciary requires that he or she deny recommended care in certain circumstances, the risk of having a license to practice suspended or otherwise limited can certainly have a chilling effect on the free exercise of discretion in this context.

Several courts have held that while ERISA preempts a direct claim by a plan participant or beneficiary against an ERISA plan’s medical director for an allegedly wrongful benefit denial, there is no ERISA preemption of a state licensing board’s professional grievance proceedings against a medical director concerning such benefit denials.

Conclusion

In Davila, the Supreme Court scrupulously avoided a discussion of potential liability under ERISA §502(a)(3) or ERISA §502(a)(2). Justice Thomas’s footnotes and Justice Ginsburg’s concurring opinion concerning possible “make whole” relief suggest that these sections may become the new battleground for plan participants who feel aggrieved by their ERISA-regulated healthcare plan’s denial of benefits and who seek relief beyond the limited remedies provided by ERISA §502(a)(1)(B).

The future composition of the Supreme Court may play a role in how these questions will be answered. The rumor mill continues to spin out stories speculating about the impending retirement of some of the Court’s more senior members, but none of the justices has formally announced retirement. As this is a presidential election year, the future composition of the Supreme Court will become a more visible issue with far-reaching implications on a variety of subjects. But as always with ERISA, it is likely that whatever the Supreme Court’s composition, it will be up to Congress to rewrite ERISA’s remedial sections rather than look to the Court to fill the “remedial vacuum” identified by Justice Ginsburg. Until that day arrives, it is unlikely that the Supreme Court will willingly step in to fill that void on its own.

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