The United States Supreme Court and Health Law: The Year in Review

The Supreme Court Federalizes Managed Care Liability

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About this Column

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The U.S. Supreme Court's recently completed Term was notable even relative to the Court's normal standard of prominence, with several key decisions touching a number of deeply contested issues of law and policy. Initial public commentary on the Term has understandably focused on a handful of decisions of immediate impact and notoriety. A group of cases addressing the scope of the President's wartime powers assertively proclaimed that even a dire emergency was no "blank check" for the executive branch to evade judicial review.[1] Another key decision on the constitutionality of state sentencing enhancements has already had a calamitous effect on the entrenched and carefully wrought – if highly unpopular – federal sentencing guidelines scheme, and the Court will revisit that issue soon.[2] These decisions are undeniably important and merit the close scrutiny they have already received in the legal academy and in broader civic discourse.

In the long view, however, it is possible that this Term's leading health law decision, *Aetna Health Inc. v. Davila*[3] (hereinafter *"Aetna"*), will ultimately impact the American health insurance system, and the federal regulation of that industry, to an extent that matches the influence of any case this year. *Aetna's* core holding – that a wide swath of coverage decisions made by ERISA-regulated managed care organizations are immune from liability under state tort law – has important ramifications immediately, and these are examined below. But the decision's greatest influence is a latent one, embodied in its signal to Congress and the broader American public that regulation of a central feature of managed care is a matter of exclusively national government concern. The Court's ouster of the states from a key component of managed care regulation will create enhanced pressure on Congress to act more robustly in this area of acute public interest. In this sense the *Aetna* decision can be viewed as an implicit signal to Congress (made explicit in Justice Ginsburg's concurrence) that the Court expects greater federal legislative attention to the fundamental choices managed care organizations make. To the extent the decision provokes a long-awaited Congressional action in this area, or more substantive federal judicial intervention in managed care decisions, its catalyzing force will be vastly greater than its immediate ruling on ERISA's remedial exclusivity.

This essay explores the *Aetna* decision in some detail and, to a lesser extent, one other decision in the Court's 2003-2004 Term that relates to health law and policy. Particularly due to the *Aetna* decision, this Term underscores once again the crucial role of the Supreme Court in the field of health law and policy.

The Legal and Factual Background of *Aetna v. Davila*

The factual and legal background of the *Aetna v. Davila* litigation serves as a virtual time capsule of the market forces and legal influences that have shaped and reshaped managed care over the past decade. The failure of the Clinton-era health reforms of the early 1990s spurred a private sector focus on medical management to reduce escalating heath care costs. The increasing market penetration of plans that assertively managed care, coupled with significant consumer and physician unease about the effect of such care management on the provision of health care, produced a "backlash" against managed care that is well-known and well-studied. At present, the most significant fruits of this backlash are not embodied in positive legal changes, but rather in a vastly different private marketplace for managed care than that which existed a decade, or even five years ago. In response to consumer and provider pressures, health plans have moved dramatically away from the more aggressive forms of care management, substituting new patient-based incentives and sophisticated underwriting strategies for the prospective utilization review and tightly limited provider networks of the mid- to late-1990s.[4]

But this transition to a "kinder, gentler" managed care[5] did not eradicate public concerns about hierarchical care management, and the fact remains that some states had pushed forward with affirmative statutory initiatives – which remain on the statute books – to regulate the decisions made by health plans. The core issue in the paired cases that the Supreme Court addressed this Term involved one such state law, the Texas Health Care Liability Act (THCLA), which imposed tort liability on managed care organizations for breach of "ordinary care" in making mixed treatment/benefit decisions.[6] The plaintiffs suffered adverse health outcomes, allegedly caused by coverage decisions made by their health plans that directly and adversely (in the plaintiffs' view) affected the quality of care they received, and brought suit in Texas state court under the THCLA. For one plaintiff, the contested

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decision involved the plan's coverage of one arthritis drug but not another recommended by his physician; the other plaintiff alleged negligence in the plan's decision to cover only a short hospital stay following surgery.

The central question presented to the Supreme Court in the *Aetna* case was whether the Texas liability statute was completely preempted by the Employee Retirement Income Security Act (ERISA).[7] The two plaintiffs received health insurance as an employment benefit, as do most Americans, and as such were facially within the ambit of ERISA's sweeping preemption clauses. ERISA's preemption language is extraordinarily broad – purporting to preempt any state laws that "relate to" an employee benefit plan.[8] Even more importantly for the case at hand, ERISA's civil enforcement remedies are regarded as exclusive under ERISA's text and Supreme Court precedent, so that even prior to *Aetna* a complaint for benefits that could be brought against a managed care organization under the ERISA civil remedy was likely *exclusively* actionable via that federal remedy.

However, some of the Court's own cases in recent years gave the plaintiffs a plausible argument for avoiding preemption. The Court had, in a series of decisions from the year 2000 forward, narrowed ERISA's preemptive scope to uphold state laws that regulated various features of managed care organizations also subject to ERISA. The Court sustained against preemption challenges state laws that regulated managed care organizations by requiring an independent physician review for some treatment decisions (such as *Rush Prudential HMO, Inc. v. Moran)*[9] and by imposing an "any willing provider" requirement on provider network plans (*Kentucky Ass'n of Health Plans, Inc. v. Miller)*.[10] In the case most relevant to the *Aetna* litigation, *Pegram v. Herdrich,*[11] the Court held that "mixed" treatment and benefit eligibility decisions were not fiduciary acts subject to ERISA preemption, at least when made by the treating physician. *Pegram* was motivated in part by the Court's desire to preserve the traditional leading role of states in regulating medical treatment decisions, and a related aversion to "federaliz[ing] malpractice litigation in the name of fiduciary duty."[12] Even an ardent textualist like Justice Scalia has endorsed the Court's efforts to narrow ERISA's preemptive scope beyond what its plain meaning might suggest, stating that the "statutory text provides an illusory [preemption] test, unless the Court is willing to decree a degree of preemption that no sensible person could have intended."[13]

The *Aetna* Ruling

The issue at the core of the *Aetna v. Davila* litigation was left undecided in *Pegram:* whether ERISA preempted state law liability against health plans for mixed coverage-treatment decisions made by persons *other than the treating physician.* And the Court this Term resoundingly answered that question in favor of complete preemption. Writing for a unanimous Court, Justice Thomas stressed the "extraordinary preemptive power" of ERISA's enforcement provisions.[14] Section 502(a)(1)(B) of ERISA permits a plan participant or beneficiary to bring a civil action "to recover benefits due to him under the terms of his plan" or "to enforce his rights under the terms of the plan."[15] The Court had on several occasions previously held this civil remedy, wherever available to a plan participant, to be the exclusive remedy, preempting any other state law cause of action for denial of benefits.[16] With this textual and doctrinal background in place, the Court's decision in *Aetna* turned rather mechanically on whether the two plaintiffs might have styled their particular grievances – a truncated hospital stay and a denial of coverage for a preferred arthritis drug – as a denial of benefits under ERISA's section 502. The answer to that question is most assuredly "yes," and so with the issue thus framed by the Court the plaintiffs had one and only one remedial option: to seek recovery of the denied benefit via ERISA's civil enforcement provisions. In so holding the Court dismissed the reasoning of the Fifth Circuit that the THCLA's character as a remedy in tort placed it beyond the reach of ERISA's remedial exclusivity for contractual claims.

As the Court's unanimity suggests, its opinion in *Aetna* is a reasonable application of ERISA's language and the Court's prior case law, both of which point to a broad remedial exclusivity for claims involving benefit denials. Measured, however, as a statement of health policy or as thoughtful health law jurisprudence, the opinion is problematic and incomplete in several respects. As a matter of policy, the practical remedial deficiency in ERISA's enforcement regime is most glaring. The *Aetna* decision limits ERISA health plan participants to one and only one legal remedy for wrongful denials of coverage, even such denials that directly and adversely affect health outcomes. If ERISA's civil enforcement remedy were adequate and complete, such a decision would be still controversial but significantly less problematic than *Aetna* actually is.

In reality, ERISA's remedial provisions are so penurious that *Aetna's* holding of complete preemption produces a legal regime that vastly under-compensates plan members who suffer a wrongful denial of care. Current ERISA law permits recovery under section 502 of actual benefits, but not of consequential damages flowing from a benefit denial, no matter how proximate and predictable such damages are.[17] In the health plan context this means that a patient who suffers grievous harm as a direct result of an improper denial of treatment may recover *ex post* only the value of that treatment, and nothing for the injuries that were a foreseeable consequence of such denial.

This crabbed enforcement scheme fails to serve the baseline goals of compensation and deterrence that undergird remedial law in tort and contract. For reasons described above, the inability to recover consequential damages means that many victims of wrongful coverage denials will be under-compensated even when they bring, and prevail in, a federal civil action. The fact that many victims of medical error fail to recover any damages, or do not bring a suit at all, compounds the systemic compensatory deficiencies in the ERISA remedy. Likewise, ERISA's current remedial scheme is an inadequate deterrent to wrongful denials of care. Punitive damages are, like compensatories, unavailable through the ERISA provisions, so that plan administrators who wantonly denied care would still profit so long as only a fraction of beneficiaries actu-

ally filed suit and recovered. And even if a plan faced full after-the-fact liability for *every* denial of care, a rational plan administrator might still deny care and pay later to capture the time value of the money otherwise spent on benefits. This parade of horribles is probably overstated; market pressures and the threat of consumer revulsion place some practical limits on a plan's ability to deny care, but such extralegal pressures would exist even absent ERISA, a fact that underscores how little additional work is done by its inadequate remedy. So deficient is the ERISA remedy that even Richard Epstein, a leading contractarian health law scholar ordinarily unsympathetic to greater regulation of managed care, has advocated a more robust measure of damages under ERISA.[18] By conferring exclusive status on a remedy so widely viewed as inadequate, the *Aetna* decision has created a policy result that is highly unstable and undesirable, and one unlikely to last long without Congressional or judicial revision.

Beyond these immediate policy concerns, the *Aetna* decision embodies a style of categorical reasoning that, from the perspective of a more nuanced health law jurisprudence is, if not erroneous, at least somewhat incomplete. Set alongside the Court's earlier decision in *Pegram v. Herdrich,* the *Aetna* holding appears to give priority to organizational form at the expense of a functional analysis of the nature of decision-making in the managed care context. *Pegram* held that a "mixed" treatment/eligibility decision made by a treating physician was not a fiduciary act, and so was not preempted by ERISA, and so was amenable to state malpractice lawsuits. *Aetna* holds the reverse, and grounds the distinction in the placement of the decision within the managed care organization's hierarchy. Mixed treatment and coverage decisions made by treating physicians are not fiduciary acts, but similar decisions made by plan administrators – which the Court acknowledged are "infused with medical judgments"[19] – are treated quite differently in *Aetna,* despite the functional similarities of the decisions themselves. Like the physician's decision in *Pegram,* the coverage decisions plan administrators make (say to authorize one drug and not another, or to extend or limit a hospital stay) are "mixed" decisions about eligibility and treatment efficacy, and are often made in the shadow of occasionally cross-cutting incentives to provide quality care on the one hand, and to contain costs on the other. *Aetna* and *Pegram* stand together to mean that the same substantive decision about patient care might be subject to different liability rules based on the identity of the decision-maker. By grounding its decision on the characteristics of the decision-maker rather than the decision itself, the court missed another opportunity to more substantively discuss the rich array of competing values and considerations that inhere in any decision to ration medical care.

Beyond these jurisprudential concerns, the Court's sharp distinction between "mixed" decisions made by treating physicians and similar decisions made by plan administrators may have the unintended (and unpopular) consequence of reinvigorating the practice of assertive utilization review by administrators of managed care plans. Part of the market response to the "backlash" against aggressively managed care in recent years has been a devolution of decisional authority to treating physicians, with a related de-emphasis on hierarchical utilization review by plans.[20] But the Court in *Pegram* and *Aetna* has created an imbalanced liability rule structure that may halt or reverse this popular decentralizing trend. As noted above, ERISA's penurious remedial scheme means that a plan administrator's wrongful decision not to give a particular kind of care is significantly less costly than an identical decision made by a treating physician. In light of the robust medical malpractice liability risks that treating physicians face, even when making "mixed" treatment/eligibility decisions, the *Aetna* holding creates a sort of non-liability windfall to be captured by plans that push such mixed decisions upward in their organizational hierarchy away from treating physicians. One would expect some plans to try to capture this windfall by restructuring their decisional practices, and one would also expect some physicians to try to share this windfall in future contracting with plans. In this last sense *Aetna* may force a difficult choice on physicians between maximizing traditional clinical autonomy, and marginally reducing malpractice risk by ceding certain kinds of decisions to plan administrators. If the liability imbalance *Aetna* creates does result in a partial market reversal back to hierarchical care management, it will render the decision's policy result even more unpopular, and perhaps provoke a speedier response from Congress.

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A Message to Congress…and the Federal Courts?

For all of these problematic features of the *Aetna,* it may be that the Supreme Court did the best it could within the constraints of ERISA's existing text and doctrinal framework. At least two Justices are clearly unhappy with the state of the law in this area, but felt compelled to join the Court in this case: Justice Ginsburg concurred separately (joined by Justice Breyer) to urge Congressional or judicial revision of the Court's result.[21] Justice Ginsburg's is an express message to Congress, but in a larger sense the full ruling in *Aetna* is properly viewed as an institutional signal from the Court to Congress. In theory, every one of the Court's subconstitutional decisions has this dialogic function, since Congress can, and occasionally does, revise the Court's statutory interpretation choices. But there is reason to think that the judicial message here is one that will have particular resonance with Congress. In terms of the vertical allocation of authority over managed care in the American federal system, the Court has subtly reversed the course of some prior Terms, and made it quite clear that the problem of managed care liability is one for the federal government alone. Given the continuing public distrust of managed care organizations, this grant of remedial exclusivity to Congress carries with it a burden to act to improve the presently inadequate ERISA remedies. The mainstream press, and some members of Congress, have already taken note of this fact, and called for revival of some of the patients' rights proposals of past sessions.[22] Herein lies *Aetna's* greatest potential impact. By shifting the equilibrium point of managed care regulation from a shared federal-state enterprise to one that is (in this area, at least) exclusively federal, the Court has put more immediate pressure on federal government actors to come forward with concrete solutions to public concerns about managed care decision-making.

It is almost assured that *Aetna's* result – and public critique of it – will spur renewed debate in Congress about managed care regulation. And once opened, it is possible that such debate will sweep even more broadly to include discourse on other hot button issues like universal access, prescription drug costs, and general medical malpractice reform. What is much less certain is that Congress will succeed in enacting new remedial legislation. Experience with the Clinton health plan a decade ago and the patients' rights proposals of more recent years has demonstrated that even measures with strong ini-

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tial momentum can founder in the complex institutional setting of federal lawmaking.[23] Well-organized interest groups abound on all sides of the managed care question, ready to block proposals viewed as undesirable.

If Congress again fails to act, a final intriguing question about the *Aetna* decision is the extent to which the Supreme Court and other federal courts will themselves endeavor to correct the evident failings of ERISA's remedial scheme. Justice Ginsburg's message to Congress contained an alternative suggestion, in which she declared that "this Court" might revisit the substantive content of ERISA's remedy if Congress did not.[24] The current rule against consequential damages in ERISA actions is compelled more by the Court's own holdings than by ERISA's plain text, and there is significant intellectual support for a judicial construction of ERISA that would permit a more complete damages recovery.[25] Absent timely legislative correction the Supreme Court may take a fresh look at the turn in its own jurisprudence that narrowed ERISA's remedial force. Such judicial revision, of course, would be unnecessary if Congress itself expressly modifies ERISA. Either way, *Aetna* is unlikely to be the last word on managed care liability.

Concluding Thoughts on *Aetna* and Other Cases

In *Aetna v. Davila,* the Court has issued a decision that will certainly create institutional debate, probably result in federal legislative or judicial action, and possibly produce a very different regime of managed care regulation than the immediate status quo. This potential for broad prospective impact makes it one of the important decisions the Court issued in the past year. Other rulings made more specific impact in areas touching on health policy. For instance, in *General Dynamics Land Systems v. Cline,*[26] a divided Court held that the Age Discrimination in Employment Act did not bar discrimination against younger workers in the provision of health benefits. Just as *Aetna's* preemption of state law liability for ERISA managed care plans offers employers the prospect – in the short term, at least – of some cost reduction, *Cline* gives employers the flexibility to control costs by reducing health insurance benefits for younger employees. It may be that the Court took account of the rising health insurance costs employers face[27] in reaching its decisions in these cases. What is certain is that the Court in *Aetna* assured a even more prominent role for the federal government, and perhaps the Court itself, in the next decade's debate over managed care regulation.

References

1. See Hamdi v. Rumsfeld, 124 S.Ct. 2633 (2004) (emphasizing due process rights of citizens detained in the war on terror declaring that "a state of war is not a blank check for the President when it comes to the rights of the Nation's citizens"); Rasul v. Bush, 124 S.Ct. 2686, 2692-99 (2004) (holding that United States courts have jurisdiction to consider the legality of detention of foreign nationals captured abroad and held at Guantanamo Bay).
2. See Blakely v. Washington, 124 S.Ct. 2531 (2004). *Blakely* held that the U.S. Constitution requires a jury determination of certain types of sentencing enhancements, a decision that had caused several lower federal courts to conclude that aspects of the U.S. Sentencing Guidelines are unconstitutional, a development with potentially cataclysmic impact on federal law enforcement. The Supreme Court recently agreed to hear two of these lower court decisions this fall. See United States v. Booker, 2004 WL 1713654 (Aug. 2, 2004) (grant of certiorari); United States v. Fanfan, 2004 WL 1713655 (Aug. 2, 2004) (same).
3. 124 S.Ct. 2488 (2004). The decision discussed here addressed two consolidated cases, respectively styled *Aetna Health, Inc. v. Davila* and *Cigna HealthCare of Texas, Inc. v. Calad.* The legal questions that the two cases presented to the Court were identical.
4. See generally M. Gregg Bloche, "One Step Ahead of the Law: Market Pressures and the Evolution of Managed Care," in M. Gregg Bloche, ed., *The Privatization of Health Care Reform* (New York: Oxford University Press, 2003), at 28-31 (explaining how health plans responded to physician and consumer pressures by "backing away from aggressive preauthorization review").
5. See B. Strunk & J. Reschovsky, "Kinder and Gentler: Physicians and Managed Care, 1997-2001," *HSC Tracking Report from Community Tracking Study,* No. 5, Nov. 2002.
6. See Texas Civ. Prac. & Rem. Code Ann. Sec. 88001-88.003 (2004 Supp.).
7. See 29 U.S.C. §§1001-1461 (2004).
8. See 29 U.S.C. §1144(a) (2004).
9. See 536 U.S. 355 (2002).
10. 538 U.S. 329 (2002).
11. See 530 U.S. 211 (2000).
12. See *id.* at 236.
13. See Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc., 519 U.S. 316, 335 (1997) (Scalia, J., concurring).
14. 124 S.Ct. at 2486 (quoting *Metropolitan Life Ins. Co. v. Taylor,* 481 U.S. 58, 65-66 [1987]).
15. 29 U.S.C. §1132(a)(1)(B).
16. See Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54-56 (1987); see also Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 143-45 (1990).
17. See *id.*
18. See R. Epstein and A. Sykes, "The Assault on Managed Care: Vicarious Liability, ERISA Preemption, and Class Actions," *Journal of Legal Studies* 30 (2001): 625, 641-42 (explaining that "it is not difficult to fashion an argument that this current ERISA remedy is inadequate").
19. See 124 S.Ct. at 2501.
20. See B. Strunk and J. Reschovshy, "Kinder and Gentler," supra note 5.
21. See 124 S.Ct. at 2503.
22. See, *e.g.,* Kaiser Daily Health Policy Report, June 22, 2004 (noting reintroduction of patients' rights legislation in the House of Representatives in response to *Aetna*).
23. On the institutional dynamics contributing to the failure of the Clinton health plan, see J.P. Ruger, *Aristotelian Justice and Health Policy: Capability and Incompletely Theorized Agreements* (Cambridge, MA: Doctoral Dissertation, Harvard University, 1998).
24. See 124 S.Ct. at 2504.
25. See J. Langbein, "What ERISA Means By 'Equitable': The Supreme Court's Trail of Error in Russell, Mertens, and Great-West," *Columbia Law Review* 103 (2003): 1317-66.
26. See 124 S.Ct. 1236 (2004).
27. See J. Gabel et al., "Health Benefits in 2003: Premiums Reach Thirteen-Year High as Employers Adopt New Forms of Cost-Sharing," *Health Affairs* 22, no. 5 (2003):117-126.