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

The Supreme Court Federalizes Managed Care Liability

Theodore W. Ruger

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 powersassertively proclaimed that even a dire emergency was no “blank check” for the executive branch to evade judicial review. 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. 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 (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 health 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.

But this transition to a “kinder, gentler” managed care 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.

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. 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.8 The Texas liability statute was the “statutory text provides an illusory [preemption] test,” unless the is was willing to decree a degree of preemption that no sensible person could have intended.9

**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 an 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, whenever 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 THCLAs’s character as a remedially 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 deficieny 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.27 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 deny care would still profit so long as only a fraction of beneficiaries actu-
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 ERISAs 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.19 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

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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 restructing 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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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-
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.

made more specific impact in areas touching on health policy. For instance, in General Dynamics Land Systems v. Cline, 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 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.

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

References


2. See Blakey v. Washington, 124 S.Ct. 2531 (2004). Blakey 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. 2486 (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.


12. See id. at 236.


15. 29 U.S.C. §132(a)(1)/B


17. See id.


19. See 124 S.Ct. at 2501.


21. See 124 S.Ct. at 2503.


24. See 124 S.Ct. at 2504.

