



SUMMARY OF ORAL ARGUMENTS

DATE: March 23, 2004

COURT: United States Supreme Court

CASE: *Aetna Health Inc. v. Davila and Cigna Healthcare, Inc. v. Calad*

On Tuesday, March 23, 2004, the United States Supreme Court heard oral arguments in two related cases involving the issue of ERISA preemption of state tort law claims in the medical malpractice context: *Aetna Health Inc. v. Davila and Cigna Healthcare, Inc. v. Calad*. At issue is whether the remedies available under state medical malpractice laws or the federal remedies available under ERISA should govern when an insurance company makes a benefits decision that involves medical judgment. From the Council's perspective, the oral arguments seemed to go very well. Miguel Estrada, counsel for Aetna and Cigna, expertly argued points consistent with an employer- plan sponsor's position in the case. The general tone of the questions by the Justices seemed to favor Aetna and Cigna's position as well. The majority of their comments focused on the fact that the plan was not making medical treatment decisions (which would subject the plan to the Texas liability statute), but rather was making decisions about whether the plan would *pay* for a certain medical treatment (i.e., a *benefits* determination subject to ERISA.) Also appearing before the Court were attorneys for the plaintiffs, the U.S. Solicitor General's office, and the state of Texas.

Mr. Estrada began the oral arguments. Justice O'Connor first drew a distinction between complete preemption under ERISA Section 502(a) and conflict preemption under Section 514. Mr. Estrada argued that, in this case, Section 502 completely preempts the Texas statute. Justice Stephens asked many questions about the nature of the preemption and what types of challenges would be preempted. Justice Kennedy noted that the line between treatment and benefits decisions blurs around the edges if the person has no other money; in that case the benefits decision becomes a treatment determination. Mr. Estrada reminded the Court that the purpose of an employee benefit plan is to provide some benefits for employees. In the case of a medical plan, a determination about the scope of coverage will always include some medical factors. In fact, Department of Labor (DOL) regulations require that if a plan denies coverage for a treatment, the administrator must turn to a plan fiduciary who must consult with a medical professional. He also noted that there is a difference between a doctor-patient

relationship and an insurer-insured relationship. If a person uses medical judgment to make a plan benefit determination, we do not sue that person for his medical judgment. That person merely made a decision about whether the plan would pay or not pay.

Justice Stevens seemed concerned with the facts in the *Calad* case. He noted that the plan had the discretion to authorize a second day of hospital care if necessary in the administrator's medical judgment, and that it was clear that medical judgment was required. Mr. Estrada noted that Calad or her doctor could have appealed the decision but they did not. Justices Stevens, Ginsburg, and O'Connor asked questions about the nature of a "medical necessity" determination. However, Justice Ginsburg noted that "medical necessity" is a coverage term, not a medical term. Mr. Estrada added that the American Medical Association's Code of Ethics prohibits a doctor from being swayed by the existence or lack of coverage.

Mr. Estrada also emphasized that policy considerations and intent of Congress when adopting ERISA were to encourage employers to provide care to the extent they can. There are very few federal requirements to provide benefits if an employer chooses to sponsor a plan. The purpose of ERISA was to encourage employers to sponsor plans and Congress limited liability to help create predictability for employers.

Justice O'Connor asked whether, under ERISA, there was any way for a plaintiff to recover any money for pain and suffering. The Court in *Great West* held that ERISA only contemplated remedies in equity. Justice Ginsburg noted that because Aetna and Cigna were fiduciaries they are also trustees. Therefore, it might be possible in equity to create a remedy for make whole relief. Justice Breyer noted that, if that were possible, it might provide the plaintiffs in this case with a remedy. If the Court finds that ERISA preempted the claims, the effect is that the plaintiffs would get nothing. This make whole solution might help fill that hole.

The Justices continued exploring the possibility of make whole relief with Mr. Feldman of the Solicitor General's office. Justice Stevens also asked many questions about the fact that there was no time for Calad to appeal the benefits determination. Mr. Feldman disagreed. First, Calad was told in advance that her hospital stay would only be for one day. In addition, DOL regulations provide for determinations to be made as soon as possible, appeals can be made orally, and they can be made by the doctor on the participant's behalf. The other safeguard is the doctor-patient relationship; the decision about when the doctor determines, in his medical judgment, that the patient is ready to be released from the hospital is separate from any decision made by the plan.

Justice Stevens asked whether Texas was denied all ability to provide a remedy. Mr. Feldman replied that the state may provide remedies for the treatment decisions and/or medical ethics. However, that is not this case.

Justice Ginsburg asked what would happen if Davila couldn't pay for the more expensive drug. Mr. Feldman responded that Davila took the drug for several weeks in which there was time to appeal the decision. In addition, Texas law provides an external review provision of which Davila did not avail himself. The ERISA issue is simply one of a benefits determination. States may govern the doctor-patient relationship but may not extend remedies to situations governed by ERISA Section 502.

Mr. Young argued on behalf of Davila and Calad. Mr. Young began his arguments with the point that a plan, such as an HMO, can use whatever medical standards it wants (such as those of a witch doctor, he claimed) as the basis for medical judgments. Justice Scalia was quick to challenge that all the plan did was decide that the plan would not *pay* for the treatment (the drug Vioxx in Davila's case). The plan did not decide which drug the patient could have; the patient had the right to buy whatever drug he and his doctor decided was appropriate.

Justice Breyer asked whether, if the state is trying to fill a hole, there is a hole perhaps because the Court interpreted ERISA wrongly and the state is trying to fill that gap. Mr. Young responded that the Texas statute requires a duty of care by the plan. Justice Souter noted that the Texas statute requires a standard of care, but the plan is not providing care, it is providing money.

Chief Justice Rehnquist moved the discussion to one of complete v. conflict preemption under *Pilot Life*. Justice Souter summarized the circular argument the attorney was making: if *Pilot Life* doesn't apply, there would be complete preemption under ERISA Section 502. However, because the Texas statute says the plan is practicing medicine, the state can say it is regulating insurance, and under the ERISA insurance savings clause the statute will not be preempted by ERISA.

Mr. Young then turned his attention to the timing of the plan's benefit decisions. If the plan made the decision after the fact, it would look like a decision to pay money. However, because the plan makes its decision earlier in the process, he argued the plan is trying to influence treatment. Justice Scalia argued that Aetna does not care which drug Davila took. It is the patient that wants to know the decision early so he can work with his doctor to determine which drug to take. Justice Souter seemed to agree with this point.

Justice O'Connor asked about the application of *Pilot Life*. Mr. Young responded that that case only applies in a very narrow circumstance. Justice O'Connor replied that she thought this case was that narrow circumstance. The effect would be complete preemption under ERISA. Justice Souter continued that the touchstone of *Pilot Life* is a denial of benefits, which is exactly this case. Mr. Young argued that there could be a denial based on the terms of the plan, but that could still violate the state rule. Justice Scalia noted that is exactly why this type of statute is preempted.

Much of Mr. Young's argument turned on the distinction between complete preemption and a statute that could be saved under ERISA's insurance savings clause. Justice Ginsburg noted that the plaintiffs did not make that argument before the Court of Appeals for the Fifth Circuit. Mr. Young said that it was in a footnote in the brief. Mr. Estrada later noted that the argument was not properly included earlier in the case and therefore, under the Supreme Court's rules, could not be argued now.

With the final attorney, who argued on behalf of the state of Texas, Justices Scalia, Breyer, and Rehnquist all continued with similar lines of questioning: the plan was making decisions about whether to pay for a treatment, not whether the participant could receive the treatment. The attorney also tried to draw a distinction between the role of a managed care plan and a plan sponsor. He noted that the Texas statute does not apply to employers or plan sponsors and therefore has no impact on them. The argument was not directly made that when a case like this affects the managed care organization, operating in its role as an administrator of the employer sponsored plan, it will, in effect, impact the employer. Mr. Estrada, however, was able to briefly draw the Court's attention to the employer- administrator relationship by noting that Cigna, in this case, was operating as an administrator for a self-insured plan. In addition, he reminded the Court that in *Pegram* it had acknowledged that there is a contract relationship between a plan and an HMO.

The American Benefits Council filed [an amicus brief](#) in the two cases on December 19, 2003, along with the American Association of Insurance Plans (AAIP, formerly AAHP/HIAA) and the Blue Cross Blue Shield Association. The Council's brief supports the merits of the petitioners' (Aetna and Cigna) arguments that ERISA's remedies and not those under state law apply in such cases. A brief filed by [the Solicitor General of the United States](#) reaches the same conclusion. The Supreme Court is expected to issue its decision in the cases within the next several months, possibly by June 2004. For additional information, please contact [Susan Relland](#), Council health policy legal counsel, or [Paul Dennett](#), Council vice president, health policy, at 202/289-6700.

March 24, 2004