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The Supreme Court Limits Lawsuits Against Managed Care Organizations

Although a win for the managed care industry, the Davila case also is a compromise of sorts and puts the ball back in Congress's court.

by **Timothy Stoltzfus Jost**

ABSTRACT: In *Aetna Health Inc. v. Davila*, the United States Supreme Court revisited the question of whether the Employee Retirement Income Security Act (ERISA) precludes state lawsuits against ERISA plans. The Court held that ERISA preempts damage actions brought against managed care organizations under the Texas Health Care Liability Act because ERISA itself provides the exclusive remedy for challenging ERISA plans' coverage decisions. The Court suggested, however, that health plans might be liable for treatment decisions made by employed physicians. It also volleyed back to Congress the question of whether ERISA beneficiaries should have any remedy for damages caused by coverage decisions.

ON 21 JUNE 2004 THE U.S. SUPREME COURT decided the combined cases of *Aetna Health Inc. v. Davila* and *CIGNA Healthcare of Texas, Inc. v. Calad*, holding that beneficiaries of employment-related managed care plans cannot sue those plans for damages under state law when the beneficiaries have been injured as a result of coverage denial decisions. Justice Clarence Thomas, writing for a unanimous Court, concluded that the remedial provisions of the Employee Retirement Income Security Act (ERISA) of 1974 provide the only judicial remedies available to an ERISA plan beneficiary under these circumstances. *Davila* rounds out a series of Supreme Court decisions examining the roles of federal and state law in overseeing managed care decision making under ERISA. *Davila* effectively insulates employment-related health plans from tort liability for the consequences of their utilization review decisions, provider network limitations, and formulary provisions unless and until Congress decides to act on a managed care bill of rights. The Court leaves open, however, the possibility of state tort suits against managed care plans that deliver treatment directly.

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The Legal Context

The *Davila* and *Calad* decisions were part of a larger case decided by the Fifth Circuit Court of Appeals in 2002 under the title *Roark v. Humana*.¹ All four plaintiffs in that combined case had sued their managed care plans under the Texas Health Care Liability Act (THCLA), which, like statutes in nine other states, authorizes lawsuits for injuries suffered because of negligent managed care plan decisions. Ruby Calad, insured with CIGNA through her husband's work, underwent a hysterectomy with rectal, bladder, and vaginal repair. She was discharged from the hospital after one day pursuant to the decision of CIGNA's discharge nurse, even though her doctor recommended a longer stay. Calad suffered complications requiring a return to the emergency room a few days later, which she claimed were due to her early release. She sued CIGNA under the THCLA, claiming that CIGNA had failed to use ordinary care in making its medical necessity decision and that "CIGNA's system made substandard care more likely."

Juan Davila, who received coverage from Aetna through his employer's health plan, was prescribed Vioxx by his primary care physician for arthritis pain. Aetna required Davila to enter its "step program," using two different medications before it would approve coverage of Vioxx. After three weeks of taking naprosyn (a cheaper pain reliever), Davila was rushed to the emergency room with bleeding ulcers. Davila remained in critical care for five days and was not thereafter able to take any pain medication absorbed through the stomach. Davila sued Aetna under the THCLA, raising claims identical to those raised by Calad.

Both cases were dismissed by the district court, which held that the THCLA claims were completely "preempted" by ERISA. That is, the remedies provided by ERISA's section 502(a) are the only remedies available to plan members for challenging plan decisions, and all alternative or additional state remedies are excluded. The Fifth Circuit Court of Appeals reversed, holding that Davila and Calad were essentially suing their managed care plans for malpractice and that ERISA did not preempt these claims because ERISA itself provides no remedy for malpractice.

The Supreme Court reversed the Appeals Court, reinstating the district court judgments.² The Court held that ERISA's section 502 (29 U.S.C., sec. 1132) indeed provides the exclusive remedy for a plan beneficiary denied coverage by an ERISA plan. Under 502, Davila and Calad could have either paid for the services they needed and sued their plan for the cost of those services, or sued for an injunction to force their plans to pay for the services initially. Their THCLA claims, the Court held, were based on their plans' coverage denials. The THCLA was, therefore, an invalid attempt to provide an alternative or supplemental state remedy for the remedies ERISA provides for improper coverage determinations. The plaintiffs' THCLA claims, according to the Court, should have been removed into federal court, where they should have been dismissed because of ERISA preemption.

The History Of ERISA Preemption

To make sense of the Supreme Court's decision, it is necessary to understand the long and tangled history of ERISA preemption. Congress's primary concern in adopting ERISA in 1974 was with defaults and administrative malfeasance in pension funds, and most of ERISA's provisions address these problems. ERISA governs not only pension plans but also employee welfare benefit plans—including health plans. But ERISA not only subjects employment-related welfare benefit plans to federal regulation, it also largely removes them from state oversight.

Section 514 specifies that the provisions of ERISA shall, except as otherwise provided, “supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.” It further defines “State law” to include “all laws, decisions, rules, regulations, or other State action having the effect of law.” This extremely broad language was added to ERISA at the last minute in conference committee, replacing earlier language that had merely preempted state regulation of subject matters specifically addressed by ERISA.³ It was apparently added at the behest of unions, which were concerned about state taxation and regulation of pension funds and regulation of prepaid legal services plans.

Section 514 of ERISA is, however, subject to several exceptions. Most importantly, it exempts from preemption “any law of any State which regulates insurance, banking, or securities.” This “savings clause,” requested by the National Association of Insurance Commissioners (NAIC), reflects the tradition that insurance regulation is left to the states. The savings clause is also subject to its own exception—the “deemer clause”: “Neither an employee benefit plan...nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer” subject to state regulation under the savings clause.

ERISA preemption is not limited, however, to the express language of 514. Section 502 of ERISA (which was at issue in *Davila and Calad*) allows a participant or beneficiary to sue (1) “to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan”; (2) to compel a plan fiduciary to make good to a plan losses caused by a breach of fiduciary duties; and (3) to obtain an injunction or “other appropriate equitable relief” to enforce ERISA or the terms of a plan. The Supreme Court has held that this “comprehensive and reticulate scheme” of ERISA remedies leaves no scope for the creation of state remedies against ERISA plans and thus preempts any such remedies.

From the outset, the Supreme Court read the preemptive scope of 514 and 502 very broadly. In its first case interpreting 514, the Court held that Congress “meant to establish pension plan regulation as exclusively a federal concern” and that ERISA preempts not just state laws that directly regulate pension plans, but also laws that indirectly affect them.⁴ In its next 514 case, the Court turned to the dictionary to define 514's scope: A law “relates to” a benefit plan “if it has a connection with or reference to such a plan.”⁵ The Court also identified the purpose of

ERISA preemption: to avoid “the need for interstate employers to administer their plans differently in each State in which they have employees.”⁶

Two years later in *Metropolitan Life Insurance Company v. Massachusetts* the Supreme Court interpreted ERISA’s savings and deemer clauses in a case addressing for the first time ERISA’s effect on a law regulating health insurance. The Court held that a Massachusetts statute mandating minimum mental health benefits was a “law which regulates insurance” and was thus saved from preemption and enforceable.⁷ The Court also noted that the “deemer” clause freed “uninsured” (that is, self-insured) plans from state regulation, a position that it developed in later cases.

The Supreme Court set the stage for its interpretation of 502 preemption, and thus eventually for *Davila*, in *Massachusetts Mutual Life v. Russell*.⁸ Russell, a plan beneficiary, had sued her disability insurer claiming that she had been injured because her ERISA plan had wrongfully denied and delayed disability benefits. She sued, claiming compensatory and punitive damages under 502(a)(2), which provides a civil remedy for enforcing another provision of ERISA, section 409(a), which in turn authorizes “such other equitable or remedial relief as the court may deem appropriate” to sanction breaches of fiduciary duty. The Supreme Court rejected her claim, holding that 409(a) does not afford relief to individuals but only provides remedies for the benefit of a plan itself. The Court further held, moreover, that there is no authorization anywhere in 502(a) for individual “extracontractual” damages (that is, damages in excess of the value of the benefits denied), observing:

The six carefully integrated civil enforcement provisions of § 502(a) of the statute as finally enacted...provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly. The assumption of inadvertent omission is rendered especially suspect upon close consideration of ERISA’s interlocking, interrelated, and interdependent remedial scheme, which is in turn part of a “comprehensive and reticulated statute.”⁹

The Court confronted the ramifications of 502’s comprehensive remedial scheme for preemption of state law in 1987 in *Pilot Life Insurance Company v. Dedeaux*.¹⁰ *Pilot Life* also involved a claim against a disability insurer for “mental and emotional distress” and “punitive and exemplary damages” for wrongful termination of disability benefits. Dedeaux, however, sued under state law for tortious breach of contract because the Court’s decision in *Russell* had blocked access to such damages under ERISA itself. The Court found that 514 preemption applied to this claim and that Mississippi’s bad-faith breach-of-contract law was not “specifically directed” toward the insurance industry and thus not saved from preemption.

The Court could have stopped there. It went on, however, to observe that Congress had intended 502(a) to provide the exclusive remedy for “plan participants and beneficiaries asserting improper processing of a claim for benefits and that varying state causes of action for claims within the scope of 502(a) would pose an obstacle to the purposes and objectives of Congress.”¹¹ Explicating the remedial structure of 502, and citing *Russell*, the Court held that ERISA left no room for state suits for extracontractual damages. The Court claimed that Congress had in-

tended to “displace entirely any state cause of action” and make any ERISA suit “purely a creature of federal law.”¹² The Court suggested that even if Dedeaux’s cause of action had been saved from 514 preemption, it would have still be preempted under 502, because it conflicted with the “clear expression of congressional intent that ERISA’s civil enforcement scheme be exclusive.”¹³

In *Metropolitan Life v. Taylor*, a second ERISA preemption case decided the same day, the Court further applied to ERISA claims a third form of preemption also at issue in *Davila*: “complete preemption.”¹⁴ Under this doctrine, any case that could be brought against an ERISA plan as a 502 benefits claim is a claim “arising under the laws of the United States.” If it is brought in state court, therefore, the defendant can, under settled law of federal jurisdiction, remove the case into federal court, even if ERISA is nowhere mentioned in the plaintiff’s complaint.

By the end of the 1980s, therefore, the Court had established a number of rules governing ERISA preemption and claims: (1) Section 514 broadly preempts any state law that refers to or is connected with an ERISA plan. (2) Section 514’s “savings clause” saves from preemption state laws that regulate insurance. (3) Self-insured plans are not subject to state insurance regulation. (4) State law claims directed at ERISA plans that could be brought as claims for benefits are preempted by Section 502 and can be removed into federal court, where they will be dismissed. (5) ERISA itself does not provide any “extracontractual” damages for injuries caused by claim denials.

Challenges To The Preemption Paradigm

The 1990s brought two challenges to this paradigm. First, the nature of health care benefits began to change dramatically. Although prepaid health care had existed in 1974, the predominant model of health insurance through much of the 1980s provided retroactive fee-for-service reimbursement for services provided. ERISA benefit cases were essentially disputes over whether an ERISA plan, a provider, or a patient would be stuck with the cost of a service already rendered.

As the 1990s progressed, employee health benefit plans became managed care plans. Claims disputes were no longer arguments about payment for a service rendered but rather about whether the service would be provided at all or in a timely fashion. This was most obviously true in staff-model health maintenance organizations (HMOs), where staff physicians decided which services to provide to patients, but it was also true when utilization reviewers refused to approve coverage for a proposed procedure or for a continued hospitalization, or when network limitations delayed access to services or steered patients to inferior or inappropriate providers or products. The traditional 502 remedy—recovery of the cost of the service denied—became woefully inadequate when the injury the patient suffered was not a denial or payment but rather loss of life or permanent disability because a plan had refused to provide or approve necessary care.

Under state tort law, managed care plans could be held responsible for injuries

suffered by their members from negligent coverage decisions.¹⁵ When ERISA beneficiaries sued their plans in state court, however, the cases were removed into federal court under the complete preemption doctrine and then dismissed altogether because 514 preempted all state laws governing ERISA plans, 502 preempted all state remedies against them, and ERISA itself provided no remedy for damages beyond the cost of the denied service.¹⁶ Lower courts were outraged by their inability to redress serious injustices, but ERISA's rules seemed clear.¹⁷

At the same time, the Supreme Court began to awaken to the ramifications—and limits—of its ERISA preemption jurisprudence. In *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers*, the Court confronted a state hospital rate regulation scheme that required hospitals to charge lower rates to Blue Cross plans than to commercial or self-insured plans.¹⁸ Acknowledging that the scheme clearly “related to” ERISA plans, the Court recognized that it also fell within the scope of traditional state health care regulation. Quoting Henry James for the proposition that “really, universally, relations stop nowhere,” the Court abandoned a literal reading of 514 and focused on its purpose. It held that state laws that only indirectly affect benefit plans are not preempted by ERISA unless the economic consequences for those plans are too “acute.”

In 2000 and 2002 the Court in *Pegram v. Herdrich* and *Rush Prudential HMO, Inc. v. Moran* directly confronted the implications of ERISA for managed care. In *Pegram*, the Court rejected a frontal attack on managed care, holding that the physicians in a physician-owned and -operated HMO were not acting as ERISA-plan fiduciaries in making decisions that involved both coverage and treatment and thus were not obligated under ERISA to make such determinations “solely in the interest” of plan beneficiaries. The Court observed *in dicta* that such decisions might be subject to state malpractice law, a traditional state domain preserved from preemption by *Travelers*.¹⁹ In *Moran*, however, the Court held that state laws subjecting ERISA plans' decisions to external review were saved from preemption because the laws regulated insurance.²⁰

At the same time, the lower courts, confronted with cases brought by ERISA beneficiaries who claimed to be suffering the consequences of negligent managed care treatment decisions, tried to find a way to provide a remedy. Even before *Travelers*, it seemed clear that doctors could not escape malpractice liability simply by working for ERISA HMOs. It was a small stretch to hold ERISA HMOs liable vicariously for the malpractice of their professional employees or of professionals who they had led their members to believe were their agents.²¹ In its path-breaking decision in *Dukes v. U.S. Healthcare*, the Third Circuit Court of Appeals went further, holding that state tort claims challenging ERISA plans' treatment decisions affecting the “quality” of care provided to beneficiaries were not preempted, even though claims challenging coverage decisions affecting the “quantity” of care were.²² Following the Court's decision in *Pegram*, some courts went further yet, holding that at least some “mixed” ERISA-plan decisions involving coverage of

treatment options were subject to state negligence lawsuits.²³

When confronted with situations where ERISA-plan beneficiaries claimed simply that they had been injured by their plans' utilization review decisions denying or delaying coverage for particular procedures or denying access to nonnetwork providers, most courts held that state tort remedies were preempted by Sections 502 or 514 of ERISA.²⁴ *Pilot Life's* reading of 502 blocked the use of state tort remedies against ERISA plans for decisions involving only benefit determinations. This result was very troubling to the courts because, as several judges noted in concurring or dissenting opinions, the Supreme Court's position that ERISA itself provided no federal cause of action for extracontractual damages caused by negligent plan decisions (a reading of the statute that was far from necessary) left aggrieved ERISA beneficiaries with neither federal nor state relief.²⁵

The Fifth Circuit's *Davila* decision tried to cut the Gordian knot. It simply held that because 502 does not provide a tort remedy against managed care plans, it does not block the states from doing so. The Supreme Court decision, however, held that *Pilot Life* is still good law and that claims that could be brought against ERISA plans as claims for benefits under 502 can be removed into federal court, where any state claims that supplement or supplant the basic claim for benefits under 502 must be dismissed. The opinion was written by Justice Thomas, who had dissented in *Moran* and seemed eager in *Davila* as well to protect employers from burdensome state regulations.

The Court rejected all of the reasons given by the Fifth Circuit for evading preemption. Specifically, it held that it did not matter that the THCLA purported to "create cause of action" for failure to exercise ordinary care, because the THCLA in fact simply created an alternative remedy for a coverage denial. Any injury caused by the plan resulted from a coverage decision, not a treatment decision, and thus had to be redressed, if at all, under ERISA. It did not matter that the Texas law regulated insurance and thus was saved from 514 preemption, since 502 independently preempts alternative or additional state remedies. Most importantly, the Court distinguished *Pegram*, in which it had suggested that mixed eligibility and treatment decisions might be subject to state regulation, or even malpractice litigation. The Court noted that *Pegram* involved a physician-owned and -operated HMO and that the physicians in *Pegram* were acting as treating physicians as well as benefit administrators. The Court noted that in the *Davila* and *Calad* cases, where the decisionmakers were neither treating physicians nor their employers, coverage decisions were pure eligibility decisions, governed by ERISA and not subject to state malpractice law.

Issues Resolved And Unresolved

Davila clarifies a great deal, although it also leaves some questions unresolved. First, it draws a clear line between managed care plans that are owned and operated by treating physicians or provide care through their own employed physi-

cians, and plans that merely impose coverage constraints on independent providers through coverage rules or decisions. The former are subject to direct and vicarious liability under state malpractice law; the latter are protected from state tort liability by ERISA. This distinction mirrors the quality/quantity distinction recognized in *Dukes*, but it focuses on the relationship of the decisionmaker to the patient rather than on the nature of the decision. This will create yet another incentive for employers and managed care plans to move away from tighter staff-model HMOs to preferred provider organizations (PPOs) and looser HMO or point-of-service (POS) arrangements.²⁶ This trend has already been under way for some time for other reasons but is likely to become even stronger after *Davila*.

Second, *Davila* makes excruciatingly clear that as to plans that do not provide care through their own professionals, to quote Justice Ruth Bader Ginsburg's concurring opinion, "a 'regulatory vacuum' exists: [V]irtually all state law remedies are preempted but very few federal substitutes are provided."²⁷ If one believes that managed care organizations, like everyone else, should be legally accountable when they injure others and that legal responsibility can deter ill-considered actions, this situation is problematic.

Third, *Davila* clarifies what the Court sees as the limits that ERISA places on the regulation of health plans. In *Moran*, a narrow majority of the Court went out on a limb in terms of ERISA precedent to uphold state external review statutes. *Davila* also refers approvingly to the recently implemented Department of Labor ERISA claims regulations, which impose internal claims appeals procedures on ERISA plans. A majority of the Court has concluded, however, that internal and subsequent external claims review, supplemented by the possibility of a federal judicial review of coverage denials under 502, is all the relief ERISA allows.²⁸

Fourth, *Davila* clarifies that ERISA plan administrators are "fiduciaries" with respect to coverage decisions. This is not necessarily helpful for beneficiaries. Although fiduciaries should discharge their duties "solely in the interest of plan participants and beneficiaries," *Pegram* recognized that ERISA administrators can have mixed allegiances and must sometimes consider the interests of the plan or employer who established it.²⁹ Also, unless the Court abandons its earlier precedents prohibiting individual damage recoveries for the breach of ERISA fiduciary duties, this holding will do little to help specific beneficiaries.

This raises a fifth issue presented by *Davila*: the possibility of the Court's allowing broader damages under ERISA itself. This idea has been put forward by a number of lower court judges in concurring and dissenting opinions, as well as by the Solicitor General as *amicus* in *Davila* itself. The possibility of revisiting this issue was left open by the Court's footnote seven, which noted the issue but stated that it was not before the Court. It was also enthusiastically endorsed in a concurring opinion by Justice Ginsburg. The fact that only Justice Stephen Breyer joined her in this opinion, however, strongly suggests that a majority of the Court does not share her enthusiasm for revisiting this issue.

Looking To Congress For The Policy Resolution

This leads to the final ramification of *Davila*. If anyone is going to permit tort actions to be brought against managed care organizations, it will have to be Congress. Congress can amend ERISA and indeed seemed to be very close to doing so in September 2001 before Osama bin Ladin changed the subject. President George W. Bush presided over the enactment of the THCLA as governor of Texas (although he let it become law without his signature) and advocated its adoption as a national model in the 2000 debates. But he seems unlikely to advocate a tort remedy against managed care plans in his 2004 reelection campaign. Imposing liability on managed care plans would also seem to run counter to the current drive to cap liability against physicians. Perhaps even more importantly, times have changed, and market forces operating in the shadow of the law may have brought about a kinder, gentler form of managed care that litigators who brought cases like *Davila* had hoped would be brought about by the courts (although this offers little comfort to those like Davila and Calad who were injured in the past by managed care decisions).³⁰ If employers move toward consumer-driven health care, plans' liability could be even less salient as a political issue. Most importantly, policymakers seem more concerned about the possibility of employers' dropping insurance coverage—which many argue would be exacerbated by the higher costs imposed by plan liability—than about protecting ERISA-plan beneficiaries from rationing decisions. Thus, congressional action does not seem likely.

Davila is unlikely to be the Supreme Court's last word on ERISA. The Court may revisit the question of the availability of extracontractual remedies under ERISA, as Justice Ginsburg urges it to. And the Court's characterization of utilization review decisions as fiduciary decisions leaves open questions as to the scope of judicial review of those decisions.³¹ But *Davila* may well represent a final resolution of sorts for the basic conundrums of ERISA preemption. Under the savings clause, states are largely free to regulate the terms and conditions of insured ERISA plans, although they cannot regulate self-insured plans. The states may not, however, allow ERISA plan members to sue their plans for damages for coverage decisions, except where the coverage decision is made by a treating physician who is employed by the plan. Although *Davila* is clearly a win for the managed care industry, the Court's resolution of the preemption conundrum is also a compromise of sorts, affording some protection to plan beneficiaries but also encouraging employer sponsorship of benefit plans and protecting ERISA plans from tort judgments that would likely drive up premiums. It may very well be the final resolution of the problem of ERISA preemption for some time to come.

NOTES

1. *Roark v. Humana, Inc.*, 307 F.3d 298 (5th Cir. 2002).
2. *Aetna Health Inc. v. Davila*, 124 S.Ct. 2488 (2004).
3. D.C. Schaffer and D.M. Fox, "Semi-Preemption in ERISA: Legislative Process and Health Policy," *American Journal of Tax Policy* 7, no. 1 (1988): 47-69; and L.E. Irish and H.J. Cohen, "ERISA Preemption: Judicial Flexi-

- bility and Statutory Rigidity,” *University of Michigan Journal of Law Reform* 19, no. 1 (1985): 112–163.
4. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1980).
 5. *Shaw v. Delta Airlines*, 463 U.S. 85, 96–97 (1983).
 6. *Ibid.*, at 105.
 7. *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724, 740–744 (1985).
 8. 473 U.S. 134 (1985).
 9. *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 146 (1985).
 10. 481 U.S. 41 (1985).
 11. *Ibid.*, at 52.
 12. *Ibid.*, at 56.
 13. *Ibid.*, at 57.
 14. 481 U.S. 58, 63–67 (1987).
 15. See *Wickline v. State of California*, 239 Cal. Rptr. 810 (Cal. App. 1982); and *Hughes v. Blue Cross of Northern California*, 263 Ca. Rptr. 85 (1989).
 16. See *Corcoran v. United Healthcare, Inc.*, 965 F.3d 1321 (5th Cir. 1992).
 17. This rage is perhaps clearest in the eloquent decision of Judge William Young in *Andrews-Clarke v. Travelers Insurance Company*, 984 F.Supp. 49 (D. Mass. 1997).
 18. 514 U.S. 645 (1995).
 19. *Pegram v. Herdrich*, 530 U.S. 211, 235–237 (2000).
 20. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 378 (2002).
 21. *Estate of Frappier v. Wishnov*, 678 S.O.2d 884 (Ct. App. 1996).
 22. 57 F.3d 350 (3d Cir. 1995).
 23. *Cicio v. Does I–8*, 321 F.3d 83 (2003); and *Pappas v. Asbel*, 564 Pa. 407, 786 A.2d 1089 (Pa. Sup. Ct. 2001).
 24. *Pryzbowski v. U.S. Healthcare*, 245 F.3d 266 (3d Cir. 2001) (sec. 502); *Haynes v. Prudential Health Care*, 313 F.3d 330 (5th Cir. 2002) (sec. 514); *Marks v. Watters*, 322 F.3d 316 (4th Cir. 2003) (sec. 502); *DeFelice v. Aetna U.S. Healthcare*, 346 F.3d 442 (3d Cir. 2003) (sec. 502); *Thompson v. Gencare Health Systems, Inc.*, 202 F.3d 1072 (8th Cir. 2000) (sec. 502); and *Howard v. Coventry Health Care of Iowa*, 293 F.3d 442 (8th Cir. 2002) (sec. 514).
 25. See *Cicio v. Does*, 321 F.3d 83, 105 (2d Cir. 2002) (Calabrezi, J., dissenting in part); and *Defelice v. Aetna U.S. Healthcare*, 346 F.3d. 442, 453 (3d Cir. 2003) (Becker, J., concurring). Both cases cited J. Langbein, “What ERISA Means by ‘Equitable’: The Supreme Court’s Trail of Error in *Russell*, *Mertens*, and *Great-West*,” *Columbia Law Review* 103, no. 6 (2003): 1317–1366.
 26. *Davila* also suggests that employers do not have to worry about being held liable for coverage decisions made by employee benefit plan administrators, as they are further removed from treatment decisions.
 27. 124 S.Ct. at 2503, quoting *Defelice v. Aetna U.S. Healthcare*.
 28. It is possible that *Davila* would not bar a state statute subjecting all managed care plans to liability for the negligent treatment decisions of their contracting physicians. Such a law would clearly be preempted by section 514, however, and would probably not be a law regulating insurance saved from preemption. It is also possible that state litigation could be brought after *Davila* claiming that an ERISA plan was negligently designed insofar as it created improper incentives for physicians. These claims have rarely been successful, and the Court in *Pegram* seemed skeptical about plan-design claims against ERISA plans. Also, *Davila* itself involved a negligent formulary design claim, although the Court did not characterize it as such. Finally, lawsuits against plans for negligent selection of providers might still be possible after *Davila*, although, again, these claims could be characterized as challenging coverage determinations.
 29. 29 U.S.C. 1104(a)(1).
 30. M.G. Bloche and D. Studdert, “A Quiet Revolution: Law as an Agent of Health System Change,” *Health Affairs* 23, no. 2 (2004): 29–42.
 31. See P. Jacobson, *Strangers in the Night* (New York: Oxford, 2002), 222–249.