NO. 03-83

IN THE

Supreme Court of the United States

CIGNA HEALTHCARE OF TEXAS, INC.,
Petitioner,

v.

RUBY R. CALAD, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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BRIEF FOR PETITIONER CIGNA HEALTHCARE OF TEXAS, INC.

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QUESTION PRESENTED

Whether § 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a), completely preempts a state-law tort claim seeking damages for an allegedly erroneous determination of entitlement to a benefit under an ERISA-governed health benefit plan when the determination is based in part on the exercise of medical judgment.

PARTIES TO THE PROCEEDINGS BELOW

Petitioner CIGNA HealthCare of Texas, Inc., was defendant-appellee in appeal No. 01-10891 below. Respondent Ruby R. Calad was plaintiff-appellant-cross-appellee in No. 01-10891. The following individuals were parties to two other cases consolidated for argument with No. 01-10891 in the court of appeals. Aetna Health Inc., successor to Aetna U.S. Healthcare Inc. and Aetna U.S. Healthcare of North Texas Inc., defendants-appellees in No. 01-10905 and defendants-appellees-cross-appellants in No. 01-10891; Juan Davila, plaintiff-appellant in No. 10905; Walter Patrick Thorn, plaintiff-cross-appellee in No. 01-10891; Robert Roark and Robert Roark, on behalf of the estate of Gwen Roark, plaintiffs-appellants in No. 01-10831; Humana Inc., Humana Health Plan of Texas, Inc., and Humana HMO Texas, Inc., defendants-appellees in No. 01-10831.

RULE 29.6 DISCLOSURE

The parent of CIGNA HealthCare of Texas, Inc., is CIGNA Corporation, a publicly-traded company.

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BRIEF FOR PETITIONERS

OPINIONS BELOW

The opinion of the court of appeals is reported at 307 F.3d 298 (5th Cir. 2002), and is reprinted in the appendix to CIGNA HealthCare of Texas, Inc.'s Petition for a Writ of Certiorari ("*Calad* Pet. App.") at 1a. The memorandum opinion and order of the United States District Court for the Northern District of Texas denying respondent Calad's motion to remand and dismissing the complaint with prejudice is unpublished and is reprinted at *Calad* Pet. App. 29a.

JURISDICTION

The district court asserted jurisdiction over the plaintiff's claims under 28 U.S.C. § 1331 and the complete preemption effected by 29 U.S.C. § 1132. The court of appeals asserted jurisdiction over the district court's final judgment pursuant to 28 U.S.C. § 1291. The judgment of the court of appeals was entered on September 17, 2002. The court of appeals denied CIGNA's petition for rehearing en banc on April 15, 2003. This Court has jurisdiction under 28 U.S.C. § 1254(1). Because this proceeding challenges the constitutionality of a state statute under the Supremacy Clause of the Constitution, notification required by Rule 29.4(c) has been submitted to the Attorney General of Texas.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the United States Constitution provides: "This Constitution, and the laws which shall be made in pursuance thereof . . . shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any thing in the Constitution or laws of any State to the contrary notwithstanding." U.S. Const. art. VI, cl. 2. The pertinent provisions of ERISA, 29 U.S.C. §§ 1001 et seq., and the Texas Health Care Liability Act ("THCLA"), Tex. Civ. Prac. & Rem. Code Ann. §§ 88.001-.003, are reprinted at *Calad* Pet. App. 47a-67a.

STATEMENT OF THE CASE

Respondent Ruby Calad ("Calad") is the beneficiary of a medical benefit plan sponsored by The Ryland Group ("Ryland"), her husband's employer. J.A. 201. During the relevant period, the plan was called the Flexible Benefit Program of the Ryland Group, Inc. ("Plan" or "Ryland Plan"). J.A. 200. The Plan provided Ryland employees and their beneficiaries certain medical, surgical and hospital care benefits. *Id.* The Ryland Plan is an employee welfare benefit plan governed by ERISA. J.A. 201. Ryland self-insured the Plan and designated itself the Plan Administrator, but in 1999, Ryland delegated certain administrative responsibilities for the Plan to petitioner CIGNA HealthCare of Texas, Inc. ("CIGNA"). J.A. 200, 201, 207, 280-81.

This case arose when Calad sought coverage under the Plan for an extended hospital stay following a surgical procedure. CIGNA, acting in its capacity to administer Plan benefits and to determine whether the Plan covers a particular medical condition or procedure, made an initial determination, in accordance with a discharge protocol, that the Ryland Plan did not cover the additional hospital stay Calad sought. J.A. 184, 295-97. Calad did not appeal that determination within the Plan, but instead filed suit in state court, alleging that CIGNA's benefit determination caused her injury, in the form of stress and unspecified post-surgical complications, which she claims she would not have suffered had CIGNA determined that the Plan covered the additional time in the hospital. Calad asserts that CIGNA failed to exercise "ordinary care" in determining that the Plan would not cover the additional hospital stay. She seeks compensatory and punitive damages from CIGNA. The issue is whether ERISA § 502(a)(1)(B), 29 U.S.C. §1132(a)(1)(B), which provides an exclusive cause of action and remedy for improper denials of employee plan benefits, preempts Calad's state-law tort claim for damages caused by the allegedly improper denial of her benefits.

1. The Ryland Plan provided that 100% of Calad's medical expenses would be paid by the Plan (by Ryland, that is) if the expenses were incurred because of a procedure or treatment recommended by a physician and necessary. The Ryland Plan also provided that 100% of Calad's hospitalization expenses would be paid by the Plan, if – but only if – the hospitalization is "certified" as "medically necessary" by the Plan's claims administrator, CIGNA in this case. The approval process is identified in the Plan as Pre-Admission Certification ("PAC") and Continued Stay Review ("CSR"), which are used "to certify the medical necessity and length of any Hospital Confinement." J.A. 219-20. The Plan specifically excludes expenses for "Hospital charges for Bed and Board, during a Hospital Confinement for which PAC is performed, which are made for any day in excess of the number of days certified through PAC or CSR." J.A. 220. PAC or CSR certification is obtained under the Plan by submitting a claim to the Plan's utilization review organization, contracted by CIGNA and staffed by Registered Graduate Nurses and consultant physicians. J.A. 219, 221. Thus, the "medical necessity" coverage determination under the Ryland Plan is not made by the beneficiary's treating physician, but by the nurses and consultant physicians in the designated review organization.

The Ryland Plan also conferred on beneficiaries "the right to have the Plan review and reconsider [a denied] claim." J.A. 282. In addition, effective September 1, 1999, Texas law guarantees an independent, outside review of any plan's "medical necessity" determinations. Tex. Ins. Code Ann. art. 21.58A, § 6A.

2. According to the facts alleged in her complaint, Calad was admitted to the hospital for a hysterectomy on September 9, 1999. She alleges that her treating physician recommended a stay in the hospital after her surgery of more than one day, but that, after pursuing the Ryland Plan's PAC and CSR procedures with a CIGNA administrator, she was in-

formed that CIGNA had authorized coverage for only a 24-hour stay unless complications arose from the surgery.

Although Calad had the right to appeal this determination within the Plan, including the right under state law to obtain an outside determination as to whether an additional stay in the hospital was "medically necessary," Calad did not invoke any of these procedures. She alleges that she was unable to incur the expense of a longer stay herself, and so, after the full day in the hospital covered by the Plan, she went home.

A few days after her release, Calad alleges that she returned to the emergency room suffering stress and unnamed complications from the surgery. Calad attributes emotional and physical injuries to CIGNA's determination that her plan entitled her to no more than one post-operative day in the hospital.

3. a. Calad sued CIGNA in Texas state court under the Texas Health Care Liability Act ("THCLA"), Tex. Civ. Prac. & Rem. Code Ann. §§ 88.001-88.003. That statute imposes a duty on HMOs "to exercise ordinary care when making health care treatment decisions" and creates a cause of action for damages for "harm to an insured or an enrollee" proximately caused by the failure to exercise ordinary care. *Id.* § 88.002(a). Calad asserted a negligence cause of action under the statute, alleging that CIGNA had failed to use ordinary care in making its medical necessity determinations. Her complaint sought compensatory damages for lost earnings, pecuniary loss, physical pain, and mental anguish, as well as punitive damages.

b. CIGNA removed the case to federal district court on December 11, 2000, asserting that Calad's claims were completely preempted by ERISA and were therefore removable based on the district court's federal question jurisdiction. Calad's motion to remand was denied. The district court concluded that Calad was effectively challenging a plan benefit determination and that relief was therefore available

exclusively under ERISA's remedial provision, § 502(a), 29 U.S.C. § 1132(a). *Calad* Pet. App. 40a. Because Calad informed the district court that she would not amend her pleading to bring an ERISA claim, J.A. 298, the court dismissed her complaint. Calad appealed.

c. The Fifth Circuit consolidated Calad's appeal for argument with several other removed actions, including *Aetna Health Inc. v. Davila*, No. 02-1845, and reversed. *Calad* Pet. App. 2a. The court held that because tort damages for medical malpractice were not available under ERISA § 502(a), Calad's THCLA claim did not "duplicate" § 502(a) remedies and thus was not preempted. *Id.* at 19a. The court therefore found that Calad's claims did not arise under federal law, as required for removal jurisdiction, and ordered the case remanded to state court for adjudication of Calad's THCLA claim. *Id.* at 20a.

d. This Court granted certiorari on November 3, 2003, and consolidated this case with No. 02-1845.

SUMMARY OF ARGUMENT

I. ERISA protects employees' rights under pension and welfare benefit plans by establishing an integrated system of federal civil actions designed to enforce such rights. ERISA § 502(a), 29 U.S.C. § 1132(a). One element of that system is a federal cause of action to enforce the right to benefits under a plan. ERISA §502(a)(1)(B), 29 U.S.C. §1132(a)(1)(B). The sole monetary remedy a court may provide in such an action is the benefit itself; other remedies for wrongful benefit denials, such as consequential or punitive damages, are not allowed. In *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), this Court held that the remedies Congress devised to protect employee rights under benefit plans, including especially the right to the benefits themselves, were intended to be exclusive, and thus preempt any state-law claims that purport to provide different or additional remedies for allegedly erroneous benefit denials. In *Metropolitan*

Life Insurance Co. v. Taylor, 481 U.S. 58 (1987), decided the same day as *Pilot Life*, the Court held that the §502(a) remedial scheme not only preempts such state-law claims, but "completely preempts" them, such that any state-law claim subject to *Pilot Life* preemption is effectively converted into a federal claim and becomes the basis for removal by the defendant. The *Pilot Life* preemption rule has been repeatedly reaffirmed by this Court, most recently in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2001). Contrary to the conclusion of the court below, neither *Rush Prudential* nor any other precedent of this Court holds that *Pilot Life* preemption applies only to state-law claims that "duplicate" ERISA claims or provide solely contract remedies.

II. Under a proper reading of *Pilot Life*, Calad's THCLA claim is preempted because it seeks non-ERISA remedies – including consequential and punitive damages – for what she alleges is CIGNA's failure to authorize payment, under the terms of the Ryland Plan, for more than a 24-hour stay in the hospital following her surgical procedure. Calad cannot seriously deny that her claim is one for benefits encompassed by §502(a)(1)(B): when she learned that CIGNA would not authorize payment for an additional hospital stay, she could have taken an appeal under the Plan and then filed a § 502(a)(1)(B) action to compel payment, or she could have arranged for payment up front and then filed a § 502(a)(1)(B) action to obtain reimbursement. It is immaterial that coverage was denied as not "medically necessary"; what matters is that the decision targeted by her THCLA claim is a decision to deny her benefits, as to which § 502(a)(1)(B) prescribes the exclusive remedy.

Pegram v. Herdrich, 530 U.S. 211 (2001), is not to the contrary. Relying on *Pegram*, some courts have concluded that when a plan's decision about benefit coverage includes some element of medical judgment, the coverage decision is transformed from a fiduciary act into a nonfiduciary act, and

therefore may be regulated by states through private causes of action challenging the exercise of medical judgment. But even if the coverage decision were nonfiduciary, it would still be a benefit determination, and state-law claims seeking non-ERISA remedies for allegedly wrongful plan benefit determinations are governed exclusively by § 502(a)(1)(B). Further, *Pegram*'s discussion of fiduciary acts addressed the materially different situation of where the beneficiary's *own treating physician* is also an agent for the HMO and, acting in both capacities, makes a decision that is simultaneously a medical treatment decision and a benefit eligibility determination. In that case the treating physician's decision is nonfiduciary. But when the coverage decision is made solely as part of the plan benefit determination process – which this Court has made clear is a fiduciary process – the decision is fiduciary, even if it is imbued with medical judgment about whether a particular treatment is "medically necessary."

The fact that Calad's THCLA claim is based on the state's interest in regulating health care, an area of traditional state regulation, does not remove it from the ambit of *Pilot Life*. This Court has on several occasions found state laws involving subjects of traditional state regulation preempted where Congress has clearly manifested its purpose that ERISA provide the exclusive remedial scheme. This Court identified just such a purpose in *Pilot Life*, and neither ERISA, nor any precedent of this Court, suggests the existence of some unspoken health-care exemption from § 502(a)'s preemptive force.

III. While the statute and precedents are clear and must control the outcome of this case, it bears emphasis that the policy arguments apparently motivating resistance to *Pilot Life* among some courts are misplaced. Contrary to the perceptions of some, plan beneficiaries have myriad protections under ERISA and its governing regulations, as well as under non-preempted state laws requiring independent review of benefit denials. It is also wrong to say that additional reme-

dies are necessary because HMOs have financial incentives to deny benefit claims. Here, for example, the Ryland Plan is funded by the employer, meaning that Ryland, *not* CIGNA, pays for whatever care CIGNA determines is covered. And even where the HMO does act as insurer, the market imposes numerous incentives to ensure that benefits are granted properly. Nor is it true that the utilization review processes characteristic of managed care lead to increased adverse outcomes for which special tort remedies should be allowed. On the other side of the balance, allowing states to impose varying and unpredictable tort remedies on HMOs for their health plan benefit determination decisions (inviting the less-than-praiseworthy medical malpractice regime into the administration of employee benefit programs, that is) will inevitably increase benefit costs, and just as inevitably decrease the availability of health plan benefits, contrary to ERISA's policy – enforced by *Pilot Life* preemption – of encouraging the provision of benefits by creating a single, uniform system of federal enforcement.

ARGUMENT

Congress enacted ERISA in 1974 as a comprehensive statute designed "to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) (internal quotation marks omitted). Congress did not choose to mandate the creation of benefit plans, but instead chose to provide procedural protections for the rights of employees and beneficiaries to whatever benefits their employers decide to provide. *See Black & Decker Disab. Plan v. Nord*, 123 S. Ct. 1965, 1970, 1971 (2003). One of the statute's key tools for accomplishing Congress's purpose of securing employee benefit rights is its civil enforcement provision, ERISA § 502(a), 29 U.S.C. § 1132(a). *See Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 52 (1987) (§ 502(a) "is one of the essential tools for accomplishing the stated purposes of ER-

ISA"). Section 502(a) authorizes nine specific civil actions under ERISA, including actions by beneficiaries for breach of fiduciary duty, equitable actions to redress violations of ERISA or enforce provisions of the statute, and actions by beneficiaries to recover benefits due, to obtain declaratory judgments concerning entitlement to certain benefits, and to clarify rights to benefits. *See* 29 U.S.C. § 1132(a)(1)-(3); *see Calad* Pet. App. 47a (setting forth § 502(a) in full).

This Court held in *Pilot Life* that the "detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." *Pilot Life*, 481 U.S. at 54. In view of the importance of this careful balancing of interests to the statute's structure and purpose, in conjunction with other evidence of congressional intent, the Court in *Pilot Life* unanimously concluded that Congress intended for § 502(a) to provide *the exclusive remedies* for the improper denial of benefits and other violations of ERISA. *Id.* at 54-57. Accordingly, the Court held, § 502 necessarily preempts any state law that provides different remedies for an erroneous benefit denial or other ERISA violation. *Id.*

In this case respondent Calad asserts a state-law tort claim seeking compensatory and punitive damages, which are not available under ERISA, as a remedy for what she claims to be CIGNA's negligent failure to authorize payment, under the terms of the Ryland Plan, for the expense of an additional day in the hospital. J.A. 185, 188. As we now demonstrate, this means that her state-law claim is completely preempted under the *Pilot Life* doctrine.

I. UNDER *PILOT LIFE* AND ITS PROGENY, STATE-LAW CONTRACT AND TORT CLAIMS ASSERTING IMPROPER DENIAL OF BENEFITS AND SEEKING NON-ERISA REMEDIES ARE COMPLETELY PREEMPTED

The Fifth Circuit in this case did not make a meaningful effort to distinguish *Pilot Life*. To the contrary, the court all but conceded that, by its terms, *Pilot Life* itself enunciates a rule – that state laws providing ERISA plan beneficiaries with non-ERISA remedies for improper benefit denials are preempted – which would result in preemption of Calad's THCLA claim. *Calad* Pet. App. 18a & n.14. But rather than apply the rule set out in *Pilot Life* itself, the Fifth Circuit read this Court's "most recent word on the matter, *Rush Prudential HMO, Inc. v. Moran*, [536 U.S. 355 (2001)]," as "indicat[ing] that *Pilot Life* does not sweep so broadly." *Calad* Pet. App. 18a-19a. In the court's words:

> We glean from *Rush Prudential* that *Pilot Life*'s rule is a narrow one: States may not duplicate the causes of action listed in ERISA § 502(a). This is, essentially, the test employed for "complete preemption." Because the THCLA does not provide an action for collecting benefits, it is not preempted by §502(a)(1)(B) under *Pilot Life*.

Calad Pet. App. 19a-20a.

Rush Prudential says nothing of the kind. To the contrary, as we explain below, *Rush Prudential* unambiguously reaffirms the *Pilot Life* rule exactly as set forth in *Pilot Life*. None of this Court's precedents supports the Fifth Circuit's conclusion that "the test for complete preemption" is whether the state-law claim "duplicates" an ERISA claim. Nor does any precedent support the Fifth Circuit's related conclusion that complete preemption under §502(a) is limited only to contract claims and remedies analogous to the contract-like claim provided under ERISA § 502(a)(1)(B).

A. *Pilot Life* And *Taylor* Hold That ERISA § 502(a) Establishes The Exclusive Vehicle For Challenging Benefit Determinations And Preempts State Laws That Alter or Supplement Those Remedies

When Congress enacted ERISA in 1974, it deliberately chose not to require employers to establish plans or to provide any particular benefits; whether to establish a plan, and, if so, what kind of benefits to provide, was and is entirely a matter of private choice under ERISA. *See Nord*, 123 S. Ct. at 1971; *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). Rather, what Congress did was to ensure that *if* an employer established a benefit plan, employees' rights under the plan would be secured by a uniform body of federal law, enforceable in federal court. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). Congress recognized that such uniformity in benefit enforcement would indirectly promote the spread of benefit plans, *id.*; as this Court put it recently, ERISA's policy is to "induc[e] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002).

As this Court recognized in its seminal decisions in *Pilot Life* and its companion *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987), the only way to create a "uniform regime of ultimate remedial orders and awards," *Rush Prudential*, 536 U.S. at 379, is both to create a single remedial regime and to preempt any state laws that would affect or alter that regime.

1. *Pilot Life* involved a challenge under Mississippi state tort law to a decision denying an employee long-term disability benefits under an ERISA-governed welfare plan. The employer funded the plan, but Pilot Life processed disability claims and "bore responsibility for determining who would receive disability benefits." 481 U.S. at 43. An employee

sought long-term disability benefits under his employer's plan, but, after a period of coverage, Pilot Life ultimately terminated the benefits. *Id.* The employee sued, but he "did not assert any of the several causes of action available to him under ERISA." *Id.* at 44. Instead the employee stated only state-law claims, primarily tort claims: "Tortious Breach of Contract," "Breach of Fiduciary Duty," and "Fraud in the Inducement." *Id.* at 43. As remedies for those asserted state-law violations, the employee sought compensatory damages, including damages for mental and emotional stress, as well as punitive damages. *Id.* at 43-44.

The Court unanimously held those state-law claims pre-empted by ERISA. As an initial matter, the Court found it obvious that the Mississippi tort claims "'relate to' an employee benefit plan and therefore fall under ERISA's express pre-emption clause, § 514(a)." *Id.* at 47. But the Court did not end its preemption analysis with the mere "relate to" conclusion under § 514, 29 U.S.C. § 1144. The employee in *Pilot Life* asserted that although the Mississippi tort claims fell within the compass of § 514, they were nevertheless "saved" from preemption by ERISA's insurance "savings clause," 29 U.S.C. § 1144(b)(2)(A), which exempts from § 514 preemption any law "which regulates insurance." In explaining why the Mississippi tort laws could not be considered laws "which regulate insurance" within the sweep of the savings clause, the Court identified the "most important[]" factor to be "the clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive," 481 U.S. at 57 – that is, that ERISA § 502(a) displace *any* state-law cause of action that operated to "supplement[] or supplant[]" the remedies detailed in § 502(a), *id.* at 56.

The Court began this analysis by emphasizing the centrality of ERISA's enforcement mechanisms in the statute's overall design for protecting employee benefits. "The civil enforcement scheme of § 502(a)," the Court noted, "is one of

the essential tools for accomplishing the stated purposes of ERISA." *Id.* at 52. Under that scheme,

> a plan participant or beneficiary may sue to recover benefits due under the plan, to enforce the participant's rights under the plan, or to clarify right to future benefits. Relief may take the form of accrued benefits due, a declaratory judgment on entitlement to benefits, or an injunction against a plan administrator's improper refusal to pay benefits. A participant or beneficiary may also bring a cause of action for breach of fiduciary duty, and under this cause of action may seek removal of the fiduciary. In an action under these civil enforcement provisions, the court in its discretion may allow an award of attorney's fees to either party.

Id. at 53. Referring to the Court's earlier decision not to imply punitive damages into this detailed enforcement scheme, *see Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985), the *Pilot Life* Court reaffirmed that "'"[t]he presumption that a remedy was deliberately omitted from a statute is strongest when Congress has enacted a comprehensive legislative scheme including an integrated system of procedures for enforcement."'" 481 U.S. at 54 (quoting *Russell*, 473 U.S. 147 (quoting in turn *Northwest Airlines, Inc. v. Transport Workers*, 451 U.S. 77, 97 (1981))). Applying that presumption to the comprehensive and integrated remedial scheme set forth in § 502(a), the Court concluded that § 502(a) was intended to establish the "exclusive" set of remedies available for the denial of benefits under any ERISA-governed benefit plan, to the exclusion of any and all different or additional remedies states may seek to provide:

> In sum, the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. *The policy choices reflected in the in-*

> *clusion of certain remedies and the exclusion of others would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.* "The six [now nine] carefully integrated civil enforcement provisions found in § 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 deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive.

Id. at 54 (quoting *Russell*, 473 U.S. at 146) (first emphasis added).

In addition to the powerful structural evidence of the exclusive nature – and therefore preemptive force – of ERISA's remedies, the Court further noted that Congress "modeled" § 502(a) on § 301 of the Labor-Management Relations Act ("LMRA"), which had already been held by the Court to "displace all state actions for violations of contracts between an employer and a labor organization, even when the state action purported to authorize a remedy unavailable under the federal provision." *Id.* at 55. Because § 301 had also been construed by the Court as having such preemptive force that it transformed any state-law suit within its ambit into a suit asserting a federal claim, *id.* at 56, the Court concluded that "Congress' specific reference to § 301 of the LMRA to describe the civil enforcement scheme of ERISA makes clear its intention that all suits brought by beneficiaries or participants asserting improper processing of claims under ERISA-regulated plans be treated as federal questions governed by § 502(a)." *Id.* Although Congress expected that a "federal common law of rights and obligations under ERISA-regulated plans would develop," as it had with respect to col-

lective bargaining agreements, the Court explained that Congress's "expectation, indeed, the entire comparison of ERISA's § 502(a) to § 301 of the LMRA, would make little sense if the remedies available to ERISA participants and beneficiaries under §502(a) could be supplemented or supplanted by varying state laws." *Id.*

Accordingly, on the basis of ERISA's comprehensive and integrated remedial structure and Congress's references to LMRA §301, this Court concluded in *Pilot Life* that the Mississippi tort actions seeking to provide additional remedies for allegedly wrongful benefit denials were preempted by ERISA and not saved as laws that regulate insurance.[1]

2. It was *Pilot Life*'s companion case, *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987) – decided the same day and also authored by Justice O'Connor – that confirmed the full force of the *Pilot Life* preemption rule. The complaint in *Pilot Life*, although asserting only state-law claims, had been filed in federal court on the basis of the court's diversity jurisdiction. *Pilot Life* itself thus presented only a question of preemption, not jurisdiction. Like *Pilot Life*, *Taylor* involved state-law contract and tort claims challenging the wrongful denial of disability benefits under an ERISA-governed employee welfare benefit plan. The plaintiff in *Taylor*, however, filed his state-law claims in state court. Thus the Court in *Taylor* faced the jurisdictional issue raised but not answered by the preemption holding of *Pilot Life*: whether state common-law contract and tort causes of action challenging improper benefit denials "are not only pre-empted by ERISA, but also displaced by ERISA's civil enforcement provision, §502(a)(1)(B) . . . to the extent that

[1] *Pilot Life* refers to causes of action for "improper processing of claims," 481 U.S. at 52, but it is clear from the context that "improper processing" includes substantively improper denials. The plaintiff in *Pilot Life* was complaining that his benefits had been wrongfully denied. *See id.* at 43 (suit sought damages for "failure to provide benefits under the insurance policy").

complaints filed in state courts purporting to plead such common-law causes of action are removable to federal court under 28 U.S.C. § 1441(b)." *Taylor*, 481 U.S. at 60. The Court's answer was yes.

The Court began by confirming that "[u]nder our decision in *Pilot Life* . . . Taylor's common law contract and tort claims are pre-empted by ERISA." 481 U.S. at 62. But "ordinarily" preemption is only a "federal defense to the plaintiff's suit," and "[a]s a defense, it does not appear on the face of a well-pleaded complaint, and, therefore, does not authorize removal to federal court." *Id.* at 63. Accordingly, "ERISA pre-emption, without more, does not convert a state claim into an action arising under federal law." *Id.* at 64. On the other hand, the Court noted a "corollary of the well-pleaded complaint rule": "Congress may so completely pre-empt a particular area that any civil complaint raising this select group of claims is necessarily federal in character," and hence removable. *Id.* at 63-64. Before *Taylor*, the Court had recognized such "complete preemption" – i.e., preemption sufficient to confer removal jurisdiction over the pre-empted claims – in only one other circumstance: preemption under LMRA § 301. *Id.* (citing *Avco Corp. v. Aero Lodge No. 735*, 390 U.S. 557 (1968)). Because Congress had modeled ERISA § 502(a) on LMRA § 301, *see supra* at 14-15, the *Taylor* Court concluded that ERISA § 502(a) operates not only to preempt state-law claims challenging improper benefit denials, but also to extend the *Avco* principle of "complete preemption" to such claims. *Id.* at 64-65. In short, Congress "clearly manifested an intent to make causes of action within the scope of the civil enforcement provisions of § 502(a) removable to federal court." *Id.* at 66.

In sum, *Pilot Life* establishes categorically that a state-law contract or tort claim asserting that a benefit under an ERISA-governed plan was improperly denied, and seeking remedies different from or in addition to the exclusive set of remedies set forth in ERISA § 502(a), is preempted by

§ 502(a). *Taylor*, in turn, establishes that the state-law contract and tort claims covered by *Pilot Life*'s categorical preemption rule are not just preempted, they are so completely preempted that a complaint purporting to assert them is rendered necessarily federal in character and subject to removal to federal court.

B. Subsequent Cases Have Confirmed And Reinforced *Pilot Life*'s Categorical Preemption Rule

The categorical preemption rule of *Pilot Life* has been reiterated by this Court in several subsequent decisions.

1. The first is *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990). The plaintiff in that case alleged that his employer had fired him to avoid paying him pension benefits which had been about to vest. He sued in state court, seeking "compensatory and punitive damages under various tort and contract theories." *Id.* at 136. This Court held the plaintiff's tort and contract claims preempted by ERISA in two respects. First, the Court held that they "relate[d] to" the plaintiff's ERISA plan within the meaning of ERISA's express preemption provision, § 514, because the existence of the claims depended on the existence of the ERISA plan. 498 U.S. at 139-40. Second, the Court held that "[e]ven if there were no express preemption in th[e] case," the claims would still be preempted because they "conflict[ed] directly with an ERISA cause of action," specifically, § 510, 29 U.S.C. § 1140, which prohibits adverse employment actions intended to interfere with the attainment of a right provided under a plan. *Id.* at 142-43. Noting that § 510 is among the rights enforceable through § 502(a), the Court repeated the key passage in *Pilot Life* summarizing why § 502(a) preempts state laws and causes of action providing additional remedies for the violation of rights protected by ERISA: "The 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 and beneficiaries were free to obtain remedies un-

der state law that Congress rejected in ERISA." *Id.* at 144 (internal quotation marks omitted). Because the state-law claims would allow the plaintiff to recover compensatory and punitive damages for his wrongful discharge, whereas ERISA's § 502(a) remedies would allow him to recover only equitable relief, the Court held the claims preempted. *Id.* at 144-45.

Of particular importance here, the *Ingersoll-Rand* Court specifically rejected the argument that the wrongful discharge tort was not a claim within the "purview" of § 502(a) (*id.* at 145) because the plaintiff "was *not* seeking lost *pension benefits* but [was] instead seeking lost future wages, mental anguish and punitive damages as a result of the wrongful discharge." *Id.* at 136 (alterations and emphasis in original; internal quotation marks omitted). The exclusivity of § 502(a), the Court explained, does not apply only to actions seeking the literal recovery of benefits. *Id.* at 145. What matters is that "the relief requested here is well within the power of federal courts to provide." *Id.* If Congress chose not to authorize such relief under the statute, that is a policy choice that must be respected and enforced, as *Pilot Life* instructs. "Consequently, it is no answer to a preemption argument to say that a particular plaintiff is not seeking recovery of pension benefits." *Id.*

2. The Court revisited these issues at length in *Rush Prudential*, and reaffirmed and amplified what it called the "categorical preemption" rule of *Pilot Life*. 536 U.S. at 380.

Rush Prudential involved a state law allowing an ERISA health benefit plan beneficiary to appeal a decision by an HMO denying benefits as not "medically necessary" to an independent medical reviewer. The HMO argued, *inter alia*, that the law was preempted by ERISA, as construed in *Pilot Life*, because (said the HMO) the beneficiary's right of appeal to an independent reviewer constituted "a remedy that 'supplement[s] or supplant[s]' the remedies available under ERISA." *Id.* at 378 (quoting *Pilot Life*, 481 U.S. at 56). The

Court rejected that argument, but did not cast doubt on the *Pilot Life* rule. Rather, the Court simply held that, contrary to the HMO's submission, the external review law did not come within the sweep of *Pilot Life* preemption because it did *not* provide an additional remedy for the denial of a benefit. *Id.* at 379-80.

The Court began its analysis of the HMO's *Pilot Life* argument by reiterating the fundamental principle of *Pilot Life*:

> In ERISA law, we have recognized one example of . . . overpowering federal policy in the civil enforcement provisions, 29 U.S.C. § 1132(a), authorizing civil actions for six [now nine] specific types of relief. In *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985), we said those provisions amounted to an "interlocking, interrelated, and interdependent remedial scheme," *id.*, at 146, which *Pilot Life* described as "represent[ing] a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans," 481 U.S., at 54. So, we have held, the civil enforcement provision are of such extraordinary preemptive power that they override even the "well-pleaded" complaint rule for establishing the conditions under which a cause of action may be removed to a federal forum. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S., at 63-64.

Rush Prudential, 536 U.S. at 376. The "state tort and contract claims" (*id.* at 377) in *Pilot Life* were preempted, the *Rush Prudential* Court explained, because they sought "monetary awards" which "were claimed as remedies to be provided at the ultimate step of plan enforcement," but "would have significantly expanded the potential scope of ultimate liability imposed upon employers by the ERISA scheme." *Id.* at 378-79.

The Court then noted that in *Ingersoll-Rand*, it had found a state tort claim of wrongful discharge preempted because, "while state law duplicated the elements of a claim available under ERISA, it converted the remedy from an equitable one under § 1132(a)(3) (available exclusively in federal district courts) into a legal one for money damages (available in a state tribunal)." *Id.* at 379. "Thus, *Ingersoll-Rand* fit within the category of state laws *Pilot Life* had held to be incompatible with ERISA's enforcement scheme; *the law provided a form of ultimate relief in a judicial forum that added to the remedies provided by ERISA*." *Id.* (emphasis added). "Any such provision," the *Rush Prudential* Court emphasized, "patently violates ERISA's policy of inducing employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Id.* (citing *Pilot Life*, 481 U.S. at 56). It was for this reason, the Court explained, that *Pilot Life* erected a "categorical bar" to state laws that provide remedies for benefit denials beyond those provided by ERISA. *Id.* at 381.[2]

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[2] In one passage the Court in *Rush Prudential* described part of *Pilot Life* as "dictum." 536 U.S. at 377. This was *not* a reference to the basic *Pilot Life* "complete preemption" rule so firmly reinforced in *Rush Prudential*. The element of *Pilot Life* to which *Rush Prudential* was referring here is the suggestion that even where a state law is one that "regulates insurance" under the saving clause, it may still be preempted – even though the point of the saving clause is to save genuine insurance laws from preemption – where the remedies conflict as in *Pilot Life*. *See supra* at 12-15. As the *Rush Prudential* Court put it: "Although we have yet to encounter a forced choice between the congressional policies of exclusively federal remedies and the 'reservation of the business of insurance to the States' . . . we have anticipated such a conflict, with the state insurance regulation losing out if it allows plan participants 'to obtain remedies . . . that Congress rejected in ERISA,' *Pilot Life*, *supra*, at 54." 536 U.S. at 377 (citation omitted). The "forced choice" the Court was describing, in other words, would be presented by a law that both falls within the insurance savings clause but also adds to ERISA's reme-

Having thus strongly reaffirmed the *Pilot Life* rule, the *Rush Prudential* Court then turned to the question whether the rule actually covered the external review law – whether, that is, the external review statute in fact provided an additional remedy. The Court held that it did not. *Pilot Life* preemption did not apply, the Court explained, because the external review law "provide[d] no new cause of action under state law and authorize[d] no new form of ultimate relief." *Id.* at 379. "[T]he state statute does not enlarge the claim beyond the benefits available in any action brought under § 1132(a)." *Id.* at 379-80. The external reviewer's "medical necessity" determination might well have the effect of providing the dispositive "decision rule" as to what benefits would be provided as "medically necessary" under the plan, the Court acknowledged, but "the relief ultimately available would still be what ERISA authorizes in a suit for benefits under § 1132(a)." *Id.* at 380. Underscoring the vitality of *Pilot Life* one last time, the Court concluded: "This case therefore does not involve the sort of additional claim or remedy exemplified in *Pilot Life*, *Russell*, and *Ingersoll-Rand*[.]" *Id.*

C. *Pilot Life* Preemption Is Not Limited To Contract Claims Or Claims That "Duplicate" ERISA's Remedies

It is clear from the foregoing that the Fifth Circuit's twin rationales for holding Calad's THCLA claim not preempted – that *Pilot Life* preemption applies only to state-law breach of contract claims, and more generally only to state-law claims that "duplicate" ERISA claims – are without merit.

1. There is no basis whatsoever in *Pilot Life* or any of its progeny for the contract-tort distinction drawn by the Fifth Circuit. To the contrary, *Pilot Life* itself involved tort

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dies for a benefit denial. The instant case does not present such a choice – no court has found, and nobody contends, that the THCLA is saved from a preemption as a law that "regulates insurance."

claims, *see* 481 U.S. at 43, as did *Ingersoll-Rand*, *see* 498 U.S. at 136. *See also Rush Prudential*, 536 U.S. at 377, 379 (referring to preemption of tort claims in both cases). Nor would such a distinction make any sense under *Pilot Life*'s rule – the entire point of which is to ensure that, when the denial of a benefit under an ERISA-governed plan is at issue, the only remedies available are those set forth in § 502(a). If a state could circumvent the rule and provide a supplemental remedy – including the punitive damages sought in *Pilot Life*, *Ingersoll-Rand*, and by respondent here – merely by labeling it a remedy in tort, there would be little point to the doctrine in the first place. *Cf. Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 211 (1985) (LMRA § 301 preempts both contract and tort claims relating to rights under a collective bargaining agreement because "[a]ny other result would elevate form over substance and allow parties to evade the requirements of § 301 by relabeling their contract claims as claims for tortious breach of contract").

2. Much the same goes for the Fifth Circuit's related suggestion that the *Pilot Life* rule preempts only those state-law claims that "duplicate" claims available under ERISA. No precedent of this Court has ever construed *Pilot Life* preemption in those terms. The Fifth Circuit "glean[ed]" this rule solely from *Rush Prudential*, but in fact the formulation of *Pilot Life* enunciated and applied in *Rush Prudential* was virtually the *opposite* of the rule adopted by the Fifth Circuit. *Rush Prudential* held the external review law not preempted under *Pilot Life* because it "provide[d] *no new cause of action* under state law," 536 U.S. at 379 (emphasis added), and "d[id] not *enlarge the claim* beyond the benefits available in any action brought under § 1132(a)," *id.* at 379-80 (emphasis added). The fundamental rule of *Pilot Life*, this Court made clear, continues to be simply whether the state-law claim provides "a form of ultimate relief in a judicial forum that add[s] to the judicial remedies provided by ERISA." 536 U.S. at 379. Nothing in *Rush Prudential* suggests that a

state-law claim providing remedies for the denial of a benefit will not be preempted so long as the claim includes some element – such as a tort element of intent or malice – that differs from an ERISA § 502(a)(1)(B) claim for denial of a benefit.[3]

It is thus beside the point that "THCLA does not provide an action for collecting benefits." *Calad* Pet. App. 19a-20a. So long as THCLA *does* provide a non-ERISA remedy for *the denial of benefits* – and it assuredly does, *see infra* Part II – then the fact that a beneficiary can obtain some remedy *other than* the recovery of benefits is precisely what establishes preemption under *Pilot Life*. *See, e.g.*, *Ingersoll-Rand*, 498 U.S. at 145 (state tort claim preempted even though it did not seek "recovery of . . . benefits"). When an ERISA

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[3] The Fifth Circuit's conclusion to the contrary rests on a misunderstanding of a passage from *Rush Prudential* describing the Court's earlier holding in *Ingersoll-Rand*. The Fifth Circuit stated:

> The *Rush Prudential* Court explained its holding in *Ingersoll-Rand*: "[The] state law duplicated the elements of a claim under ERISA, it converted the remedy from an equitable one under § 1132(a)(3) (available exclusively in federal district courts) into a legal one for money damages (available in a state tribunal)." *Rush Prudential*, [536 U.S. at 379].

Calad Pet. App. 19a. It was solely from the first half of this quotation from *Rush Prudential* that the Fifth Circuit "glean[ed]" its new "duplication" rule of preemption. But the quotation omits the first word of the passage, which actually makes no sense as quoted by the court. The passage in fact says, *"while* state law duplicated the elements of a claim available under ERISA, it converted the remedy [into one not available under ERISA]." *Rush Prudential*, 536 U.S. at 379 (emphasis added). Properly quoted, it is clear what the passage is saying: while the state-law claim requires a plaintiff to prove the same things she would have to prove to establish an ERISA claim, the state-law claim adds to the remedies available under ERISA. Just the same is true here: Calad can obtain relief under the THCLA only if she proves that her benefits were improperly denied, a violation of ERISA already covered by § 502(a)(1)(B); what THCLA adds are different remedies for that violation. *See infra* Part II.

plan benefit is improperly denied, Congress provided a remedy, *viz.*, an action to recover the benefit under § 502(a)(1)(B). And the very point of *Pilot Life*'s categorical preemption rule is that a state cannot be allowed to provide *different* remedies for erroneous benefit denials, because to do so would be to contradict the carefully balanced policy choices Congress made in deciding which remedies would be available and, equally important, which would not.

II. RESPONDENT'S THCLA CLAIM IS PREEMPTED BECAUSE IT SEEKS NON-ERISA REMEDIES FOR AN ASSERTEDLY IMPROPER BENEFIT DENIAL

As the prior section demonstrated, Calad's THCLA claim is preempted if it seeks (a) non-ERISA remedies (b) for the violation of a right protected by ERISA. It does.

There is no dispute that Calad's THCLA claim seeks remedies beyond those ERISA provides. She seeks consequential monetary damages and punitive damages, neither of which is available in an action under ERISA §502(a). *See Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985) (punitive damages not allowed); *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993) (money damages not allowed).

The real question is whether her THCLA claim seeks to remediate the violation of a right already protected by ERISA. The answer is yes: Calad's claim asserts that CIGNA erred in determining that she was not entitled to one of the health care benefits promised under the Ryland Plan – specifically, the benefit of payment of expenses for a "medically necessary" hospital stay. J.A. 182. And the injuries she seeks to remedy follow only from the fact that CIGNA, she says, improperly refused to cover the expenses of the additional time in the hospital. J.A. 185.

ERISA already protects the right to benefits under a plan, and provides a cause of action to secure that right in § 502(a)(1)(B). It is undeniable that Calad could have

brought a § 502(a)(1)(B) action to obtain exactly what her THCLA claim asserts was wrongfully denied her – the payment of the expenses of the additional hospital stay. But the exclusive remedy available in such an action would have been recovery of *that benefit* – not the consequential and punitive damages she now seeks. *See* 29 U.S.C. § 1132(a)(1)(B) (remedy prescribed is "benefits due . . . under the terms of the plan"); *Conover v. Aetna US Health Care, Inc.*, 320 F.3d 1076, 1080 (10th Cir. 2003), *pet. for cert. filed*, No. 02-1864. Because Calad's THCLA claim seeks additional remedies for an assertedly improper denial of her hospital stay benefit, it is completely preempted under *Pilot Life*. And contrary to the decisions of several courts that have declined to follow *Pilot Life* in this context, this Court's opinion in *Pegram v. Herdrich*, 530 U.S. 211 (2000) does not dictate a different result merely because the decision denying her the hospital stay benefit was imbued with some element of medical judgment.

A. A Plan Decision Denying Coverage For Reasons Involving Medical Judgment Is Still A Plan Decision Denying Coverage

Like most other health benefit plans, the Ryland Plan involved in this case does not promise to cover any and all health care sought or desired by beneficiaries. As with any employee benefit, health benefits come at a price: the more health care needs a plan covers, the more costly it is to insure (or self-insure) the plan. One of the health benefits Ryland decided to provide was payment for certain costs of hospitalization. Ryland could have chosen to pay for unlimited time in the hospital, or it could have agreed only to pay for, say, up to three days of hospitalization, or it could have agreed to pay for, say, only half the costs of each day of hospital time. The point is that it was up to Ryland, and Ryland alone, to decide the extent to which it would pay for the costs of hospitalization. *See supra* at 11.

Under the health plan option selected by Calad's husband (the "Exclusive Provider Medical Benefits" ("EPMB") option), Ryland agreed to provide beneficiaries a hospitalization benefit that included payment of 100% of the daily costs of hospitalization at a "Participating Hospital" – i.e., a hospital that had contracted with CIGNA, which administers Ryland's plan, to provide hospital services at a fixed daily rate. J.A. 210-11, 236. If a Ryland Plan beneficiary chose to be hospitalized at a hospital outside the CIGNA participating network, in other words, the Plan would not pay for the costs of the hospitalization.

Agreeing to pay for hospitalization only at network hospitals was not the only limitation Ryland chose to place on the hospital benefit. The Ryland Plan EPMB option further provides that hospital confinement expenses are only covered by the Plan to the extent that the confinement is certified as medically necessary by a utilization review organization under contract to CIGNA. J.A. 219. The initial certification must come either "prior to the date of admission" or, "in the case of an emergency admission, by the end of the first scheduled work day after the date of admission." J.A. 220. If the certification is not obtained, the Plan will not cover the costs of the stay. If coverage for a hospital stay is sought for a period beyond that initially certified, the beneficiary must submit, prior to the end of the certified period, a request to the review organization for certification of a continued stay. J.A. 219. If a continued stay is not certified, the Plan will not cover the costs of the continued stay.

The decision whether to certify a hospital stay as medically necessary is, in short, simply a decision whether the Ryland Plan's hospitalization benefit covers the stay requested. The benefit can be denied for any number of reasons. The utilization review personnel may determine that the certification request was untimely. They may determine that certification was requested for a stay at a non-network hospital. Or they may determine that the stay sought was not

"medically necessary." In each case, the consequence of the determination is a denial of the requested benefit. The fact that in one case the benefit was denied for reasons involving the exercise of medical judgment does not change the fact that what happened was the denial of a benefit.

The law confirms in many ways that coverage determinations including an element of medical judgment are "benefit denials" within the compass of §502(a), meaning that non-ERISA remedies for such denials must be preempted.

1. Most important, it is clear that a beneficiary can pursue an action under § 502(a)(1)(B) for recovery of benefits when coverage for a procedure or treatment is denied as "medically unnecessary." This is easiest to see when coverage is denied *after* treatment has been provided.

Suppose, for example, that an employer established a plan that promised to cover "medically necessary" care, but provided the benefit through a traditional indemnity insurance arrangement. If the insurer in that situation determined after the fact that some previously-provided care was not medically necessary, and therefore refused to provide reimbursement for the care, nobody disputes that the beneficiary could bring an action under ERISA § 502(a)(1)(B) for recovery of the benefit, i.e., reimbursement for the previously provided care. There is nothing materially different about a benefit determination that is made *before* the provision of care, as is often the case with managed care structures.

This case, in fact, demonstrates that even in a managed care situation, medical necessity benefit determinations can be made after the fact. Under the Ryland Plan, a beneficiary may be admitted on an emergency basis without pre-certification, with payment subject to the next-day filing and subsequent certification of the stay. If the beneficiary is admitted for a single day on an emergency basis, submits the certification form after she is released the next day, and the certification – and hence coverage – is denied as not medi-

cally necessary, her exclusive remedy is a § 502(a)(1)(B) action to compel payment for the day in the hospital.

The question, then, is whether there would be anything analytically different when the same medical necessity coverage decision is made *before* care is provided. It is impossible to see what that difference could be: even where the benefit is denied before care is provided, the beneficiary still has enforcement remedies under § 502(a)(1)(B). For instance, Department of Labor regulations promulgated to protect benefit rights require that the plan provide a prompt response to a coverage request and immediate internal appeal, *see* 29 C.F.R. § 2560.503-1(f)(2),(h)(3)(vi), and if the appeal is denied, a beneficiary can of course seek immediate relief in a § 502(a)(1)(B) action to compel payment of the requested benefit. Alternatively, the beneficiary can pay for the procedure up front, and then seek reimbursement in a § 502(a)(1)(B) action. That is just what the plaintiff in *Rush Prudential* did: after being denied pre-certification of coverage for a procedure, she arranged for payment and underwent the procedure anyway, and filed an action for reimbursement of the expenses incurred, which action was later held to be a claim for benefits under § 502(a)(1)(B). *See* 536 U.S. at 363; *see also id.* at 391 (Thomas, J., dissenting). The *Rush Prudential* plaintiff's actions are in no way unique in that respect; in fact, "[m]ost ERISA litigation concerning the denial of health plan benefits involves cases in which treatment has already been given, and the issue is whether the plan will pay for it." John H. Langbein & Bruce A. Wolk, *Pension and Employee Benefit Law* 894 (3d ed. 2000).[4]

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[4] The leading employee benefits treatise cites and discusses scores and scores of decisions reviewing health benefit coverage decisions made by HMOs acting as ERISA plan fiduciaries, many of which involve post-treatment actions seeking reimbursement of expenses. *See Employee Benefits Law* 1014-1030 (Steven J. Sacher, *et al.*, eds., 2d ed. 2000) & *id.* 461-72 (Supp. 2002). For just a few examples of recent post-treatment coverage cases that reached the appellate courts, *see Mario v. P & C*

The availability of § 502(a)(1)(B) remedies for a pre-treatment benefit denial establishes unambiguously that such a benefit denial is just that – a benefit denial. And if it is, then the remedies provided under § 502(a)(1)(B) are exclusive, and preempt any state-law claim that provides additional remedies for the benefit denial. *See supra* Part I.

2. Regulations promulgated by the Department of Labor governing benefit determinations confirm that "medical necessity" determinations incident to coverage determinations made by a plan fiduciary (i.e., not the beneficiary's treating physician, *see infra* at 32-34) are benefit claim determinations subject to § 502(a), even though they include an element of medical judgment.

ERISA § 503(2) provides that, "[i]n accordance with regulations of the Secretary, every employee benefit plan shall . . . afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. § 1133(2). To that end, the Secretary promulgated regulations establishing standards for full and fair review of benefit denials. *See generally* 29 C.F.R. § 2560.503-1. With respect to health benefit plans, those regulations provide that,

> in deciding an appeal of any *adverse benefit determination that is based in whole or in part on a medical*

Food Mkts., Inc., 313 F.3d 758, 762-63 (2d Cir. 2002) (reviewing question of whether sex change was "medically necessary" under § 502(a)); *Fritcher v. Health Care Serv. Corp.*, 301 F.3d 811, 814-15 (7th Cir. 2002) (reviewing claim challenging HMO's determination that care was not "medically necessary" under § 502(a)); *Bynum v. CIGNA HealthCare, Inc.*, 287 F.3d 305 (4th Cir. 2002) (reviewing determination that a procedure was cosmetic and not medically necessary as a benefits determination under § 502(a)). *See also* Langbein & Wolk, *supra*, at 892 ("Although only a tiny fraction of benefit denials under health care plans becomes contentious, the sheer magnitude of the health care enterprise has resulted in extensive litigation [over benefit denials].").

> *judgment*, including determinations with regard to whether a particular treatment . . . is . . . not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment.

Id. § 2560.503-1(h)(3)(iii) (emphasis added). That provision on its face treats "medical necessity" determinations as part of the benefit determination process. And of course the entire point of the Department's regulations in this area is to ensure that ERISA plan beneficiaries' *rights to plan benefits* are adequately protected. *See* 65 Fed. Reg. 70246, 70246 (Nov. 21, 2000) ("The new standards are intended to ensure more timely benefit determinations, to improve access to information on which a benefit determination is made, and to assure that participants and beneficiaries will be afforded a full and fair review of denied claims."). The very fact that the Department has asserted regulatory authority over the medical necessity determination process of ERISA plans presupposes that the medical necessity decision is part of the benefit determination.

3. In *Rush Prudential*, this Court itself also recognized that medical necessity coverage determinations, when made by a plan fiduciary, are benefit denials subject to § 502(a)(1)(B) remedies. This was the essential premise for the Court's holding that a state law requiring external review of a plan's medical necessity determination is not preempted under *Pilot Life*. As the Court described the law at issue in *Rush Prudential*, it provided HMO subscribers with "a right to independent medical review of certain denials of benefits." 536 U.S. at 359; *see id.* at 360. The Court then explained that the state external review law did not provide a non-ERISA remedy – and thus was not preempted under *Pilot Life* – because the independent reviewer only provided a decision rule as to whether coverage should be provided as medically necessary, which decision would then be enforce-

able in an action to recover benefits under § 502(a)(1)(B). *See id.* at 380 ("[A]lthough the reviewer's determination would presumably replace that of the HMO as to what is 'medically necessary' under this contract, the relief ultimately available would still be what ERISA authorizes in a suit for benefits under § 1132(a)."); *see also id.* at 362 n.2 (suggesting that suit under either § 502(a)(3) to compel compliance with the plan, or under § 502(a)(1)(B) to recover benefits, would be a proper action to ensure compliance with state external review law). In other words, it is only because the state law requiring independent review of an HMO's medical necessity determination was effectively enforceable under § 502(a) that this Court was able to conclude that the state law was not preempted under *Pilot Life*. And if, as *Rush Prudential* squarely held, such a medical necessity determination is part of a benefit determination enforceable under § 502(a), then any state-law remedy for the denial of such a benefit that goes beyond the § 502(a) remedies is preempted under *Pilot Life*.

B. *Pegram v. Herdrich* Is Not To The Contrary

Several of the circuits that have upheld state regulation of benefit denials based in part on the exercise of medical judgment have done so in reliance on statements in *Pegram* explaining that benefit eligibility decisions made by treating physicians, when such decisions are "mixed" with judgments about appropriate medical treatments, were not intended by Congress to be fiduciary decisions, and thus may be regulated by state tort and medical malpractice law. *See Land v. CIGNA HealthCare, Inc.*, 339 F.3d 1286, 1293 (11th Cir. 2003), *pet. for cert. filed*, No. 03-649; *Cicio v. Does*, 321 F.3d 83, 100-04 (2d Cir. 2003), *pet. for cert. filed*, No. 03-69. Other courts and authorities have concluded that such reliance on *Pegram* is misplaced. *See DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 450 (3d Cir. 2003); *Cicio*, 321 F.3d at 109 (Calabresi, J., dissenting); SG Br., *Rush Pruden-*

tial HMO, Inc. v. Moran, No. 00-1021 ("SG *Rush Prudential* Br."), at 8. The latter view is correct.

Pegram obviously was not a preemption case, and did not purport to decide any preemption issues. What *Pegram* did decide is that an ERISA plan beneficiary cannot state a claim of fiduciary breach for a "mixed" treatment/eligibility determination *when such a determination is made by physician who is both the beneficiary's treating physician and an agent for the HMO.* As framed by the Court in the opening sentence of the opinion, the issue in *Pegram* was "whether treatment decisions made by a health maintenance organization, *acting through its physician employees*, are fiduciary acts within the meaning of [ERISA]." 530 U.S. at 214 (emphasis added). That construction is consistent throughout the opinion. *See id.* at 231 ("we think Congress did not intend Carle or any other HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians"; "Mixed eligibility decisions by an HMO acting through its physicians have . . . only a limited resemblance to the usual business of traditional trustees."); *id.* at 234 (explaining that while "the incentive of the HMO physician is to give treatment sparingly, imposing a fiduciary obligation upon him" would not necessarily lead him to "treat aggressively"); *id.* at 237 ("We hold that mixed eligibility decisions by HMO physicians are not fiduciary decisions under ERISA."). *Pegram* held that if a mixed eligibility decision made by a treating physician acting on behalf of the HMO is a fiduciary act, it would force the creation of a federalized malpractice law to be applied in adjudicating fiduciary breach claims against treating physicians under § 502(a)(2). *Id.* at 236-37. Moreover, the Court noted, creating such federal malpractice law "would raise a puzzling issue of preemption," in that the new federal fiduciary malpractice cause of action "would cover the subject of a state-law malpractice claim." *Id.* at 236. Rather than resolve that preemption issue, the Court avoided it by concluding that a

treating physician's "mixed" treatment/eligibility decision is not a fiduciary act under ERISA, and thus would not preempt (and thereby federalize as a fiduciary claim) a state-law malpractice claim against the physician for failing to provide appropriate medical care. *Id.*

Pegram's references to fiduciary acts and preemption do not speak to the preemption issue in this case for two reasons.

1. First, *Pegram*'s discussion applies at most to preemption of claims under ERISA § 502(a)(2)&(3) *for breach of fiduciary duty*. As we have seen, in this case Calad asserts what is effectively a wrongful denial of benefits claim under § 502(a)(1)(B), *not* a claim of fiduciary breach under § 502(a)(2) or § 502(a)(3). Regardless whether the denial of her benefits was a breach of fiduciary duty, it was still a denial of her benefits, and if that denial was erroneous, § 502(a)(1)(B) prescribes her exclusive remedy.[5]

2. Second, it is in any event wrong to read *Pegram* as concluding that an HMO's benefit eligibility decision is not a fiduciary decision when – as here – it is made *not* by the beneficiary's treating physician acting on behalf of the HMO, but by an HMO employee or agent whose sole responsibility is to decide whether the benefit sought is covered by the Plan. As the Solicitor General has explained, in a brief joined by the Department of Labor:

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[5] For the reasons explained in the text following this footnote, however, § 502(a)(1)(B) would not preempt a medical malpractice claim directed at the *treatment* decision of the beneficiary's *treating physician*, even where that decision is "mixed" with a benefit determination made simultaneously by that treating physician. In that situation, the malpractice claim does not seek a non-ERISA remedy for the wrongful denial of a plan benefit, but for the wrongful breach of the physician's duty to provide appropriate care. The malpractice claim in such circumstances would not require the plaintiff to prove a breach of the terms of the ERISA plan, only that the treatment itself was improper.

> The better reading of *Pegram* . . . is that it addresses only mixed decisions made by *treating* physicians. *Pegram* grew out of such a decision by the plaintiff's treating physician . . . and there is no indication that the plaintiff sought review pursuant to the HMO's appeals process. Furthermore . . . the Court did appear to view her claim as involving only an attack on the compensation policies [of HMOs] as they affected treating physicians.

SG *Rush Prudential* Br. 8. In Judge Calabresi's words, *Pegram*'s analysis of fiduciary acts "can only make sense where the underlying negligence also plausibly constitutes medical maltreatment by a party who can be deemed to be a treating physician or such physician's employer, as was the case in *Pegram*." *Cicio*, 321 F.3d at 109 (Calabresi, J., dissenting). The Solicitor General and Judge Calabresi are correct for a number of reasons.

a. To start, this Court has already recognized in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), that a plan's benefit determination under ERISA – at least when not combined with a treating physician's traditional care obligations – is a fiduciary act. In *Bruch*, this Court held that trust law principles, including the traditional fiduciary responsibilities of trustees, apply to plan benefit determinations, such that courts reviewing such determinations in § 502(a)(1)(B) actions must review the determination *de novo*, unless the plan document confers discretion on the plan administrator. *Id.* at 111-13.

ERISA itself confirms *Bruch*'s treatment of plan benefit decisions as fiduciary acts. The statute explicitly requires that an ERISA plan provide for one or more "named fiduciaries," who "jointly or severally shall have authority to control and manage the operation and administration of the plan." 29 U.S.C. § 1102(a)(1). Section 503, in turn, specifies minimum requirements for a plan's "Claims procedure," and provides that a plan must "afford a reasonable opportu-

nity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. § 1133(2). The federal circuits unanimously agree that this statutory structure implicitly includes a requirement that, in order to state a claim for plan benefits under § 502(a)(1)(B), a beneficiary must first exhaust her internal plan remedies, thereby ensuring that the plan's final benefit determination was made by a plan fiduciary. *See Fallick v. Nationwide Mut. Ins. Co.*, 162 F.3d 410, 418 n.4 (6th Cir. 1998) (citing precedents from all but the Fifth Circuit); *Denton v. First Nat'l Bank*, 765 F.2d 1295, 1300-03 (5th Cir. 1985). The circuits have recognized that exhaustion must be required in order to respect the pivotal role of the fiduciaries "to whom Congress, in Section 503, assigned the primary responsibility for evaluating claims for benefits." *Zipf v. AT&T Co.*, 799 F.2d 889, 892 (3d Cir. 1986). "[T]he exhaustion requirement enables plan fiduciaries to efficiently manage their funds; correct their errors; interpret plan provisions; and assemble a factual record which will assist a court in reviewing the fiduciaries' actions." *Makar v. Health Care Corp.*, 872 F.2d 80, 83 (4th Cir. 1989); *see Mason v. Continental Group, Inc.*, 763 F.2d 1219, 1227 (11th Cir. 1985); *Amato v. Bernard*, 618 F.2d 559, 567-68 (9th Cir. 1980). The exhaustion requirement thus recognizes and fulfills Congress's intention that "plan fiduciaries . . . have primary responsibility for claims processing." *Makar*, 872 F.2d at 83.

Accordingly, it is clear – indeed undisputed, so far as we are aware – that a typical benefit determination is part of a plan's process of exercising fiduciary responsibility to administer the plan. The question here is whether a benefit determination made as part of that process – and not by a treating physician – somehow becomes nonfiduciary merely by dint of the fact that it involves some aspect of medical judgment. Certainly nothing in the text or structure of ERISA suggests any such distinction. And the Department of Labor

regulations governing internal plan review of benefit denials, discussed above, *supra* at 29-30, confirm that no such distinction exists. The regulation applicable to health plans explicitly commits benefit determinations based in part on medical judgments to a plan fiduciary. It provides that the appeal of any "adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment . . . is . . . not medically necessary or appropriate," must be made to an "*appropriate named fiduciary*," who must in turn consult with a health care professional with expertise in the area of the decision under review. 29 C.F.R. § 2560.503-1(h)(3)(iii) (emphasis added). If the decision is nonfiduciary, there would be no reason to require the plan fiduciary's involvement.[6]

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[6] In this case, the initial benefit determination was made by a utilization-review "discharge nurse," who indisputably was not Calad's treating physician or treating nurse. But the nurse *herself* may or may not have been a fiduciary to the Plan. ERISA states that "a person is a fiduciary with respect to a plan to the extent" that, *inter alia*, "he has any discretionary authority or discretionary responsibility in the administration of such plan." 29 U.S.C. § 1002(21)(A)(iii). It is not clear from the record how much discretionary authority the discharge nurse possessed. The point is academic, however, because even if she was not a fiduciary, her decision was simply the trigger for what the statute and regulations explicitly contemplate will be a fiduciary benefit determination process. The fact that Calad did not invoke her Plan remedies as would be required before she could obtain benefits in a §502(a)(1)(B) action, in other words, does not render the benefit denial in this case a nonfiduciary act; it simply means that Calad, while having a cause of action under § 502(a)(1)(B), would not have been entitled to prevail on that action. Her state-law claim seeking damages for the denial of benefits would still come within the compass of § 502(a). If it were otherwise, an ERISA plan beneficiary could obtain otherwise preempted tort remedies against an ERISA-plan HMO administrator simply by refusing to exhaust her internal plan remedies, thereby undercutting the strong federal policies underlying ERISA of making benefit denials a fiduciary responsibility by requiring exhaustion of appeals to the plan's named fiduciary. *See, e.g., Springer v. Wal-Mart Assocs.' Group Health Plan*, 908 F.2d 897,

c. Not surprisingly, the concerns enunciated in *Pegram* with labeling a treating physician's mixed treatment/eligibility determination as fiduciary have no application to a benefit determination that, although imbued with medical judgment, is not made by a treating physician. As noted above, the Court's concern in *Pegram* was that if ERISA's fiduciary standard applies whenever a beneficiary's own doctor makes a decision that is at once about treatment and eligibility, then it would seem that malpractice rules would have to be applied to the decision, which would both preempt state-law malpractice claims against the doctor and essentially federalize such claims under the guise of an ERISA claim for fiduciary breach. Accordingly, the Court held, in order to recognize such a claim when a treating physician's decision is involved, a federal body of malpractice law would essentially have to be invented. That simply is not true with respect to a benefit determination made not by a treating physician, but by an HMO employee merely implementing the fiduciary plan benefit determination process. In that situation, the eligibility determination is – and has long been – governed by well-developed law establishing the processes and standards for making benefit determinations. *See supra* note 4. There is thus no fear that treating the benefit determination as fiduciary would result in a newly federalized malpractice regime.[7]

d. Reading *Pegram* as suggesting that a decision denying benefits was rendered nonfiduciary simply because it involved the exercise of medical judgment would raise a host of confusing ERISA plan benefit enforcement issues. It is

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900 (11th Cir. 1990) ("a strong policy favoring such exhaustion underlies the statutory scheme").

[7] Relatedly, holding that a benefit determination is fiduciary when it is not made by a treating physician acting on behalf of the HMO would not affect state-law malpractice claims against treating physicians acting on behalf of HMOs (for which HMOs may also be vicariously liable). *See supra* note 5.

not clear, for example, whether or why the DOL regulations guaranteeing a full and fair appeal to a named fiduciary would apply when the adverse benefit determination involves medical judgment. For if the decision is inherently nonfiduciary, the Department should have no basis for requiring an appeal to a fiduciary. Surely it cannot have been Congress's intention that a health plan beneficiary denied benefits partly for medical reasons gets no internal appeal.

Nor is it even clear that such a beneficiary would have any judicial remedy under ERISA. As noted above, ERISA requires that a final benefit determination be made by a named fiduciary. 29 U.S.C. § 1133(2). If the named fiduciary's denial of benefits is transformed into a nonfiduciary act when it is predicated partly on medical judgment, the status of the decision under ERISA would be obscure. As Calad essentially argues, perhaps it is not a "benefit determination" at all. But if there is no final benefit determination, then the beneficiary likely would not have an action under § 502(a)(1)(B). And if the decision is not fiduciary when made before treatment, it cannot be fiduciary when made *after* treatment either, meaning that a beneficiary might not have an ERISA action for reimbursement of expenses in that situation, which simply cannot be true.

But perhaps an appeal to a named fiduciary and suit against the plan is still proper, except that we just arbitrarily designate this one type of decision (i.e., a benefit determination based partly on medical judgment) by the named fiduciary as nonfiduciary in order to facilitate state tort suits. If we do that, however, then it must be true that the fiduciary would be relieved of his fiduciary responsibilities with respect to benefit determinations based on medical judgment – if it is not a fiduciary decision, then fiduciary duties cannot be enforced. Those duties would normally require the named fiduciary deciding a benefit appeal to make his decision in the best interests of *all* participants and beneficiaries, and "in accordance with the documents and instruments gov-

erning the plan." 29 U.S.C. § 1104(a)(1)(D). But if the decisionmaker bears no fiduciary responsibilities for benefit determinations based partly on medical judgment, he almost certainly would be induced – by the threat of state tort liability, *see infra* at 48-49 – simply to approve most benefit claims, to the detriment of future claimants and plan assets, and virtually guaranteeing higher premiums and fewer benefits. Surely neither Congress nor the Department had that outcome in mind in requiring that adverse benefit determinations be appealable to a named fiduciary.

e. Finally, it is hard even to see what constructive purpose Congress would have had in mind for creating § 502(a) remedies that are exclusive when benefits are denied for some reasons (i.e., non-medical errors) but not when they are denied for other reasons (i.e., medical errors). From the perspective of a beneficiary who seeks monetary compensation for an extra-contractual injury caused by an improper denial of coverage, it hardly matters whether the coverage was denied because of an error in medical judgment or some kind of ministerial error. "Improperly erroneous coverage decisions can be made for any number of reasons, medical and non-medical," and where there is no doctor-patient relationship that can be directly regulated as such by the states, "there is no apparent reason, in state or federal law, for treating the unlawful coverage decision any differently from any other unlawful coverage decision that is *not* based on medical error." *Cicio*, 321 F.3d at 109 (Calabresi, J., dissenting).[8]

[8] The majority opinion from which Judge Calabresi was dissenting exemplifies his point. In *Cicio*, the plaintiff brought state-law claims challenging a decision by the HMO's medical director denying coverage for a requested treatment on the ground that it was experimental and therefore excluded by the terms of the plan. The plaintiff challenged as a violation of state law both the timeliness and the substance of the denial, because by the time the medical director ultimately decided and denied the claim, it was too late for the treatment to matter. Even though both state-law claims were challenging the same benefit decision and were asserting the same consequential injury from the decision, the panel ma-

As noted above, nothing in the text, structure or policies of ERISA suggests that ERISA's §502(a) remedies are exclusive only as to *certain types* of errors made in benefit determinations.

C. A State's Interest In Regulating Health Care Does Not Justify The Establishment Of A Private State-Law Remedy For Allegedly Improper Benefit Denials Based On Medical Judgment

This Court has previously recognized that "in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." *Pegram*, 530 U.S. at 237 (citing *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654-55 (1995)); *see Rush Prudential*, 536 U.S. at 387. But in *Pilot Life* this Court identified just that degree of congressional purpose underlying § 502(a) preemption: Congress "*clearly expressed* an intent that the civil enforcement provisions of ERISA §502(a) be the exclusive vehicle for actions by ERISA-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." 481 U.S. at 52 (emphasis added); *see also Taylor*, 481 U.S. at 66 (Congress "*clearly manifested* an intent to make causes of action within the scope of the civil enforcement provisions of § 502(a) re-

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jority found the timeliness claim preempted under the § 502(a) complete preemption rule of *Pilot Life* and *Taylor*, *id.* at 95-96, but, citing *Pegram*, found the substantive claim of medical negligence not preempted, *id.* at 103-04. The facts of *Cicio* shows why it makes little practical sense to distinguish between state-law challenges based on "ministerial" errors, such as timeliness, and challenges based on medical errors. Either way, the plaintiff was asserting an injury from the allegedly erroneous denial of a benefit. ERISA's remedies in that situation are either exclusive, or they are not, but there is no basis in ERISA for distinguishing between the *types* of errors that may be made in denying a benefit.

movable to federal court" (emphasis added)). Because THCLA claims fall well within the compass of §502(a), as shown above, the fact that THCLA concerns health care does not save such claims from preemption.

Indeed, this Court has found state-law claims involving other subjects of traditional state regulation preempted when they run into direct conflict with ERISA. *See*, *e.g.*, *Egelhoff v. Egelhoff*, 532 U.S. 141, 151 (2001); *Boggs v. Boggs*, 520 U.S. 833 (1997). The Court stated in *Egelhoff*:

> [R]espondents emphasize that the Washington statute involves both family law and probate law, areas of traditional state regulation. There is indeed a presumption against pre-emption in areas of traditional state regulation such as family law. . . . But that presumption can be overcome where, as here, Congress has made clear its desire for pre-emption. Accordingly, we have not hesitated to find state family law pre-empted when it conflicts with ERISA or relates to ERISA plans. See, *e.g.*, *Boggs v. Boggs*, 520 U.S. 833 (1997).

532 U.S. at 152. In *Boggs*, the Court was equally direct. Although "community property laws . . . implement policies and values lying within the traditional domain of the States," the Court explained, 520 U.S. at 840, "[w]e can begin, and in this case end, the analysis by simply asking if state law conflicts with the provisions of ERISA or operates to frustrate its objects," *id.* at 841. Finding a "direct clash between state law and the purposes and objectives of ERISA," the Court concluded that "the state law cannot stand." *Id.* at 844. The state law was preempted because it would "undermine the purpose" of an ERISA provision, and "States are not free to change ERISA's structure and balance." *Id.*

So it is here. For all the reasons we have shown, Calad's THCLA claim directly clashes with the "provisions and objectives" of ERISA, *Pilot Life*, 481 U.S. at 52, by effectively

negating Congress's decision not to allow tort remedies and monetary damages for erroneous benefit denials. THCLA claims plainly alter ERISA's structure and balance with respect to the enforcement of benefit rights. This no state may do, even in the service of an interest traditionally within the states' domain.

III. THERE IS NO SOUND POLICY REASON FOR OVERRULING OR MODIFYING *PILOT LIFE*

Part of the impetus for denying preemption among some lower courts has been a concern that, absent a state tort remedy, ERISA plan beneficiaries will frequently be left with uncompensated injuries for erroneous benefit denials resulting from managed-care utilization review systems. Some also believe that the failure to expose ERISA plans to the risk of tort liability for erroneous benefit denials gives them incentives that result in "overdenials" of coverage. These concerns, although no doubt well-intentioned, are misplaced. Not only are they matters properly addressed to Congress, which designed ERISA's integrated remedial structure and is fully capable of amending it should the need arise, but in fact the perceptions underlying recent judicial efforts to relegislate ERISA's remedial scheme are almost entirely inaccurate. Although this Court must be guided by precedent, not policy, in this case there is no conflict between the two.

A. The Law Already Provides Numerous Protections For ERISA Plan Beneficiaries' Rights

The system of benefit enforcement envisioned by Congress in enacting §502(a) gives beneficiaries a "panoply of remedial devices," *Russell*, 473 U.S. at 146-47, including in cases where coverage is denied as not "medically necessary."

1. Such remedies start within the plan. As already discussed, ERISA requires that every plan have an appeal procedure designed to ensure "full and review" of a coverage denial. With respect to health benefit plans, such an appeal must include consultation with a health care professional not

involved in the initial benefit determination. 29 C.F.R. § 2560.503-1(h)(3)(v). Further, in cases of urgent care needs, the regulations require a process of expedited review, including oral submission of the request and a decision "as soon as possible, taking into account the medical exigencies." *Id.* § 2560.503-1(h)(3)(vi),(*i*)(2)(i).

2. In addition to the required full and fair internal appeal, including health care professional consultation, forty-four states – including Texas – have enacted external review laws of the kind upheld in *Rush Prudential*. *See 2004 State-By-State Guide to Managed Care Law* § 5.2, Tbl. 5-2 (Lillian MacEachern & Donald R. Levy eds. 2004). Such laws require that a plan submit a benefit determination based on "medical necessity" to an independent physician or review board. The Texas law also requires that a beneficiary be notified of the procedures for appealing an adverse benefits determination to an independent review organization, that the independent review organization be given the beneficiary's medical records and the names of any treating physicians, and that the utilization review agent pay for the independent review. Texas Ins. Code Ann. art. 21.58A, §§ 6, 6A. In the case of emergency care denials and denials of continued stays for hospitalized patients, the time frame for appeal must be expedited. *Id.* § 6(b)(4).

3. If, after all these steps are taken, it is still determined that the coverage the beneficiary seeks is not available under the plan because it is not "medically necessary," the beneficiary is still not without recourse. She can bring an action under § 502(a)(1)(B) to compel the payment of the benefit sought. She can also arrange to pay for the procedure outside the plan, and then file a § 502(a)(1)(B) action seeking reimbursement for the expenses, as effectively happened in *Rush Prudential* and in many other cases. *See supra* at 27-28.

4. All of the foregoing remedies within ERISA's enforcement structure were available to Calad, but she did not

invoke *any* of them. Calad's Ryland Plan included a right to appeal, although it is not stated in the record who would have reviewed her claim (her benefit determination took place before the Department's regulations were promulgated). In any event, the review on appeal would have been full and fair, as required by law. And because Calad did not appeal her benefit denial, she could not seek independent review under Texas law either. Nor did she challenge the coverage decision in court, or provide for payment and seek reimbursement in a subsequent § 502(a)(1)(B) action. In short, Calad's situation does not reflect the reality of benefits enforcement in the vast run of cases.

B. Employers Will Not Employ Benefit Review Mechanisms That Routinely Deny Benefits

The utilization review techniques employed by managed care organizations that insure or administer benefit plans – and increasingly by indemnity insurers as well – are of course designed to ensure that quality care is delivered as cost-efficiently as possible. But the lack of a tort remedy for erroneous coverage denials does not mean that "the most profitable HMOs will be those that deny claims most frequently." *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 459 (3d Cir. 2003) (Becker, J., concurring). Far from it.

First, it is flatly untrue that HMOs always have a direct financial incentive to deny care. Many HMOs – including CIGNA in this case – provide only administrative services to health benefit plans funded by employers. In that situation, the HMO makes initial coverage determinations, but claims are paid directly by the employer. The HMO receives the same fixed, periodic payment for its services regardless of how many claims it approves or denies.

To be sure, one might suppose that a more indirect incentive exists to deny claims to please the employer, but that supposition conflicts with market reality. Courts have repeatedly recognized that it makes no economic sense for em-

ployers to appoint benefit plan administrators who "make it a practice of resisting claims for benefits." *Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995). The entire point of an employee benefits plan "is to please employees, not to result in the employer's bad reputation," *Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181, 184 (1st Cir. 1998), and a consistent practice of denying benefit coverage will only "dampen loyalties of current employees while hindering attempts to attract new talent," *Chalmers*, 61 F.3d at 1344; *see Nazay v. Miller*, 949 F.2d 1323, 1335 (3d Cir. 1991); *Gallo v. Amoco Corp.*, 102 F.3d 918, 921 (7th Cir. 1996). In addition, erroneous denials of "medically necessary" care that lead to adverse medical outcomes will only impose *greater* costs on employers, including the loss of employees to longer-term medical leave and the payment of short- or long-term disability benefits. For all these reasons, HMOs – whether they bear risk or only provide administrative services – feel market pressure from employers to handle benefit claims properly. *See Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999) ("Travelers can hardly sell policies if it is too severe in administering them.").[9]

But the effect of various incentives on health benefit claims administration is not just speculative; it is a matter of empirical record: health benefit claims are *not* routinely denied, despite the supposed financial benefit to insurers and HMO administrators to deny claims. According to a recent survey of insurance companies,[10] 86 percent of all health

[9] It bears noting as well that unions often seek to obtain health benefits provided or administered by HMOs as a way of providing their members the best possible health coverage at affordable prices. Unions obviously have no incentive whatsoever to minimize the coverage their own members receive. If HMOs, in fact, routinely denied coverage as not "medically necessary," unions would hardly be attracted to them.

[10] Health Ins. Ass'n of Am., Results from an HIAA Survey on Claims Payment Processes (March 2003), *available at* http://membership.hiaa.org/pdfs/chartbook_rev.pdf.

care claims are paid. Of the 14 percent that are denied, claims for non-covered benefits, presumably including (but hardly limited to) those denied because they were not "medically necessary," represent only 20 percent – or 2.8 percent of the total claims submitted. Because that 2.8 percent includes denials based on other types of coverage determinations, claims denied because they are not medically necessary represent an even smaller percentage of the total claims submitted. Those numbers simply do not support assertions that HMOs pursue profits by denying claims without attention to their merit.

C. Utilization Review Does Not Cause Adverse Outcomes Necessitating A Tort Remedy Against Managed Care Plan Administrators

Another misperception apparently underlying some efforts to contort settled preemption doctrine to avoid preemption of laws like the THCLA is that utilization review techniques employed by HMOs are likely to cause adverse medical outcomes, for which the HMO should be held liable in tort. The evidence does not support that premise either.

Studies of utilization review relating to hospital stays – the benefit at issue in this case – in fact show just the opposite: the introduction of measures designed to monitor and control hospitalization rates has not resulted in adverse medical outcomes. The *New England Journal of Medicine*, for instance, recently published a study of the utilization review system employed by the U.S. Government's Veterans Administration demonstrating that, although hospital bed-day rates fell by 50 percent between 1994 and 1998, the decline "did not curtail access to needed services and was not associated with serious consequences for chronically ill VA beneficiaries." Carol M. Ashton, M.D., M.P.H., *et al.*, *Hospital Use and Survival among Veterans Affairs Beneficiaries*, 349 New Eng. J. Med. 1637, 1637 (Oct. 23, 2003). Another study of maternity stays showed that HMO discharge protocols had no adverse effects on the health of newborns.

Jennie M. Madden, Ph.D., *et al.*, *Effects of Law Against Early Post-Partum Discharge on Newborn Follow-Up, Adverse Events, and HMO Expenditures*, 347 New Eng. J. Med. 2031, 2031 (Dec. 19, 2002). Overall, the editors of the *New England Journal of Medicine* have concluded that the problem of medical practice overutilization – which managed care is designed to address – results in lower quality of care than the more conservative practice patterns encouraged as a result of utilization review systems. *See* Editorial, 349 New Eng. L. Med. 17, 17 (Oct. 23, 2003); *see also infra* at 48-49 (discussing overutilization).

Utilization review systems have not been perfected, of course, and may never be. But the evidence shows that, properly employed, they do not inevitably lead to an increase in adverse outcomes, for which we must newly assign blame under the tort system. To the contrary, managed care utilization review mechanisms, while indisputably making health care more affordable and therefore more accessible to all, also *increase* quality of care, by mitigating the harmful effects of overutilized procedures and by allowing limited resources to be employed where they are actually needed.

It is for reasons such as these that "for over 27 [now 30] years the Congress of the United States has promoted the formation of HMO practices." *Pegram*, 530 U.S. at 233 (noting that Congress in 1973 – the year before ERISA was enacted – enacted Health Maintenance Organization Act of 1973, 42 U.S.C. §300e *et seq.*, and has amended it several times, most recently in 1996). The strong federal policy favoring the use of utilization review to control quality and cost is also reflected in the heavy reliance on managed care in federal employee benefit plans. *See generally* U.S. Office Pers. Mgmt., *2004 Guide to Federal Employees Health Benefit Plans* (2003). The consistency of federal support for managed care gives the lie to the caricatures underlying much of the criticism of utilization review and other features of managed care.

D. Allowing States To Impose Varying Medical Malpractice Tort Remedies For Adverse Benefit Determinations Would Undermine ERISA's Goal Of Promoting Plan Formation

It can hardly be disputed that imposing the medical malpractice tort regimes of the various states on employee health benefit coverage decisions will vastly increase the costs of providing benefits, all but guaranteeing that less coverage – and thus less health care overall – will be provided to the nation's employees and union members.

The medical malpractice litigation system in our country may or may not be fundamentally "broken," as many contend, but nobody can deny that medical malpractice insurance premiums have been driven up dramatically in recent years, in turn driving up the costs of health care delivery. *See generally* Robert W. Shaw, *Punitive Damages In Medical Malpractice: An Economic Evaluation*, 81 N. Car. L. Rev. 2371 (2003); Joseph Treaster, *Malpractice Rates are Rising Sharply; Health Costs Follow*, N.Y. Times, at A1 (September 10, 2001). In addition to the direct effect of increased premiums on the cost of care, the mere threat of costly medical malpractice litigation – let alone a damages award by a lay jury facing an obviously injured plaintiff – encourages "defensive medicine", i.e., the practice of ordering needless tests and procedures just to avoid litigation. *See, e.g.*, Daniel Kessler and Mark McClellan, *The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care*, 60 Law & Contemp. Probs. 81, 83 (1997) (studies attribute at least five to nine percent of total medical expenditures to defensive behavior).[11]

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[11] The U.S. Department of Health and Human Services ("HHS") has issued a series of reports detailing the enormous pressure medical malpractice litigation is imposing on the delivery of health care in this country. *See* HHS, *Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care* (March 3, 2003), *available at* http://aspe.hhs.gov/daltcp/reports/medliab.htm;

It is only logical that the medical malpractice tort system, if imported into employee health benefit plan administration, would have precisely the same effects on health benefits it has had on medical care. The threat of tort liability would give HMOs insuring or administering ERISA plans the same incentive to approve payment for procedures and treatments that doctors have to provide them – increasing the cost of providing the benefit. HMOs insuring or administering ERISA plans would have to obtain the same kind of increasingly expensive malpractice insurance that doctors must obtain – again, increasing the cost of the benefit. Employers, of course, do not have unlimited funds to pay for employee health benefits. As health benefit costs inevitably increase, employers will inevitably provide fewer benefits to fewer employees. The necessary result will be more Americans without any health care coverage at all – a guaranteed prescription for lower quality overall care.

Not only is this unsound policy in the abstract, it is directly contrary to the specific policy of ERISA, which aims to "induc[e] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Rush Prudential*, 536 U.S. at 379. Altering the preemption rule that underlies ERISA's uniform benefit enforcement system, to allow states to regulate the administration of health plan benefits through varying tort and medical malpractice laws with unpredictable jury award remedies, would contradict that policy in every respect.

HHS, *Update on the Medical Litigation Crisis: Not the Result of the "Insurance Cycle"* (September 25, 2002), *available at* http://aspe.hhs.gov/daltcp/reports/mlupd2.htm; HHS, *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System* (July 25, 2002), *available at* http://aspe.hhs.gov/daltcp/reports/litrefm.htm.

CONCLUSION

For the foregoing reasons, the judgment should be reversed.

Respectfully submitted,

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