**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**

## REPLY BRIEF FOR PETITIONER CIGNA HEALTHCARE OF TEXAS, INC.

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## TABLE OF AUTHORITIES

**Page**

## TABLE OF AUTHORITIES

**Page(s)**

### CASES

## TABLE OF AUTHORITIES
## (continued)

**Page(s)**



### STATUTES & CODES

## TABLE OF AUTHORITIES
## (continued)

**Page(s)**

### OTHER AUTHORITIES

## REPLY BRIEF FOR PETITIONER

Respondent Ruby Calad ("Calad") is the beneficiary of a health benefit plan established by her husband's employer Ryland Group ("Ryland"). Ryland self-insures the Plan, which is governed by the Employee Retirement Income Security Act ("ERISA") and is administered by respondent Cigna HealthCare of Texas, Inc. ("CIGNA"). Under the terms of the Plan, Ryland agreed to pay for health care deemed to be "medically necessary." But neither Ryland, nor the Ryland Plan, nor CIGNA, was ever responsible for providing Calad medical care directly. The duty to provide care was assumed solely by Dr. Estrada, Calad's treating physician. Calad alleges that Dr. Estrada recommended more than one day in the hospital following a surgical procedure, but that CIGNA determined that she did not qualify for the additional day under the terms of the Ryland Plan and therefore refused to authorize payment for the additional day.

Calad's state-law claim alleges that CIGNA's decision not to authorize payment for additional time in the hospital was wrong as a matter of state law, and caused her injuries for which she seeks damages. But in their brief to this Court, respondents do not – and could not – deny that CIGNA's decision whether to authorize payment for the additional time was a decision about whether Calad was entitled to a particular benefit under the terms of Calad's ERISA-governed benefit plan. Though conceding that CIGNA's decision was a benefit determination, respondents say it was *also something else* – specifically, an exercise of medical judgment. And for that reason and that reason alone, respondents contend that the benefit determination at issue here may be treated differently from all other ERISA plan benefit determinations: it may be regulated by standards prescribed by state law, rather than the fiduciary standards governing other ERISA plan benefit determinations, and it may be subject to remedies prescribed by state law, rather than those set forth in ERISA's integrated remedial structure.

Respondents are wrong. The fact that CIGNA's benefit determination was based in part on an exercise of medical judgment does not make it anything other than a benefit determination. And because it is a benefit determination, it is unambiguously governed by ERISA § 502(a), 29 U.S.C. § 1132(a), which this Court has held establishes the sole and exclusive remedial scheme for allegedly erroneous benefit denials. The sole question for decision here is whether a state may, consistent with ERISA and this Court's precedents, provide plan beneficiaries with remedies for allegedly erroneous plan benefit determinations beyond the remedies ERISA already provides in § 502(a).

The answer is no. Nobody disputes that health care is, in general, a subject of traditional state regulation. Nor does anybody dispute that, when an HMO that administers or insures an ERISA plan arranges to assume responsibility for the actual provision of health care – as when the HMO is owned by or employs the physicians responsible for treating plan beneficiaries – the state is entitled to regulate and provide remedies for the HMO's alleged failure to provide adequate medical treatment. But those are not the issues before this Court, for a simple but fundamentally important reason: CIGNA in this case did not decide whether CIGNA should *provide* medical care; it decided only whether the medical care should be *paid for* under the terms of the employer's ERISA-governed benefit plan. *That* decision is, without question, nothing more or less than a plan benefit determination. And whatever steps a state may take to regulate health care, a state cannot provide ERISA plan beneficiaries new remedies for health care plan benefit determinations, even on the theory that the scope of a person's health care benefits relates to health care treatment. There is no health care exception to ERISA preemption: Unless and until Congress says otherwise, ERISA plan benefit determinations of all kinds are governed exclusively by ERISA § 502(a). The judgment below should be reversed.

## ARGUMENT

### I. CIGNA'S DECISION DENYING PLAN BENEFITS IS GOVERNED EXCLUSIVELY BY § 502(a)(1)(B) AND THEREFORE IS COMPLETELY PREEMPTED

#### A. Congress "Clearly Manifested" Its Intent To Completely Preempt Any State-Law Claim Asserting Improper Denial Of ERISA Plan Benefits

The central contention of respondents and their amici is that there is a "formidable presumption" against federal preemption of state laws that concern "general health-care issues," which presumption has not been overcome here because Congress's intent to preempt state-law medical tort claims was not "clear and manifest." Resp. Br. 17.

This argument utterly misses the point. There may be a presumption against federal preemption of state laws regulating *health care*, but any such presumption has *nothing to do with this case*. The question here is simply whether Calad's state-law claims seek to regulate the administration and enforcement of *ERISA plan benefits*. If so, then the claims are completely preempted – regardless whether they relate in some way to health care. This Court has already held – twice, unanimously both times – that Congress did "clearly manifest[]" its intention to completely preempt state-law claims that seek non-ERISA remedies for the allegedly improper denial of ERISA plan benefits. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 66 (1987); *see Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987). Nothing in those precedents, or in ERISA's text or history, suggests that Congress intended to exclude from the scope of this clear preemption state laws regulating health care benefit determinations, just because the benefits involve health care.[1] Even if the benefit

[1] Respondents and some of their amici contend that the 1974 Congress that enacted ERISA was primarily concerned with *pension* plans, not welfare plans (which provide health benefits), and that Congress did

determination comes prior to treatment and thus may, as a practical matter, directly affect the treatment the beneficiary ultimately receives, that does not make the benefit determination anything other than a pure benefit determination. And if the claim challenges a benefit determination, then Congress made manifest its intention, through the structure and history of the integrated remedial provisions set forth in § 502(a), 29 U.S.C. 1132(a), that it be completely preempted. *See also Egelhoff v. Egelhoff*, 532 U.S. 141, 151 (2001) (finding ERISA preemption of state law implicating traditional area of state regulation); *Boggs v. Boggs*, 520 U.S. 833, 844 (1997) (same).

To be perfectly clear: we do not contend that ERISA preempts state-law claims directed at the actual provision of *health care* – as opposed to health care *benefits* – by an HMO. Aetna Br. 3 n.1 (distinguishing between "network" model HMOs, which do not provide medical care, and "group" or "staff" model HMOs, which do provide care). Thus, for example, if a beneficiary of a plan insured or administered by an HMO is treated by a physician who is em-

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not intend for ERISA to regulate the quality of health care provided by HMOs. *See* Resp. Br. 47-48; Sen. Kennedy et al. Br. 5-9. Neither point helps respondents. First, although Congress may have focused primarily on pension benefits, nothing in the statute distinguishes between pension and welfare benefits *for preemption purposes*. Indeed, this Court's decisions in *Pilot Life* and *Taylor* involved welfare plans (disability plans, specifically), establishing conclusively that § 502(a) preemption applies with full force outside the pension context. Second, we fully agree that Congress did not intend for ERISA to regulate *health care* – what Congress intended was for ERISA to regulate health care (and other) *benefits* provided under ERISA-governed employee benefit plans.

For the same reason, any indication from the legislative history of the Health Maintenance Organization Act of 1973, Pub. L. 96-222, 87 Stat. 914, that Congress intended to leave to states the authority "to regulate the quality of medical care that HMOs provide," Resp. Br. 49, is irrelevant to the issue in this case: states *can* regulate care decisions when the HMO itself provides the care, but they cannot regulate benefit decisions about whether to pay for care.

ployed by the HMO, and that physician makes a negligent care decision, the HMO does not escape liability for negligence merely because it is insuring or administering an ERISA-governed employee benefit plan. CIGNA Br. 33 n.5, 37 n.7; *see, e.g.*, *Pacificare, Inc. v. Burrage*, 59 F.2d 151, 155 (10th Cir. 1995). But if the claim is directed at an HMO decision that solely determines whether an ERISA-governed health benefit plan authorizes provision of a benefit, then the claim is preempted by ERISA, even if the decision requires the HMO to exercise medical judgment. U.S. Br. 23.

Because, as we show below, the decision at issue in this case was a decision denying benefits, made by a CIGNA employee who was *not* Calad's treating physician, her state-law challenge to that decision is completely preempted.

### B. Calad's THCLA Claim Is Completely Preempted Because It Asserts That Her ERISA Plan Benefits Were Improperly Denied

1. The preemption rule that governs this case is settled and unambiguous: "all suits brought by beneficiaries or participants asserting improper processing of claims under ERISA-regulated plans [are] treated as federal questions governed by § 502(a)." *Pilot Life*, 481 U.S. at 56. Calad's claim under the Texas Health Care Liability Act ("THCLA") is just such a suit. She is the beneficiary of an ERISA-governed employee health benefit plan (the Ryland Plan), which is insured by Ryland and administered by CIGNA. J.A. 184. One of the benefits provided to her by the Ryland Plan is payment for certain courses of medical treatments (including hospitalization), if – but only if – the Plan determines that the treatments are "medically necessary." In other words, if the treatment is *not* "medically necessary" within the meaning of the Plan, then it is not covered by the terms of the Plan and there would be nothing at all improper about the Plan's refusal to pay for the treatment sought. The Ryland Plan is in no way unique in this respect: any medical benefit plan necessarily provides coverage only for *medical* care, and it

logically provides coverage only for medical care that is *necessary* (it would be economically irrational for an employer to provide coverage for *un*necessary medical care). Accordingly, the threshold decision in virtually *any* health benefit determination is whether payment is being sought for medically necessary care.

Calad alleges that her treating physician recommended more than one day in the hospital following a surgical procedure, but that CIGNA determined that she "did not qualify under Cigna's medical necessity criteria for continued hospital stay." J.A. 181. "Going through pre-authorization and *coverage* procedures with Cigna, Ruby was informed that for the scheduled major surgery, Cigna authorized only one day for her hospital stay." *Id.* at 184 (emphasis added). Because she was "unable to incur the expense personally," she alleges, CIGNA's determination that additional hospitalization was not "medically necessary" – *and thus that she did not qualify for "coverage" under the Ryland Plan* – "forced" her to leave the hospital "prematurely," causing her unspecified injuries. *Id.* at 181; *see id.* at 185. Calad's THCLA claim seeks compensatory and punitive damages – neither of which is available under ERISA – for CIGNA's allegedly erroneous determination that she did not "qualify" for "coverage" by the Plan of the additional hospitalization.

2. Calad's claim obviously asserts the improper denial of benefits under an ERISA governed-plan; it is for that reason just as obviously preempted under *Pilot Life*. The contrary arguments of respondents and their amici are unavailing.

a. Respondents contend that Calad's THCLA claim does not actually challenge an ERISA plan benefit determination because, they say, THCLA imposes on HMOs "'rights and obligations' that are independent of an ERISA plan." Resp. Br. 26. A THCLA claim, respondents argue, asserts a violation of a state-law duty that is wholly external to and independent of whatever obligations an HMO may incur under the terms of an ERISA plan.

This contention is refuted both by the plain text of THCLA itself and by the State of Texas, respondents' own amicus. THCLA plainly states that it "create[s] no obligation on the part of the health insurance carrier, health maintenance organization, or other managed care entity to provide to an insured or enrollee treatment *which is not covered by the health care plan of the entity*." Tex. Civ. Prac. & Rem. Code § 88.002(d) (emphasis added). And the State of Texas emphasizes that THCLA's non-ERISA remedies exist to "ensure[] that HMOs administer those plans consistent with sound medical judgment, *within the terms of the HMO agreement*." Texas Br. 15 (emphasis added). Accordingly, the only "rights and obligations" that *could* be at issue in a THCLA claim against an HMO that did not itself provide care are the rights and obligations arising from the terms of the benefit plan administered by the HMO. In other words, THCLA does not require plans to cover "medically necessary" care, but if a plan assumes that obligation and provides such coverage through an HMO, THCLA intercedes to add state-law remedies to the enforcement of that particular ERISA plan benefit.[2]

A THCLA claim challenging an HMO's "medical necessity" coverage determination thus necessarily challenges precisely the same plan benefit decision that would be at issue in a § 502(a)(1)(B) action. A simple hypothetical both proves the point and demonstrates why the THCLA claim

[2] Respondents erroneously suggest that when an ERISA plan provides health benefits through an HMO, the "benefit" for purposes of § 502(a) is merely membership in the HMO, not coverage for any particular treatment or expense. Resp. Br. 28-29. This Court specifically held to the contrary in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), when it treated a medical necessity determination adverse to the beneficiary as a denial of a benefit under § 502(a), *id*. at 359, 360, 362 n.2, 380. As a practical matter, treating HMO membership as the "benefit" would mean that no beneficiary could *ever* challenge a medical-necessity-based denial of benefits under § 502(a)(1)(B), contrary to settled case law recognizing such claims. CIGNA Br. 28 n.4.

must be preempted. Nobody disputes that, after Calad was informed that coverage had been denied, she could have appealed that decision within the Plan and then sought an injunction in federal court under § 502(a)(1)(B) to compel coverage of the additional hospitalization. Indeed, "[t]here have been numerous cases in which federal courts have issued preliminary injunctions under similar circumstances." *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 274 (3d Cir. 2001); *see* U.S. Br. 16 n.4 (citing examples). Had such a suit been brought, the district court would have evaluated the Plan's medical necessity determination under recognized federal principles governing health plan benefit determinations by plan fiduciaries. *See* CIGNA Br. 37. Applying those federal principles (including in most instances deference to the plan administrator's benefit eligibility determination), the court might well have upheld the Plan's determination that Calad did not qualify for additional hospitalization under the Plan's medical necessity criteria. Had she then gone home, and suffered the same alleged complications, Calad might then have sought to sue under THCLA – and her suit would have sought damages for *exactly the same decision* already upheld by the federal court as permissible under ERISA's governing standards. The very point of ERISA preemption is to preclude such a result.

b. The foregoing discussion also explains why analogy to preemption under § 301 of the Labor-Management Relations Act ("LMRA") – the preemption doctrine upon which Congress and this Court based complete preemption under § 502(a)(1)(B), *see Pilot Life*, 481 U.S. at 55-56 – fully confirms preemption of Calad's claim, contrary to respondents' submission. Resp. Br. 25-27.

LMRA § 301 creates federal jurisdiction over "[s]uits for violation of contracts between an employer and a labor organization representing employees in an industry affecting commerce . . . or between any such labor organizations." 29 U.S.C. § 185(a). This Court has consistently interpreted

§ 301 as completely preempting state law suits that arise from, or require an interpretation of a term or duty in, the collective bargaining contract. In *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202 (1985), for instance, the Court held preempted a state tort action against an employer and insurer alleging bad faith handling of an insurance claim under a disability plan included in a collective bargaining agreement. The claim was preempted, the Court explained, because although the state may try to "define the tort as 'independent' of any contract question," the extent of the employer's duty ultimately depended on the terms, both implicit and explicit, of the agreement between the parties. *Id.* at 216, 218. In other words, the "duties imposed and rights established through the state tort . . . derive from the rights and obligations established by the contract." *Id.* at 217.[3]

Likewise, in *United Steelworkers of America v. Rawson*, 495 U.S. 362 (1990), the Court held preempted a wrongful death action filed against a union, claiming that the union's failure to properly conduct safety inspections of the mines proximately caused a mine fire that killed 91 miners. The Supreme Court of Idaho held that the LMRA did not preempt the tort suit because the standard of care applicable to the mine inspection was imposed by state law, not by the collective bargaining agreement. *Id.* at 367-68. This Court held, however, that the duty to inspect the mines – the duty on which the state-law negligence action was based – arose solely out of the collective bargaining agreement signed by the union. *Id.* at 371. Preemption could not be "avoided by

[3] In addition, as noted in our opening brief at p.22, the Court explicitly rejected any distinction between tort and contract claims for § 301 preemption purposes: because "nearly any alleged willful breach of contract can be restated as a tort claim for breach of a good-faith obligation under a contract," 471 U.S. at 219, distinguishing between tort and contract claims 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," *id*. at 211.

characterizing the union's negligent performance of what it does on behalf of the members of the bargaining unit pursuant to the terms of the collective-bargaining contract as a state-law tort." *Id.* at 371-72.

The § 301 preemption doctrine set forth in *Allis-Chalmers* and *Rawson* unquestionably supports preemption of Calad's claim under the analogous § 502(a)(1)(B) preemption doctrine. Calad's THCLA claim is based upon CIGNA's asserted failure to authorize payment of a benefit, a duty that arises solely out of her ERISA-governed benefits plan and is enforceable through ERISA § 502(a). That is, just as the state laws at issue in *Allis-Chalmers* and *Rawson* purported to impose state-law standards and remedies on obligations that arose entirely out of a collective bargaining agreement, Calad's THCLA claim seeks to impose state-law standards and remedies on the enforcement of obligations that arise entirely out of an ERISA plan. Like the claims at issue in *Allis-Chalmers* and *Rawson*, then, Calad's THCLA claim is completely preempted.

c. The § 301 analogy also shows why it is immaterial that ERISA does not itself create a specific substantive standard for health benefit determinations. *See* Resp. Br. 31; Council State Gov. Br. 18. The LMRA also does not create a specific standard of, for example, "just cause" to be applied in employee termination cases, but instead leaves the standard to be adopted by the parties in negotiating the collective bargaining agreement. The role of the federal courts is simply to enforce the parties' private agreement (usually as construed through contractual arbitration). *See Eastern Assoc. Coal Co. v. United Mine Workers of Am.*, 531 U.S. 57, 61-62 (2000); *Textile Workers Union of Am. v. Lincoln Mills*, 353 U.S. 448, 456-57 (1957). And the function of § 301 preemption is to preclude states from interfering with federal enforcement of collective bargaining rights by imposing different remedies for the violation of rights arising out of collective bargaining agreements. *See Caterpillar, Inc. v. Wil-*

*liams*, 482 U.S. 386, 391 n.4 (1987); *Franchise Tax Bd.. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 23 (1983).

The same is true under ERISA. Just as the federal labor laws essentially leave the content of labor agreements to private choice, ERISA largely leaves to employers the discretion to decide what substantive benefit rights their employee benefit plans provide. The role of federal courts is to enforce those rights through ERISA's exclusive remedies – and the function of ERISA preemption is to preclude states from interfering with the federal scheme of benefit rights enforcement by imposing different remedies for the violation of those rights.[4] Not only do *Pilot Life* and *Taylor* establish the point, they exemplify it: both cases involved disability benefit plan benefit determinations, and even though ERISA does not prescribe a specific standard of "disability" applicable to such benefit determinations, the Court held preempted state-law claims seeking non-ERISA remedies for assertedly erroneous disability benefit determinations. *Pilot Life* and *Taylor*, like their §301 forebears, show that the absence of a specific standard for ERISA plan health benefit determinations has nothing to do with the preemptive force of ERISA's integrated scheme of benefit enforcement.[5]

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[4] Calad's claim requires a court to interpret a term of the Ryland Plan ("medical necessity") in the same way that a § 301 action requires a court to interpret a term of a collective bargaining agreement (discharge for "cause," for example). *See also* Chamber Br. 28.

[5] To be clear, however, it is not quite accurate to say that ERISA does not establish *any* federal standard applicable to health benefit determinations. In fact, ERISA does impose on all ERISA-governed plans the general obligation to make benefit determinations in accordance with traditional fiduciary principles. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111-13 (1989). Those fiduciary principles, and the federal common law of benefit determinations that has developed through federal-court enforcement of those principles, provide the relevant federal standard applicable to health benefit determinations. CIGNA Br. 28-29 n.4 (citing cases). The absence of a more *specific*

d. Respondents also argue that Congress could not possibly have intended for health-benefit-determination tort claims to be preempted, because otherwise plan claimants who are denied benefits and consequently suffer injuries – when they are unable to pay for treatment the plan declined to cover – are left in a "regulatory vacuum." Resp. Br. 41. That argument misapprehends the benefit enforcement structure envisioned by Congress and discussed above. Consistent with its intention to leave the establishment of plan benefits up to employers, Congress created a system of essentially private enforcement, with three interrelated components. First, Congress established a fiduciary obligation to administer plan benefits in the interest of plan beneficiaries and consistent with plan documents. 29 U.S.C. § 1104(a)(1)(D). Second, Congress conferred on the Department of Labor the authority to regulate the process by which ERISA plans make fiduciary benefit determinations. CIGNA Br. 29-30. Those regulations ensure that benefit determinations are made fairly after thorough consideration, but as expeditiously as possible given the circumstances.[6] (They also presuppose that health benefit determinations are indeed fiduciary benefit determinations subject to § 502(a)

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standard thus does not mean that ERISA creates *no* federal standard. More important, it is clear that ERISA's scheme for enforcing benefit rights in accordance with federal fiduciary principles completely preempts state laws that attempt to establish a different benefit enforcement scheme under the guise of ostensibly "independent" tort standards and remedies.

[6] Respondents incorrectly state that "[t]he quickest appeal process now available under federal law is 72 hours." Resp. Br. 5. In fact, federal regulations require that, in "urgent care" situations, the plan notify the claimant of its decisions "as soon as possible, taking into account the medical exigencies, but *not later* than 72 hours after" the appeal is first sought. 29 C.F.R. §2560.503-1(*i*)(2)(i) (emphasis added). In other words, 72 hours is not the "quickest" possible appeal, it is the longest allowable time for an appeal, and the permissible time could be much shorter, depending on the exigencies of the particular case.

remedies, even though they often include an element of medical judgment. CIGNA Br. 29-30, 35-36.[7]) Third, Congress created federal jurisdiction and a set of federal remedies to enforce benefit rights and ensure that plans exercise their fiduciary responsibilities properly.

This tripartite enforcement system ensures that, contrary to respondents' assertion, plan beneficiaries *always* have a remedy for an allegedly improper denial of benefits. In the circumstances of this case, for example, Congress assumed that when a treating physician recommends treatment as "medically necessary," but the managed care entity providing administrative services to the plan denies coverage, the beneficiary would have a strong incentive to appeal that decision within the plan and obtain full and fair review of the denial by a true plan fiduciary, including, under the Department of Labor regulations, assessment of medical necessity by a qualified medical professional uninvolved in the initial benefit denial. CIGNA Br. 42-43. For the rare case where there remains disagreement between the treating physician and the plan at the conclusion of that process, Congress allowed the beneficiary to seek immediate relief in federal court under § 502(a)(1)(B).[8] It is therefore inaccurate to say that a beneficiary in Calad's position lacks any remedy under ERISA's enforcement system.

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[7] Respondents cite statements in the regulations' proposal notice stating that they would not directly address preemption of state laws that may relate to benefit plans or medical decisions. Resp. Br. 39-40 (citing 65 Fed. Reg. 70246, 70254 & n.34 (Nov. 21, 2000)). These statements are irrelevant: it is true that the regulations do not address preemption, but they do establish – unambiguously – that decisions denying health benefits on grounds of medical necessity are *benefit denials*, subject to full and fair internal review by a named fiduciary. CIGNA Br. 29-30.

[8] Such an action would not be a "federalized malpractice" action, as respondents contend. Resp. Br. 45. It would proceed under recognized and widely applied fiduciary principles governing plan benefit determinations. *See, e.g.*, *Kopicki v. Fitzgerald Auto. Family Employee Benefits Plan*, 121 F. Supp. 2d 467 (D. Md. 2000); *see also supra* note 5.

To be sure, ERISA does not provide the particular remedy set forth in THCLA – a post hoc damages remedy that could be imposed even after another court determines that the plan properly exercised its fiduciary responsibility in denying coverage. But that is hardly surprising given the costs and disarray such an enforcement scheme would impose on the administration of employee benefit plans. CIGNA Br. 48-49. More important, contrary to respondents' submission, Resp. Br. 41, the absence of a THCLA-like remedy in ERISA hardly establishes that such remedies are not preempted. Just the opposite is true: "The policy choices reflected in the inclusion 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." *Pilot Life*, 481 U.S. at 54 (quoting *Massachusetts. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)). Similarly, the fact that respondents' state-law claims do not specifically seek plan benefits as a remedy, Resp. Br. 22, does not mean that the claims survive preemption. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 145 (1990) ("it is no answer to a preemption argument that a particular plaintiff is not seeking . . . benefits"). To the contrary, the fact that respondents' state-law claims seek remedies for violations of plan benefit obligations that Congress chose not to provide under ERISA is precisely why they *are* preempted. CIGNA Br. 23-24.

e. Finally, there is no merit in respondents' efforts to distinguish, for preemption purposes, between an "ongoing denial of financial benefits" (that is, a denial that is challenged before the medical expense is incurred or the treatment is provided) and a denial of benefits that is challenged only after treatment has been provided. Resp. Br. 28. Nothing in ERISA or in this Court's § 502(a) preemption precedents supports such a distinction. As shown above, Calad could have sought an injunction under § 502(a)(1)(B) compelling coverage of additional hospitalization before treatment was

provided. Or she could have arranged for payment and then sought recovery of the expenses in a post-treatment § 502(a)(1)(B) action. The fact that a beneficiary "acquiesces" in an initial benefit determination rather than pursue any internal plan appeal rights and ERISA remedies (Resp. Br. 28) in no way changes the nature of her state-law claim: it still asserts that the denial of coverage was improper. It is true that, once the beneficiary decides not to exercise her appeal rights, ERISA does not afford her a damages remedy if she later concludes that the coverage decision was incorrect, but as discussed above, that is what *establishes* – not refutes – preemption of a state-law claim providing such a remedy.

**C. Section 514 Analysis Does Not Alter The Result**

Respondents argue that Calad's THCLA claim is not "completely preempted" under *Pilot Life* and *Taylor* because (they say) it is not preempted under ERISA § 514, which explicitly preempts state laws that "relate to" ERISA plans, 29 U.S.C. § 1144. Resp. Br. 34. This argument is erroneous: because a THCLA claim seeks to provide non-ERISA remedies for allegedly erroneous ERISA plan benefit denials, the claim *necessarily* "relates to" ERISA plans under § 514.

Respondents themselves concede that the "complete preemption" effectuated by § 502(a)'s exclusive remedial structure "presupposes" that a state-law claim purporting to alter or supplement that structure "relates to" ERISA plans. Resp. Br. 33. That is of course correct. A state law "relates to" an ERISA plan under § 514 if it directly affects "employee benefit structures or their administration." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995). Obviously a state-law claim that alters the enforcement of ERISA health plan benefit rights directly affects both the "structure[]" and "administration" of ERISA benefit plans. This Court recognized as much in *Pilot Life* and *Taylor*, when it held such state-law claims not only preempted under § 514, but also completely preempted in light of ERISA § 502(a)'s exclusive benefit

enforcement structure. In other words, so long as a state-law claim alters the enforcement of benefit rights – as Calad's does – it is both preempted under § 514 and completely preempted under § 502(a).

Because § 514 preemption of Calad's claim follows automatically from the fact that the claim alters ERISA's integrated benefit enforcement structure, respondents can claim no support from the "trilogy" of decisions rejecting § 514 preemption arguments based solely on the "indirect economic effects" of state laws on ERISA plans. Resp. Br. 42-45 (discussing *Travelers*, *supra*; *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813-14 (1997); *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 329 (1997)). Calad's state-law claim is not preempted because THCLA has some "tenuous" (Resp. Br. 44) economic impact on the Ryland Plan – it is preempted because it would directly and significantly affect the administration of benefits under the ERISA-governed Ryland Plan by creating new monetary liabilities for erroneous benefit determinations.

### D. Calad's THCLA Claim Is Not Saved From Preemption By ERISA's Insurance Savings Clause

Respondents also argue – for the first time ever in this litigation – that if Calad's THCLA claim is completely preempted, it is nevertheless "saved" from preemption under ERISA's insurance savings clause, 29 U.S.C. 1144(b) (saving from preemption any state law "which regulates insurance"). This argument should be rejected.

First, it is waived. Neither respondent even hinted at a savings clause argument in the district court, the court of appeals, or in their brief opposing certiorari, and the court of appeals court of appeals did not mention it sua sponte. *See Glover v. United States*, 531 U.S. 198, 205 (2001).

Second, it is wrong. Respondents themselves concede that this Court has held in numerous cases that even when a

state law is explicitly "saved" from preemption, the state law is still preempted if it "prevents or frustrates the accomplishments of an explicit federal objective." Resp. Br. 61-62 (citing cases). The exclusive remedial structure of § 502(a) exerts just this type of "extraordinarily preemptive power," as the Court made clear in *Rush Prudential*, 536 U.S. at 376: Congress's intent to displace state law "sometimes is so clear that it overrides a statutory provision designed to save state law from being preempted," the Court observed, and "[i]n ERISA law, we have recognized one example of this sort of overpowering federal policy in the civil enforcement provisions [of § 502(a)]," *id.* at 375. When a state law "provide[s] a form of ultimate relief in a judicial forum that add[s] to the judicial remedies provided by ERISA," the Court explained, the law is completely preempted notwithstanding the saving clause because the law "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.* at 379. Accordingly, the Court observed, although no case has yet presented the "forced choice" of a law that both regulates insurance *and* frustrates the policy choices reflected in § 502(a)'s exclusive remedial scheme, the Court has "anticipated such a conflict" and concluded that even a state law regulating insurance must "los[e] out if it allows plan participants 'to obtain remedies . . . that Congress rejected in ERISA.'" *Id.* at 377 (quoting *Pilot Life*, 481 U.S. at 54).

THCLA, we have seen, does exactly that: it allows plan participants to obtain remedies for benefit denials that Congress rejected in ERISA. As the Court squarely held in *Pilot Life*, a state law imposing non-ERISA remedies "pose[s] an obstacle to the purposes and objectives of Congress," *Pilot Life*, 481 U.S. at 52 – the very circumstance under which even a "saved" law will be preempted, as respondents acknowledge. *See supra* at 17. Indeed, even though the Court

in *Pilot Life* concluded that the state tort claim at issue there did not "regulate[] insurance" within the meaning of the saving clause, the Court nevertheless identified "the clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive" as the "most important[]" reason the state tort claim was not saved from preemption. 481 U.S. at 57. In short, a state law that relates to ERISA benefit plans may be saved from preemption only if it regulates insurance *and* "provides no new cause of action [for challenging ERISA plan benefit denials] under state law and authorizes no new form of ultimate relief." *Rush Prudential*, 536 U.S. at 379. Because Calad's THCLA claim does provide a new state-law form of ultimate relief for the allegedly improper denial of an ERISA health plan benefit, it completely undermines Congress's remedial objectives and is therefore completely preempted, regardless whether it is a law which regulates insurance.

## II. RESPONDENTS' POLICY ARGUMENTS DO NOT JUSTIFY IGNORING THE EXCLUSIVITY OF ERISA'S § 502(a) REMEDIES

Our opening brief showed why the complete preemption of Calad's claims dictated by *Pilot Life* is supported by sound bases in policy: studies indicate that threatening health plan benefit determinations with medical malpractice liability will inevitably increase the cost of providing health benefits and thereby decrease the overall availability of benefits, with little offsetting gain, given that beneficiaries already have numerous remedies and HMOs already have substantial incentives to treat claims seriously. CIGNA Br. 42-49; *see also* Chamber Br. 18-26; AAHP-HIAA Br. 22-26. Citing different studies, respondents and their amici argue that the better policy outcome would be to allow malpractice actions against HMOs for their benefit determinations.

These arguments fundamentally miss the point. The question for this Court is *not* which policy outcome it should promote with its decision in this case. This Court must be

guided by precedents such as *Pilot Life* and by the respect such precedents accord to the policy choices *Congress* made in the design of § 502(a)'s exclusive and comprehensive benefits enforcement structure. The point of the policy discussion in our opening brief was to explain why some lower courts have erred in assuming either that Congress could not possibly have decided that § 502(a) would be exclusive in circumstances such as these, or that if Congress did make such a decision, it was so unacceptable it must be judicially revised. Respondents and their amici do not and could not show that the congressional choices identified in *Pilot Life* lack *any* rational policy basis; at the very most they establish only that the best policy approach is a matter of dispute. And all that establishes, in turn, is that this Court should not decide for itself whether Congress was right or wrong to make § 502(a)'s benefit enforcement remedies exclusive. "As an institution . . . Congress is far better equipped than the judiciary to amass and evaluate the vast amounts of data bearing upon an issue as complex and dynamic as that presented here." *Turner Broad. Sys. v. FCC*, 512 U.S. 622, 665-66 (1994) (plurality) (internal quotation marks omitted).[9]

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[9] In any event, respondents' policy views are not even supported by the empirical evidence on which they rely. The principal conclusion of the Congressional Budget Office study was not that imposing monetary liability on HMO benefit determinations would have *no* effect on the cost or availability of benefits, but that the effect was difficult to quantify. CBO Cost Estimate, H.R. 3605/S. 1890, Patients' Bill of Right Act of 1998, at 22 (July 16, 1998). The CBO's own best estimate, however, was that employer-sponsored plans would suffer an increase in liability costs of 60 to 75 percent, more than half of which would be attributable to "potential suits associated with decisions on medical necessity and coverage." *Id.* at 25. The General Accounting Office likewise noted the difficulties of measuring the prevalence and costs of defensive medicine, but the GAO acknowledged that "most published studies … generally conclude that physicians practice defensive medicine in specified circumstances and that doing so raises health care costs." Medical Malpractice: Implications of Rising Premiums on Access to Health Care, GAO-03-836, at 26 (Aug. 2003). Whatever the *precise* effects, nobody seri-

Indeed, as respondents' amici observe, Congress has for several years actively considered the "Patient's Bill of Rights," part of which would effectively revise § 502(a) and overrule *Pilot Life*. Sen. Kennedy et al. Br. 15-19, 23. Congress's efforts presume that *Pilot Life* governs preemption of claims like Calad's, contrary to respondents' position here. *See* Employer-Based Managed Care Plans, ERISA's Effect on Remedies for Benefit Denials and Medical Malpractice, GAO-HEHS-98-154, at 14 (July 1998) (citing *Pilot Life* and noting that "ERISA does not contain any provisions for compensating for damages that may occur because of benefit denial such as lost wages, additional health care costs, or pain and suffering"). Even more important, the Patients' Bill of Rights debate shows that if *Congress* concludes that § 502(a)'s remedies should not be exclusive, Congress can act on that policy judgment. But unless and until Congress does so, this Court should adhere to its own § 502(a) precedents and hold that Calad's state-law challenge to the denial of her benefits is completely preempted.

## CONCLUSION

For the foregoing reasons, and for the reasons previously stated, the judgment should be reversed.

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ously denies that, as one recent actuarial analysis concluded, the "significant escalation in medical malpractice costs has contributed to the increase in health care costs in the U.S. over the past 30 years." Tillinghast-Towers Perrin, U.S. Tort Costs: 2003 Update, Trends and Findings on the Costs of the U.S. Tort System 3 (Dec. 2003). The experience of Texas plans since the enactment of THCLA in 1998 (Resp. Br. 68) certainly does not show that employee benefit plans would be somehow immune from the premium-increasing effects of malpractice liability, given that from 1992 until the decision below, the Fifth Circuit effectively precluded enforcement of medical malpractice challenges to HMO benefit determinations, as respondents themselves observe. Resp. Br. 67.

Respectfully submitted,

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