CLIENT ALERT

ERISA Preempts State Law Claims Challenging Coverage Denials

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The United States Supreme Court has unanimously ruled that ERISA preempted claims brought by two individuals against their HMOs under a Texas law that allows patients to sue HMOs for refusing to cover services recommended by their treating physicians. The Supreme Court decision confirms the reach of ERISA preemption where state law claims challenge the coverage decisions of employee benefit plans. *Aetna Health Inc. v. Davila* and *Cigna Healthcare of Texas, Inc. v. Calad,* 542 U.S. ____ (June 21, 2004) No. 02-1845 and No. 03-83. http://www.supremecourtus.gov/opinions/03pdf/02-1845.pdf

The two plaintiffs were both enrolled in ERISA-regulated employee benefit plans, and had both suffered injuries that they alleged were proximately caused from their HMOs' decisions not to provide coverage for certain treatments recommended by their treating physicians. Pursuant to the Texas Health Care Liability Act (THCLA), the respondents sued their HMOs in state court, alleging that the HMOs' refusal to cover the recommended services violated the HMOs' duty set forth in the THCLA to exercise ordinary care when making health care treatment decisions. The HMOs argued that the respondents' causes of action fit within the scope of ERISA § 502(a)(1)(B), and were thus preempted and removable from state court to federal court. Their claims were dismissed at the trial court level on ERISA preemption grounds, but reinstated by the Fifth Circuit Court of Appeals.

Justice Thomas, writing for the Court, held that that the respondents' THCLA causes of action sought only to redress denials of coverage promised to the respondents' under the terms of their ERISA-regulated benefit plans. The Court rejected the respondents' argument that THCLA claims actually alleged the violation of a legal duty independent of ERISA- namely, that the HMOs made decisions that violated the duty of ordinary care set forth in the THCLA. The Court reasoned that if an ERISA plan did not cover a particular treatment, then an HMO could not be held liable under the THCLA for denying coverage for that treatment; accordingly, the Court determined that THCLA liability derived entirely from the particular rights and obligations established by the plans. Because the respondents' THCLA claims were thus deemed to be not entirely independent of their ERISA plans, the Court held that the respondents' state law claims fell within the scope of the ERISA remedial scheme and were preempted.

The Court rejected several arguments presented in support of the plaintiffs' position. The Court first rejected the contention that ERISA preemption can be avoided by labeling a claim as a tort claim rather than a contract claim. The Court noted that this would allow parties to evade ERISA preemption simply by relabeling contract claims as claims for tortious breach of contract. The Court also rejected the theory that the Court's opinion in *Rush Prudential* suggested that ERISA's preemption is limited to situations where state causes of action precisely duplicate ERISA claims. The Court held that "Congress' intent to make the ERISA civil enforcement mechanism exclusive would be undermined if state causes of action that supplement the ERISA § 502(a) remedies were permitted, even if the elements of the state cause of action did not precisely duplicate the elements of an ERISA claim." The Court further rejected the respondents' argument that the THCLA regulated insurance and was thus saved from preemption by ERISA § 514(b)(2)(A). Citing *Rush Prudential* and *Pilot Life*, the Court stated that ERISA's preemption language must be interpreted in light of Congress' intent to create an exclusive federal remedy in ERISA's remedial provisions, and thus

state laws that can arguably be characterized as "regulating insurance" will be preempted if they provide a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme.

Finally, the Court rejected the argument that respondents' claims did not "relate to [an] employee benefit plan" because the HMOs' actions were mixed eligibility and treatment decisions under the Supreme Court's decision in *Pegram v. Herdrich*. The Court interpreted *Pegram* to mean that only when eligibility decisions and treatment decisions are made by the same party (or by parties in an employment relationship) are they "truly 'mixed eligibility and treatment decisions.'" In contrast, the Court reasoned that when administrators like the petitioner HMOs only make benefits determinations - even when those determinations are based largely on medical judgments - the administrators are acting as plan fiduciaries and the language from *Pegram* is not implicated.

The Court declined to address a suggestion in an amicus curiae brief filed by the United States Solicitor General that some individuals in plaintiffs' positions could possibly receive some form of "make-whole" relief under ERISA §502(a)(3). It also declined to consider an argument by the plaintiffs that their ERISA benefit was enrollment in their HMOs, rather than the benefits provided by the HMOs. It treated this argument as having been waived in the proceedings below by the plaintiffs. This argument would reverse years of precedent placing HMO and insurance benefit determination as coming within the scope of ERISA regulation.

Justice Ginsburg, joined by Justice Breyer, wrote a concurring opinion in which she called for Congress and the Court to revisit the ERISA regime to address a "regulatory vacuum" whereby "[v]irtually all state law remedies are preempted but very few federal substitutes are provided."

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