Supreme Court, U.S.
FILED
03 69 JUL 1 1 2003
OFFICE OF THE CLERK

No. 03-

IN THE

Supreme Court of the United States

VYTRA HEALTHCARE AND BRENT SPEARS, M.D.,

Petitioners,

v.

BONNIE CICIO,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

PETITION FOR A WRIT OF CERTIORARI

CHARLES G. MOERDLER
STROOCK & STROOCK
& LAVAN LLP
180 Maiden Lane
New York, NY 10038
(212) 806-5400

Of Counsel

GLEN D. NAGER
(*Counsel of Record*)
TRACI L. LOVITT
JONES DAY
51 Louisiana Ave., N.W.
Washington, D.C. 20001
(202) 879-3939

Counsel for Petitioners

QUESTION PRESENTED

Whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, preempts state law claims that challenge a non-treating physician's alleged medical judgment in determining eligibility for coverage under an employee benefit plan?

PARTIES TO THE PROCEEDING

Petitioners are (1) Vytra Health Plans Long Island, Inc., a not-for-profit independent practice association model Health Maintenance Organization, which is controlled by and affiliated with Health Insurance Plan of Greater New York, Inc., a New York not-for-profit corporation, and (2) Brent Spears, M.D., who at all applicable times was the medical director of Vytra Health Plans. Respondent is Bonnie Cicio, acting individually and as administratrix of the estate of Carmine Cicio.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
PARTIES TO THE PROCEEDING	ii
TABLE OF AUTHORITIES	iv
OPINIONS BELOW	1
JURISDICTION	1
CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED	1
STATEMENT	2
REASONS FOR GRANTING THE WRIT	9
I. THE DECISION BELOW ADDS TO THE CONSIDERABLE CONFUSION IN THE LOWER COURTS ABOUT WHETHER, AFTER *PEGRAM*, ERISA PREEMPTS STATE LAW CLAIMS INVOLVING ALLEGED MEDICALLY-BASED ELIGIBILITY DETERMINATIONS	10
II. THE QUESTION PRESENTED IS A RECURRING ONE OF NATIONAL IMPORTANCE THAT REQUIRES IMMEDIATE RESOLUTION	18
III. THE SECOND CIRCUIT ERRED IN CONCLUDING THAT CICIO'S CLAIM IS NOT PREEMPTED BY ERISA	22
CONCLUSION	28

TABLE OF AUTHORITIES

Page

Cases

Alessi v. Raybestos-Manhattan, Inc.,
451 U.S. 504 (1981) 2
Bast v. Prudential Ins. Co. of Am.,
150 F.3d 1003 (9th Cir. 1998) 11
Boggs v. Boggs,
520 U.S. 833 (1997) 19
Caffey v. Unum Life Ins. Co.,
302 F.3d 576 (6th Cir. 2002) 14
Calif. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.,
519 U.S. 316 (1997) 23
Cannon v. Group Health Serv. of Okla., Inc.,
77 F.3d 1270 (10th Cir. 1996) 11
Corcoran v. United HealthCare, Inc.,
965 F.2d 1321 (5th Cir. 1992) 7, 11, 16
Danca v. Private Health Care Sys., Inc.,
185 F.3d 1 (1st Cir. 1999) 10
District of Columbia v. Greater Wash. Bd. of Trade,
506 U.S. 125 (1992) 23
Dukes v. U.S. Healthcare, Inc.,
57 F.3d 350 (3d Cir. 1995) 13
Eid v. Duke,
816 A.2d 844 (Md. 2003) 16, 17
Fort Halifax Packing Co. v. Coyne,
482 U.S. 1 (1987) 3
Gerosa v. Savasta & Co.,
329 F.3d 317 (2d Cir. 2003) 18
Haynes v. Prudential Health Care,
313 F.3d 330 (5th Cir. 2002) 16, 18

TABLE OF AUTHORITIES
(continued)

Page

Howard v. Coventry Health Care of Iowa, Inc.,
293 F.3d 442 (8th Cir. 2002) 15
Ingersoll-Rand Co. v. McClendon,
498 U.S. 133 (1990) 3, 23
Isaac v. Seabury & Smith, Inc.,
No. IPO-1-C1437 B/S, 2002 WL 1461710
(S.D. Ind. July 5, 2002) 19
Jass v. Prudential Health Care Plan, Inc.,
88 F.3d 1482 (7th Cir. 1996) 7, 11
Kuhl v. Lincoln Nat'l Health Plan of Kan. City, Inc.,
999 F.2d 298 (8th Cir. 1993) 11
Land v. Cigna Healthcare,
No. 02-15549EE
(11th Cir. filed Oct. 7, 2002) 19
Marks v. Watters,
322 F.3d 316 (4th Cir. 2003) 13
Mertens v. Hewitt Assocs.,
508 U.S. 248 (1993) 21, 26
Metro. Life Ins. Co. v. Taylor,
481 U.S. 58 (1987) 25
N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.,
514 U.S. 645 (1995) 23
Pappas v. Asbel,
768 A.2d 1089 (Pa. 2001),
cert. denied sub nom.
U.S. Health Care Sys. of Pa., Inc. v. Pa. Hosp. Ins. Co., 536 U.S. 938 (2002) 12, 21
Patterson v. Shumate,
504 U.S. 753 (1992) 19
Pegram v. Herdrich,
530 U.S. 211 (2000) .... *passim*
Pilot Life Ins. Co. v. Dedeaux,
481 U.S. 41 (1987) 3, 21, 24, 25

TABLE OF AUTHORITIES
(continued)

Page

Pryzbowski v. U.S. Healthcare, Inc.,
245 F.3d 266 (3d Cir. 2001) 7, 13, 18, 21
Rivers v. Health Options Connect, Inc.,
96 F. Supp. 2d 1370 (S.D. Fla. 2000) 20
Roark v. Humana, Inc.,
307 F.3d 298 (5th Cir. 2002),
petition for cert. filed, 71 U.S.L.W. 3791
(U.S. June 3, 2003) (No. 02-1826), and
petition for cert. filed sub nom.
Aetna Health, Inc. v. Davila, -- U.S.L.W. --
(U.S. June 20, 2003) (No. 02-1845) 15
Rubin-Schneiderman v. Merit Behavioral Care Corp.,
60 Fed. Appx. 887 (2d Cir. Apr. 18, 2003) 18
Rush Prudential HMO, Inc. v. Moran,
536 U.S. 355 (2002) 3, 25
Schusteric v. United Healthcare Ins. Co. of Ill.,
No. 00 C 4156, 2000 WL 1263581
(N.D. Ill. Sept. 5, 2000) 20
Shaw v. Delta Air Lines, Inc.,
463 U.S. 85 (1983) 23, 24
Tanous v. United Behavioral Health,
No. 8:01CV297, 2002 WL 378508
(D. Neb. Mar. 12, 2002) 19-20
Thompson v. Gencare Health Sys., Inc.,
202 F.3d 1072 (8th Cir. 2000) 11, 15
Tolton v. Am. Biodyne, Inc.,
48 F.3d 937 (6th Cir. 1995) 7, 11
Tran v. Kaiser Found. Health Plan of Tex.,
No. Civ.A. 300 CV1559P, 2001 WL 1082418
(N.D. Tex. Sept. 7, 2001) 20
Turner v. Fallon Community Health Plan, Inc.,
127 F.3d 196 (1st Cir. 1997) 10
Villazon v. Prudential Health Care Plan, Inc.,
843 So. 2d 842 (Fla. 2003) 12

TABLE OF AUTHORITIES
(continued)

Page

Waldschmidt v. Aetna U.S. Healthcare,
225 F. Supp. 2d 560 (W.D. Pa. 2002) 19

Federal Constitutional Provisions & Statutes

U.S. CONST. art. VI 1
28 U.S.C.
§ 1291. 1
§ 1254(1). 1
§ 1331. 1
§ 1367(a). 1
ERISA (29 U.S.C.)
§ 1002(3). 3
§ 1009(a). 27
§§ 1021-1031. 2
§§ 1101-1114. 2
§§ 1131-1145. 2
§ 1132 1
§ 1132(a) 1
§ 1132(a)(1)(B) . . . . *passim*
§ 1132(e)(1) 3
§ 1144(a) . . . . *passim*

Miscellaneous

Leo T. Crowley, *Door Opens for Malpractice Claims to Outlast Preemption Disputes*,
N.Y.L.J. (Mar. 6, 2003) 20
M. Freudenheim, *A Court Says Insurance Companies Should be Accountable for Damage to a Patient's Health*, N.Y. TIMES (Feb. 20, 2003) 20-21
Judy Greenwald, *Court may revisit* Pegram*; Interpretations muddy waters on HMO ruling*,
BUS. INS. (Oct. 8, 2001) 18

TABLE OF AUTHORITIES
(continued)

Page

David Hechler, *After ERISA Decision, Confusion Remains*, N.Y.L.J. (Mar. 6, 2003) 17
Stephanie Kanwit, *Should HMO Coverage Decisions be Subject to Medical Malpractice Lawsuits? No: It Makes No Sense*, THE REGULATOR (May 2003) 21
Thomas A. Moore & Matthew Gaier, *Recent Second Decision on HMO Liablity*, N.Y.L.J. (Mar. 10, 2003) 20
Robert Pear, *A Court Expands the Rights of Patients to Sue* HMO's, N.Y. TIMES (Feb. 18, 2003) 20
Roni Rabin, *HMO Can Be Sued* NEWSDAY (Feb. 21, 2003) 20
R. Rosenblatt, *et al.*, LAW & THE AMERICAN HEALTH CARE SYSTEM (1997) 19

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-44a) is reported at 321 F.3d 83, and the district court's opinion (Pet. App. 45a-52a) is reported at 208 F. Supp. 2d 288.

JURISDICTION

The district court exercised jurisdiction over the plaintiff's claims under 28 U.S.C. § 1331, the complete preemption brought about by 29 U.S.C. § 1132, and the supplemental jurisdiction provision, 28 U.S.C. § 1367(a). The court of appeals asserted jurisdiction pursuant to 28 U.S.C. § 1291, and entered judgment on February 11, 2003. The court of appeals subsequently denied a timely-filed petition for rehearing and for rehearing *en banc* on April 21, 2003. Pet. App. 71a-72a. Jurisdiction in this Court exists under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the United States Constitution, U.S. Const. art. VI, cl. 2, provides in pertinent part:

> This Constitution, and the Laws of the United States 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.

Section 502(a) of ERISA, 29 U.S.C. § 1132(a) states in pertinent part:

> (a) Persons empowered to bring a civil action. A civil action may be brought (1) by a participant or beneficiary (A) for the relief provided in sub-section (c) of this section, or (B) to recover benefits due to him under the terms of the plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan . . . .

Section 514(a) of ERISA, 29 U.S.C. § 1144(a), states as follows:

> (a) Supersedure; effective date. Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

STATEMENT

This case squarely presents a recurring federal question that is dividing and confusing the lower courts—namely, whether ERISA preempts state law claims that challenge a medical judgment made in connection with a benefit eligibility determination by a non-treating physician. This important question deserves this Court's immediate attention.

1. In 1974, after a decade of study, Congress enacted ERISA, a declared policy of which is to protect participants in employee benefit plans "by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b), (c). ERISA generally leaves to plan sponsors the decision whether to establish a benefit plan and, if so, the substantive terms of such a plan. *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 512-13 (1981). But once an employer decides to establish a plan, ERISA imposes requirements for reporting and disclosure relating to such plans. 29 U.S.C. §§ 1021-1031. It also establishes certain standards of conduct for fiduciaries of employee benefit plans. *Id.* §§ 1101-1114. And it establishes comprehensive rules for the administration and enforcement of employee rights in such plans. *Id.* §§ 1131-1145.

As part of this scheme, § 502(a) of ERISA authorizes a participant, beneficiary, or fiduciary to bring suit "to recover benefits due to him under the terms of his plan, to enforce his

rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan" or generally "to enjoin any act or practice which violates any provision of [Title I of ERISA] or the terms of the plan." 29 U.S.C. §§ 1132(a)(1)(B), (3). Section 502 also confers exclusive federal jurisdiction over such suits. 29 U.S.C. § 1132(e)(1).

ERISA further provides in § 514(a) that, except where expressly noted otherwise, "the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any [covered] employee benefit plan . . . ." 29 U.S.C. § 1144(a). The principal goal of § 514(a) is "to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987).

In light of ERISA's uniformity goal, this Court has recognized that state laws can be preempted by ERISA in at least two ways. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138-44 (1990) (discussing ERISA's preemptive scope). *First*, § 502(a) completely preempts state law causes of action that add to or alter the remedies created under that section. *See id.* at 144-45; *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 377-81 (2002). *Second*, under § 514(a) of ERISA, state laws that "refer to" or have a "connection with" an employee benefit plan are also preempted. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47-48 (1987).

2. Petitioner Vytra Health Plans Long Island, Inc. ("Vytra"), is a Health Maintenance Organization ("HMO") that administers healthcare benefits to subscribers. Vytra contracts with employers to provide these benefits under an "Agreement for Comprehensive Health Services" (the "Plan"), an "employee benefit plan" within the meaning of ERISA, *see* 29 U.S.C. § 1002(3). Pet. App. 3a.

Respondent Bonnie Cicio ("Cicio") and her late husband Carmine Cicio received benefits under the Plan through Cicio's employer, North Fork Bank. As part of the Plan, the Cicios were entitled to "diagnosis and treatment of disease, injury or other conditions." *Id.* (quoting Plan Art. III, § 3.1(b)).

Vytra was not, however, required under the Plan to provide medical services unless they were medically "necessary." *Id.*; *see also id.* at 78a (Plan Art. III, § 3.5(a)) ("Vytra shall provide only Medically Necessary Vytra Services."). Vytra also was not required to provide "'[a]ny procedure or service which, in the judgment of Vytra's Medical Director, is experimental or is not generally recognized to be effective for a particular condition, diagnosis, or body area.'" *Id.* at 4a (quoting Plan Art. IX, § 9.3(f)).

In March 1997, Mr. Cicio was diagnosed with multiple myeloma, a form of blood cancer. Pet. App. 2a. After one type of chemotherapy failed, Mr. Cicio's then-treating oncologist, Dr. Edward Samuel, wrote Vytra "request[ing] insurance approval for treatment of Mr. Cicio with high dose chemotherapy supported with peripheral blood stem cell transplantation, in a tandem double transplant, for a diagnosis of multiple myeloma." *Id.* at 4a (citing Letter from Edward T. Samuel to Vytra dated January 28, 1998, at 1). Vytra's medical director, Dr. Brent Spears, denied Dr. Samuel's request. *Id.* Dr. Spears explained that the proposed procedure was "not a covered benefit according to this member's plan which states [that] experimental/investigational procedures are not covered." *Id.* (citing Letter from Brent W. Spears to Edward T. Samuel dated February 23, 1998, at 1).

Dr. Samuel wrote again to Dr. Spears, arguing that double or single stem transplants are promising treatments for multiple myeloma. Pet. App. 5a. Dr. Spears responded that a single stem cell transplant for Mr. Cicio would be covered by the Plan, but again denied coverage for a tandem stem cell

transplant. *Id.* (citing Letter from Brent W. Spears to Edward T. Samuel dated March 25, 1998, at 1). According to the Complaint, Mr. Cicio was, by that time, no longer a candidate for a double stem cell transplant and died on May 11, 1998. *Id.* (citing Compl. ¶ 31).

3. Respondent Cicio subsequently filed a complaint, on behalf of herself and the estate of her late husband in the New York State Supreme Court. Pet. App. 6a. The Complaint alleges eighteen state law causes of action based on Dr. Spears' conclusion that tandem stem cell transplants are experimental and thus not covered under the Plan. *Id.*

On May 30, 2000, Vytra and Dr. Spears (hereinafter, collectively "Vytra") removed the proceedings to the United States District Court for the Eastern District of New York. *Id.* On June 21, 2000, Vytra moved to dismiss the complaint for failure to state a claim. *Id.*

The motion was referred to Magistrate Judge E. Thomas Boyle, who found that the court had removal jurisdiction and that Vytra's Rule 12(b)(6) motion should be granted. Pet. App. 53a-70a. In relevant part, Judge Boyle reasoned that Cicio's state law claims were preempted under §§ 502(a) and 514(a) of ERISA, 29 U.S.C. §§ 1132(a)(1)(B), 1144(a), because "Vytra functioned solely as a plan administrator and bore no responsibility as a provider of medical services . . . . For this reason, the challenge here does not target the quality of care but rather attacks the benefits decision that was made." Pet. App. 67a.

The district court adopted the report and recommendation in full. *Id.* at 45a-52a. The court agreed that the Plan was an "employee benefit plan" under ERISA and thus subject to its requirements. *Id.* at 48a. In addition, the court agreed that Cicio's claims could not escape preemption simply because they arose from an eligibility determination involving medical judgment. *Id.* at 50a-51a.

4. In a divided decision, the Second Circuit reversed in part. Pet. App. 1a-44a. While the court affirmed the dismissal of most of Cicio's claims, it held that Cicio's medical malpractice claims were not preempted. *Id.* at 31a-36a.

a. With respect to the malpractice claims, the court found that such claims were different from the other claims asserted in Cicio's Complaint, because they involved Vytra's exercise of medical judgment, namely its decision that the treatment proposed by Dr. Samuel was experimental. *Id.* at 30a-31a. According to the Second Circuit, ERISA does not preempt such a traditional area of state law, even where mere coverage determinations are at issue. *Id.* at 31a-33a.

The Second Circuit based its holding on *Pegram v. Herdrich*, 530 U.S. 211 (2000). Although the Second Circuit recognized that *Pegram* was not an ERISA preemption case but concerned "only whether an HMO had . . . breached its fiduciary duty to members" (Pet. App. 28a), the court concluded that *Pegram* was nonetheless determinative:

> [*Pegram*] suggests that . . . some [healthcare] decisions involve interpretation of a benefits contract, eligibility decisions, and some involve application of medical judgment to a particular patient's condition, treatment decisions. And these two categories overlap. The resulting third category, described in *Pegram*, of "mixed eligibility and treatment decisions," is not limited to decisions made by treating physicians . . . who both assess which benefits a plan provides and make treatment decisions . . . . [E]ven if a physician does not directly control, direct, or influence a plaintiff's treatment, and even if the sole consequence of a physician's decision is reimbursement or its denial, that decision may nonetheless be a mixed eligibility and treatment decision.

Id. at 29a-30a (internal citations omitted).

In light of *Pegram*, the Second Circuit found that a "categorical distinction between 'quality of care' decisions and 'benefits administration' questions . . . . is no longer tenable." *Id.* at 31a-32a. Rather, *Pegram* "strongly suggests" that mixed eligibility determinations are not preempted and "that a defendant can no longer simply point to the overlay of medical decision-making on contractual claims and ask the Court to conclude that, because ERISA preempts the contract claims, it also preempts all state tort-law claims based on the same decision." *Id.* at 32a. Based on *Pegram*, the court held that Dr. Spears' denial "must be treated as a mixed decision because it allegedly involved both an exercise of medical judgment and an element of contract interpretation," and thus claims based on his decision were not preempted. *Id.* at 31a.

The Second Circuit recognized that "[o]ther courts addressing similar facts have concluded that malpractice claims based on utilization review decisions are indeed preempted by § 514." Pet. App. 26a (citing *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1326 (5th Cir. 1992), *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1488 (7th Cir. 1996), and *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 942 (6th Cir. 1995)). In the Second Circuit's view, these decisions were no longer persuasive because they "were decided before the Supreme Court's recent retrenchment of ERISA's preemption's margins, and before the Court, in its unanimous decision in *Pegram v. Herdrich*, addressed (albeit in *dicta*) medical malpractice actions against those engaged in medical decision making." *Id.* at 27a. The Second Circuit also recognized that its decision conflicted with the post-*Pegram* decision in *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 273 (3d Cir. 2001). Pet. App. 31a. But the court "decline[d] to adopt the categorical distinction between 'quality of care' decisions and 'benefits administration' questions applied by" the Third Circuit in that case. *Id.* In the Second Circuit's view, "*Pegram* teaches that this dichotomy is no longer tenable." *Id.* at 32a.

b. Judge Calabresi dissented. Pet. App. 37a-44a. In his view, "the majority's holding [could not be reconciled] with the Supreme Court's precedents and with the structure of ERISA itself, given those precedents." *Id.* at 38a. He reasoned:

> On these facts it seems to me clear beyond peradventure a) that the plan administrators were not, in any way, acting as Mr. Cicio's doctors, b) that what they were doing was—perhaps negligently—determining the scope and coverage of an ERISA-plan contract, c) that as a result of that allegedly improper denial of coverage, Mr. Cicio was financially unable to obtain, in time, the treatment he and his treating physician continued to seek, and d) that catastrophic, consequential damages—Mr. Cicio's death—flowed from the improper misreading of the ERISA-plan coverage. Mrs. Cicio then sued for those damages. If this is not a paradigmatic suit to remedy the violation of rights under the terms of the plan, I don't know what is.

Id. at 42a-43a. Judge Calabresi added that the majority made too "much of the fact that the coverage decision was erroneously made because of a *medical error* on the plan administrator's part. That may well be, but that fact seems to me irrelevant." *Id.* at 43a (emphasis in original).

With respect to *Pegram*, Judge Calabresi argued that the Court's *dicta* about preemption could "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 a physician's employer, as was the case in *Pegram.*" *Id.* at 43a-44a. But "[w]here, as here, no such relationship exist[s], 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." *Id.* at 44a (emphasis in original).

5. On April 21, 2003, the Second Circuit denied a timely-filed petition for rehearing and rehearing *en banc*. Pet. App. 71a-72a.

REASONS FOR GRANTING THE WRIT

Every day, administrators of employee benefit plans, including non-treating physicians, make judgments about whether a proposed treatment is eligible for coverage under a benefit plan. Many of these judgments involve medical or clinical considerations, as benefit plans usually cover, for example, only "medically necessary" procedures and frequently exclude "experimental" treatments.

In *Pegram*, this Court considered whether medically-based coverage determinations, when made by a treating physician, are fiduciary acts under ERISA and held that such "mixed eligibility" decisions are not fiduciary acts. In doing so, the Court noted in *dicta* that its holding avoided "a puzzling issue of preemption"—to wit, whether applying federal fiduciary law to "mixed eligibility" decisions would preempt state medical malpractice challenges. *Pegram*, 530 U.S. at 236.

Since *Pegram* was decided, both the Executive Branch and numerous circuit courts and state courts of last resort have struggled to resolve a distinct but related preemption question under ERISA—namely, whether ERISA preempts state law claims challenging a non-treating physician's alleged medical judgment in determining eligibility for coverage under an employee benefit plan. The Executive Branch has argued to this Court that such state law causes of action should be preempted. But the lower courts have split into at least four different camps on the issue, and the jurisprudence in this area has become hopelessly confused. Seizing upon the *dicta* in *Pegram*, the Second Circuit and one state court of last resort have held that ERISA does not preempt state law claims challenging a non-treating physician's alleged medical judgment made in determining eligibility for coverage. In contrast, four other federal circuit courts—the Third, Fourth,

Sixth, and Eighth—have held these causes of action preempted under §§ 502(a) and 514(a) of ERISA. The Fifth Circuit has held that alleged medically-based eligibility determinations do not fall within the scope of § 502(a) of ERISA but are preempted under § 514(a). Finally, the Maryland Court of Appeals has held that ERISA preempts state law claims that challenge eligibility decisions unless a traditional medical malpractice action is involved.

This Court should clarify this confusion. The preemption issue dividing the courts is of vital importance. In addition, allowing the confusion to remain is contrary to ERISA's own expressed interest in uniform national rules for benefit plans. Finally, as Judge Calabresi argued in dissent below, the Second Circuit's view of this ERISA preemption question cannot be squared with this "Court's precedents and with the structure of ERISA itself . . . ." Pet. App. 38a.

I. THE DECISION BELOW ADDS TO THE CONSIDERABLE CONFUSION IN THE LOWER COURTS ABOUT WHETHER, AFTER *PEGRAM*, ERISA PREEMPTS STATE LAW CLAIMS INVOLVING ALLEGED MEDICALLY-BASED ELIGIBILITY DETERMINATIONS.

Prior to *Pegram*, at least seven federal courts of appeal—the First, Fifth, Sixth, Seventh, Eighth, Ninth, and Tenth Circuits—had concluded that state law claims challenging alleged medically-based eligibility determinations are preempted by ERISA. *See Turner v. Fallon Community Health Plan, Inc.*, 127 F.3d 196, 199-200 (1st Cir. 1997) (denial of breast cancer treatment on ground that it was experimental was not actionable in light of ERISA preemption); *Danca v. Private Health Care Sys., Inc.*, 185 F.3d 1, 5-7 (1st Cir. 1999) ("Although we recognize that the allegedly negligent decision making and consultation at issue here may be characterized as medical in nature, this fact alone does not remove the state causes of action from the scope of

§ 502(a)."); *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1332 (5th Cir. 1992) (state law claims based on denial of hospitalization benefits as medically unnecessary not actionable because a benefit plan administrator "makes medical decisions as part and parcel of its mandate to decide what benefits are available."); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937, 942-43 (6th Cir. 1995) (claims based on denial of hospitalization as medically unnecessary preempted by ERISA); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1493 (7th Cir. 1996) (alleged failure to treat preempted as related to eligibility decision); *Thompson v. Gencare Health Sys., Inc.*, 202 F.3d 1072, 1073-74 (8th Cir. 2000) (refusal to extend benefits for breast cancer treatment as medically unnecessary was not actionable under medical malpractice law); *Kuhl v. Lincoln Nat'l Health Plan of Kan. City, Inc.*, 999 F.2d 298 (8th Cir. 1993) (state law claims based on delay in approving heart surgery preempted); *Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1008 (9th Cir. 1998) (no state law claim allowed for breast cancer treatment denied as experimental); *Cannon v. Group Health Serv. of Okla., Inc.*, 77 F.3d 1270, 1273-74 (10th Cir. 1996) (decision to deny leukemia treatment as experimental could not be the basis of state law claims because claims were preempted by ERISA). Three circuits had, indeed, rejected state law claims based on the exact factual scenario here—specifically, an allegation that a non-treating physician was negligent in denying coverage for some proposed medical treatment as experimental. *Bast*, 150 F.3d at 1008; *Turner*, 127 F.3d at 199-200; *Cannon*, 77 F.3d at 1273-74.

This widespread judicial consensus quickly eroded in the wake of this Court's decision in *Pegram*. Since June 2000, at least six federal circuit courts and two state courts of last resort have considered whether state law claims challenging alleged medically-based eligibility determinations are preempted by ERISA, and they have rendered conflicting decisions based on four different, inconsistent rationales.

Some courts have held that state law claims concerning alleged medically-based eligibility determinations are not preempted at all, under any provision of ERISA. Others, however, have held that such claims are completely preempted under §§ 502(a) and 514(a) of ERISA. Still another court has held that, while state law claims are not within the scope of § 502(a), they are preempted under § 514(a). Finally, one court has held that ERISA preempts state law claims except insofar as a traditional malpractice claim is involved.

In the first camp, the Pennsylvania Supreme Court has joined the Second Circuit and held that alleged medically-based eligibility determinations are not preempted by any provision of ERISA. *See Pappas v. Asbel*, 768 A.2d 1089 (Pa. 2001), *cert. denied sub nom. U.S. Healthcare Sys. of Pa., Inc. v. Pa. Hosp. Ins. Co.*, 536 U.S. 938 (2002). Like the Second Circuit, the Pennsylvania Supreme Court concluded that *Pegram* instructs that a "mixed eligibility and treatment decision implicates a state law claim for medical malpractice, not an ERISA cause of action for fiduciary breach. Thus if [plaintiff's] third party claim against [the benefit plan administrator] arose out of a mixed decision, it is, according to *Pegram*, subject to state medical malpractice law." *Pappas*, 768 A.2d. at 1095; *see also id.* at 1096 ("His was a mixed eligibility and treatment decision, the adverse consequences of which, if any, are properly redressed, as *Pegram* teaches, through state medical malpractice law. This law . . . is not preempted by ERISA."). *See also Villazon v. Prudential Health Care Plan, Inc.*, 843 So. 2d 842, 850-51 (Fla. 2003) (although not deciding preemption question here, observing that *Cicio* decision "is consistent with and reflective of the current state of the law in Florida" and that it will apply in future preemption cases "the analysis employed in . . . *Pappas*.").

In contrast, the Third, Fourth and Sixth Circuits have held that state law claims challenging alleged medically-based eligibility determinations are preempted by both §§ 502(a) and

514(a) of ERISA. The Eighth Circuit has indicated that it is in this camp as well.

In *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001), a post-*Pegram* decision that the Second Circuit expressly acknowledged conflicts with its own (Pet. App. 31a), the Third Circuit held that a state law claim seeking damages for a denial of coverage was completely preempted by ERISA. The court acknowledged that *Pegram* "suggests preferable terminology" for courts to use when analyzing ERISA claims, but concluded that *Pegram* ultimately does not alter preemption analysis:

> [r]egardless of the language used, the ultimate distinction to make for purposes of complete preemption is whether the claim challenges the administration of or eligibility for benefits, which falls within the scope of § 502(a) and is completely preempted, or the quality of the medical treatment performed, which may be the subject of a state action.

Id. at 273. Accordingly, the court reaffirmed its pre-*Pegram* preemption decisions, *see id.* (citing *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 356 (3d Cir. 1995)), and held that "a claim alleging that an HMO declined to approve certain requested medical services or treatment on the ground that they were not covered under the plan would manifestly be one regarding the proper administration of benefits. Such a claim, no matter how couched, is completely preempted and removable on that basis." *Id.*

Similarly, in *Marks v. Watters*, 322 F.3d 316 (4th Cir. 2003), the Fourth Circuit held that state law claims challenging alleged medically-based eligibility determinations are completely preempted by ERISA. It, too, rejected the argument that *Pegram* should be read to alter ERISA's preemption analysis:

> [E]ven though the distinction between pure eligibility decisions and treatment decisions may tend to blur when the treating physician is also responsible for making eligibility decisions . . . that is not the case here where the treating physicians and [benefits administrator] were institutionally segregated from one another. [The administrator] worked for an independent utilization review agent that was under contract with [a preferred provider network] . . . and the treating physicians were simply employed by, or connected with, the hospital to which [the insured] was admitted. Under this arrangement, treatment decisions and eligibility decisions were made by different people at different times according to different policies."

Id. at 326. The Fourth Circuit concluded that the plaintiffs could not "transform what is properly considered a § 502(a) claim into a state-law claim for malpractice simply by making unsubstantiated and incorrect statements that an independent utilization review agent was responsible for medical decisions." *Id.* at 326-37.

The Sixth Circuit has also reaffirmed, since *Pegram* was decided, its earlier decisions holding state law actions arising from medically-based eligibility determinations preempted. Specifically, in *Caffey v. Unum Life Ins. Co.*, 302 F.3d 576, 582 (6th Cir. 2002), the Sixth Circuit considered a state law claim arising from a benefit administrator's decision that a proposed medical treatment was not covered, in part, because the treating physician's diagnosis was incorrect. *Id.* at 579. The court concluded that the claim was preempted because "[a]ll of plaintiff's state-law claims stem from the actions of [the administrator] in the processing of her claim for benefits." *Id.* at 582. Although the court did not specifically discuss *Pegram*, it concluded that its view of ERISA preemption was compelled by this Court's jurisprudence. *See id.*

The Eighth Circuit has also strongly indicated in a pair of cases that state law claims challenging alleged medically-

based eligibility determinations are preempted. Prior to *Pegram*, in *Thompson v. Gencare Health-Systems, Inc.*, 202 F.3d 1072, 1073 (8th Cir. 2000), the court rejected the argument that a plaintiff's medical malpractice claim was not preempted because it implicated a medical judgment, reasoning that the plaintiff "and her treating physicians retained the ultimate decision-making authority regarding her medical care." *Id.* at 1074. Subsequently, in *Howard v. Coventry Health Care of Iowa, Inc.*, 293 F.3d 442 (8th Cir. 2002), the court refused to modify its ERISA preemption analysis in light of *Pegram*:

> *Pegram* addresses an issue not before this court: ERISA actions in the context of claims for breach of duties by plan fiduciaries. Moreover, *Pegram* did not hold that all quality of care claims exist outside the scope of ERISA or support [plaintiff's] contention of a cause of action outside of ERISA. Thus, *Pegram* does not support [plaintiff's] claim.

Id. at 445 (internal citations omitted).

In contrast to these courts, the Fifth Circuit has concluded that state law challenges to alleged medically-based eligibility determinations are *not* preempted under § 502(a) of ERISA but are subject to § 514(a) preemption. In *Roark v. Humana, Inc.*, 307 F.3d 298, 315 (5th Cir. 2002), *petition for cert. filed*, 71 U.S.L.W. 3791 (U.S. June 3, 2003) (No. 02-1826), and *petition for cert. filed sub nom. Aetna Health Inc. v. Davila*, -- U.S.L.W. -- (U.S. June 20, 2003) (No. 02-1845), the Fifth Circuit considered four consolidated appeals, all of which involved coverage claims asserting delay or refusal of physician-recommended treatment. The court reasoned that *Pegram* altered the analysis of complete preemption under § 502(a) of ERISA such that an eligibility determination involving a medical judgment by a non-treating physician was not completely preempted by that section of ERISA. *Id.* at 307-08. In the court's view, *Pegram* suggested that § 502(a) was not intended to federalize medical malpractice law, and

claims challenging medically-based eligibility determinations are such malpractice challenges. *Id.* at 308-11. With respect to preemption under § 514 of ERISA, however, the court concluded that *Pegram* could *not* be read to overrule the Fifth Circuit's earlier decisions holding that claims involving alleged medically-based eligibility determinations are preempted by this provision of ERISA. *Id.* (citing *Corcoran,* 965 F.2d at 1332-34). An *en banc* panel of the Fifth Circuit subsequently declined to rehear the case *en banc* or revisit its earlier § 514 precedent. *See also Haynes v. Prudential Health Care*, 313 F.3d 330, 336 (5th Cir. 2002) ("[W]e do not read *Pegram* to entail that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment.").

The final approach to preemption was announced by the Maryland Court of Appeals in *Eid v. Duke*, 816 A.2d 844 (Md. 2003). Without specifying the particular source of ERISA preemption, the court held that a cause of action challenging an alleged medically-based eligibility determination is preempted unless it states a claim under traditional malpractice law. In the Maryland Court of Appeals' view, *Pegram* means that:

> [T]he issue of preemption is inextricably bound up with the availability of a traditional medical malpractice claim under state law. If the nature of the action constitutes a traditional state law medical malpractice action, it is probably not preempted by ERISA. If, however, a physician's decision would not give rise to a traditional medical malpractice action, but is entirely an administrative decision concerning eligibility under or coverage of an ERISA plan, it is preempted.

Id. at 852. Applying this rule, the court held that the action before it—which involved a determination that the plaintiff was not disabled, *see id.* at 847-48—was preempted, because Maryland malpractice law required a "relationship of doctor

and patient as a result of a contract . . . that the doctor will treat the patient." *Id.* at 852. But the plaintiff had no such relationship with the benefits administrator; rather, the administrator "was acting entirely within his capacity as a fiduciary under the Plan." *Id.* at 853.

The conflict does not end with the lower courts, as the United States has also published its views on the preemption issue in a brief submitted to this Court. Specifically, in its *amicus* brief signed by the Solicitor General and the Solicitor of the Department of Labor and filed in *Rush Prudential HMO, Inc. v. Moran*, No. 00-1021, 2001 WL 1480556 (filed Nov. 7, 2001), the United States argued that state law challenges to eligibility decisions under benefit plans should be preempted "even if the subject of the decision is 'medical necessity' and the decisionmaker is a physician." *Id.* at *10; *see also id.* at *8-9 (discussing *Pegram*). With regard to *Pegram*, the United States stated that:

> Some statements in *Pegram*, if read in isolation, might suggest that such "mixed decisions" . . . are never fiduciary acts under ERISA, regardless of whether they are made by the treating physician or by another physician who is ruling on a beneficiary's internal appeal of the denial of her claim. If so, there might then be a question whether a state law governing mixed decisions "relates to" ERISA plans at all. The better reading of *Pegram*, however, is that it addresses only mixed decisions made by treating physicians. *Pegram* grew out of such a decision by the plaintiff's treating physician.

Id. at 8.

Not surprisingly, much has already been written about the confusion and conflict that has arisen in *Pegram*'s wake. Discussing this case, Carter Phillips has called ERISA "a nightmare," and its preemption provision "largely imponderable." David Hechler, *After ERISA Decision, Confusion Remains*, N.Y.L.J., Mar. 6, 2003, at 5 (quoting

Carter Phillips). Other practitioners have offered that "[t]he bottom line is the courts are split on this issue about how to read *Pegram*, and whether there is pre-emption where there is a mixed medical and eligibility decision." Judy Greenwald, *Court may revisit* Pegram; *Interpretations muddy waters on HMO ruling*, BUS. INS. at 1 (Oct. 8, 2001).

This conflict, moreover, will not resolve itself over time but will worsen. There is no reason to expect that the Second Circuit will reconsider its *Cicio* decision. The court denied a motion to rehear the case *en banc* despite Judge Calabresi's dissenting vote, and the court has since cited *Cicio* as settled circuit precedent. *See Gerosa v. Savasta & Co.*, 329 F.3d 317, 326 n.7 (2d Cir. 2003); *Rubin-Schneiderman v. Merit Behavioral Care Corp.*, 60 Fed. Appx. 887, 887 (2d Cir. Apr. 18, 2003) (remanding to district court in light of *Cicio*). Courts on the other side of the preemption issue, moreover, have expressly rejected the Second Circuit's reasoning. *See, e.g., Pryzbowski*, 245 F.3d at 274-75; *Haynes*, 313 F.3d at 336. So has the United States in its *amicus* brief in *Rush*. In short, even though *Pegram* was decided just a few years ago, its *dicta* has already deeply divided and confused the lower courts, and the arguments on every side of the issue have been well ventilated. This Court's immediate review of the preemption issue is thus necessary and appropriate.

II. THE QUESTION PRESENTED IS A RECURRING ONE OF NATIONAL IMPORTANCE THAT REQUIRES IMMEDIATE RESOLUTION.

Beyond implicating a split of authority, the question presented is one of national importance that arises with great frequency. Failure to resolve the issue promptly will undermine the uniformity objective of ERISA, waste substantial judicial resources, and have a deleterious impact on health care coverage.

There can be no serious debate that ERISA preemption questions have great national importance. This Court has

characterized the policy underlying ERISA preemption—"uniform national treatment" of benefits—as one of great importance. *See Patterson v. Shumate*, 504 U.S. 753, 765 (1992). Indeed, the Court has recognized that "ERISA pre-emption questions are recurrent" precisely because of "the comprehensive nature of the statute, the centrality of pension and welfare plans in the national economy, and their importance to the financial security of the Nation's work force." *Boggs v. Boggs*, 520 U.S. 833, 839 (1997).

The particular preemption question presented here—whether state law claims challenging alleged medically-based eligibility determinations are preempted—is especially important, because so many coverage decisions involve medical determinations. *See* R. Rosenblatt, *et al.*, LAW & THE AMERICAN HEALTH CARE SYSTEM 211-12, 568-70 (1997). For example, benefit administrators frequently make decisions about the efficacy of medical procedures, whether procedures are experimental and/or whether a procedure is medically necessary. *Id.* at 211-15. Moreover, because of the rate of technological change and scientific and medical experimentation, as well as the growth of healthcare fraud and unduly defensive medical practice, novel eligibility and coverage questions involving benefit provisions of this type arise with great frequency. *Id.* at 19, 212-13. Accordingly, the question presented here affects literally thousands of benefit plans and millions of healthcare decisions by benefit administrators. Indeed, in the three years since *Pegram* was decided, eight courts of appeal and state courts of last resort have already opined on this preemption question. And the same issue is pending in or has recently been decided by numerous district courts as well. *See Land v. Cigna Healthcare*, No. 02-15549EE (11th Cir. notice of appeal filed Oct. 7, 2002); *Waldschmidt v. Aetna U.S. Healthcare*, 225 F. Supp. 2d 560, 565-66 (W.D. Pa. 2002); *Isaac v. Seabury & Smith, Inc.*, No. IP0-1-C1437 B/S, 2002 WL 1461710, at *1 (S.D. Ind. July 5, 2002); *Tanous v. United Behavioral Health*,

No. 8:01CV297, 2002 WL 378508, at *1-*2 (D. Neb. Mar. 12, 2002); *Tran v. Kaiser Found. Health Plan of Tex.*, No. Civ.A. 300CV1559P, 2001 WL 1082418, at *6 (N.D. Tex. Sept. 7, 2001); *Schusteric v. United Healthcare Ins. Co. of Ill.*, No. 00 C 4156, 2000 WL 1263581, at *2 (N.D. Ill. Sept. 5, 2000); *Rivers v. Health Options Connect, Inc.*, 96 F. Supp. 2d 1370, 1373 (S.D. Fla. 2000).

For this reason, the Solicitor General in his petition-stage *amicus* brief in *Rush* characterized the preemption issue here as one "of very broad significance." *See Rush Prudential, Inc. v. Moran*, No. 00-1021 (Br. filed May 31, 2001). Consistent with this observation, in the court below, five national and state organizations—the American Medical Association, the American College of Legal Medicine, the Medical Society of the State of New York, the American Association of Health Plans, and the New York Health Plan Association—signed *amicus* briefs addressing this preemption question. Finally, both legal academics and national news commentators have opined on the importance of the issue:

> the significance of the holding by the Second Circuit cannot be overstated. Its broad interpretation of *Pegram* and its protection of state law causes of action regarding medical practice and health care are monumental.

Thomas A. Moore & Matthew Gaier, *Recent Second Circuit Decision on HMO Liability*, N.Y.L.J., Mar. 10, 2003, at 3; *see also* Roni Rabin, *HMO Can Be Sued*, NEWSDAY, Feb. 21, 2003, at A4 (calling *Cicio* a "significant" ruling that "touches on a key controversy"); Leo T. Crowley, *Door Opens for Malpractice Claims to Outlast Preemption Disputes*, N.Y.L.J., Mar. 6, 2003, at 3 (observing that *Cicio* decision "creates a huge gap in the once-formidable wall of ERISA preemption"); Robert Pear, *A Court Expands the Rights of Patients to Sue HMO's*, N.Y. TIMES, Feb. 18, 2003, at A14 (observing that decision greatly "expanded patients' rights"); M. Freudenheim, *A Court says Insurance Companies Should*

be Accountable for Damage to a Patient's Health, N.Y. TIMES, Feb. 20, 2003, at C7 (quoting Dr. Richard Corlin that "[*Cicio*] is a very important case in which the highest court in the country below the Supreme Court has completely pierced ERISA.").

The Court should not delay in resolving the issue and the conflict over it. Every day that the conflict is allowed to persist, ERISA's goal of "set[ting] 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" is undermined. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). The state of the law in Pennsylvania amply demonstrates how harmful this disuniformity can be: In that State, citizens and health plans are subject to plainly inconsistent legal standards, depending upon whether they are in federal or state court. *Compare Pryzbowski*, 245 F.3d at 273 *with Pappas*, 768 A.2d at 1095. Moreover, the diversity in judicial opinion about this issue creates an incentive for forum shopping and for arbitrary legal results, since benefit plans cover employees who may work and/or reside in a multi-State area.

In addition, as this Court has recognized, continuing legal uncertainty harms plan participants by causing employers to reduce or eliminate coverage. *See Pilot Life*, 481 U.S. at 54; *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262-63 (1993). One expert in this field has explained (in discussing this precise preemption question) that "[a]ny increase in costs as well as the uncertainty that accompanies litigation will force employers to confront the costs associated with the potential for large damage awards or settlements, and would discourage them from including broad categories of coverage, or from even sponsoring coverage for their employees altogether." Stephanie Kanwit, *Should HMO Coverage Decisions be Subject to Medical Malpractice Lawsuits? No: It Makes No Sense*, THE REGULATOR, May 2003, at 12. Indeed, failing to

review the question presented now would waste tremendous private and judicial resources, as numerous district courts consider the same recurring issue and render deeply conflicted decisions.

This case is an excellent vehicle for the Court to use in resolving this ERISA preemption question. The court below considered and rejected ERISA preemption under *both* § 502(a) and § 514(a), thus allowing the Court to consider the entire preemption issue in a single case. Both the § 502(a) and § 514(a) questions were cleanly presented to the lower court, and there are no procedural or jurisdictional issues that might preclude the Court's review. Moreover, the Second Circuit expressly acknowledged the conflict in this area, and its decision was issued over a forceful and informative dissent by Judge Calabresi. In short, the time has come for the Court to resolve the ERISA preemption question presented, and this case is the proper medium through which to do so.

III. THE SECOND CIRCUIT ERRED IN CONCLUDING THAT CICIO'S CLAIM IS NOT PREEMPTED BY ERISA.

The Court should also be concerned to correct the error of the court below. The Second Circuit's holding that state law claims challenging alleged medically-based eligibility determinations are not preempted is, as Judge Calabresi argued, contrary to ERISA's structure and the overwhelming precedent of this Court.

First, the lower court's determination that these state law claims are not preempted under § 514(a) of ERISA is erroneous. Section 514(a) provides, in relevant part, that ERISA "shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan." 29 U.S.C. § 1144(a). A state law medical malpractice action challenging an eligibility determination, even one that involves medical judgment, is plainly such a law.

A benefit plan within the meaning of ERISA is "a set of rules that define the rights of a beneficiary and provide for their enforcement. Rules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a plan." *Pegram*, 530 U.S. at 223. Moreover, this Court has said that a state law "relate[s] to" such a benefit plan if it "has a connection with or reference to [the] plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983). Under the latter inquiry, the Court has held preempted laws that "impos[e] requirements by reference to [ERISA] covered programs," *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 130-31 (1992), and laws that establish the existence of an ERISA plan as the "critical factor in establishing liability under the State's [law]." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139-40 (1990). With respect to the former inquiry, this Court has suggested that it should be understood in a "broad sense." *Shaw*, 463 U.S. at 98. Of course, more recently, the Court has made clear "that an 'uncritical literalism' in applying this standard offer[s] scant utility in determining Congress' intent as to the extent of § 514(a)'s reach." *Calif. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997) (quoting *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995)). "Rather, to determine whether a state law has the forbidden connection, [the Court] look[s] both to 'the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive,' as well as to the nature of the effect of the state law on ERISA plans." *Id.* (quoting *Travelers*, 514 U.S. at 656) (internal citation omitted).

Regardless of the exact approach to § 514(a) preemption this Court has applied, it has *always* recognized that state law claims like the one asserted here—that directly implicate the construction and administration of the benefits plan—are

preempted. In *Shaw*, for example, the Court held that the New York Human Rights Law, which prohibited employers from establishing benefit plans that discriminated on the basis of pregnancy, was preempted because the law had the effect of "requir[ing] employers to pay employees specific benefits." *Shaw*, 463 U.S. at 97. In the first half of this Court's decision in *Pilot Life*, 481 U.S. at 48, the Court concluded that common law claims "based on alleged improper processing of a claim for benefits under an employee benefit plan, *undoubtedly* meet the criteria for pre-emption under § 514(a)." *Id.* (emphasis supplied). More recently, in *Rush*, the Court, considering a case involving whether a proposed treatment was "medically necessary," observed that a state law requiring independent review of disputes between HMOs and primary care physicians over the "medical necessity" of a treatment was "beyond serious dispute" a law that "relates to employee benefit plans within the meaning of [§ 514(a)]" because it required HMOs "to submit to an extra layer of review for certain benefit denials." 536 U.S. at 365.

The state law cause of action at issue here—a malpractice action challenging an alleged improper determination of whether a medical procedure was covered under an employee benefit plan—is no different in kind or degree from these preempted state laws. Like the common law claim at issue in *Pilot Life*, the claim here is based on an allegation that some alleged benefit was improperly denied. And Cicio's claim, like the Illinois law at issue in *Rush*, seeks to add another layer of review on top of benefit denials involving medical judgments, only this time the review sought is by a court rather than an arbitrator. Ultimately, the dispute here turns on the rules regarding "definition of benefits," which is part and parcel of a benefit plan. *Pegram*, 530 U.S. at 223.

There is, moreover, no exception to § 514(a) preemption applicable here that might save Cicio's claims from preemption. Unlike the law at issue in *Rush*, which this Court ultimately held was saved from preemption because it

regulated insurance, common law tort principles governing medical malpractice claims are not such insurance regulations. Indeed, this Court has repeatedly held that a "common law of general application . . . is not a law regulating insurance" within the meaning of ERISA's savings clause. *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 62 (1987); *see Pilot Life*, 481 U.S. at 51 (rejecting argument that state law bad faith claim was an insurance regulation because it "has developed from general principles of tort and contract law.").

Second, Cicio's claims are also preempted under § 502(a). This section provides a federal remedy for "a participant or beneficiary" of an employee benefit plan "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). As this Court has recognized, if an action under state law falls within § 502(a)'s scope, it is preempted to the extent the state law entitles a plan participant to remedies that are not provided for in § 502(a). *Rush*, 536 U.S. at 379 (observing that any law that "provided a form of ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA . . . . patently violates ERISA's policy of inducing employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct").

Clearly, state law claims, such as Cicio's, which allege that benefits were improperly denied as a result of a mistaken medical judgment by a non-treating physician, fall within the scope of § 502(a)(1)(B). Indeed, this case is little different from *Metropolitan Life.* In that case, this Court held that tort and contract law claims arising from an alleged improper determination that an employee was not disabled, and not entitled to disability benefits, fell "directly under § 502(a)(1)(B) of ERISA," because the suit was "by a beneficiary to recover benefits from a covered plan." 481 U.S. at 62-63. Cicio's claim is analytically indistinguishable.

In addition, the remedies that Cicio seeks, consequential and punitive damages in excess of $220 million, are not authorized under § 502(a). *See Mertens*, 508 U.S. at 261-63. Allowing Cicio's action to proceed would thus impermissibly alter the remedies provided under ERISA. As Judge Calabresi observed, the Supreme Court "has moved more and more in the direction of barring only those state actions which, if local law were permitted to govern, would expand (or contract) the relief available beyond that provided by § 502(a) of ERISA," but "[e]ven accepting this more limited . . . scope of preemption, where does that leave Mrs. Cicio's suit? . . . . I regretfully conclude that it is barred." Pet. App. 41a.

Third, the Second Circuit improperly read *Pegram* to save state law causes of action challenging alleged medically-based eligibility determinations. *Pegram* was not even an ERISA preemption case. The sole issue that *Pegram* addressed was whether a "mixed eligibility" decision was a fiduciary act under ERISA. Moreover, in *Pegram*, this fiduciary act question arose in a context where a *single* physician functioned both as the treating physician and as the administrator rendering eligibility determinations. *Pegram*, 530 U.S. at 237. This case, in contrast, asks whether ERISA preempts a state law action challenging an eligibility determination by a *non-treating* physician.

To be sure, there is (as Judge Calabresi characterized it) some "unexplained" and "well intentioned *dicta*" in *Pegram* (Pet. App. 43a) which could be read to suggest that, when a benefit plan administrator makes any sort of eligibility determination that requires medical judgment, it never acts as a fiduciary under ERISA. *See id.* at 231. But this is not, as the Solicitor General has argued, the proper way to read *Pegram*'s *dicta*. *Rush Prudential HMO, Inc. v. Moran*, No. 00-1021, 2001 WL 1480556, at *8 (filed Nov. 7, 2001) (emphasis supplied). *Id.* "The better reading of *Pegram*, . . . is that it addresses only mixed decisions *made by treating physicians*." *Id.* (emphasis added).

In any event, the Court's *dicta* in *Pegram* provides no guidance here. *Pegram*'s *dicta*, including its remarks about a "puzzling issue" of ERISA preemption, concerned whether application of ERISA's fiduciary duty provisions to "mixed eligibility" decisions would work a preemption of state malpractice claims. *See* 29 U.S.C. § 1109(a). Nothing in the opinion speaks to the distinct ERISA preemption question here—to wit, whether a challenge to a benefits coverage determination is preempted by the provisions of §§ 502 and 514 of ERISA that make enforcement of the terms of an employee benefit plan the exclusive province of federal law. *See id.* §§ 1132(a)(1)(B); 1144(a). Whether a "mixed eligibility" decision is a fiduciary act or not, a coverage determination is in all events a construction of the terms of a benefit plan within the scope of § 514(a) for which ERISA provides a direct cause of action under a provision of § 502—a cause of action that is separate from the statute's fiduciary duty and enforcement provisions. For this reason, *Pegram*'s *dicta* about the scope of fiduciary duties (and related preemption issues) is wholly inconclusive of the distinct ERISA preemption question presented here.

Of course, *Pegram*'s concern about not unnecessarily preempting state medical malpractice law is implicated here too. But there is no suggestion being made here that a state law challenge to a physician's *treatment* decision is preempted under ERISA. Rather, the suggestion made here is simply that *coverage* determinations themselves are at the heart of ERISA and that state law challenges to coverage decisions are preempted, whether they involve medical considerations or not. *Pegram*'s discussion of fiduciary duties and related preemption questions simply do not address, much less answer, this fundamentally different question.

CONCLUSION

For these reasons, the petition for a writ of *certiorari* should be granted.

Respectfully submitted,

CHARLES G. MOERDLER
STROOCK & STROOCK
& LAVAN LLP
180 Maiden Lane
New York, NY 10038
(212) 806-5400

Of Counsel

GLEN D. NAGER
(*Counsel of Record*)
TRACI L. LOVITT
JONES DAY
51 Louisiana Ave., N.W.
Washington, D.C. 20001
(202) 879-3939

Counsel for Petitioners

July 11, 2003