Health Law: Quality & Liability

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Reading Packet for Week 12 (Fall 2018)

Weekly Summary

ERISA Preemption. Last week, we examined the liability of hospitals and MCOs. To better balance the workload across weeks, we saved one related issue for this week. Since most patients have health insurance as a benefit of their employment, when they complain about a coverage denial, they are effectively complaining about not getting owed employee benefits. Such claims are governed by the federal ERISA statute which preempts analogous state law claims based in tort, contract, or state statutes.

Please remember that ERISA only preempts those claims against MCOs that pertain to payment and coverage (i.e. the denial of private employee benefits). It affects only one type of direct liability. We will examine when ERISA preemption applies. And we will explore the impact of making the remedies in section 502 exclusive.

Reading

All the following materials are collected into a single PDF document:

- ERISA, 29 U.S.C. §§ 1132 & 1144 (preemption)
- *Aetna v. Davila* (U.S. 2004) (ERISA preemption)
- *Sarkisyan v. CIGNA* (C.D. Cal. 2009) (ERISA preemption)

Objectives

By the end of this week, you will be able to:

- Analyze and apply the theory of negligent utilization review. (6.3)
- Analyze and apply the doctrine of ERISA preemption under sections 502 and 514. (6.4)

Statutory Provisions Related to ERISA

U.S. Constitution, Article VI

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, 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.

29 U.S.C. 1132

a) Persons empowered to bring a civil action

A civil action may be brought--

(1) by a participant or beneficiary-- . . .

(B) 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; . . . .

(e) (1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021(f)(1) of this title. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

28 U.S.C. 1441

(a) Except as otherwise expressly provided by Act of Congress, any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending. For purposes of removal under this chapter, the citizenship of defendants sued under fictitious names shall be disregarded.

(b) Any civil action of which the district courts have original jurisdiction founded on a claim or right arising under the Constitution, treaties or laws of the United States shall be removable without regard to the citizenship or residence of the parties. Any other such action shall be removable only if none of the parties in interest properly joined and served as defendants is a citizen of the State in which such action is brought.

(c) Whenever a separate and independent claim or cause of action within the jurisdiction conferred by section 1331 of this title is joined with one or more otherwise non-removable claims or causes of action, the entire case may be removed and the district court may determine all issues therein, or, in its discretion, may remand all matters in which State law predominates.

(d) Any civil action brought in a State court against a foreign state as defined in section 1603(a) of this title may be removed by the foreign state to the district court of the United States for the district and division embracing the place where such action is pending. Upon removal the action shall be tried by the court without jury. Where removal is based upon this subsection, the time limitations of section 1446(b) of this chapter may be enlarged at any time for cause shown.

(e)(1) Notwithstanding the provisions of subsection (b) of this section, a defendant in a civil action in a State court may remove the action to the district court of the United States for the district and division embracing the place where the action is pending if--

(A) the action could have been brought in a United States district court under section 1369 of this title; or

(B) the defendant is a party to an action which is or could have been brought, in whole or in part, under section 1369 in a United States district court and arises from the same accident as the action in State court, even if the action to be removed could not have been brought in a district court as an original matter.

The removal of an action under this subsection shall be made in accordance with section 1446 of this title, except that a notice of removal may also be filed before trial of the action in State court within 30 days after the date on which the defendant first becomes a party to an action under section 1369 in a United States district court that arises from the same accident as the action in State court, or at a later time with leave of the district court.

(2) Whenever an action is removed under this subsection and the district court to which it is removed or transferred under section 1407(j) has made a liability determination requiring further proceedings as to damages, the district court shall remand the action to the State court from which it had been removed for the determination of damages, unless the court finds that, for the convenience of parties and witnesses and in the interest of justice, the action should be retained for the determination of damages.

(3) Any remand under paragraph (2) shall not be effective until 60 days after the district court has issued an order determining liability and has certified its intention to remand the removed action for the determination of damages. An appeal with respect to the liability determination of the district court may be taken during that 60-day period to the court of appeals with appellate jurisdiction over the district court. In the event a party files such an appeal, the remand shall not be effective until the appeal has been finally disposed of. Once the remand has become effective, the liability determination shall not be subject to further review by appeal or otherwise.

(4) Any decision under this subsection concerning remand for the determination of damages shall not be reviewable by appeal or otherwise.

(5) An action removed under this subsection shall be deemed to be an action under section 1369 and an action in which jurisdiction is based on section 1369 of this title for purposes of this section and sections 1407, 1697, and 1785 of this title.

(6) Nothing in this subsection shall restrict the authority of the district court to transfer or dismiss an action on the ground of inconvenient forum.

(f) The court to which a civil action is removed under this section is not precluded from hearing and determining any claim in such civil action because the State court from which such civil action is removed did not have jurisdiction over that claim.

29 U.S.C. 1144

(a) 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. This section shall take effect on January 1, 1975.

(b) (1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies. . . .

(c) For purposes of this section:

> (1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.
>
> (2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

Supreme Court of the United States
AETNA HEALTH INC., fka Aetna U.S. Healthcare Inc. and Aetna U.S. Healthcare of North Texas, Inc., Petitioner,
v.
Juan DAVILA.
Cigna HealthCare of Texas, Inc., dba Cigna Corporation, Petitioner,
v.
Ruby R. Calad, et al.
Nos. 02-1845, 03-83.

Argued March 23, 2004.
Decided June 21, 2004.

Background: Participant in, and beneficiary under, separate employee benefit plans governed by Employee Retirement Income Security Act (ERISA) sued respective plan administrators under Texas Health Care Liability Act (THCLA), in state court, alleging that they suffered injuries due to administrators' decisions not to provide coverage for treatment recommended by their physicians. The United States District Court for the Northern District of Texas, Terry R. Means, J., 2001 WL 34354948, and Barefoot Sanders, Senior Judge, 2001 WL 705776, denied participant's and beneficiary's motions to remand to state court. Participant and beneficiary appealed, appeals were consolidated with several others, and the United States Court of Appeals for the Fifth Circuit, 307 F.3d 298, reversed. Certiorari was granted.

Holding: The Supreme Court, Justice Thomas, held that THCLA claims were completely preempted by ERISA.

Reversed and remanded.

Justice Ginsburg filed concurring opinion, in which Justice Breyer joined.

Justice THOMAS delivered the opinion of the Court.

***204** In these consolidated cases, two individuals sued their respective health maintenance organizations (HMOs) for alleged failures to exercise ordinary care in the handling of coverage decisions, in violation of a duty imposed by the Texas Health Care Liability Act (THCLA), Tex. Civ. Prac. & Rem.Code Ann. §§ 88.001-88.003 (West 2004 Supp. Pamphlet). We granted certiorari to decide whether the individuals' causes of action are completely pre-empted by the "interlocking, interrelated, and interdependent remedial scheme," ****2493** *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985), found at § 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 891, as amended, 29 U.S.C. § 1132(a) *et seq.* 540 U.S. 981, 124 S.Ct. 462, 463, 157 L.Ed.2d 370 (2003). We hold that the causes of action are completely pre-empted and hence removable from state to federal court. The Court of Appeals, having reached a contrary conclusion, is reversed.

I

A

Respondent Juan Davila is a participant, and respondent Ruby Calad is a beneficiary, in ERISA-regulated employee benefit plans. Their respective plan sponsors had entered into agreements with petitioners, Aetna Health Inc. and CIGNA HealthCare of Texas, Inc., to administer the plans. Under Dav-

ila's plan, for instance, Aetna reviews requests for coverage and pays providers, such as doctors, hospitals, and nursing homes, which perform covered services for members; under Calad's plan sponsor's agreement, CIGNA is responsible for plan benefits and coverage decisions.

Respondents both suffered injuries allegedly arising from Aetna's and CIGNA's decisions not to provide coverage for ***205** certain treatment and services recommended by respondents' treating physicians. Davila's treating physician prescribed Vioxx to remedy Davila's arthritis pain, but Aetna refused to pay for it. Davila did not appeal or contest this decision, nor did he purchase Vioxx with his own resources and seek reimbursement. Instead, Davila began taking Naprosyn, from which he allegedly suffered a severe reaction that required extensive treatment and hospitalization. Calad underwent surgery, and although her treating physician recommended an extended hospital stay, a CIGNA discharge nurse determined that Calad did not meet the plan's criteria for a continued hospital stay. CIGNA consequently denied coverage for the extended hospital stay. Calad experienced postsurgery complications forcing her to return to the hospital. She alleges that these complications would not have occurred had CIGNA approved coverage for a longer hospital stay.

Respondents brought separate suits in Texas state court against petitioners. Invoking THCLA § 88.002(a), respondents argued that petitioners' refusal to cover the requested services violated their "duty to exercise ordinary care when making health care treatment decisions," and that these refusals "proximately caused" their injuries. *Ibid.* Petitioners removed the cases to Federal District Courts, arguing that respondents' causes of action fit within the scope of, and were therefore completely preempted by, ERISA § 502(a). The respective District Courts agreed, and declined to remand the cases to state court. Because respondents refused to amend their complaints to bring explicit ERISA claims, the District Courts dismissed the complaints with prejudice.

B

Both Davila and Calad appealed the refusals to remand to state court. The United States Court of Appeals for the Fifth Circuit consolidated their cases with several others raising similar issues. The Court of Appeals recognized ***206** that state causes of action that "duplicat[e] or fal[l] within the scope of an ERISA § 502(a) remedy" are completely preempted and hence removable to federal court. *Roark v. Humana, Inc.*, 307 F.3d 298, 305 (2002) (internal quotation marks omitted). After examining the causes of action available under § 502(a), the Court of Appeals determined****2494** that respondents' claims could possibly fall under only two: § 502(a)(1)(B), which provides a cause of action for the recovery of wrongfully denied benefits, and § 502(a)(2), which allows suit against a plan fiduciary for breaches of fiduciary duty to the plan.

Analyzing § 502(a)(2) first, the Court of Appeals concluded that, under *Pegram v. Herdrich*, 530 U.S. 211, 120 S.Ct. 2143, 147 L.Ed.2d 164 (2000), the decisions for which petitioners were being sued were "mixed eligibility and treatment decisions" and hence were not fiduciary in nature. 307 F.3d, at 307-308.[FN1] The Court of Appeals next determined that respondents' claims did not fall within § 502(a)(1)(B)'s scope. It found significant that respondents "assert tort claims," while § 502(a)(1)(B) "creates a cause of action for breach of contract," *id.*, at 309, and also that respondents "are not seeking reimbursement for benefits denied them," but rather request "tort damages" arising from "an external, statutorily imposed duty of 'ordinary care,' " *ibid.* From *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002), the Court of Appeals derived the principle that complete pre-emption is limited to situations in which "States ... duplicate the causes of action listed in ERISA § 502(a)," and concluded that "[b]ecause the THCLA does not provide an action for collecting benefits," it fell outside the scope of

§ 502(a)(1)(B). 307 F.3d, at 310-311.

> FN1. In this Court, petitioners do not claim or argue that respondents' causes of action fall under ERISA § 502(a)(2). Because petitioners do not argue this point, and since we can resolve these cases entirely by reference to ERISA § 502(a)(1)(B), we do not address ERISA § 502(a)(2).

***207** II

A

Under the removal statute, "any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant" to federal court. 28 U.S.C. § 1441(a). One category of cases of which district courts have original jurisdiction is "[f]ederal question" cases: cases "arising under the Constitution, laws, or treaties of the United States." § 1331. We face in these cases the issue whether respondents' causes of action arise under federal law.

[1][2][3] Ordinarily, determining whether a particular case arises under federal law turns on the " 'well-pleaded complaint' " rule. *Franchise Tax Bd. of Cal. v. Construction Laborers Vacation Trust for Southern Cal.*, 463 U.S. 1, 9-10, 103 S.Ct. 2841, 77 L.Ed.2d 420 (1983). The Court has explained that

> "whether a case is one arising under the Constitution or a law or treaty of the United States, in the sense of the jurisdictional statute[,] ... must be determined from what necessarily appears in the plaintiff's statement of his own claim in the bill or declaration, unaided by anything alleged in anticipation of avoidance of defenses which it is thought the defendant may interpose." *Taylor v. Anderson*, 234 U.S. 74, 75-76, 34 S.Ct. 724, 58 L.Ed. 1218 (1914).

In particular, the existence of a federal defense normally does not create statutory "arising under" jurisdiction, *Louisville & Nashville R. Co. v. Mottley*, 211 U.S. 149, 29 S.Ct. 42, 53 L.Ed. 126 (1908), and "a defendant may not [generally] remove a case to federal court unless the *plaintiff's* complaint establishes that the case 'arises under' federal law," *Franchise Tax Bd., supra*, at 10, 103 S.Ct. 2841. There is an ****2495** exception, however, to the well-pleaded complaint rule. "[W]hen a federal statute wholly displaces the state-law cause of action through complete pre-emption," the state claim can be removed. *Beneficial Nat. Bank v. Anderson*, 539 U.S. 1, 8, 123 S.Ct. 2058, 156 L.Ed.2d 1 (2003). This is so because "[w]hen ***208** the federal statute completely pre-empts the state-law cause of action, a claim which comes within the scope of that cause of action, even if pleaded in terms of state law, is in reality based on federal law." *Ibid.* ERISA is one of these statutes.

B

[4] Congress enacted ERISA to "protect ... the interests of participants in employee benefit plans and their beneficiaries" by setting out substantive regulatory requirements for employee benefit plans and to "provid [e] for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b). The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans. To this end, ERISA includes expansive pre-emption provisions, see ERISA § 514, 29 U.S.C. § 1144, which are intended to ensure that employee benefit plan regulation would be "exclusively a federal concern." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523, 101 S.Ct. 1895, 68 L.Ed.2d 402 (1981).

[5] ERISA's "comprehensive legislative scheme" includes "an integrated system of procedures for enforcement." *Russell*, 473 U.S., at 147, 105 S.Ct. 3085 (internal quotation marks omitted). This integrated enforcement mechanism, ERISA § 502(a), 29 U.S.C. § 1132(a), is a distinctive feature of ERISA, and essential to accomplish Congress' purpose of

creating a comprehensive statute for the regulation of employee benefit plans. As the Court said in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987):

> "[T]he detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan ***209** participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. 'The six carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted ... provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.' " *Id.*, at 54, 107 S.Ct. 1549 (quoting *Russell, supra*, at 146, 105 S.Ct. 3085).

Therefore, any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted. See 481 U.S., at 54-56, 107 S.Ct. 1549; see also *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 143-145, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990).

[6] The pre-emptive force of ERISA § 502(a) is still stronger. In *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 65-66, 107 S.Ct. 1542, 95 L.Ed.2d 55 (1987), the Court determined that the similarity of the language used in the Labor Management Relations Act, 1947 (LMRA), and ERISA, combined with the "clear intention" of Congress "to make § 502(a)(1)(B) suits brought by participants or beneficiaries federal questions for the purposes of federal court jurisdiction in like manner as ****2496** § 301 of the LMRA," established that ERISA § 502(a)(1)(B)'s pre-emptive force mirrored the pre-emptive force of LMRA § 301. Since LMRA § 301 converts state causes of action into federal ones for purposes of determining the propriety of removal, see *Avco Corp. v. Machinists*, 390 U.S. 557, 88 S.Ct. 1235, 20 L.Ed.2d 126 (1968), so too does ERISA § 502(a)(1)(B). Thus, the ERISA civil enforcement mechanism is one of those provisions with such "extraordinary pre-emptive power" that it "converts an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule." *Metropolitan Life*, 481 U.S., at 65-66, 107 S.Ct. 1542. Hence, "causes of action within the scope of the civil enforcement provisions of § 502(a) [are] removable to federal court." *Id.*, at 66, 107 S.Ct. 1542.

***210** III

A

[7] ERISA § 502(a)(1)(B) provides:

> "A civil action may be brought-(1) by a participant or beneficiary-... (B) 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).

This provision is relatively straightforward. If a participant or beneficiary believes that benefits promised to him under the terms of the plan are not provided, he can bring suit seeking provision of those benefits. A participant or beneficiary can also bring suit generically to "enforce his rights" under the plan, or to clarify any of his rights to future benefits. Any dispute over the precise terms of the plan is resolved by a court under a *de novo* review standard, unless the terms of the plan "giv[e] the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989).

[8] It follows that if an individual brings suit complaining of a denial of coverage for medical care, where the individual is entitled to such coverage only because of the terms of an ERISA-regulated employee benefit plan, and where no legal duty (state or federal) independent of ERISA or the plan terms is violated, then the suit falls "within the scope of" ERISA § 502(a)(1)(B). *Metropolitan Life, supra,* at 66, 107 S.Ct. 1542. In other words, if an individual, at some point in time, could have brought his claim under ERISA § 502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant's actions, then the individual's cause of action is completely pre-empted by ERISA § 502(a)(1)(B).

[9] ***211** To determine whether respondents' causes of action fall "within the scope" of ERISA § 502(a)(1)(B), we must examine respondents' complaints, the statute on which their claims are based (the THCLA), and the various plan documents. Davila alleges that Aetna provides health coverage under his employer's health benefits plan. App. H to Pet. for Cert. in No. 02-1845, p. 67a, & ¶ 11. Davila also alleges that after his primary care physician prescribed Vioxx, Aetna refused to pay for it. *Id.,* at 67a, & ¶ 12. The only action complained of was Aetna's refusal to approve payment for Davila's Vioxx prescription. Further, the only relationship Aetna had with Davila was its partial administration of Davila's employer's benefit plan. See App. JA-25, JA-31, JA-39 to JA-40, JA-45 to JA-48, JA-108.

Similarly, Calad alleges that she receives, as her husband's beneficiary under an ERISA-regulated benefit plan, health ****2497** coverage from CIGNA. *Id.,* at JA-184, & ¶ 17. She alleges that she was informed by CIGNA, upon admittance into a hospital for major surgery, that she would be authorized to stay for only one day. *Id.,* at JA-184, & ¶ 18. She also alleges that CIGNA, acting through a discharge nurse, refused to authorize more than a single day despite the advice and recommendation of her treating physician. *Id.,* at JA-185, & ¶¶ 20, 21. Calad contests only CIGNA's decision to refuse coverage for her hospital stay. *Id.,* at JA-185, & ¶ 20. And, as in Davila's case, the only connection between Calad and CIGNA is CIGNA's administration of portions of Calad's ERISA-regulated benefit plan. *Id.,* at JA-219 to JA-221.

It is clear, then, that respondents complain only about denials of coverage promised under the terms of ERISA-regulated employee benefit plans. Upon the denial of benefits, respondents could have paid for the treatment themselves and then sought reimbursement through a § 502(a)(1)(B) action, or sought a preliminary injunction, see ***212***Pryzbowski v. U.S. Healthcare, Inc.,* 245 F.3d 266, 274 (C.A.3 2001) (giving examples where federal courts have issued such preliminary injunctions).[FN2]

FN2. Respondents also argue that the benefit due under their ERISA-regulated employee benefit plans is simply the membership in the respective HMOs, not coverage for the particular medical treatments that are delineated in the plan documents. See Brief for Respondents 28-30. Respondents did not identify this possible argument in their brief in opposition to the petitions for certiorari, and we deem it waived. See this Court's Rule 15.2.

Respondents contend, however, that the complained-of actions violate legal duties that arise independently of ERISA or the terms of the employee benefit plans at issue in these cases. Both respondents brought suit specifically under the THCLA, alleging that petitioners "controlled, influenced, participated in and made decisions which affected the quality of the diagnosis, care, and treatment provided" in a manner that violated "the duty of ordinary care set forth in §§ 88.001 and 88.002." App. H to Pet. for Cert. in No. 02-1845, at 69a, & ¶ 18; see also App. JA-187, & ¶ 28. Respondents contend that this duty of ordinary care is an independent legal duty. They analogize to this Court's decisions interpreting LMRA § 301, 29 U.S.C. § 185, with particular focus on *Caterpillar Inc. v. Williams,* 482 U.S. 386, 107 S.Ct. 2425, 96 L.Ed.2d

318 (1987) (suit for breach of individual employment contract, even if defendant's action also constituted a breach of an entirely separate collective-bargaining agreement, not pre-empted by LMRA § 301). Because this duty of ordinary care arises independently of any duty imposed by ERISA or the plan terms, the argument goes, any civil action to enforce this duty is not within the scope of the ERISA civil enforcement mechanism.

The duties imposed by the THCLA in the context of these cases, however, do not arise independently of ERISA or the plan terms. The THCLA does impose a duty on managed care entities to "exercise ordinary care when making health care treatment decisions," and makes them liable for damages proximately caused by failures to abide by that duty. ***213** § 88.002(a). However, if a managed care entity correctly concluded that, under the terms of the relevant plan, a particular treatment was not covered, the managed care entity's denial of coverage would not be a proximate cause of any injuries arising from the denial. Rather, the failure of the plan itself to cover the requested treatment would be the proximate cause.[FN3] More significantly, ****2498** the THCLA clearly states that "[t]he standards in Subsections (a) and (b) create 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." § 88.002(d). Hence, a managed care entity could not be subject to liability under the THCLA if it denied coverage for any treatment not covered by the health care plan that it was administering.

FN3. To take a clear example, if the terms of the health care plan specifically exclude from coverage the cost of an appendectomy, then any injuries caused by the refusal to cover the appendectomy are properly attributed to the terms of the plan itself, not the managed care entity that applied those terms.

Thus, interpretation of the terms of respondents' benefit plans forms an essential part of their THCLA claim, and THCLA liability would exist here only because of petitioners' administration of ERISA-regulated benefit plans. Petitioners' potential liability under the THCLA in these cases, then, derives entirely from the particular rights and obligations established by the benefit plans. So, unlike the state-law claims in *Caterpillar, supra,* respondents' THCLA causes of action are not entirely independent of the federally regulated contract itself. Cf. *Allis-Chalmers Corp. v. Lueck,* 471 U.S. 202, 217, 105 S.Ct. 1904, 85 L.Ed.2d 206 (1985) (state-law tort of bad-faith handling of insurance claim pre-empted by LMRA § 301, since the "duties imposed and rights established through the state tort ... derive[d] from the rights and obligations established by the contract"); ***214***Steelworkers v. Rawson,* 495 U.S. 362, 371, 110 S.Ct. 1904, 109 L.Ed.2d 362 (1990) (state-law tort action brought due to alleged negligence in the inspection of a mine was pre-empted, as the duty to inspect the mine arose solely out of the collective-bargaining agreement).

Hence, respondents bring suit only to rectify a wrongful denial of benefits promised under ERISA-regulated plans, and do not attempt to remedy any violation of a legal duty independent of ERISA. We hold that respondents' state causes of action fall "within the scope of" ERISA § 502(a)(1)(B), *Metropolitan Life,* 481 U.S., at 66, 107 S.Ct. 1542, and are therefore completely pre-empted by ERISA § 502 and removable to federal district court.[FN4]

FN4. Respondents also argue that ERISA § 502(a) completely pre-empts a state cause of action only if the cause of action would be pre-empted under ERISA § 514(a); respondents then argue that their causes of action do not fall under the terms of § 514(a). But a state cause of action that provides an alternative remedy to those provided by the ERISA civil enforcement mechanism conflicts with Congress' clear intent to make the ERISA mechanism exclusive. See *Ingersoll-Rand Co. v. Mc-*

Clendon, 498 U.S. 133, 142, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990) (holding that "[e]ven if there were no express pre-emption [under ERISA § 514(a)]" of the cause of action in that case, it "would be pre-empted because it conflict[ed] directly with an ERISA cause of action").

B

The Court of Appeals came to a contrary conclusion for several reasons, all of them erroneous. First, the Court of Appeals found significant that respondents "assert a tort claim for tort damages" rather than "a contract claim for contract damages," and that respondents "are not seeking reimbursement for benefits denied them." 307 F.3d, at 309. But, distinguishing between pre-empted and non-pre-empted claims based on the particular label affixed to them would "elevate form over substance and allow parties to evade" the pre-emptive scope of ERISA simply "by relabeling their contract claims as claims for tortious breach of contract." ****2499** *Allis-Chalmers, supra,* at 211, 105 S.Ct. 1904. Nor can the mere fact that the state cause of action attempts to authorize remedies beyond those authorized by ERISA § 502(a) put the cause ***215** of action outside the scope of the ERISA civil enforcement mechanism. In *Pilot Life, Metropolitan Life,* and *Ingersoll-Rand,* the plaintiffs all brought state claims that were labeled either tort or tort-like. See *Pilot Life,* 481 U.S., at 43, 107 S.Ct. 1549 (suit for, *inter alia*, " 'Tortious Breach of Contract' "); *Metropolitan Life, supra,* at 61-62, 107 S.Ct. 1542 (suit requesting damages for "mental anguish caused by breach of [the] contract"); *Ingersoll-Rand,* 498 U.S., at 136, 111 S.Ct. 478 (suit brought under various tort and contract theories). And, the plaintiffs in these three cases all sought remedies beyond those authorized under ERISA. See *Pilot Life, supra,* at 43, 107 S.Ct. 1549 (compensatory and punitive damages); *Metropolitan Life, supra,* at 61, 107 S.Ct. 1542 (mental anguish); *Ingersoll-Rand, supra,* at 136, 111 S.Ct. 478 (punitive damages, mental anguish). And, in all these cases, the plaintiffs' claims were pre-empted. The limited remedies available under ERISA are an inherent part of the "careful balancing" between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans. *Pilot Life, supra,* at 55, 107 S.Ct. 1549.

Second, the Court of Appeals believed that "the wording of [respondents'] plans is immaterial" to their claims, as "they invoke an external, statutorily imposed duty of 'ordinary care.' " 307 F.3d, at 309. But as we have already discussed, the wording of the plans is certainly material to their state causes of action, and the duty of "ordinary care" that the THCLA creates is not external to their rights under their respective plans.

Ultimately, the Court of Appeals rested its decision on one line from *Rush Prudential.* There, we described our holding in *Ingersoll-Rand* as follows: "[W]hile state law duplicated the elements of a claim available under ERISA, it converted the remedy from an equitable one under § 1132(a)(3) (available exclusively in federal district courts) into a legal one for money damages (available in a state tribunal)." 536 U.S., at 379, 122 S.Ct. 2151. The point of this sentence was to describe why the state cause of action in *Ingersoll-Rand* was pre-empted by ERISA § 502(a): It was pre-empted because it attempted ***216** to convert an equitable remedy into a legal remedy. Nowhere in *Rush Prudential* did we suggest that the pre-emptive force of ERISA § 502(a) is limited to the situation in which a state cause of action precisely duplicates a cause of action under ERISA § 502(a).

Nor would it be consistent with our precedent to conclude that only strictly duplicative state causes of action are pre-empted. Frequently, in order to receive exemplary damages on a state claim, a plaintiff must prove facts beyond the bare minimum necessary to establish entitlement to an award. Cf. *Allis-Chalmers, supra,* at 217, 105 S.Ct. 1904 (bad-faith refusal to honor a claim needed to be proved in order to recover exemplary damages). In order to recover for mental anguish, for instance,

the plaintiffs in *Ingersoll-Rand* and *Metropolitan Life* would presumably have had to prove the existence of mental anguish; there is no such element in an ordinary suit brought under ERISA § 502(a)(1)(B). See *Ingersoll-Rand, supra,* at 136, 111 S.Ct. 478; *Metropolitan Life, supra,* at 61, 107 S.Ct. 1542. This did not save these state causes of action from pre-emption. Congress' intent to make the ERISA civil enforcement mechanism exclusive would be undermined if state causes of action that supplement ****2500** 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.

C

[10][11] Respondents also argue-for the first time in their brief to this Court-that the THCLA is a law that regulates insurance, and hence that ERISA § 514(b)(2)(A) saves their causes of action from pre-emption (and thereby from complete pre-emption). FN5 This argument is unavailing. The existence of ***217** a comprehensive remedial scheme can demonstrate an "overpowering federal policy" that determines the interpretation of a statutory provision designed to save state law from being pre-empted. *Rush Prudential,* 536 U.S., at 375, 122 S.Ct. 2151. ERISA's civil enforcement provision is one such example. See *ibid.*

> FN5. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), reads, as relevant: "[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

As this Court stated in *Pilot Life,* "our understanding of [§ 514(b)(2)(A)] must be informed by the legislative intent concerning the civil enforcement provisions provided by ERISA § 502(a), 29 U.S.C. § 1132(a)." 481 U.S., at 52, 107 S.Ct. 1549. The Court concluded that "[t]he policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." *Id.,* at 54, 107 S.Ct. 1549. The Court then held, based on

> "the common-sense understanding of the saving clause, the McCarran-Ferguson Act factors defining the business of insurance, and, *most importantly*, the clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive, ... that [the plaintiff's] state law suit asserting improper processing of a claim for benefits under an ERISA-regulated plan is not saved by § 514(b)(2)(A)." *Id.,* at 57, 107 S.Ct. 1549 (emphasis added).

[12] *Pilot Life's* reasoning applies here with full force. Allowing respondents to proceed with their state-law suits would "pose an obstacle to the purposes and objectives of Congress." *Id.,* at 52, 107 S.Ct. 1549. As this Court has recognized in both *Rush Prudential* and *Pilot Life,* ERISA § 514(b)(2)(A) must be interpreted in light of the congressional intent to create an exclusive federal remedy in ERISA § 502(a). Under ordinary principles of conflict pre-emption, then, even a state law that can arguably be characterized as "regulating insurance" will be pre-empted if it provides a separate vehicle to assert ***218** a claim for benefits outside of, or in addition to, ERISA's remedial scheme.

IV

Respondents, their *amici,* and some Courts of Appeals have relied heavily upon *Pegram v. Herdrich,* 530 U.S. 211, 120 S.Ct. 2143, 147 L.Ed.2d 164 (2000), in arguing that ERISA does not pre-empt or completely pre-empt state suits such as respondents'. They contend that *Pegram* makes it clear that causes of action such as respondents' do not "relate to [an] employee benefit plan," ERISA § 514(a), 29 U.S.C. § 1144(a), and hence are not pre-empted.

See Brief for Respondents 35-38; *Cicio v. Does,* 321 F.3d 83, 100-104 (C.A.2 2003), cert. pending *sub nom. Vytra Healthcare v. Cicio,* No. 03-69 [Reporter's Note: See *post,* 542 U.S. 933, 124 S.Ct. 2902]; see also ****2501***Land v. CIGNA Healthcare of Fla.,* 339 F.3d 1286, 1292-1294 (C.A.11 2003).

Pegram cannot be read so broadly. In *Pegram,* the plaintiff sued her physician-owned-and-operated HMO (which provided medical coverage through plaintiff's employer pursuant to an ERISA-regulated benefit plan) and her treating physician, both for medical malpractice and for a breach of an ERISA fiduciary duty. See 530 U.S., at 215-216, 120 S.Ct. 2143. The plaintiff's treating physician was also the person charged with administering plaintiff's benefits; it was she who decided whether certain treatments were covered. See *id.,* at 228, 120 S.Ct. 2143. We reasoned that the physician's "eligibility decision and the treatment decision were inextricably mixed." *Id.,* at 229, 120 S.Ct. 2143. We concluded that "Congress did not intend [the defendant HMO] or any other HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians." *Id.,* at 231, 120 S.Ct. 2143.

A benefit determination under ERISA, though, is generally a fiduciary act. See *Bruch,* 489 U.S., at 111-113, 109 S.Ct. 948. "At common law, fiduciary duties characteristically attach to decisions about managing assets and distributing property to beneficiaries." *Pegram, supra,* at 231, 120 S.Ct. 2143; cf. 2A A. Scott & W. Fratcher, Law of Trusts §§ 182, 183 (4th ed.1987); ***219** G. Bogert & G. Bogert, Law of Trusts & Trustees § 541 (rev.2d ed.1993). Hence, a benefit determination is part and parcel of the ordinary fiduciary responsibilities connected to the administration of a plan. See *Varity Corp. v. Howe,* 516 U.S. 489, 512, 116 S.Ct. 1065, 134 L.Ed.2d 130 (1996) (relevant plan fiduciaries owe a "fiduciary duty with respect to the interpretation of plan documents and the payment of claims"). The fact that a benefits determination is infused with medical judgments does not alter this result.

Pegram itself recognized this principle. *Pegram,* in highlighting its conclusion that "mixed eligibility decisions" were not fiduciary in nature, contrasted the operation of "[t]raditional trustees administer[ing] a medical trust" and "physicians through whom HMOs act." 530 U.S., at 231-232, 120 S.Ct. 2143. A traditional medical trust is administered by "paying out money to buy medical care, whereas physicians making mixed eligibility decisions consume the money as well." *Ibid.* And, significantly, the Court stated that "[p]rivate trustees do not make treatment judgments." *Id.,* at 232, 120 S.Ct. 2143. But a trustee managing a medical trust undoubtedly must make administrative decisions that require the exercise of medical judgment. Petitioners are not the employers of respondents' treating physicians and are therefore in a somewhat analogous position to that of a trustee for a traditional medical trust. FN6

FN6. Both *Pilot Life* and *Metropolitan Life* support this understanding. The plaintiffs in *Pilot Life* and *Metropolitan Life* challenged disability determinations made by the insurers of their ERISA-regulated employee benefit plans. See *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 43, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987); *Metropolitan Life Ins. Co. v. Taylor,* 481 U.S. 58, 61, 107 S.Ct. 1542, 95 L.Ed.2d 55 (1987). A disability determination often involves medical judgments. See, *e.g., ibid.* (plaintiff determined not to be disabled only after a medical examination undertaken by one of his employer's physicians). Yet, in both *Pilot Life* and *Metropolitan Life,* the Court held that the causes of action were pre-empted. Cf. *Black & Decker Disability Plan v. Nord,* 538 U.S. 822, 123 S.Ct. 1965, 155 L.Ed.2d 1034 (2003) (discussing "treating physician" rule in the context of disability determinations made by ERISA-regulated disability plans).

***220** ERISA itself and its implementing regulations

confirm this interpretation. ERISA defines a fiduciary as any person "to the extent ... he has any discretionary authority or discretionary responsibility in ****2502** the administration of [an employee benefit] plan." § 3(21)(A)(iii), 29 U.S.C. § 1002(21)(A)(iii). When administering employee benefit plans, HMOs must make discretionary decisions regarding eligibility for plan benefits, and, in this regard, must be treated as plan fiduciaries. See *Varity Corp., supra,* at 511, 116 S.Ct. 1065 (plan administrator "engages in a fiduciary act when making a discretionary determination about whether a claimant is entitled to benefits under the terms of the plan documents"). Also, ERISA § 503, which specifies minimum requirements for a plan's claim procedure, requires plans to "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. § 1133(2). This strongly suggests that the ultimate decisionmaker in a plan regarding an award of benefits must be a fiduciary and must be acting as a fiduciary when determining a participant's or beneficiary's claim. The relevant regulations also establish extensive requirements to ensure full and fair review of benefit denials. See 29 CFR § 2560.503-1 (2003). These regulations, on their face, apply equally to health benefit plans and other plans, and do not draw distinctions between medical and nonmedical benefits determinations. Indeed, the regulations strongly imply that benefits determinations involving medical judgments are, just as much as any other benefits determinations, actions by plan fiduciaries. See, *e.g.*, § 2560.503-1(h)(3)(iii). Classifying any entity with discretionary authority over benefits determinations as anything but a plan fiduciary would thus conflict with ERISA's statutory and regulatory scheme.

Since administrators making benefits determinations, even determinations based extensively on medical judgments, are ordinarily acting as plan fiduciaries, it was essential to *Pegram*'s***221** conclusion that the decisions challenged there were truly "mixed eligibility and treatment decisions," 530 U.S., at 229, 120 S.Ct. 2143, *i.e.*, medical necessity decisions made by the plaintiff's treating physician *qua* treating physician and *qua* benefits administrator. Put another way, the reasoning of *Pegram* "only make[s] 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." *Cicio,* 321 F.3d, at 109 (Calabresi, J., dissenting in part). Here, however, petitioners are neither respondents' treating physicians nor the employers of respondents' treating physicians. Petitioners' coverage decisions, then, are pure eligibility decisions, and *Pegram* is not implicated.

V

We hold that respondents' causes of action, brought to remedy only the denial of benefits under ERISA-regulated benefit plans, fall within the scope of, and are completely pre-empted by, ERISA § 502(a)(1)(B), and thus removable to federal district court. The judgment of the Court of Appeals is reversed, and the cases are remanded for further proceedings consistent with this opinion.[FN7]

FN7. The United States, as *amicus,* suggests that some individuals in respondents' positions could possibly receive some form of "make-whole" relief under ERISA § 502(a)(3). Brief for United States as *Amicus Curiae* 27, n. 13. However, after their respective District Courts denied their motions for remand, respondents had the opportunity to amend their complaints to bring expressly a claim under ERISA § 502(a). Respondents declined to do so; the District Courts therefore dismissed their complaints with prejudice. See App. JA-147 to JA-148; *id.*, at JA-298; App. B to Pet. for Cert. in No. 02-1845, pp. 34a-35a; App. B to Pet. for Cert. in No. 03-83, p. 40a. Respondents have thus chosen not to pursue any ERISA claim, including any

LINK: 10

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

HILDA SARKISYAN and GRIGOR SARKISYAN, Plaintiffs, vs. CIGNA HEALTHCARE OF CALIFORNIA, INC., CIGNA HEALTHCARE, INC., and DOES 1-100, inclusive, Defendants.	**Case No. CV 09-00335 GAF (RCx)** MEMORANDUM & ORDER REGARDING MOTION TO DISMISS

I. INTRODUCTION

Plaintiffs Grigor and Hilda Sarkisyan initiated the present lawsuit against defendants CIGNA Healthcare of California, Inc. and CIGNA Healthcare, Inc. (collectively, "CIGNA") on December 18, 2008 in Los Angeles Superior Court for injuries they suffered after their minor daughter, Nataline, died of liver failure. Plaintiffs allege that CIGNA, the administrator of Plaintiffs' employee benefit health plan, wrongfully denied coverage for a liver transplant that may have saved Nataline's life, and have asserted claims of breach of contract, breach of the implied covenant of good faith and fair dealing, unfair business practices under section 17200 of the California Business & Professions Code, and intentional infliction of emotional distress. Plaintiffs seek compensatory and punitive damages and permanent

injunctive relief, as well as prejudgment interest, reasonable attorneys' fees, and court costs.

CIGNA removed the case to this Court on January 15, 2009. Presently before the Court is CIGNA's motion to dismiss Plaintiffs' claims under Rule 12(b)(6) of the Federal Rules of Civil Procedure. CIGNA contends that Plaintiffs' claims are preempted by sections 502(a) and 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1132(a), 1144(a), because the claims challenge or relate to a denial of benefits under an employee benefit plan that is subject to ERISA. The Court agrees that ERISA preempts Plaintiffs' breach of contract, breach of the implied covenant of good faith and fair dealing, and unfair business practices claims because they are directly related to CIGNA's denial of benefits. Accordingly, CIGNA's motion to dismiss those claims is **GRANTED**, and the claims are **DISMISSED WITH PREJUDICE**. The Court concludes, however, that ERISA does not preempt Plaintiffs' intentional infliction of emotional distress claim insofar as that claim is based on events that occurred during Plaintiffs' visit to CIGNA's headquarters more than one year after the coverage decision. Accordingly, the motion to dismiss the emotional distress claim is **DENIED**. The Court explains its reasoning in detail below.

II. BACKGROUND

In April 2005, Sonic Automotive, Inc. ("Sonic") and non-party Connecticut General Life Insurance Company ("CGLIC"), a CIGNA affiliate, entered into an Administrative Services Only Agreement whereby Sonic agreed to pay CGLIC to administer an employee health benefit plan that Sonic funds and provides to its employees ("Sonic Benefit Plan" or "Plan"). (See Lipar Decl. (Not. Removal) ¶ 3, Ex. A [Administrative Services Only Agreement at 1–5].) As a Sonic employee, plaintiff Grigor Sarkisyan enrolled himself and his wife in the Sonic Benefit Plan as of May 1, 2007. (Lipar Decl. (Not. Removal) ¶ 2.) Nataline was a beneficiary under the Plan. (Id.)

In 2004, when she was fourteen years old, Nataline was diagnosed with Acute Lymphoblastic Leukemia. (Compl. ¶ 16.) After undergoing chemotherapy treatment, Nataline's physicians determined that her cancer was in remission. (Id.) In or about August 2007, however, Nataline relapsed and again underwent chemotherapy treatment. (Compl. ¶ 17.) Nataline's physicians subsequently determined that she required a bone marrow transplant, and in late-November 2007, Nataline underwent a transplant procedure using her brother's bone marrow. (Compl. ¶¶ 17–18.) Although the transplant was initially considered a success, Nataline's liver soon began to fail while she was still recovering from the procedure. (Compl. ¶¶ 18–19.) Nataline's physicians immediately informed her parents that a liver transplant was necessary to save Nataline's life. (Compl. ¶ 19.)

In early December 2007, Plaintiffs and Nataline's physicians from the UCLA Medical Center in Los Angeles, California contacted CIGNA to report that Nataline would need a life-saving liver transplant, and to seek pre-authorization for the procedure. (Compl. ¶ 20.) CIGNA immediately sent a "Notice of Denial of Coverage" letter to Plaintiffs, declining to authorize the transplant. (Compl. ¶ 21.) Plaintiffs and Nataline's physicians appealed the denial of coverage, and on December 11, 2007, four of Nataline's physicians sent a joint letter to CIGNA requesting reconsideration of the coverage decision. (Compl. ¶¶ 22–23.) The physicians' letter highlighted the urgency of Nataline's situation, and their belief that Nataline was an excellent candidate for a liver transplant. (Compl. ¶ 23.) Nevertheless, CIGNA denied coverage on the ground that Nataline's medical benefits did not cover "experimental, investigational and unproven services." (Compl. ¶ 24.) Over the course of the next few days, Nataline's condition worsened. (Compl. ¶ 25.) On the afternoon of December 20, 2007, Nataline died of acute liver failure. (Compl. ¶ 26.)

III. DISCUSSION

A. LEGAL STANDARD

On a Rule 12(b)(6) motion to dismiss for failure to state a claim, a court must accept all factual allegations pleaded in the complaint as true, and construe those facts and draw all reasonable inferences therefrom "in the light most favorable to the nonmoving party." Cahill v. Liberty Mut. Ins. Co., 80 F.3d 336, 337–38 (9th Cir. 1996); see also Stoner v. Santa Clara County Office of Educ., 502 F.3d 1116, 1120–21 (9th Cir. 2007). A court may dismiss a complaint under Rule 12(b)(6) only if it appears beyond doubt that the alleged facts, even if true, will not entitle the plaintiff to relief on the theories asserted. See Bell Atl. Corp. v. Twombly, 127 S. Ct. 1955, 1968–69 (2007); Stoner, 502 F.3d at 1120–21; see also Cahill, 80 F.3d at 338. While a complaint need not contain detailed factual allegations, "a plaintiff's obligation to provide the grounds of his entitlement to relief requires more than labels and conclusions, and a formulaic recitation of a cause of action's elements will not do." Twombly, 127 S. Ct. at 1964–65 (citation, alteration, and internal quotation marks omitted). Moreover, the court is not "required to accept as true allegations that are merely conclusory, unwarranted deductions of fact, or unreasonable inferences." Sprewell v. Golden State Warriors, 266 F.3d 979, 988 (9th Cir. 2001). Finally, although the court generally cannot look beyond the pleadings, it may consider (1) any documents attached to the pleadings, Warren v. Fox Family Worldwide, Inc., 328 F.3d 1136, 1141 n.5 (9th Cir. 2003); (2) materials that are properly subject to judicial notice under Rule 201 of the Federal Rules of Evidence, MGIC Indem. Corp. v. Weisman, 803 F.2d 500, 504 (9th Cir. 1986); and (3) evidence upon which the complaint "necessarily relies" so long as (a) the complaint refers to the document, (b) the document is central to the plaintiff's claim, and (c) no party questions the authenticity of the document, Marder v. Lopez, 450 F.3d 445, 448 (9th Cir. 2006).

B. APPLICABILITY OF ERISA

ERISA governs "any employee benefit plan . . . established or maintained . . . by any employer engaged in commerce or in any industry or activity affecting commerce." 29 U.S.C. § 1003(a)(1). An "employee benefit plan" is

> any plan, fund, or program . . . established or maintained by an employer or by an employee organization, or by both . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment.

Id. § 1002(1). Here, the Administrative Services Only Agreement entered into between Sonic and CGLIC expressly states that "the Plan is subject to [ERISA]," and that Sonic, "in its role as plan sponsor, has adopted the program of employee welfare benefits described in Exhibit A ("Plan") for its employees and their eligible dependents." (Lipar Decl. (Not. Removal) ¶ 3, Ex. A [Administrative Services Only Agreement at 1].) The agreement also provides that CGLIC will review claims for benefits and make benefit determinations pursuant to ERISA. (Id. at 2.) In addition, the February 2007 Summary Plan Agreement, which describes the terms and conditions of the Sonic Benefit Plan, refers expressly to ERISA when setting forth the applicable "claim determination procedures" under the Plan. (Lipar Decl. (Not. Removal) ¶ 4, Ex. B [Summary Plan Agreement at 60–62].) Finally, Plaintiffs do not oppose CIGNA's assertion that the Sonic Benefit Plan is subject to ERISA, and, in fact, refer to the Plan in their papers as "an employee benefit contract." (Opp. at 13:1.) Accordingly, ERISA's applicability to the present lawsuit cannot reasonably be questioned. The Court therefore proceeds to determine the sole issue before it: whether ERISA preempts Plaintiffs' state law claims.

C. PREEMPTION UNDER ERISA

In general, federal law may preempt state law by express provision, by implication, or because of a conflict between the federal and state laws. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S.

645, 654 (1995). As explained below, ERISA contains an express preemption provision whereby ERISA preempts state-law claims that relate to an ERISA benefit plan. 29 U.S.C. § 1144(a). But ERISA's civil enforcement provision, id. § 1132(a), also preempts by conflict any state-law claims that fall within its scope, even if those claims do not fall within the scope of the express preemption provision. See Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990); Cleghorn v. Blue Shield of California, 408 F.3d 1222, 1225 (9th Cir. 2005). Thus, "[t]here are two strands to ERISA's powerful preemptive force," Cleghorn, 408 F.3d at 1225, both of which are implicated in the present action.

1. SECTION 514(a): EXPRESS PREEMPTION

Section 514(a), ERISA's express preemption provision, provides that, subject to various exceptions not applicable here, ERISA "supersede[s] any and all State laws insofar as they may . . . relate to any employee benefit plan." 29 U.S.C. § 1144(a). The basic purpose of this provision is "to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." Travelers, 514 U.S. at 657; see also McClendon, 498 U.S. at 142 (explaining that Congress enacted ERISA "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law").[1] A state law claim "relates to" an employee benefit plan "'if it

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[1]In McClendon, the Court explained that the goal of section 514(a) is

> to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government. Otherwise, the inefficiencies created could work to the detriment of plan beneficiaries. Allowing state based actions like the one at issue here would subject plans and plan sponsors to burdens not unlike those that Congress sought to foreclose through § 514(a). Particularly disruptive is the potential for conflict in substantive law. It is foreseeable that state courts, exercising their common law powers, might develop different substantive standards applicable to the same employer conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement.

498 U.S. at 142 (citations omitted).

has a connection with or reference to such a plan.'" Travelers, 514 U.S. at 656 (quoting Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96–97 (1983)); accord Providence Health Plan v. McDowell, 385 F.3d 1168, 1172 (9th Cir. 2004).

A recent Ninth Circuit case, Bast v. Prudential Ins. Co. of Am., 150 F.3d 1003 (9th Cir. 1998), is directly on point and compels a finding that section 514(a) preempts Plaintiffs' claims to the extent that those claims allege a wrongful denial of benefits. Rhonda Bast was diagnosed with lung cancer in August 1991. Id. at 1005. Shortly thereafter, her physicians recommended that she undergo a bone marrow transplant. Id. On September 9, 1991, Bast's physicians contacted the defendant administrator of Bast's employer health insurance plan to request pre-authorization for the withdrawal, processing, and storage of Bast's bone marrow. Id. The defendant denied the request and stated that the bone marrow transplant was not covered by Bast's health insurance policy because the procedure was "investigational and/or experimental in nature." Id. After an appeal, however, the defendant reversed its decision in April 1992 upon determining that the procedure was in fact covered. Id. at 1006. But by then, the cancer had already metastasized to Bast's brain, disqualifying her from undergoing the procedure. Id. Bast died a short time later. Id. Bast's estate and her minor child sued the defendant administrator on various state law grounds, including breach of contract, breach of the implied duty of good faith and fair dealing, and emotional distress. Id. at 1006. The Ninth Circuit held that section 514(a) of ERISA preempted those claims because the claims were directly related to the administration of an ERISA benefit plan. Id. at 1007–08.

Bast's holding accords with the great weight of authority in ERISA jurisprudence. For example, in Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41 (1987), the Supreme Court held that a common law claim "based on [an] improper processing of a claim for benefits under an employee benefit plan . . . undoubtedly meet[s] the criteria for pre-emption under § 514(a)." Id. at 47–48. The Ninth Circuit expressly adopted this rule in Kanne v. Connecticut Gen. Life Ins. Co., 867 F.2d 489,

493 (9th Cir. 1993) (per curiam). There, the court held that ERISA preempted the plaintiffs' breach of contract and breach of the implied duty of good faith and fair dealing claims because the claims were based on the insurance provider's failure to reimburse the plaintiffs for certain expenses relating to their son's care, and thus arose from the alleged improper processing of a claim of benefits. Id. at 491, 493–94. The Ninth Circuit reached a similar conclusion in Spain v. Aetna Life Insurance Co., 11 F.3d 129 (9th Cir. 1993) (per curiam). In Spain, a case that was very similar on its facts to Bast, the court held that section 514(a) preempted a wrongful death claim brought by a deceased cancer victim's survivors against an ERISA-covered employee benefit plan administrator that withdrew its prior authorization of a bone marrow transplant. 11 F.3d at 131–32. The court reasoned that a finding of preemption was appropriate because the plaintiffs sought damages "for the negligent administration of benefit claims," and therefore, their claim was directly related to "the administration and disbursement of ERISA plan benefits." Id. at 131.

Based on the well-established precedent in this area of federal jurisprudence, ERISA plainly preempts Plaintiffs' claims to the extent that Plaintiffs seek redress for what they claim to be CIGNA's wrongful denial of benefits to their daughter. Plaintiffs do not contend otherwise, but rather attempt to persuade the Court that they do not seek relief for the wrongful denial of benefits. The Court therefore analyzes the allegations pertaining to each of Plaintiffs' four claims to determine whether, and the extent to which, those claims are preempted.

a. Breach of Contract

Plaintiffs allege in the complaint that CIGNA breached the Sonic Benefit Plan "by unreasonably refusing to pay, and continuing to withhold Policy benefits due and payable, under the terms of the Policy." (Compl. ¶ 37.) In addition, Plaintiffs aver that "CIGNA further breached the Policy by making unreasonable demands on Plaintiffs, improperly denying Plaintiffs' claim, misrepresenting the terms of the Policy and forcing Plaintiffs to institute this litigation to obtain their benefits." (Compl. ¶ 38.) The

plain import of these allegations is that Plaintiffs' breach of contract claim arises out of CIGNA's denial of benefits. Plaintiffs essentially concede the point in their opposition papers. (See Opp. at 2:5–19.) Accordingly, the Court concludes that section 514(a) preempts Plaintiffs' breach of contract claim.

b. Breach of the Implied Covenant of Good Faith & Fair Dealing

In their opposition papers, Plaintiffs emphasize that their breach of the implied covenant of good faith and fair dealing claim is based on their allegation that they were "wrongfully induced into entering into a CIGNA policy because CIGNA fraudulently represented to them that it would act in good faith . . . while [administering] their insurance plan." (Opp. at 12:19–21.) Plaintiffs contend that this averment does not bring the claim within ERISA's scope because it relates to an act that occurred before Grigor Sarkisyan entered into the Sonic Benefit Plan and Nataline became a beneficiary thereof. However, the allegations set forth in the complaint directly contradict and undermine Plaintiffs' contention. For instance, in paragraph 47 of the complaint, Plaintiffs aver that CIGNA "tortuously [sic] breached [the] implied covenant of good faith and fair dealing . . . by unreasonably withholding benefits due under the Policy, and by other conduct . . . after accepting insurance premiums from Plaintiffs." (Compl. ¶ 47.) The "other conduct" to which Plaintiffs refer presumably entails "CIGNA's overall scheme to reduce the costs of legitimate insurance claims." (Compl. ¶ 51.) Plaintiffs cannot reasonably contend that these allegations do not relate to the Sonic Benefit Plan. Moreover, the conclusory assertion that CIGNA, "in [its] capacity as insurance agent[], induced Plaintiffs to purchase healthcare insurance coverage" (Compl. ¶ 11) falls well short of satisfying the heightened pleading requirement for fraud claims set forth in Rule 9(b) of the Federal Rules of Civil Procedure. Plaintiffs cannot avoid that requirement by disguising their fraudulent inducement claim as a breach of the implied covenant of

good faith and fair dealing claim. As pleaded, Plaintiffs' claim directly relates to CIGNA's denial of benefits, and is therefore preempted by section 514(a).[2]

c. Unfair Business Practices

Plaintiffs allege in the complaint that CIGNA is currently violating section 17200 of the California Business and Professions Code[3] through its "continued misconduct under California laws regarding claims adjusting and denials and other unlawful and unfair business practices." (Compl. ¶ 3.) Specifically, Plaintiffs contend that CIGNA violated section 17200 by denying Plaintiffs' benefit claim without adequately investigating the claim and by retaining personnel who were not equipped "to conduct the necessary research, analysis, and investigation of Nataline's need for a life saving [sic] liver transplant." (Compl. ¶ 58.) They aver that CIGNA's denial was "intended to minimize its costs of paying the Policy's benefits to Plaintiffs and their daughter Nataline Sarkisyan, and other California residents similarly situated, and [to] maximize profits obtained through its collection of premiums," and that "[i]n handling, investigating, and adjusting . . . Plaintiffs' claim, CIGNA systematically, methodically, and generally engaged in . . . improper, unfair, fraudulent, unreasonable, and/or discriminatory claims practices directed at Plaintiffs and Nataline Sarkisyan and other insureds." (Compl. ¶¶ 29–30.) Plaintiffs admit in the complaint itself that these allegations are based on CIGNA's alleged "improper claims handling practices." (Compl. ¶ 32.) Thus, Plaintiffs' argument in their opposition papers that their section 17200 claims refer to "pre-plan activity" finds no support in the complaint. Accordingly, the Court concludes that section 514(a) preempts Plaintiffs' section 17200 claim.

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[2]The Court offers no opinion at this time as to whether section 514(a) would preempt a fraudulent inducement claim under present circumstances, because no such claim is presently before the Court.

[3]Section 17200 prohibits "any unlawful, unfair or fraudulent business act or practice and unfair, deceptive, untrue or misleading advertising." Cal. Bus. & Prof. Code § 17200.

d. Intentional Infliction of Emotional Distress

Plaintiffs rest their emotional distress claim on two distinct events. First, they allege that they suffered emotional distress as a result of Nataline's death "after she was unable to receive a life saving [sic] liver transplant as a result of CIGNA's wrongful denial of her healthcare benefits." (Compl. ¶ 65.) For all of the aforementioned reasons, ERISA preempts the emotional distress claim to the extent that it is based on this allegation. However, Plaintiffs also allege that they suffered emotional distress because of the "verbal abuse" they suffered at the hands of CIGNA employees on October 29, 2008 when they visited CIGNA's headquarters in Philadelphia, Pennsylvania. (Compl. ¶ 67.) Plaintiffs aver that during their visit, CIGNA employees heckled them, and one CIGNA employee directed "a lewd hand gesture at Plaintiffs," causing Plaintiffs to suffer "severe emotional distress." (Compl. ¶¶ 67–69.) To the extent that Plaintiffs' emotional distress claim is premised upon the events of October 29, 2008, the claim falls outside of the scope of ERISA, and is therefore not preempted thereby, because the claim has "only a tenuous, remote, [and] peripheral connection" with CIGNA's administration of the Sonic Benefit Plan. Dishman v. UNUM Life Ins. Co. of Am., 269 F.3d 974, 984 (9th Cir. 2001). Indeed, insofar as the claim is based on the events of October 29, 2008, it does not arise out of CIGNA's denial of coverage, nor does its resolution depend upon the Court's interpretation of the Plan's terms.

The question therefore remains whether Plaintiffs have pleaded sufficient facts to state a claim of emotional distress. Under California law, a claim of intentional interference with emotional distress requires proof of four elements: "(1) extreme and outrageous conduct by the defendant with the intention of causing, or reckless disregard of the probability of causing, emotional distress; (2) the plaintiff's suffering severe or extreme emotional distress; and (3) actual and proximate causation of the emotional distress by the defendant's outrageous conduct." Christensen v. Superior Court, 820 P.2d 181, 202 (Cal. 1991) (internal quotation marks omitted). "Conduct to

be outrageous must be so extreme as to exceed all bounds of that usually tolerated in a civilized community. The defendant must have engaged in conduct intended to inflict injury or engaged in with the realization that injury will result." Id. (citation and internal quotation marks omitted).

Here, the allegations in the complaint, though perhaps thin, are sufficient to satisfy the notice pleading requirement set forth in Rule 8(a) of the Federal Rules of Civil Procedure. Plaintiffs allege that the conduct of CIGNA employees on October 29, 2008 was "extreme and outrageous so as to shock the conscience of a reasonable person," that the conduct was intentional and reckless, and that Plaintiffs suffered mental anguish and severe emotional distress as a direct result of that conduct. (Compl. ¶¶ 67–69.) Although CIGNA is technically correct that the relevant paragraphs do not allege that Plaintiffs "experienced any emotional distress or other injury resulting independently from the 'lewd hand gesture' or heckling that occurred in October 2008" (Reply at 4:26–5:1), this is the clear implication of the allegations in the complaint, particularly those set forth in paragraphs 67 to 69. To hold otherwise would be to promote form over substance. Accordingly, the Court concludes that Plaintiffs have pleaded sufficient facts to state a claim of intentional infliction of emotional distress based on the events of October 29, 2008.

2. SECTION 502(a): CONFLICT PREEMPTION

Even if the Court were to conclude that section 514(a) does not preempt Plaintiffs' claims, the breach of contract, breach of the implied covenant of good faith and fair dealing, and unfair business practices claims conflict with, and are therefore preempted by, ERISA's civil enforcement provision, set forth in section 502(a). Section 502(a) provides that "[a] civil action may be brought . . . by a participant or beneficiary . . . 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). Section 502(a) also establishes that a participant, beneficiary, or fiduciary may file suit under ERISA "to enjoin any act

or practice which violates any provision of this subchapter or the terms of the plan, or . . . to obtain other appropriate equitable relief . . . to redress such violations or . . . to enforce any provisions of this subchapter or the terms of the plan." Id. § 1132(a)(3).

"[A]ny state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." Aetna Health Inc. v. Davila, 542 U.S. 200, 209 (2004). Thus,

> [i]f an individual brings suit complaining of a denial of coverage for medical care, where the individual is entitled to such coverage only because of the terms of an ERISA-regulated employee benefit plan, and where no legal duty (state or federal) independent of ERISA or the plan terms is violated, then the suit falls 'within the scope of' ERISA § 502(a)(1)(B). In other words, if an individual, at some point in time, could have brought his claim under ERISA § 502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant's actions, then the individual's cause of action is completely pre-empted by ERISA § 502(a)(1)(B).

Id. at 210 (citation omitted). Moreover, a state-law claim need not be strictly duplicative of a section 502(a) claim to be preempted. See id. at 216. Davila therefore makes clear that, to the extent that Plaintiffs' claims are intended to rectify a wrongful denial of benefits promised under an ERISA-regulated plan, and not to remedy a violation of a legal duty independent of ERISA, the claims are preempted. Id. at 214.

In Cleghorn, the Ninth Circuit applied these principles to a lawsuit initiated by the member of an employer benefit plan whose insurer denied a claim for reimbursement of costs the plaintiff incurred when obtaining emergency medical care. 408 F.3d at 1224. The plaintiff had sued the defendant insurer under the California Legal Remedies Act and section 17200 of the California Business and Professions Code. Id. The claims were based on an alleged violation of section 1371.4(c) of the California Health and Safety Code, which the plaintiff argued prohibited preauthorization requirements for emergency services. Id. After the insurer removed the case to federal court, the district court determined that ERISA preempted the

plaintiff's claims and refused to remand the case. Id. The district court subsequently dismissed the case pursuant to Rule 12(b)(6) because the plaintiff failed to amend his complaint to add an ERISA claim. Id. at 1224–25. The Ninth Circuit upheld the dismissal, reasoning that "[t]he only factual basis for relief pleaded in [the plaintiff]'s complaint is the refusal of [the insurer] to reimburse him for the emergency medical care he received. Any duty or liability that [the insurer] had to reimburse him 'would exist here only because of [the insurer's] administration of ERISA-regulated benefit plans.'" Id. at 1226–27 (quoting Davila, 542 U.S. at 213).

After reviewing Plaintiffs' complaint and the applicable plan documents, the Court concludes that Plaintiffs' claims of breach of contract, breach of the implied covenant of good faith and fair dealing, and unfair business practices all fall within the scope of section 502(a)(1)(B) because Plaintiffs' only relevant connection to CIGNA with respect to these three claims is CIGNA's partial administration of the Sonic Benefit Plan. See Davila, 542 U.S. at 211. In other words, CIGNA may be held liable pursuant to these claims only if Plaintiffs can prove that CIGNA's administration of the Sonic Benefit Plan was unlawful. Thus, CIGNA's liability under these claims would "derive[] entirely from the particular rights and obligations established by the benefit plan[]." Id. at 213. Section 502(a)(1)(B) therefore preempts these claims. The same holds true with respect to Plaintiffs' intentional infliction of emotional distress claim, but only to the extent that the claim is premised upon a theory of wrongful denial of benefits. As discussed above, this claim is also premised upon the alleged wrongful behavior of CIGNA employees on October 29, 2008 at CIGNA's headquarters during Plaintiffs' visit. Presuming for purposes of discussion that CIGNA may be held vicariously liable for the tortious actions of its employees on that date, any such liability would have only an indirect connection to CIGNA's denial of benefits. Accordingly, section 502(a)(1)(B) does not preempt Plaintiffs' emotional distress claim, but only insofar as the claim rests on the events of October 29, 2008.

IV. CONCLUSION

For the foregoing reasons, the Court concludes that ERISA preempts Plaintiffs' breach of contract, breach of the implied covenant of good faith and fair dealing, and unfair business practices claims.[4] Accordingly, CIGNA's motion to dismiss is **GRANTED** as to those claims, which are **DISMISSED WITH PREJUDICE**. To the extent that Plaintiffs' seek redress for emotional distress resulting from the conduct of CIGNA employees on October 29, 2008, CIGNA's motion to dismiss Plaintiffs' intentional infliction of emotional distress claim is **DENIED** because that claim falls outside ERISA's preemptive reach. Plaintiffs shall have until ***Monday, May 11, 2009*** to file an amended complaint. Should Plaintiffs fail to amend their complaint by that date, the Court will remand their emotional distress claim to state court pursuant to 28 U.S.C. § 1367(c). The hearing previously scheduled for Monday, April 20, 2009 is **VACATED**.

IT IS SO ORDERED.

DATED: April 16, 2009

Judge Gary Allen Feess
United States District Court

[4]In reaching this conclusion, the Court is mindful of the possibility that a finding of ERISA preemption may ultimately deprive Plaintiffs of a meaningful remedy for CIGNA's denial of coverage, even if wrongful, because the benefits are no longer necessary in view of Nataline's death, and because "extracontractual, compensatory, and punitive damages are not available under ERISA." Bast, 150 F.3d at 1009. This is an unfortunate consequence of the compromise Congress made by enacting ERISA, but it cannot preclude a finding of preemption. Id. at 1009–10.