No.

In the Supreme Court of the United States

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.,

Petitioner,

v.

PENNSYLVANIA HOSPITAL INSURANCE CO. AND THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND,

Respondents.

On Petition for a Writ of Certiorari to the Supreme Court of Pennsylvania

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether ERISA preempts a state tort action challenging a health maintenance organization's determination, under an ERISA-governed health plan, that a subscriber was eligible for coverage for services from a participating rather than a non-participating provider in the HMO's network.

RULE 14.1(b) AND 29.6 STATEMENT

Pursuant to Rule 14.1(b), petitioner United States Healthcare Systems of Pennsylvania, Inc., states that the other parties to this action are Pennsylvania Hospital Insurance Co. and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund. Basile Pappas and Theodora Pappas were plaintiffs in the trial court, but their claims against defendants Dr. David S. Asbel and Haverford Community Hospital were settled. App., *infra*, 46a n.2. As a result of the settlement, Mr. and Mrs. Pappas and Dr. Asbel are no longer parties to this litigation. After the settlement, respondents Pennsylvania Hospital Insurance Co. and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Fund, who were the insurers for defendant Haverford Community Hospital, were substituted as the real parties in interest for the Hospital. *Ibid.*

Pursuant to Rule 29.6, petitioner states that the ultimate parent company of United States Healthcare Systems of Pennsylvania, Inc. ("U.S. Healthcare"), is Aetna Inc., a Pennsylvania corporation. U.S. Healthcare does business as the Health Maintenance Organization of Pennsylvania and Aetna U.S. Healthcare; it has no subsidiaries.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner respectfully asks this Court to issue a writ of certiorari to review the judgment of the Supreme Court of Pennsylvania in this case.

OPINIONS BELOW

The opinion of the Supreme Court of Pennsylvania on remand (App., *infra*, 1a-29a) is reported at 768 A.2d 1089. The prior opinion of the Supreme Court of Pennsylvania (App., *infra*, 30a-42a) is reported at 555 Pa. 342, 724 A.2d 889. The opinion of the Pennsylvania Superior Court reinstating the third-party complaint by defendant Haverford Community Hospital against petitioner (App., *infra*, 43a-55a) is reported at 450 Pa. Super. 162, 675 A.2d 711. The opinion of the Court of Common Pleas of Delaware County granting petitioner's motion for summary judgment on the third-party complaint (App., *infra*, 56a-65a) is unreported.

JURISDICTION

The Supreme Court of Pennsylvania rendered its decision on remand on April 3, 2001. App., *infra*, 1a. On June 18, 2001, Justice Souter extended the time within which to file a petition for a writ of certiorari to and including August 1, 2001. This Court's jurisdiction is invoked under 28 U.S.C. § 1257. See *Cox Broadcasting Corp.* v. *Cohn*, 420 U.S. 469, 482-483 (1975).[1]

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[1] On the prior occasion when this case came before this Court, in the exact same procedural posture as this occasion, respondent extensively challenged this Court's jurisdiction. Not only did petitioner demonstrate in its reply brief that this Court had jurisdiction, but also the Solicitor General, in his Court-invited amicus brief filed on December 17, 1999, expressly "agreed with petitioner * * * that this case meets the four requirements for immediate appellate review under *Cox*." 98-1836 U.S. Br. 7 n.4. The Court ultimately granted certiorari and vacated the judgment below. *United States Healthcare Sys. of Pennsylvania, Inc.* v. *Pennsylvania Hospital Ins. Co.*, 530 U.S. 1241 (2000). The Court's order was a standard "GVR" order and did not mention jurisdiction, but of course the Court could not have taken the

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the United States Constitution provides that the laws of the federal government "shall be the supreme Law of the Land; * * * any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. CONST. Art. VI, cl.2.

Section 502(a) of ERISA states that "[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; * * * (3) by a participant, beneficiary, or fiduciary * * * (B) to obtain other appropriate equitable relief (I) to redress such violations [of this subchapter or the terms of the plan] or (ii) to enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. § 1132(a).

Section 514(a) of ERISA states that "the provisions of this title * * * shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a).

STATEMENT

A. Factual Background

Basile Pappas was a subscriber of the Health Maintenance Organization of Pennsylvania ("HMO Pa."), a subsidiary of petitioner, through an employee welfare benefit plan provided to his wife by her employer. App., *infra*, 57a-58a. HMO Pa. administers this benefit plan by contracting with participating providers to provide health care services to plan subscribers for

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action it did without satisfying itself of its own jurisdiction first. See *ASARCO, Inc.* v. *Kadish*, 490 U.S. 605, 621 n.1 (1989) (Court lacks "the power to disturb the state court's judgment," even summarily, when "we lack jurisdiction").

a pre-determined price. As a condition of coverage, subscribers agree to receive services from these participating providers, and pay a small co-payment and no deductible or co-insurance.

On May 20, 1991, Mr. Pappas went to his primary-care physician, Dr. David Asbel, complaining of neck and shoulder pain. App., *infra*, 57a. Dr. Asbel examined Mr. Pappas and treated him with an intramuscular injection of steroids. *Id*. at 44a. The next morning, Mr. Pappas was unable to walk and was experiencing numbness in his extremities. *Ibid.* He was transported by ambulance to Haverford Community Hospital. *Id*. at 57a. The emergency room physician at Haverford, Dr. Steven Dickter, diagnosed Mr. Pappas as suffering from an epidural abscess that pressed on his spinal column. *Id*. at 58a. Dr. Dickter concluded that Mr. Pappas should be treated at a "university" hospital, which would have more extensive facilities than Haverford. *Ibid.*

Dr. Dickter decided to transfer Mr. Pappas to Jefferson University Hospital. App., *infra*, 58a. When the ambulance arrived at Haverford at 12:40 p.m. to pick up Mr. Pappas, Dr. Dickter was informed by the ambulance personnel that Jefferson was not an HMO Pa. participating hospital, meaning that it was not one of the hospitals with which HMO Pa. contracts to provide hospital services to its plan members. *Ibid.* At 12:50 p.m., Dr. Dickter telephoned HMO Pa. to inquire as to Jefferson's status with HMO Pa. *Id*. at 44a.

The record reflects that Dr. Dickter spoke only with administrative — not medical — personnel of HMO Pa. Pa. Super. Ct. App. 67a-68a (deposition of Dr. Dickter at 47-52). The record further reflects that HMO Pa. administrative personnel consulted with their superior, the HMO's medical director, Dr. Leibowitz. *Ibid.* There is, however, no record of the considerations Medical Director Leibowitz took into account, or the information that was presented to him, in deciding whether to authorize treatment at Jefferson, because the parties opted not to depose Medical Director Leibowitz or to ask such questions of the administrative personnel who consulted with him.

Within fifteen minutes, HMO Pa. advised Dr. Dickter that coverage would not be provided for treatment at Jefferson, since it was not a participant in HMO Pa.'s network, but that there were three HMO Pa. participating university hospitals in the vicinity (Temple University, Hahnemann University, and Medical College of Pennsylvania) to which Mr. Pappas could be transferred. App., *infra*, 44a. No allegation has been made that these three hospitals were inferior to Jefferson, or that they were not appropriately equipped and staffed to treat Mr. Pappas' medical condition.

Thereafter, Dr. Dickter of Haverford called Dr. Asbel, Mr. Pappas's primary physician, to ascertain Dr. Asbel's preference concerning his patient's destination. App., *infra*, 58a. Dr. Asbel expressed a preference for Hahnemann, but Hahnemann delayed in responding to Dr. Dickter's request concerning its intensive care unit bed space availability. App., *infra*, 58a-59a. At approximately 2:20 p.m., Hahnemann called Dr. Dickter and advised him that it would be at least 30 more minutes before Hahnemann could determine whether it had space for Mr. Pappas. *Id*. at 59a Dr. Dickter then called Medical College of Pennsylvania, where Mr. Pappas was transported. *Ibid.*

Mr. Pappas and his wife brought a medical malpractice action against Dr. Asbel and Haverford, alleging that their delay in transferring Mr. Pappas to a hospital capable of treating his condition caused his spinal cord compression to continue and led to quadriplegia. App., *infra*, 6a n.2. Mr. and Mrs. Pappas did not sue petitioner. Haverford then filed a third-party complaint for contribution and indemnification against petitioner, complaining that it had "refused to authorize transfer of [Mr. Pappas] to a hospital selected by physicians at Haverford Community Hospital," namely Jefferson. Third-Party Cplt. ¶ 7. Haverford also incorporated the allegation in the Pappases' complaint that there was an inordinate delay in transferring Mr. Pappas from Haverford to a more suitable hospital. *Id*. ¶ 6.

B. Procedural History

1. After discovery, petitioner moved for summary judgment on the third-party complaint by Haverford on the ground that all of Haverford's claims are preempted by Section 514(a) of ERISA. The trial court granted the motion, stating that Haverford's allegations against petitioner "fall within the rubric of administration of an employee benefit plan. As such, the application of any state law in that regard implicates the ERISA preemption provision." App., *infra*, 62a. The trial court further observed: "Haverford Hospital seems to suggest that [petitioner] is responsible because its neglect led to a delayed delivery of health care benefits. Yet, there is no dispute but that the delay was occasioned while it was determined which facilities were available to the plaintiff under [petitioner's] programs. We cannot avoid the conclusion that this circumstance relates to the benefit plan." App., *infra*, 64a.

The plaintiffs' claims against Dr. Asbel and Haverford were settled. The trial court then entered an order substituting Haverford's insurers, respondents Pennsylvania Hospital Insurance Company ("PHICO") and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund (the "CAT Fund"), for Haverford as the real parties in interest to the claim for contribution or indemnification. App., *infra*, 46a n.2.

2. PHICO and the CAT Fund appealed the summary judgment order to the Pennsylvania Superior Court, which reversed. The Superior Court acknowledged that what was at issue was an administrative determination and that "the argument has *never* been advanced that the decision to withhold approval for transfer to Jefferson was *at all* related to medical considerations." App., *infra*, 50a (emphasis added). Nevertheless, the court held that Haverford's claims against petitioner were not preempted under Section 514(a) of ERISA. App., *infra*, 54a. According to the Superior Court, "[c]onsiderations of cost containment of the type which drive the decision making process in HMOs" are not encompassed within the preemptive ambit of Section 514(a). App., *infra*, 50a.

3. In its first consideration of this case ("*Pappas I*"), the Supreme Court of Pennsylvania, although disagreeing with the reasoning of the Superior Court, affirmed its decision that Haverford's claims against petitioner were not preempted. App., *infra*, 31a. The court acknowledged that this Court gave a "deliberately expansive" interpretation to the preemption provision in Section 514(a) of ERISA in *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 46 (1987); *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 96 (1983); and *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 739 (1985). App., *infra*, 35a. Expressly refusing to follow those decisions, however, the court asserted that they were overruled *sub silentio* by *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645 (1995); *California Div. of Labor Standards Enforcement* v. *Dillingham Construction*, 519 U.S. 316 (1997); and *DeBuono* v. *NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806 (1997). App., *infra*, 35a-39a.

In a sweeping pronouncement not confined to the facts of this case, the Pennsylvania Supreme Court stated in *Pappas I* that, "[b]ased upon our interpretation of the *Travelers* line of cases, we conclude that negligence claims against a health maintenance organization do not 'relate to' an ERISA plan." App., *infra*, 39a. The court did not draw any distinction between negligence claims arising from an HMO's administration of plan benefits and negligence claims based on an HMO's purported vicarious liability for providers' malpractice or direct liability for its own exercise of medical judgment. Instead, the court's broad holding in *Pappas I* — which it reaffirmed in *Pappas II*, see App., *infra*, 2a, 14a — appears to preclude an HMO that has been sued for negligence from invoking the preemption provision of Section 514(a) under any set of circumstances.

4. On October 4, 1999, this Court invited the Solicitor General to file a brief expressing the views of the United States. 528 U.S. 804. The United States strongly disagreed with the broad holding of *Pappas I*, noting that *Travelers* reaffirmed, rather than questioned, the relevant holding of *Pilot Life*.

98-1836 U.S. Br. 16. The government also went further and considered whether a narrower rationale could be substituted for that indefensible broad holding. "When an HMO acts as a medical service provider, a number of courts have held — and we agree — that the HMO is subject to suit under state law for negligence in performing its medical duties." 98-1836 U.S. Br. 10. "On the other hand, when an HMO makes benefit determinations in its role as a plan administrator, most courts have held — and we agree — that ERISA preempts any state-law challenges to those decisions." *Ibid.* Despite a record that did not disclose any exercise of medical judgment and briefing that did not hint at any claim of such an exercise, the United States expressly considered, in the abstract, the possibility of the exercise of some medical judgment in the course of making a benefit eligibility determination. According to the government:

> As both the case law and the regulations show, such benefit determinations will often involve a significant component of medical judgment, and may have tragic medical consequences. But, so long as the judgment is an adjunct to a plan coverage decision, rather than a judgment made primarily in the course of diagnosis or treatment, it is a "benefit determination nonetheless."

Id. at 11 (quoting *Corcoran* v. *United Healthcare, Inc.*, 965 F.2d 1321, 1332 (5th Cir.), cert. denied, 506 U.S. 1033 (1992)).

The application of those abstract principles to the record in this case led to the unequivocal conclusion that "[r]espondents' common-law negligence claim is therefore preempted." 98-1836 U.S. Br. 14. As the government summarized (*id.* at 7):

> [I]t appears that petitioner denied Mr. Pappas a benefit he was entitled to receive under the terms of his plan — emergency care at a hospital outside the HMO network — and that respondents seek to hold petitioner liable for its negligence in making that erroneous benefit determination. When viewed in that light, respondents' claims are pre-empted by ERISA because they relate to plan adminis-

> tration and would provide an independent enforcement mechanism as an alternative to ERISA's limited remedies. As a result, the Pennsylvania Supreme Court decision is both incorrect in this case and overbroad as a general matter under existing law.

The United States rested its conclusions not only on the "relate to" language of Section 514(a), but also on the "field preemption" effect of ERISA Section 502(a), 29 U.S.C. § 1132(a), as construed in *Pilot Life*, 481 U.S. at 52. 98-1836 U.S. Br. 15-16.

The United States suggested that the Court hold the petition pending its decision in *Pegram* v. *Herdrich*, No. 98-1949, or, alternatively, grant plenary review because of "the conflict between the Pennsylvania Supreme Court and several courts of appeals, and the importance of the question presented here." 98-1836 U.S. Br. 6.

5. After this Court decided *Pegram* v. *Herdrich*, 530 U.S. 211 (2000), it granted the petition for certiorari in *Pappas I*, vacated the judgment, and remanded the case for further consideration. 530 U.S. 1241. Despite having called *Pappas I* both overbroad and wrong in its brief before this Court, the government filed a brief on remand before the Pennsylvania Supreme Court saying that its views "have changed in light of *Pegram*." U.S. Remand Br. 2. *Pegram*, according to the government, had "rejected the government's understanding * * * that an HMO's coverage decision is plan administration that is subject to ERISA's fiduciary standards even when it involves medical judgment about how to treat a patient." U.S. Remand Br. 11. In other words, the government was now taking the position — contrary to the position it took before this Court — that a coverage decision that included medical judgments was not necessarily "plan administration," but rather a "mixed treatment and eligibility" decision that would not be preempted. *Id.* at 12. Backing away from its earlier observation that there was *no* evidence in the record that petitioner made any medical decisions, the government now contended — without citing to the record — that petitioner's "transfer decision *may have*

involved some exercise of medical judgment." *Id.* at 16 (emphasis added). It therefore suggested that the Pennsylvania Supreme Court vacate the grant of summary judgment and remand to the Court of Common Pleas.

On remand ("*Pappas II*"), the Supreme Court of Pennsylvania, by a divided vote, held again that the claims against petitioner were not preempted. The majority rested its decision on two grounds. First, the majority "adhere[d] to [its] original opinion and order" and "confirm[ed] [its] original disposition." App., *infra*, 2a, 14a. Because, the majority held, its "analysis of ERISA preemption in *Pappas I* was founded on [Section 514(a) of ERISA] and the Supreme Court's most recent teaching on the matter," the analysis in *Pappas I* "continues to apply," App., *infra*, 14a n.7 — and thus "negligence claims against a health maintenance organization do not 'relate to' an ERISA plan," App., *infra*, 39a, and are therefore not preempted.

The majority also asserted that *Pegram* supports the same result. Although *Pegram* concerned fiduciary status under ERISA, and not the scope of ERISA preemption, the majority stated that *Pegram* set forth "two guiding principles." App., *infra*, 8a. First, "HMO physicians" act like both "plan administrators" and as "health care providers." Second, they may make "three types of decisions": "pure eligibility decisions," "treatment decisions," and "mixed eligibility and treatment decisions." Quoting *Pegram*, the majority stated (App., *infra*, 8a (citations omitted)):

> "[P]ure 'eligibility decisions' turn on the plan's coverage of a particular condition or medical procedure for its treatment," such as "whether a plan covers an undisputed case of appendicitis." "'Treatment decisions,' by contrast, are choices about how to go about diagnosing and treating a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response?" "Mixed eligibility and treatment decisions" are just what their name implies — decisions in which coverage and medical judgment are intertwined.

Under *Pegram*, the majority held, "an HMO's mixed eligibility and treatment decision implicates a state law claim for medical malpractice * * * [that] is not preempted by ERISA." App., *infra*, 11a. The majority ignored the contrary decision in *Corporate Health Ins., Inc.* v. *Texas Department of Ins.*, in which the Fifth Circuit held that "[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." 220 F.3d 641, 643 (5th Cir.), denying rehearing to 215 F.3d 526 (5th Cir. 2000), petition for cert. pending, No. 00-665. The majority also ignored the contrary decision in *Pryzbowski* v. *U.S. Healthcare, Inc.*, in which the Third Circuit held that ERISA § 502(a), 29 U.S.C. § 1132(a), did completely preempt a state-law claim that an HMO had negligently delayed approving a particular form of treatment — claims that like the ones in this case challenged "the policy adopted by [HMOs] requiring beneficiaries either to use in-network specialists or to obtain approval from the HMO for out-of-network specialists." 245 F.3d 266, 273 (3d Cir. 2001).[2]

The majority paid no heed, either, to the essential differences between the type of HMO involved in *Pegram*, in which the doctors who treated the patients were also owners/employees of the HMO, and HMO Pa., which contracts with independent doctors in private practice to provide all medical diagnosis and treatment. Finally, without citing the record — and contrary to what had been conceded throughout this litigation — the majority held that the "undisputed facts" established that petitioner's decision not to approve transfer to an out-of-network hospital was one of "mixed eligibility and treatment." App., *infra*, 12a-13a.[3] The claims therefore survived.

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[2] "Where a claim is preempted under § 502(a) it is necessarily preempted under § 514(a)." *Rice* v. *Panchal*, 65 F.3d 637, 646 n.10 (7th Cir. 1995). Respondents have previously conceded this point. 98-1836 Br. in Opp. 8.

[3] In so holding, the majority asserted that Medical Director Leibowitz, who made the decision not to approve benefits for a non-participating hospi-

Justice Saylor dissented. Citing both *Corporate Health Ins.* and *Pryzbowski*, he warned that "there remains a division of authority regarding the appropriate construct pursuant to which ERISA preemption of laws regulating the decisions of managed care organizations should be determined" — and, in particular, that "other courts have been more circumspect" in holding that state claims are not preempted. App., *infra*, 16a. Justice Saylor read *Pegram* to "give[] cause for the exercise of a degree of caution" on courts' parts in "defining the duties of managed care organizations (or at least those that are deemed to perform administrative functions under ERISA) for purposes of tort jurisprudence." App., *infra*, 17a. In particular, Justice Saylor wrote, contrary to the majority's reading *Pegram* manifested this Court's "disapproval of standards that would penalize HMOs based solely upon their structure and/or system for doing business." *Id*. at 20a. Justice Saylor then echoed the Third Circuit's comments in *Pryzbowski*: "A holding that Pryzbowski's claims against U.S. Healthcare" — claims indistinguishable in relevant part from the ones in this case — "are not completely preempted would open the door for legal challenges to core

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tal, was exercising "clinical judgment" (App., *infra*, 13a). Even if that statement had support in the record, it hardly would resolve the question whether the HMO's decision remained a "benefit determination" squarely governed by *Pilot Life*. Rather, as the United States correctly observed in 1999, a nontreating physician's determination with regard to benefit eligibility unquestionably constitutes an interpretation of the ERISA-governed plan, even if clinical judgment is involved. See 98-1836 U.S. Br. 11. But in any event the Pennsylvania court made up the "fact" of the exercise of "clinical judgment" out of thin air. Nothing in the record supports any suggestion that Medical Director Leibowitz was doing anything other than administering the plan and making a standard benefit eligibility determination. Indeed, the majority's newly minted suggestion in *Pappas II* that medical judgments were involved was contrary to the court's position in *Pappas I*, as the Solicitor General noted. 98-1836 U.S. Br. 12. Rather, "the undisputed facts indicate that petitioner, responding to an inquiry from a physician on behalf of a patient, made a *benefit determination*," *ibid.* (emphasis added), and not a medical decision. See also App., *infra*, 50a ("the argument has *never* been advanced that the decision to withhold approval for transfer to Jefferson was *at all* related to medical considerations") (emphasis added).

managed care practices (e.g., the policy of favoring in-network specialists over out-of-network specialists)." Those challenges, however, were precisely the ones "eschewed in *Pegram*." App., *infra,* 20a n.6 (quoting *Pryzbowski,* 245 F.3d at 274-275).

REASONS FOR GRANTING THE PETITION

A. The Decision Below Conflicts With This Court's Decisions Construing Sections 502(a) And 514(a) Of ERISA

The third-party complaint by Haverford against petitioner challenges a straightforward and commonplace ERISA plan benefit eligibility determination: coverage would be provided to Mr. Pappas if he was transferred to any of three hospitals that had contracted with petitioner to provide hospital services to plan members, but would not be provided if he was transferred to Jefferson, which had no such contractual relationship with petitioner. Because Haverford's negligence claim against petitioner arises from and directly relates to the administration of benefits under the ERISA-governed health plan, and provides an alternative enforcement mechanism to ERISA, it falls squarely within the preemptive scope of Sections 502(a) and 514(a) of ERISA.

As the United States recognized in its *amicus* brief in *Pappas I*, the Pennsylvania Supreme Court's decision directly conflicts with this Court's decision in *Pilot Life*.[4] In *Pilot Life*, plaintiff had alleged that an insurance company engaged in the processing and review of claims for benefits under an employee benefit plan had acted tortiously when it terminated his disability benefits. Relying on *Metropolitan Life* and *Shaw*, this Court emphasized the "expansive sweep of the pre-emption clause" in Section 514(a) of ERISA. *Pilot Life*, 481 U.S. at 47. The Court noted that the legislative history of ERISA reflects

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[4] 98-1836 U.S. Br. 6 ("the blanket non-preemption rule announced by the Pennsylvania Supreme Court conflicts with the core holding of *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 48 (1987)").

"both the breadth and importance of the pre-emption provisions." *Id.* at 46. The Court held that "[t]he common law causes of action raised in Dedeaux's complaint, each 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.* at 48. The Court further held that "varying state causes of action for claims within the scope of § 502(a) would pose an obstacle to the purposes and objectives of Congress." *Id*. at 52.

The Pennsylvania Supreme Court's decision also conflicts with this Court's decisions in *Metropolitan Life* and *Shaw*. In both of those cases, this Court held that ERISA preempts state laws that require an ERISA-governed plan to provide certain types of coverage, because such a requirement "bears indirectly but substantially on all insured benefit plans." *Metropolitan Life*, 471 U.S. at 739. The Pennsylvania Supreme Court's ruling subjects petitioner and other health maintenance organizations to tort liability for failing to authorize a member's treatment at a non-participating hospital. In essence, the decision imposes a substantive coverage requirement on ERISA-governed health plans: either permit a member to be admitted to whatever hospital the treating physician selects — regardless of whether that hospital participates in the health maintenance organization's network — or face liability in tort for damages. Such a result cannot be reconciled with *Metropolitan Life* and *Shaw*. Moreover, it would wreak havoc on the federal and state HMO laws requiring plans to establish networks of participating providers. See 42 U.S.C. § 300e; 28 Pa. Code § 9.75.

The Pennsylvania Supreme Court tacitly acknowledged in *Pappas I* that the third-party complaint against petitioner would be preempted under *Pilot Life*, *Shaw*, and *Metropolitan Life*, but it expressly declined to follow those decisions, characterizing them as "superannuated." App., *infra*, 37a. Instead, it took the view that this Court "noticeably changed tack" in *Travelers* by adopting a "new position on ERISA preemption," and it further opined that "*Travelers* and its progeny [*Dillingham* and

DeBuono] have thrown the expansive holdings of those earlier cases into question." App., *infra*, 35a, 37a, 38a. The Pennsylvania Supreme Court relied very heavily in *Pappas I* on the concurring opinion in *Dillingham* by Justice Scalia (joined by Justice Ginsburg), and it asserted that Justice Scalia had "reproached the Court for not forthrightly acknowledging that the holdings of these older cases 'have in effect been abandoned.'" App., *infra*, 37a. However, the Pennsylvania Supreme Court truncated its quotation of Justice Scalia's comment, deleting the earlier part of his sentence in which he noted that the Court's opinion in *Dillingham* "does obeisance to all our prior cases." 519 U.S. at 335. Justice Scalia also stated in his concurring opinion in *Dillingham* that the majority opinion "is a fair description of our prior case law, and a fair application of the more recent of that case law" (*ibid.*), thereby acknowledging that *Pilot Life* remained good law.

Similarly, contrary to the Pennsylvania Supreme Court's mistaken belief, this Court's decision in *Travelers* did not overrule *Pilot Life*, *Shaw*, or *Metropolitan Life*, either expressly or by implication. To the contrary, *Travelers* concludes by expressing "fidelity to the views expressed in our prior opinions on the matter." 514 U.S. at 668. The continuing vitality of *Pilot Life* and *Metropolitan Life* was most recently reaffirmed by this Court's decision *in UNUM Life Ins. Co. of Am.* v. *Ward*, 526 U.S. 358 (1999).

In addition to *Travelers*, the Pennsylvania Supreme Court relied in *Pappas I* on *DeBuono* v. *NYSA-ILA Medical & Clinical Serv. Fund*, 520 U.S. 806 (1997), in support of its contention that this Court's earlier decisions in *Pilot Life*, *Shaw*, and *Metropolitan Life* had been tacitly overruled. However, in *DeBuono*, this Court said just the opposite: it emphasized that these cases were not overruled, noting that "[i]n our earlier ERISA pre-emption cases, it had not been necessary to rely on the expansive character of ERISA's literal language in order to find pre-emption because the state laws at issue in those cases had a clear 'connection with or reference to' * * * ERISA

benefit plans." *Id.* at 813. Here, too, it is not necessary to rely on an expansive interpretation of "relate to" in order to find preemption, because the negligence claim at issue arises directly from the petitioner's administration of benefits under the plan. Allegations that petitioner should have pre-approved Mr. Pappas's admission at a non-participating hospital and that it delayed unduly in advising the treating physician as to the participating hospitals to which Mr. Pappas could be transferred have a clear and direct "connection with or reference to" Mr. Pappas's benefit plan, and thus are preempted.

Travelers involved a state law having only a peripheral connection to ERISA benefit plans; significantly, the Court contrasted the statute before it with earlier cases where "ERISA pre-empted state laws that mandated employee benefit structures or their administration." 514 U.S. at 658. Here, subjecting petitioner to potential liability in tort on account of its refusal to pre-authorize a subscriber's admission to a non-participating hospital is tantamount to "mandat[ing] employee benefit structures or their administration." This is certainly true when an administrator makes a pure eligibility decision, as petitioner did here, but it is no less true when an administrator makes a "mixed eligibility and treatment" decision: in both cases, tort liability "would have a marked effect on plan administration," *UNUM Life Ins.*, 526 U.S. at 378-379. Given that effect, such a state-law claim would clearly "relate to" an ERISA plan under Section 514(a) and would thus be preempted.

Nor was the Pennsylvania Supreme Court free to disregard *Pilot Life*, *Shaw*, and *Metropolitan Life* simply because it thought them "superannuated." App., *infra*, 37a. This Court has admonished lower courts not to anticipate the overruling of precedent, stating that "[o]ur decisions remain binding precedent until we see fit to reconsider them, regardless of whether subsequent cases have raised doubts about their continuing vitality." *Hohn* v. *United States*, 524 U.S. 236, 252-253 (1998); accord *Rodriguez de Quijas* v. *Shearson/American Express, Inc.*, 490 U.S. 477, 484 (1989) ("If a precedent of this Court has

direct application in a case, yet appears to rest on reasons rejected in some other line of decisions, the [lower court] should follow the case which directly controls, leaving to this Court the prerogative of overruling its own decisions.").

The Pennsylvania Supreme Court's unprecedented holding in *Pappas I* — expressly reaffirmed in *Pappas II* — that any and all negligence actions against health maintenance organizations do not "relate to" an ERISA plan stands in direct conflict with this Court's decision in *Pilot Life*, where this Court held that Sections 502(a) and 514(a) preempt suits alleging improper processing of a claim for benefits. A cause of action predicated on a health maintenance organization's alleged negligence in administering benefits under an ERISA-governed plan plainly "relates to" the plan and provides an alternative enforcement mechanism not contemplated by ERISA itself, and is therefore preempted under Sections 502(a) and 514(a) of ERISA.

This Court's recent decision in *Pegram* does not suggest otherwise. To begin with, *Pegram* was not a preemption case at all, holding only that ERISA does not impose a fiduciary duty on HMO physicians for their mixed eligibility and treatment decisions. 530 U.S. at 237. Indeed, the Court nowhere even alluded to the meaning of the critical phrase "relate to" in Section 514(a) or to the scope of field preemption effected by Section 502(a). The Court did, however, specifically note that it did not have occasion "to discuss the interaction" of claims for denials of benefits "with state law causes of action." 530 U.S. at 229 n.9; see also Note, *What Is an Employee Benefit Plan? ERISA Preemption of "Any Willing Provider" Laws After* Pegram, 101 COLUM. L. REV. 1107, 1123 (2001) ("Of course, even after *Pegram*, the previous cases analyzing the meaning of 'relate to' remain good law.").

Moreover, in *Pegram* this Court eschewed legal challenges to practices like the "rationing" of care that "go[] to the very point of any HMO scheme." 530 U.S. at 221; see also *Pryzbowski*, 245 F.3d at 274-275. Subjecting petitioner to state tort law

liability for providing coverage at network hospitals rather than an out-of-network hospital would thus be contrary to — not consistent with — *Pegram*.

In fact, in his dissent in this case Justice Saylor noted that even on the majority's terms petitioner's decision would have survived, given the important difference between the types of HMOs involved here and in *Pegram* (App., *infra*, 17a n.3):

> [T]he decision made in *Pappas* was far closer on the continuum to the eligibility form than that which was at issue in *Pegram*, since, under U.S. Healthcare's modified IPA-style structure, the decision was not made by the actual treating physician as was the case under the capitated arrangement at issue in *Pegram*. Indeed, arguably an IPA-style HMO's decision whether to pay for out-of-network services touches the eligibility end of the spectrum, since in relation to out-of-network providers, the HMO no longer itself functions as a service provider through its pre-arranged contracts, but rather, is relegated to a traditional fee-for-service insurance function. *See generally Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 2001 WL 292997, 2001 U.S. App. LEXIS 4903 (3d Cir. Mar. 27, 2001) (holding that a delay-in-approval claim against U.S. Healthcare fell squarely within the realm of the HMO's administrative function).

Indeed, this type of litigation is so clearly preempted by the exclusive remedies set forth in ERISA that many courts of appeals would permit removal of a suit of this nature on that ground alone. Perhaps for that reason, Mr. and Mrs. Pappas never brought suit against petitioner. It would be anomalous to permit third parties, such as respondent, effectively to circumvent the congressional scheme by the simple expedient of bringing a third-party complaint against petitioner.

B. The Decision Below Conflicts With Decisions By The Third Circuit And Numerous Other Courts Of Appeals Throughout The Country

Conspicuous by its absence from the decisions in *Pappas I* and *Pappas II* is the citation of any case from any court that supports either the Pennsylvania Supreme Court's astonishing assertion that all negligence claims against health maintenance organizations fall outside the preemptive scope of Section 514(a) or its alternative holding that all "mixed" decisions survive ERISA preemption in the wake of *Pegram*. Indeed, the Pennsylvania Supreme Court did not and could not cite any case in support, and none exists.

The Pennsylvania Supreme Court's affirmation in *Pappas II* of its ruling in *Pappas I* that all negligence claims against HMOs are not preempted conflicts with the Third Circuit's decisions in *Dukes* v. *U.S. Healthcare, Inc.*, 57 F.3d 350, cert. denied, 516 U.S.1009 (1995), and *Pryzbowski* v. *U.S. Healthcare, Inc.*, 245 F.3d 266 (2001), creating a split between the state and federal courts in Pennsylvania on this issue. Resolution of this conflict is necessary to prevent forum shopping. See *Yee* v. *City of Escondido*, 503 U.S. 519, 538 (1992) (granting certiorari to resolve conflict between Ninth Circuit and California state courts, this Court noted that "[f]orum shopping is thus of particular concern"); *Baldwin* v. *Alabama*, 472 U.S. 372, 374 (1985) (granting certiorari to resolve conflict between Eleventh Circuit and Supreme Court of Alabama).

In *Dukes*, the Third Circuit held that ERISA preempts claims based on utilization review decisions and other plan benefit eligibility determinations, but does not preempt claims challenging the quality of care a subscriber receives. The Pennsylvania Supreme Court's declaration that all negligence claims against a health maintenance organization are outside the preemptive scope of Section 514(a), even if they relate to the administration of benefits under a plan, is in direct conflict with *Dukes*. See *Huss* v. *Green Spring Health Services, Inc.*, No. 98-6055, 1999 U.S. Dist. LEXIS 5101, *13 (E.D. Pa. April 16,

1999) (noting the "tension" between *Dukes* and the Pennsylvania Supreme Court's decision in this case and following *Dukes*). Remarkably, the Pennsylvania Supreme Court made no mention at all of *Dukes* in either *Pappas I* or *Pappas II*, simply ignoring the suggestion by Justice Nigro in his concurring opinion in *Pappas I* to adopt the rationale of the *Dukes* decision. App., *infra*, 41a-42a.[5]

The *Pappas II* majority likewise ignored *Pryzbowski* (in the face of Justice Saylor's discussion of *Pryzbowski* in his dissent). In that case, construing Section 502(a), the Third Circuit held that ERISA completely preempted negligence and other state law claims arising from delay in approving requested services because such delay was "conduct falling squarely within administrative function." 245 F.3d at 274. As Judge Sloviter's opinion for the unanimous court explained: "A holding that Pryzbowski's claims against U.S. Healthcare are not completely preempted would open the door for legal challenges to core managed care practices (e.g., the policy of favoring in-network specialists over out-of-network specialists), which the Supreme Court eschewed in *Pegram*." *Id.* at 274-275. By comparison, in *Pappas II*, the Pennsylvania Supreme Court held that claims based on delay in approving treatment are not preempted by ERISA and characterized its own ruling in *Pappas I* as "consistent with the Supreme Court's decision in *Pegram*." App., *infra*, 13a-14a. As Justice Saylor observed in his dissenting opinion in *Pappas II*, there is a direct conflict between *Pappas II* and *Pryzbowski*. App., *infra*, 18a n.3.

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[5] In our prior certiorari petition (98-1836 Pet. 14 n.4), we explained that Justice Nigro misread *Dukes*. Furthermore, *Dukes* itself draws a tenuous and manipulable line between "quality of care" and "quantity of care" that may not ultimately represent a faithful interpretation of ERISA. But what matters for present purposes is that the Supreme Court of Pennsylvania has consistently ignored *Dukes* and drawn a line completely inconsistent with the analysis in *Dukes*, as well as inconsistent with the contrary post-*Pegram* decision on indistinguishable facts in *Pryzbowski*.

The Pennsylvania Supreme Court did acknowledge in *Pappas I* (though not in *Pappas II*) that a number of federal appellate decisions hold to be preempted or completely preempted negligence claims against health maintenance organizations that, like the claim asserted here against petitioner, arise from the administration and processing of claims for benefits under an ERISA-governed plan. App., *infra*, 38a n.5. However, just as it refused to follow this Court's pre-*Travelers* decisions because it believed they were no longer good law, so too did it disregard the many relevant court of appeals decisions, declaring that "it would be inappropriate for us to utilize the reasoning of these courts of appeal cases as they fail to discuss the *Travelers* line of decisions." *Ibid.*

In fact, after *Travelers*, the federal courts of appeals have continued to hold — uniformly — that, under *Pilot Life*, Sections 502(a) and 514(a) preempt claims arising from the administration of benefits under an ERISA plan, such as refusals to authorize coverage for a particular type of treatment or refusals to authorize coverage at a particular hospital. See *Pryzbowski*, 245 F.3d at 274 (claims for delay in approving surgery are preempted by ERISA because they involve "conduct falling squarely within administrative function"); *Thompson* v. *Gencare Health Sys., Inc.*, 202 F.3d 1072 (8th Cir. 2000) (ERISA preempted claims arising from refusal to authorize high dose chemotherapy or bone marrow transplant); *Hull* v. *Fallon*, 188 F.3d 939, 943 (8th Cir. 1999) (claims involving denial of thallium stress test "relate to the administration of benefits" and are preempted by ERISA), cert. denied, 528 U.S. 1189 (2000); *Danca* v. *Private Health Care Sys., Inc.*, 185 F.3d 1 (1st Cir. 1999) (ERISA preempted claims for denial of precertification for treatment at one hospital and precertification for admission to a different hospital); *Bast* v. *Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1008 (9th Cir. 1998) (claims arising from delay in authorizing bone marrow transplant were preempted); *Parrino* v. *FHP, Inc.*, 146 F.3d 699, 705 (9th Cir.) (claims arising out of delay in approving proton beam cancer therapy were preempted), cert. denied, 525 U.S. 1001 (1998); *Englehardt* v.

Paul Revere Life Ins. Co., 139 F.3d 1346, 1353 (11th Cir. 1998) (ERISA preempted tort challenge to plan's decision to deny plaintiff's claim for benefits); *Turner* v. *Fallon Community Health Plan, Inc.*, 127 F.3d 196, 199 (1st Cir. 1997) (ERISA preempted claims arising from refusal to authorize coverage for bone marrow transplant), cert. denied, 523 U.S. 1072 (1998); *Painter* v. *Golden Rule Ins. Co.*, 121 F.3d 436, 440 (8th Cir. 1997) (ERISA preempted claim stemming from refusal to authorize coverage for high-dose chemotherapy cancer treatment), cert. denied, 523 U.S. 1074 (1998); *Jass* v. *Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1495 (7th Cir. 1996) (ERISA preemption applies to "allegations of negligence based on a failure to treat where the plan denied benefits for the proposed treatment"); *Cannon* v. *Group Health Serv.*, 77 F.3d 1270, 1273 (10th Cir.) (ERISA preempted suit arising from delay in authorizing bone marrow transplant), cert. denied, 519 U.S. 816 (1996).[6]

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[6] The Pennsylvania Supreme Court's decision also conflicts with a number of pre-*Travelers* court of appeals decisions that, relying on *Pilot Life*, had held that ERISA preempted claims based on the alleged improper administration of benefits under a plan. *Tolton* v. *American Biodyne, Inc.*, 48 F.3d 937, 942 (6th Cir. 1995) (ERISA preempted claims arising from refusal to authorize psychiatric treatment under the plan; "American Biodyne and its employees were determining what benefits were available to Tolton under the plan."); *Spain* v. *Aetna Life Ins. Co.*, 11 F.3d 129, 131 (9th Cir. 1993) (ERISA preempted claim based on delay in authorizing coverage for bone marrow transplant; plaintiff's claim "seeks damages for the negligent administration of benefit claims"), cert. denied, 511 U.S. 1052 (1994); *Kuhl* v. *Lincoln National Health Plan*, 999 F.2d 298, 303 (8th Cir. 1993) (plan refused to certify payment for heart surgery at a hospital outside the plan's service area; "the decision not to precertify payment relates directly to Lincoln National's administration of benefits"), cert. denied, 510 U.S. 1045 (1994); *Corcoran* v. *United Healthcare, Inc.*, 965 F.2d 1321, 1332 (5th Cir.) (plan authorized home nursing care for pregnant woman rather than hospitalization; "the Corcorans are attempting to recover for a tort allegedly committed in the course of handling a benefit determination"), cert. denied, 506 U.S. 1033 (1992); *Settles* v. *Golden Rule Ins. Co.*, 927 F.2d 505, 509 (10th Cir. 1991) (claim based on allegedly unlawful termination of coverage was preempted; "[t]he factual basis for each of plaintiff's state law claims directly concerns the alleged improper administration of the benefit plan").

Not only is there a direct conflict between the broad holding that *no* "negligence claims against a health maintenance organization" can "'relate to' an ERISA plan" under Section 514(a) and the federal courts of appeals cases cited above, there is an equally direct conflict between the federal courts of appeals and the alternative holding in *Pappas II* that "mixed eligibility and treatment" decisions can, in light of *Pegram*, be challenged under state law. In *Corporate Health Ins.* — which the Pennsylvania Supreme Court failed to mention — the Fifth Circuit stated so expressly: "[W]e do not read *Pegram* to entail that every conceivable state law claim survives preemption as long as it is based on a mixed question of eligibility and treatment." 220 F.3d at 643. Here, the Pennsylvania Supreme Court read *Pegram* exactly as the Fifth Circuit did not. And the Pennsylvania Supreme Court's decision conflicts as well with the Third Circuit's decision in *Pryzbowski*.

There, a patient sued under state law for supposed negligence in an HMO's delay in authorizing particular treatment. Borrowing the same terminology from *Pegram* as did the Pennsylvania Supreme Court, the Third Circuit held that such a claim was one "to enforce [a person's] rights under the terms of the plan" and thus completely preempted under ERISA Section 502(a) and, *a fortiori*, "relate[d] to" a plan under Section 514(a). See 245 F.3d at 274-275 (preemption of delay claims consistent with *Pegram*'s rejection of "legal challenges to core managed care practices (e.g., the policy of favoring in-network specialists over out-of-network specialists)").[7]

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[7] See also *Calad* v. *Cigna Healthcare of Texas, Inc.*, No. CIV. 300-CV-2693-H, 2001 WL 705776 (N.D. Tex. June 21, 2001) (noting that *Pegram* "was not a preemption case" and holding that "claims arising from a delay or denial of benefits are ERISA-preempted"); *Roark* v. *Humana, Inc.*, No. CIV. A. 3:00-CV-2368D, 2001 WL 585874, *4 (N.D.Tex. May 25, 2001) (holding *Pegram* inapplicable to claim for delay or denial of approval for skilled nursing home care because the claim "is about administration of benefits, not quality of medical treatment"); *Rubin-Schneiderman* v. *Merit Behavioral Care Corp.*, 25 EMPL. BEN. CAS. 2542 (CCH) ¶ 23971U (S.D.N.Y. Apr. 10, 2001) (relying on *Pryzbowski* for holding that

Critical to the Third Circuit's analysis under *Pegram* was its understanding that this Court determined that Congress wanted to *reject* broad-based state-law attacks on the business justifications for HMOs. A claim such as the one in *Pryzbowski* — and the one here — that an HMO had wrongly delayed or denied benefits "would open the door for legal challenges to core managed care practices (e.g., the policy of favoring in-network specialists over out-of-network specialists)." 245 F.3d at 274-275. Such challenges are precisely the kind that Congress decided to preempt. See *id.* at 275 (noting that in *Pegram* the Court "reject[ed] claims attacking financial incentives behind HMO structure, in light of [the] congressional policy of promoting HMOs").

Petitioner's decision that Mr. Pappas would be afforded coverage if he was transferred to any of the three designated participating hospitals, but not if he was transferred to a non-participating hospital (Jefferson), was a prototypical determination concerning the eligibility of Mr. Pappas to benefits and under *Pilot Life* should have been held preempted. And even if petitioner's decision had been "mixed" (which it was not), involving both an eligibility determination and questions of treatment, it should also have been preempted. In holding that either *no* negligence claims are preempted, or that at least negligence claims challenging mixed decisions are not preempted, the Pennsylvania Supreme Court has created a conflict with decisions of other courts. The latter holding not only reflects an erroneous attribution of talismanic significance, for preemption purposes, to the "mixed" label, but also reflects a legally (see

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"determinations of whether requested treatment is covered under a policy relate to plan administration" and challenges to them are therefore preempted); *Schusteric* v. *United Healthcare Ins. Co. of Ill.*, No. 00 C 4156, 2001 WL 1263581, *2 (N.D. Ill. Sept. 5, 2000) ("*Pegram*'s discussion of whether the plaintiff could state a claim for breach of fiduciary duty under ERISA § 1109 says nothing about whether a negligence claim of the type alleged in this case [*i.e.*, for delay in approving physical therapy] is completely preempted by § 502(a).")

98-1936 U.S. Br. 11) and factually (see note 3, *supra*) erroneous classification of this case as one involving a "mixed" determination.

The third-party complaint brought by Haverford not only complains of petitioner's refusal to pre-authorize coverage for Mr. Pappas at Jefferson, but also alleges that petitioner contributed to the delay in transferring Mr. Pappas from Haverford to a more suitable hospital. App., *infra*, 6a & n.2. The Pennsylvania Supreme Court stated in *Pappas I* that "[c]laims that an HMO was negligent when it provided contractually-guaranteed medical benefits in such a dilatory fashion that the patient was injured indisputably are intertwined with the provision of safe medical care" and are not preempted. App., *infra*, 39a. However, that ruling conflicts with six of the federal appellate decisions cited above, where the courts of appeals held that, under *Pilot Life*, ERISA preempts claims based on undue delays by plan administrators in approving particular treatments or benefits. *Pryzbowski*, 245 F.3d at 273 ("Underlying these allegations of delay is the policy adopted by U.S. Healthcare (and many other HMOs) requiring beneficiaries either to use in-network specialists or to obtain approval from the HMO for out-of-network specialists. These activities fall within the realm of the administration of benefits."); *Bast* v. *Prudential Ins. Co.*, 150 F.3d 1003; *Parrino* v. *FHP, Inc.*, 146 F.3d 699; *Cannon* v. *Group Health Service*, 77 F.3d 1270; *Spain* v. *Aetna Life Ins.*, 11 F.3d 129; *Kuhl* v. *Lincoln Nat. Health Plan*, 999 F.2d 298.

The decision in *Pappas I*, as re-affirmed and expounded on in *Pappas II*, stands alone in its wholesale evisceration of the preemption defense that other courts have upheld for ERISA plan benefit eligibility determinations. As the United States observed in its amicus curiae brief in *Pappas I*, the Pennsylvania Supreme Court's decision "conflicts with a long line of federal court of appeals decisions, both before and after *Travelers*, holding that ERISA preempts state-law challenges to decisions by HMOs, insurers, utilization review organizations, and

other plan administrators to deny or delay authorization for particular medical treatments or treatment at particular hospitals." 98-1836 U.S. Br. 17. The conflict between the Pennsylvania Supreme Court's decision and all of the federal courts of appeals decisions referred to above is stark, and that conflict can be resolved only by this Court.

C. This Court's Review Is Needed To Bring Coherence To An Important Area Of Law That Has Caused Confusion In Lower Courts

Although this Court has rendered decisions in 18 cases addressing the boundaries of ERISA's preemptive reach,[8] it has not yet addressed ERISA preemption in the context of a medical malpractice or negligence-based action against an ERISA-governed health maintenance organization. This Court observed in *DeBuono* that the ERISA preemption issue has "generated an avalanche of litigation in the lower courts" (520 U.S. at 808 n.1); a significant portion of that avalanche is composed of malpractice and negligence lawsuits against health maintenance organizations.

Lacking guidance from this Court, the federal and state courts have struggled mightily with the interplay of Sections 502(a) and 514(a) of ERISA with the myriad types of tort claims asserted against health maintenance organizations and other ERISA-governed health plans. The courts have employed differing analytical frameworks, have reached widely divergent conclusions, and have created tremendous confusion, uncertainty, and unpredictability in a vitally important area of the law that affects the tens of millions of people who

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[8] The Court itself identified 16 cases in *DeBuono*, 520 U.S. at 808 n.1. Since then, the Court has decided *UNUM Life Ins.*, 526 U.S. 358, and *Egelhoff* v. *Egelhoff ex rel. Breiner*, 121 S. Ct. 1322 (2001). Contrary to the Pennsylvania Supreme Court's apparent belief that this Court no longer regards ERISA as having any meaningful preemptive scope, *Egelhoff* (in full) and *UNUM* (in part, 526 U.S. at 377-379) resulted in determinations that state law was preempted by ERISA.

participate in managed health care. Ascertaining the appropriate scope of ERISA preemption is crucial because ERISA affects virtually all Americans who obtain health benefits through a private employer. All health benefit plans obtained through a qualified employer are within the scope of ERISA, regardless of whether the benefits are provided through a contract with an insurer, an HMO, or a self-funded plan.

In its amicus curiae brief in *Pappas I*, the government stated (98-1836 U.S. Br. 18):

> We agree with petitioner (Pet. 19-22) that, regardless of the merits, this is an area of law of great importance. A majority of the 123 million Americans who receive health care through ERISA-regulated employee benefit plans are now subject to a managed care regime in which at least some coverage decisions are made before treatment is provided. * * * The profusion of litigation in the lower courts as to the extent of ERISA preemption with respect to activities by HMOs is further testament to the importance of the issues presented and the regularity with which they arise. And while Congress may eventually enact new legislation in this field, it has not yet done so, and the issues under current law are significant enough to warrant review by the Court.[9]

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[9] The government's December 1999 statement in this case that the issues are sufficiently important to deserve review in this Court notwithstanding the possibility of new legislation contrasts with its June 2001 statement that somewhat related issues — involving not preemption of state tort actions, but rather preemption of state statutes mandating external independent review of managed care organizations' medical necessity decisions — should not be reviewed because essentially the same issues are pending before Congress. Brief for the United States as Amicus Curiae (June 2001), *Montemayor* v. *Corporate Health Ins., Inc.*, No. 00-665, and *Rush Prudential HMO, Inc.* v. *Moran*, No. 00-1021. This Court's June 29 grant of certiorari in *Rush Prudential* suggests that neither the circuit split involved in that case nor the related but different split involved in this case should go unresolved just because of the possibility of legislation. In any event, as of the date of the filing of this petition, the prospects for new legislation in the near future are

Numerous commentators have noted that "lower courts have struggled, in vain, to find a manageable framework * * * through which they could apply ERISA preemption to claims against HMOs. The result has been a panoply of confusion among courts, HMOs, physicians, and subscribers * * *." B. Richardson, *Health Care: ERISA Preemption and HMO Liability — A Fresh Look at ERISA Preemption in the Context of Subscriber Claims Against HMOs*, 49 OKLA. L. REV. 677, 679 (1996). The "myriad of confusion" that now exists in the federal and state courts with respect to the proper application of ERISA preemption to tort claims against HMOs "has served to erode the public trust of HMOs, government, and the judicial system." *Id.* at 701.

"With no specific guidance from the Supreme Court in this area, lower courts have floundered and strained," and "there is no consistency in the logic courts have applied, and therefore no clarification of the scope of ERISA pre-emption." R. Charrow & L. Greenlees, *ERISA Pre-emption — A Law in Search of a Doctrine*, HEALTH LAW DIGEST, March 1999, at 10. The authors conclude as follows:

> Until the Supreme Court addresses the ERISA pre-emption issue, healthcare attorneys can expect three things. First, there will be an increase in the frequency of federal appeals court decisions devoted to ERISA pre-emption issues. Second, the courts will continue to struggle by drawing distinctions — some meaningful, some not — in the hope of reaching results that are both equitable and in accord

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doubtful. See *White House Tries to Influence Debate on Patients' Bill of Rights Legislation*, 70 U.S.L.W. 2042 (July 17, 2001) (although S. 1052 has passed the Senate, President Bush has threatened to veto it "on grounds that it provides for far too broad an expansion of the scope for lawsuits," and competing bills are pending in the House, making the entire outcome as well as its intermediate steps quite unclear); Amy Goldstein & Juliet Eilperin, *Bush Lobbies Hill On Patient Rights*, WASH. POST, July 27, 2001, at A1 (reflecting postponement of House vote and uncertainty of timing of future House consideration).

> with the broad pre-emption provision. Third, the mass of appeals court decisions will be of little help; it will still be difficult for any tort litigant to predict with any degree of certainty the outcome of most ERISA pre-emption cases. It is this uncertainty that makes ERISA pre-emption a complex and tense issue in need of Supreme Court guidance.

Id. at 14. Accord K. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption*, 13 YALE J. ON REG. 255, 304 (1996) ("the outcomes on the issue of ERISA preemption [of tort claims against HMOs] have been inconsistent — indeed, the situation might be characterized as one of utter confusion on the issue"); K. Bartholomew, *ERISA Preemption of Medical Malpractice Claims in Managed Care: Asserting a New Statutory Interpretation*, 52 VAND. L. REV. 1131, 1133 (1999) (noting "doctrinal confusion and 'chaos' in the lower courts," with the result that "[l]ittle judicial guidance * * * currently exists for interpreting ERISA's poorly constructed preemption clause"); P. Jacobson & S. Pomfret, *Form, Function and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence*, 35 HOUS. L. REV. 985, 1032 (1998) (decisions considering ERISA preemption of tort claims against HMOs have been marked by "instability, unpredictability, and a lack of uniformity — exactly the problem Congress intended the preemption clause to cure"); Note, *You Can't Get There From Here — Questioning the Erosion of ERISA Preemption in Medical Malpractice Actions Against HMOs*, 30 GA. L. REV. 1023, 1051 (1996) ("these various approaches have created incongruity and analytical inconsistency among courts").

Pegram has hardly solved the problem. Although there are those who (perhaps opportunistically) purport to find hidden in *Pegram* clear guidance about preemption — even though preemption was *not* at issue in *Pegram* — others correctly observe that, "[a]fter *Pegram*, the limits of ERISA preemption are as murky as ever, with the Supreme Court's opinion casting as

much shadow as light on an issue that has long cried out for resolution." A. Rosoff, *Breach of Fiduciary Duty Lawsuits Against MCOs: What's Left After Pegram v. Herdrich?*, 22 J. LEGAL. MED. 55, 56 (2001); see also *ibid.* ("judicial clarification * * * [is] still sorely needed"); *id.* at 75 ("the *Pegram* decision gives mixed and conflicting signals"). The conflict between the decision below and *Pryzbowski* reflects the inevitability of continued discord in the lower courts, post-*Pegram*, unless this Court steps in. See also Brief for the United States as Amicus Curiae 17-19 & nn.5-6 (June 2001), *Montemayor* v. *Corporate Health Ins., Inc.*, No. 00-665, and *Rush Prudential HMO, Inc.* v. *Moran*, No. 00-1021 (recognizing conflict between decision below and *Pryzbowski*; framing the question as "what effect, if any, *Pegram*'s discussion of ERISA's fiduciary responsibilities has on ERISA preemption analysis"; observing that "[t]he answer to that question could be of very broad significance"; and repeating that "the question concerning the effect, if any, of *Pegram* on ERISA preemption analysis could have very broad implications").[10]

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[10] There is a sufficient overlap between the issues on which the Court has granted certiorari in *Rush Prudential* and the issues raised by this petition that this case should at least be held pending the disposition of *Rush Prudential*, yet the cases also are sufficiently different that an outright grant rather than a hold would be better. On the one hand, both cases pose the question whether *Pegram*, which was a fiduciary duty case and not a preemption case, changes preemption analysis at all. As the quotations in the text show, the United States — despite the brief it filed in the Pennsylvania Supreme Court — now seems to be signaling this Court that it has grave doubts that *Pegram* has "any" "effect * * * on ERISA preemption analysis." 00-665 U.S. Br. 18. On the other hand, the existence of the necessary "relat[ion] to" an ERISA plan was accepted by the Court below in *Rush Prudential*, whereas the existence of such a relation is what is at issue in this case. See *Moran* v. *Rush Prudential HMO, Inc.*, 230 F.3d 959, 968 (7th Cir. 2000). *Rush Prudential* seems likely to turn more on the insurance savings clause of ERISA, 29 U.S.C. § 1144(b)(2)(A), than on the construction of 29 U.S.C. §§ 1132(a) and 1144(a) at issue here. Compare 230 F.3d at 969-973 (construing insurance savings clause to have dispositive effect in that case), with 98-1836 U.S. Br. 14 n.10 ("this case [*Pappas*] does not involve ERISA's insurance savings clause or its construction in *Pilot Life*").

ERISA preemption in the context of negligence claims against managed health care companies is an important and recurring issue that will continue to perplex and divide the federal and state courts until this Court finally steps in and provides much-needed guidance and clarity. This case offers an excellent opportunity to the Court to assist the lower courts in grappling with this difficult issue. Indeed, legal commentators have described the decision in *Pappas II* as one whose "implications * * * are 'enormous'"[11] and as potentially "the case everyone is waiting for" to secure this Court's review.[12]

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

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[11] *On Remand From U.S. Supreme Court, Pennsylvania Finds No ERISA Bar To Suit*, 10 HEALTH LAW REP. (BNA) 592, 593 (Apr. 12, 2001).

[12] M. Morrissey, *An HMO Tale of Rashomon*, NAT'L L.J., June 18, 2001, at A1, A17.