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NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States v. Detroit Timber & Lumber Co.*, 200 U. S. 321, 337.

SUPREME COURT OF THE UNITED STATES

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AETNA HEALTH INC., FKA AETNA U. S.
HEALTHCARE INC. ET AL. *v.* DAVILACERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR
THE FIFTH CIRCUIT

No. 02–1845. Argued March 23, 2004—Decided June 21, 2004*

Respondents brought separate Texas state-court suits, alleging that petitioners, their health maintenance organizations (HMOs), had refused to cover certain medical services in violation of an HMO’s duty “to exercise ordinary care” under the Texas Health Care Liability Act (THCLA), and that those refusals “proximately caused” respondents’ injuries. Petitioners removed the cases to federal courts, claiming that the actions fit within the scope of, and were thus completely preempted by, §502 of the Employee Retirement Income Security Act of 1974 (ERISA). The District Courts agreed, declined to remand the cases to state court, and dismissed the complaints with prejudice after respondents refused to amend them to bring explicit ERISA claims. Consolidating these and other cases, the Fifth Circuit reversed. It found that respondents’ claims did not fall under ERISA §502(a)(2), which allows suit against a plan fiduciary for breaches of fiduciary duty to the plan, because petitioners were being sued for mixed eligibility and treatment decisions that were not fiduciary in nature, see *Pegram v. Herdrich*, 530 U. S. 211; and did not fall within the scope of §502(a)(1)(B), which provides a cause of action for the recovery of wrongfully denied benefits, because THCLA did not duplicate that cause of action, see *Rush Prudential HMO, Inc. v. Moran*, 536 U. S. 355.

Held: Respondents’ state causes of action fall within ERISA

*Together with No. 03–83, *CIGNA HealthCare of Texas, Inc., dba CIGNA Corp. v. Calad et al.*, also on certiorari to the same court.

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§502(a)(1)(B), and are therefore completely pre-empted by ERISA §502 and removable to federal court. Pp. 4–20.

(a) When a federal statute completely pre-emptes a state-law cause of action, the state claim can be removed. See *Beneficial Nat. Bank v. Anderson*, 539 U. S. 1, 8. ERISA is such a statute. Because its purpose is to provide a uniform regulatory regime, ERISA includes expansive pre-emption provisions, such as ERISA §502(a)’s integrated enforcement mechanism, which are intended to ensure that employee benefit plan regulation is “exclusively a federal concern,” *Alessi v. Raybestos-Manhattan, Inc.*, 451 U. S. 504, 523. Any state-law cause of action that duplicates, supplements, or supplants ERISA’s civil enforcement remedy conflicts with clear congressional intent to make that remedy exclusive, and is therefore pre-empted. ERISA §502(a)’s pre-emptive force is still stronger. Since ERISA §502(a)(1)(B)’s pre-emptive force mirrors that of §301 of the Labor Management Relations Act, 1947, *Metropolitan Life Ins. Co. v. Taylor*, 481 U. S. 58, 65–66, and since §301 converts state causes of actions into federal ones for purposes of determining the propriety of removal, so too does ERISA §502(a)(1)(B). Pp. 4–7.

(b) If an individual, at some point in time, could have brought his claim under ERISA §502(a)(1)(B), and where no other independent legal duty is implicated by a defendant’s actions, then the individual’s cause of action is completely pre-empted by ERISA §502(a)(1)(B). Respondents brought suit only to rectify wrongful benefits denials, and their only relationship with petitioners is petitioners’ partial administration of their ERISA-regulated benefit plans; respondents therefore could have brought §502(a)(1)(B) claims to recover the allegedly wrongfully denied benefits. Both respondents allege violations of the THCLA’s duty of ordinary care, which they claim is entirely independent of any ERISA duty or the employee benefits plans at issue. However, respondents’ claims do not arise independently of ERISA or the plan terms. If a managed care entity correctly concluded that, under the relevant plan’s terms, a particular treatment was not covered, the plan’s failure to cover the requested treatment would be the proximate cause of any injury arising from the denial. More significantly, the THCLA provides that a managed care entity is not subject to THCLA liability if it denies coverage for a treatment not covered by the plan it administers. Pp. 7–12.

(c) The Fifth Circuit’s reasons for reaching its contrary conclusion are all erroneous. First, it found significant that respondents asserted tort, rather than contract, claims and that they were not seeking reimbursement for benefits denied. However, distinguishing between pre-empted and non-pre-empted claims based on the par-

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ticular label affixed to them would allow parties to evade ERISA's pre-emptive scope simply by relabeling contract claims as claims for tortious breach of contracts. And the fact that a state cause of action attempts to authorize remedies beyond those that ERISA §502(a) authorizes does not put it outside the scope of ERISA's civil enforcement mechanism. See, e.g., *Pilot Life Ins. Co. v. Dedeaux*, 481 U. S. 41, 43. Second, the court believed the plans' wording immaterial because the claims invoked an external ordinary care duty, but the wording is material to the state causes of action and the THCLA creates a duty that is not external to respondents' rights under their respective plans. Finally, nowhere in *Rush Prudential* did this Court suggest that ERISA §502(a)'s pre-emptive force is limited to state causes of action that precisely duplicate an ERISA §502(a) cause. Nor would it be consistent with this Court's precedent to do so. Pp. 12–14.

(d) Also unavailing is respondents' argument that the THCLA is a law regulating insurance that is saved from pre-emption by ERISA §514(b)(2)(A). This Court's understanding of §514(b)(2)(A) is informed by the overpowering federal policy embodied in ERISA §502(a), which is intended to create an exclusive federal remedy, *Pilot Life*, 481 U. S., at 52. Allowing respondents to proceed with their state-law suits would "pose an obstacle" to that objective. *Ibid.* Pp. 14–16.

(e) *Pegram*'s holding that an HMO is not intended to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians is not implicated here because petitioners' coverage decisions are pure eligibility decisions. A benefit determination under ERISA is part and parcel of the ordinary fiduciary responsibilities connected to the administration of a plan. That it is infused with medical judgments does not alter this result. *Pegram* itself recognized this principle, see 530 U. S., at 231–232. And ERISA and its implementing regulations confirm this interpretation. Here, petitioners are neither respondents' treating physicians nor those physicians' employees. Pp. 16–19.

307 F. 3d 298, reversed and remanded.

THOMAS, J., delivered the opinion for a unanimous Court. GINSBURG, J., filed a concurring opinion, in which BREYER, J., joined.