Rel: September 18, 2020

SUPREME COURT OF ALABAMA

SPECIAL TERM, 2020

1190107

Kathleen Hendrix, as administratrix of the Estate of Kenneth Morris Hendrix, deceased

v.

United Healthcare Insurance Company of the River Valley

Appeal from Etowah Circuit Court
(CV-17-900732)

SELLERS, Justice.

Kathleen Hendrix ("Hendrix"), as administratrix of the estate of Kenneth Morris Hendrix, deceased, appeals from a judgment of the Etowah Circuit Court, dismissing Hendrix's medical-malpractice wrongful-death claim against United

Healthcare Insurance Company of the River Valley ("United"). Kenneth, who was covered by a health-insurance policy issued by United, died after United refused to pay for a course of medical treatment recommended by Kenneth's treating physician. The trial court determined that Hendrix's claim is preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq. ("ERISA"), because the claim "relate[s] to" the ERISA-governed employee-benefit plan pursuant to which United had issued Kenneth's health-insurance policy. See 29 U.S.C. § 1144(a) ("Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan ...."). We affirm the trial court's judgment.

Introduction

ERISA governs "voluntarily established health and pension plans in private industry." Kennedy v. Lilly Extended Disability Plan, 856 F.3d 1136, 1138 (7th Cir. 2017). It "comprehensively regulates, among other things, employee welfare benefit plans that, 'through the purchase of insurance or otherwise,' provide medical, surgical, or hospital care, or

benefits in the event of sickness, accident, disability, or death. § 3(1), 29 U.S.C. § 1002(1)." Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 44 (1987).

ERISA's express preemption provision, § 514(a), 29 U.S.C. § 1144(a), provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." State law that may be preempted because it relates to an ERISA employee-benefit plan "includes all laws, decisions, rules, regulations, or other State action having the effect of law." 29 U.S.C. § 1144(c)(1). This includes civil causes of action brought pursuant to state law. Aldridge v. DaimlerChrysler Corp., 809 So. 2d 785, 792 (Ala. 2001) ("ERISA's express preemption provision ... 'defeats claims that seek relief under state-law causes of action that "relate to" an ERISA plan.'" (quoting Butero v. Royal Maccabees Life Ins. Co., 174 F.3d 1207, 1215 (11th Cir. 1999))); Seafarers' Welfare Plan v. Dixon, 512 So. 2d 23 (Ala. 1987) (holding that causes of action alleging breach of contract and bad-faith failure to pay insurance benefits were preempted by ERISA). Thus, if Hendrix's cause of action

against United "relate[s] to" an ERISA-governed plan, it is preempted under § 514(a).[1]

In October 2015, Kenneth was injured in an automobile accident. He was admitted to Gadsden Regional Medical Center for treatment. Approximately one week later, a physician treating Kenneth at the hospital ordered that he be admitted to an inpatient-rehabilitation facility. The complaint indicates that Kenneth accepted his treating physician's recommendation and that Kenneth "desired that [he] be admitted to such an inpatient facility." The complaint also indicates, and Hendrix concedes, that the United health-insurance policy covering Kenneth was issued as part of an ERISA-governed employee-benefit plan administered by United ("the health-benefit plan").

According to the complaint, after Kenneth's treating physician ordered inpatient rehabilitation, representatives of the hospital and a rehabilitation facility "all contacted [United] numerous times in an attempt to get [Kenneth] admitted to an inpatient facility." Hendrix asserts that

[1]Preemption under § 514(a) is referred to herein as "defensive" preemption. There is a distinction between the concept of defensive preemption and "complete" preemption, which is discussed later in this opinion.

United then "imposed itself as [Kenneth's] health care provider, took control of [Kenneth's] medical care, and made a medical treatment decision that [Kenneth] should not receive further treatment, rehabilitation, and care at an inpatient facility." Hendrix asserted in the complaint that, instead, United "made the medical treatment decision that [Kenneth] should be discharged to his home ... and receive a lower quality of care (i.e., home health care) than had been ordered by [his] physicians, therapists, and nurses." Because United rejected Kenneth's request for inpatient rehabilitation, Kenneth was sent home. Kenneth died on October 25, 2015, due to a pulmonary thromboembolism, which, the complaint asserts, would not have occurred had United approved inpatient rehabilitation.

Alleging wrongful death under § 6-5-410, Ala. Code 1975, Hendrix sued the estate of the other driver involved in the automobile accident, that driver's employer, the owner of the other vehicle involved in the accident, and United.[2] In support of her claim against United, Hendrix alleged medical

[2]Hendrix also sued Kenneth's own automobile insurer seeking uninsured/underinsured-motorist benefits.

malpractice under § 6-5-480 et seq., Ala. Code 1975, and § 6-5-540 et seq., Ala. Code 1975. Hendrix alleged that United

> "voluntarily assumed one or more of the following duties, jointly or in the alternative; (1) a duty to act with reasonable care in determining the quality of health care that [Kenneth] would receive; (2) a duty to not provide to [Kenneth] a quality of health care so low that it knew that [Kenneth] was likely to be injured or killed; and/or (3) a duty to exercise such reasonable care, skill, and diligence as other similarly situated health care providers in the same general line of practice ordinarily have and exercise in a like case."

Hendrix alleged further that United

> "negligently and wantonly breached the standard of care that applied to [United's] voluntarily undertaken duties in one or more of the following respects: (a) by providing healthcare for [Kenneth] that fell beneath the standard of care; (b) by making the medical treatment decision and mandating that [Kenneth] not receive further treatment, rehabilitation, and care at an inpatient facility following his discharge from [the hospital]; (c) by violating a physician's orders which required that [Kenneth] receive further treatment, rehabilitation, and care at an inpatient facility following his discharge from [the hospital]; (d) by interfering with [Kenneth's] medical care and preventing him from receiving further treatment, rehabilitation, and care at an inpatient facility following his discharge from [the hospital]."

Although somewhat vague, the complaint demonstrates that, based on the recommendation of his treating physician at Gadsden Regional Medical Center, Kenneth wanted to be admitted

to an inpatient-rehabilitation facility, that his medical providers requested United pay for that course of treatment pursuant to an insurance policy that is part of an ERISA-governed plan, that United denied that request, and that Kenneth was unable to participate in inpatient rehabilitation because United refused to pay for it.[3]

United removed Hendrix's action to the United States District Court for the Northern District of Alabama. In its notice of removal, United asserted that federal-question jurisdiction existed under 28 U.S.C. § 1331 because, United contended, Hendrix's claim against United should be treated as

[3]We note that Kenneth's health-insurance policy, which is referenced in Hendrix's complaint and was submitted to the trial court along with United's motion to dismiss, provides that United will pay for "a service, treatment, supply, device, or item, Hospital, medical or otherwise, which is medically necessary" as determined by United. A determination whether a recommended course of treatment is medically necessary includes an analysis of whether the treatment "is consistent with generally accepted principles of medical practice" and is "cost-effective." Hendrix's complaint alleges that United made "the medical treatment decision" that Kenneth should not be treated in an inpatient-rehabilitation facility. The complaint, however, does not allege that United determined that inpatient rehabilitation was not medically necessary and therefore not covered by the insurance policy. What is clear from the complaint, however, is that United denied the request made by Kenneth's treating physician for benefits under the United insurance policy and that Kenneth did not go to inpatient rehabilitation because United refused to pay for it.

one seeking relief under the civil-enforcement provisions of ERISA and was therefore completely preempted by ERISA. See ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) (authorizing an ERISA plan participant or beneficiary to bring a civil action "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"); Garrison v. Northeast Georgia Med. Ctr., Inc., 66 F. Supp. 2d 1336, 1340 (N.D. Ga. 1999) ("[C]laims seeking relief available from section 502(a), ERISA's civil enforcement provision, 29 U.S.C. § 1132, are completely preempted, and removal jurisdiction exists.").

In Aetna Health Inc. v. Davila, 542 U.S. 200 (2004), the United States Supreme Court reiterated that the civil-enforcement provisions set out in § 502(a) of ERISA have complete preemptive effect and that state-law causes of action that fit within the scope of those enforcement provisions are to be treated as federal claims that can removed to federal court. According to the Court in Davila:

> "[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). Metropolitan Life [Ins. Co. v. Taylor, 481 U.S. 58, 66 (1987)]. 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)."

542 U.S. at 210. The federal district court in the present case noted that Alabama's wrongful-death statute creates a "new right" that arises after the decedent's death and allows for the recovery of only punitive damages. According to the district court, "[b]ecause the wrongful-death claim vests in the decedent's personal representative as a new right and does not compensate for an injury to the ERISA beneficiary, but instead provides punitive damages for next of kin," Hendrix could not have brought her wrongful-death claim under ERISA § 502(a), her claim should not be treated as one seeking ERISA benefits, complete preemption does not exist, and the cause had to be remanded to state court.

After remand, United moved the trial court to dismiss Hendrix's claim based on defensive preemption under ERISA's express preemption provision, § 514(a). As noted, § 514(a)

provides that ERISA "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) (emphasis added). According to United, Hendrix's medical-malpractice wrongful-death claim "relate[s] to" the ERISA-governed health-benefit plan and is therefore defensively preempted. The trial court agreed, granted United's motion to dismiss, and certified its judgment as final under Rule 54(b), Ala. R. Civ. P. Hendrix appealed.[4]

Standard of Review

The parties agree that the appropriate standard of review in this case is the standard applicable to the granting of a motion to dismiss under Rule 12(b)(6), Ala. R. Civ. P. We review such dismissals de novo. Little v. Robinson, 72 So. 3d 1168, 1171 (Ala. 2011). In reviewing the dismissal of a cause of action based on an affirmative defense, we must decide whether the existence of that defense is clear from the face of the plaintiff's complaint. Limon v. Sandlin, 200 So. 3d 21, 24 (Ala. 2015). We must accept as true all the factual

[4]United's motion to dismiss was based solely on defensive preemption under ERISA § 514(a).

allegations set out in the complaint. Ex parte Liberty Nat'l Life Ins. Co., 209 So. 3d 486, 494 (Ala. 2016).

Hendrix points out that both she and United submitted evidentiary materials in support of, and in opposition to, United's motion to dismiss. She also points out that Rule 12(b) provides that, if, on a motion asserting Rule 12(b)(6) as a defense, "matters outside the pleading [sought to be dismissed] are presented to and not excluded by the court, the motion shall be treated as one for summary judgment and disposed of as provided in Rule 56[, Ala. R. Civ. P.]." She asserts that the trial court "should have converted" United's motion into a summary-judgment motion and allowed her to conduct discovery pursuant to Rule 56(f), Ala. R. Civ. P., which provides:

> "Should it appear from the affidavits of a party opposing the motion [for a summary judgment] that the party cannot, for reasons stated, present by affidavit facts essential to justify the party's opposition, the court may deny the motion for summary judgment or may order a continuance to permit affidavits to be obtained or depositions to be taken or discovery to be had or may make such other order as is just."

In her opening brief to this Court, Hendrix ignores the fact that the trial court expressly refused to consider many

of the materials that had been submitted. Rather, the trial court stated that it had considered only documents evidencing Kenneth's insurance coverage submitted by United, which included an insurance application, a certificate of coverage, and a "Large Employer Group Health Contract." The trial court expressly stated in its dismissal order that any consideration it gave the insurance documents did not convert United's motion to dismiss into a summary-judgment motion because Hendrix's complaint referenced "United's management and administration of [Kenneth's] claims for coverage under the [health-benefit plan]." The trial court pointed to Donoghue v. American National Insurance Co., 838 So. 2d 1032, 1035 (Ala. 2002), in which this Court embraced "the well-founded rule ... precluding conversion [of a motion to dismiss to a summary-judgment motion] when the exhibits in question are referred to in, and are central to, the plaintiff's complaint."

Before the trial court ruled on United's motion to dismiss, Hendrix and United took opposing positions as to whether the motion should be treated as a summary-judgment motion, and Hendrix specifically argued that the rule adopted

in Donoghue did not apply. In her opening brief on appeal, however, Hendrix ignores the trial court's reliance on Donoghue and its reasoning regarding the reference in the complaint to Kenneth's request for benefits under the health-benefit plan. She addresses those matters in her reply brief, arguing that the insurance documents are not "central" to her claim, but this Court typically will not consider arguments made for the first time in a reply brief. Melton v. Harbor Pointe, LLC, 57 So. 3d 695, 696 n.1 (Ala. 2010). In any event, Hendrix's complaint demonstrates that the relationship between Kenneth and United created by the insurance documents is what prompted United's actions that, Hendrix claims, ultimately resulted in a voluntarily assumed duty to provide medical care. Without the existence of those documents and that relationship, United would have played no role at all in Kenneth's care and could not have been remotely subject to a claim of medical malpractice. Based on the arguments before us, we cannot say that Hendrix has demonstrated that the trial court erred in concluding that the insurance documents are central to her claim.[5]

[5]Moreover, this Court can determine from Hendrix's complaint alone, without reference to the insurance documents,

Discussion

As noted, the federal district court rejected United's assertion that Hendrix's claim against United is completely preempted by ERISA. In a 2009 opinion, the United States Court of Appeals for the Eleventh Circuit discussed the distinction between complete preemption and defensive preemption and noted that a federal court's decision that a plaintiff's state-law claims are not completely preempted does not settle the question whether those claims are defensively preempted:

> "[Defensive preemption under ERISA] is a substantive defense to preempted state law claims. Jones v. LMR Int'l, Inc., 457 F.3d 1174, 1179 (11th Cir. 2006). This type of preemption arises from ERISA's express preemption provision, § 514(a), which preempts any state law claim that 'relates to' an ERISA plan. 29 U.S.C. § 1144(a). ...
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> "Complete preemption, also known as super preemption, is a judicially-recognized exception to the well-pleaded complaint rule. It differs from defensive preemption because it is jurisdictional in nature rather than an affirmative defense. Jones, 457 F.3d at 1179 (citing Ervast [v. Flexible Prods. Co., 346 F.3d 1007, 1014 (11th Cir. 2003)]). Complete preemption under ERISA derives from ERISA's civil enforcement provision, § 502(a), which has such 'extraordinary' preemptive power that it 'converts an ordinary state common law complaint

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that her claim against United "relate[s] to" the health-benefit plan.

> into one stating a federal claim for purposes of the well-pleaded complaint rule.' [Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 65-66 (1987)]. Consequently, any 'cause[] of action within the scope of the civil enforcement provisions of § 502(a) [is] removable to federal court.' Id. at 66.
>
> "Although related, complete and defensive preemption are not coextensive:
>
> > "'Complete preemption is [] narrower than "defensive" ERISA preemption, which broadly "supersede[s] any and all State laws insofar as they ... relate to any [ERISA] plan." ERISA § 514(a), 29 U.S.C. § 1144(a) (emphasis added). Therefore, a state-law claim may be defensively preempted under § 514(a) but not completely preempted under § 502(a). In such a case, the defendant may assert preemption as a defense, but preemption will not provide a basis for removal to federal court.'
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> "Cotton v. Mass. Mut. Life Ins. Co., 402 F.3d 1267, 1281 (11th Cir. 2005); accord Ervast, 346 F.3d at 1012 n. 6 ('Super preemption is distinguished from defensive preemption, which provides only an affirmative defense to state law claims and is not a basis for removal.')."

Connecticut State Dental Ass'n v. Anthem Health Plans, Inc., 591 F.3d 1337, 1344 (11th Cir. 2009). See also Evans v. Infirmary Health Servs., Inc., 634 F. Supp. 2d 1276, 1292 (S.D. Ala. 2009) ("This Court's holding that plaintiff's claims are not completely preempted by ERISA resolves the jurisdictional question, but is not and cannot be dispositive

of [the defendant's] affirmative defense of defensive preemption."). Thus, the federal district court's decision in this case that United was unable to establish complete preemption in no way forecloses United from relying on defensive preemption under § 514(a).[6]

The preemption language used in § 514(a) is "deliberately expansive." Pilot Life Ins. Co., 481 U.S. at 46. It is aimed at "'eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans.'" Id. at 46 (quoting 120 Cong. Rec. 29197 (1974)). See also Egelhoff v. Egelhoff, 532 U.S. 141, 148 (2001) (stating that a "principal goal[] of ERISA" was "to enable employers 'to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits'" and that "[u]niformity is impossible ... if plans are subject to different legal obligations in different States" (quoting Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 9 (1987))); Kuhl v. Lincoln Nat'l

[6]The parties have framed the primary issue before this Court as whether Hendrix's claim "relates to" an ERISA benefit plan and is therefore defensively preempted. We have not been asked to express an opinion as to the federal district court's conclusion that Hendrix's claim is not completely preempted.

Health Plan of Kansas City, Inc., 999 F.2d 298, 301 (8th Cir. 1993) ("Consistent with the decision to create a comprehensive, uniform federal scheme for regulation of employee benefit plans, Congress drafted ERISA's preemption clause in broad terms.").

A state law relates to a benefit plan "if it has a connection with or reference to such a plan." Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 97 (1983). A state law has an impermissible connection to an ERISA plan if it "'governs ... a central matter of plan administration' or 'interferes with nationally uniform plan administration.'" Gobeille v. Liberty Mut. Ins. Co., ___ U.S. ___, ___, 136 S. Ct. 936, 943 (2016) (quoting Egelhoff, 532 U.S. at 148). "'[A] state law may "relate to" a benefit plan, and thereby be preempted, even if the law is not specifically designed to affect such plans, or the effect is only indirect.'" Weems v. Jefferson-Pilot Life Ins. Co., 663 So. 2d 905, 908 (Ala. 1995) (quoting Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 139 (1990), quoting in turn Pilot Life Ins. Co., 481 U.S. at 47).

In Pilot Life Insurance Co., the plaintiff, who had suffered a back injury at work and had received disability-

insurance benefits for two years under an ERISA benefit plan, sued the disability insurer after it terminated his benefits. The plaintiff asserted causes of action alleging tortious breach of contract, breach of fiduciary duty, and fraud in the inducement. 481 U.S. at 43. He sought an unspecified amount of damages "'for failure to provide benefits under the insurance policy,'" damages for emotional distress, "'other incidental damages,'" and punitive damages. Id. Emphasizing the expansive sweep of § 514(a), the United States Supreme Court held that the plaintiff's claims related to an ERISA plan and were therefore preempted. In so holding, the Court stated that "[t]he common law causes of action raised in [the plaintiff'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. See also HealthAmerica v. Menton, 551 So. 2d 235, 239 (Ala. 1989) (describing Pilot Life Insurance Co. and stating that "claims seeking damages for improperly processing ... claims for benefits under an ERISA-regulated plan" are preempted).

In Davila, the plaintiffs alleged facially state-law causes of action against the administrators of ERISA-governed benefit plans after those administrators refused to pay for treatments that had been recommended by the plaintiffs' treating physicians. The plaintiffs' claims were brought under a Texas statute that imposed a duty on health-insurance carriers, health-maintenance organizations, and other managed-care entities to exercise ordinary care when making health-care-treatment decisions. According to the plaintiffs, the administrators' "refusal to cover the requested services violated their 'duty to exercise ordinary care when making health care treatment decisions.'" 542 U.S. at 205. The plaintiffs claimed they had suffered physical injuries because they were unable to obtain the treatments that had been recommended by their treating physicians. Similar to Hendrix's claim in the present case, the plaintiffs in Davila asserted that the administrators "'controlled, influenced, participated in and made decisions which affected the quality of the diagnosis, care, and treatment provided'" the plaintiffs. 542 U.S. at 212. The United States Supreme Court held that the plaintiffs' claims were completely preempted

because they were aimed at remedying the denial of benefits under ERISA plans and fell within the scope of ERISA's civil-enforcement provisions. Although Davila was a complete preemption case, it is still helpful in considering whether Hendrix's claim in the present case "relate[s] to" the health-benefit plan. Indeed, the Supreme Court considered an argument made by the plaintiffs in Davila that their claims did not "relate to" the ERISA plan involved in that case because, they argued, the ERISA plan administrators had exercised judgment regarding proper medical care. In addressing that argument, the Court noted that benefit determinations under ERISA-regulated plans are "part and parcel of the ordinary fiduciary responsibilities connected to the administration of a plan," even if those determinations are "infused with medical judgments." 542 U.S. at 219. Thus, the fact that an ERISA plan administrator makes medical judgments in considering a claim for benefits does not mean that the administrator has stepped outside its role as an administrator for purposes of preemption under ERISA.

In Kuhl, supra, Buddy Kuhl, a beneficiary of an ERISA-governed health plan established by his employer, suffered a

heart attack. His treating physician concluded that he needed heart surgery and that the surgery should be performed at a hospital in St. Louis, Missouri. After the surgery was scheduled, the health-maintenance organization ("HMO") responsible for considering and paying claims under the health plan refused to pre-certify payment for the surgery because the hospital where the surgery was to be performed was outside the HMO's coverage area. Later, the HMO determined that it would indeed pay for the surgery, but, by that time, Kuhl's condition had deteriorated to the point that the surgery was not a viable option. Kuhl died while waiting for a heart transplant. His family members sued the HMO, alleging medical malpractice, tortious interference with Kuhl's right to contract for medical care, and breach of the contract between Kuhl's employer and the HMO. The trial court entered a summary judgment for the HMO, concluding that the state-law claims were preempted under § 514(a) of ERISA. On appeal, the United States Court of Appeals for the Eighth Circuit affirmed the summary judgment, stating:

> "We have no difficulty in concluding that the Kuhls' three state law claims that rely on Buddy Kuhl's status as a beneficiary of the [ERISA plan] are preempted by ERISA. The Kuhls' claims are all

> based on [the HMO's] alleged misconduct in delaying Buddy Kuhl's heart surgery in St. Louis. The Kuhls contend that [the HMO] tortiously interfered with the contractual relationship between Buddy Kuhl and his doctors, that [the HMO] committed medical malpractice because it assumed the role of Buddy Kuhl's physician by making decisions about proper medical treatment and made decisions that constitute medical malpractice, and that [the HMO] breached its contract with [Kuhl's employer], to which Buddy Kuhl was a third-party beneficiary, by delaying the surgery in St. Louis. The district court found that all of these state law claims arise from the administration of benefits under the [ERISA plan] and are therefore preempted by ERISA. We agree."

999 F.2d at 302. The court continued:

> "[The HMO] became involved in the cancellation of the St. Louis surgery only after the [St. Louis hospital] staff requested a precertification review. [The HMO's] admission that it 'cancelled' the surgery cannot be stretched to imply that [the HMO] went beyond the administration of benefits and undertook to provide Buddy Kuhl with medical advice. Although the surgery in St. Louis was unquestionably cancelled as a result of [the HMO's] decision not to precertify payment, the decision not to precertify payment relates directly to [the HMO's] administration of benefits."

999 F.2d at 303.

Hendrix's complaint avers that Kenneth's treating physician at Gadsden Regional Medical Center determined that Kenneth needed inpatient rehabilitation and that Kenneth accepted his doctor's advice. The complaint also avers that, at all relevant times, "[Kenneth] had health insurance

coverage that was provided and administered by [United]." The complaint then asserts that "Gadsden Regional Medical Center personnel [and representatives of an inpatient-rehabilitation facility] all contacted [United] numerous times in an attempt to get [Kenneth] admitted to an inpatient facility." The complaint avers that United refused to authorize inpatient rehabilitation based on a "medical treatment decision."

It is clear from Hendrix's allegations that the health-care providers who were actually treating Kenneth contacted United because United was the administrator of the ERISA-regulated health-benefit plan, that those health-care providers asked United to approve a request for benefits under that plan, and that Kenneth allegedly died because United denied all requests for benefits. Under the wrongful-death statute, Hendrix seeks to punish United for a death that allegedly resulted because of a denial of benefits. Thus, as United puts it in its brief to this Court, Hendrix's claim "is, at bottom, '[b]ased on the alleged improper processing of a claim for benefits'" and, if allowed to proceed, would "'interfere[] with nationally uniform plan administration.'" (Quoting Pilot Life, 481 U.S. at 47-48, and Egelhoff, 532

U.S. at 150.) Any "medical treatment decision" made by United was made in its role as the administrator of the health-benefit plan, not as a health-care provider. The fact that a medical judgment is made in the course of denying a request for benefits does not mean that a cause of action seeking recovery for an injury or death resulting from that denial does not "relate to" the relevant ERISA benefit plan.[7]

Additional opinions from other jurisdictions, which we find persuasive, are consistent with our conclusion in this case. See Garrison v. Northeast Georgia Med. Ctr., Inc., 66 F. Supp. 2d at 1345 (holding that state-law medical-

[7]Hendrix suggests throughout her brief that her claim against United is not defensively preempted because it seeks to recover punitive damages for wrongful death, not for the value of benefits under an ERISA plan. But she misses the point, since preemption merely requires that her claim "relate to" such a plan. Hendrix seeks damages based on a death that allegedly resulted because United denied a request for benefits under an ERISA-governed plan. Her claim relates to that plan regardless of the fact that she seeks only punitive damages for wrongful death. Moreover, the Court simply cannot accept Hendrix's suggestion that her claim is not preempted because, she says, ERISA would not provide a remedy for Kenneth's death. As other courts have recognized, the lack of a remedy sometimes is an unfortunate consequence of ERISA and its preemption of state law. See, e.g., Tolton v. American Biodyne, Inc., 48 F.3d 937, 943 (6th Cir. 1995) ("One consequence of ERISA preemption, therefore, is that plan beneficiaries or participants bringing certain types of state actions -- such as wrongful death -- may be left without a meaningful remedy.").

malpractice action alleging that administrator of an ERISA plan made a "medical decision" to deny a beneficiary's request for a particular medical procedure related to an ERISA plan under § 514(a)); Bast v. Prudential Ins. Co., 150 F.3d 1003 (9th Cir. 1998) (holding that state-law cause of action alleging that ERISA plan beneficiary died because the plan administrator delayed approval of a recommended course of treatment based on the administrator's initial conclusion that the treatment was "investigational and/or experimental" was preempted under § 514(a)); Spain v. Aetna Life Ins. Co., 11 F.3d 129 (9th Cir. 1993) (holding that state-law cause of action against the administrator of an ERISA-regulated plan that improperly withdrew authorization for a particular medical procedure, causing plan beneficiary's death, related to the ERISA plan).

Hendrix points to a pre-Davila case, Pegram v. Herdrich, 530 U.S. 211 (2000), in support of her medical-treatment-decision argument. In Pegram, the plaintiff sued her physician-owned-and-operated HMO, which provided medical coverage pursuant to an ERISA-regulated benefit plan, after the plaintiff's doctor, Dr. Lori Pegram, decided not to order

an immediate ultrasound at a local medical facility when she discovered an inflamed mass in the plaintiff's abdomen. Instead, Dr. Pegram ordered that the ultrasound take place several days later at a different facility staffed by the HMO's physicians. The plaintiff claimed that Dr. Pegram's delay caused her to suffer a ruptured appendix. The defendant HMO was owned and operated by a group of doctors that included Dr. Pegram. In other words, one of the HMO's physicians was the plaintiff's treating physician.

Against the HMO, the plaintiff asserted an ERISA breach-of-fiduciary-duty claim under 29 U.S.C. § 1109, which allows for such a claim against "[a]ny person who is a fiduciary with respect to a plan." The United States Supreme Court, however, held that the HMO was not an ERISA fiduciary because it had, through Dr. Pegram, made a "mixed" decision involving both eligibility under the ERISA plan and the proper course of medical treatment for the plaintiff. According to the Court, "Congress did not intend [an] HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians." 530 U.S. at 231.

Pegram focused on whether a plaintiff could maintain an ERISA fiduciary claim under 29 U.S.C. § 1109. It did not involve preemption. Some courts, however, relied on its reasoning in concluding that state-law claims arising from mixed eligibility and treatment decisions are not preempted. For example, in Land v. CIGNA Healthcare of Florida, 339 F.3d 1286 (11th Cir. 2003), the plaintiff commenced a medical-malpractice claim under state law against the administrator of his ERISA-governed benefit plan after a nurse working for that administrator refused to approve an extended hospital stay that had been recommended by the plaintiff's treating physicians, which the plaintiff claimed resulted in the eventual amputation of one of his fingers. Pointing to Pegram, the United States Court of Appeals for the Eleventh Circuit held that the malpractice claim was not completely preempted by ERISA because the nurse had made a "mixed eligibility and treatment decision." 339 F.3d at 1292. However, in Davila, which was decided after Pegram and Land, the United States Supreme Court stated the following regarding the holding in Pegram:

> "Since [ERISA plan] administrators making benefits determinations, even determinations based

> extensively on medical judgments, are ordinarily acting as plan fiduciaries, it was essential to Pegram's conclusion that the decisions challenged there were truly 'mixed eligibility and treatment decisions,' 530 U.S., at 229, 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 [v. Does, 339 F.3d 83, 109 (2d Cir. 2003)] (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."

542 U.S. at 220–21. The Eleventh Circuit Court of Appeals' opinion in Land was vacated by the United States Supreme Court based on Davila, and the Eleventh Circuit eventually held that the plaintiff's claims in Land indeed were preempted. See Land v. CIGNA Healthcare of Florida, 381 F.3d 1274 (11th Cir. 2004).

There are no facts alleged in the complaint in the present case supporting Hendrix's conclusory assertion that an agent of United voluntarily undertook a duty to act as Kenneth's treating physician by taking "control" of Kenneth's treatment or that United made the sort of "mixed eligibility

and treatment" decision the HMO made in Pegram. The complaint makes clear that Kenneth's treating physician at the hospital recommended inpatient rehabilitation and that he applied for benefits from United to pay for that treatment, but United denied that request.[8]

Conclusion

Hendrix's claim relates to an ERISA-governed benefit plan. Thus, it is preempted under § 514(a) of ERISA. Accordingly, we affirm the trial court's judgment.[9]

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[8]Other authority from this Court and the United States Supreme Court, upon which Hendrix relies, did not involve preemption of state-law causes of action seeking judgments for injury or death that resulted because of the denial of ERISA benefits. For example, HealthAmerica v. Menton, 551 So. 2d 235 (Ala. 1989), and Ingram v. American Chambers Life Insurance Co., 643 So. 2d 575 (Ala. 1994), involved claims alleging that the plaintiffs were fraudulently induced to purchase ERISA-governed insurance policies. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., 514 U.S. 645 (1995), involved whether ERISA preempted a state statute imposing a surcharge on hospital patients who had insurance coverage provided by an insurer other than Blue Cross/Blue Shield.

[9]Hendrix relies on opinions that, she says, demonstrate the existence of a presumption against ERISA preemption of state-law causes of action. For its part, United points to the 2016 opinion of the United States Supreme Court in Puerto Rico v. Franklin California Tax-Free Trust, ___ U.S. ___, 136 S.Ct. 1938 (2016), for the proposition that the Court rejected any presumption against preemption when dealing with express preemption provisions. Hendrix responds that Puerto Rico involved an express preemption provision in a bankruptcy

AFFIRMED.

Bolin and Mendheim, JJ., concur.

Shaw and Bryan, JJ., concur in the result.

Parker, C.J., and Wise and Stewart, JJ., dissent.

Mitchell, J., recuses himself.

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statute, not ERISA. We note that other courts have refused to limit the Puerto Rico holding on that issue to cases involving bankruptcy law. See Dialysis Newco, Inc. v. Community Health Sys. Grp. Health Plan, 938 F.3d 246, 258 (5th Cir. 2019) (applying Puerto Rico's rejection of a presumption against preemption to ERISA and noting that other courts have not limited Puerto Rico to bankruptcy cases). In any event, assuming there is a presumption against preemption under § 514(a) of ERISA, the trial court did not err in concluding that United has overcome it. We have no doubt that Hendrix's claim against United "relate[s] to" an ERISA plan within the meaning of § 514(a).

SHAW, Justice (concurring in the result).

I concur in the result. I am not convinced that the preemption provided by 29 U.S.C. § 1144(a) bars a wrongful-death action in circumstances where an insurance company, allegedly acting to administer a health-benefit plan, in fact assumes medical care of its insured and by that action causes the death of the insured. However, after reviewing the particular complaint at issue in this case, I am not persuaded that, for the purpose of reviewing the trial court's entry of a dismissal under the applicable Rule 12(b)(6), Ala. R. Civ. P., standard of review, such preemption can be avoided.

Bryan, J., concurs.

PARKER, Chief Justice (dissenting).

I believe the plurality opinion strays from the language of ERISA.[10] The crux of that opinion is that "Hendrix's claim relates to an ERISA-governed benefit plan" and therefore "is preempted under [§ 1144(a)] of ERISA." But a closer examination of the text of 29 U.S.C. § 1144 makes that conclusion far from obvious. That text provides that specific ERISA enforcement provisions supersede certain state laws. Thus, any conclusion that ERISA preempts a state-law claim, without reference to those provisions, is problematic. And it is not at all apparent to me that the enforcement scheme embodied in those provisions supplants an Alabama wrongful-death claim against an ERISA administrator.

Defensive preemption is a product of 29 U.S.C. § 1144(a): "[T]he provisions of ... subchapter [I] and subchapter III [of ERISA] shall supersede any and all State laws insofar as they ... relate to any [ERISA-governed] employee benefit plan ...." Section 1132, ERISA's civil-enforcement provision located in subchapter I, creates rights of action in plan beneficiaries and participants, the Secretary of Labor, plan fiduciaries,

[10]The Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq.

and employers. 29 U.S.C. § 1132(a). Notably, the civil-enforcement provision does not mention claims by third parties; it does not create or expressly abrogate any third-party right of action.

Consistent with this focus of subchapter I, cases in which this Court has found § 1144(a) defensive preemption involved claims by a beneficiary to enforce rights under a policy or to compensate for harm resulting from an insurer's improper administration of a policy. See Seafarers' Welfare Plan v. Dixon, 512 So. 2d 53, 54–55 (Ala. 1987) (explaining that a life-insurance beneficiary's "state common law causes of action claiming benefits under an employee benefit plan regulated by ERISA [were] preempted by ERISA, and that the proper recourse [was] to utilize the civil enforcement provisions of ERISA"); Weems v. Jefferson-Pilot Life Ins. Co., 663 So. 2d 905, 909 (Ala. 1995) (beneficiaries' claims for breach of contract, bad faith, fraud, negligence, wantonness, and willfulness); Landy v. Travelers Ins. Co., 530 So. 2d 214, 215 (Ala. 1988) (beneficiary's breach-of-contract claim); Hood v. Prudential Ins. Co. of Am., 522 So. 2d 265 (Ala. 1988)

(beneficiary's claim alleging bad-faith refusal to pay insurance benefits).

In contrast, this Court has recognized that § 1144(a) does not preempt certain claims that merely tangentially implicate a beneficiary's rights. See HealthAmerica v. Menton, 551 So. 2d 235, 238 (Ala. 1989) ("We hold that a [beneficiary's] claim for fraud in the inducement [based on an insurer's misrepresentation about policy benefits] does not 'relate to' an employee benefit plan and is therefore not preempted by ERISA."); see also Ingram v. American Chambers Life Ins. Co., 643 So. 2d 575, 577 (Ala. 1994) (disagreeing with defendant's argument that Weems repudiated HealthAmerica). In particular, § 1144(a) does not preempt a third-party claim against an insurer where the claim does not seek benefits under the policy. See Brookwood Med. Ctr. v. Celtic Life Ins. Co., 637 So. 2d 1385 (Ala. Civ. App. 1994) (holding that ERISA did not preempt state-law claims of third-party health-care provider against employee-benefit provider based on negligent misrepresentation of coverage). As the Court of Civil Appeals explained in Brookwood: "ERISA preempts a state law cause of action brought by an ERISA plan

participant or beneficiary alleging improper processing of a claim for plan benefits," id. at 1387, but

> "'[c]ourts are more likely to find that a state law relates to a benefit plan if it affects relations among the principal ERISA entities -- the employer, the plan, the plan fiduciaries, and the beneficiaries -- than if it affects relations between one of these entities and an outside party, or between two outside parties with only an incidental effect on the plan.'"

Id. (quoting Sommers Drug Stores Co. Emp. Profit Sharing Trust v. Corrigan Enters., Inc., 793 F.2d 1456, 1467 (5th Cir. 1986)).

In a similar vein, the United States Supreme Court has contrasted "civil enforcement actions ... to secure specified relief, including the recovery of plan benefits," with "lawsuits against ERISA plans for run-of-the-mill state-law claims such as ... torts committed by an ERISA plan." Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 833 (1988). ERISA preempts the former but not the latter. Id.

An Alabama wrongful-death claim of the kind alleged here does not seek to enforce a beneficiary's rights under a policy or seek compensation for a beneficiary for harm from improper plan administration. The wrongful-death statute provides that

> "[a] personal representative may commence an action and recover ... damages ... for the wrongful act, omission, or negligence of any ... corporation ... or [its] servants or agents, whereby the death of the testator or intestate was caused, provided the testator or intestate could have commenced an action for the wrongful act, omission, or negligence if it had not caused death."

§ 6-5-410, Ala. Code 1975. The claim is brought by a third party, a personal representative, who essentially acts as the State's agent and not as the agent of a beneficiary. Moreover, the statute does not compensate the decedent's estate for the decedent's death; rather, the statute is punitive and deterrent, creating a new right of action in the personal representative. In effect, the personal representative acts as the State's agent to punish the wrongful killing of the decedent and to deter conduct that tends to lead to wrongful deaths. See Deaton, Inc. v. Burroughs, 456 So. 2d 771, 776 (Ala. 1984) ("In a wrongful death action ..., the only damages recoverable are punitive in nature, and the amount thereof is determined by the gravity of the wrong done, the propriety of punishing the wrongdoer, and the need for deterring others from committing the same or similar wrongful conduct."); 1 Alabama Personal Injury and Torts § 9:6 (2020) ("The Wrongful Death Act creates the right in the personal representative of

the decedent to act as agent by legislative appointment for the effectuation of a legislative policy of the prevention of homicides through the deterrent value of the infliction of punitive damages.").[11] Notably, Alabama is the only state whose

[11]This Court recently reiterated its historically consistent position that Alabama's wrongful-death statute is noncompensatory:

> "'This statute authorizes suit to be brought by the personal representative for a definite legislative purpose -- to prevent homicide. In prosecuting such actions, the personal representative does not act strictly in his capacity as administrator of the estate of his decedent, because he is not proceeding to reduce to possession the estate of his decedent, but rather he is asserting a right arising after his death, and because the damages recovered are not subject to the payment of the debts or liabilities of the decedent. He acts rather as an agent of legislative appointment for the effectuation of the legislative policy.... And the right is vested in the personal representative alone.'"

Pollard v. H.C. P'ship, [Ms. 1180795, March 13, 2020] ___ So. 3d ___, ___ (Ala. 2020) (quoting Hatas v. Partin, 278 Ala. 65, 67-68, 175 So. 2d 759, 761 (1965)). Elaborating in his special concurrence, Justice Bolin explained further:

> "The legislature created a remedy for the wrongful death of a human being, the stated purpose being to deter homicide by the imposition of punitive damages; no benefits of this remedy would inure to the benefit of the decedent's estate but, rather, would be prosecuted by a trustee, whom the legislature determined to be the personal representative, for the benefit of the decedent's heirs at law ...."

wrongful-death statute is noncompensatory. 2 Trial Handbook for Alabama Lawyers § 38:23 (3d ed. 2020). This noncompensatory nature distinguishes the statute from other states' wrongful-death statutes that courts have held are defensively preempted by § 1144(a). See Garrison v. Northeast Georgia Med. Ctr. Inc., 66 F. Supp. 2d 1336 (N.D. Ga. 1999); Bast v. Prudential Ins. Co., 150 F.3d 1003 (9th Cir. 1998); Spain v. Aetna Life Ins. Co., 11 F.3d 129 (9th Cir. 1993).

In this case, it is clear that United Healthcare Insurance Company of the River Valley ("United") seeks to extend defensive preemption to a different kind of claim from those that ERISA plainly preempts. In my view, United and the plurality opinion have not established a clear statutory indication that defensive preemption applies to this claim.

Wise, J., concurs.

Id. at ___.