No. _____

# In the Supreme Court of the United States

SAMANTHA MILBY,

*Petitioner*,

v.

MCMC LLC,

*Respondent*.

*On Petition for Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit*

## PETITION FOR WRIT OF CERTIORARI


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## QUESTION PRESENTED

This petition concerns the tension between the presumption against federal jurisdiction over traditional state law claims and the judicially created doctrine of complete preemption under the Employee Retirement Income Security Act of 1974 ("ERISA").

Kentucky, like all States, has an interest in regulating the practice of medicine. Kentucky does so by statute, and provides its citizens with a private right of action. Based on Kentucky's prohibition on the unlicensed practice of medicine, Petitioner asserted a single state law claim against a third-party service provider to an ERISA plan. The third-party service provider admittedly could not be a proper defendant under ERISA §502(a)(1)(B).

The courts below held ERISA completely preempts Petitioner's state law claim, applying this Court's conjunctive two-part test under which federal question jurisdiction only exists when: (1) "at some point in time" the claim could have been brought "under ERISA § 502(a)(1)(B)," and (2) "where there is no other independent legal duty that is implicated by a defendant's actions." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004).

The question presented is:

Whether, under the ERISA complete preemption doctrine, federal courts are precluded from exercising federal question jurisdiction over independent state law claims against third-party service providers who cannot be liable or a proper defendant under ERISA § 502(a)(1)(B)?

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## INTRODUCTION

> Federal courts are courts of limited jurisdiction. They possess only that power authorized by Constitution and statute, which is not to be expanded by judicial decree. It is to be presumed that a cause lies outside this limited jurisdiction.

*Kokkonen v. Guardian Life Ins. Co. of Am.*, 511 U.S. 375, 377 (1994) (internal citations omitted). Accordingly, this Court has long adhered to the "well-pleaded complaint rule," which "makes the plaintiff the master of the claim; he or she may avoid federal jurisdiction by exclusive reliance on state law." *Caterpillar, Inc. v. Williams*, 482 U.S. 386, 392, (1987) (internal citations omitted).

ERISA, by virtue of the judicially created doctrine of complete preemption, is one of the limited exceptions to the well-pleaded complaint rule. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 207-08 (2004). A trial court can essentially re-write the plaintiff's state law cause of action as an ERISA claim, thereby creating the requisite subject matter jurisdiction.

Because ERISA affects the insurance benefits of millions of private employees and retirees throughout the country, necessarily implicating numerous state law health and welfare concerns, the courts have struggled with maintaining a balance between *Kokkonen*'s presumption against judicially created federal question jurisdiction and ERISA's complete preemption doctrine. This Court has cautioned that, consistent with the general presumption against federal jurisdiction, ERISA was never intended to

displace the States' authority over "general health care regulation." *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995).

In *Davila*, this Court set forth a conjunctive two-part test that only supports finding federal question jurisdiction when: (1) "at some point in time" the claim could have been brought "under ERISA § 502(a)(1)(B)" against the defendant; and (2) "where there is no other independent legal duty that is implicated by a defendant's actions." 542 U.S. at 210.

The issue, and conflict amongst the lower courts, has been the application of both parts of the *Davila* test. The Sixth Circuit concluded that the first element does not require consideration of whether the defendant could be a proper ERISA defendant for a § 502(a)(1)(B) claim. The Sixth Circuit's interpretation of the first element conflicts with opinions from at least the Ninth and Tenth Circuits.

Addressing the second element, the Sixth Circuit did not consider whether Petitioner's state law negligence per se claim was independent of ERISA – i.e. whether it required an analysis of plan terms. The Sixth Circuit looked instead to the ultimate merits of the claim. The Sixth Circuit's interpretation of the second element ("independent legal duty") conflicts with opinions from at least the Second, Third, Seventh, Ninth, and Tenth Circuits.

The Sixth Circuit's opinion significantly expands the already broad reach of ERISA – effectively insulating non-ERISA entities from state law liability. ERISA's goals can be achieved while at the same time

respecting Constitutional, state sovereignty, and public policy concerns. This petition warrants immediate review by this Court to resolve this jurisdictional tension.

## OPINIONS BELOW

The Sixth Circuit's opinion and order is reported at 844 F.3d 605. Pet. App. 1. The district court's opinions and orders denying remand and granting Respondent's motion to dismiss are not reported. The order denying Petitioner's motion to remand is available at 2016 U.S. Dist. LEXIS 15975. Pet App. 16. The order granting Respondent's motion to dismiss is available at 2016 U.S. Dist. LEXIS 35034. Pet App. 13.

## JURISDICTION

The Sixth Circuit entered judgment on December 22, 2016. Pet. App. 1. By order entered March 9, 2017 (No. 16A883), the time for filing this petition was extended to May 21, 2017. This Court's jurisdiction rests on 28 U.S.C. § 1254(1).

## STATUTORY PROVISIONS INVOLVED

The Judicial Article of the U.S. Constitution provides:

> The judicial power shall extend to all cases, in law and equity, arising under this Constitution, the laws of the United States, and treaties made, or which shall be made, under their authority;--to all cases affecting ambassadors, other public ministers and consuls;--to all cases of admiralty and maritime jurisdiction;--to controversies to which the United States shall be

> a party;--to controversies between two or more states;--between a state and citizens of another state;--between citizens of different states;--between citizens of the same state claiming lands under grants of different states, and between a state, or the citizens thereof, and foreign states, citizens or subjects.

U.S. Const. art. III, cl. 2.

The Supremacy Clause of the U.S. Constitution provides:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

U.S. Const. art. VI, cl. 2.

28 U.S.C. § 1331 provides:

> The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States.

28 U.S.C. § 1441 regarding removal of civil actions provides:

> (a) Generally. Except as otherwise expressly provided by Act of Congress, any civil action brought in a State court of which the district courts of the United States have original

> jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending.

Section 2(c) of ERISA, codified at 29 U.S.C. § 1001(c), provides:

> (c) … It is hereby further declared to be the policy of this chapter to protect interstate commerce, the Federal taxing power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance.

Section 502(a)(1)(B) of ERISA, codified at 29 U.S.C. § 1132(a)(1)(B), provides:

> A civil action may be brought—
>
> (1) by a participant or beneficiary—
> (A) for the relief provided for in subsection (c) of this section, or
> (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[.]

Section 514 of ERISA, codified at 29 U.S.C. § 1144, provides:

> (a) Supersedure; effective date. Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) [29 USCS § 1003(a)] and not exempt under section 4(b) [29 USCS § 1003(b)]. This section shall take effect on January 1, 1975.

Kentucky defines the practice of medicine at K.R.S. § 311.550(10) as:

> (10) Except as provided in subsection (11) of this section, the "practice of medicine or osteopathy" means the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities.

Kentucky's medical licensure statute, K.R.S. § 311.560, provides:

> (1) Except as provided in subsection (2) of this section, no person shall engage or attempt to engage in the practice of medicine or osteopathy within this state, or open, maintain, or occupy an office or place of business within this state for engaging in practice, or in any manner announce or express a readiness to engage in practice within this state, unless the person holds a valid and effective license or permit issued by the board as hereinafter provided.

Kentucky's private right of action statute, K.R.S. § 446.070, provides:

> A person injured by the violation of any statute may recover from the offender such damages as he sustained by reason of the violation, although a penalty or forfeiture is imposed for such violation.

## STATEMENT OF THE CASE

### A. Factual Background

Because of Petitioner Samantha Milby's employment as a nurse at University of Louisville Hospital in Kentucky, Ms. Milby was covered by a group long-term disability insurance policy issued by Liberty Life Assurance Company of Boston. In April 2011, Ms. Milby's health conditions – physical restrictions and limitations – prevented her from continuing to work. She applied for and initially received long-term disability benefits under the Liberty insurance policy. Pet. App. 3.

After approximately seventeen months of benefits, Liberty terminated Ms. Milby's claim as the result of an "eligibility review." Pet. App. 3. As part of the eligibility review, Liberty sought a medical opinion regarding Ms. Milby's diagnosis, treatment, and correction. Rather than contacting Ms. Milby's Kentucky treating physicians, Liberty contracted with Respondent MCMC, a wholly independent third-party medical reviewer. Pursuant to the contract, MCMC agreed to review Ms. "Milby's medical documents and provide an opinion on whether the medical evidence supported Milby's work restrictions" – a medical

opinion concerning her diagnosis and resulting treatment plan. *Id*.

MCMC's agent, Jamie Lewis, reviewed Ms. Milby's medical records and issued a medical opinion that Ms. Milby's treatment did not require any physical restrictions or limitations that would affect her ability to engage in full-time employment, specifically:

> The opinions of [Ms. Milby's treating physicians] are not supported by the available medical documentation as there are no objective findings which would support the claimant's inability to stand and move for more than just a few minutes, as well as repetitively bend, squat, kneel, and crouch. The claimant would have the capacity to perform sustained full time work without restrictions as of 02/22/2013 forward.

MCMC finalized the medical opinion and forwarded it to Liberty. After receiving MCMC's medical opinion, Liberty concluded its claim review and decided to terminate Ms. Milby's long-term disability benefits. *Id*.

It is undisputed that neither "MCMC nor its agent Jamie Lewis was licensed to practice medicine in the Commonwealth of Kentucky at the time they rendered the medical opinion on Milby." *Id*.

### B. Statutory History

Since 1952, Kentucky has statutorily "regulated and controlled" the practice of medicine in the Commonwealth "to prevent empiricism and to protect the health and safety of the public." K.R.S. § 311.555; *see also, Williams v. Commonwealth*, 213 S.W.3d 671, 675 (Ky. 2006) ("[I]t is apparent that the medical

profession is one of the most pervasively regulated industries in the Commonwealth."). As a matter of public policy, Kentucky prohibits anyone from engaging in or attempting to engage in "the practice of medicine" in Kentucky without "a valid and effective license or permit" issued by the Kentucky Board of Medical Licensure. K.R.S. § 311.560.

Kentucky broadly defines the "practice of medicine" as "the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities." K.R.S. § 311.550(10). Under Kentucky case law, "medical opinions" encompass both diagnosis and treatment. *See Williams v. Frymire*, 377 S.W.3d 579 (Ky. App. 2012) (discussing medical opinions in the context of diagnosis and treatment); *Ky. River Enters. v. Elkins*, 107 S.W.3d 206, 210 (Ky. 2003) ("the proper interpretation of the *Guides* and the proper assessment of an impairment rating are medical questions"); *Belt v. Campbell*, 2007 Ky. App. Unpub. LEXIS 1088, *4 (Ky. App. Aug. 17, 2007) ("Impairment is a medical question.").

The Kentucky Board of Medical Licensure has held that conducting a medical record review and issuing opinions based on that review constitutes the practice of medicine. *See Hackney v. Lincoln Nat'l Fire Ins. Co*., 657 Fed. Appx. 563, 579 (6th Cir. 2016) (citing KBML opinions finding that "out-of-state doctors" were engaged in the practice of medicine under Kentucky law).

### C. Procedural History

Ms. Milby filed her lawsuit against MCMC in Kentucky state court asserting a single negligence per se claim under K.R.S. § 311.560 for MCMC's violation of Kentucky's medical licensing laws. Pet. App. 21.

MCMC removed the case to the Western District of Kentucky predicated on ERISA complete preemption federal question jurisdiction. MCMC did not allege diversity jurisdiction. Pet. App. 2-3.

Based in part on the clear statement in her complaint that she was not "assert[ing] any claim arising under federal law," Ms. Milby moved to remand the case to state court. Pet. App. 21. Ms. Milby further challenged whether MCMC had satisfied each of the required *Davila* elements necessary to support a finding of complete preemption and, by extension, federal question jurisdiction.

The district court acknowledged a federal question "[was] not apparent on the face of Milby's complaint." Pet. App. 17. Addressing the issue of ERISA complete preemption and federal question jurisdiction, the court characterized the *Davila* test as asking whether "(1) the plaintiff complains about the denial of benefits to which he is entitled 'only because of the terms of an ERISA-regulated employee benefit plan'; and (2) the plaintiff does not allege the violation of any 'legal duty (state or federal) independent of ERISA or the plan terms[.]'" *Id*. at 19.

The district court did not separately analyze each part of the *Davila* conjunctive test. Instead, the court focused on its characterization of Ms. Milby's damages and held that in "seeking damages related to a medical

professional's medical review for ERISA plan benefit determination, a plaintiff must seek damages under ERISA." *Id*. at 19. Based on this analysis, the District Court concluded that Ms. Milby's "suit against MCMC arises only because of her ERISA benefit claim review" and "does not allege a violation of any legal duty beyond the scope of the ERISA plan and the review of her benefit claim." *Id*. at 20.

Following its decision finding ERISA completely preempted Ms. Milby's state law claim, in a separate two-page order, the district court granted MCMC's Rule 12(b)(6) motion to dismiss holding that because "MCMC is not the proper Defendant in an ERISA action concerning benefits" Ms. Milby's "complaint fails to state a claim to relief." Pet. App. 14. The court noted that Ms. Milby "has a pending suit against the insurer for wrongful denial of benefits," and that "is the appropriate avenue for Milby's sought relief." *Id*.[1]

Ms. Milby timely appealed. The Sixth Circuit Court of Appeals affirmed and acknowledged it "is not always simple" to determine whether complete preemption under ERISA applies. Pet App. 5.

Similar to the district court's analysis, the Sixth Circuit characterized *Davila* as supporting ERISA complete preemption "when a claim satisfies both prongs" of the following test:

> (1) the plaintiff complains about the denial of benefits to which he is entitled only because of

[1] Ms. Milby separately sued Liberty for the denial of her long-term disability benefits. Liberty is not a party to this Petition or the proceedings below. Pet App. 3.

> the terms of an ERISA-regulated employee benefit plan; and (2) the plaintiff does not allege the violation of any legal duty (state or federal) independent of ERISA or the plan terms.

*Id*. at 6.

Regarding the first prong, the Sixth Circuit found it determinative that "the damages in this case '*arise from* the ultimate denial of disability benefits.'" *Id*. at 8 (emphasis added). The Sixth Circuit relied heavily on an earlier decision in which it held that ERISA completely preempted state law negligence per se claims, based on the practice of medicine without a license, against two medical reviewers who were *employees* of an insurance company that administered an ERISA plan. *Id*. at 6-8 (citing *Hogan v. Jacobson*, 823 F.3d 872 (6th Cir. 2016)). In *Hogan*, the Sixth Circuit held that preemption applied because the claims involved "a relationship created solely by the ERISA plan and an incident that is subsumed entirely within the denial of benefits under an ERISA plan." 823 F.3d at 881.

In the opinion below, the Sixth Circuit noted a "meaningful difference" between the facts of *Hogan* and those here, because "the medical professionals in *Hogan* were straight employees of the plan administrator," while "the medical professionals here were employed by an independent third party." Pet. App. 7. Moreover, because "a third-party reviewer is not acting as the plan administrator nor making the benefits determination—and depending upon laws a state may have enacted to govern such separate entity or actions—the type of claim here may edge toward the category of those not preempted." *Id*. at 7-8.

The Sixth Circuit acknowledged "MCMC is not a proper defendant for an ERISA action and therefore Milby could not have brought her claim against MCMC under ERISA." *Id.* at 8. In addressing this point, the Sixth Circuit relied solely on *Hogan*, which held that "the analysis hinges on 'whether in essence such a claim is for the recovery of an ERISA plan benefit,' and not on who was sued." Pet App. 8. As with the district court, the Sixth Circuit did not specifically address or analyze the first element of the *Davila* test requiring that plaintiff, "at some point in time, could have brought his claim under ERISA § 502(a)(1)(B)." *Davila*, 542 U.S. at 210. The Sixth Circuit simply concluded that Ms. "Milby's claim in this case arises from the denial of benefits from an ERISA plan and satisfies the first prong of the Davila test for complete preemption." Pet. App. 8.

Regarding the second *Davila* element, the Sixth Circuit recognized and stated the obvious conclusion that "an independent duty may exist even when an ERISA plan is the basis for the relationship between the parties." *Id*. at 9. Otherwise, absent an ERISA plan, there would never be a need to apply the *Davila* test. The Sixth Circuit proceeded to conclude that Ms. Milby's state law negligence per se claim was not based on an independent legal duty. The conclusion did not consider whether Ms. Milby's state law claim was independent from ERISA – whether it required the analysis of ERISA plan terms as in *Davila*. Instead, the Sixth Circuit conducted its own evaluation of the merits of Ms. Milby's state law claim and concluded that MCMC's "reviewing medical records does not by itself constitute the practice of medicine in Kentucky." *Id*. at 10. Therefore, the Sixth Circuit held that MCMC

"[was] not practicing medicine and does not have an independent duty to Milby under the Kentucky medical licensing statute." *Id*. at 11.

## REASONS FOR GRANTING THE WRIT

### I. The Sixth Circuit's decision is an unprecedented expansion of federal question jurisdiction and conflicts with this Court's *Davila* test for analyzing ERISA complete preemption.

Despite the reach of ERISA, this Court has consistently held that ERISA preemption must, and does, have limits. *Gobeille v. Liberty Mut. Ins. Co.,* 136 S. Ct. 936, 943 (2016) (If ERISA's express preemption language was "taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course" and that is a result "no sensible person could have intended."); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990) (The fact that a claim "might burden the administration of a plan did not, by itself, compel pre-emption."). ERISA does not preempt the "'myriad state laws' of general applicability that impose some burdens on the administration of ERISA plans." *De Buono v. Nysa-Ila Med. & Clinical Servs. Fund*, 520 U.S. 806, 815 (1997). ERISA is not concerned with any potential burden placed on a non-ERISA entity – a third-party vendor providing medical opinions. This is an issue of state interest alone.[2]

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[2] Whether requiring third-party vendors to comply with applicable state laws might "impose some burden" on an ERISA plan is not the issue presented here. Moreover, given each state has hundreds, if not thousands, of licensed doctors who could ostensibly provide a medical opinion, any alleged burden would be de minimis.

Moreover, ERISA's express preemption provision, § 514, "makes clear that Congress did not intend to pre-empt entirely every state cause of action relating to" ERISA plans and, therefore, a § 514 ERISA preemption defense alone does not make an otherwise state law claim removable to federal court. *See Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 25 (1983).

Instead, for a state law claim to be removable to federal court under federal question jurisdiction, ERISA must completely preempt the claim. The removing defendant must satisfy the conjunctive, two-part test established in *Davila*. The *Davila* test represents the outer limits for federal question jurisdiction based on ERISA complete preemption. *See* Kesselheim and Brennan, *The Swinging Pendulum: the Supreme Court Reverses Course on ERISA and Managed Care*, 5 Yale J. of Health Policy, Law & Ethics 451, 462 (2005).

The Sixth Circuit's decision goes well beyond the *Kokkonen* and *Davila* jurisdictional limits, and creates conflict and confusion amongst the lower courts.

### A. ERISA does not completely preempt claims against entities that are not proper ERISA defendants (plan entities or fiduciaries) for ERISA benefit claims.

As this Court recognized in first extending the judicially-created doctrine of complete preemption to ERISA, complete preemption requires something more than express preemption. The Court explained that "a state action that was not only pre-empted by ERISA, but also came 'within the scope of § 502(a) of ERISA'

might fall within" the complete preemption rule first established for the Labor Management Relations Act. *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 64 (1987). Accordingly, the Court held that "causes of action within the scope of the civil enforcement provisions of § 502(a)" are completely preempted and "removable to federal court." *Id*. at 66.

The reason for federal jurisdiction under the doctrine is that "Congress may so completely pre-empt a particular area that any civil complaint raising this select group of claims is necessarily federal in character." *Id.* at 63-64. Specific to ERISA, "the policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." *Id*. at 64-65. Complete preemption, however, is "extraordinary." *Id*. at 65.

Congress, of course, made *no choices* in enacting ERISA regarding the inclusion or exclusion of remedies against non-ERISA entities. Rather, in enacting ERISA, Congress intended "to ensure that *plans and plan sponsors* would be subject to a uniform body of benefits law." *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co*., 514 U.S. 645, 656 (1995) (emphasis added). It is not surprising, then, that this Court has held complete ERISA preemption is only applicable in cases involving claims between and among ERISA entities.

In *Taylor*, the Court addressed preemption in the context of a state law claim for "improper processing of a claim for benefits" that was asserted as a breach of

contract against the ERISA plan entity. 481 U.S. at 60-61. The Court concluded the state law claim was expressly preempted as "a suit by a beneficiary to recover benefits from a covered plan." *Id* at 62-63.

Three years later, the Court held that ERISA completely preempted claims against an employer for wrongfully terminating the plaintiff "primarily because of the employer's desire to avoid contributing to, or paying benefits under, the employee's pension fund." *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990). There, the plaintiff's state law claims fell "squarely within the ambit of ERISA," which specifically provides that employers cannot discharge an employee "for the purpose of interfering with the attainment of any right to which such participant may become entitled under" ERISA. *Id*. at 142-43. Again, ERISA also expressly preempted these claims. *Id*. at 142.

Next, the Court held that ERISA did not completely preempt an Illinois statute proving a "right to independent medical review of certain denials" of health insurance benefits. *See Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 359 (2002). Again, the claims were between ERISA entities—an ERISA-plan beneficiary and a Health Maintenance Organization, which was also an ERISA-insurer. *Id*. at 359-60. The Court noted that one consideration in assessing complete preemption under ERISA is whether the state law "expanded the potential scope of ultimate liability imposed *upon employers* by the ERISA scheme." *Id*. at 379 (emphasis added). The Court also noted "ERISA's policy of inducing *employers* to offer benefits by assuring a predictable set of liabilities, under uniform

standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Id*. (emphasis added). The Court held that although independent medical opinion reviews "may well settle the fate of a benefit claim under a particular contract, the state statute does not enlarge the claim beyond the benefits available in any action brought under" ERISA § 502(a). *Id*. at 379-80.

The only other case in which the Court has held that ERISA completely preempts a state law claim is *Davila*. And, once again, the claims there were between ERISA entities. The petitioners were ERISA-plan administrators, and the respondents were an ERISA-plan beneficiary and participant. 542 U.S. at 204.

In *Davila*, the Court addressed the requirements for complete preemption in more detail than in earlier opinions, holding that:

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

> of action is completely pre-empted by ERISA § 502(a)(1)(B).

*Id*. at 210 (internal citations omitted).

Regarding the first prong of the conjunctive *Davila* test, the Court explained that the *Davila* respondents "complain only about denials of coverage promised under the terms of ERISA-regulated employee benefit plans." *Id*. at 211. Upon the denial of their plan benefits, "respondents could have paid for the treatment themselves and then sought reimbursement through a § 502(a)(1)(B) action, or sought a preliminary injunction." *Id*. The fact that the respondents could have properly brought these ERISA claims *against the Davila petitioners* – ERISA entities and proper defendants under § 502(a)(1)(B) – was apparent and preemption warranted. *Id.* ("respondents complain only about denials of coverage").

Without question, the same is not true here. As the Sixth Circuit acknowledged, respondent MCMC is not a proper defendant to an ERISA claim. Pet App. 8. MCMC readily admitted this fact, stating it "is not the plan administrator and, therefore, is not the proper defendant in an ERISA action concerning benefits." MCMC's Mem. in Supp. Mot. to Dismiss at 1. MCMC could never be liable to Ms. Milby for a claim under ERISA §502(a)(1)(B) for denial of plan benefits.

Setting aside the issue of complete preemption, there is no question that ERISA "is not designed to regulate or afford remedies against entities that provide services to plans." *Pharm. Care Mgmt. Ass'n v. Rowe*, 429 F.3d 294, 305 (1st Cir. 2005); *see also Oliver*

*v. Coca Cola Co*., 497 F.3d 1181, 1195 (11th Cir. 2007) (vacated in part on other grounds).

Legal commentators have discussed the potential extension of permissible ERISA benefit claim defendants beyond the ERISA plan to include the entity ultimately liable for paying the benefit claim (e.g. an ERISA plan insurer and claim fiduciary), but even those commentators have not argued ERISA's reach could extend benefit liability to non-ERISA third-party service providers. For example, consistent with the statutory language, one commentator suggested that ERISA § 502(a)(1)(B) claims should be limited to any "party that is actually responsible to pay benefits due under the terms of a plan." Bogan, *The Silliness of ERISA*, 16 Marquette Benefits & Social Welfare Law Rev. 393, 435 (2015). But MCMC would not meet this test. Another commentator explained ERISA's reach is limited to the plan sponsor, administrators, fiduciaries, and beneficiaries and participants. Snoe, *ERISA Preemption: A Product Rule and the Neglected Workhorse*, 3 Suffolk J. of Health & Biomed. Law. 217, 221 (2007). But "all service and product suppliers outside the plan relationship" would remain subject to state regulation. *Id*.

Instead of analyzing whether Ms. Milby could have properly brought her claims against MCMC in federal court under ERISA § 502(a)(1)(B), the Sixth Circuit explained that "the analysis hinges on 'whether in essence such a claim is for the recovery of an ERISA plan benefit,' and not on who was sued." Pet. App. 8. Thus, the Court held that "Milby's claim in this case *arises from* the denial of benefits from an ERISA plan

and satisfies the first prong of the *Davila* test for complete preemption." *Id*. (emphasis added).

Neither the language of ERISA nor this Court's precedent require, or even suggest, that a non-ERISA third-party vendor should be afforded the benefits of ERISA preemption without also being subject to the obligations imposed by ERISA. To find otherwise, as did the Sixth Circuit, would result in additional questions concerning ERISA's application to these non-ERISA entities. By way of example, are independent third-party service providers to ERISA plans subject to ERISA's reporting and disclosure requirements? *See* 29 U.S.C. §§ 1021-1031. Are these independent entities subject to the fiduciary duties established by ERISA? *See* 29 U.S.C. § 1104. Is the Department of Labor now obligated to investigate and oversee such entities? *See,* 29 U.S.C. § 1134.[3]

By dismissing the claim against MCMC because it was not a "proper" defendant for an ERISA claim, the Sixth Circuit implicitly answered the above questions in the negative – MCMC was, and could not be, subject to ERISA §502(a)(1)(B) liability. Pet. App. 8. But, the decision cannot be reconciled with the Sixth Circuit's finding of ERISA complete preemption. Taken to its logical ends, non-ERISA third-party vendors would have significantly *greater* rights and protections than actual ERISA entities subject to liability under

[3] Affirmative answers to the questions would reasonably lead to increased burdens, both on the impacted ERISA plans and on the non-ERISA third-party vendors. Simply because a vendor is providing services to an ERISA plan, the vendor would not be subject or accountable to applicable state law. Such a result would undermine state interest, public policy, and the Constitution.

§ 502(a)(1)(B). The third-party vendors would receive all of the benefits provided to ERISA entities, with none of the obligations or liabilities. They would not be subject to any claims "arising from" their actions — no matter how egregious — simply because their services were provided to an ERISA plan. Such a result does not protect the "careful" balance intended under ERISA, but rather completely disrupts that balance. *Davila*, 542 U.S. at 215 (explaining that the "limited remedies available under ERISA are an inherent part of the 'careful balancing' between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans").

Accordingly, the Sixth Circuit's opinion will likely cause significant confusion and uncertainty among the lower courts regarding the first *Davila* prong and the important areas of federal question jurisdiction and complete preemption.

### B. ERISA does not completely preempt independent, state law claims based on a conclusory assessment of their merits.

Unless both prongs of the *Davila* test are met, a state law claim is not completely preempted and cannot be removed to federal court based on federal question jurisdiction. 542 U.S. at 210. As set out in *Davila*, the second prong prohibits removal of state law claims unless "there is no other independent legal duty that is implicated by a defendant's actions." *Id.* The Sixth Circuit's opinion did not apply this second prong consistent with *Davila* or with the other appellate courts. Instead, the Sixth Circuit focused on the ultimate success of Ms. Milby's state law claim, and not on whether the state law claim required an analysis of

the ERISA plan as a precondition to relief. Pet. App. 10 (MCMC "is not practicing medicine and does not have an independent duty to Milby").

In *Davila*, the respondents based their state law claims on alleged violations of the Texas Health Care Liability Act, a statute specifically targeted at managed care entities. 542 U.S. at 212. The respondents alleged that petitioners' "refusal to cover the requested services violated their 'duty to exercise ordinary care when making health care treatment decisions,'" in violation of the statute. *Id*. at 205. Despite establishing a general duty of ordinary care, the language of the statute *required* review of ERISA plan terms to determine liability. The Texas statute provided that there could be "no obligation on the part of the health insurance carrier, health maintenance organization, or other managed care entity to provide to an insured or enrollee treatment *which is not covered by the health care plan* of the entity." *Id*. at 213 (quoting Tex. Civ. Prac. & Rem. Code § 88.002(d) (emphasis added)). Thus, the Court held that "interpretation of the terms of respondents' benefit plans forms an essential part of their THCLA claim," so the claims were not "independent of the federally regulated contract." 542 U.S. at 213.

The Sixth Circuit, in contrast, did not analyze the language of the Kentucky medical licensure statute. Notably, the statute is one of general application and is not directed or specific to ERISA plans. The statute broadly prohibits *any person* from engaging in "the practice of medicine" in Kentucky without "a valid and effective license or permit" issued by the Kentucky Board of Medical Licensure. K.R.S. § 311.560. Liability

under the statute requires *no* interpretation of an ERISA plan.

Instead of analyzing the statute and the duties it creates independent of any ERISA plan, the Sixth Circuit summarily concluded that MCMC "is not practicing medicine" by providing medical opinions and, accordingly, "does not have an independent duty to Ms. Milby under the Kentucky medical licensing statute." Pet. App. 11.[4] That analysis is directly contrary to the second prong of the *Davila* test. Whereas *Davila* focused on Texas's statutory requirement of an adverse benefits determination and necessary interpretation of an ERISA plan, the Sixth Circuit looked *beyond* the language of Kentucky's statute.

The Sixth Circuit's analysis focused not on whether her claim required an analysis of plan terms, but instead on whether Ms. Milby's state law claim would *ultimately succeed*. There is nothing in *Davila*, or the complete preemption doctrine in general, to support this sort of merits based analysis. Whether a plaintiff can ultimately prevail on a state law claim in state court is irrelevant to the issue of whether the state law claim requires the analysis of the terms of an ERISA plan.

The Sixth Circuit's revised formulation of the second prong of the *Davila* test is even more expansive than ERISA's express preemption provision. The express preemption language asks whether a state law

[4] Because Ms. Milby's claim was before it on a motion to dismiss, and not summary judgment, the Sixth Circuit's conclusion was not based on a complete factual record.

claim "relates to" an ERISA plan. *See* 29 U.S.C. § 1144. But, in contrast to complete preemption, express preemption is only an affirmative defense, and *not* a basis for removal to federal court. *See Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 25 (1983).

Independent of the Sixth Circuit's analytical blurring of the complete and express ERISA preemption, its revised formulation undercuts the uniform interpretation and application of federal law that is the justification for complete preemption. *Davila*, 542 U.S. at 208 (The "purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans."); *see also* Seinfeld, *The Puzzle of Complete Preemption*, 155 U. of Penn. Law Rev. 537, 542-43 (2007) (noting "uniformity in the application and interpretation of federal law" and "state judicial bias" as the traditional rationales supporting federal question jurisdiction).

State courts, including Kentucky, regularly address express preemption under ERISA § 514, because that defense does not provide a basis for removal. *See, e.g., Deaton v. Connecticut Gen. Life Ins. Co.,* 17 S.W.3d 896, 897 (Ky. App. 2000) (holding that ERISA expressly preempted attorneys' restitution claims against ERISA-insurer); *Curry v. Cincinnati Equitable Ins. Co.*, 834 S.W.2d 701, 703 (Ky. App. 1992) (ERISA preempted plaintiff's claims "to recover benefits allegedly due under a group health insurance policy."). If state courts are capable to ask and answer the dispositive question at the heart of complete preemption under ERISA through the lens of an ERISA § 514 affirmative defense, what is the basis or need for

removal? And if a defendant could defeat a plaintiff's right to choose a state forum by its own artful pleading – simply citing ERISA § 502 in the removal petition – why would there be any need for an exception to the well-pleaded complaint rule?

As discussed in Part A, *supra*, the Sixth Circuit's opinion is likely to cause significant confusion and uncertainty among the lower courts regarding the second *Davila* prong and the important areas of federal question jurisdiction and complete preemption.

## II. The Sixth Circuit's application of the *Davila* test conflicts with decisions from the other Circuits.

In addition to conflicting with this Court's holding in *Davila*, the Sixth Circuit's decision also conflicts with and creates a circuit split.

### A. The Sixth Circuit's application of the first *Davila* prong conflicts with decisions from the Ninth and Tenth Circuits.

Based on the first *Davila* prong and whether Ms. Milby could have brought her state law claim against MCMC under ERISA, the Sixth Circuit's decision directly conflicts with opinions from the Ninth and Tenth Circuit, each holding that claims against non-ERISA entities — or arising from the actions of such entities — do not support complete preemption.

Even prior to *Davila*, the Ninth Circuit held that ERISA did not completely preempt claims arising from the actions of a third-party service provider to an ERISA insurer. *Dishman v. UNUM Life Ins. Co. of*

*Am*., 269 F.3d 974, 983 (9th Cir. 2001). In *Dishman*, the Ninth Circuit held that ERISA does not completely or expressly preempt state law claims for tortious invasion of privacy arising from an ERISA insurer's use of private investigators to assess a plaintiff's claims for ERISA benefits. As the court explained, "Dishman is not seeking to obtain through a tort remedy that which he could not obtain through ERISA." *Id*. at 983. Moreover:

> [The] fact that the conduct at issue allegedly occurred "in the course of UNUM's administration of the plan" does not create a relationship sufficient to warrant preemption. If that were the case, a plan administrator could "investigate" a claim in all manner of tortious ways with impunity. What if one of UNUM's investigators had accidentally rear-ended Dishman's car while surveilling him? Would the fact that the surveillance was intended to shed light on his claim shield UNUM and the investigator from liability? What if UNUM had tapped Dishman's phone, put a tracer on his car, or trained a video camera into his bedroom in an effort to obtain information? Must that be tolerated simply because it is done purportedly in furtherance of plan administration? To ask the question is to answer it. Though there is clearly some relationship between the conduct alleged and the administration of the plan, it is not enough of a relationship to warrant preemption.

*Id*. at 984.

More recently, the Tenth Circuit similarly held that state law claims against "outside parties," who are not ERISA "plan entities," are not completely preempted. *See David P. Coldesina, D.D.S., P.C., Empl. Profit Sharing Plan & Trust v. Estate of Simper*, 407 F.3d 1126, 1137 (10th Cir. 2005). *Coldesina* involved an alleged theft from an ERISA plan by the plan's investment advisor. The plan brought "an ERISA claim and various state law claims" for negligent supervision and vicarious liability against the investment advisor's estate and against various other plan administrators and accountants. *Id*. at 1131.

The Tenth Circuit held that negligent supervision claims against "outside parties," who were not "plan entities," were not completely preempted. *Id*. at 1137. The court noted that "[n]either the plan nor ERISA are involved." *Id*. The "negligent supervision claim is not based on" the actions of a plan fiduciary (the investment advisor), but on the actions of individuals outside of the plan. *Id*. at 1138. Indeed, "other than being part of the factual backdrop of this case, the plan's existence is irrelevant here." *Id*.

In contrast to the opinions of the Ninth and Tenth Circuits, the Sixth Circuit has held on two occasions that claims against independent, third-party service providers to ERISA plans are completely preempted under the first *Davila* prong. Pet. App. 8; *see also*, *Hackney v. AllMed Healthcare Mgmt. Inc*., 2017 WL 656752, at *3 (6th Cir. Feb. 17, 2017) ("*Davila* hinges not on who was sued, but on 'whether in essence such a claim is for the recovery of an ERISA plan benefit.'").

### B. The Sixth Circuit's application of the *Davila* second prong conflicts with decisions from the Second, Third, Seventh, Ninth, and Tenth Circuits.

Regarding the second *Davila* prong, the Second, Third, Seventh, Ninth, and Tenth Circuits have appropriately focused on the nature of the duty underlying the state law claims – considering whether resolution of the claim required analysis of an ERISA plan terms. In contrast, the Sixth Circuit's opinion focused instead on the ultimate likelihood of success of the state law claim. Pet. App. 10-11.

For example, the Second Circuit held that ERISA does not completely preempt a New York subrogation statute, which provides that "benefit providers have no 'right of subrogation or reimbursement against'" parties settling personal injury claims. *Wurtz v. Rawlings Co., LLC*, 761 F.3d 232 (2d Cir. 2014), *cert. denied*, 135 S.Ct. 1400 (2015). The Second Circuit explained that plaintiffs "do not seek to 'enforce' or 'clarify' their rights 'under the terms of [their] plan[s]' because the state right they seek to enforce — to be free from subrogation — is not provided by their plans." *Id*. at 242 ("Indeed, the terms of plaintiffs' ERISA plans are irrelevant to their claims."). In addition, the Second Circuit observed that the duty plaintiffs sought to enforce arose from state statute and was "independent because it is unrelated to whatever plaintiffs' ERISA plans provide about reimbursement." *Id*. at 243; *see also Stevenson v. Bank of N.Y. Co*., 609 F.3d 56, 61 (2d Cir. 2010) (None of the "state law causes of action purport to require a plan administrator, employer, or

beneficiary to follow a standard inconsistent with those provided by ERISA.").

Similarly, the Third, Seventh, Ninth, and Tenth Circuits have looked to the nature of the state law duty at issue, and the underlying necessary proof, to determine whether *Davila* supports finding that ERISA completely preempts the claim. *N.J. Carpenters v. Tishman Constr. Corp.,* 760 F.3d 297, 304 (3d Cir. 2014) (ERISA did not preempt state statute, where "independence" of the statute "is best understood by looking to what the plaintiffs must prove to prevail."); *Franciscan Skemp Healthcare, Inc. v. Cent. States Joint Bd. Health & Welfare Trust Fund*, 538 F.3d 594, 601 (7th Cir. 2008) (ERISA did not completely preempt state law claims "based on the alleged shortcomings in the communications between" plaintiff and ERISA plan); *Marin Gen. Hosp. v. Modesto & Empire Traction Co*., 581 F.3d 941, 948 (9th Cir. 2009) (ERISA did not completely preempt state law claims where the "asserted obligation to make the additional payment stems from the alleged oral contract" between the participant and the ERISA plan); *Salzer v. SSM Health Care of Okla. Inc*., 762 F.3d 1130, 1136 (10th Cir. 2014) (The "merit of Salzer's claim that he is a third-party beneficiary of the Provider Agreement is not properly part of our jurisdictional analysis as to the removal question. The possibility that Salzer fails to make out a winning state law claim does not indicate that complete preemption applies.").

The very purpose of ERISA complete preemption is to provide uniformity in decisions regarding an important area of federal law. *See, e.g., Davila*, 542 U.S. at 208 (The "purpose of ERISA is to provide a

uniform regulatory regime over employee benefit plans."). That purpose is not being met. The Sixth Circuit's divergent and minority view of *Davila*'s second prong has created a conflict amongst the lower courts warranting this Court's immediate review.

## III. The Sixth Circuit's expansion of ERISA's federal question jurisdiction raises Constitutional concerns that merit the Court's immediate review.

Based on ERISA §514 and this Court's precedent, the extent of ERISA's complete preemption of state law is limited by *Davila*. By further expanding the scope of ERISA complete preemption, the Sixth Circuit's opinion further erodes state sovereignty, blurring the line between federal and state law thereby raising significant Constitutional concerns.

Justice Thomas' recent concurring opinion concerning the Constitutional issues raised by ERISA's preemption of state law is instructive.

> [ERISA] … raises constitutional concerns. The Supremacy Clause gives 'supreme' status only to those federal laws that are 'made in Pursuance' of the Constitution.
>
> ... The Constitution requires a distinction between what is truly national and what is truly local. If the Federal Government were to take over the regulation of entire areas of traditional state concern, including areas having nothing to do with the regulation of commercial activities, then the boundaries between the spheres of federal and state authority would blur and political responsibility would become illusory.

> Just because Congress can regulate some aspects of ERISA plans pursuant to the Commerce Clause does not mean that Congress can exempt ERISA plans from state regulations that have nothing to do with interstate commerce.

*Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 947-48 (2016) (J. Thomas, concurrence) (internal citations and punctuation omitted).

To give perspective to the significant impact of ERISA preemption on areas of traditional state concern, one need only look at Department of Labor statistics. As recently as 2014, there were an estimated 51,600 ERISA welfare plans covering approximately 59 million participants and beneficiaries.[5] In addition, there were an estimated 625,000 pension plans covering 89.9 million participants and beneficiaries.[6] The number of affected private employers, as well as employees, is significant. When these figures are expanded to encompass non-ERISA entities, such as third-party vendors, the resulting impact on what are inherently state rights and interests is significant.

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[5] *See* U.S. Dept. of Labor, Annual Report to Congress on Self-Insured Group Health Plans, March 2017, at p.3 (found at https://www.dol.gov/sites/default/files/ebsa/researchers/statistics/retirement-bulletins/annual-report-on-self-insured-group-health-plans-2017.pdf, last visited May 9, 2017).

[6] *See* U.S. Dept. of Labor, Private Pension Plan Bulletin, September 2016, at p. 1 (found at https://www.dol.gov/sites/default/files/ebsa/researchers/statistics/retirement-bulletins/private-pension-plan-bulletins-abstract-2014.pdf, last visited May 9, 2017).

Presumably, to give meaning to Congress' stated purpose behind ERISA, each of the private employers sponsoring an ERISA plan must be engaged in "interstate commerce." *See* 29 U.S.C. § 1001(c). But, the definition of interstate commerce must have some limits. Otherwise, ERISA would engulf private plans of any kind with the result that any "related" state law or regulation would be usurped by federal law. As this Court recognized in *Travelers*, even the "relates to" clause of ERISA has limits. *See N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co*., 514 U.S. 645 (1995)

> If "relate to" were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for "really, universally, relations stop nowhere."

*Id*. at 655. To effectuate Congress' objectives, while respecting Constitutional limitations respecting state law, a similar analysis should apply to limit ERISA's complete preemption doctrine in the context of independent legal duties – i.e. state laws of general applicability that "have nothing to do with interstate commerce." *Gobeille*, 136 S. Ct. at 948 (J. Thomas, concurrence). Kentucky's decision to regulate the practice of medicine is but one example of a state law that has little to do with interstate commerce and everything to do with the protection of state interests.

Turning back to the DOL statistics cited above, the Sixth Circuit's expansion of ERISA complete preemption will unquestionably have a profound impact – both on state interests and individual rights to obtain judicial relief from non-ERISA entities.

Recasting state law claims as preempted only to then dismiss the same claim based on a "failure to state a claim" runs afoul of Constitutional protections. Moreover, it is, "to say the least, 'difficult to believe that Congress would, without comment, remove all means of judicial recourse for those injured by illegal conduct." *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 487 (1996).

Indeed, the general presumption *against* preemption begins with the Supremacy Clause. U.S. Const. art. VI, cl. 2; *see also* McCuskey, *Body of Preemption: Health Law Traditions and the Presumption Against Preemption*, 89 Temple Law Rev. 95, 106 (2016). "Because the States are independent sovereigns in our federal system, we have long presumed that Congress does not cavalierly preempt state law causes of action." *Medtronic, Inc.*, 518 U.S. 470, 485 (1996). The presumption against preemption is particularly strong in areas traditionally governed by state law, such as "health care regulation." *Travelers Ins. Co*., 514 U.S. at 661.

The Sixth Circuit's opinion is inconsistent with this Court's *Davila* test, and conflicts with the other federal appellate courts. The resulting uncertainty amongst the lower courts, and the corresponding Constitutional concerns, warrants this Court's immediate review.

## CONCLUSION

For the foregoing reasons, this petition for a writ of certiorari should be granted.

Respectfully submitted,

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# APPENDIX

# APPENDIX

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## APPENDIX A

**RECOMMENDED FOR FULL-TEXT PUBLICATION**
**Pursuant to Sixth Circuit I.O.P. 32.1(b)**
**File Name: 16a0300p.06**

**UNITED STATES COURT OF APPEALS**
**FOR THE SIXTH CIRCUIT**

**No. 16-5483**

**[Filed December 22, 2016]**

SAMANTHA MILBY, *Plaintiff-Appellant*,

*v.*

MCMC LLC, *Defendant-Appellee*.

Appeal from the United States District Court for the Western District of Kentucky at Louisville. No. 3:15-cv-00814—Charles R. Simpson III, District Judge.

Decided and Filed: December 22, 2016

Before: BATCHELDER, STRANCH, and DONALD, Circuit Judges.

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## COUNSEL

**ON BRIEF:** Michael D. Grabhorn, Andrew M. Grabhorn, GRABHORN LAW OFFICE, PLLC, Louisville, Kentucky, for Appellant. Matthew W. Breetz, Michael E. Kleinert, STITES & HARISON, PLLC, Louisville, Kentucky, for Appellee.

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## OPINION

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JANE B. STRANCH, Circuit Judge. Samantha Milby was granted monthly long-term disability benefits through a group insurance policy provided by her employer, University of Louisville Hospital. Her benefits were subsequently terminated after her disability carrier hired defendant MCMC, a third-party medical record reviewer, and MCMC opined that Milby could return to work. Milby brought this state-law claim against MCMC, which removed the case to federal court alleging complete preemption under the Employee Retirement Income Security Act of 1974 (ERISA). Milby appeals the district court's denial of her motion to remand the case and its grant of MCMC's motion to dismiss her case. Based on this court's decision in *Hogan v. Jacobson*, 823 F.3d 872, 879–83 (6th Cir. 2016), applied to the specific facts in this record, we **affirm**.

## I. BACKGROUND

Milby worked as a nurse at the University of Louisville Hospital in Kentucky. Through her employment, Milby was covered by a long-term

disability insurance policy. In April 2011, health conditions made it so Milby could no longer work. She applied for and received disability benefits through her insurance policy for approximately seventeen months. As part of a subsequent eligibility review, the plan engaged MCMC, a Massachusetts-based third-party reviewer, to go through Milby's medical documents and provide an opinion on whether the medical evidence supported Milby's work restrictions. MCMC and its agent opined that Milby was able to work, stating:

> The opinions of [Milby's treating physicians] are not supported by the available medical documentation as there are no objective findings which would support the claimant's inability to stand and move for more than just a few minutes, as well as repetitively bend, squat, kneel, and crouch. The claimant would have the capacity to perform sustained full time work without restrictions as of 2/22/2013 forward.

(R. 1-1, PageID 13) Neither MCMC nor its agent Jamie Lewis was licensed to practice medicine in the Commonwealth of Kentucky at the time they rendered the medical opinion on Milby. Based in part on MCMC's recommendation, the plan terminated Milby's benefits effective February 21, 2013.

Milby filed a lawsuit in state court, separate from this one, against her disability insurance provider. That case was removed to federal court and remains pending. *See Milby v. Liberty Life Assurance Co. of Boston*, No. 3:13-cv-487 (W.D. Ky.).

Milby filed this lawsuit in state court alleging a state-law claim of negligence per se against MCMC for

practicing medicine in Kentucky without the appropriate licenses. MCMC removed the case to federal court based on complete preemption under ERISA. The trial court denied Milby's motion to remand the case to state court and granted MCMC's motion to dismiss under Rule 12(b)(6). Milby timely appealed the final judgment against her.

## II. ANALYSIS

### A. Standard of Review

We review de novo a district court's decision involving legal questions of subject matter jurisdiction. *Hogan v. Jacobson*, 823 F.3d 872, 879 (6th Cir. 2016). Factual determinations regarding jurisdictional matters are reviewed for clear error. *Id*. A district court's ruling on a motion to dismiss a claim is reviewed de novo. *Id*. at 883.

### B. Complete Preemption of State-Law Claims under ERISA

We begin with an overview. ERISA creates a "uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004). Congress intended that this federal regime protect beneficiaries of employee benefit plans while providing employers with uniform national standards for plan administration. *Id*. ERISA's regime includes "an integrated system of procedures for enforcement." *Id*. (quoting *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985)). Section 1132(a) of ERISA completely preempts "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy" because such actions "conflict[] with the clear congressional intent to make the ERISA

remedy exclusive . . . ." *Hogan*, 823 F.3d at 879 (quoting *Davila*, 542 U.S. at 209). But claims that stem from a duty that "is not derived from, or conditioned upon, the terms" of an ERISA plan are not completely preempted. *Gardner v. Heartland Indus. Partners, LP*, 715 F.3d 609, 614 (6th Cir. 2013). This division between preempted and not preempted claims is part of a "carefully integrated" civil enforcement scheme. *Id*. at 613 (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987)).

Determining the side of the dividing line on which a claim should fall is not always simple. Courts have provided guidance, however, by placing a range of state-law claims in the category of no preemption. *See, e.g.*, *Darcangelo v. Verizon Commc'ns, Inc.*, 292 F.3d 181, 186 (4th Cir. 2002) (tort claims for disseminating private medical information as part of a scheme to get an employee fired); *Erlandson v. Liberty Life Assur. Co. of Boston*, 320 F. Supp. 2d 501, 508 (N.D. Tex. 2004) (claims for assault and invasion of privacy stemming from an investigation ordered by an insurer); *Byars v. Greenway*, No. 14-cv-1181, 2014 WL 7335694, *4 (W.D. Tenn. Dec. 19, 2014) (unpublished opinion) (negligence claims related to notarization process). Other claims have been placed in the category of claims that duplicate ERISA's enforcement mechanism and are completely preempted. *See, e.g.*, *Hogan*, 823 F.3d at 883 (negligence per se for unlicensed practice of medicine); *Davila*, 542 U.S. at 210.

In *Davila*, the Supreme Court articulated a two-prong test to determine whether a claim falls in the category that is completely preempted or in the category not preempted. 542 U.S. at 210. A claim falls

in the category of complete preemption under § 1132(a) when a claim satisfies both prongs of the following test:

> (1) the plaintiff complains about the denial of benefits to which he is entitled only because of the terms of an ERISA-regulated employee benefit plan; and (2) the plaintiff does not allege the violation of any legal duty (state or federal) independent of ERISA or the plan terms.

*Gardner*, 715 F.3d at 613 (quoting *Davila*, 542 U.S. at 210). The state-law claims in *Davila* involved insurance plans failing to exercise ordinary care when the plans denied coverage for certain medical procedures. *Davila*, 542 U.S. at 204 05. Those claims involved "pure eligibility decisions" and were preempted by ERISA. *Id*. at 221.

In light of this overview of the governing law, we turn to the *Davila* test and its application to Milby's case.

1. Claims Based on the Terms of an ERISA-Regulated Plan

To determine whether a claim satisfies the first prong of the *Davila* test, courts look beyond the "label placed on a state law claim" and instead ask "whether in essence such a claim is for the recovery of an ERISA benefit plan." *Hogan*, 823 F.3d at 880 (quoting *Peters v. Lincoln Elec. Co*., 285 F.3d 456, 469 (6th Cir. 2002)). A claim "likely falls within the scope of § 1132 when the only action complained of is a refusal to provide benefits under an ERISA plan and the only relationship between the plaintiff and defendant is based on the plan." *Id*. (quoting *Davila*, 542 U.S. at 211).

The plaintiff in *Hogan* brought negligence per se claims against two medical professionals who were employees of the insurance company that administered a plan governed by ERISA. *Id*. at 877. The medical professionals were allegedly negligent because they were not licensed to practice medicine or psychology in the Commonwealth of Kentucky at the time they reviewed the plaintiff's records and rendered opinions that were relied on by the insurance company. *Id*. In *Hogan,* we held that the claim of negligence per se against the plan's medical professionals involved "a relationship created solely by the ERISA plan and an incident that is subsumed entirely within the denial of benefits under an ERISA plan." *Id*. at 881. The claim was completely preempted by ERISA because the negligence it alleged was "the negligent processing and denial of [Hogan's] claim for ERISA benefits." *Id*.

As both parties concede, the claim in this case shares many parallels with the claims in *Hogan*. The alleged negligence of medical professionals in both cases involves the same Kentucky licensing law: Ky. Rev. Stat. § 311.560. *Id*. at 878. As in this case, the medical professional defendants in *Hogan* rendered opinions that were considered by the plan as it decided to deny benefits. *Id*. at 877. There is also a meaningful difference between the facts in the cases—the medical professionals in *Hogan* were straight employees of the plan administrator; the medical professionals here were employed by an independent third party. Claims against an employee of the plan administrator are more likely to be duplicative of ERISA's enforcement mechanism than are claims against third parties, who generally fall outside the ERISA enforcement regime. *See id*. at 884. Because a third-party reviewer is not

acting as the plan administrator nor making the benefits determination—and depending upon laws a state may have enacted to govern such separate entity or actions—the type of claim here may edge toward the category of those not preempted.

Despite this relevant factual difference, however, *Hogan* determines the outcome for the first prong of the *Davila* test here. MCMC's "conduct was indisputably part of the process used to assess a participant's claim for a benefit payment under the plan, making the negligence claim an alternative enforcement mechanism to ERISA's civil enforcement provisions." *Id*. at 880 (quoting *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1282, 1489 (7th Cir. 1996)). As in *Hogan*, the damages in this case "arise from the ultimate denial of disability benefits." *Id*. at 881.

Milby argues that the first prong of the *Davila* test is not satisfied because MCMC is not a proper defendant for an ERISA action and therefore Milby could not have brought her claim against MCMC under ERISA. But *Hogan* addressed this issue and determined that the analysis hinges on "whether in essence such a claim is for the recovery of an ERISA plan benefit," and not on who was sued. 823 F.3d at 880. Milby's claim in this case arises from the denial of benefits from an ERISA plan and satisfies the first prong of the *Davila* test for complete preemption.

2. Legal Duty Independent of ERISA

The second prong of the *Davila* test instructs us to ask whether the plaintiff alleges the violation of an independent legal duty. 542 U.S. at 210. A state-law

tort is independent of ERISA when the duty conferred was "not derived from, or conditioned upon, the terms of" the plan and there is no "need[] to interpret the plan to determine whether that duty exists." *Gardner*, 715 F.3d at 614. In *Gardner*, we held that a claim for tortious interference with a plaintiff's right to receive benefits under an ERISA plan was not preempted when the court could determine liability without having to interpret any plan terms. *Id*. at 615. Similarly, a duty can be created by a contract that is separate from the agreement that created the ERISA-governed plan; such a duty may be breached and liability may be determined independent of the ERISA plan. *Erlandson*, 320 F. Supp. 2d at 509. In *Erlandson*, a breach of contract claim against a third-party service provider was not preempted despite a relationship to an ERISA plan because the claim arose from a separate contract between the plan administrator and the third-party provider. *Id*.

Milby argues that the claim here does not require the interpretation of any terms in the plan agreement so the duty is independent. MCMC argues that the independent duty inquiry should end with the determination that the relationship between it and Milby arose solely from an ERISA plan. But as *Gardner* and *Erlandson* demonstrate, an independent duty may exist even when an ERISA plan is the basis for the relationship between the parties. *See Gardner*, 715 F.3d at 615; *see also Erlandson*, 320 F. Supp. 2d at 509. Essentially, MCMC would have us ask whether an ERISA plan is the "but-for" cause of a relationship between the parties. But such a test would capture too many claims that courts have found to be based on independent duties. *See, e.g.*, *Gardner*, 715 F.3d at 615;

*Erlandson*, 320 F. Supp. 2d at 508; *Byars*, 2014 WL 7335694 at *4. The inquiry is instead a case-specific one that requires examination of the complaint and its alleged facts, the state law on which the claims are based, and various plan documents. *Davila*, 542 U.S. at 211.

We turn to Kentucky law to determine whether state law creates an independent duty between the medical reviewers and Milby. Milby asserts that the medical reviewers owe her an independent duty under Ky. Rev. Stat. § 311.560, which prohibits the practice of medicine without a license. We recently addressed a similar issue in *Hackney v. Lincoln Nat'l Life Ins. Co.*, No. 15-5563, 2016 WL 6471763 (6th Cir. Nov. 2, 2016) (unpublished opinion), another case involving claims of negligence per se for the unlicensed practice of medicine. In *Hackney*, we determined that reviewing medical records does not by itself constitute the practice of medicine in Kentucky. *Id*. at *12. The practice of medicine is defined as "the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities." *Id*. (quoting Ky. Rev. Stat. § 311.550(10)). The *Hackney* court determined that the nurses who reviewed the medical files in that case "made no determinations regarding the medical necessity of any treatment; they simply determined whether Hackney was capable of performing the necessary functions of his job." *Id*. The court found that "[s]uch determinations d[id] not fall within the ambit of § 311.560." *Id*. If medical professionals reviewing documents without making determinations regarding medical necessity are not practicing medicine

within the meaning of the Kentucky licensing law, it follows that the licensing law does not create a duty that flows from those professionals to claimants. As such, MCMC—which the complaint does not allege is involved in any determinations regarding medical necessity of treatments—is not practicing medicine and does not have an independent duty to Milby under the Kentucky medical licensing statute invoked in this case. Instead, the allegations in Milby's complaint implicitly rely on ERISA to establish the duty required for her negligence claim. The claim here therefore satisfies the second prong of the *Davila* test.

Because both of the prongs of the *Davila* test are met, the state-law negligence claim in this case fits in the category of claims that are completely preempted by ERISA. We affirm the district court's denial of Milby's motion to have the case remanded to state court.

**C. Dismissal under Rule 12(b)(6)**

The district court found that MCMC was not a proper defendant for an ERISA claim and dismissed the complaint. In *Hogan*, we affirmed dismissal of similar claims against nurses employed by a plan administrator in part because "the proper defendant in an ERISA action concerning benefits is the plan administrator." 823 F.3d at 884 (quoting *Riverview Health Inst. LLC v. Med. Mut. of Ohio*, 601 F.3d 505, 522 (6th Cir. 2010)). The appropriate avenue for Milby's potential relief on these matters is in the pending case against the plan administrator. We therefore affirm the district court's grant of MCMC's motion to dismiss the claim under Rule 12(b)(6).

## III. CONCLUSION

The state-law claim in this case fits in the category of claims that are completely preempted by ERISA. First, the claim is in essence about the denial of benefits under an ERISA plan. Second, the defendant does not owe an independent duty to the plaintiff because the defendants were not practicing medicine under the specific Kentucky law invoked here as the basis for negligence per se. Denial of the plaintiff's motion to remand and dismissal of the claim were proper. The district court's judgment is therefore **affirmed**.

## APPENDIX B

**UNITED STATES DISTRICT COURT**
**WESTERN DISTRICT OF KENTUCKY**
**AT LOUISVILLE**

**CIVIL ACTION NO. 3:15-cv-00814-CRS**

**[Filed March 17, 2016]**

| | |
|---|---|
| SAMANTHA MILBY | ) |
| PLAINTIFF | ) |
| | ) |
| v. | ) |
| | ) |
| MCMC LLC | ) |
| DEFENDANT | ) |
| | ) |

**MEMORANDUM OPINION AND ORDER**

Plaintiff Samantha Milby brought this action in Jefferson Circuit Court in Louisville, Kentucky, against Defendant MCMC LLC ("MCMC"). MCMC removed the action to this Court. MCMC now moves to dismiss Milby's claims under Fed. R. Civ. P. 12(b)(6). For the reasons below, the Court will grant MCMC's motion.

When evaluating a motion to dismiss under Fed. R. Civ. P. 12(b)(6), the Court must determine whether the complaint alleges "sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)) (internal quotation marks omitted). A claim is

plausible if "the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.* (citing *Twombly*, 550 U.S. at 556).

In this Court's February 10, 2016 memorandum opinion and order the Court ruled that the Employment Retirement Income Security Act ("ERISA") completely preempts Milby's state law claims. ECF No. 13. Milby has only pleaded claims under Kentucky law and has not amended her complaint. When ERISA completely preempts a state law claim and the party does not amend the complaint, the Court construes the claim as an ERISA claim. *Loffredo v. Daimler AG*, 500 F. App'x 491, 495 (6th Cir. 2012).

Milby correctly points out that she cannot assert an ERISA claim against MCMC. *See* Pl.'s Resp. 1, ECF No. 14. The Court's February 10, 2016 memorandum opinion and order said that "Milby's challenge to MCMC practitioners' medical qualifications are subsumed within Milby's ERISA claim for wrongful denial of benefits." 4. "[T]he proper defendant in an ERISA action concerning benefits is the plan administrator." *Riverview Health Inst. LLC v. Med. Mut. of Ohio*, 601 F.3d 505, 522 (6th Cir. 2010). MCMC is not the plan administrator. As MCMC is not the proper Defendant in an ERISA action concerning benefits, Milby's complaint fails to state a claim to relief.

Notably, Milby already has a pending suit against the insurer for wrongful denial of benefits. *See Milby v. Liberty Life Assurance Co. of Boston*, Case No.

3:13-cv-00487-CRS, (W.D. Ky. Apr. 30, 2015). This is the appropriate avenue for Milby's sought relief.

The Court being otherwise sufficiently advised, **IT IS HEREBY ORDERED AND ADJUDGED** that the Court **GRANTS** Defendant MCMC LLC's motion to dismiss (DN 5).

**IT IS FURTHER ORDERED** that the Court **DISMISSES** Plaintiff Samantha Milby's complaint against Defendant MCMC LLC **WITH PREJUDICE** in its entirety.

**IT IS SO ORDERED.**

March 17, 2016

s/_____
Charles R. Simpson III, Senior Judge
United States District Court

## APPENDIX C

**UNITED STATES DISTRICT COURT**
**WESTERN DISTRICT OF KENTUCKY**
**AT LOUISVILLE**

**CIVIL ACTION NO. 3:15-cv-00814-CRS**

**[Filed February 9, 2016]**

SAMANTHA MILBY )
PLAINTIFF )
)
v. )
)
MCMC LLC )
DEFENDANT )

**MEMORANDUM OPINION AND ORDER**

Plaintiff Samantha Milby brought this action in Jefferson Circuit Court in Louisville, Kentucky, against Defendant MCMC LLC ("MCMC"). MCMC removed the action to this Court. Milby now moves for remand and seeks attorney fees and costs. For the reasons below, the Court will deny Milby's motion.

Removal to federal court is proper for "any civil action brought in a State court of which the district courts of the United States have original jurisdiction." 28 U.S.C. § 1441(a). This Court has original jurisdiction over cases "arising under the … laws … of the United States." 28 U.S.C. § 1331. In determining whether a particular case arises under federal law, the Court

determines whether a federal question necessarily appears in the plaintiff's complaint. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 207 (2004). "[W]hen a federal statute wholly displaces the state-law cause of action through complete pre-emption," the state law claim can be removed. *Beneficial Nat. Bank v. Anderson*, 539 U.S. 1, 8, (2003). "When the federal statute completely pre-empts the state-law cause of action, a claim which comes within the scope of that cause of action, even if pleaded in terms of state law, is in reality based on federal law." *Id.* In particular, ERISA "converts an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule." *Davila*, 542 U.S. 200, 209 (2004) (quoting *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 65 (1987)).

Removability is not apparent on the face of Milby's complaint. Indeed, Milby's complaint reads as an attempt to evade federal jurisdiction. *See, e.g.*, Compl. ¶ 2, ECF No. 1-1 ("Plaintiff's claims arise solely under the laws of the Commonwealth of Kentucky. Plaintiff *does not* assert any claim arising under federal law."). Just as the proclamation that windmills are giants does not alter the structure's actual nature, Milbly's persistent recital that these claims are grounded solely in state law cannot vanquish the evident federal jurisdiction.

In her complaint, Milby asserted state law claims against MCMC alleging it issued a medical opinion concerning Milby without a license to practice medicine in the Commonwealth as required under KRS § 311.560. MCMC rendered the medical opinion in reviewing Milby's claim for Employee Retirement

Income Security Act ("ERISA") benefits. Milby claims that the medical opinion led to the denial of her claim. Milby does not dispute that the medical review occurred for ERISA plan benefit determination purposes.

Congress enacted ERISA to "protect … the interests of participants in employee benefit plans and their beneficiaries … by establishing standards of conduct, responsibility, and obligation for fiduciaries" and to "provid[e] for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b). "The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004). To achieve this uniformity, ERISA includes expansive preemption provisions, *see* 29 U.S.C. § 1144, intended to safeguard employee benefit plans as "exclusively a federal concern." *Davila*, 542 U.S. at 208 (internal quotation and citation omitted); *see also Sherfel v. Newson*, 768 F.3d 561, 564 (6th Cir. 2014) ("ERISA is a statute unique in its preemptive effect.").

ERISA "supersede[s] any and all State laws insofar as they may … relate to any [covered] employee benefit plan." 29 U.S.C. §1144(a). "[A]ny state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." *Davila*, 542 U.S. at 209. "As long as ERISA exclusively regulates the activity (deciding whether to award benefits), ERISA prevents the distinct state law tort scheme from superimposing an extra layer of regulation on top of the ERISA-regulated plan benefit determination."

*Hutchison v. Fifth Third Bancorp.*, 469 F.3d 583, 588 (6th Cir. 2006).

A claim is within the scope of Section 1132(a)(1)(B) – ERISA's civil enforcement remedy – for preemption purposes if: "(1) the plaintiff complains about the denial of benefits to which he is entitled 'only because of the terms of an ERISA-regulated employee benefit plan'; and (2) the plaintiff does not allege the violation of any 'legal duty (state or federal) independent of ERISA or the plan terms[.]'" *Gardner v. Heartland Indus. Partners*, 715 F.3d 609, 613 (6th Cir. 2013) (quoting *Davila*, 542 U.S. at 210).

This Court and other courts within this circuit have ruled on cases with similar facts. *See, e.g.*, *Hogan v. Jacobson,* No. 3:12CV-820 (W.D. Ky. Sept. 26, 2013) (finding ERISA completely preempted plaintiff's state law claim under KRS § 311.560 because the defendant nurses were only involved in denying Hogan's benefits "to the extent that they were each asked to review [the plaintiff's] file when she appealed the initial denial of benefits"). Similarly, the Court finds here that Milby's challenge to MCMC practitioners' medical qualifications are subsumed within Milby's ERISA claim for wrongful denial of benefits.

Milby argues that when MCMC issued a medical opinion neither it nor its agent was licensed in the Commonwealth to practice medicine. Milby's ERISA plan insurer relied on this plan in denying her benefits. In seeking damages related to a medical professional's medical review for ERISA plan benefit determination, a plaintiff must seek damages under ERISA. *See Hogan,* No. 3:12CV-820. Otherwise, a state enforcement mechanism supplants Congress' uniform

enforcement system. Indeed, Milby already has a pending suit against the insurer for wrongful denial of benefits. *See Milby v. Liberty Life Assurance Co. of Boston*, Case No. 3:12-cv-487-CRS, (W.D. Ky. Apr. 30, 2015). Milby's suit against MCMC arises only because of her ERISA benefit claim review. Milby does not allege a violation of any legal duty beyond the scope of the ERISA plan and the review of her benefit claim.

As the Court will deny Milby's motion to remand, awarding Milby attorney fees and costs is unwarranted.

The Court **DENIES** Plaintiff Samantha Milby's motion to remand (DN 6).

**IT IS SO ORDERED.**

February 9, 2016

s/_____
Charles R. Simpson III, Senior Judge
United States District Court

## APPENDIX D

**JEFFERSON CIRCUIT COURT**
**DIVISION TWO (2)**

**15 CI 05056**

**[Filed October 2, 2015]**

| | |
|---|---|
| SAMANTHA MILBY, | ) |
| | ) |
| Plaintiff, | ) |
| | ) |
| v. | ) |
| | ) |
| MCMC LLC | ) |
| | ) |
| Defendant. | ) |
| | ) |

Introduction

1. This action is brought on behalf of the Plaintiff Samantha Milby relating to Defendant MCMC LLC's actions in rendering an unlicensed medical opinion concerning her diagnosis, treatment, and correction.

2. Plaintiffs claims arise solely under the laws of the Commonwealth of Kentucky. Plaintiff *does not* assert any claim arising under federal law.

3. The headings contained in this complaint are intended only to assist in reviewing the statements and allegations contained herein. To avoid the unnecessary

repetition in each section, Plaintiff hereby affirms and incorporates each paragraph in each section of this complaint as though fully set forth therein.

4. The factual allegations found in this complaint are not exhaustive or exclusive and are presented throughout this complaint only so as to provide the requisite notice of the basis for Plaintiffs allegations.

Jurisdiction and Venue

5. This Court has jurisdiction over the claims asserted in this action for monetary and equitable relief because the relief sought exceeds the minimum jurisdictional amount of this general trial court and because at all times relevant herein the Defendant was transacting business in the Commonwealth of Kentucky.

Parties

6. At all relevant times, Samantha Milby ("Ms. Milby") was a citizen and resident of the Commonwealth of Kentucky, residing in Jefferson County, Kentucky.

7. At all relevant times, MCMC LLC ("MCMC") was doing business within the Commonwealth of Kentucky. MCMC's business address is 300 Crown Drive Suite 203, Quincy, Massachusetts, 02169. MCMC LLC is registered with the Kentucky Secretary of State as a foreign corporation. Its designated agent for service of process is CSC-Lawyers Incorporating Service Company, 421 West Main Street, Frankfort, Kentucky 40601. MCMC was not, and is not, licensed

to practice medicine within the Commonwealth of Kentucky as required by KRS 311.560.

Factual Allegations

8. Ms. Milby is a resident of the Commonwealth of Kentucky and was employed by University of Louisville Hospital.

9. As a contractual benefit of her employment, Ms. Milby was covered by a group long term disability insurance policy.

10. The insurance policy provided Ms. Milby with monthly income should she become disabled and unable to continue working.

11. In April 2011 , Ms. Milby' s medical condition had deteriorated to the point she could not continue working on a full-time basis.

12. As a result of her physical limitations and restrictions, Ms. Milby filed for the disability income benefits payable under the insurance policy.

13. The insurer provided her with the insurance policy's disability benefits for the next 17 months only to then abruptly terminate her insurance benefits.

14. The insurer's decision to terminate Ms. Milby's insurance benefits was based on a medical opinion MCMC provided concerning her diagnosis, treatment and correction.

15. At the insurer's request, and in exchange for payment, MCMC had agreed to provide a medical opinion concerning Ms. Milby's diagnosis, treatment, and correction.

16. With the assistance of its agent, Jamie L. Lewis ("Lewis"), MCMC issued a written medical opinion concerning Ms. Milby's diagnosis, treatment and correction – including opinions relating to her physical restrictions and limitations.

17. MCMC's medical opinion concluded Ms. Milby was not subject to any physical restrictions or limitations that would affect her ability to engage in full-time gainful employment as follows: "The opinions of Dr. Bowlds and Barefoot are not supported by the available medical documentation as there are no objective findings which would support the claimant's inability to stand and move for more than just a few minutes, as well as repetitively bend, squat, kneel, and crouch. The claimant would have the capacity to perform sustained full time work without restrictions as of 02/22/2013 forward."

18. As a direct result of MCMC's medical opinions concerning Ms. Milby's physical limitations and restrictions, the insurer denied Ms. Milby's claim for ongoing monthly disability insurance benefits.

19. When MCMC issued its medical opinion, neither it nor its agent Lewis were licensed to practice medicine in the Commonwealth of Kentucky. They are not currently licensed and, upon reasonable belief, have not made any effort to otherwise comply with Kentucky's medical licensing statutes.

20. MCMC was aware of its Kentucky's medical licensing requirements, but willfully disregarded the requirements for its own financial gain.

21. In addition to failing to comply with Kentucky's medical licensing requirements, MCMC did

not seek to issue an accurate medical opinion concerning Ms. Milby. Instead, again for its own financial gain and in furtherance of its practice of catering to insurance companies, MCMC provided medical opinions that would support the insurer's claim denial – without regard to accuracy or to the negative financial impact to Ms. Milby.

22. Based upon MCMC's medical opinions, Ms. Milby was damaged.

Claim

Negligence *Per Se*

23. For its own financial gain, MCMC issued a medical opinion concerning Ms. Milby's (a Kentucky resident) diagnosis, treatment and correction.

24. At the time MCMC provided its medical opinion concerning Ms. Milby, it was not licensed to practice medicine in the Commonwealth of Kentucky as required by KRS 311.560.

25. MCMC's actions were willful and done without regard to the resulting injury to Ms. Milby.

26. By issuing unlicensed medical opinions concerning Ms. Milby's (a Kentucky resident) diagnosis, treatment and correction, MCMC violated KRS 311.560. The violation constitutes negligence *per se*.

27. Ms. Milby is within the protected class of KRS 311.560.

28. Ms. Milby has been, and continues to be, damaged as a result of MCMC's willful statutory violations.

29. KRS 446.070 is the enforcement mechanism which allows Ms. Milby to recover damages resulting from MCMC's actions and willful violation of KRS 311.560.

30. Based on the foregoing, Ms. Milby seeks compensatory, equitable, and exemplary relief against MCMC in an amount to be determined by a jury at trial to include costs, interest, attorneys' fees, and such other relief as is just and appropriate.

Prayer for Relief

31. Judgment against MCMC and in favor of Ms. Milby including an amount of money sufficient to satisfy her claims (not to exceed $75,000) inclusive of pre- and post-judgment interest, attorneys' fees and costs, including the cost of any experts, and any other and further relief as the Court deems appropriate.

32. A jury on issues so triable.

33. Leave to amend the complaint as necessary.

Dated: 10/2/15

Respectfully submitted,

s/_____

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