No. 00-1021

IN THE

Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC.,
Petitioner,

v.

DEBRA C. MORAN AND STATE OF ILLINOIS,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF FOR PETITIONER

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QUESTION PRESENTED

Section 4-10 of the Illinois Health Maintenance Organization Act provides that, if a patient's primary care physician deems a proposed procedure desired by the patient to be medically necessary, but the HMO disagrees and denies coverage for the procedure, the patient may have the HMO's decision reviewed by an outside physician, and the HMO must abide by the reviewing physician's determination. The Seventh Circuit held in this case that this independent review process was not preempted by the Employee Retirement Income Security Act ("ERISA")—in square conflict with a recent Fifth Circuit decision holding that a materially identical Texas law *was* preempted by ERISA.

The question presented is:

Whether the independent review provision of the Illinois HMO Act, which is similar to laws adopted in 37 States and the District of Columbia, is preempted by ERISA.

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

Petitioner Rush Prudential HMO, Inc., now known as UNICARE Health Plans of the Midwest, Inc., is wholly owned by UNICARE Illinois Services, Inc., an Illinois corporation, which is ultimately owned by WellPoint Health Networks Inc., a publicly held company.

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OPINIONS BELOW

The opinion of the Seventh Circuit, together with the dissent from denial of rehearing en banc, is reported at 230 F.3d 959. The opinion is reproduced in the appendix to the petition for certiorari ("Pet. App.") at 1a, and the dissent from denial of rehearing en banc is reproduced at Pet. App. 24a. The opinions and orders of the United States District Court for the Northern District of Illinois dated June 9, 1998, March 24, 1999, May 6, 1999, and June 15, 1999, are not reported; they are reproduced at Pet. App. 28a, 35a, 44a, and 47a, respectively.

JURISDICTION

The judgment of the Seventh Circuit was entered on October 19, 2000. Pet. App. 1a. The petition for certiorari was filed on December 22, 2000, and granted on June 29, 2001. 121 S. Ct. 2589. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the United States Constitution provides in pertinent part:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof * * * 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.]

Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA")—the statute's civil enforcement provision—provides in pertinent part:

> (a) Persons empowered to bring a civil action. 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 * * *. [29 U.S.C. § 1132(a).]

Section 514(a) of ERISA—the preemption provision—provides in pertinent part:

> (a) Supersedure; effective date. Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. [29 U.S.C. § 1144(a).]

Section 514(b)(2) of ERISA—the saving clause—provides in pertinent part:

> (b) Construction and application. * * * (2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.
>
> (B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title * * * , nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies. [29 U.S.C. § 1144(b)(2).]

Section 4-10 of the Illinois Health Maintenance Organization Act provides:

> Medical Necessity—Dispute Resolution—Independent Second Opinion. Each Health Maintenance Organization shall provide a mechanism for the timely review by a physician holding the same class of license as the primary care physician, who is unaffiliated with the Health Maintenance Organization, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself), primary care physician and the Health Maintenance Organization in the event of a dispute between the primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician. In the event that the reviewing physician determines the covered service to be medically

necessary, the Health Maintenance Organization shall provide the covered service. Future contractual or employment action by the Health Maintenance Organization regarding the primary care physician shall not be based solely on the physician's participation in this procedure. [215 Ill. Comp. Stat. 125/4-10.]

INTRODUCTION

Health Maintenance Organizations, or HMOs, have become a common feature of the American health care system. Their growing prominence has drawn the attention of state lawmakers, who in recent years have subjected HMOs to increasing regulation. States have demonstrated particular interest in regulating "utilization review," the process by which HMOs determine whether patient treatments are covered under the terms of the HMO contract, a determination which is typically "keyed to standards of medical necessity or the reasonableness of the proposed treatment." *Pegram* v. *Herdrich*, 530 U.S. 211, 219 (2000).

Petitioner Rush Prudential HMO, Inc. ("Rush") is an HMO that provided access to medical and hospital care under a medical benefits plan sponsored by the employer of the husband of respondent Debra C. Moran ("Moran"). The plan is an employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* Under the applicable Certificate of Group Coverage ("Certificate"), Rush provides coverage only when it determines services to be "medically necessary," and it exercises "the broadest possible discretion" to make that determination. Pet. App. 3a (quoting Certificate).

Moran sought to have Rush pay for an unusual surgical procedure that Rush had determined was not medically necessary. Moran disagreed with that determination. ERISA provided Moran with a remedy in such a circumstance—a civil action "to recover benefits due to [her] under the terms of [her] plan," or "to enforce [her] rights under the terms of

the plan." 29 U.S.C. § 1132(a)(1)(B). As this Court held in *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 52 (1987), this remedy "was intended to be exclusive." Moran, however, invoked a different remedy to recover the benefits to which she believed she was entitled, a remedy provided by the Illinois Health Maintenance Organization Act, 215 Ill. Comp. Stat. 125/4-10: independent review of Rush's medical necessity determination by an unaffiliated physician. Under the Illinois law, if that physician "determines the covered service to be medically necessary, the [HMO] shall provide the covered service." *Id.* The reviewing physician made such a determination in this case, and Moran brought a claim under Section 4-10 to recover the benefits the reviewer had decreed should be paid. Rush resisted, on the ground that the state law independent review remedy was preempted by ERISA.

That was what the Fifth Circuit determined with respect to an indistinguishable Texas independent review law, holding that the law "creates an alternative mechanism through which plan members may seek benefits due them under the terms of the plan," in "conflict with ERISA's exclusive remedy." *Corporate Health Ins., Inc.* v. *Texas Dep't of Ins.*, 215 F.3d 526, 539 (5th Cir.), *further opinion on pet. for reh'g*, 220 F.3d 641 (2000), *pet. for cert. filed sub nom. Montemayor* v. *Corporate Health Ins., Inc.*, No. 00-665 (Oct. 24, 2000). The Seventh Circuit below disagreed, reasoning that the Illinois law "simply adds to the contract, by operation of law, an additional dispute resolving mechanism," which can then be enforced like any other term of the contract in the civil action authorized by ERISA. Pet. App. 22a. Judge Posner, joined by three other judges, dissented from the denial of rehearing en banc. He explained that the Illinois law "establishes a system of appellate review of benefits decisions that is distinct from the provision in ERISA for suits in federal court to enforce entitlements conferred by ERISA plans. By doing

so, the law interferes with the federally specified system for enforcing such entitlements." *Id.* at 25a-26a.

The decision below is wrong and should be reversed. The Illinois law rather plainly affords a new and different remedy to those seeking benefits under an ERISA plan, and this Court has squarely held in a unanimous opinion that Congress intended the remedies provided under ERISA to be exclusive. Calling the new state law remedy a plan term added "by operation of law," and then reasoning that the action to implement that remedy simply seeks to enforce a plan term as authorized by ERISA, Pet. App. 22a, would render this Court's ERISA preemption jurisprudence a dead letter, and "invite[] states to evade the preemptive force of ERISA simply by deeming [their] regulations of ERISA plans to be plan terms." *Id.* at 27a (Posner, J., dissenting from denial of rehearing en banc). Such a result would be flatly inconsistent with this Court's bedrock recognition that Congress intended ERISA's remedies to be exclusive.

STATEMENT OF THE CASE

Statutory Background. 1. ERISA "subjects to federal regulation plans providing employees with fringe benefits." *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983). ERISA's "intricate, comprehensive" statutory scheme, *Boggs* v. *Boggs*, 520 U.S. 833, 841 (1997), regulates employee pension and welfare plans providing "medical, surgical or hospital care or benefits" "through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1), (3).

One of ERISA's "principal goals," *Egelhoff* v. *Egelhoff*, 121 S. Ct. 1322, 1328 (2001), was to "establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits." *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 9 (1987). When it passed ERISA, Congress intended

> to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government * * * [and to prevent] the potential for conflict in substantive law * * * requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. [*New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 656-657 (1995).]

Several provisions safeguard the uniformity of ERISA's comprehensive administrative scheme. Section 514(a) preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. 29 U.S.C. § 1144(a). ERISA contains a few exceptions to that broad preemption provision, only one of which is potentially relevant here: Section 514(b)(2)(A), the saving clause, which exempts from preemption "any law of any State which regulates insurance, banking, or securities." *Id.* § 1144(b)(2)(A).

ERISA also contains a civil enforcement provision, Section 502(a), *id.* § 1132(a), which this Court has found to be the "exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits." *Pilot Life*, 481 U.S. at 52. The civil enforcement provision—"one of the essential tools for accomplishing the stated purposes of ERISA," *id.*—allows plan participants, among other things, to sue to recover benefits due under the plan, to enforce their rights under the plan, or to clarify their rights to future benefits under the plan. 29 U.S.C. § 1132(a)(1)(B). As this Court held in *Pilot Life*, the provisions of Section 502(a), crafted by Congress with "deliberate care,"

> set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit

> plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. [481 U.S. at 54.]

See also Massachusetts Mut. Life Ins. Co. v. *Russell*, 473 U.S. 134, 146 (1985) ("The six carefully integrated civil enforcement provisions found in § 502(a) * * * provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly") (emphasis in original).

2. Despite the foregoing, recent years have seen a proliferation of state laws entitling a patient to an independent review or external appeal of an HMO's decision that a particular procedure is not covered by an ERISA plan. By 2000, thirty-seven States and the District of Columbia had enacted independent review laws. *See* Pet. for Cert. at 16-17. The laws vary in their scope and in the form of review they require. Some States require HMOs to submit challenged benefits determinations to panels of reviewers composed of from one to seven people and varyingly made up of health care practitioners, fellow employees, attorneys, or some combination of these. *See, e.g.*, G. Dallek & K. Pollitz, Georgetown Univ. Inst. for Health Care Research & Policy, *External Review of Health Plan Decisions: An Update* 9 & n.10, 13 (May 2000) (noting, among others, Michigan's "seven-member task force," which independently reviews non-expedited benefits determinations). Other States provide for review by "Independent Review Organizations," or "IROs," which in turn contract with physicians who, singly or in groups (again depending on the state law) perform independent reviews. *Id.* at 9. Independent review laws also vary in their scope: some States limit independent or external review to an HMO's determination that a proposed procedure is not medically necessary or appropriate, while

others permit review of a broader range of decisions, including basic coverage determinations. *Id.* at 6-7, 13.

As Judge Posner observed below, independent external review laws "add[ ] heavy new procedural burdens to ERISA plans." Pet. App. 26a (dissent from denial of rehearing en banc). Indeed, "[t]he expense of an arbitration by the independent physician could easily equal the expense of the medical treatment that the HMO had refused to authorize." *Id.*

Facts. Moran sought treatment in 1996 from Dr. Arthur LaMarre, a Rush-affiliated primary care physician, for pain, numbness, loss of function, and decreased mobility in her right shoulder. LaMarre began to treat Moran's symptoms with physiotherapy. While she was still undergoing this treatment, Moran sought the opinion of Dr. Julia Terzis, an out-of-network surgeon in Virginia. Terzis confirmed the diagnosis of Moran's symptoms as brachial plexopathy and thoracic outlet syndrome ("TOS"), a syndrome caused by the compression of nerves between the shoulder and neck. *See* Pet. App. 3a-4a.

As treatment for Moran's condition, "surgery is not indicated unless more conservative measures"—such as the physiotherapy LaMarre had already prescribed—"fail to manage the symptoms." *Id.* at 4a. If surgery becomes necessary, "the standard procedure for TOS involves decompression by way of first rib resection (the complete removal of the uppermost rib) or first rib resection with scalenectomy (the removal of the rib and the attached muscle)." *Id.* Terzis, however, recommended for Moran a more complicated and rare surgical procedure that Terzis herself had developed: "Dr. Terzis' surgery consists of rib resection, extensive scalenectomy, and, if indicated, microneurolysis of the lower roots of the brachial plexus under intraoperative microscopic magnification." *Id.*

Moran asked LaMarre to obtain approval from Rush for the Terzis surgery. LaMarre sought out the views of two other thoracic surgeons, neither of whom recommended the Terzis surgery for Moran, but LaMarre nonetheless requested that Rush approve the surgery. After Rush declined to approve payment for the treatment because it was not medically necessary, Moran appealed the decision pursuant to the review procedure provided under the benefit plan. Upon further review, Rush affirmed its denial on the ground that the extensive surgery proposed by Terzis was not medically necessary, but advised Moran that it would cover the standard TOS surgery—first rib resection with scalenectomy—performed by a network surgeon. Moran made an additional appeal to Rush's membership advisory committee, which upheld Rush's medical necessity decision. *Id.* at 5a.

Having exhausted the various review procedures provided in the benefit plan without obtaining a favorable ruling on medical necessity, Moran could have pursued the remedy afforded by ERISA—a civil action to recover benefits due or to enforce her asserted rights under the plan. 29 U.S.C. § 1132(a)(1)(B). In such an action, Rush's determination pursuant to plan procedures that the Terzis surgery was not medically necessary could be set aside only if the court—applying standards developed under ERISA's body of federal common law—determined that it constituted an abuse of discretion. *See, e.g.*, Pet. App. 54a-55a (citing cases).

Moran, however, elected a different remedy: a binding determination of her claim for benefits by a different decisionmaker, as mandated by Section 4-10 of the Illinois HMO Act. Under Section 4-10, a determination by an HMO that a procedure is not medically necessary may be reviewed by an independent physician. 215 Ill. Comp. Stat. 125/4-10. The law provides that if the reviewing physician "determines the covered service to be medically necessary, the [HMO] shall provide the covered service." *Id.*

While Moran's request for independent review was still pending, she decided to undergo the microneurolysis surgery. Dr. Terzis performed the 14-hour procedure, which together with post-operative care cost nearly $95,000. After paying for the surgery herself, Moran sought reimbursement from Rush. Rush undertook yet another investigation of the claim, seeking opinions from additional experts. None of the doctors consulted by Rush concluded that Moran's surgery was medically necessary, and Rush declined to reimburse Moran. Pet. App. 6a.

Proceedings Below. This litigation began when Moran filed a complaint in state court seeking, *inter alia*, specific performance of the external review provisions in Section 4-10 of the Illinois law. J.A. 12.[1] The state court ordered Rush to permit the review provided for in Section 4-10. J.A. 15-16. That review was conducted by one Dr. Dellon, who "concluded that the surgery was medically necessary," while noting that he would have used a less intrusive and less time-consuming procedure. Pet. App. 8a. After reviewing Dr. Dellon's report and reports from three other physicians reaching the opposite conclusion, Rush again denied Moran's claim on the ground that the surgery was not medically necessary.

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[1] Because the complaint sought to obtain or compel benefits under an ERISA-regulated employee welfare benefit plan and was, in Rush's view, completely preempted by federal law, Rush removed the case to federal court. Moran moved to remand to state court, and the District Court granted her motion. The court reasoned that the request for specific performance of the review procedure was not a claim under ERISA's civil enforcement provisions and therefore was not completely preempted. The District Court noted, however, that a claim for reimbursement after the external review had been completed might well be a claim for benefits that is completely preempted by ERISA. *See* Pet. App. 28a, 33a-34a.

Moran amended her complaint to seek reimbursement for the surgery in the amount of $94,841.27. J.A. 17, 21. Rush removed the suit to federal court on the ground that a demand for reimbursement is completely preempted by ERISA and must be brought under Section 502(a) of ERISA, the statute's civil enforcement provision. 29 U.S.C. § 1132(a). Recognizing that the claim was now simply one for benefits, and that ERISA provided the exclusive vehicle for securing benefits under a covered plan, the District Court denied Moran's motion to remand. Pet. App. 41a-43a.

The District Court determined that Moran's Section 4-10 demand for payment was "preempted by ERISA's civil enforcement policy in § 502(a)." *Id.* at 53a. As the court explained:

> Regardless of how she characterizes it, Moran's current claim is a § 502(a) denial of benefits claim. Moran asserts her right to have Rush cover the costs of medical treatment pursued outside of her HMO plan. Rush refused to reimburse her for the treatment. Rush's refusal is a determination of benefits within the meaning of ERISA. Accordingly, Moran's claim for reimbursement is preempted by ERISA. [*Id.* at 41a-42a.]

The District Court also rejected Moran's effort to escape preemption through ERISA's so-called "saving clause," 29 U.S.C. § 1144(b)(2)(A). That clause provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." Finding that the Illinois law "does not operate to transfer or spread a policyholder's risk" but only "affects the administration and adjudication structure of a health plan in particular instances," the District Court concluded that Section 4-10 is not a law that "regulates

insurance" and that the saving clause therefore did not rescue the state law from preemption. Pet. App. 42a-43a.[2]

After concluding that Moran's claim for reimbursement was properly characterized as a claim for benefits under the ERISA plan, and was therefore properly removed to federal court, the District Court analyzed Moran's demand for reimbursement under principles of federal law. Given that Moran's ERISA plan "afforded Rush 'the broadest possible discretion to interpret the terms of the * * * Certificate and to determine which benefits the Employee and his/her eligible dependents are entitled to receive,' " *id.* at 56a (quoting Certificate), those principles required review of Rush's determination under "a highly deferential standard." *Id.* at 54a. Applying that standard, the District Court entered summary judgment for Rush on the ground that "Rush did not abuse its discretion or act arbitrarily in denying Moran's benefits claim." *Id.* at 56a. As the District Court concluded, "[i]n reaching its [benefits] determination, Rush acted in accordance with the protocol set out in Moran's insurance certificate." *Id.* In addition, Rush relied on expert opinions

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[2] Moran sought reconsideration of the District Court's decision on the saving clause after this Court's decision in *UNUM Life Insurance Co. of America* v. *Ward*, 526 U.S. 358 (1999), which clarified the test to be applied for determining when a law "regulates insurance." The District Court determined that even if the saving clause applied, an exemption from the clause—the so-called "deemer clause"—once again gave preemptive effect to the federal law. Pet. App. 46a. The deemer clause provides that an employee benefit plan cannot "be deemed to be an insurance company or other insurer, * * * or to be engaged in the business of insurance" for purposes of applying the saving clause. 29 U.S.C. § 1144(b)(2)(B). As the District Court explained, "[b]ecause the Illinois HMO Act has the effect of directly regulating employee benefit plans rather than an insurance company, it is exempt from the savings clause under the deemer clause." Pet. App. 46a.

establishing that "Moran's condition did not require extensive brachial plexopathy treatment." *Id.* at 57a-58a.

The Seventh Circuit reversed. It first determined that removal was proper because "Ms. Moran's state law claims are properly recharacterized as claims for benefits under Section 502(a)(1)(B) of ERISA and, therefore, are completely preempted." Pet. App. 13a. The Court of Appeals also concluded that the state law claims were initially within the reach of ERISA's express preemption provision, found in Section 514(a) of the Act. 29 U.S.C. § 1144(a) (except as provided in subparagraph (b), the provisions of ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan"). *See* Pet. App. 14a.

The Seventh Circuit then considered whether Section 4-10 of the Illinois law regulates insurance and therefore could escape preemption under the saving clause. Applying this Court's multi-factor test for determining whether a law regulates insurance, *see UNUM*, 526 U.S. at 367, the Seventh Circuit concluded that Section 4-10 did so. Pet. App. 17a.[3]

The Seventh Circuit then considered whether Section 4-10, despite falling within the saving clause, was nonetheless preempted because it "conflicts with a substantive provision of ERISA." *Id.* at 19a. Despite having concluded when considering the propriety of removal that "Moran's state law claims are properly recharacterized as claims for benefits under § 502(a)(1)(B) of ERISA and, therefore, are completely preempted," Pet. App. 13a, the court now found that

[3] The court also determined that the "deemer clause" did not apply in this case. The employee welfare benefit plan here is not self-funded but rather is an insured plan, and the Court of Appeals determined that the deemer clause did not apply to such plans. *Id.* at 18a-19a.

the provisions of Section 4-10 were *not* preempted by Section 502(a)(1)(B). Pet. App. 19a-23a. It reasoned that the provisions of Section 4-10 were incorporated into the plan and that therefore "a suit by [Moran] to enforce the HMO Act's provisions is simply a suit to enforce the terms of the plan—precisely the sort of suit that is contemplated by § 502(a)(1)(B) 'to enforce rights' and 'to recover benefits' under the plan." Pet. App. 21a.

The court recognized that its decision conflicted with the Fifth Circuit's decision in *Corporate Health*, "in which the court considered an independent review statute from Texas that is quite similar to § 4-10 of Illinois' HMO Act." Pet. App. 19a. The Seventh Circuit disagreed with the Fifth Circuit's conclusion that the state law independent review mechanism created an alternative civil enforcement scheme inconsistent with that provided in ERISA itself. It relied instead on its view that Section 4-10 created an additional term of the plan by operation of law. Thus, it concluded that a suit to enforce rights under the provision "is simply a suit to enforce the terms of the plan," and not an enforcement mechanism in conflict with the exclusive mechanism provided by ERISA. *Id.* at 21a. Applying Section 4-10, the Court of Appeals reversed the District Court's summary judgment in favor of Rush and granted summary judgment to Moran, enforcing the independent reviewer's determination under Section 4-10 that the Terzis surgery was "medically necessary." *Id.* at 24a.

Four circuit judges voted to rehear the case en banc. Writing for those judges in a dissent from the denial of rehearing en banc, Judge Posner observed that the "panel's decision creates a square conflict with another circuit, is probably unsound, and will affect an enormous number of cases." *Id.* In the view of the dissenters, "[t]he Illinois statute, unless preempted by ERISA insofar as the statute's application to ERISA plans is concerned, will * * * effect a substantial change in the employer's plan." *Id.* at 25a. The state law

"establishes a system of appellate review of benefits decisions that is distinct from the provision in ERISA for suits in federal court to enforce entitlements conferred by ERISA plans," and therefore "interferes with the federally specified system for enforcing such entitlements." *Id.* at 25a-26a. The dissenters observed that the panel's reliance on the fiction that state law is incorporated into the plan would permit "transparent * * * evasion[s] of ERISA's preemption clause." *Id.* at 26a-27a.

Finally, the dissenters noted the "unresolved tension in the panel's opinion" between two propositions on which it relied: "first, that the Illinois law regulates insurance rather than ERISA plans and thus is not preempted; second, that by virtue of Illinois law the requirement of independent physician review is written not only into an insurance contract but also into the plan itself, which makes the requirement enforceable in federal court." *Id.* at 27a. Judge Posner explained that "[t]he two propositions are incompatible." *Id.*

> If the statute merely regulates insurance and therefore is not preempted, how can it be part of an ERISA plan and enforceable in federal court? If, on the other hand, the requirement imposed by the statute is and must be incorporated into the plan, then Illinois has done more than merely regulate the contents of an insurance policy. It has regulated the contents of an ERISA plan—which means that its law is preempted. [*Id.*]

This Court granted certiorari. 121 S. Ct. 2589 (2001).

SUMMARY OF ARGUMENT

I. ERISA provides a remedy for beneficiaries under an employee pension or welfare plan who believe they have been wrongfully denied benefits under the plan. Section 502(a) specifies that beneficiaries may bring a civil action "to recover benefits due * * * under the terms of [the] plan" or "to enforce [their] rights under the terms of the plan." 29

U.S.C. § 1132(a)(1)(B). This Court held in *Pilot Life* that this remedy was intended to be "the *exclusive vehicle* for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits." 481 U.S. at 52 (emphasis added). As the Court explained, this conclusion was compelled by Congress' clear intent that the question of "rights and obligations" under an ERISA plan be governed by a developing body of uniform federal common law, not disparate state laws. *Id.* "The expectations that a federal common law of rights and obligations under ERISA-regulated plans would develop * * * would make little sense if the remedies available to ERISA participants and beneficiaries under 502(a) could be supplemented by varying state laws." *Id.* at 56.

Section 4-10 of the Illinois HMO Act, however, purports to afford beneficiaries an additional and alternative remedy "to recover benefits due" or "to enforce [their] rights under the terms of the plan." Under Section 4-10, a beneficiary can force the HMO to submit the question of medical necessity under a plan to an unaffiliated physician for a de novo determination that binds the HMO. This compulsory arbitration offers beneficiaries a more attractive remedy than that afforded by ERISA, because as a matter of federal common law an HMO's discretionary medical necessity determination is reviewed in a Section 502(a) action only for abuse of that discretion. *See Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 111 (1989). The additional and alternative remedy provided by Section 4-10 necessarily conflicts with ERISA's exclusive remedy, and is preempted.

The court below erred in ruling that there was no conflict because Section 4-10 was "incorporated" into the ERISA plan, and then enforced in what the court recharacterized as a Section 502(a) suit. Under such circular reasoning, any State could impose any type of remedy, simply by deeming it a term of an ERISA plan. This Court's considered conclusion

that Congress intended ERISA's remedial scheme to be exclusive is not so easily circumvented.

II. Nor is Section 4-10 saved from preemption by ERISA's saving clause. Although it is often difficult to determine whether a state law falls under the imprecise terms of that clause, *Pilot Life* held that a state law that conflicted with ERISA's exclusive remedial scheme could not be considered to be within the scope of the clause. Whatever laws the saving clause was meant to save from preemption, additional and alternative state law remedies were not among them, and Section 4-10 accordingly cannot escape preemption.

The same result follows from application of the "tests" for whether a state law "regulates insurance" under the saving clause. Section 4-10 is not a regulation of insurance as a matter of common sense because it is directed at HMOs, not insurers, and the two are not the same—not all HMOs offer insurance or bear insurance risk. The McCarran-Ferguson factors also confirm that Section 4-10 does not regulate the business of insurance. First, Section 4-10 does not transfer or spread risk, but simply affords an additional means of enforcing the risk-spreading previously agreed to in the plan. Second, the provision is not an integral part of an insurance policy relationship, because the terms of that relationship were set in the plan. Section 4-10 simply provides an alternative method of enforcing that relationship. Third, Section 4-10 is not limited to entities in the insurance industry, but applies to HMOs regardless of whether they act as insurers or third-party administrators. For all these reasons—but "most importantly, the clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive," *Pilot Life*, 481 U.S. at 57—Section 4-10 is preempted and not saved by the saving clause.

ARGUMENT

I. THE INDEPENDENT REVIEW PROVISION OF THE ILLINOIS HMO ACT CONFLICTS WITH ERISA'S EXCLUSIVE REMEDIAL SCHEME

This Court, and the lower courts, have often struggled with the scope of ERISA preemption. *See De Buono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 808 n.1 (1997) (noting 16 ERISA preemption cases between 1974 and the 1996 Term). But there is one area of ERISA where the Court has had no difficulty discerning a bright line preemption rule. The Court has consistently and repeatedly held that state laws that seek to supplant or add to the exclusive remedies set forth in Section 502(a) of ERISA, 29 U.S.C. § 1132(a), are necessarily preempted because such laws conflict with Congress' overriding intent to create a uniform national system, governed by federal statutory and common law, for enforcing rights under ERISA plans. *See, e.g., Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 142-145 (1990); *Metropolitan Life Ins. Co.* v. *Taylor*, 481 U.S. 58, 65 (1987); *Pilot Life*, 481 U.S. at 52-54.

Section 4-10 is preempted under these precedents because it provides an additional, and alternative, remedy for those seeking benefits under an ERISA plan, and therefore conflicts with ERISA's exclusive remedial scheme. The attempted reconciliation offered by the court below—that Section 4-10 poses no conflict with ERISA's exclusive remedies because it merely adds a mandatory term to the plan, which can then be enforced through ERISA—is no reconciliation at all and, if adopted by this Court, would nullify Congress' intent to establish a uniform federal scheme for enforcing rights under ERISA plans.

A. Section 4-10 Conflicts With ERISA's Exclusive Remedy For The Recovery Of Benefits Under An ERISA Plan And Is Therefore Preempted

"One of the principal goals of ERISA is 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.' " *Egelhoff*, 121 S. Ct. at 1328 (quoting *Fort Halifax*, 482 U.S. at 9). That goal is accomplished in large part through ERISA's exclusive remedies, set forth in Section 502(a) of the Act. In Section 502(a), Congress enacted "a 'carefully integrated' civil enforcement scheme that 'is one of the essential tools for accomplishing the stated purposes of ERISA.' " *Ingersoll-Rand*, 498 U.S. at 137 (quoting *Pilot Life*, 481 U.S. at 52, 54) (additional quotation and citation omitted). Among other things, Section 502(a) provides an exclusive federal remedy for a beneficiary seeking "to recover benefits due to him under the terms of his plan" or "to enforce his rights under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B).

The exclusivity of the Section 502(a) remedies is well-established. As this Court has held,

> Congress clearly expressed an intent that the civil enforcement provisions of ERISA § 502(a) be the *exclusive* vehicle for actions for ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits, *and that varying state causes of action for claims within the scope of § 502(a) would pose an obstacle to the purposes and objectives of Congress.* [*Pilot Life*, 481 U.S. at 52 (emphases added).[4]]

[4] *See also id.* at 54 ("The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive.").

The exclusive remedies of Section 502(a) have a broader preemptive effect than do other provisions of federal law. ERISA's exclusive remedies have "extraordinary pre-emptive power," such as has been found in only one other federal statute, Section 301 of the Labor Management Relations Act, 29 U.S.C. § 185. *Taylor*, 481 U.S. at 65. Congress not only intended to preempt state laws that conflict with ERISA's exclusive remedies, but also expressed a "clear intention to make § 502(a)(1)(B) suits brought by participants or beneficiaries federal questions for purposes of federal court jurisdiction * * *." *Id.* at 66. All actions asserting improper processing of benefits under an ERISA plan are accordingly "treated as federal questions" arising from a "federal common law of rights and obligations under ERISA-regulated plans." *Pilot Life*, 481 U.S. at 56. *See id.* (" 'It is also intended that a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans.' ") (quoting 120 Cong. Rec. 29942 (1974) (Sen. Javits)); *accord Firestone*, 489 U.S. at 110. Any suit attempting to set forth a state law cause of action seeking to recover benefits under an ERISA plan is preempted, and becomes " 'purely a creature of federal law notwithstanding the fact that state law would provide a cause of action in the absence of [federal law].' " *Taylor*, 481 U.S. at 64 (quoting *Franchise Tax Bd.* v. *Construction Laborers Vacation Trust*, 463 U.S. 1, 23 (1983)).

Section 4-10 attempts to supplant ERISA's exclusive federal remedies, and is therefore preempted. The sole effect of Section 4-10 is to provide an alternative state law remedy in place of the exclusive remedy under ERISA "to recover benefits due * * * under the terms of his plan" or "to enforce * * * rights under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Moran seeks nothing other than benefits that she believes are "medically necessary" and, therefore, covered under the terms of the plan as written. *See* Opp.

Cert. 7 ("Moran sought * * * to recover benefits under and to enforce her rights under the terms of her plan"). Yet instead of utilizing the exclusive remedy authorized under ERISA for recovery of those benefits, Moran invoked the remedy under Section 4-10, which requires that her claim for benefits under the plan be determined by a different decisionmaker.

Under Section 502(a)(1)(B) and its implementing federal common law, ERISA's exclusive remedy consists of an action under federal law to determine whether Rush acted arbitrarily or capriciously in exercising the full discretion conferred on it to interpret the terms of the plan, including the term "medically necessary." *See Firestone*, 489 U.S. at 110-112; Pet. App. 54a-55a (citing cases). By contrast, the alternative remedy invoked by Moran under Section 4-10 consists of a form of binding de novo arbitration before an independent physician. Under Section 4-10, "[i]n the event that the reviewing physician determines the covered service to be medically necessary, the Health Maintenance Organization shall provide the covered service." Section 4-10 does not provide employees with any additional benefits under the plan; it simply purports to give them a different way to recover plan benefits, by appealing to a different decisionmaker.[5]

[5] The conflict with ERISA's exclusive remedies is underscored by the fact that Section 4-10 also conflicts with ERISA's fiduciary requirements. Under ERISA, plan administrators must provide for a full and fair review of benefits denials "by the appropriate named fiduciary." 29 U.S.C. § 1133(2). The independent reviewer under Section 4-10, who is expressly required to be "unaffiliated with the Health Maintenance Organization," is not a fiduciary of the plan as required by this provision. Nor is the reviewer someone whom the plan administrator, independently exercising its own fiduciary duties, has designated to carry out fiduciary responsibilities under the plan. *See id.* § 1105(c)(1)(b). Rather, the reviewer is an *independent*, external decisionmaker who is mandated by state law to resolve certain disputes between the plan's fiduciary and its beneficiaries through a de novo determination of medical necessity. Under ERISA, an HMO fiduciary's discretionary determination of medical necessity is reviewed by federal judges, who apply a uniform body of federal common law to determine whether the plan fiduciary has abused the discretion granted to it under the plan.

As the District Court succinctly put it:

> Regardless of how she characterizes it, Moran's current claim is a § 502(a) denial of benefits claim. Moran asserts her right to have Rush cover the costs of medical treatment pursued outside of her HMO plan. Rush refused to reimburse her for the treatment. Rush's refusal is a determination of benefits within the meaning of ERISA. Accordingly, Moran's claim for reimbursement is preempted by ERISA. [Pet. App. 41a-42a (citations omitted).]

This Court's precedents establish that such an alternative state law remedy impermissibly conflicts with ERISA's exclusive remedies and the federal common law governing ERISA claims. For example, in *Pilot Life*, the Court considered a state law claim for, among other things, "damages for failure to provide benefits under [an] insurance policy." 481 U.S. at 43. The Court held that this claim, and the others asserted in that case, conflicted with ERISA's exclusive remedies. As the Court explained,

> the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of certain others under the federal scheme would be completely undermined if ERISA plan participants and beneficiaries were free to obtain remedies un-

der state law that Congress rejected in ERISA. [*Id.* at 54.]

See also Travelers, 514 U.S. at 646 (ERISA preempts laws that provide "alternative enforcement mechanisms"); *Taylor*, 481 U.S. at 66 (holding that state law claims for benefits owed under ERISA plan were "displaced by the civil enforcement provisions of § 502(a)").

Likewise, in *Ingersoll-Rand*, *supra*, the Court considered a claim under Texas law seeking damages for a wrongful discharge allegedly motivated by a desire to prevent the plaintiff from accruing vested rights under an ERISA pension plan. Following *Pilot Life*, the Court held that this claim was preempted because it conflicted with ERISA's exclusive remedy intended to accomplish the same objective. *See* 498 U.S. at 142 ("Even if there were no express pre-emption * * *, the Texas cause of action would be pre-empted because it conflicts directly with an ERISA cause of action."). In that case, the exclusive remedy was an action under Section 502(a)(3) to enforce the wrongful discharge prohibition found in Section 510 of ERISA. As the Court stated:

> Unquestionably, the Texas cause of action purports to provide a remedy for the violation of a right guaranteed by § 510 and exclusively enforced by § 502(a). Accordingly, we hold that " 'when it is clear or may fairly be assumed that the activities which a State purports to regulate are protected' by § 510 of ERISA, 'due regard for the federal enactment requires that state jurisdiction must yield.' " [*Id.* at 145 (quoting *Lingle* v. *Norge Div. of Magic Chef, Inc.*, 486 U.S. 399, 409 n.8 (1988)).]

So too here, Section 4-10 impermissibly conflicts with ERISA's exclusive remedial scheme. Whereas Congress contemplated that rights under ERISA plans would be determined according to a uniform body of federal common law, Section 4-10 purports to establish a new state law remedy—a form of binding arbitration before an independent

physician—that conflicts with this intent to create an exclusive, uniform national enforcement mechanism. As the Court held in *Pilot Life*, "[t]he expectations that a federal common law of rights and obligations under ERISA-regulated plans would develop * * * would make little sense if the remedies available to ERISA participants and beneficiaries under 502(a) could be supplemented or supplanted by varying state laws." *Id.* at 56. Thus, state laws—like Section 4-10—which attempt to supplement or supplant this federal enforcement scheme with additional or alternative means of determining rights to benefits under ERISA plans, necessarily destroy both the exclusivity and uniformity intended by Congress. Section 4-10 is therefore preempted.[6]

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[6] Affirming the decision below would also pose the troubling situation of a federal cause of action (under Section 502(a)) governed entirely by state law (under Section 4-10). Congress " 'intended that a body of Federal substantive law [would] be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans.' " *Pilot Life*, 481 U.S. at 56 (quoting 120 Cong. Rec. 29942 (1974) (Sen. Javits)). That "body of Federal substantive law" satisfies the Article III "arising under" requirement in the typical 502(a) case. *See Textile Workers Union* v. *Lincoln Mills*, 353 U.S. 448, 456-457 (1957). In a case under Section 4-10, however, the question of rights and obligations under the plan has been vested by state law in the independent reviewer. There is no call for the development or application of a "body of Federal substantive law;" all that the federal court hearing a Section 502(a) case invoking Section 4-10 need do is apply what the actor vested with authority under state law has determined. What is left for the federal court is "only rubber-stamp work;" from all that appears the court is simply "to enter a judgment pursuant to a decision the court has no authority to evaluate." *Gutierrez de Martinez* v. *Lamagno*, 515 U.S. 417, 429-430 (1995). That is in fact what the Court of Appeals did here. *See* Pet. App. 24a ("Dr. Dellon determined * * * that the surgery performed by Dr. Terzis was 'medically necessary.' Thus, Ms. Moran is entitled to summary judgment."). Under the decision below, Section 502(a) simply confers federal court jurisdic-

B. The Court Of Appeals' Reasoning, If Adopted, Would Completely Subvert Congress' Intent To Establish Uniform, Exclusive Federal Remedies

The Court of Appeals correctly recognized that even if a state law would otherwise be within the scope of ERISA's saving clause, such a law "nevertheless may be preempted if that law conflicts with a substantive provision of ERISA." Pet. App. 19a. But the court nonetheless held that Section 4-10 "cannot be characterized as creating an alternative remedy scheme that conflicts with § 502(a)." *Id.* at 21a. According to the court, no conflict exists because Section 4-10 "simply adds to the contract, by operation of law, an additional dispute resolving mechanism," which can then be enforced through an ERISA action under Section 502(a)(1)(B). *Id.* at 22a.

This reasoning, if accepted, would nullify Congress' intent to establish uniform, exclusive federal remedies under ERISA. Of the approximately 124 million people covered by ERISA plans, it is estimated that more than 70 million are covered by fully insured plans.[7] Yet under the Court of

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tion over a suit for the enforcement of state law. As this Court explained in *Mesa* v. *California*, 489 U.S. 121, 136 (1989), "pure jurisdictional statutes which seek 'to do nothing more than grant jurisdiction over a particular class of cases' cannot support Art. III 'arising under' jurisdiction." (quoting *Verlinden B.V.* v. *Central Bank of Nigeria*, 461 U.S. 480, 496 (1983)).

To permit a federal court to entertain a purportedly federal cause of action that is predicated entirely on state law—as did the Seventh Circuit—would thus raise the most troubling constitutional questions under Article III. The statute should be interpreted to avoid such a result, by reaffirming the Court's precedents holding that ERISA preempts state laws that seek to supplant its exclusive remedies. *See Mesa*, 489 U.S. at 137 (declining to adopt reading of statute which "raises serious constitutional doubt").

[7] *See* Karen A. Jordan, *Preemption of a State "Legislatively Created" Right to Sue HMOs for Negligence*, Health Care Law Monthly 13 (Apr. 1999) (estimating 124 million workers insured by ERISA plans); Self-Insurance Inst. of America, Inc., *Self-Insured Health Plans: Questions and Answers, reprinted at* http://www.siia.org/public/articles/index.cfm?Cat=24 (estimating 50 million workers covered by self-insured ERISA plans).

Appeals' reasoning, any State could circumvent ERISA's exclusive remedies for insured plans simply by deeming any alternative state law remedy to be a term of the plan. As Judge Posner noted, the Court of Appeals' reasoning "invites states to evade the preemptive force of ERISA simply by deeming [their] regulations of ERISA plans to be plan terms." Pet. App. 27a.

Here, the additional remedy consists of binding de novo arbitration before an independent physician. But under the reasoning of the court below, States could require claims for benefits to be decided by state court juries, state court judges, administrative bodies, or any other decisionmaker, simply by requiring plan administrators—as a new state-mandated term of the plan—to abide by such determinations. States could likewise require insured plans to abide by the decision of a jury awarding punitive or treble damages for wrongfully denied benefits—a result forbidden by ERISA, *see Massachusetts Mut. Life Ins. Co.* v. *Russell*, 473 U.S. 134 (1985)—simply by mandating such a result as a term of the plan. States could direct benefits decisions to be made by a panel of other patients according to state law tort rules. In fact, States could save from preemption *any* alternative remedies through the linguistic sleight-of-hand of providing that their remedies are to be incorporated as plan terms.[8]

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[8] The Seventh Circuit observed in a footnote that the Certificate defining Moran's rights under the plan "incorporated" Section 4-10 by stating that " 'if the provisions of this Certificate do not conform to the requirements of any state or federal law that applies to the Certificate, the Certificate is automatically changed to conform with the requirements of that law.' " Pet. App. 21a n.4 (quoting Certificate). But if ERISA preempts state law, that law

This Court has made clear that States cannot frustrate the core purposes of ERISA so easily. In *Fort Halifax*, *supra*, the Court considered whether ERISA preempted a state law mandating severance benefits. Although the Court found no preemption because the law did not relate to an ERISA plan, the Court expressly rejected the rationale of the lower court—that a State could avoid ERISA preemption simply by mandating a particular employee benefit plan. 482 U.S. at 16-17. As the Court held, such an approach "would permit States to circumvent ERISA's pre-emption provision, by allowing them to require directly what they are forbidden to regulate." *Id.* at 16. Such a rule would "pose a formidable barrier to the development of a uniform set of administrative practices" because employers "would face the prospect that numerous other States would impose their own distinct requirements—a result squarely inconsistent with the goal of ERISA preemption." *Id.* at 17.[9]

The same frustration of ERISA's central goal would occur if States were permitted to circumvent ERISA preemption simply by recasting prohibited alternative remedies as

does not "appl[y] to the Certificate" and is not incorporated into the plan. *See Light* v. *Blue Cross & Blue Shield of Ala., Inc.*, 790 F.2d 1247, 1248 (5th Cir. 1986) (rejecting same argument and holding that "[i]f ERISA pre-empts state law, there is no applicable state law to which the [plan] administrator must conform"); *see also Heidelberg* v. *National Found. Life Ins. Co.*, 2001 WL 238211, at *2 (E.D. La. Mar. 6, 2001) ("allow[ing] a boiler-plate provision * * * to replace federal law with state law in every respect * * * would undermine the purpose of ERISA's preemption provision").

[9] In *UNUM*, 526 U.S. at 376, the Court held that an ERISA plan cannot "displace any state regulation simply by inserting a contrary term in plan documents." A similar principle applies to States. While plans cannot avoid valid state regulation simply by inserting contract terms, a State cannot use the same tactics to save invalid state regulation.

mandated contract terms. "[D]iffering state regulations affecting an ERISA plan's 'system for processing claims and paying benefits' impose 'precisely the burden that ERISA pre-emption was intended to avoid.' " *Egelhoff*, 121 S. Ct. at 1329 (quoting *Fort Halifax*, 482 U.S. at 10). Faced with a hodgepodge of alternative state remedies disguised as additional plan terms, administrators of nationwide ERISA plans could no longer develop a uniform medical necessity standard or predict with any degree of certainty the financial consequences of coverage decisions. As this Court has held, allowing States to "develop different substantive standards applicable to the same employer conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction" is "fundamentally at odds with the goal of uniformity that Congress sought to implement." *Ingersoll-Rand*, 498 U.S. at 142. *See also Egelhoff*, 121 S. Ct. at 1328 ("Requiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal of 'minimiz[ing] the administrative burdens * * * ultimately borne by the beneficiaries.' ") (quoting *Ingersoll-Rand*, 498 U.S. at 142).

The result of this "patchwork scheme of regulation" would be "considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." *Fort Halifax*, 482 U.S. at 11. *See also FMC Corp.* v. *Holliday*, 498 U.S. 52, 60 (1990) (disuniformity produces "inefficiencies that employers might offset with decreased benefits"). Given the prospect that independent physicians in one State, or administrative tribunals in another, or juries in a third, may decide medical necessity differently from the plan's fiduciary and may award varying forms of relief, employers will have no choice but to reduce benefits or increase premiums. *See* Pet. App. 26a (Posner, J., dissenting from denial of rehearing en banc) (Section 4-10 "adds heavy new procedural burdens to ERISA plans. These

burdens do not come without cost. * * * Piling on costs in the administration of ERISA plans will shrink benefits and deter some employers from offering health insurance at all."). Nor is ERISA's objective of uniform benefit claims administration limited to the interests of employers. ERISA's federal common law scheme also supports the interests of plan participants by promoting fairness and consistency in plan-wide claims adjudication. Section 4-10 plays mischief with this objective by raising the specter of inconsistent and inequitable claims adjudication for participants in the same ERISA plan, depending on the varying judgments of different independent reviewers in different States.

In devising its rule, the Court of Appeals relied on this Court's precedents holding that ERISA does not preclude States from regulating the substantive contractual rights of insureds and insurers through mandatory insurance policy provisions that do not conflict with ERISA's own requirements. *See UNUM*, 526 U.S. 358; *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724 (1985). That reliance was misplaced. Neither *UNUM* nor *Metropolitan Life* addressed state laws that conflicted with ERISA's exclusive enforcement scheme. *Metropolitan Life* involved a typical mandated-benefits law, which required insurance policies to include specified mental health benefits. 471 U.S. at 739. The law said nothing about the remedy for seeking that mandated coverage, or any other benefits. *UNUM* involved a rule that prohibited an insurance company from enforcing contractual notice provisions if it was not prejudiced by late notice. That rule, as well, did not purport to supplant ERISA's exclusive remedies. As the Court noted, the preemptive effect of Section 502(a) was "not implicated" in *UNUM*. 526 U.S. at 376. Although the notice-prejudice rule would supply one of the rules of decision in a Section 502(a) action, the participant's remedy remained an action under federal law to determine whether the plan's fiduciary abused the discretion granted to it under the plan. *See* Pet. App. 25a

(*UNUM* involved "typical regulation of insurance rather than anything either special to ERISA plans or likely to be mischievous in its impact on those plans.") (Posner, J., dissenting from denial of rehearing en banc).

This case, by contrast, does not involve a law altering the substantive contractual rights of insureds and insurers. The plan provides coverage for "medically necessary" treatments, and Section 4-10 does not purport to alter that provision, or mandate coverage of other benefits. Rather, Section 4-10 establishes an alternative decisionmaker—the independent physician—to determine whether a particular procedure is "medically necessary" and, therefore, covered under the plan as written. *See Corporate Health*, 220 F.3d at 645 (independent review provisions "are plainly a state regime for reviewing benefit decisions and not a system for implementing a mandated term of insurance regulating a minimal standard of care"). This law is entirely unlike the laws considered in *Metropolitan Life* and *UNUM*, and just like the laws the Court has consistently held conflict with ERISA's exclusive remedies.[10]

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[10] It is immaterial that the remedy created by Section 4-10 consists of a form of compulsory binding arbitration rather than a judicial cause of action. In either instance, allowing state law to operate would impermissibly establish an alternative remedy in place of ERISA's exclusive ones. " '[T]he distinction between rights and remedies is fundamental. A right is a well founded or acknowledged claim; a remedy is the means employed to enforce a right or redress an injury.' " *Lewis* v. *Lewis & Clark Marine, Inc.*, 121 S. Ct. 993, 999 (2001) (quoting *Chelentis* v. *Luckenbach S.S. Co.*, 247 U.S. 372, 384 (1918)). Section 4-10 compels binding arbitration to enforce an ERISA plan beneficiary's putative right to benefits. That is plainly an alternative remedy, even though the independent physician's decision—like the decision of any arbitrator—is enforceable through a subsequent judicial action. As this Court has held, when a party voluntarily agrees to arbitration, that party does not forego substantive rights, but instead "submits to their resolution in an arbitral, rather than a judicial, forum."

ERISA "does not go about protecting plan participants and their beneficiaries by requiring employers to provide any given set of minimum benefits," *Travelers*, 514 U.S. at 651, and laws regulating insurance in such a manner are therefore not preempted. But the entire purpose of ERISA is to "control[ ] the administration of benefit plans" through, among other things, a "comprehensive civil enforcement scheme." *Id.* *See Metropolitan Life*, 471 U.S. at 732 (ERISA "established various uniform procedural standards" but "does not regulate the substantive content of welfare-benefit plans"). As this Court has repeatedly held, laws like Section 4-10, which interfere or conflict with that comprehensive enforcement scheme, are necessarily preempted. [11]

II. THE INDEPENDENT REVIEW PROVISION OF THE ILLINOIS HMO ACT IS NOT SAVED BY ERISA'S SAVING CLAUSE

A. Laws That Conflict With ERISA's Exclusive Remedies Are Not Within The Scope Of The Saving Clause

As the Court of Appeals recognized, this Court held in *Pilot Life* that ERISA's saving clause, Section 514(b)(2), 29 U.S.C. § 1144(b)(2), does not save from preemption laws

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Mitsubishi Motors Corp. v. *Soler Chrysler-Plymouth, Inc.*, 473 U.S. 614, 628 (1985). Here, Moran's substantive right is her contractual right to coverage for medically necessary procedures; Section 4-10 simply supplies an alternative means to enforce that right. Section 4-10 therefore conflicts with ERISA's exclusive remedies and is preempted.

[11] This conclusion is entirely consistent with Department of Labor regulations, scheduled to take effect next year, which will govern *internal* appeals of adverse benefit determinations. *See* 65 Fed. Reg. 70,246 (2000) (to be codified at 29 C.F.R. § 2560.503-1 *et seq.*). Those regulations expressly state that *external* review laws, such as the one at issue here, are "beyond the scope of the regulation." 65 Fed. Reg. at 70,254.

that conflict with ERISA's exclusive remedies. *See* Pet. App. 19a; *see also Corporate Health*, 215 F.3d at 538 ("even if the provisions would otherwise be saved, they may nonetheless be preempted if they conflict with a substantive provision of ERISA"). On this point, the Court of Appeals was plainly correct. This Court's precedents are clear that a law which conflicts with ERISA's exclusive remedies is necessarily preempted regardless of whether the law might otherwise fall within the scope of the saving clause.

In *Pilot Life*, the Court held that the "understanding of the saving clause must be informed by the legislative intent concerning the civil enforcement provisions provided by ERISA § 502(a), 29 U.S.C. § 1132(a)." 481 U.S. at 52. Based on this reasoning, the Court rejected the argument that a state law cause of action asserting improper processing of an insurance claim was saved from preemption:

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

See also id. at 57 n.4 ("[w]e conclude that [plaintiff's] state common law claims fall under the ERISA pre-emption clause and are not rescued by the saving clause").

In other words, a state law that conflicts with ERISA's exclusive remedies (or any other provision of ERISA, for that matter) cannot be a law that "regulates insurance" within the meaning of the saving clause. Rather than regulating insurance—an area Congress did not intend for ERISA to regulate—such a law governs the procedural remedies for enforcing rights under ERISA plans—an area Congress very

much intended to be the exclusive province of ERISA. *See Corporate Health*, 215 F.3d at 539 ("the saving clause does not operate if the state law at issue creates an alternative remedy for obtaining benefits under an ERISA plan").

If there were any doubt on that point, the Court dispelled it in *John Hancock Mutual Life Insurance Co.* v. *Harris Trust Savings Bank*, 510 U.S. 86 (1993). In that case, the Court held that ERISA "calls for federal supremacy when the two regimes [federal and state] cannot be harmonized or accommodated." *Id.* at 98. Thus, the Court reiterated that the saving clause cannot save state laws that actually conflict with ERISA's provisions:

> [W]e discern no solid basis for believing that Congress, when it designed ERISA, intended fundamentally to alter traditional preemption analysis. State law governing insurance generally is not displaced, but "where [that] law stands as an obstacle to the accomplishment of the full purposes and objectives of Congress," federal preemption occurs. [*Id.* at 99 (quoting *Silkwood* v. *Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984)).]

See also Boggs v. *Boggs*, 520 U.S. at 844 ("In the face of this direct clash between state law and the provisions and objectives of ERISA, the state law cannot stand. * * * States are not free to change ERISA's structure and balance."). Thus, as the Court emphasized, "[n]o decision of this Court has applied the saving clause to supersede a provision of ERISA itself." *John Hancock*, 510 U.S. at 99 n.9. That is precisely what respondent would have the Court do in this case.

In the fourteen years since *Pilot Life*, Congress has had ample opportunity to change this Court's holding that insurance laws that actually conflict with ERISA are not saved from preemption, but it has not done so. There is therefore no cause for this Court to change course now. *Cf. Illinois Brick Co.* v. *Illinois*, 431 U.S. 720, 736 (1977) ("[W]e must bear in mind that considerations of stare decisis weigh

heavily in the area of statutory construction, where Congress is free to change this Court's interpretation of its legislation."). Nor has the *Pilot Life* rule "proven to be intolerable simply in defying practical workability." *Planned Parenthood of Southeastern Pa.* v. *Casey*, 505 U.S. 833, 854 (1992). Quite to the contrary, the lower courts, while struggling with other aspects of ERISA preemption, have had little difficulty following *Pilot Life*'s command that state laws that conflict with ERISA's exclusive remedies are preempted and not saved by the saving clause.[12] What defies practical workability is not the clear *Pilot Life* rule, but rather the abandonment of that rule, which would relegate all preemption questions regarding insurance laws to the indeterminate balancing of the remaining saving clause factors. *See infra* at 37- 40.

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[12] *See, e.g.*, Pet. App. 19a; *Corporate Health*, 215 F.3d at 538; *Dang* v. *UNUM Life Ins. Co. of Am.*, 175 F.3d 1186, 1191 (10th Cir. 1999); *Gaylor* v. *John Hancock Mut. Life Ins. Co.*, 112 F.3d 460 (10th Cir. 1997); *Smith* v. *Provident Bank*, 170 F.3d 609, 615 (6th Cir. 1999) ("In essence, the test for application of the saving clause is whether the law substantively regulates a relationship or merely provides alternative remedies for harms for which ERISA already provides redress."); *United of Omaha* v. *Business Men's Assurance Co. of Am.*, 104 F.3d 1034, 1041-42 (8th Cir. 1997); *In re Life Ins. Co. of N. Am.*, 857 F.2d 1190, 1194 (8th Cir. 1988) ("The Court in *Pilot Life* could not have stated with any greater clarity that the remedies afforded under ERISA are exclusive, and no state law purporting to supply additional remedies will escape the preemptive effect of § 1144(a) as laws 'which regulate insurance' under § 1144(b)(2)(A)."); *Smith* v. *Jefferson Pilot Life Ins. Co.*, 14 F.3d 562, 570-571 (11th Cir.), *cert. denied*, 513 U.S. 808 (1994); *Tingey* v. *Pixley-Richards West, Inc.*, 953 F.2d 1124, 1132 (9th Cir. 1992); *Kanne* v. *Connecticut Gen. Life Ins. Co.*, 867 F.2d 489, 493-494 (9th Cir. 1988), *cert. denied*, 492 U.S. 906 (1989); *International Resources, Inc.* v. *New York Life Ins. Co.*, 950 F.2d 294, 300-301 (6th Cir. 1991), *cert. denied*, 504 U.S. 973 (1992).

There is good reason why Congress has not seen fit to alter the *Pilot Life* rule. If all laws addressing insurers could be considered laws which "regulate insurance" within the meaning of the saving clause *even* when such laws conflict with ERISA's substantive provisions, then Congress' intent to create uniform federal standards for ERISA plan administration would be rendered chimerical. *See* Explanatory Statement Concerning S. 3589, 116 Cong. Rec. 7284, 7288 (1970) (Congress intended ERISA to be "the exclusive form of regulation for employee benefit plans within the areas covered" by the Act, leaving intact only those state laws "which *otherwise* regulate insurance, banking, or securities") (emphasis supplied). Under such a rule, the saving clause would not simply save state laws which—unlike ERISA—regulate insurance, but rather would swallow ERISA whole.

B. Section 4-10 Is Not, In Any Event, A State Law That "Regulates Insurance"

The remaining tests for application of the saving clause bolster the conclusion that Section 4-10 is not saved from preemption. From a "common sense view of the matter," *Metropolitan Life*, 471 U.S. at 740, Section 4-10 does not "regulate insurance;" it regulates the administrative practices of HMOs. Nor does Section 4-10 satisfy the three factors commonly employed to determine whether a law fits within the "business of insurance" as that phrase is used in the McCarran-Ferguson Act—" '*first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.' " *Id.* at 743 (quoting *Union Labor Life Ins. Co.* v. *Pireno*, 458 U.S. 119, 129 (1982) (emphases in original)).

1. The "common-sense view of the word 'regulates' would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry,

but must be *specifically directed toward that industry.*" *Pilot Life*, 481 U.S. at 50 (emphasis added). In *UNUM*, for example, this Court concluded that a state notice-prejudice rule that was " 'directed specifically at the insurance industry and * * * applicable only to insurance contracts' " was saved from preemption. 526 U.S. at 368 (quoting *Cisneros* v. *UNUM Life Ins. Co.*, 134 F.3d 939, 945 (9th Cir. 1998), *cert. denied*, 526 U.S. 1086 (1999)). Similarly, in *Metropolitan Life*, 471 U.S. at 742-743, this Court found that a state mandated-benefit law regulating the substantive content of insurance policies was saved from preemption under the saving clause. *Cf. FMC Corp.* v. *Holliday*, 498 U.S. at 61 (state law which invalidated subrogation provisions of insurance contracts was "aimed at" insurance industry and covered by saving clause).

Section 4-10, however, is not "directed specifically at the insurance industry," *UNUM*, 526 U.S. at 368; it is directed toward HMOs. *See* Pet. App. 25a (Posner, J., dissenting from denial of rehearing en banc) (Section 4-10 "is not a general regulation of insurance, or even of health insurance; it is a regulation of HMOs, which are the service providers under a great many ERISA medical-benefits plans"). The two are not fungible, for the simple reason that not all HMOs offer insurance products, and even those that do offer insurance options do not always bear the risk for the health plans with which they contract. *See* Jonathan P. Weiner & Gregory de Lissovoy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. Health Pol., Pol'y & L. 75, 76, 81 (1993) (hereinafter "Weiner & de Lissovoy"). HMOs have on occasion been described as general "insurance vehicle[s]," *see Anderson* v. *Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994); but it is more accurate to say, as the Solicitor General noted in its brief in *Pegram* v. *Herdrich*, that an HMO only "acts as an insurer to the extent that it bears risk." Br. for United States as Amicus Curiae Supporting Petitioners, No. 98-1949, at 11 n.5. Some HMOs

may "insure, manage, and provide care;" but others are simply "providers and managers; and still others only administer." Weiner & de Lissovoy at 78.

Recognizing that HMOs and other managed care organizations ("MCOs") may not bear risk in all circumstances, some States have enacted statutes regulating MCOs which are limited by their terms to only those entities' insurance functions. *See, e.g., Stuart Circle Hosp. Corp.* v. *Aetna Health Mgmt.*, 995 F.2d 500, 501 (4th Cir. 1993) (statute regulating insurer-operated preferred-provider "health benefit program[s]" saved under saving clause). Section 4-10, however, has no such limits on its scope. The Illinois HMO Act broadly defines HMOs as "*any* organization formed under the laws of this or another state to provide *or* arrange for one or more health care plans under a system which causes any part of the risk of health care delivery to be borne by the organization *or its providers*." 215 Ill. Comp. Stat. § 125/1-2(9) (emphases added). By its terms, that definition captures HMOs that themselves do not bear the "risk of health care delivery," and thus applies broadly to HMOs that act in a purely administrative role and devolve all risk onto their providers[13] or onto a third-party insurer. *Id.*; *see* Weiner & de Lissovoy at 81. Section 4-10 does not further distinguish between risk-bearing and non-risk-bearing HMOs; it applies to "*each* Health Maintenance Organization." 215 Ill.

[13] *See* E.H. Morreim, *Confusion in the Courts: Managed Care Financial Structures and their Impact on Medical Care*, 35 Tort & Ins. L. J. 699, 705 (2000) (noting that in capitated arrangements, where MCO pays doctors a fixed fee per patient per month, organization "transfers its financial risk" to doctors); *see also Arizona* v. *Maricopa County Med. Soc'y*, 457 U.S. 332, 339 n.7 (1982) (noting that for HMOs in which the "consumer pays a fixed periodic fee to a functionally integrated group of doctors in exchange for the group's agreement to provide any medical treatment that the subscriber might need," "the economic risk is * * * borne by the doctors").

Comp. Stat. § 125/4-10 (emphasis added). The statute thus covers HMOs even when they are not acting as insurers; HMOs acting solely as administrators for a plan or its providers are just as obligated under the statute to submit to independent review of their medical-necessity determinations as HMOs that also function as insurers.[14]

Section 4-10 applies across the board to all HMOs because it does not regulate an HMO's insurance functions. The services targeted by Section 4-10 are administrative services performed by both non-risk-bearing and risk-bearing HMOs alike.[15] The statute purports to regulate HMOs' administration of benefit plans by directing them to comply with a third, external level of review of their medical necessity decisions. The law certainly affects HMOs acting as insurers, just as it affects HMOs that only administer a plan; but a state law otherwise preempted under ERISA is only saved by the saving clause if it regulates *insurance*, not *insurers*. *See Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 217 (1979) ("The exemption is for the 'business of insurance,' not the 'business of insurance companies.' "). Section 4-10 may impact some insurers—but it does not regulate insurance. *See Prudential Ins. Co. of Am.* v. *National Park Med. Ctr., Inc.*, 154 F.3d 812, 829 (8th Cir. 1998)

[14] Another section of the Act likewise confirms that HMOs include entities operating as other than insurers: Section 2-3 of the Act grants HMOs the power to "contract[ ] with an insurance company * * * for the provision of insurance, indemnity, or reimbursement against the cost of health care service provided by the Health Maintenance Organization." 215 Ill. Comp. Stat. § 125/2-3.

[15] Administration of a health benefit plan includes "claims services, utilization review, auditing, plan design consulting, contracting for excess risk coverage, client reports, [and] record keeping." Self-Insurance Institute of America, Inc., *Facts About Self-Insurance of Health Benefits* 4 (1994). Third-party administrators manage plans covering more than 56 million employees. *Id.*

(state law "directed at regulation of broadly defined health benefit plans, only some of which fall within the insurance industry," not saved under ERISA saving clause); *Texas Pharm. Ass'n* v. *Prudential Ins. Co. of Am.*, 105 F.3d 1035, 1039 (5th Cir.) (finding state "any willing provider" law preempted and not saved, where MCOs were subject to requirement regardless of whether an insurer was involved), *cert. denied*, 522 U.S. 820 (1997).

2. a. Section 4-10 also fails to satisfy any of the three McCarran-Ferguson factors, which are used as "checking points or guideposts" in the saving clause inquiry. *UNUM*, 526 U.S. at 374. First, the law does not have the effect of transferring or spreading risk—an "indispensable characteristic" of the business of insurance. *Royal Drug*, 440 U.S. at 211-212.[16] As this Court explained in *Pireno*, transfer of risk occurs "at the time that the [insurance] contract is entered;" the policy "defines the scope of risk assumed by the insurer from the insured." 458 U.S. at 130-131. When a policy limits coverage to "medically necessary" treatments, "that limitation is the measure of the risk that has actually been transferred to the insurer." *Id.* at 130. An insurance law spreads risk only if it changes the substantive terms of the insurance contract by mandating certain benefits or expanding the services offered by the terms of the contract. *See Metropolitan Life*, 471 U.S. at 731, 743 (mandated-benefits statute spreads risk of mental health coverage to larger pool of insurance risks); *see also Smith* v. *Jefferson Pilot Life Ins. Co.*, 14 F.3d 562, 569-570 (11th Cir. 1994) (examining whether statute "affect[s] the apportionment of risks, *i.e.*, what medical costs are covered, that the parties made upon entering the contract").

[16] The panel below did not dispute that Section 4-10 did not spread risk. *See* Pet. App. 18a n.3. *See also Corporate Health*, 215 F.3d at 538 (independent review provisions "probably do not meet the first factor of reallocating the risk between the insured and insurer," though that failure not regarded as determinative).

Section 4-10 does not alter or redistribute the risk of medical services among plan enrollees; it enforces the risk already negotiated, by adding an (impermissible) alternative avenue of review of an HMO's benefits decision. With or without Section 4-10, Rush must pay for medically necessary procedures. Nothing about Section 4-10 changes that standard or grants enrollees broader coverage rights.[17]

b. For similar reasons, Section 4-10 fails to satisfy the second McCarran-Ferguson factor. The provision is not an "integral" part of the policy relationship between insurer and insured, because it does not "define the terms of th[at] relationship." *Pilot Life*, 481 U.S. at 51. The terms of the relationship between insurer and insured—including the "medically necessary" standard for determining coverage—are established in the plan and unchanged by Section 4-10. Section 4-10 simply offers a different avenue by which a beneficiary can enforce those terms. *See Pireno*, 458 U.S. at 131 (insurer's use of peer review committee not an "integral part of the policy relationship between insurer and insured," despite committee's "interpretation and enforcement of the insurance contract") (quotation omitted). The notice-prejudice rule in *UNUM*, in contrast, "dictate[d] the terms of the relationship between the insurer and insured," because it substantively altered the bargain between the two by "requiring an insurer to prove prejudice before enforcing a timeliness-of-claim provision." 526 U.S. at 374-375.

[17] It is of course true that Section 4-10 would require HMOs to bear costs in particular cases that they otherwise would not bear. The same is true of the remedies provided by ERISA. Viewing that possibility as "risk-spreading" under the first McCarran-Ferguson factor proves too much; shifting incremental costs is not the same as spreading risk. *See Cisneros* v. *UNUM Life Ins. Co.*, 134 F.3d at 946 (state notice-prejudice law "shift[s] the risk of lost coverage" depending on the timing of a claim, but "does not alter the allocation of risk for which the parties originally contracted") (citing *Pireno*, 458 U.S. at 130).

Section 4-10 does not require Rush to prove anything other than what the plan already requires. It just changes the decisionmaker who is to determine the contractual issue.

c. Finally, Section 4-10 does not satisfy the third McCarran-Ferguson factor—whether the law is "limited to entities within the insurance industry," *UNUM*, 526 U.S. at 375—for the same reason that it fails the common sense test. The law applies to HMOs regardless of whether they act as insurers or third-party administrators.

Far from a "typical regulation of insurance"—like the notice-prejudice rule at issue in *UNUM*—Section 4-10 is directly aimed at ERISA plan administration and is "likely to be mischievous in its impact on those plans." Pet. App. 25a (Posner, J., dissenting from denial of rehearing en banc). It does not spread risk. It does not add a substantive benefit to the plan. It does not apply solely to insurance entities. It merely creates an alternative remedy for plan beneficiaries to seek benefits they claim they are owed under the plan. That is precisely what ERISA exclusively regulates under Section 502(a). The "extraordinary pre-emptive power" of Section 502(a), *Taylor*, 481 U.S. at 65, bolstered by application of the common-sense and McCarran-Ferguson tests, requires a finding that Section 4-10 is preempted by ERISA.

3. At the same time, it cannot be denied that answering the question whether a state law "regulates insurance" under the saving clause is far more difficult than it should be, particularly for such a threshold issue as preemption. The difficulties began with what this Court has noted is not a paragon of legislative draftsmanship. *See, e.g., John Hancock*, 510 U.S. at 99 ("ERISA's preemption and saving clauses ' "are not a model of legislative drafting," ' and the legislative history of the provision is sparse.") (quoting *Pilot Life*, 481 U.S. at 46, quoting *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. at 739). Add a multi-factor balancing test incorporating "common sense" (as only one factor to consider, to be sure)

and the concededly indefinite McCarran-Ferguson factors—not all of which need be satisfied and no one of which is determinative, *UNUM*, 526 U.S. at 373-374—and the goal of reasonable predictability in the law becomes increasingly elusive.

Nor is the problem limited to legislative draftsmanship and "supple" precedent. *Id.* at 373. Changes in the underlying industry have strained once-familiar categories and contributed to the endemic uncertainty. When ERISA was enacted, one health insurance arrangement predominated in the market: traditional indemnity insurance plans. *See* Weiner & de Lissovoy at 76. In the early 1980s, approximately ninety percent of working Americans covered under insurance plans were covered by indemnity plans; five percent participated in a prepaid HMO during the same period. *Id.* at 76-77. Over the next decade, as employers attempted to manage sharply rising health care costs, the industry underwent a massive change; "[b]y 1990, conventional (i.e., unmanaged) indemnity health insurance policies no longer covered the majority of Americans." *Id.* at 77. As they grew in popularity, HMOs and other MCOs began in some circumstances to act as provider and insurer; and as indemnity insurance companies sought to contain their own costs, some began to take on the characteristic features of an HMO. *See Corporate Health*, 215 F.3d at 531 (noting that as managed care organizations grew in popularity, "at the same time, the insurance industry began to offer administrative services to employers and to contract with doctors for services at set rates").

Poorly drafted laws, multi-factor balancing tests, and a blurring of pertinent distinctions in the health insurance industry have combined to form the present prescription for generating circuit conflicts, causing this area of the law to

demand far more of this Court's attention than it deserves.[18] The indeterminacy itself goes far to undermine ERISA's goal of establishing a " 'uniform body of benefits law' " for ERISA plans. *Travelers*, 514 U.S. at 656 (quoting *Ingersoll-Rand*, 498 U.S. at 142).

Yet amidst this roiling sea lies a rock island of certainty and stability. ERISA's remedies are exclusive, notwithstanding the saving clause. That is what this Court held in *Pilot Life*. However you interpret the saving clause, however many factors you weigh, at the end of the day the "most important[]" is "the clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive." *Pilot Life*, 481 U.S. at 57. Section 4-10 does not add a new, substantive coverage term to an insurance policy, like the mandated-benefit provision in *Metropolitan Life*. It creates a new remedy to enforce the terms of an ERISA benefit plan, just like the laws found preempted and not saved by the saving clause in *Pilot Life*. A state law inventing a new remedy for ERISA plan beneficiaries directly conflicts with ERISA; basic federal supremacy principles forbid that result. *See John Hancock*, 510 U.S. at 99; *Ingersoll-Rand*, 498 U.S. at 144; *Pilot Life*, 481 U.S. at 52. The Court should cling to what certainty there is in this area and hold that Section 4-10 is therefore preempted.

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[18] Since the Court noted in 1997 that it had been compelled to hear 16 ERISA preemption cases between 1974 and the 1996 Term, *De Buono*, 520 U.S. at 808 n.1, at least three more have been added to the list—*UNUM*, *Egelhoff*, and this case. Other ERISA preemption conflicts continue to brew in the lower courts. *See, e.g.*, Justin Goodyear, Note, *What Is An Employee Benefit Plan? ERISA Preemption Of "Any Willing Provider" Laws After* Pegram, 101 Colum. L. Rev. 1107, 1117 (2001) (noting "broad[ ]" circuit split on issue whether state "Any Willing Provider" laws are preempted under ERISA or saved by insurance saving clause).

CONCLUSION

For the foregoing reasons, the judgment below should be reversed.

Respectfully submitted,

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