No. 00-1021

In the Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC., PETITIONER

v.

DEBRA C. MORAN, ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

BRIEF FOR THE UNITED STATES
AS AMICUS CURIAE

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QUESTION PRESENTED

Section 4-10 of the Illinois Health Maintenance Organization Act (215 Ill. Comp. Stat. Ann. 125/4-10 (West 1993 & Supp. 2001) requires a health maintenance organization to "provide a mechanism for * * * review by a physician * * * 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," and provides that "[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." The question presented is whether Section 4-10 of the Illinois Health Maintenance Organization Act is preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*

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No. 00-1021

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v.

DEBRA C. MORAN, ET AL.

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BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

INTEREST OF THE UNITED STATES

This case concerns the interrelationship of the preemption provision of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1144(a), its insurance saving clause, 29 U.S.C. 1144(b)(2)(A), and ERISA's civil enforcement provision, 29 U.S.C. 1132(a) (1994 & Supp. V 1999). The Secretary of Labor has primary authority for enforcing and administering Title I of ERISA, see 29 U.S.C. 1002(13), 1136(b), which contains the ERISA provisions that are at issue. The United States filed an amicus brief in this case in the court below and at the petition stage in response to this Court's order inviting the Solicitor General to express the views of the United States.

STATEMENT

1. Respondent Debra C. Moran is a beneficiary under a medical benefit plan sponsored by her husband's employer and governed by ERISA. Pet. App. 3a. Respondent Rush Prudential HMO (Rush) provides "medically necessary" services under the plan. *Ibid.* Moran sought treatment in 1996 from her Rush-affiliated primary care physician for pain, numbness, loss of function, and decreased mobility in her

right shoulder. *Ibid.* Moran then consulted at her own expense with Dr. Julia Terzis, an out-of-network surgeon. *Id.* at 4a. Dr. Terzis recommended that Moran undergo a surgical microneurological procedure to correct her problem. *Ibid.* Two Rush-affiliated thoracic surgeons recommended a less expensive surgical procedure. *Id.* at 4a, 5a. Rush denied Moran's request for the procedure recommended by Dr. Terzis. *Id.* at 5a.

2. In January 1998, Moran sought independent review under Section 4-10 of the Illinois Health Maintenance Organization Act, 215 Ill. Comp. Stat. Ann. 125/4-10 (West 1993 & Supp. 2001) (reproduced at App., *infra*, 1a). Section 4-10 requires a Health Maintenance Organization (HMO), at the option of the patient, to submit to binding review by an unaffiliated physician whenever there is a disagreement between the patient's primary care physician and the HMO over whether a course of treatment is medically necessary. Pet. App. 6a.[1] When Rush did not act on her request, Moran filed an action in state court to require Rush to submit to independent review. *Id.* at 6a-7a. Rush removed the action to federal district court on the ground that the claim was completely preempted by ERISA, see *Metropolitan Life Ins. Co.* v. *Taylor*, 481 U.S. 58 (1987), but the district court remanded the case to the state court. Pet. App. 6a-7a, 28a-34a. In the meantime, Moran underwent the surgery by Dr. Terzis. *Id.* at 6a. She submitted the bill for $94,841.27 to Rush. *Ibid.*

3. On remand, the state court ordered Rush to submit to independent review. Pet. App. 7a, 36a. The independent reviewer determined that the surgery had been medically necessary. Rush, however, denied Moran's claim for reimbursement. *Id.* at 7a-8a, 56a-57a.

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[1] In 1999, after the events in this case, Illinois enacted a new statute that subjects the independent review process to more detailed requirements. 215 Ill. Comp. Stat. Ann. 134/1 *et seq.* (West 2000 & Supp. 2001).

4. Moran then sought an order from the state court requiring Rush to reimburse her for the surgery. Pet. App. 8a, 36a. Rush again removed the case to federal district court. That court refused to remand to state court, holding that Moran's suit to compel reimbursement for surgery was properly characterized as a claim for benefits under Section 502(a)(1)(B) of ERISA, 29 U.S.C. 1132(a)(1)(B). Pet. App. 41a-42a. On the merits, the court concluded that Section 4-10 is preempted by ERISA and is not saved as an insurance regulation under 29 U.S.C. 1144(b)(2)(A) because it does not spread risk. Pet. App. 42a-43a. Subsequently, the district court granted summary judgment to Rush. *Id.* at 58a. The court noted that the plan granted Rush "the broadest possible discretion" in making benefit determinations and held that Rush had not abused that discretion. *Id.* at 56a-58a.

5. The Seventh Circuit reversed. Pet. App. 1a-24a. The court concluded that Section 4-10 of the Illinois HMO Act "relates to" ERISA plans, Pet. App. 16a, but that it "regulates insurance" and therefore falls within ERISA's insurance saving clause, 29 U.S.C. 1144(b)(2)(A). Pet. App. 16a-18a. The court found that Section 4-10 satisfies the "common sense" test of insurance regulation because it "is directed at the HMO industry as insurers." *Id.* at 17a. The court also concluded that the terms of the statutory independent-review provision "are substantive terms of all insurance policies in Illinois by operation of law," *ibid.*, and are therefore "'integral' to the insurer/insured relationship," *id.* at 18a (quoting *UNUM Life Ins. Co.* v. *Ward*, 526 U.S. 358, 374-375 (1999)). In light of those determinations, the court did not find it necessary to reach the question whether Section 4-10 spreads risk. Pet. App. 18a n.3.

The court further held that Section 4-10 does not "creat[e] an alternative remedy scheme that conflicts with" Section 502(a) of ERISA, 29 U.S.C. 1132(a) (1994 & Supp. V 1999). Pet. App. 21a. It reasoned that, because Section 4-10 simply "adds to the contract * * * an additional dispute resolving

mechanism," *id.* at 22a, a suit "to enforce [Section 4-10] is simply a suit * * * 'to enforce rights' and 'to recover benefits' under the plan" under Section 502(a)(1)(B). *Id.* at 21a. The court concluded that unlike the state-law cause of action held preempted in *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41 (1987), Section 4-10 mandates insurance contract terms of the kind that were held in *UNUM* to be saved as the regulation of insurance. Pet. App. 23a.

Judge Posner, joined by three other judges, dissented from the denial of rehearing en banc. Pet. App. 24a-27a. In Judge Posner's view, the Illinois external review provision "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." *Id.* at 25a. He expressed the view that that scheme improperly transforms contractual suits envisioned under Section 502(a)(1) into suits "for judicial review of the independent physician's decision." *Id.* at 26a.

SUMMARY OF ARGUMENT

Section 4-10 of the Illinois HMO Act "relates to" ERISA plans within the meaning of ERISA's preemption clause, 29 U.S.C. 1144(a), because the processing of benefit claims is a core concern of ERISA and Section 4-10 affects how HMOs make benefit determinations on behalf of ERISA plans.

Section 4-10, however, is saved from "relates to" preemption because it is a law that "regulates insurance" under ERISA's insurance saving clause, 29 U.S.C. 1144(b)(2)(A). The law regulates insurance as a matter of "common sense" because it is directed at HMOs, which are generally risk-bearing organizations that combine a traditional insurance function with the provision of medical services. The fact that some HMOs by contract transfer the risk to another entity —whether individual medical providers, a physicians' practice group, or a reinsurance company—does not alter the analysis, because the HMO generally remains ultimately li-

able for the medical care it has promised to provide. In any event, HMOs that retain a claims-processing function when they pass on risk to providers necessarily retain an insurance function, because claims processing is inextricably intertwined with the bearing of risk. For similar reasons, Section 4-10 also satisfies the factors used to determine what constitutes the "business of insurance" under the McCarran-Ferguson Act.

Even if a law comes within the terms of the insurance saving clause, it may nonetheless be preempted if it conflicts with a specific provision of ERISA. See *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 51-56 (1987). Section 4-10's provision for a private dispute resolution mechanism, however, does not conflict with Section 502(a) of ERISA. In contrast to *Pilot Life*, in which the Court addressed a state law creating a cause of action with alternative remedies to those in Section 502(a), Section 4-10 merely requires HMO contracts to include an arbitration-like dispute-resolution mechanism of the sort that private parties routinely include in contracts. Even under Section 4-10—as under labor arbitration provisions generally—a suit pursuant to Section 502(a) remains necessary to enforce a reviewer's decision. Moreover, unlike in *Pilot Life*, neither the external reviewer nor the court can award relief that goes beyond what is provided for in the plan itself. Section 4-10 does not interfere with any right guaranteed under Section 502(a), because the plan participant or beneficiary retains the ability to seek benefits directly in court in an action under Section 502(a).

ARGUMENT

I. SECTION 4-10 OF THE ILLINOIS HMO ACT "RELATES TO" ERISA PLANS FOR PURPOSES OF ERISA'S EXPRESS PREEMPTION PROVISION

A. Section 4-10 "Relates To" ERISA Plans Because It Governs How Plans Make Benefits Determinations

Under Section 514(a) of ERISA, 29 U.S.C. 1144(a), the provisions of ERISA "shall supersede any and all State laws insofar as they * * * relate to any employee benefit plan." Section 514(a) "indicates Congress's intent to establish the regulation of * * * [ERISA] plans 'as exclusively a federal concern.'" *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 651, 656 (1995) (quoting *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)). Section 514(a) was designed "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law," and thus "minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government." *Id.* at 656 (quoting *Ingersoll-Rand* v. *McClendon*, 498 U.S. 133, 142 (1990)); see *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 98-100 & n.20 (1983) (quoting remarks of Congressional sponsors). Accordingly, Section 514(a) is "clearly expansive" in its preemptive sweep. *Egelhoff* v. *Egelhoff*, 121 S. Ct. 1322 (2001).

In general, a state law "relate[s] to" an ERISA plan "if it has a connection with or reference to such a plan." *Egelhoff*, 121 S. Ct. 1322, 1327 (quoting *Shaw*, 463 U.S. at 97). Although "relates to" preemption is not without limits, *Travelers*, 514 U.S. at 655, where a state law purports to regulate matters at the core of ERISA—such as the content or administration of ERISA plans or the mechanisms for enforcing rights under the plans—the requisite connection to ERISA plans is present. See 514 U.S. at 657-658 (discussing

Shaw, *Alessi*, *Ingersoll-Rand*, and *FMC Corp.* v. *Holliday*, 498 U.S. 52, 60 (1990)).

Section 4-10 does not specifically refer to ERISA plans, but it does have the requisite connection to such plans. As the court of appeals held, by requiring an HMO to provide a mechanism for independent review of a benefit determination and to abide by the reviewer's decision, Section 4-10 "has an effect on how benefit determinations are made." Pet. App. 16a. Accord *Corporate Health Ins., Inc.* v. *Texas Dep't of Ins.*, 215 F.3d 526, 537 (5th Cir.), opinion on denial of reh'g, 220 F.3d 641 (5th Cir. 2000), petition for cert. pending, No. 00-665. Thus, Section 4-10 "squarely fall[s] within ERISA's preemption clause." Pet. App. 16a; see *Egelhoff*, 121 S. Ct. at 1325 (by binding "plan administrators to a particular choice of rules for determining beneficiary status," the state probate statute "implicates an area of core ERISA concern"); *Travelers*, 514 U.S. at 658 (ERISA preempts state laws that "mandate[] employee benefit structures or their administration").

B. *Pegram* v. *Herdrich* Is Not To The Contrary

1. This Court's recent decision in *Pegram* v. *Herdrich*, 530 U.S. 211 (2000), does not alter the conclusion that Section 4-10 "relates to" ERISA plans. In *Pegram*, an ERISA plan participant contended that an HMO had violated its fiduciary duties under ERISA by structuring its operations so that its physician-owners received greater profits if they held down the HMO's medical treatment expenses. The plaintiff alleged that the plan's physicians acted in a fiduciary capacity when they made "mixed eligibility and treatment decisions," *id.* at 229—decisions that mix questions concerning "the plan's coverage of a particular condition or medical procedure for its treatment" with "choices about how to go about diagnosing and treating a patient's condition," *id.* at 228. This Court held that "mixed eligibility [and treatment] deci-

sions by HMO physicians are not fiduciary decisions" subject to suit for breach of fiduciary duty under ERISA. *Id.* at 237.

Some statements in *Pegram*, if read in isolation, might suggest that such "mixed decisions"—which appear to be the subject of the disputes addressed by Section 4-10—are never fiduciary acts under ERISA, regardless of whether they are made by the treating physician or by another physician who is ruling on a beneficiary's internal appeal of the denial of her claim. See, *e.g.*, 530 U.S. at 231. If so, there might then be a question whether a state law governing mixed decisions "relates to" ERISA plans at all.[2]

The better reading of *Pegram*, however, is that it addresses only mixed decisions made by *treating* physicians. *Pegram* grew out of such a decision by the plaintiff's treating physician, see 530 U.S. at 215, 217, 231, and there is no indication that the plaintiff then sought review pursuant to the HMO's appeals process. Furthermore, although the Court did not regard the plaintiff's claim of a fiduciary breach as limited to that one incident, see *id.* at 226, the Court did appear to view her claim as involving only an attack on the compensation policies as they affected treating physicians. See, *e.g.*, *id.* at 228 (noting that treatment and eligibility decisions are "practically inextricable from one another * * * not merely because" they are "made by the same person, the *treating physician*," but also "because a great many * * * coverage questions are not simple yes-or-no questions") (emphasis added); *id.* at 232 ("physicians through whom HMOs act make just the sorts of decisions made by licensed medical practitioners millions of times every day").[3]

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[2] Such an argument was presented to the Fifth Circuit on rehearing in *Corporate Health* and rejected by that court. 220 F.3d. at 643-644. It was not briefed or addressed in the Seventh Circuit.

[3] The Secretary of Labor addressed the import of *Pegram* in an amicus brief filed with the Supreme Court of Pennsylvania in *Pappas* v. *Asbell*, 768 A.2d 1089 (2001), petition for cert. pending, No. 01-200, on remand from this Court, see *United States Healthcare Sys. of Pa., Inc.* v.

2. *Pegram* also must be read against the background of provisions of ERISA itself and longstanding Labor Department regulations that provide that plan administrators who make coverage decisions on review of the denials of claims for benefits *are* plan fiduciaries. Section 503(2) of ERISA, 29 U.S.C. 1133(2), provides that "[i]n accordance with regulations of the Secretary, every employee benefit plan shall * * * afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review *by the appropriate named fiduciary* of the decision denying the claim." See also 29 U.S.C. 1102(a) (plan must provide for "one or more named fiduciaries * * * to control and manage the operation and administration of the plan"; "'named fiduciary' means a fiduciary who is named in the plan instrument, or who, pursuant to a procedure specified in the plan, is identified as a fiduciary"). Thus, Section 503 of ERISA itself requires that appeals within a plan—even as to medical necessity issues that are decided by a non-treating physician—must be decided by someone who is subject to fiduciary responsibilities.[4]

Section 503(2) also requires ERISA plans to decide claims "[i]n accordance with regulations of the Secretary." 29 U.S.C. 1133. In regulations promulgated last year, the

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Pennsylvania Hosp. Ins. Co., 530 U.S. 1241 (2000). In *Pappas*, an HMO employee—who was not a treating physician—refused to authorize out-of-network treatment for an HMO subscriber. The Secretary contended that "the logic of *Pegram* applie[d]" to that case. Sec'y of Labor Br. at 11 n.6. However, the Secretary also noted that "[d]ifferent considerations may apply when an HMO * * * uses medical judgment in deciding whether a claim for treatment that has already been provided should be paid." *Id.* at 12 n.7. In any event, for the reasons given in the text, regardless of whether the claim is made before or after treatment, the better view is that an HMO employee deciding a claim is an ERISA fiduciary.

[4] Those responsibilities include that the decisionmaker "discharge his duties * * * in accordance with the documents and instruments of the plan." 29 U.S.C. 1104(a)(1)(D). Thus, the decisionmaker's fiduciary duty is to be faithful to the terms of the plan, not to favor the position of the claimant who took the appeal.

Secretary made clear that claimants must have an opportunity to appeal "an adverse benefit determination *to an appropriate named fiduciary*." 65 Fed. Reg. 70,268 (2000) (to be codified at 29 C.F.R. 2560.503-1(h)(1)) (emphasis added); *id.* at 70,269 (to be codified at 29 C.F.R. 2560.503-1(h)(3)(ii) and (*i*)(1)(ii)). The predecessor regulation, 29 C.F.R. 2560.503-1(g)(1)(2000), promulgated in 1977 (see 42 Fed. Reg. 27,426), likewise provided for review by "an appropriate named fiduciary or to a person designated by such fiduciary." See also Dep't of Labor Advisory Op. 81-50A, 1981 WL 17772, at *2 (June 4, 1981) (citing prior opinions).

More generally, "a person is a fiduciary with respect to a plan to the extent * * * he has any discretionary authority or discretionary responsibility in the administration of such plan." 29 U.S.C. 1002(21)(A)(iii). Mixed decisions involving medical necessity necessarily require the exercise of judgment, and for that reason they are "discretionary" rather than merely "ministerial." Personnel who make such judgments on appeal under an HMO's claims procedures are therefore fiduciaries under ERISA. See *Varity Corp.* v. *Howe*, 516 U.S. 489, 511-512 (1996); *id.* at 530 (Thomas, J., dissenting); *Pilot Life*, 481 U.S. at 53; Dep't of Labor Advisory Op. 92-24A, 1992 WL 337539, at *4 n.4 (Nov. 6, 1992). Accordingly, a state law that regulates such ERISA fiduciary decisions necessarily "relates to" ERISA plans under Section 514(a), even if the subject of the decision is "medical necessity" and the decisionmaker is a physician.

3. Even if *Pegram* were read to state that a medical necessity determination by a plan administrator is not the subject of an ERISA-based fiduciary obligation, *Pegram* still would not lead to the conclusion that Section 4-10 does not relate to ERISA plans. Although Section 4-10 does not directly regulate medical necessity determinations by, for example, specifying what treatments are medically necessary in certain defined circumstances (see Pet. App. 22a n.6),

it does regulate the processes to be used by HMOs (and thus by plans) to adjudicate disputes when medical necessity decisions are at issue. Nothing in *Pegram* suggests that—in the absence of ERISA's insurance saving clause, discussed below—States would have authority to regulate the claims-resolution processes utilized by ERISA plans.

II. SECTION 4-10 "REGULATES INSURANCE" FOR PURPOSES OF ERISA'S INSURANCE SAVING CLAUSE

ERISA's insurance saving 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." That clause is one of a series of provisions of Section 514 that preserve certain other laws—state and federal—even though they "relate to" ERISA plans. By saving state laws that "regulate[] insurance," Section 514(b)(2)(A) "leaves room for complementary or dual federal and state regulation," *John Hancock Mut. Life Ins. Co.* v. *Harris Trust & Sav. Bank*, 510 U.S. 86, 98 (1993), and preserves the States' traditional role in insurance regulation.[5]

To determine whether a state law "regulates insurance" for purposes of the insurance saving clause, a court must first undertake a "common-sense" examination of whether the state law regulates insurance. *UNUM*, 526 U.S. at 367 (citing *Metropolitan Life*, 471 U.S. at 740, and *Pilot Life*, 481 U.S. at 48). To satisfy the "common-sense" test, "a law must

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[5] The insurance saving clause is qualified by the "deemer" clause, 29 U.S.C. 1144(b)(2)(B), which provides that an employee benefit plan shall not be "deemed to be an insurance company or other insurer * * * or to be engaged in the business of insurance * * * for purposes of any law of any State purporting to regulate insurance companies, [or] insurance contracts." The effect is to preclude States from "deem[ing]" self-insured plans to be insurers and thereby subjecting them to state insurance laws. *FMC Corp.* v. *Holliday*, 498 U.S. 57, 61, 62 (1990). We agree with the court of appeals (Pet. App. 18a) that, because the health plan here is insured, the "deemer clause" is inapplicable to this case. See *UNUM*, 526 U.S. at 367 n.2.

not just have an impact on the insurance industry, but must be specifically directed toward that industry." *Pilot Life*, 481 U.S. at 50. The Court then considers the three factors used to determine what constitutes the "business of insurance" under the McCarran-Ferguson Act. *UNUM*, 526 U.S. at 367. Those three factors—(1) whether the law transfers or spreads the policyholder's risk, (2) whether the law is an integral part of the policy relationship between the insurer and the insured, and (3) whether the law is limited to entities within the insurance industry—are helpful "guideposts" to be considered, rather than essential elements, each of which must be satisfied. *Id.* at 374-375.

The court of appeals in this case and the Fifth Circuit in *Corporate Health* agreed that the respective state independent review provisions come within the insurance saving clause. Both courts held that the provisions satisfy the "common sense" test and two of the three McCarran-Ferguson factors. See Pet. App. 18a; *Corporate Health*, 215 F. 3d at 538. Those conclusions are correct.

A. As A Matter Of "Common-Sense," Section 4-10 Regulates Insurance

1. Section 4-10 meets the common sense test of insurance regulation. In general, HMOs combine in various ways an insurance function (taking on the risk of beneficiaries' medical expenses in return for fixed payments) and a medical care function. As the court of appeals explained, that appears to be true under Illinois law, which recognizes HMOs as insurance vehicles. Pet App. 17a (citing *Anderson* v. *Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994)). That view also is supported by this Court's understanding of HMOs as "risk-bearing organizations," akin to traditional insurance companies. *Pegram*, 530 U.S. at 219. Indeed, this Court noted in *Pegram* that the Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914, 42 U.S.C. 300e *et seq.*, "allowed the formation of HMOs that assume financial risks for the provision of health care services." 530 U.S.

at 233; see 42 U.S.C. 300e(c)(2) (qualified HMO must assume "full financial risk").[6] Because it appears that Section 4-10 is aimed exclusively at HMOs in their role of furnishing insurance, it regulates insurance from a "common-sense" perspective.

2. Petitioner argues that Section 4-10 does not regulate insurance because it is directed both to HMOs that concededly bear risk as insurers and to HMOs that petitioner asserts "act in a purely administrative role and devolve all risk onto their providers or onto a third-party insurer."

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[6] Petitioner's amici, American Association of Health Plans, *et al.*, assert (Br., 24 n.11) that Congress's enactment in 1973 of federal requirements for the administration of qualified HMOs is inconsistent with the proposition that Congress intended when it enacted ERISA in 1974 to allow the States to regulate HMOs that serve ERISA plan beneficiaries. Congress's concern in 1973 was that some restrictive state laws had prevented the development of HMOs. Congress therefore included in the 1973 Act a provision that exempts HMOs from state-law insurance requirements "respecting initial capitalization and establishment of financial reserves against insolvency," where such requirements would prevent HMOs from operating in accordance with the federal Act. See §§ 2, 87 Stat. 931 (§ 1311(a)(1)(D), 42 U.S.C. 30e-10(a)(1)(D)); S. Rep. No. 129, 93d Cong., 1st Sess. 26-27 (1973). The obvious premise of that partial preemption of state insurance laws was that many States *did* regard HMOs as insurers. Significantly, moreover, Congress preempted only certain provisions of state insurance law. This feature of the 1973 HMO Act underscores that when Congress enacted ERISA one year later, it anticipated that there were aspects of state insurance regulation that affected HMOs and would fall within the States's reserved power to "regulate[] insurance."

Petitioner's amici likewise err in relying (Br. 24) on the discussion in *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 226 (1979), of the treatment of prepaid health plans by the States at the time the McCarran-Ferguson Act was passed. State practices in 1945 do not control the interpretation of ERISA's insurance saving clause, which was enacted almost 30 years later, especially in light of the fact that the ERISA saving clause is broader than the McCarran-Ferguson Act's narrow exemption from the antitrust laws, at issue in *Royal Drug*. See note 8, *infra*. Moreover, the Court stated in *Royal Drug* that the contract between a prepaid plan and its members may be the "business of insurance" under the McCarran-Ferguson Act, even though the provider agreements challenged in that case were not. See *id.* at 227 n.34, 230 nn. 37-38.

Br. 38 (internal quotation marks and citation omitted). This effort to remove Section 4-10 from the scope of the insurance saving clause is unavailing.[7]

HMOs may split up their functions in various ways. For example, as petitioner notes (Br. 37-38), an HMO may contract to transfer its medical care function to providers who are not themselves employees of the HMO. Although the HMO assumes by contract the financial risk of members' medical expenses, it may also re-transfer (in petitioner's term "devolve," Br. 38) that risk to the medical providers by

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[7] The Illinois HMO Act defines an HMO as an "organization formed * * * 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. Ann. 125/1-2 (West 1993 & Supp. 2001) (emphasis added). The Act defines "[h]ealth care plan" to mean "any arrangement whereby any organization undertakes to *provide or arrange for and pay for or reimburse the cost of basic health care services* from providers selected by [a] Health Maintenance Organization and such arrangement consists of arranging for or the provision of such health care services, as distinguished from mere indemnification against the cost of such services." *Ibid.* (emphasis added). Those definitions make clear that the law applies only to HMOs that either bear the "risk of health care delivery" themselves or have undertaken that risk and then transferred it through contractual arrangements with their providers.

For this reason, petitioner's amici err in arguing (Br. 21) that Section 4-10 "applies to HMOs that perform purely *administrative* services for self-funded [*i.e.*, self-insured] plans" and that this supposed feature "destroys any attempt by the State to rely on" ERISA's insurance saving clause. Even if Section 4-10 were construed to apply to such HMOs, however, that would have no effect on the application of Section 4-10 to HMOs that insure *non*-self-insured ERISA plans. A state insurance law that includes self-insured plans among the insurers within its reach is still a law that regulates "insurance" within the meaning of the insurance saving clause, even though the deemer clause, 29 U.S.C. 1144(a)(2)(B), would preempt the *application* of that state insurance law to the self-insured plans. See *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 735-736 n.14, 740-747 (1985); *FMC*, 498 U.S. at 61 ("We read the deemer clause to exempt self-funded ERISA plans from state laws that 'regulat[e] insurance' within the meaning of the saving clause."); cf. *General Elec. Co.* v. *Gilbert*, 429 U.S. 125, 138 n.16 (1976). ("That General Electric self-insures does not change the fact that it is, in effect, acting as an insurer.").

paying them a fixed, per-patient ("capitation") fee. In doing so, the HMO may retain administrative functions (such as rendering decisions on claims) associated with the risk-bearing function. Regardless of how the HMO divides up the risk-bearing function and its associated administrative responsibilities (such as claims processing), however, Section 4-10 is still directed toward insurance, for two reasons.

First, the HMO's transfer of its risk by contract to another entity or entities (such as individual medical providers, a physicians' practice group, or a reinsurance company) does not alter its own continuing responsibility to its members for the costs of their medical care. As the law-review articles cited by petitioner (Br. 37, 38 n.13) recognize, even an HMO that has a "capitation" arrangement with medical providers nonetheless typically retains some risk, including the risk that the providers will become financially unable to provide services, since "[t]he HMO is legally committed to furnish care to its enrollees." J. P. Weiner & G. de Lissovoy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. Health Pol., Pol'y, & L. 75, 96 (1993); see also E.H. Morreim, *Confusion in the Courts: Managed Care Financial Structures and their Impact on Medical Care*, 35 Tort & Ins. L.J. 699, 705-706 (2000) ("if the physicians use up all of their [capitation] funds too quickly, the [HMO] is still obligated to provide care and could potentially be required to infuse money beyond the contracted capitation amount").

Second, even HMOs that pass on risk to network providers necessarily retain an insurance function, because they retain a claims-processing function and claims processing is inextricably intertwined with insurance and the bearing of risk. Claims processing is the means by which an insurer pays for a risk it has undertaken, and the regulation of claims processing therefore is a central feature of state insurance law. See, *e.g.*, *Metropolitan Life*, 471 U.S. at 728 n.2 ("Laws regulating aspects of transacting the business of

group insurance include, for example, those regulating *claims practices* or rates.") (emphasis added); *UNUM*, 526 U.S. at 375 n.5 (same). That is true regardless of whether the entity that does the claims processing also bears the risk or is an independent entity that has contracted with risk-bearing entities (such as insurance companies or providers operating under a capitation agreement) to perform this insurance function. Cf. *Barnett Bank* v. *Nelson*, 517 U.S. 25, 39 (1996) (regulation of agents of insurance companies relates to the "business of insurance"). An insurer that reinsures 100% of its risks, but continues to process claims, is still an insurer. Such an insurer may not simply contract itself out of state insurance law that is saved under ERISA by offloading the primary risk-bearing function to an independent entity.

B. Section 4-10 Satisfies At Least Two Of The McCarran-Ferguson Factors

1. The McCarran-Ferguson factors reinforce the commonsense conclusion that Section 4-10 is a law regulating insurance. Regardless of whether the risk-spreading factor is satisfied—an issue left open by the court of appeals, Pet. App. 18a n.3—that court correctly concluded that Section 4-10 satisfies the other two factors. *Id.* at 18a.[8]

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[8] The Court in *UNUM* noted, but found it unnecessary to pursue, the argument of the United States that "[i]nsofar as the notice-prejudice rule shifts the risk of late notice and stale evidence from the insured to the insurance company in some instances, it has the effect of raising premiums and spreading risk among policyholders." 526 U.S. at 374. Similarly here, Section 4-10 can be viewed as spreading the risk of loss resulting from the erroneous denial of claims by an HMO.

Petitioner (Br. 40) and its amici (Br. 29) rely on the statement in *Pireno* that the transfer of risk occurs "at the time the [insurance] contract is entered." See 458 U.S. at 130-131. But as the Court later pointed out in *Department of Treasury* v. *Fabe*, 508 U.S. 491, 503-504 (1993), where it upheld a state statute giving priority to policyholders in the event of insolvency, that statement in *Pireno* "presumes that the insurance contract in fact will be enforced," for "[w]ithout performance of the terms of the insurance policy, there is no risk transfer at all." Like the priority statute

Because Section 4-10 creates a procedural right enforceable by the insured against the HMO as insurer, it is integral to the relationship between the insured and the insurer. See Pet. App. 17a-18a. Petitioner relies (Br. 41) on the Court's conclusion in *Pireno* that an insurer's use of a peer review committee was not an "integral part of the policy relationship between insurer and insured." See 458 U.S. at 131. In *Pireno*, however, the insurer's arrangement with the peer review committee was separate from its contract with its insured, *id.* at 131-132; the committee's opinions were not binding on the insurer; and the committee therefore was not part of "the claims adjustment process itself," but was instead merely "ancillary" to it, *id.* at 134 n.8. See *Fabe*, 508 U.S. at 503. Here, by contrast, Section 4-10 "dictates the terms of the relationship between the insurer and the insured," *UNUM*, 526 U.S. at 374, because the independent review process it mandates is triggered by the insured, the independent reviewer's decision is binding on the HMO, and the independent review therefore is an integral part of the claims-adjustment process. See also note 8, *supra*. Furthermore, because the Illinois law is aimed exclusively at HMOs in the furnishing of insurance (see pp. 12-16, *supra*), it also satisfies the third McCarran-Ferguson factor. Pet. App. 18a.

2. If Section 4-10 is not saved as a regulation of insurance, then it would appear that state laws mandating that

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in *Fabe*, Section 4-10 is concerned with the performance of undertakings in the insurance contract. Moreover, *Pireno* (like *Royal Drug*, also cited by petitioner (Br. 40)), involved the *second* clause of Section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. 1012(b), which was designed to carve out only a narrow exemption from the federal antitrust laws, while the *first* clause, at issue in *Fabe*, preserves to the States broad regulatory authority over the business of insurance generally. See 508 U.S. at 504-505. ERISA's insurance saving clause parallels the *first* clause of Section 2(b) of the McCarran-Ferguson Act in its broader purpose of preserving general authority over insurance to the States. See *Metropolitan Life*, 471 U.S. at 740-741, 744 n.21; U.S. Amicus Br. Pet. Stage (at 15-16), *Kentucky Ass'n of Health Plans, Inc.* v. *Miller*, No. 00-1471.

HMOs provide certain medical benefits would likewise not be saved. This Court made clear in *Metropolitan Life*, however, that state laws mandating that *non*-HMO health insurers provide certain benefits are saved by ERISA's insurance saving clause and may be applied to health insurance policies purchased by ERISA plans. Under petitioner's argument, therefore, while state laws requiring other health insurers to provide certain benefits are valid under ERISA, state laws requiring HMOs to provide the same benefits are preempted. Petitioner does not attempt to explain why Congress would have intended that ERISA plans obtain that extra exemption from state insurance law merely by purchasing HMO coverage rather than traditional health insurance.

III. SECTION 4-10 DOES NOT CONFLICT WITH SECTION 502(a) OF ERISA, WHICH PROVIDES THE EXCLUSIVE CIVIL ACTION UNDER ERISA

A. Under *Pilot Life*, A State Insurance Law That Conflicts With A Provision Of ERISA Is Preempted

Even if a state law "regulates insurance" and is therefore saved from "relates to" preemption, it may still be preempted if it "conflict[s] with a substantive provision of ERISA." *Pilot Life*, 481 U.S. at 57. More generally, "this Court has repeatedly declined to give broad effect to saving clauses where doing so would upset the careful regulatory scheme established by federal law." *Geier* v. *American Honda Motor Co.*, 529 U.S. 861, 870 (2000) (internal quotation marks omitted); see also *id.* at 869 (concluding that the saving clause at issue there "does *not* bar the ordinary working of conflict pre-emption principles"). Thus, although Section 4-10 is a law regulating insurance, there remains the inquiry whether it is nonetheless preempted because it conflicts with a provision of ERISA.[9]

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[9] We note, in this regard, that both the House and Senate have passed legislation this year that would amend ERISA to require plans to adopt external review procedures for denials of claims for benefits. See, *e.g.*,

In Section 502(a) of ERISA, 29 U.S.C. 1132(a), Congress included "a 'carefully integrated' civil enforcement scheme that 'is one of the most 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)). That "comprehensive" scheme "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." *Pilot Life*, 481 U.S. at 54; see also *Mertens* v. *Hewitt Assocs.*, 508 U.S. 248, 252 (1993). Section 502(a)(1)(B)—the specific provision pertinent here—confers upon a participant or beneficiary a federal cause of action "to recover benefits due to him under the terms of the 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)(1)(B).

In *Pilot Life*, this Court concluded that "ERISA's civil enforcement [remedies were intended to] be exclusive." 481 U.S. at 57. In particular, *Pilot Life* held that a state common law tort and contract action asserting improper processing of a claim for benefits conflicted with Section 502(a)(1)(B)'s provision for a federal cause of action by a participant or beneficiary to recover on a claim for benefits due under the plan or to enforce his rights under the plan, and with Section 502(a)(2)'s provision for a suit by a participant or beneficiary for breach of fiduciary duty. 481 U.S. at 53-57.

In *Metropolitan Life*, by contrast, this Court held that a state mandated-benefit law is within the scope of the insur-

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H.R. 2563, 107th Cong., 1st Sess., § 104(a); S. 1052, 107th Cong., 1st Sess., § 104(a) (2001). Both bills would set out in federal law new detailed and comprehensive procedures for external review, including timelines for review, qualifications of external reviewers, and limitations on the availability of remedies. Should Congress adopt external review procedures under ERISA, those provisions might well preempt any state external review procedures.

ance saving clause and therefore may be applied to insurance policies issued to ERISA plans. See 471 U.S. at 739-747. The Court reasoned that such a law "regulates the terms of certain insurance contracts," and thus is saved under a clause that preserves state laws "which regulate[] insurance." *Id.* at 740. That conclusion was reinforced by the deemer clause, which provides that an employee benefit plan shall not be deemed to be an insurance company "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)(B) (emphasis added). The Court reasoned that the deemer clause "makes explicit Congress's intention to include laws that regulate insurance contracts within the scope of the insurance laws preserved by the saving clause," for otherwise it would have been unnecessary for the deemer clause explicitly to exempt such laws from the saving clause when they are applied directly to benefit plans. 471 U.S. at 741; see also *FMC*, 498 U.S. at 62-63, 64.

The state mandated-benefit laws saved under *Metropolitan Life* do not conflict with Section 502(a) of ERISA because the mandated benefit is incorporated into the insurance policy purchased by the ERISA plan (and therefore into the plan itself). The mandated-benefit requirement can then be enforced in a suit by a participant or beneficiary under Section 502(a)(1)(B) "to recover benefits due under the terms of his plan" or "to enforce his rights under the terms of the plan." See *UNUM*, 526 U.S. at 377. The same analysis cannot be applied to a state law creating a cause of action for compensatory and punitive damages, as in *Pilot Life*, because private parties could not meaningfully contract for such a cause of action, and the state law creating such a cause of action therefore would not merely "regulate[] the substantive terms of the insurance contract." *Metropolitan Life*, 471 U.S. at 741. As we explain more fully below,

Section 4-10 does not conflict with Section 502(a) under these principles.

B. Section 4-10's Provision For Private Dispute Resolution Does Not Conflict With Section 502(a)

As petitioner repeatedly emphasizes, Section 4-10 "consists of a form of compulsory binding arbitration rather than a judicial cause of action." Br. 31 n.10; see also *id.* at 17, 22, 24, 27. Private parties routinely contract to arbitrate disputes. Section 4-10 merely makes an arbitration-like clause a mandatory provision of contracts between HMOs in Illinois and those who purchase their services, including ERISA plans. Both the duty to arbitrate under that provision and any award of benefits in favor of a participant or beneficiary may be enforced in a suit against the plan under Section 502(a)(1)(B) of ERISA. Furthermore, neither the external reviewer nor the court in a suit under Section 502(a)(1)(B) to enforce the reviewer's decision may award relief that goes beyond what is provided for in the plan itself—an award of benefits, in kind or in cash, for medically necessary services. Because the arbitration-like mechanism that Section 4-10 requires to be included in HMO insurance policies does not authorize a civil action in court or any relief beyond that provided in the plan itself, it does not conflict with Section 502(a).

1. a. The text of Section 502 gives no indication that it was intended to prevent the operation of private, non-judicial modes of dispute resolution, such as that provided for under Section 4-10. Section 502 is entitled "Civil enforcement." Submission of a dispute to an independent reviewer under Section 4-10 constitutes *compliance* with an ERISA plan; it is not "enforcement" of the plan in the sense that Section 502 uses that term, because a private arbitrator does not have the coercive powers of a court. The reviewer's decision can be enforced only in a subsequent judicial action, such as the present action under Section 502(a). *United*

Paperworkers Int'l Union v. *Misco, Inc.*, 484 U.S. 29, 37 (1987); see also *Iron Workers Local 272* v. *Bowen*, 624 F.2d 1255, 1259 (5th Cir. 1980) (court in Section 502(a) suit may order trustees to comply with arbitrator's award). Moreover, subsection (a) of Section 502, which is entitled "Persons entitled to bring a civil action," is itself concerned *solely* with creating causes of action in court; it provides that "[a] civil action may be brought" by certain parties in specified circumstances for specified relief. 29 U.S.C. 1132(a) (1994 & Supp. V 1999). Its text does not address private dispute-resolution mechanisms.

b. Section 4-10 does not interfere with any rights granted by Section 502(a). The relevant provision is Section 502(a)(1)(B), which grants a right to "a participant or beneficiary" to bring a cause of action "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). Section 4-10 does not interfere with that right in any aspect. Nothing in Section 4-10 purports to force a plan participant or beneficiary to invoke the external review mechanism that Section 4-10 obligates the HMO to make available. Instead, a plan participant or beneficiary retains the right to bring an action directly in court under Section 502(a)(1)(B) to challenge the denial of a requested service. Indeed, the preamble to the claims-processing regulations recently promulgated by the Secretary of Labor notes that, "while [external review] procedures as established by State law are not preempted by the regulation, * * * claimants cannot be required to submit their claims to such procedures in order to be entitled to file suit under section 502(a) of the Act." 65 Fed. Reg. 70,254 (2000); accord *id.* at 70,254 n.33.[10] Further-

[10] See also 65 Fed. Reg. at 70,254, 70,270-70,271 (to be codified at 29 C.F.R. 2560.503-1(k)) (explaining that claims regulation does not preempt state law regulating insurance unless it prevents application of a requirement of the regulation, and that state external-review laws "are beyond the scope of the regulation").

more, if the participant or beneficiary chooses to invoke the procedure that Section 4-10 affords, he retains the right to bring an action under Section 502(a)(1)(B) of ERISA—either to recover the benefits due if the independent reviewer rules in his favor, or to challenge the decision if it is adverse. Thus, Section 4-10 does not purport to—and may not be applied to—interfere with a participant's or beneficiary's rights under Section 502(a)(1)(B).

Neither Section 4-10 nor the Secretary's claims-processing regulations confer a similar right on an HMO or an ERISA plan insured by an HMO to bypass the independent review procedure. But that omission does not conflict with Section 502(a)(1)(B). That Section does not even mention, much less confer a right of immediate access to court on, an HMO or ERISA plan. See *Harris Trust & Sav. Bank* v. *Salomon Smith Barney*, 530 U.S. 238, 246 (2000).

c. A private, non-judicial arbitration-like mechanism to settle disputes is fully consistent with the exclusivity of the federal cause of action under Section 502(a)(1)(B). In *Pilot Life*, this Court noted that "the pre-emptive force of § 502(a) was modeled on the exclusive remedy provided by § 301 of the Labor-Management Relations Act, 1947." See 481 U.S. at 52. Binding arbitration is fully consistent with Section 301's provision of an exclusive cause of action to enforce a collective bargaining agreement. Indeed, arbitration is strongly encouraged by federal labor law. See, *e.g.*, *Teamsters* v. *Lucas Flour Co.*, 369 U.S. 95 (1962); *Textile Workers* v. *Lincoln Mills*, 353 U.S. 448, 455-456 (1957). The same conclusion follows with respect to Section 502(a) of ERISA.[11]

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[11] In *Pilot Life*, the Court explained that "[t]he expectations that a federal common law of rights and obligations under ERISA-regulated plans would develop, indeed, the entire comparison of ERISA's § 502(a) to § 301 of the LMRA, 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." 481 U.S. at 56. As noted in text, Congress's plan, embodied in Section 301, for a "federal common law

The logic of petitioner's contrary argument is that Congress intended that Section 502(a)(1)(B) provide not only the exclusive judicial remedy, but also the exclusive binding mechanism of any sort for resolving disputes over medical necessity or other questions arising under an ERISA plan. If so, petitioner's position is necessarily in deep tension with permitting binding voluntary agreements to arbitrate benefit disputes. Yet, since 1978, Department of Labor regulations have recognized that arbitration of disputes regarding plan benefits is permissible under ERISA. See generally *Circuit City Stores, Inc.* v. *Adams*, 532 U.S. 105, 116 (2001) (discussing benefits of arbitration); *Chappel* v. *Laboratory Corp. of America*, 232 F.3d 713, 724 (9th Cir. 2000). Those regulations provide that when a collective bargaining agreement contains procedures (including arbitration) for the resolution of disputes, those procedures will generally be deemed to satisfy the requirements of ERISA that a plan's dispute-resolution procedures must be fair and reasonable. 29 C.F.R. 2560.503-1(b)(2)(i) (1978, 2000). That provision has been carried forward in the Secretary's new claims-processing regulations. See 65 Fed. Reg. at 70,266 (to be codified at 29 C.F.R. 2560-503-1(b)(6)); see also *id.* at 70,267 (to be codified at 29 C.F.R. 2560.503-1(c)(4)(ii)).[12]

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of rights and obligations under" labor contracts is entirely consistent with permitting binding private arbitration of disputes under those contracts. It follows that, contrary to petitioner's suggestion (Br. 25 n.6), Congress's intention that courts develop a federal common law of rights and obligations under ERISA plans is consistent with permitting arbitral mechanisms, like that provided by Section 4-10, for resolving disputes under ERISA plans. Moreover, as is true under Section 301 of the LMRA, the basic ERISA plan contract remains governed by federal law, although by virtue of the insurance saving clause, some provisions of that contract may be mandated by state law. Compare *Lincoln Mills*, 353 U.S. at 457 (discussing absorption of state law into federal law under Section 301).

[12] Petitioner argues (Br. 22 n.5) that Section 4-10 "conflicts with ERISA's fiduciary requirements" because Section 503 of ERISA requires plans to provide for review of denied claims by a fiduciary. See pp. 9-10, *supra*. Section 503, however, governs internal plan appeals, not external

d. The fact that the arbitration-like procedure here is mandated by the State as a term of the underlying contract of insurance does not create a conflict with Section 502(a) of ERISA. Section 502(a), like Section 301 of the LMRDA, does not regulate the terms of the underlying contract. Each takes the contract as it finds it.

Many saved state insurance laws, such as the mandated-benefits law in *Metropolitan Life*, will in effect add terms to ERISA plans. So long as the state insurance law does not

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review; in this case, respondent has already invoked her right of internal appeal to a named fiduciary. Section 4-10 applies only "in the event of a dispute between the primary care physician and the [HMO] regarding the medical necessity of a covered service"—*i.e.*, only *after* the HMO, acting as plan administrator through a plan fiduciary, has made its final decision. See also 65 Fed. Reg. at 70,270-70,271 (claims-processing regulations do not preempt state law "merely because such State law establishes a review procedure * * * involving adverse benefit determinations under group health plans so long as the review procedure is conducted by a person other than * * * *plan fiduciaries*") (emphasis added) (to be codified at 29 C.F.R. 2560-503.1(k)(2)(i)).

Petitioner's amici suggest (Br. 27 n.13) that the Federal Arbitration Act (FAA), 9 U.S.C. 1 *et seq.*, would preserve a plan's or HMO's ability to provide for arbitration, if it voluntarily chooses to do so, even if the external review procedure under Section 4-10 is preempted because the arbitrator is not a plan fiduciary. But if Section 503 precludes binding arbitration by a non-fiduciary, then there is a substantial question whether the FAA could render such arbitration lawful under ERISA. The FAA could apply to ERISA plans only by virtue of a saving provision for other federal laws that is quite similar to the saving provision for state laws regulating insurance. See 29 U.S.C. 1144(d) ("Nothing in this subchapter shall be construed to * * * modify, invalidate, impair, or supersede any law of the United States."). Thus, if the insurance saving clause does not save a state insurance law providing for arbitration of insurance disputes, it is unclear how Section 1144(d) would save a federal statute authorizing arbitration of such disputes. But even if the FAA would apply by virtue of Section 1144(d) and protect voluntary agreements to arbitrate in the manner amici assert, the McCarran-Ferguson Act also is made applicable under ERISA by Section 1144(d), and that Act independently preserves a state insurance law (like Section 4-10) that requires arbitration clauses in insurance contracts. Cf. *Metropolitan Life*, 471 U.S. at 744-745 n.21. Application of the McCarran-Ferguson Act of course "lends further support to" the validity of Section 4-10. *Ibid.*

attempt to add a contract term that conflicts with a provision of ERISA itself, the fact that the state law imposes the term on an unwilling insurer does not render it unenforceable in an action by a participant or beneficiary under Section 502(a)(1)(B). Moreover, the procedure that is incorporated into insurance contracts pursuant to Section 4-10 is well within the range of standard arbitration-like mechanisms that are accepted contractual arrangements for private resolution of disputes in a wide range of settings—including especially in the collective bargaining setting in which many ERISA plans are created.

e. Petitioner notes (Br. 21-22) that in the absence of Section 4-10, the court in a suit under Section 502(a)(1)(B) would review the *plan's* decision only for abuse of discretion, because the plan in this case vests discretion in its fiduciaries to construe and apply the plan. See *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 114 (1989). By contrast, petitioner continues, the court in a Section 502(a)(1)(B) action brought after Section 4-10 has been invoked would review the *external reviewer's* decision under the deferential standard used for review of an arbitrator's decision. That fact does not create a conflict with Section 502(a)(1)(B).

Section 502(a)(1)(B), like Section 301 of the LMRA (29 U.S.C. 185), does not itself mandate any particular standard of review. Accordingly, in *Firestone*, the Court held that it was appropriate to look to background principles of trust law *and the terms of the plan* to determine the standard of review in a Section 502(a)(1)(B) action. Here, the terms of the plan, as required by state law, provide for arbitration-like external review that is binding on the plan. In a Section 301 action following arbitration of a dispute in which the contract provides that "the arbitrator's decision is final and binding upon the parties," *Misco*, 484 U.S. at 32, this Court has held that a deferential standard should be applied in reviewing the arbitrator's decision. *Id.* at 37-38. In a Section 502(a)(1)(B) action following review of an HMO's decision

under Section 4-10, the court can draw on those same background principles, consistently with Section 502(a), and apply a deferential standard to the independent reviewer's decision.[13] Thus, under Section 502(a)(1)(B), as under Section 301, the standard of review is dictated not by the statutory authorization to file a civil action, but by the nature of the suit and the terms of the underlying contract. Compare, *e.g.*, *Misco* (deferential review of arbitrator's decision) with *Bowen* v. *United States Postal Service*, 459 U.S. 212 (1983) (trial de novo in employee's suit where union declined to file grievance).

f. Finally, Section 4-10 is fully consistent with this Court's decision in *Pilot Life*. In that case, the Court reasoned that Section 502(a) provides the exclusive avenue for *judicial* relief for ERISA participants and beneficiaries whose claims for benefits are denied—not that Section 502(a) provides the sole permissible mechanism for resolving benefit disputes. After noting that causes of action outside Section 502(a) would lead to the award of judicial remedies, such as compensatory and punitive damages, that Congress had rejected, 481 U.S. at 53-54, the Court concluded that "[t]he 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 54. That reasoning clearly prevents a State from adopting causes of action under state law to enforce the terms of an ERISA plan (including any incorporated provisions of state law) as an alternative to the cause of action under federal law in Section 502(a)(1)(B). For the same reasons, a State could not

[13] Of course, Section 4-10 does not specify a standard of review. Accordingly, if application of the deferential standard employed in Section 301 cases somehow conflicts with Section 502(a), the answer would be to adopt a standard of review consistent with Section 502(a), not to declare Section 4-10 preempted.

under any circumstances make a plan or its insurer liable to the participant or beneficiary for punitive damages. Such a requirement would be far removed from what private parties might ordinarily contract for and would directly upset the policy choices reflected in Congress' inclusion of certain remedies and the exclusion of others.

The same concerns are not implicated by a state law giving plan participants a right to arbitrate their claims, as long as federal law and the terms of the plan (including any validly incorporated provisions of state law) govern in the arbitration and the arbitrator's award is enforceable only in an action under Section 502(a)(1)(B). Because Section 4-10 provides no relief beyond that provided for in the plan itself and the enforcement mechanism for obtaining benefits under the plan remains a Section 502(a)(1)(B) action, it does not pose the challenge to Congress's policy choices that the Court addressed in *Pilot Life*.

Furthermore, the Court reasoned in *Pilot Life* that Congress was "well aware" when it patterned Section 502(a)(1)(B) of ERISA after Section 301 of the LMRA that Section 301 displaced all state actions for violations of contracts between an employer and a labor organization. See 481 U.S. at 55. Congress presumably was equally well aware that Section 301 does *not* bar arbitration clauses in such contracts. Indeed, the two cases on which the Court relied in *Pilot Life* in describing how Section 301 of the LMRA should inform the interpretation of Section 502(a) of ERISA—*Lueck* and *Lucas Flour*—both involved disputes related to arbitration clauses.[14]

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[14] In its amicus brief in *UNUM*, the United States suggested (at 19-25) that there may be reasons for the Court to reconsider the portion of *Pilot Life* discussing Section 502 to the extent it is read to mean that a cause of action provided by a state law regulating insurance would in all circumstances be preempted by Section 502. See *UNUM*, 526 U.S. at 377 n.7 (stating that the Court "need not address" that argument); see also *Franchise Tax Bd.* v. *Construction Laborers Vacation Trust*, 463 U.S. 1,

2. Petitioner argues (Br. 19) that permitting the States to enforce insurance laws like Section 4-10 "would nullify Congress' intent to establish a uniform scheme for enforcing rights under ERISA plans." See also Br. 26-30. That effect is simply a product of ERISA's insurance saving clause, which contemplates some disuniformity as "the inevitable result of the congressional decision to 'save' local insurance regulation." *UNUM*, 526 U.S. at 376 n.6. It is therefore well-settled that specific terms of plans may be affected indirectly by state insurance regulations. See, *e.g.*, *Metropolitan Life*, 471 U.S. at 747. As noted, the relevant distinction is not between substantive terms (such as mandated benefits) and procedural terms, but between state laws that require contractual provisions (including procedural provisions) and state laws that create duplicative causes of action or distinct remedies, such as punitive damages.[15] In *UNUM*, for

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25 (1983). That portion of the United States' amicus brief in *UNUM*, however, reflected a particular concern with the possible availability of a cause of action for state-created remedies or sanctions to enforce substantive state insurance law where the causes of action provided under Section 502(a) itself were not suited to that purpose. See U.S. *UNUM* Br. 22-23 & n.12, 24 n.13, 25 & n.14; see *e.g.*, *Metropolitan Life*, 471 U.S. at 734 (suit by state attorney general to enforce mandated-benefits law); *Franchise Tax Bd.*, 463 U.S. at 24-26 (action by state tax agency to levy against plan trust). The *UNUM* brief also recognized (at 24 n.13) that "notwithstanding the savings clause, an insurance law that conflicts with a provision of ERISA itself is preempted by virtue of the Supremacy Clause."

This case involves not a state-created cause of action in court, as in *Pilot Life*, but a mandatory contractual provision for private dispute resolution that, like the state-law provision at issue in *UNUM*, can readily be enforced in a suit under Section 502(a)(1)(B) of ERISA itself. Therefore, as in *UNUM*, there is no occasion for the Court to address state causes of action in situations in which such a suit cannot be brought under Section 502(a).

[15] Petitioner argues (Br. 29), for example, that if Section 4-10 is not preempted, "administrators of nationwide ERISA plans could no longer develop a uniform medical necessity standard." Of course, state mandated-benefits laws, which petitioner concedes (Br. 30, 32) are valid, could define "medical necessity" in a variety of ways, and insured plans would have to follow those definitions, no matter how much variation was intro-

example, this Court held that a state law governing the effects of a late notice of claim by the insured—a paradigmatically procedural provision—is saved by the insurance saving clause and therefore not preempted. Indeed, mandated-benefits laws create very substantial disuniformity at the heart of the ERISA scheme by varying the benefits due under a plan in different States, and they impose a serious administrative burden by requiring insurers administering ERISA plans to consider state law before accepting or rejecting each claim. By contrast, external review provisions like Section 4-10 affect only the relatively small number of benefit disputes that cannot be resolved internally. Litigation of such disputes under Section 502(a)(1)(B) necessarily proceeds—even under petitioner's account—on a case-by-case basis in any event.

CONCLUSION

The judgment of the Seventh Circuit should be affirmed.

Respectfully submitted.

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duced. Indeed, such mandated-benefits laws would likely introduce more disuniformity than case-by-case determination by external reviewers of "medical necessity" in a variety of individual cases.

[*] The Solicitor General is recused in this case.

APPENDIX

215 Ill. Comp. Stat. Ann. 125/4-10 (West 1993 & Supp. 2001) provides in pertinent part:

> 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 the reviewing physician determines the covered service to be medically necessary, the Health Maintenance Organization shall provide the covered service.