Granted

No. 98-1949

IN THE
SUPREME COURT OF THE UNITED STATES

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION, AND HEALTH ALLIANCE MEDICAL PLANS, INC.,
Petitioners,

v.

CYNTHIA HERDRICH,
Respondent.

On Writ of Certiorari To The
United States Court of Appeals
For the Seventh Circuit

BRIEF *AMICI CURIAE* OF AARP, NATIONAL EMPLOYMENT LAWYERS ASSOCIATION AND NATIONAL SENIOR CITIZENS LAW CENTER IN SUPPORT OF NEITHER PARTY

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QUESTIONS PRESENTED [1]

1. Is federal court jurisdiction lacking because Ms. Herdrich's original state law claims could not be brought under § 502(a) of ERISA's civil enforcement provisions inasmuch as Petitioners were not acting in any ERISA capacity?

2. If this Court has jurisdiction and finds that Ms. Herdrich's allegations present cognizable claims under ERISA's fiduciary rules, are ERISA fiduciaries liable to employee benefit plans, under ERISA § 502(a)(2), for restitution of bonuses and profits gained by committing fiduciary breaches?

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[1] Although *amici* will not focus on the ostensibly narrow question presented in the Petition for Writ of Certiorari, the issues of jurisdiction, preemption and remedies are subsumed within the original question presented. In addition, they were raised, briefed, and decided below, and we believe that the district court rulings on these issues were erroneous. *See* Supreme Court Rule 14.1(a) ("[t]he statement of any question presented is deemed to comprise every subsidiary question fairly included within"); Supreme Court Rule 24.1(a) (in its discretion, the Court "may consider a plain error not among the questions presented but evident from the record and otherwise within its jurisdiction to decide").

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INTEREST OF *AMICI CURIAE* [2]

Three national organizations join in this brief which focuses on two issues -- first, whether the federal court lacked jurisdiction over Ms. Herdrich's original state law claims because those claims cannot be brought pursuant to the Employees Retirement Income Security Act's (ERISA) civil enforcement provisions, and second, if there is federal court jurisdiction, whether ERISA fiduciaries are liable to employee benefit plans for restitution of bonuses and profits gained by

[2] No counsel for any party authored any portion of this brief. No persons other than the *amici curiae*, their members, or their counsel made a monetary contribution to the preparation and submission of this brief.

committing fiduciary breaches. As the following descriptions of these organizations demonstrate, they have a significant interest in the outcome of this case.

AARP is a nonprofit membership organization of more than 33 million Americans age 50 or older, dedicated to addressing the needs and interests of older people. Approximately one-third of AARP's members are working and rely on employer-funded health benefits for their health coverage. Through education, advocacy, and service, and by promoting independence, dignity, and purpose, AARP seeks to enhance the quality of life for all citizens. In its efforts to promote independence, AARP works to foster the health and economic security of individuals as they age by attempting to ensure the availability of quality and economical health coverage. As the country's largest membership organization, AARP has a long history of advocating for access to affordable health care and for controlling its costs without compromising quality.

The National Senior Citizens Law Center (NSCLC) is a nonprofit organization that advocates on behalf of elderly poor people. Since its formation in 1972, NSCLC has engaged in judicial, legislative and administrative advocacy, technical assistance, and training in many areas of elder law, including health care. NSCLC has brought numerous law suits on behalf of ERISA-covered beneficiaries to protect their rights under that federal statute and its implementing regulations.

The National Employment Lawyers Association (NELA) is a voluntary organization, founded in 1985, of over 3,000 attorneys who specialize in representing individuals in controversies arising out of the workplace. It is the country's only professional membership organization comprised of lawyers who primarily represent employees in cases involving employment discrimination, employee benefits, wrongful discharge, and other employment-related matters. NELA has devoted itself to supporting precedent-setting litigation affecting the rights of individuals in the workplace.

Each of the *amici* organizations thus advocates on behalf of individuals throughout the country to protect the rights of

individuals who are participants in private, employer-sponsored employee benefit plans covered by ERISA, 29 U.S.C. § 1001 *et seq.* For instance, AARP and NELA have filed numerous briefs *amicus curiae,* both jointly and singly, on the interpretation of ERISA's preemption clause, including in *UNUM v. Ward*, 119 S. Ct. 334 (1999); *Boggs v. Boggs*, 520 U.S. 833 (1997); *California Division of Labor Standards Enforcement v. Dillingham Construction*, 519 U.S. 316 (1997); and *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997), as well as in other types of ERISA cases. *See, e.g., Geissal v. Moore Medical Corp.*, 118 S. Ct. 1869 (1998) (COBRA rights); *Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry. Co.*, 520 U.S. 510 (1997) (application of ERISA § 510 to welfare plans); *Varity Corp. v. Howe*, 516 U.S. 489 (1996) (participant rights under ERISA § 502(a)(3)).

The decision in this case will have a direct and vital bearing on the quality of health care that older working Americans receive. In light of the significance of the issues presented by this case, *amici curiae* respectfully submit this brief.[2/]

STATEMENT OF THE CASE

Dr. Lori Pegram, a Carle Clinic Association physician, examined Cynthia Herdrich and determined that she had an inflamed mass in her abdomen. Carle Clinic, a medical corporation owned by its physician-shareholders, generally required that its HMO patients receive diagnostic tests only from Carle-owned facilities. Petition for Writ of Certiorari (Pet.) 3 & 4, n.1. While Ms. Herdrich waited eight days to obtain an ultrasound at a Carle Clinic facility, her appendix ruptured. *Herdrich v. Pegram*, 154 F.3d 362, 374 (7th Cir. 1998).

Ms. Herdrich sued Dr. Pegram and Carle Clinic in state court alleging two counts of medical malpractice and later added two other counts against Carle Clinic and Health Alliance Medical

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[2/] The written consents of the parties have been filed with the Clerk of the Court pursuant to Supreme Court Rule 37.3.

Plans (HAMP). Pet. 4. HAMP is a health maintenance organization (the HMO), a prepaid insurance plan which contracted with State Farm Insurance Company to provide Ms. Herdrich's health care through Carle Clinic. HAMP's sole shareholder is Carle Clinic. Pet. 3. Count III alleged that Carle Clinic violated the Illinois Consumer Fraud Act by failing to reveal to Ms. Herdrich that the Carle Clinic physicians hired by HAMP in fact owned HAMP and by failing to inform her that Carle doctors earned bonuses based upon the amount of profits generated by not making emergency or consultation referrals, by not ordering diagnostic tests, and by requiring patients to use only Carle-owned facilities. Respondents' Brief in Opposition, Appendix (Res. App.) 25a. Count IV alleged HAMP breached its state law contractual duties of good faith and fair dealing by limiting tests and referrals to the detriment of its patients in order to increase its profits. *Herdrich*, 154 F.3d at 366, n. 2.

Petitioners removed the case to federal court claiming that Counts III and IV were preempted by § 514(a) of ERISA (29 U.S.C. § 1144(a)) because Ms. Herdrich's health care was paid for by her husband's employer, State Farm Insurance Company. Res. App. 24a. Respondent moved for remand, arguing the claims were not preempted. Pet. App. 66a. The court ruled that Count IV was preempted on the basis that it was related to an ERISA plan, left open the question of Count III, and denied remand. *Id.* at 68a; Res. App. 8a. Subsequently, ruling on Petitioners' motion for summary judgment on Counts III and IV, the district court also held Count III was preempted under the Supreme Court's "broad interpretation of the 'relate[s] to' requirement." Pet. App. 77a. The court held because ERISA "comprehensively regulates the necessary disclosures," Count III "relate[d] to an employee benefit plan, and as such is preempted" under § 514. *Id.* at 77a and 79a . The court then ordered Ms. Herdrich to amend Count III to allege a cause of action under ERISA or face dismissal with prejudice. *Id.* at 79a-80a. The court stated that "[h]aving found Count III preempted, Herdrich must now allege which of ERISA's civil enforcement provisions, if any, would be [sic] provide a cause of action for Plaintiff. The availability of a federal remedy does

not govern the preemption decision, and thus it may be that Plaintiff has no cause of action under ERISA." *Id.* at 79a.[4/]

Following that Order, Ms. Herdrich amended Count III to allege that Carle Clinic, HAMP and Carle Health Insurance Management Co. (CHIMCO), a management entity solely owned by Carle Clinic, breached fiduciary duties under ERISA. Pet. App. 83a-87a; Pet. 3. Ms. Herdrich asked that the court order Carle Clinic to reimburse the Plan for the "supplemental medical expense payments received from HAMP and CHIMCO," and for "other equitable relief." Pet. App. 87a. Petitioners moved to dismiss Amended Count III for failure to state a claim under ERISA. *Herdrich*, 154 F.3d at 367. The district court granted that motion on the ground that "plaintiff fails to identify how any of the defendants is involved as a fiduciary to the plan." Pet. App. 63a.[5/]

On appeal, the Seventh Circuit ruled Amended Count III was sufficient to withstand a motion to dismiss. Ms. Herdrich's allegations that Petitioners had the exclusive right to decide all disputed and non-routine claims enabled the court to "reasonably infer that Carle and HAMP were plan fiduciaries due to their discretionary authority in deciding disputed claims." 154 F.3d at 370. The Seventh Circuit also held that

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[4/] Whether or not the district court was correct in its assertion as to preemption, it was incorrect with regard to the question of whether removal was proper. As discussed in the text *infra*, the propriety of removal depends on the existence of an ERISA claim under 29 U.S.C. § 1132, not on preemption under 29 U.S.C. § 1144.

[5/] In arguing for preemption, Petitioners stated HAMP "was the administrator and fiduciary of the Plan within the meaning of ERISA (29 U.S.C. § 1001 *et seq.*)." Res. App. 24a. The district court noted that throughout the litigation, Petitioners represented that they were all fiduciaries of the ERISA plan, but the district court did not expressly make such a finding. Pet. App. 69a. On appeal, Petitioners did not argue that they were not fiduciaries, but instead, argued the appeal was not timely and that Herdrich's request for damages was inappropriate because ERISA beneficiaries "may not recover 'anything other than the benefits provided expressly in the plan.'" *Herdrich*, 154 F.3d at 367.

"plan beneficiaries have standing to bring an action on behalf of the plan to recoup monies in violation of ERISA," and that Ms. Herdrich "alleged with sufficient clarity that the Plan suffered a loss as a result of the defendants' actions." *Id.* at 380. The appeals court explicitly held that the mere existence of financial incentives to limit care does not automatically give rise to a breach of fiduciary duty, but that "incentives can rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists (*i.e.*, where physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses)." *Id.* at 373. The case was remanded to give Ms. Herdrich the opportunity to prove all the elements of her claims at trial. *Id.* at 380.

SUMMARY OF ARGUMENT

Because Ms. Herdrich sued Carle Clinic physicians and the HMO they own for actions they took in running their health care business, rather than for actions they took as fiduciaries administering or managing an ERISA plan, the district court erred when it ruled that the case was properly removed because ERISA preempted her state law claims for violation of the Illinois Consumer Fraud Act and breach of the duty of good faith and fair dealing. These claims cannot be brought under ERISA's civil enforcement provisions, which are set forth in ERISA § 502, 29 U.S.C. § 1132(a). Therefore, ERISA does not provide federal court jurisdiction over her state law claims, and removal of these claims from state court was improper.

Although § 514 of ERISA is not directly implicated in this case, this Court's recent analysis of that provision demonstrates that the state law claims at issue here are not the types of claims which Congress intended to preempt under ERISA: ERISA was designed to regulate employee benefit plans, not the services which those plans purchase. The district court erred in forcing the plaintiff to replead her claims under ERISA, rather than remanding the state claims back to state court.

Amici ask the Court to address the question of whether the net of ERISA preemption was cast too widely in this case before reaching the issue of whether fiduciary liability under the statute has been stretched beyond Congress' intent as asserted in the Petition for Writ of Certiorari. Pet. 11. However, if the Court finds that original state law claims were displaced by ERISA's civil enforcement provisions and thus, federal court jurisdiction exists, and further, finds that the plaintiff has stated a cognizable claim under ERISA's fiduciary duty rules, the Court should find that disgorgement of profits to the plan is appropriate relief under ERISA § 502(a)(2).

ARGUMENT

I. BECAUSE RESPONDENT'S STATE LAW CLAIMS CANNOT BE BROUGHT UNDER ERISA'S CIVIL ENFORCEMENT PROVISIONS WHERE PETITIONERS ARE MERELY ACTING AS HEALTH CARE SERVICE PROVIDERS TO AN ERISA PLAN, THERE IS NO FEDERAL COURT JURISDICTION.

In its decisions, the district court concluded that the breadth of this Court's interpretation of ERISA's preemption clause warranted a conclusion that Ms. Herdrich's state law claims were preempted by § 514(a) (29 U.S.C. § 1144(a)). Pet. App. 77a and 79a (Count III); Res. App. 8a (Count IV). The court never held that it had jurisdiction under the civil enforcement provisions in ERISA § 502(a) (29 U.S.C. § 1132 (a)). Instead, the court assumed jurisdiction under § 514(a) and required Ms. Herdrich to replead her complaint under ERISA. Pet. App. 76a-79a. The court was wrong in its assumption of jurisdiction, an issue which was not reviewed by the Seventh Circuit.[9]

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[9] This Court should address the question of subject matter jurisdiction, whether or not it has been preserved by the parties. *Louisville & Nashville R. Co. v. Mottley*, 211 U.S. 149, 152 (1908). In *Sumner v. Mata*, 449 U.S. 539, 548, n. 2 (1981), this Court decided the underlying jurisdictional issue where, as in this case, jurisdiction was raised as an issue before the district court but abandoned before the court of appeals. *See De Buono v. NYSA-*

A. Proper Removal of a State Law Claim Requires That It Can Be Brought under Section 502(a) of ERISA.

Federal courts have concurrent jurisdiction with state courts over individual claims for benefits under the terms of an employee benefit plan, but federal courts alone have exclusive jurisdiction over all other claims authorized by ERISA § 502(a). ERISA § 502(e), 29 U.S.C. § 1132(e). Thus, in order to remove a state law claim, that claim must be displaced by ERISA's civil enforcement provisions under § 502(a). *See Ingersoll-Rand v. McClendon*, 498 U.S. 133 (1990) (state wrongful discharge action completely displaced by ERISA § 510; therefore claim properly removed). If the state law claim cannot be brought under ERISA's civil enforcement provisions, then there is no federal question jurisdiction under ERISA and removal is improper. ERISA § 502(e)(1), 29 U.S.C.§ 1132(e)(1). *See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987) ("It is long-settled law that a cause of action arises under federal law only when the plaintiff's well pleaded complaint raise issues of federal law"); *Toumajian v. Frailey*, 135 F.3d 648 (9th Cir. 1998) (no removal unless claim is encompassed within ERISA's civil enforcement scheme); *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995) (same).

Because, as discussed below, Ms. Herdrich's claims could not be brought under ERISA § 502(a), the district court did not have jurisdiction of this case and her claims were improperly removed. *See Metropolitan Life Ins. Co. v. Taylor, supra*; *Franchise Tax Bd. Of California v. Construction Laborers Vacation Trust for Southern California*, 463 U.S. 1, 9-12 (1983) (federal jurisdiction is lacking unless a federal question appears on the face of a properly pleaded complaint).

ILA Medical and Clinical Services Fund, 520 U.S. 806, 820 (1997) (Scalia, dissenting) (jurisdiction must be decided before merits are reached).

B. HMOs Are Not Subject to Suit under Section 502(a) of ERISA Where They Act as Providers of Health Care Services and Not as an ERISA Plan or in Any Other ERISA Capacity.

When an employer establishes an employee health benefits plan, there are a variety of ways it can structure the provision of those benefits to employees. Employers may implement a plan through the purchase of insurance, self-funding, and/or the use of service providers such as managed health care plans like HMOs or preferred provider organizations (PPOs). HMOs that contract with employers to provide health care services to employees through an ERISA plan can simultaneously play different roles in relation to that ERISA plan.

Many courts have recognized the different hats HMOs wear when providing managed health care for employee beneficiaries of ERISA plans. For example, in *In re U.S. Healthcare*, ___ F.3d ___, 1999 WL 728474 (3d Cir. 1999), the Third Circuit distinguished between the HMO as administrator of an ERISA plan and the HMO as provider of health care. The Third Circuit stated:

> As an administrator overseeing an ERISA plan, an HMO will have administrative responsibilities over the elements of the plan, including determining eligibility for benefits, calculating those benefits, disbursing them to the participant, monitoring available funds, and keeping records. As we held in *Dukes* [57 F.3d 350 (3d Cir. 1995)], claims that fall within the essence of the administrator's activities in this regard fall within section 502(a)(1)(B) and are completely preempted.
>
> In contrast . . . when the HMO acts under the ERISA plan as a health care provider, it arranges and provides medical treatment, directly or though contracts with hospitals, doctors, or nurses. In performing these activities, the HMO is not acting in its capacity as a plan administrator but as a provider of health care, subject to the prevailing state standard of care.

Id. at *8 (citations omitted). In reviewing plaintiffs' claims in that case, the Third Circuit found that the HMO's policies and actions were taken in its capacity as a provider of medical care, not as a determiner of benefit eligibility. Accordingly, the HMO's presumptive policy of discharging newborns within twenty four hours of birth, as well as its policy of discouraging physicians from readmitting newborn infants, were policies adopted in providing and arranging medical services, policies "that adversely influenced the medical judgment of its participating physicians." *Id.* at *10. The Third Circuit also held that the allegation that the HMO was negligent in its selection, supervision and training of the employee-doctor was clearly one involving quality of care. ERISA did not preempt those claims because they "do not involve an attempt to recover benefits due, enforce rights, or clarify future benefits under a plan, but rather seek recovery under the quality standard found in the otherwise applicable [state] law." *Id.* at *10 (quotation and citation omitted).

Similarly, *Blue Cross of California v. Anesthesia Care Associates*, 187 F.3d 1045 (9th Cir. 1999), demonstrates the distinction between an HMO acting as a fiduciary in handling benefit claims and acting as an entrepreneur in its relationships as medical care contractors. At issue were whether claims for fees under a contract between health plans and medical providers were preempted by ERISA because they fell within the civil enforcement provisions of § 502(a) or related to a plan under ERISA's express preemption clause of § 514(a). The Ninth Circuit rejected the HMO's argument that this fee dispute was really a benefit claim under § 502(a)(1)(B). Instead, the court stated that "[t]he dispute here is not over the right to payment, which might be said to depend on the patients' assignments to the Providers, but the amount, or level, of payment which depends on the terms of the provider agreements." *Blue Cross*, 187 F.3d at 1051. Moreover, merely because an ERISA plan is consulted in the course of litigating a state law claim does not cause the state law claim to be extinguished by ERISA. *Id.*; *accord, Coyne & Delany Co. v. Selman*, 98 F.3d 1457, 1472 (4th Cir. 1996). The court in *Blue Cross* also found that these claims did not relate to ERISA plans under § 514 because "there is no contention here that the

economic impact will be so acute as to force an ERISA plan to adopt a certain scheme of substantive coverage." *Blue Cross*, 187 F.3d at 1053. Nor did the providers' state law claims implicate any ERISA-governed relationship. Instead, the claims concerned contractual promises made by the HMO to its participating physicians. *Id.* at 1054. This decision clearly underscores the variety of functions that an HMO may perform and shows the necessity of reviewing the HMO's status in relation to the claim at issue on a case by case basis.

In a somewhat different context, *Washington Physicians Service Assoc. v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998), further illustrates the difference between an ERISA plan or plan fiduciary and a service provider to that plan. There, the Ninth Circuit found that a state's alternative provider statute did not have a significant connection with an ERISA plan because the statute required action solely by health providers; it did not require an ERISA plan to do anything. The statute only regulated and mandated benefits provided by insurers. The "mere fact that the Act regulates a product that ERISA plans often choose to buy does not mean that it 'relates to' an ERISA plan." *Id.* at 1045.

American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc., 973 F. Supp. 60 (D. Mass. 1997), shows the necessity of looking beyond the bare conclusory allegations that an HMO is an ERISA-governed entity. American Drug Stores brought suit to gain admission to the restricted pharmacy network through which Harvard Pilgrim, an HMO, contracted to supply its patient-customers. Massachusetts' "any willing provider" statute required that Harvard Pilgrim, the carrier, permit any pharmacy to join its network as long as the non-network pharmacy agreed to the same terms as network pharmacies, but the statute did not dictate the terms of such agreements. In a thoughtful analysis of this Court's more recent preemption cases, the court held that Massachusetts' "any willing provider" statute was not preempted because "the organization and offering of restricted networks is part of the carrier's own administration rather than its administration of ERISA plans." *Id.* at 68. In reaching its decision, the court enumerated the "limited range of administrative functions which are part of

operating an employee benefit plan" – "eligibility determinations, benefit calculations, disbursements, fund monitoring or record keeping." *Id.* at 67. Moreover, the court concluded that even if a carrier performs some activities that amount to plan administration, not "everything carriers do for ERISA plans is entitled to the same protection."[7] *Id. citing* Karen A. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption*, 13 YALE J. REG. 255, 303 (1996) (arguing for recognition of the distinction between ERISA functions and business functions).

As the above cases illustrate and Petitioners concede, Carle Clinic and HAMP serve multiple roles in their relationship to patients, ERISA plans, and third party payors. Pet. 19. While Petitioners may function as ERISA fiduciaries in some of their dealings with Respondent (*e.g.*, if they decide whether a procedure is covered by the plan), in order to determine whether the state law claims at issue must be brought under ERISA's civil enforcement provisions, the Court must look at the state law claim itself and the role of the Petitioners in relation to that claim. *Blue Cross*, 187 F.3d at 1051; *American Drug Stores*, 973 F. Supp. at 67.

Here, State Farm is the employer which established and maintained a program of health benefits for its employees and their dependants. *See Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982) ("a plan, fund or program falls within the ambit of ERISA only if the plan, fund, or program covers ERISA participants because of their employee status . . . and an employer . . . is the person that establishes or maintains the plan, fund, or program."). State Farm's employee benefits plan is the ERISA plan involved in this case. Carle Clinic and HAMP provide medical services to the ERISA plan; they are not the plan itself. State Farm pays for the services which Carle Clinic and HAMP provide to patients when those patients are State Farm employees, but that does not turn Carle Clinic's or HAMP's actions in running its own medical plan into actions

[7] "[G]eneral state contract, zoning or tort legislation can surely affect the options available to ERISA plans without thereby being preempted." *American Drug Stores*, at 66.

taken by an ERISA plan, nor does it turn Carle Clinic or HAMP into a fiduciary.[8]

To the contrary, Petitioners were acting in their capacities as medical entrepreneurs, not as an ERISA plan or any other ERISA-governed entity. In instituting bonus policies for physicians, and in failing to inform Ms. Herdrich of those policies, Petitioners were not acting as administrators determining eligibility for benefits or as fiduciaries managing plan assets or other plan administration. ERISA § 3(21), 29 U.S.C. § 1002(21). Instead, the bonus arrangement between HAMP and Carle Clinic doctors is like the provider agreements in *Blue Cross*, contractual promises between the HMO and its participating physicians having only the most tenuous connection with an ERISA plan. *Blue Cross*, 187 F.3d at 1051. Petitioners admit that when "HMOs and other health care providers make myriad discretionary judgments . . . [m]any such judgments – including the cost-containment mechanism adopted – have no direct impact on the benefits provided by an ERISA plan." Pet. 11. This admission flatly shows that the Petitioners themselves do not believe that they were acting as ERISA fiduciaries when instituting the compensation policies which were challenged by Ms. Herdrich under state law. Like the HMO in *In re U.S. Healthcare*, Carle Clinic and HAMP instituted business policies which allegedly impacted the provision and arrangement of medical care in a manner which adversely affected the medical judgment of its physicians. *In re U.S. Healthcare*, at *10. In its preemption arguments, HAMP asserted that, if successful, Ms. Herdrich's state law claims would require HAMP to become the "guarantor of the quality of care paid for by the Plan." Res. App. 36a. ERISA's civil enforcement provisions simply do not address quality of care issues. *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 357 (3rd Cir.1995).

[8] "[A] person is a fiduciary with respect to a plan to the extent . . . he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or dispositions of its assets . . . or . . . he has any discretionary authority or discretionary responsibility in the administration of such plan." 29 U.S.C. § 1002(21).

HAMP and Carle Clinic could not have been sued in any ERISA capacity under any of the "six carefully integrated civil enforcement provisions" set forth in § 502(a) because the claims against Petitioners were for their actions in creating incentive arrangements which allegedly breached contractual duties owed to patients and for alleged unfair consumer trade practices, not actions taken in administering employee benefits or managing the plan's assets. *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 146 n.3 (1985). Thus, Ms. Herdrich's state law claims could not be brought under ERISA's civil enforcement provisions, there was no federal court jurisdiction, and her state law claims were improperly removed to federal court. *Metropolitan Life Ins. Co.*, 481 U.S. at 63 (1987); *Toumajian*, 135 F.3d at 657; *Rice*, 65 F.3d at 646.

C. Where HMOs Act as Medical Entrepreneurs Rather than in an ERISA Capacity, There Is No ERISA-Governed Relationship and State Laws Regulating Them as Such Are Not Preempted By Section 514(a) of ERISA.

A review of this Court's recent cases interpreting ERISA's express preemption clause provides support for *amici's* position that there is no jurisdiction over this action.[9] With its unanimous decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), this Court signaled a shift in its ERISA preemption analysis. It held that courts must start with the presumption

[9] ERISA § 514(a), 29 U.S.C. § 1144(a), states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." In its first ruling, the district court did not have the benefit of this Court's decisions in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995); *California Division of Labor Standards Enforcement v. Dillingham Construction*, 519 U.S. 316 (1997); and *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997), and its second ruling was made only three months after the first of these cases, *Travelers*. Instead, the district court relied solely upon *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983), a case involving state mandated benefit laws, which are not at issue here.

"that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Id.* at 655.[10]

California Division of Labor Standards Enforcement v. Dillingham Construction, 519 U.S. 316 (1997), reinforced the presumption against preemption set forth in *Travelers*. In *Dillingham*, this Court held that there must be an "indication in ERISA . . . [or] its legislative history of any intent on the part of Congress to pre-empt" a traditionally state-regulated area of law. *Id.* at 331. *Dillingham* reaffirmed that a state law only "relates to" an ERISA plan if it refers to or has a significant connection with an ERISA plan.

In order to determine whether the law has a significant connection to an ERISA plan, a court must examine ERISA's objectives to determine whether the type of state law at issue is one that Congress would not have intended to preempt and then analyze the effect the state law has on ERISA plans. *Id.* at 332.

> If ERISA were concerned with any state action--such as medical-care quality standards or hospital workplace regulations--that increased costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we could scarcely see the end of ERISA's preemptive reach.

Id. at 329. Moreover, if the law merely "alters the incentives" which exist for an ERISA plan, "but does not dictate the choices," then the law is not sufficiently connected with an ERISA plan to require preemption. *Id.* at 333.

[10] This assumes of course that the state law does not refer to an ERISA plan or fall into one of the three types of state laws which are always preempted: (1) state laws that mandate employee benefit structures or their administration; (2) state laws that bind employers or plan administrators to particular choices or preclude uniform administrative practice, thereby functioning as regulations of ERISA plans themselves; and (3) state laws providing alternate enforcement mechanisms for employees to obtain ERISA plan benefits. *See Travelers*, at 657-58, 660.

In *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997), this Court emphasized the new preemption paradigm, concluding that any law "that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is preempted by the federal statute." *Id.* at 816. Here, where the state law claims at issue invoke traditional areas of state concern and do not impact relationships regulated by ERISA, they are neither preempted nor form a proper basis for removal.

In keeping with this Court's approach to ERISA preemption, the lower courts generally have found that medical malpractice claims against HMOs are not preempted and/or have been improperly removed from state court.[11] Moreover, medical malpractice claims against HMOs as medical service providers to ERISA plans are analytically indistinguishable from malpractice claims against other types of service providers to plans such as actuaries, attorneys and investment advisers.

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[11] *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995) (claims against administrator of plan under theory of respondeat superior based on malpractice of provider on list designated by plan, not on negligent selection of that provider, did not provide basis for removal); *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995) (vicarious liability claims against HMO based on malpractice of one of its treating physicians in treating patient were not preempted); *Dukes v. U.S. Healthcare*, 57 F.3d 350 (3d Cir. 1995), *cert. denied*, 116 S. Ct. 1876 (1996) (medical negligence claims against HMO's improperly removed); *Lupo v. Human Affairs International Inc.*, 28 F.3d 269 (2d Cir. 1994) (malpractice and breach of fiduciary duty claims based on doctor-patient relationship and infliction of emotional distress claim against managed psychotherapy care entity based on actions of its psychotherapist-employee improperly removed); *Pappas v. Asbel*, 724 A.2d 889 (Pa. Supreme Ct. 1998), *petition for cert. pending sub. nom. United States Healthcare System of Pennsylvania, Inc. v. Pennsylvania Hospital Co., et al.*, 67 U.S.L.W. 3717 (May 13, 1999) (No. 98-1836) (vicarious liability malpractice claim against HMO based on delay in transferring patient to an authorized facility was not preempted as "negligence laws have only a tenuous . . . connection with ERISA covered plans, . . . and therefore are not preempted"). (Internal punctuation and citations omitted.)

Courts have held repeatedly that state law claims against these non-fiduciary service providers are not preempted.[12]

The rationale for such results is obvious. Nothing in ERISA or its legislative history evinces a clear legislative intent to preempt traditional state laws of general applicability that do not affect the relations among the principal ERISA entities – the employer, the plan fiduciaries, the plan, and the beneficiaries. *See e.g., Arizona State Carpenters Pension Trust Fund v. Citibank*, 125 F.3d 715, 724 (9th Cir. 1997); *Custer v. Sweeney*, 89 F.3d 1156, 1167 (4th Cir. 1996). When a state law does not regulate an ERISA-governed relationship, it will not be preempted.[13] *See id.*; *Hospice of Metro Denver, Inc. v. Group Health Ins. of Okla., Inc.*, 944 F.2d 752, 756 (10th Cir. 1991) (law affecting the relations between an ERISA entity and an outside party is not preempted). Quite simply, if there is no regulation of an ERISA-governed relationship, more likely than not, there will be no significant effect on the structure, administration, or the type of benefits provided by the plan. *Id.*

Likewise, if the principal ERISA entities are not being regulated in their ERISA capacities, then there is no ERISA-governed relationship. *Arizona State Carpenters*, 125 F.3d at 724; *cf. John Hancock Mutual Life Ins. Co. v. Harris Trust & Savings Bank*, 510 U.S. 86, 106 (1993) (an insurance company acting as an investment manager of plan assets must comply with fiduciary standards). Conversely, but analytically parallel,

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[12] *See, e.g., LeBlanc v. Cahill*, 153 F.3d 134 (4th Cir. 1998) (investment adviser); *Arizona State Carpenters Pension Trust Fund v. Citibank*, 125 F.3d 715 (9th Cir. 1997) (bank as non-fiduciary plan asset custodian); *Coyne & Delany Co. v. Selman*, 98 F.3d 1457 (4th Cir. 1996) (insurance agent); *Custer v. Sweeney*, 89 F.3d 1156 (4th Cir. 1996) (attorney); *Airparts Co. v. Custom Benefit Services*, 28 F.3d 1062 (10th Cir. 1994) (consultant); *cf. Memorial Hospital System v. Northbrook Life Insurance Co.*, 904 F.2d 236 (5th Cir. 1990) (health care providers' state law claims against plan not preempted).

[13] Courts generally only reach the issue of an ERISA-governed relationship after they determine that the state law at issue does not fall into one of the types of three state laws that are always preempted. *See supra*, n. 10.

this Court has recognized that "lawsuits against ERISA plans for run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan" are against the plan in a capacity other than as a plan -- *i.e.*, as a commercial entity -- and are not preempted. *Mackey v. Lanier Collections Agency & Service*, 486 U.S. 825, 833 (1988).

None of Ms. Herdrich's original state law claims concern Petitioners acting in an ERISA capacity -- that is, these claims do not impact plan administration or the payment of benefits. Instead, Carle Clinic and HAMP are in the business of providing medical services and Ms. Herdrich is a consumer of such services. A provider-consumer relationship does not fit within the traditional ERISA relationships. Instead, the relationship between Ms. Herdrich and Carle Clinic and HAMP is much closer to commercial relationships where claims have been held not to be preempted. *Mackey*, 486 U.S. at 833; *Arizona State Carpenters*, 125 F.3d at 724; *Coyne & Delany Co. v. Selman*, 98 F.3d 1457, 1471 (4th Cir. 1996). The state claims at issue, which protect consumers against fraud and protect third party beneficiaries of contracts from bad faith and unfairness, cannot be preempted because those claims do not significantly impact any ERISA-governed relationship.[14/]

Moreover, the state law claims at issue here involve areas of traditional state concern. Consumer protection laws -- be they common law or statutory enactments -- are areas of traditional state regulation where courts must presume that ERISA does not preempt the state's police power unless Congress has made clear its intent to do so. *Travelers*, 514 U.S. at 655; *Dillingham*, 519 U.S. at 325. Outside the ERISA context, this Court has acknowledged that state laws relating to fraudulent business dealings are an area of traditional state regulation. For example, in *Cippolone v. Liggett Group*, 505 U.S. 504, 516

[14/] The Seventh Circuit described the Illinois Consumer Fraud Act as a "set of general business norms" and an "all-purpose truth-in-business statute." *Anderson v. Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994) (although the court found that ERISA preempted claim that deceptive information was provided, this decision was pre-*Travelers*, and there was no finding whether the HMO was an ERISA entity).

(1992), state law claims relating to fraudulent and/or misleading information from a cigarette manufacturer that were unrelated to the advertising or promotion of cigarettes were held not preempted by federal law regulating cigarette warning labels and advertisements. The state consumer protection laws that were not preempted were, generally, fraud-type claims, including claims of failure to warn, breach of express warranty, breach of the duty not to make false statements of material fact or to conceal such facts, and conspiracy to misrepresent or conceal material facts. *Id.* at 530-31.

In recent ERISA cases, courts have recognized that similar state law fraud claims are exercises of traditional state power which are not preempted. *See Woodworker's Supply, Inc. v. Principal Mutual Life Insurance Company*, 170 F.3d 985, 991 (10th Cir. 1999) (state unfair trade practices act and fraud claim not preempted because claim of fraudulent inducement against insurer was based upon its role as seller of insurance, not its role as administrator of plan); *Wilson v. Zoellner*, 114 F.3d 713 (8th Cir. 1997) (state law of negligent misrepresentation not preempted); *Morstein v. National Insurance Services, Inc.* 93 F.3d 715, 722 (11th Cir. 1996) (state law claim of fraudulent inducement to enter into ERISA plan not preempted); *Perkins v. Time Ins. Co.*, 898 F.2d 470, 473 (5th Cir. 1990) (same).

Like the claims in *Cippolone* and other recent ERISA cases, the state laws at issue here require nonfraudulent dealing in contracts and business practices and are an exercise of the traditional state police power to prohibit fraud. Consequently, the state law claims at issue are not preempted because they are areas of traditional state regulation and Petitioners are not ERISA-governed entities for purposes of the state law allegations.

II. ERISA FIDUCIARIES ARE LIABLE TO THE PLAN FOR RESTITUTION OF BONUSES AND PROFITS WHICH THEY GAIN BY THEIR COMMISSION OF FIDUCIARY BREACHES.

Assuming that this Court finds that the district court had subject matter jurisdiction and that Ms. Herdrich alleged

cognizable claims under ERISA's fiduciary duty rules, then she is entitled to seek restitution or disgorgement of profits on behalf of the plan. 29 U.S.C. §§ 1109 & 1132(a)(2); *Mertens v. Hewitt Associates*, 508 U.S. 248, 256, 260, 262 (1993). Although Ms. Herdrich did not specify in her Complaint under which subsection of ERISA § 502(a) she was proceeding, a close reading of the Complaint confirms that she was proceeding under ERISA § 502(a)(2), 29 U.S.C. § 1132 (a)(2). The Seventh Circuit read the Complaint as such. *See Herdrich*, 154 F.3d at 380. Ms. Herdrich requested relief on behalf of the plan, and she may only obtain such under ERISA § 409, as enforced through § 502(a)(2).[15/]

"Section 409 reflects ERISA's adoption of common law trust principles." *Amalgamated Clothing & Textile Workers v. Murdock*, 861 F.2d 1406, 1411 (9th Cir. 1988); *see generally Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 570 (1986) ("Rather than explicitly enumerating all of the powers and duties of trustees and other fiduciaries, Congress invoked the common law of trusts to define the general scope of their authority and responsibility."). ERISA § 409 establishes that plan fiduciaries are personally liable to the plan to make good to the plan any losses resulting from a fiduciary breach and to restore to the plan any profits from that breach. 29 U.S.C. § 1109. This provision permits other remedies that make the plan whole or otherwise cure the breach, such as removal of a fiduciary and is consistent with ERISA's goal of protecting employee benefit plans as entities unto themselves. *Id.*; *see Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985). Accordingly, under traditional trust law principles and ERISA

[15/] If the Court reaches the issue of remedies, *amici* suggest that the Court should not go beyond remedies available under § 502(a)(2). *See, e.g., Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 139 n.5 (1985) (where this Court specifically stated what it was not deciding). The lower courts are currently grappling with a variety of remedy issues under § 502(a)(3), 29 U.S.C. § 1132(a)(3). *Compare, e.g., Bast v. Prudential Ins. Co.*, 150 F.3d 1003 (9th Cir. 1998), *cert. denied*, 120 S. Ct. 170 (1999) *with Strom v. Goldman, Sachs & Co.*, 1999 WL 639844 (No. 98-7090) (2d Cir. Aug. 24, 1999). These issues are not before the Court in this case.

§ 409, restitution and disgorgement are available as equitable remedies. *Mertens v. Hewitt Associates*, 508 U.S. at 256, 260, 262.

Under the RESTATEMENT (THIRD) OF TRUSTS, when trustees breach their duty of loyalty, beneficiaries may bring suit to recover any profits made by the trustees through the breach of their duties to the trust. RESTATEMENT (THIRD) OF TRUSTS, § 205(a)(1990). This is similar to interpretations of the duty of loyalty under ERISA. *See Amalgamated Clothing & Textile Workers v. Murdock*, 861 F.2d 1406, 1411 (9th Cir. 1988), *quoting Leigh v. Engle*, 727 F.2d 113, 122 (7th Cir. 1984); *Donovan v. Bierwith*, 680 F.2d 263, 271 (2d Cir. 1982); *Eaves v. Penn*, 587 F.2d 453, 457 (10th Cir. 1978). The fundamental reason for such a rule is to act as a deterrent against fiduciaries engaging in disloyal conduct by denying them the profits of their breach. G. T. Bogert, TRUSTS, *Creation of Constructive Trusts* § 87 (6th ed. 1987) (where the fiduciary has violated the duty of undivided loyalty a constructive trust may be imposed; this applies to prevent any unjust enrichment of the trustee as a result of any breach of trust) (emphasis added).

Moreover, the RESTATEMENT (FIRST) OF RESTITUTION recognizes the special relationship which fiduciaries have with their beneficiaries. "A fiduciary who has acquired a benefit by a breach of his duty as fiduciary is under a duty of restitution to the beneficiary." RESTATEMENT (FIRST) OF RESTITUTION at § 138(1) (1936). As in the instant case, "[w]here a fiduciary in violation of his duty to the beneficiary receives or retains a bonus or commission or other profit, he holds what he receives upon a constructive trust for the beneficiary." *Id.* at § 197; *accord*, § 160, cmt. c. Significantly, this rule is applicable even if the profit received by the fiduciary is not at the expense of the beneficiary. Relief is not based on the harm done to the beneficiary, "but [instead] rests upon a broad principle of preventing a conflict of opposing interest in the minds of fiduciaries, whose duty it is to act solely for the benefit of their beneficiaries." RESTATEMENT (FIRST) OF RESTITUTION § 197 cmt. a (1936). *Accord*, G. T. Bogert, TRUSTS, *Creation of Constructive Trusts* § 86 (6th ed. 1987). It makes no difference whether the bonus was given to the fiduciaries to induce them

to violate their fiduciary duties or whether the bonus was received in good faith, as long as it was received for an act done by them in connection with the performance of their duties as a fiduciary. RESTATEMENT (FIRST) OF RESTITUTION § 197, cmt. a (1936).

Consistent with traditional principles of trust law and restitution as a form of equitable relief, courts have ordered disgorgement of profits obtained through a fiduciary breach to be paid to the plan as equitable relief. *Waller v. Blue Cross of California*, 32 F.3d 1337 (9th Cir. 1994); *Amalgamated Clothing*, 861 F.2d at 1411. In this case, Ms. Herdrich has requested disgorgement to the plan of the bonuses which the fiduciaries received due to their breaches. Her prayer for relief meets the definition of restitution, is equitable relief within the meaning of ERISA § 409, and should be granted.

CONCLUSION

For the foregoing reasons, AARP, National Senior Citizens Law Center and National Employment Lawyers Association urge the Court to hold that the district court lacked subject matter jurisdiction over Ms. Herdrich's state law claims because the claims could not be brought under ERISA's civil enforcement provisions, removal was improper, and the state law claims at issue should be remanded to state court. Should the Court find that the district court had subject matter jurisdiction and Ms. Herdrich has alleged cognizable claims under ERISA, then the Court should hold that ERISA fiduciaries are liable for restitution to the State Farm ERISA plan of bonuses and profits which they gained by commission of fiduciary breaches.

Respectfully submitted,

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