No. 98-1949

In the

Supreme Court of the United States

Lori Pegram,

Petitioner,

v.

CYNTHIA HERDRICH,

Respondent.

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

BRIEF OF THE STATES OF ILLINOIS, CALIFORNIA, DELAWARE, FLORIDA, IOWA, MASSACHUSETTS, MISSISSIPPI, MISSOURI, MONTANA, NEVADA, NEW JERSEY, NORTH CAROLINA, OHIO, OKLAHOMA, PENNSYLVANIA, RHODE ISLAND, TENNESSEE AND TEXAS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

JAMES E. RYAN
Attorney General of Illinois
* JOEL D. BERTOCCHI
Solicitor General of Illinois
Jacqueline Zydeck
Assistant Attorney General
100 West Randolph Street
Chicago, IL 60601
(312) 814-7175

Of Counsel:
Dan Schweitzer
National Association of
Attorneys General
750 First St., N.E., Suite 1100
Washington, D.C. 20002

* *Counsel of Record*
[additional counsel listed on inside cover]

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

INTEREST OF THE *AMICI* CURIAE 1

SUMMARY OF ARGUMENT 2

ARGUMENT 6

I. HMOS ARE NOT ERISA PLANS--THEY ARE HEALTHCARE BUSINESSES THAT SELL PRODUCTS AND SERVICES 6

A. The ERISA Plan and Benefit 8

B. HMO Services and Plan Administration . . . 11

II. THE ORIGINAL COUNT III IS NOT PREEMPTED BY ERISA 16

III. RESPONDENT STATES AN ERISA CLAIM WHEN SHE PLEADS THAT HMO BENEFIT DETERMINATIONS IN ADMINISTRATION OF THE PLAN WERE BASED ON THE HMO'S OWN FINANCIAL INTERESTS 23

CONCLUSION 27

TABLE OF AUTHORITIES

Page

CASES:

American Drug Stores, Inc.,
v. *Harvard Pilgrim Health Care, Inc.,*
973 F.Supp. 60 (D. Mass. 1997) 13-15

Anderson v. *Humana, Inc.,*
24 F.3d 889 (7th Cir. 1994) 20, 21

Arizona State Carpenters Pension Trust Fund
v. *Citibank,*
125 F.3d 715 (9th Cir. 1997) 12

Blue Cross of California
v. Anesthesia Care Associates Medical Group, Inc.,
187 F.3d 1045 (9th Cir. 1999) 22

Cipollone v. Liggett Group,
505 U.S. 504 (1992) 18

Conley v. *Gibson,*
355 U.S. 41 (1957) 23

Coyne & Delany Co. v. Selman,
98 F.3d 1457 (4th Cir. 1996) 22

Curtiss-Wright Corp. v. *Schoonejongen,*
514 U.S. 73 (1995) 2

Custer v. Sweeney,
89 F.3d 1156 (4th Cir. 1996) 12

De Buono v. *NYSA-ILA Medical*
& Clinical Serv. Fund,
520 U.S. 806 (1997) . . . . . *Passim*

Donovan v. Bierwirth,
680 F.2d 263 (2d Cir.),
cert. denied, 459 U.S. 1069 (1982) 25

Donovan v. *Dillingham,*
688 F.2d 1367 (11th Cir. 1982) 8

Dukes v. *U.S. Healthcare, Inc.,*
57 F.3d 350 (3d Cir.),
cert. denied, 516 U.S. 1009 (1995) 16, 24

Engelhardt v. *Paul Revere Life Ins. Co.,*
139 F.3d 1346 (11th Cir. 1998) 16

Fort Halifax Packing Co, Inc. v. *Coyne,*
482 U.S. 1 (1987) 9, 16

Herdrich v. *Pegram,*
154 F.3d 362 (7th Cir. 1998) 24

Hospice of Metro Denver, Inc.
v. *Group Health Ins. of Oklahoma, Inc.,*
944 F.2d 752 (10th Cir. 1991) 12

Hughes Aircraft Co. v. *Jacobson,*
525 U.S. 432 (1999) 16

In re U.S. Healthcare, Inc.,
193 F.3d 151 (3rd Cir. 1999) 15, 22

Labor Standards Enforcement
v. Dillingham Construction, N.A., Inc.,
519 U.S. 316 (1997) 21

Libbey-Owens-Ford Co.
v. *Blue Cross & Blue Shield Mut. of Ohio,*
982 F.2d 1031 (6th Cir),
cert. denied, 510 U.S. 819 (1993) 16

Lockheed Corp. v. *Spink*,
517 U.S. 882 (1996) 16

Lupo v. Human Affairs Intern., Inc.,
28 F.3d 269 (2d Cir. 1994) 24

Massachusetts v. *Morash*,
490 U.S. 107 (1989) 6

Metropolitan Life Insur. Co. v. *Massachusetts*,
471 U.S. 724 (1985) 8

Napoletano v. *CIGNA Healthcare of Connecticut*,
238 Conn. 216 (Sup. Ct. Conn. 1996),
cert. denied, 520 U.S. 1103 (1997) 14

New York State Conference of Blue Cross & Blue Shield Plans v. *Travelers Ins. Co.*,
514 U.S. 645 (1995) . . . . . *Passim*

Pacificare of Oklahoma, Inc. v. Burrage,
59 F.3d 151 (10th Cir. 1995) 24

Pilot Life Insurance Co. v. *Dedeaux*,
481 U.S. 41 (1987) 10, 16

Scheuer v. Rhodes,
416 U.S. 232 (1974) 23

Shaw v. *Delta Airlines, Inc.*,
463 U.S. 85, (1983) 11

Shea v. *Esensten*,
107 F.3d 625 (8th Cir.),
cert. denied, 522 U.S. 914 (1997) 20

Totz v. *Continental DuPage Acura*,
236 Ill. App. 3d 891 (2d Dist. 1992) 18

UNUM Life Insurance Co. v. *Ward*,
526 U.S. 358 (1999) 8, 10, 16

Washington Physicians Serv. Ass'n v. *Gregoire*,
147 F.3d 1039 (9th Cir. 1998),
cert. denied, 119 S.Ct. 1033 (1999) . . . . . *Passim*

STATUTES AND LEGISLATIVE MATERIALS:

Del. Code Ann. tit. 18, § 6407 (1998) 14

29 C.F.R. § 2509.75-5 7

29 U.S.C. § 1002(l) 8

29 U.S.C. § 1002(l) 8

29 U.S.C. § 1022(b) 18

29 U.S.C. § 1102(a)(1 7

29 U.S.C. § 1144(b)(2) 5

29 U.S.C. § 1144(b)(2)(A) 8

29 U.S.C. § 1191b (a)(1) 9

29 U.S.C. § 1191b (a)(2) 9

40 Pa. Const. Stat. Ann. § 991.2112 (West Supp. 1999) 14

42 U.S.C. § 300e(c)(2) 5

Alaska Stat. § 21.86.150 (i)(2) (Michie 1999) 14

Alaska Stat. § 21.86.160(I)(4)(Michie 1998) 14

Cal. Health & Safety Code § 1346.6 (West Supp. 1999) 14

Georgia Code Ann. § 33-20A-G (Supp. 1999) 14

Idaho Code § 41-3928 (1998 14

Ill. Rev. State ch. 815, para. 505/2 (1998) 18, 19

Kansas Stat. Ann. § 40-4605 (Supp. 1998) 14

La. Rev. Stat. Ann. § 22:215.19 (West Supp. 1999) . . 14

Md. Code Ann. Ins. § 15-113(c) (1997) 14

Minn. Stat. § 72A.20, Subd. 33 (1999) 14

Mo. Rev. Stat. § 354.606(5) (Supp. 1999) 14

Mont. Code Ann. § 33-36-204(2) (1997) 14

Neb. Rev. Stat. § 44-7106(2)(h) (Supp. 1998) 14

Nev. Rev. Stat. § 695G.260 (1998) 14

Ohio Rev. Code Ann. § 1751.13(D)(1)(a) (Anderson Supp. 1998) 14

Pa. Stat. Ann., tit. 40, § 991.2113 (Purdon 1999) 14

R.I. Gen. Laws § 23-17-17-3(B)(6) (1996) 14

Tex. Ins. Code Ann. Arts. 20A.14(1), 3.70-3C, § (7)(d) (Vernon Supp. 2000) 14

OTHER MATERIALS:

Karen A. Jordan,
Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption,
13 Yale J. Reg. 255 (1996) 13

INTEREST OF THE *AMICI* CURIAE

Amici curiae, the States of Illinois, California, Delaware, Florida, Iowa, Massachusetts, Mississippi, Missouri, Montana, Nevada, New Jersey, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, Tennessee and Texas, submit this brief in support of respondent Cynthia Herdrich. The issues posed in this case have significant implications for the States' ability to regulate two areas of traditional state concern: the medical care provided to their citizens and the business practices of medical care providers. The *amici* States have a strong interest in assuring that their citizens are provided with competent medical care and that healthcare businesses market and perform their services fairly. As managed care, through the proliferation of health maintenance organizations (HMOs), has become a more common vehicle for healthcare delivery, the States have become more active in its regulation. *Amici* regulate medical care and the business of HMOs through healthcare statutes, insurance statutes, laws of general application such as consumer protection statutes, common law standards and the provision of both statutory and common law remedies.

The *amici* States also have a strong interest in the construction of ERISA. ERISA preempts State laws that "relate to" ERISA plans and are not saved from preemption by ERISA's insurance savings clause. This Court has held that state laws that "mandate employee benefit structures or their administration" "relate to" ERISA plans, *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 646 (1995), and that "'myriad state laws' of general applicability that impose some burdens on the administration of ERISA plans" do not "relate to" ERISA plans, *De Buono* v. *NYSA-ILA Medical & Clinical Serv. Fund*,

520 U.S. 806, 815 (1997). The Court's determination of the circumstances in which an HMO engages in ERISA plan administration will have significant implications for the States' ability to regulate HMOs. The States have a strong interest in preserving the appropriate balance of authority between the States and the federal government and in ensuring that ERISA preemption is not extended beyond Congressional intent. This is particularly important because the States protect consumers' interests in healthcare in numerous respects, while ERISA provides little substantive federal regulation of healthcare. *Curtiss-Wright Corp.* v. *Schoonejongen*, 514 U.S. 73, 78 (1995).

SUMMARY OF ARGUMENT

In the late 1960s and early 1970s, when ERISA was drafted and debated in Congress, the delivery of medical care was dominated by reimbursed fee-for-service medicine. Physicians rendered services they deemed appropriate for patients. After services were provided, insurers were presented with the bill and paid the reasonable cost. Healthcare services and the payment for those services were separate functions, and there was little "managed care." ERISA was not enacted with HMOs in mind.

Today, managed care is the norm. Healthcare services and payment for care are integrated into a single organization, typically the HMO. The trend toward managed care is expected to continue into the next century.

The States have traditionally regulated healthcare and the business of healthcare providers in order to protect consumers' rights to healthcare and insurance. The "starting presumption",

Travelers, 514 U.S. at 654, is that Congress, when it enacted ERISA, intended such State regulation to continue -- the Court has "unequivocally concluded" that there was no intention to undermine traditional State regulation. *De Buono,* 520 U.S. at 813. ERISA was enacted to protect consumers--"'to promote the interests of employees and their beneficiaries in employee benefit plans,' ...and 'to protect contractually defined benefits'"[1]--and is thus consistent with State consumer protection regulation and remedies. While Congress indicated a desire for uniform administration of benefit plans, *Travelers,* ERISA was never intended to protect healthcare businesses from State regulation and from liability for wrongful acts under State laws.

Because healthcare and managed care have become virtually synonymous, regulation of healthcare implies regulation of HMOs. In parsing federal and State interests with respect to HMOs, *amici* believe the Court should be guided by five general principles.

1. *The HMO is not the ERISA plan.* HMOs and other managed care organizations are not ERISA plans. They are healthcare businesses. They sell a product, healthcare, they arrange services, and they manage their own business. These areas are traditionally subject to State regulation, and ERISA does not change this.

2. *The fact that an HMO provides services to an ERISA plan does not relieve it from State law regulation as a healthcare business and provider of medical care.* State law regulates

---

[1] *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 113 (1989). *See also* 29 U.S.C. § 1001(b).

healthcare business and medical care and provides remedies to consumers for wrongful acts of healthcare providers. ERISA was enacted to augment these protections, not to eliminate them.

3. *The ERISA healthcare benefit is payment for healthcare.* ERISA plans are benefit plans created by employers. The plans are comprised of a set of rules for disbursing employee benefits. Employers may implement the plans in a variety of ways: through the purchase of insurance, through self insurance, by providing medical services themselves in-kind[2] and/or by contracting with HMOs for the arrangement and provision of medical services. The benefit is not any one of these vehicles, nor is it any particular services--it is payment for healthcare.

4. *Only the administration of the ERISA plan implicates ERISA duties; the administration of the HMO's business, including the arrangement and provision of healthcare, does not.* The administration of the ERISA plan is a matter of federal concern. The administration of the HMO's business is a matter of State concern.

When the HMO is selected by the employer--or, as in this case, by the employee who has been given a choice of healthcare vehicles by the employer--the HMO arranges and provides medical care. The delivery and arrangement of care and the administration of the HMO's own business are not acts

[2]An employee benefit plan can arrange to provide services in-kind operating its own medical facility, as was done by the plan in *De Buono*, or by contracting directly with a physician network.

of ERISA plan administration. They are subject to State regulation, not to ERISA duties.

When benefit determinations are delegated to the HMO, it wears a second hat. Under this hat, the HMO participates in the administration of the ERISA plan. When and to the extent it does so, it is subject to ERISA duties.

5. *Even when the HMO engages in plan administration, it is subject to State regulation as an insurer.* The HMO is an insurer, assuming risk of healthcare loss. 42 U.S.C. § 300e(c)(2).[3] *See also Washington Physicians Serv. Ass'n* v. *Gregoire*, 147 F.3d 1039, 1046 (9th Cir. 1998), *cert. denied*, 119 S.Ct. 1033 (1999). Even acts of plan administration may be regulated by the States under State insurance, banking, or securities laws. 29 U.S.C. § 1144(b)(2).

These principles have a number of implications for this case. First, respondent's original Count III--that the HMO's failure to disclose its ownership structure and financial incentive arrangements violated the Illinois Consumer Fraud Act--is not preempted by ERISA. This claim was brought against the HMO as a healthcare provider and business marketing its product to consumers. It was not brought against the HMO for acts of ERISA plan administration. The district court's preemption ruling was not appealed, but it was based on an assumed equivalence between the HMO and the ERISA plan that is incorrect.

[3]Pursuant to the statute, the HMO may share this risk with other entities.

Second, there is no ERISA claim based on the existence of financial incentives in HMO arrangements with providers, and there is no ERISA claim based on medical treatment decisions or the arrangement of medical care, even when the HMO is also engaged in plan administration. The HMO's business and its healthcare services are not acts of plan administration. They are matters of State, not federal, concern.

Third, when the HMO wears two hats--as healthcare arranger and provider and as ERISA plan administrator--it is subject to both State and federal requirements. Respondent's original Count III stated a State claim based on the HMO's business as healthcare provider. But after the district court dismissed this claim, respondent amended her complaint, alleging in new Count III that the HMO administered the ERISA plan improperly. This is an ERISA claim. Respondent should be given an opportunity to prove that the HMO's administration of the plan was based on the HMO's financial interests and not on the standards in the plan.

ARGUMENT

I. HMOS ARE NOT ERISA PLANS--THEY ARE HEALTHCARE BUSINESSES THAT SELL PRODUCTS AND SERVICES

The nature of ERISA plan administration is central to this case. ERISA imposes fiduciary duties--and respondent states an ERISA claim--only in connection with acts of plan management or administration. This is consistent with the purpose of ERISA: to ensure that employees' expectation of benefits is not defeated by poor plan administration. *Massachusetts* v. *Morash*, 490 U.S. 107, 112 (1989). ERISA

was enacted to control "the administration of benefit plans." *Travelers,* 514 U.S. at 651.

A person is an ERISA plan fiduciary "to the extent" that he or she "exercises any discretionary authority or discretionary control respecting management" of the plan or "has any discretionary authority or discretionary responsibility in the administration of such plan" (with certain exceptions not relevant here[4]). 29 U.S.C. § 1002 (21)(A). An entity contracting with an ERISA plan only acts as a fiduciary when performing administrative functions for the plan. *Varity Corp.* v. *Howe,* 516 U.S. 489 (1996).[5]

The nature of plan "administration" is also central to *amici*'s interest in this case. State regulation and State remedies are preempted when they "relate to" an ERISA plan (and are not saved by the insurance savings clause). The Court interprets "relate to"--a term of "frustrating difficulty", *Travelers,* 514 U.S. at 656--with reference to the "basic thrust of the preemption statute": "to permit the nationally uniform *administration* of employee benefit plans." *Id.,* at 657 (emphasis added). A State law that regulates HMO plan administration activities "relates to" the plan. A State law

---

[4]All ERISA plans are required to have a "named" fiduciary, a person, group of persons or corporation, identified in a written plan instrument. 29 U.S.C. § 1102(a)(1). A person who provides investment advice to a plan for a fee is also a fiduciary. 29 U.S.C. § 1002 (21)(A).

[5] Rendering services to a plan is not enough to make one a fiduciary of the plan. Services providers, such as attorneys, accountants and consultants act as an ERISA fiduciary only when they are exercising discretionary authority in the administration or management of an ERISA plan. *See* 29 C.F.R. § 2509.75-5.

regulating HMO activities that do not constitute ERISA plan administration does not "relate to" the plan.[6]

Of course, under the "savings" clause, the States can also regulate HMOs as insurers--petitioners agree that HMOs are insurers (Pet. Br. 26-27[7])--under State insurance laws even when such laws mandate plan administration and thus "relate to" an ERISA plan. 29 U.S.C. § 1144(b)(2)(A). *See, e.g., UNUM Life Insurance Co.* v. *Ward*, 526 U.S. 358 (1999).

A. The ERISA Plan and Benefit

ERISA defines an "employee welfare benefit plan" as "any plan fund or program . . . established or maintained by an employer . . . for the purpose of providing its participants or their beneficiaries, through the purchase of insurance or otherwise . . . medical, surgical, or hospital care or benefits" or other benefits. 29 U.S.C. § 1002(l). A "plan, fund or program" is not defined in the statute but has been interpreted to require the existence of benefits, intended beneficiaries, a source of funding, and a procedure to apply for and collect benefits. *Donovan* v. *Dillingham*, 688 F.2d 1367 (11th Cir. 1982).

[6]*See Washington Physicians Serv. Ass'n* v. *Gregoire*, 147 F.3d at 1044. *Gregoire* is consistent with *Metropolitan Life Insur. Co.* v. *Massachusetts*, 471 U.S. 724 (1985); the State law in *Gregoire* was addressed to HMOs and not, as in *Metropolitan Life*, to employee plans.

[7]"An HMO is, by definition, an entity that assumes 'full financial risk on a prospective basis for the provision of basic health services....' 42 U.S.C. § 300e(c)(2)." *Ibid. See also Washington Physician Serv. Ass'n* v. *Gregoire*.

The plan itself is a set of rules that govern the benefit. These rules guide "determin[ation of] the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records." *Fort Halifax Packing Co, Inc.* v. *Coyne*, 482 U.S. 1, 9 (1987). In this case, the ERISA plan comprised the documents setting forth the terms under which State Farm, respondent's husband's employer, provided benefits to its employees and their families. The plan documents did not contain the compensation arrangements between the HMO and providers. Nor did they specify HMO financial incentives available to providers.

Under ERISA, the healthcare benefit is payment for medical care. While ERISA did not originally contain a definition of "medical care," the Health Insurance Portability and Accountability Act, a 1996 amendment to ERISA, defines "medical care" as used in ERISA to mean "amounts paid for" medical care or medical insurance, 29 U.S.C. § 1191b (a)(2). The amendment is applicable to an "employee welfare benefit plan to the extent the plan provides medical care . . . to employees or dependents . . . directly or through insurance, reimbursement, or otherwise." 29 U.S.C. § 1191b (a)(1).[8] *See also Rice* v. *Panchal*, 65 F.3d 637 (7th Cir. 1995) ("benefits due to [the participant] under the Plan . . . are payments of the

[8]This definition is appropriate because ERISA benefits are provided in lieu of compensation. In most cases, ERISA benefits are strictly financial. Cash distributions are given to a beneficiary upon the occurrence of some contingent event, disability, retirement or death. Or the employer agrees to arrange for payment of certain services (*e.g.*, medical care, day care and prepaid legal services) provided to plan participants. The employer may arrange for payment in any one of several different ways, including payment of the services in kind.

costs of medical services, not the medical services themselves.").

Amici disagree with Judge Easterbrook's statement that the "HMO system"--rather than payment for healthcare services--is the ERISA plan benefit (Pet. App. 55a, 170 F.3d at 686). This view is inconsistent with the statutory rubric. It would essentially read plan administration out of ERISA. Judge Easterbrook distinguishes "treating the Carle HMO as the benefit, rather than treating the Carle HMO as the administrator of the ERISA plan," *ibid.*, and appears to view these categories--the plan benefit and the administration of the plan--as mutually exclusive. When the employer's only involvement in administration is to send checks to the HMO and when all other administrative functions are delegated to the HMO, there will be, in Judge Easterbrook's formulation, no "administration": the HMO doesn't administer because it is the benefit, and no one else engages in any administration. And if HMO membership, rather than payment for medical services, is the benefit, once the participant becomes a member, there will be no benefit to administer. ERISA fiduciary protections for acts of plan administration would thus be diluted or eliminated, frustrating a principal federal concern. HMOs would likely argue, moreover, that everything they do "relates to" the ERISA plan, since the HMO is the benefit, thus inhibiting State regulation of healthcare. Congress could not reasonably have intended--in enacting a statute for the protection of employee benefits--to reduce both State and federal protections for beneficiaries.

Judge Easterbrook's statement is also inconsistent with the Court's decisions in *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. 41, 47-48 (1987) and *UNUM, supra*, which suggest that

under traditional insurance policies the benefit is payment under the policy, not the policy. There is no reason to adopt a different rule for HMOs.

B. HMO Services and Plan Administration

HMOs are not ERISA plans, they are businesses. They administer their own affairs, which comprise, broadly speaking, arrangements, often contractual in nature, with third parties to obtain materials as diverse as office supplies, real estate, and hospital and physician services, and to package these materials as a product, healthcare.[9] The product is available to be purchased by members of the public, including ERISA plans. While the nature of the product will affect the choices available to the public, including ERISA plans, and may thus "affect a plan's shopping decisions," *Travelers*, 514 U.S. at 659, the arrangements by which the HMO creates and markets the product are not the plan and have no connection to the plan.

When an HMO is selected by an employer to provide healthcare coverage to its employees, the HMO becomes a service provider to the ERISA plan.[10] *Washington Physicians Serv. Ass'n.* v. *Gregoire.* This establishes a form of "connection" between the plan and the HMO. *Cf. Shaw* v.

---

[9]The group subscription agreement in this case identifies Carle Care HMO as "an HMO product" of the Health Alliance Medical Plans, an Illinois stock corporation. Pet App. 93-a.

[10]It is not uncommon for ERISA plan to engage outside service providers. Benefit consultants design plans for employers, investment consultants provide investment advice, third party administrators administer self-insured plans, and attorneys provide legal services, both to the plan and to plan participants as part of the benefit of pre-paid legal services.

Delta Airlines, Inc., 463 U.S. 85, 96-97 (1983). But it does not mean that the HMO becomes the plan--any more than the provision of accounting services to the plan makes such services the plan. Nor does it mean that all services provided by the HMO constitute plan "administration." The States routinely regulate the business of service providers to ERISA plans.[11] "The mere fact that many ERISA plans choose to buy health insurance for their plan members does not cause a regulation of health insurance automatically to 'relate to' an employee benefit plan--just as a plan's decision to buy an apple a day for every employee, or to offer employees a gym membership, does not cause all state regulation of apples and gyms to 'relate to' employee benefit plans." *Washington Physicians Serv. Ass'n* v. *Gregoire*, 147 F.3d at 1045.

In determining whether an HMO's activities constitute ERISA plan administration--and thus implicate ERISA duties and establish "relat[ion] to" the plan--it is necessary to consider the precise nature of the relevant activities.

1. *HMO arrangements with providers.* One of the HMO's activities is to establish contractual arrangements with healthcare providers. These arrangements typically include compensation terms and may, as in this case, include some form of financial incentives designed to lower the cost of healthcare.

[11] *See, e.g., Arizona State Carpenters Pension Trust Fund* v. *Citibank*, 125 F.3d 715 (9th Cir. 1997); *Custer v. Sweeney*, 89 F.3d 1156 (4th Cir. 1996); *Hospice of Metro Denver, Inc.* v. *Group Health Ins. of Oklahoma, Inc.*, 944 F.2d 752 (10th Cir. 1991).

"[I]t is critical to distinguish between the carrier's administration of the ERISA plan and 'its own administration of its business.' [Professor Jordan] suggests that the appropriate inquiry is 'whether the practice affected . . . is one of the on-going processes and practices developed to effectuate an employer's provision of benefits . . . or whether the practice is more properly characterized as one for the administration of the business of the third-party.'" *American Drug Stores, Inc.*, v. *Harvard Pilgrim Health Care, Inc.*, 973 F.Supp. 60, 67-68 (D. Mass. 1997), *quoting* Karen A. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption*, 13 Yale J. Reg. 255, 303 (1996) (ellipses in decision).

When an HMO establishes arrangements with providers, it is administering its own business. It is not administering an ERISA plan. "[S]election and operation of provider networks is not a traditional function of ERISA plans, and surely was not a function Congress contemplated when it enacted ERISA." *Id.*, at 67. This is so because the HMO's provider arrangements are with third parties, not with the ERISA plan. They are not contained in the plan documents. They are contained in contractual agreements with third parties. "In the emerging integrated delivery systems, some entity must perform the function of deciding which [providers] will comprise the network . . . This function is clearly attenuated from functions such as claims administration and therefore should be viewed as constituting administration of its business [rather than] administration of an ERISA plan." *Id.*, at 67, *quoting* Jordan, 13 Yale J. Reg. at 331 (ellipsis in decision). When the HMO administers its own business by contracting with third party providers, it is not administering the ERISA plan.

States regulate HMOs' business arrangements with providers in many ways. States limit or condition financial incentive arrangements between HMOs and providers.[12] They regulate the size and exclusivity of HMO's network arrangements through any willing provider and any willing pharmacy laws.[13] They regulate HMO services through alternative provider laws.[14] They provide remedies for inadequate disclosure of arrangements between HMOs and providers.[15] They regulate gag rules.[16]

"The claim that a law regulating the manner in which a third-party vendor offers a service or product is subject to preemption because it affects the options available to ERISA

---

[12]*See, e.g.,* Alaska Stat. § 21.86.160(I)(4)(Michie 1998); Cal. Health & Safety Code § 1346.6 (West Supp. 1999); Georgia Code Ann. § 33-20A-G (Supp. 1999); Idaho Code § 41-3928 (1998); Kansas Stat. Ann. § 40-4605 (Supp. 1998); La. Rev. Stat. Ann. § 22:215.19 (West Supp. 1999); Md. Code Ann. Ins. § 15-113(c) (1997); Minn. Stat. § 72A.20, Subd. 33 (1999); Mo. Rev. Stat. § 354.606(5) (Supp. 1999); Mont. Code Ann. § 33-36-204(2) (1997); Neb. Rev. Stat. § 44-7106(2)(h) (Supp. 1998); Nev. Rev. Stat. § 695G.260 (1998); Ohio Rev. Code Ann. § 1751.13(D)(1)(a) (Anderson Supp. 1998); 40 Pa. Const. Stat. Ann. § 991.2112 (West Supp. 1999); R.I. Gen. Laws § 23-17-17-3(B)(6) (1996); Tex. Ins. Code Ann. Arts. 20A.14(1), 3.70-3C, § (7)(d) (Vernon Supp. 2000).

[13]*See, e.g., American Drug Stores.*

[14]*See, e.g., Washington Physicians Serv. Ass'n* v. *Gregoire.*

[15]*See, e.g., Napoletano* v. *CIGNA Healthcare of Connecticut*, 238 Conn. 216 (Sup. Ct. Conn. 1996), *cert. denied*, 520 U.S. 1103 (1997).

[16]*See, e.g.,* Alaska Stat. § 21.86.150 (i)(2) (Michie 1999); Del. Code Ann. tit. 18, § 6407 (1998); Pa. Stat. Ann., tit. 40, § 991.2113 (Purdon 1999).

plans relies on logic that is not easily bounded; this reasoning could easily preclude state laws designed to control the quality of health care. The Supreme Court in *Travelers* emphasized that Congress did not intend ERISA to supersede such legislation." *American Drug Stores,* 973 F. Supp. at 69. The arranging of medical services is part of the healthcare business of the HMO, and it is not ERISA plan administration.

2. Healthcare services. One of the services that an ERISA plan may purchase from the HMO is medical care. The provision of medical care is not an ERISA plan administration function. "[W]hen the HMO acts under the ERISA plan as a health care provider, it arranges and provides medical treatment, directly or through 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." *In re U.S. Healthcare, Inc.,* 193 F.3d 151, 162 (3rd Cir. 1999).

The States routinely regulate the quality of healthcare provided to their citizens, including members of ERISA plans, by setting quality standards and providing remedies for inadequate quality of care. This is an important State function that the Court stated it "will never assume lightly that Congress has derogated." *Travelers,* 514 U.S. at 654. The provision of healthcare services to an ERISA plan is not an act of plan administration, and it does not relieve the HMO from its State law responsibilities as a provider of healthcare. *Id.*, at 660.

3. Claims processing or benefit determinations. Of the functions constituting plan administration, the determination of benefits--whether particular services are covered under the ERISA plan--is one of the most important to plan members.

Fort Halifax Packing, 482 U.S. at 9. This function may be performed by the employer or may be delegated to a third party, such as a company that specializes in plan administration. The function may also be delegated to the HMO.[17]

When HMOs process claims and determine benefits under an ERISA plan, they "play two roles, not just one." *Dukes* v. *U.S. Healthcare, Inc.*, 57 F.3d 350, 361 (3d Cir.), *cert. denied*, 516 U.S. 1009 (1995). Insofar as the HMO provides or arranges medical services for an ERISA plan, it is not engaging in plan administration. But the HMO does engage in plan administration--and is subject to ERISA fiduciary duties--when and to the extent it makes a discretionary determination of covered benefits.[18]

II. THE ORIGINAL COUNT III IS NOT PREEMPTED BY ERISA

Count III of the original complaint alleged that petitioners violated the Illinois Consumer Fraud Act by failing to disclose material facts regarding the ownership of the HMO and the

[17]It does not matter who makes the benefit determinations--the employer, a third party administrator, an insurer, or an HMO. Any entity processing claims is performing a plan administration function. *See, e.g., Engelhardt* v. *Paul Revere Life Ins. Co.*, 139 F.3d 1346, 1352 (11th Cir. 1998); *Libbey-Owens-Ford Co.* v. *Blue Cross & Blue Shield Mut. of Ohio*, 982 F.2d 1031, 1035 (6th Cir), *cert. denied*, 510 U.S. 819 (1993).

[18] *See, e.g., Hughes Aircraft Co.* v. *Jacobson*, 525 U.S. 432 (1999); *Lockheed Corp.* v. *Spink*, 517 U.S. 882, 887 (1996).

The States may regulate claims processing within their power to regulate the business of insurance. *See, e.g., Pilot Life , supra; UNUM.*

compensation of HMO physicians (Pet App 76a). The district court dismissed the claim, ruling that it was preempted because (1) it alleged that "defendants failed to disclose relevant information regarding operation of the Plan" (Pet App. 77a), (2) ERISA comprehensively regulates ERISA plan disclosure requirements, and (3) the claim sought to impose additional disclosure requirements on the plan administrator (Pet App. 77a).

This ruling was not appealed and is not before the Court. But it was incorrect, and it demonstrates the danger of equating the HMO with the plan and ignoring the functional distinctions between the HMO's administration of its business and the HMO's administration of the ERISA plan.[19]

The HMO is not the ERISA plan. It performs services for the plan. In this case, one of the services performed by the HMO was plan administration, the determination of benefits. But the HMO was not acting as ERISA plan administrator when it set up its business. It was not acting as plan administrator when it entered into compensation arrangements with third parties. Nor was it acting as a plan administrator when it failed to disclose these arrangements to consumers of its medical services. The disclosure requirements of the Illinois Consumer Fraud Act are imposed on HMOs as businesses that sell healthcare products to consumers in Illinois. They are not imposed on ERISA plans.

ERISA does require disclosure of certain plan information, including the identity of plan trustees, eligibility requirements

[19]*Amici* urge the Court to make clear that it does not endorse dismissal of the State claim.

for participation and benefits, the source of financing, the organization through which benefits are provided, claims procedures, and appeal rights. 29 U.S.C. § 1022(b). But respondent's State claim was predicated on the HMO's failure to disclose material facts about *its own business*, not about the plan. ERISA is not concerned with the business arrangements between service providers and third parties.

The Illinois Consumer Fraud Act permits consumers, including ERISA plan participants, to make informed benefit choices. The Act prohibits unfair or deceptive acts or practices in any trade or commerce, including the concealment, suppression or omission of any material fact with the intent to induce reliance by others. Ill. Rev. State ch. 815, para. 505/2 (1998); *Totz* v. *Continental DuPage Acura*, 236 Ill. App. 3d 891, 902 (2d Dist. 1992). It provides a remedy for a business' failure to disclose material information under the terms of the Act. ERISA plan participants are entitled to such routine protections of State law with respect to consumer transactions so long as those laws do not "relate to" an ERISA plan. *Travelers*, 514 U.S. at 655-56.

In determining whether a State law "relates to" an ERISA plan, the "starting presumption" is against "relat[ion] to" the plan. *Travelers,* 514 U.S. at 654. "[W]e have worked on the assumption 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 (citations omitted). Consumer protection is an area of traditional state concern, *Cipollone v. Liggett Group,* 505 U.S. 504, 530 (1992), as is the "state's historic powers to regulate matters of health and safety" and the "two areas of traditional state governance--the health care and insurance industries." *American Drug*

Stores, 973 F.Supp. at 65. A party seeking to eliminate State regulation or escape liability under State law "bear[s] the considerable burden of overcoming 'the starting presumption that Congress does not intend to supplant state law.'" *De Buono,* 520 U.S. at 814.

Armed with the presumption, the Court looks "to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Travelers,* 514 U.S. at 656. The principal objective, the *Travelers* Court found, is uniform plan administration. The Court stated that this objective is not implicated where State law does not "preclude uniform administrative practice or the provision of a uniform interstate benefit package if a plan wishes to provide one." *Id.*, at 660. Nor is it implicated where State law "simply bears on the costs of benefits" or where it "can affect a plan's shopping decisions, but it does not affect the fact that any plan will shop for the best deal it can get . . . ." *Ibid.*

The Illinois Consumer Fraud Act does not "mandate employee benefit structures or their administration." *Id* ., at 658. It does not preclude uniform administrative practice or a uniform interstate package. It does not regulate the terms of a plan or the calculation of benefits under a plan. It only requires a provider of services to disclose material information about its business. Ill. Rev. State ch. 815, para. 505/2 (1998).

That there is no "relat[ion] to" the plan is clear from consideration of a more draconian measure. Assume the State outlawed HMO financial incentives entirely, prohibiting HMOs from offering such incentives to providers. The only conceivable affect on an ERISA plan would be an increase in costs through the elimination of countervailing incentives to

lower cost. Benefits are unaffected. Administrative practices are unaffected. Plan terms are unaffected. But the *Travelers* Court has already said that a State law with "indirect economic influence [that] does not bind plan administrators to any particular choice" does not "relate to" an ERISA plan. A law that only "bears on the costs of benefits" does not "relate to" the plan. A law that only influences a plan's "shopping decisions" does not "relate to" the plan. *Id.*, at 659-660. Elimination of incentives in HMO contracts with third party providers might make an HMO's services more expensive, but it would have no other affect on the plan, and a law prohibiting such incentives would not "relate to" the plan. If a State law that prohibits incentives entirely does not "relate to" an ERISA plan, a State law that requires disclosure of such arrangements surely cannot.

Two circuit court decisions have held that State law claims against an HMO for failure to disclose financial incentive arrangements were preempted. *Shea* v. *Esensten*, 107 F.3d 625 (8th Cir.), *cert. denied*, 522 U.S. 914 (1997); *Anderson* v. *Humana, Inc.*, 24 F.3d 889 (7th Cir. 1994). (*Shea* also ruled that HMOs have a fiduciary duty under ERISA to disclose financial incentives.) Both decisions are incorrect, and for the same reason: the courts equated the HMO with the plan or with plan administration. In *Shea*, the court found that the claim addressed "plan disclosures" and that "administrators would be forced to tailor their plan disclosures" to State requirements. 107 F.3d at 627. But the plan did not contain the incentive arrangements--these were contained in the HMO's arrangements with providers. And the "plan" was not compelled to disclose anything; only the HMO was required to

disclose information about its business.[20] The *Anderson* court found, similarly, that the plaintiff "wants employers" to change "the descriptions of the welfare benefit plan... [in] literature distributed as part of a plan's administration," 24 F.3d at 891. Again, HMO financial incentives are not part of the plan. They are part of the HMO's business arrangements with third parties and are not contained in plan documents. The employer in *Anderson* didn't have to do anything--only the HMO as healthcare business was required to disclose material facts about its business.

HMOs provide services to ERISA plans. But this does not relieve them of their obligation to ensure that handbooks, brochures and other marketing materials offered to the public, including plan participants, contain disclosures about HMO business practices required by State law. Because HMO businesses differ from state to state (and even within states), disclosures regarding HMO business practices will differ from state to state (and even within states).[21] This does not impose

---

[20]The court also stated that "claims of misconduct against the administrator of an employer's health plan fall comfortably within ERISA's broad preemption provision." 107 F.3d at 627. Even were ERISA's preemption "broad", *cf. Travelers; California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*, 519 U.S. 316 (1997), *De Buono*, this is much too broad. Not all claims against a plan administrator are preempted--only claims based on acts of plan administration.

[21]As a result of State insurance and business regulation, both the terms and benefits offered by HMOs and the medical structures of HMOs will vary from State to State, and thus (1) disclosure by HMOs will never be uniform in all States and (2) a rule requiring disclosure of HMO financial incentives will not disturb any existing uniformity in HMO disclosure practices.

burdens on the ERISA plan, any more than HMO compliance with State laws regulating landscaping or accounting burden the plan.

The Illinois law is consistent with ERISA's goal of protecting plan members. It does not interfere in any way with any ERISA function. It is not preempted.

State laws regulating the business activities of entities that sell products to ERISA plans do not "relate to" plans. "[L]aws that regulate only the insurer, or the ways it sells insurance do not relate to benefit plans in the first instance." *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. at 741.[22] The application of the Illinois Consumer Fraud Act to the HMO does not "relate to" the ERISA plan, and the district court erred in dismissing the original Count III and not remanding the case to State court.

---

[22] In *Blue Cross of California v. Anesthesia Care Associates Medical Group, Inc.*, the court distinguished between an HMO acting as ERISA plan administrator and an HMO acting as a healthcare business engaged in a contractual relationship with providers. 187 F.3d 1045 (9th Cir. 1999). The court held that the providers' claim based on a term in the provider agreement was not preempted. In *In re U.S. Healthcare*, the court ruled that claims based on "the HMO's role in 'arranging for medical treatment' rather than its role in determining what benefits are appropriate" were not preempted, 193 F.3d at 163. Where allegations "do not raise the failure of [the HMO] to pay for a benefit or process a claim for benefits as the basis for the injury suffered" *ibid.*, the claim does not relate to the plan. In *Coyne & Delany Co. v. Selman*, the court distinguished two roles played by an employee benefit consultant who designed an ERISA plan and then became plan administrator, ruling that a professional malpractice claim against the consultant for negligence in the design of the plan was not preempted. 98 F.3d 1457 (4th Cir. 1996).

III. RESPONDENT STATES AN ERISA CLAIM WHEN SHE PLEADS THAT HMO BENEFIT DETERMINATIONS IN ADMINISTRATION OF THE PLAN WERE BASED ON THE HMO'S OWN FINANCIAL INTERESTS

"A complaint should not be dismissed for failure to state a claim unless it appears beyond doubt that the plaintiff can prove no set of facts that would entitle him to relief." *Conley v. Gibson*, 355 U.S. 41, 45-46 (1957). It is axiomatic that the complaint must be read in the light most favorable to the non-moving party. *Scheuer v. Rhodes*, 416 U.S. 232, 236 (1974).

At the district court's direction, respondent re-pled Count III under ERISA. The new claim no longer alleged failure to disclose material facts. Instead, it alleged that the HMO breached its fiduciary duty in two ways:

--i. by contracting with CARLE owner/physicians to provide the medical services contemplated in the Plan and then having those contracted owner/physicians:

(1) minimize the use of diagnostic tests;

(2) minimize the use of facilities not owned by CARLE; and

(3) minimize the use of emergency and non-emergency consultation and/or referrals to non-contracted physicians [and]

--ii. by administering disputed and non-routine health insurance claims and determining:

(1) which claims are covered under the Plan and to what extent;

(2) what the applicable standard of care is;

(3) whether a course of treatment is experimental;

(4) whether a course of treatment is reasonable and customary; and

(5) whether a medical condition is an emergency,

all in order to augment their incomes. *Herdrich* v. *Pegram*, 154 F.3d 362, 373 (7th Cir. 1998).

1. *The claim based on medical services.* The first claim refers to decisions by physicians to perform (or not perform) certain tests, to use (or not use) certain facilities, and to make (or not make) certain referrals to other physicians. Claims based on the provision or arrangement of medical services, including claims based on physicians' decisions as to the appropriate treatment, place of treatment and provider of treatment, are not ERISA claims. Physicians do not engage in plan administration when they perform medical services or make medical decisions. Any claim against the HMO based on medical services of healthcare providers must be brought under State law.[23]

2. *The claim based on benefit determinations.* While the second claim is not clearly drafted, it appears to include both allegations of improper medical decisions and improper benefit determinations. Medical decisions are subject to State regulation, whether such decisions are made by the doctor or the HMO. If, for instance, the HMO, using medical judgment, decided that a treatment was or was not medically necessary in order to increase its income, this would implicate State (not

[23]Several courts have entertained vicarious liability claims against HMOs for wrongful acts of physicians. *See, e.g., In re U.S. Healthcare; Dukes* v. U.S. Healthcare, Inc.; *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Lupo v. Human Affairs Intern., Inc.*, 28 F.3d 269, 272 (2d Cir. 1994).

federal) regulation. Without a factual record, it is not possible to ascertain whether the HMO conduct alleged in claim ii involved medical decisions or benefit determinations or both.

While the ultimate disposition of this case will depend on facts developed in discovery--and the facts may ultimately show only improper medical judgment, subject to State regulation, or discretionary determinations under the ERISA plan, subject to ERISA fiduciary duties, or both--the complaint alleges that the HMO "administer[ed] disputed and non-routine health insurance claims and determine[d] which claims are covered under the plan and to what extent . . . ." Petitioners appear to acknowledge that they were subject to ERISA fiduciary duties when administering claims; in their brief they distinguish HMO business decisions from "coverage and eligibility decisions" and concede that they are fiduciaries when making such coverage and eligibility decisions (Pet. Br. 28).

Fiduciaries breach ERISA's duty of loyalty when they place their own financial interests ahead of the interests of plan participants in making administrative decisions. *See Donovan v. Bierwirth*, 680 F.2d 263 (2d Cir.), *cert. denied*, 459 U.S. 1069 (1982). A particularly black and white instance of such a breach would occur when an administrator receives a cash payment for denying a claim (*see* U.S. Br. 34). When an administrator's fiduciary decision is alleged to be based on a personal financial interest or a corporate financial interest, rather than an evenhanded approach based on plan criteria and the employees' interest in receiving plan benefits, there is a claim for breach of an ERISA fiduciary duty.

HMOs act both as healthcare businesses and medical care providers--subject to State law--and as ERISA plan

administrators--subject to federal law. For this reason, HMOs should be responsible for their wrongful business and medical conduct under State law and for improper ERISA plan administration under federal law--and in some cases, where both business and/or medical conduct and plan administration are improper, under both laws. Put another way, (1) HMOs should not escape responsibility for their actions as ERISA plan administrators simply because they are also healthcare businesses and perform healthcare services and (2) the fact that HMOs perform some acts of plan administration does not relieve them of their State law responsibilities as healthcare businesses and providers of medical services. Because the precise nature of the HMO's actions alleged in claim ii is unclear, *amici* respectfully suggest that the case should be sent back to the district court so that the HMO's conduct may be evaluated based on a full factual record.

CONCLUSION

The judgment of the court of appeals should be affirmed to allow a full development of the record.

Respectfully submitted,

JAMES E. RYAN
Attorney General of Illinois

* JOEL D. BERTOCCHI
Solicitor General
100 West Randolph Street
Chicago, IL 60601
(312) 814-7175

Of Counsel:
Dan Schweitzer
National Association of
Attorneys General
750 First St., N.E., Suite 1100
Washington, D.C. 20002

* *Counsel of Record*

December 20, 1999