IN THE SUPREME COURT OF THE UNITED STATES

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RUSH PRUDENTIAL HMO, INC., :

Petitioner :

v. : No. 00-1021

DEBORAH C. MORAN :

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Washington, D.C.

Wednesday, January 16, 2002

The above-entitled matter came on for oral argument before the Supreme Court of the United States at 10:07 a.m.

APPEARANCES:

JOHN G. ROBERTS, JR., ESQ., Washington, D.C.; on behalf of the Petitioner.

DANIEL P.ALBERS, ESQ., on behalf of the Respondent.

EDWIN S. KNEEDLER, ESQ., Deputy Solicitor General, Department of Justice, Washington, D.C.; on behalf of the United States, as amicus curiae.

C O N T E N T S

P R O C E E D I N G S

(10:07 a.m.)

CHIEF JUSTICE REHNQUIST: We'll hear argument first this morning in Number 00-1021, Rush Prudential HMO, Inc. v. Deborah C. Moran.

Mr. Roberts.

ORAL ARGUMENT OF JOHN G. ROBERTS, JR.

ON BEHALF OF THE PETITIONER

MR. ROBERTS: Thank you, Mr. Chief Justice, and may it please the Court:

ERISA preemption cases can be exceedingly complicated, but our submission this morning is straightforward. This Court held in Pilot Life that ERISA's civil enforcement provisions were the exclusive remedy for improper processing of a claim for benefits under an ERISA-regulated plan. The Illinois independent external review law at issue in this case affords a different remedy for a beneficiary dissatisfied with an HMO's denial of benefits. The Illinois law is therefore preempted.

Just last week, in Great West Life, this Court began its analysis by noting that it was especially reluctant to tamper with ERISA's enforcement scheme, and by quoting prior precedent for the proposition that that enforcement scheme indicated that Congress did not intend

to authorize other remedies that it forgot to incorporate expressly. That same language, quoted in Great West Life, was quoted 15 years ago in Pilot Life. ERISA's remedies are exclusive, whether we're talking about additional Federal remedies or additional State remedies.

QUESTION: Mr. Roberts, could you help me with one part of the facts I'm a little puzzled about? Your opponents argue there's a difference between the plan and the HMO, and that he claims that you -- what you say would apply to a suit against the plan, but this is a suit against the HMO, and I have been unable to find the plan in the papers. Is the plan in the record?

MR. ROBERTS: The respondent alleged in the complaint, joint appendix page 32 and 38, that the certificate of coverage was the plan, and that is in the record. It is Exhibit A to the complaint.

QUESTION: The certificate of coverage -- who are the parties to the certificate of coverage?

MR. ROBERTS: The certificate of coverage is an agreement between the HMO and the employer that extends to particular employees the benefits that are set forth there.

QUESTION: And in your view, you say -- are they just hooked by their allegation, or do you think it's clear that that is the correct -- that is the plan?

MR. ROBERTS: I think they're first bound by their allegation, but second of all, even if other documents also contribute terms to the plan, certainly the certificate of coverage indicates elements of the plan. There may be other documents that set forth other terms of the plan.

QUESTION: You see, they say that's an insurance policy that is purchased by the plan, in effect. That's -- and that therefore there's a distinction between the plan and the insurance policy, and I know you disagree. You say the HMO is not an insurance policy, but is there -- explain to me why that's totally wrong.

MR. ROBERTS: Well, it's totally wrong because the question is not how the State law operates to grant a new remedy to a beneficiary. We think it's irrelevant whether it operates on the insurance policy or whether it operates on the plan. The point is, however it operates, it provides beneficiaries, under an ERISA-regulated plan, with a new remedy, and that remedy is one that's not granted by Congress in ERISA, and the Court in Pilot Life said only the remedies that are granted are available.

QUESTION: Of course, one could also say it's not really a new remedy, it's a new protection, sort of like the -- see, the question is whether Pilot Life controls or the Massachusetts case controls. It's an

interesting -- whether it's something like a compelled benefit or a compelled protection of some kind --

MR. ROBERTS: Right.

QUESTION: -- that the insurance company provides.

MR. ROBERTS: Yes, and I think the difference is, between mandated benefits laws like Massachusetts, those laws provide, as this Court said in UNUM, a rule of decision that is to be applied by whoever the decision-maker is in reviewing a denial of benefits.

Here, it's not a new rule of decision, it's a new decision-maker, and that decision-maker isn't looking to State law to say, well, they've given you mental health coverage and so that has to be provided, he's deciding what -- whether the denial of benefits was proper or not, and that can only be characterized as a remedy, whether it's --

QUESTION: Well -- no, I didn't mean to interrupt.

Isn't the problem that he's doing two things? The decision that he makes is necessarily going to have its consequence on whether the benefit denial was correct or not, but he's also making a medical kind of decision, is, in fact, this reasonable medical practice, and so he's not merely in the position which a court is in when a

court says, does the evidence show this is reasonable medical practice. He's in the decision of, in effect, making a kind of practice decision which doctors, as doctors, make, so it's somewhere in between.

MR. ROBERTS: We don't think that's a correct characterization. There is no element of a treatment component in this decision. The only thing that is at issue in this independent external review is coverage, for a number of reasons. First of all, the treatment had already taken place. There was no question of treatment. But coverage is all that Rush HMO has undertaken to provide. It does not provide health care. It doesn't provide -- it agrees to pay for health care.

QUESTION: Well, this particular -- I'm assuming in answer to your -- from your answer to Justice Stevens, I'm assuming that in this case it is so, but their argument is, you can have HMO's that have nothing to do with ERISA plans, and you can have ERISA plans that don't employ HMO's to provide welfare benefits, and therefore it's appropriate to think of this as a medical decision or as a regulation of medical practice in a particular form, rather than insurance, so once again there's -- the problem is that the facts do not place this in a clear category.

MR. ROBERTS: Well, I -- with respect, I think

the facts do place this in a very clear category, because there's no question of treatment at issue. Even if the State is purporting to articulate its definition of medical necessity, that's not the question. The question is, is this beneficiary entitled to benefits under this plan, and the judgment about what is medically necessary is something that is addressed in the plan. The plan provides the broadest possible discretion to the HMO to interpret the plan terms, including medical necessity.

QUESTION: Well, but what if the State law in effect tinkered with how you interpret the plan, and spelled out that in determining what's medically necessary the plan will make use of an independent medical consultant.

MR. ROBERTS: Well, the State law can define medical necessity. I think that's just like a mandated benefit, saying you have to --

QUESTION: And can it not say, and furthermore, if there's any dispute you will use an independent medical consultant?

MR. ROBERTS: That it cannot do consistent with Pilot Life, because that is a remedy for a denial of benefits, and Pilot Life indicated --

QUESTION: Well, not necessarily. It may be more a definition in the plan, or a provision of the

insurance plan itself, and then that in turn is enforceable under section 502.

MR. ROBERTS: Well, that's --

QUESTION: I mean, that's the argument, and I can understand that that, you could view it through that lens, could you not?

MR. ROBERTS: And I think, as Judge Posner pointed out in his dissent, if you do that, then all bets are off. If you say that this is incorporated by State law into your plan, and so when you enforce that remedy, all you're doing is enforcing a term of the plan --

QUESTION: Well, is that so surprising, in light of the fact that the ERISA law itself excludes regulations of insurance? The law itself took that out of ERISA coverage, in effect.

MR. ROBERTS: Well, now that was the specific question addressed in Pilot Life. That was -- the heavy lifting in the Pilot Life opinion was reconciling the exclusivity of the civil remedies and the Saving Clause. You can look at it one of two ways. If you give the Savings Clause full force, then the remedies aren't going to be exclusive in a case involving an insurer. If you give the exclusivity of ERISA's remedies full force, then the Savings Clause is relegated to a lower status, and --

QUESTION: Well, we had a case, U-N-U-M v. Ward,

and held that any statute that effectively creates a mandatory contract term and regulates only insurance companies is an insurance law under the Savings Clause.

MR. ROBERTS: UNUM did not involve a remedy. It said, the question under Pilot Life and 502 was, quote, not implicated, because it wasn't a State remedy that they were trying to save under the insurance Savings Clause. It was a rule of decision. This is not a rule of decision. It's a different decision-maker, and if this type of State law remedy is allowed, then there's nothing left --

QUESTION: But UNUM --

QUESTION: But Mr. Roberts, can --

QUESTION: -- wasn't a procedural ruling. UNUM was a question of how late could you file, and the State law said you could file late, and --

MR. ROBERTS: The law --

QUESTION: -- why should that be treated differently? The State is making something timely, giving the beneficiary a chance to collect that the plan itself would not have given.

MR. ROBERTS: I think that's correct. I -- the line is not -- and this is what UNUM taught. The line is not between substance and procedure when you're talking about mandated coverage. That's not the line we're

advocating. The line we're advocating is between mandated coverage, what does term, what does the plan have to provide, and UNUM said, one thing it has to provide, whatever the coverage is, coverage for those claims that are filed in a timely manner, or, if not, that did not prejudice the insurer.

This is different. This is not a new term of coverage. It's a remedy. If you don't like what the HMO has done with your benefits claim, you get to go to a State law, independent external reviewer, and get it overturned, and --

QUESTION: But it's a different kind of remedy than saying, for example, punitive damages. It's --

MR. ROBERTS: It --

QUESTION: And I thought that's what Pilot Life was about.

MR. ROBERTS: The argument is made that this is okay because all you get are the benefits that you're entitled to under the plan. We think that the Taylor decision, decided the same day as Pilot Life, rejects that argument. It says that one of the claims in that case was for the benefits due under the plan, not punitive damages, not emotional distress, the plan benefits, and the Court said, that's not only preemptive, that's completely preemptive.

ERISA preempts not only different remedies, but alternative, additional remedies.

QUESTION: Well, under your theory there could be no private arbitration agreement by an HMO plan and people covered by the plan?

MR. ROBERTS: No. I think that's certainly an open question. The issue there would be --

QUESTION: I don't see how it's open under your view.

MR. ROBERTS: Arbitration -- it's the difference between a voluntary agreement between parties, which is what ERISA seeks to enforce, and something that's compelled by State law. The analogy that the Solicitor General draws to the collective bargaining --

QUESTION: But under your rationale, 502 controls. It's a remedy. So how could a private agreement to arbitrate survive under your theory?

MR. ROBERTS: Well, it would survive because it would be regarded as an internal plan procedure, not --

QUESTION: But wouldn't it also conflict -- wouldn't it also conflict with the statutory provision?

MR. ROBERTS: No. No. I mean, the -- ERISA allows internal remedies, appeals within the plan, and again it's an open question, but we don't dispute that the arbitration would be allowed.

The problem with the analogy to the arbitration cases is that the Solicitor General stops too early. Yes, you can have voluntary arbitration, even where remedies are preempted, but surely a State law that directed that parties to a collective bargaining agreement must arbitrate, and here's how they must arbitrate, would be preempted by the Labor Management Relations Act.

If you pursue the analogy to a situation that's comparable to this case, the conclusion that there's preemption seems to follow inexorably, and the idea that everything is all right because at the end of the day you have to enforce this in a section 502 action really makes a hollow shell out of Pilot Life. You have to sometimes enforce arbitration in court, but we still think of arbitration as a different remedy. We don't say, that's a judicial remedy because it has to be enforced.

QUESTION: Yes, but there's another difference with Pilot Life, and that, the only question is whether it related to the insurance. Here, you have -- you admit it's related, but then you get onto the second ball game of whether it's a change in the insurance coverage, and one can look at this, I think -- I just need -- I want you to comment on this -- as not changing a term of the plan, but, rather, changing a term of the insurance policy purchased by the plan.

MR. ROBERTS: And we actually go on to the third game which is, if it conflicts with the substantive term of ERISA, and this is what Pilot Life held, it is preempted, and this conflicts with the exclusivity of the remedies.

We don't believe, when you go through the usual insurance Savings Clause factors, that this is the regulation of insurance, but what Pilot Life held, and this was the important part of the decision, which was unanimous, is that when you look at the Savings Clause you have to be informed by an understanding of what Congress was trying to do with the exclusive remedies, that the most important -- quote, most important consideration in deciding whether that remedy in that case is covered by the Savings Clause was that Congress said that all the remedies were exclusive. If you allow them back into this back door of the Savings Clause, then that exclusivity is going to be completely undermined. That's the issue that's here before the Court.

QUESTION: That is -- I'd like to expand just a little, because I'm actually trying to work out what's the framework within which we think of this, and I had thought that that part of Pilot Life was really part of the reason for interpreting the Savings Clause as it was there interpreted, that normally what you do is ask the first

question, is this preempted in the first place, and it is if there's field preemption, if there's conflict preemption, and maybe, with ERISA, if there's something more, and ordinarily, if there is such a conflict, the Federal side wins, but the whole point of the Savings Clause is to say, if there's a conflict in respect to insurance, the State wins. Stop right there.

But then maybe Pilot Life adds something else, which says, but it couldn't just say if there's a conflict that brought you into preemption in the first place, well, the Federal Government wins, because that would be to eviscerate the meaning of the Savings Clause. Now, that's the framework in my mind, and I'd appreciate anything you could help with that.

MR. ROBERTS: And again, that poses sort of a conflict between what the Court in Pilot Life said were the exclusive remedies and the Savings Clause. That is what this Court unanimously decided 15 years ago in Pilot Life when it said, when we look at the Savings Clause, the most important thing -- most important thing -- is to keep in mind the remedies are supposed to be exclusive, so that if this is a remedy, it is a regulation of ERISA, it is not the regulation of insurance, and the Court reaffirmed that approach in the John Hancock case where it said, and I'll just quote one sentence, no decision of this Court

has applied the Savings Clause to supersede the provision in ERISA itself.

If you apply the Savings Clause to allow this State law remedy to be applied, that would be superseding what this Court said section 502 of ERISA meant in Pilot Life, which was that these remedies are exclusive. That question was addressed. That was -- and I'll say it again, that was the hard part of the opinion in Pilot Life, and that was reaffirmed in John Hancock, and --

QUESTION: I see that. Then I'd think what you're saying, I take it, is at least where the conflict is particularly severe, it's perhaps not -- the State doesn't necessarily win, and you think this is a particularly bad one.

MR. ROBERTS: Well, I do think it's particularly bad, but I don't think it has to be. I think if the State law stands as an obstacle to the accomplishment of the Federal objectives, it is preempted. The Federal objective requires exclusivity with respect to remedies. This obviously stands as an obstacle to that objective and so is preempted.

Now, they say it's saved because the last stop in this State law remedy is a quick dash into Federal court to get a stamp that says, enforce. The State law says, if the reviewer says you've got to provide this, the

HMO has to provide it, and they say, well, that's okay, because we run into Federal court, we make this a 502 action.

Well, that makes Pilot Life ridiculous, because it says every type of remedy is okay so long as the last stop is a quick visit to the Federal courthouse. It also raises very serious Article III concerns, because Federal courts are not supposed to be looking at decisions made by -- made under State law that they have no authority to review and simply rubber-stamping them, and it gives rise to the bizarre results that the respondent and the Solicitor General support in this case that an action to enforce section 4-10 is completely preempted so that there's jurisdiction, but then it turns out section 4-10 is not preempted at all. That's a very curious result, but they have to maintain --

QUESTION: What is section 4-10, Mr. Roberts?

MR. ROBERTS: 4-10 is the State law, of the Illinois HMO act. I've been referring to it as the independent external review law. But they have to maintain that facade.

QUESTION: Would you state the absurd positions again?

(Laughter.)

QUESTION: It didn't strike me as that absurd,

but --

MR. ROBERTS: What is absurd is that they have to maintain that this can only be enforced under a 502 action, that the State law claim -- keep in mind this began, of course, as a State law claim in State court. 502 wasn't mentioned at all. It was recharacterized as a 502 action, they said because it's completely preempted, but the underlying remedy that's being enforced isn't preempted at all.

Now, those are two different questions, jurisdiction and substance, but it does seem odd that if you're going in and all you're doing is getting a rubber stamp from the Federal courthouse saying, enforced, that that's completely preempted, when the law isn't preempted at all.

QUESTION: Well, what they're -- it's not absurd, in their view, anyway, because they're saying they have a human being over here called an arbitrator and this human being tells you what the benefit is, and what your clients are really objecting to, frankly, is not this remedy. They couldn't care less.

What they're worried about is that that human being called the arbitrator is going to say that this woman has to have a certain treatment that otherwise in their view she wouldn't have to have. I mean, just

imagine the statute that said, instead of what it says, that you have to provide medical treatment whenever there's a 25-percent chance of improvement. No arbitrator at all in that one, and they'll be even more excited, and indeed, it doesn't take away the Federal remedy in my hypothetical, nor does it in this one. It just turns out that we know who's going to win.

MR. ROBERTS: Well, that's because there's a different decision-maker making the decision on your claim for the denial of benefits, and that's what makes it clear that what's involved is a different remedy.

It's also a remedy that changes dramatically what the plan actually provides, and it does that by taking away from the plan fiduciary the deference that the fiduciary --

QUESTION: Is that fiduciary, a definition of his powers of review and so forth, in the record anywhere?

MR. ROBERTS: I'm sorry, the --

QUESTION: The -- you two or three times refer to the fact that the plan gives the fiduciary this standard of review. Is that in the record?

MR. ROBERTS: No. The only elements of the plan that are in the record is the certificate of coverage, which --

QUESTION: So for all we know the plan might

actually say, whatever Illinois law requires the decision-maker to do shall be done.

MR. ROBERTS: Well, that's what the law provides.

QUESTION: I mean, maybe the plan says that, too, for all I know.

MR. ROBERTS: No, because the elements of the plan that are in the record, the certificate of coverage, notes that the HMO has the broadest possible discretion to interpret the terms of the plan in deciding coverage and, under this Court's decision in Firestone --

QUESTION: It says that in the certificate?

MR. ROBERTS: Yes, and -- pages 7 and pages 8. It's Exhibit A to the complaint -- and under this Court's decision in Firestone, that means that that decision is subject to a deferential review.

The State law changes that, and the State law gives the decision to the independent external reviewer, who makes his decision apparently de novo, so that the precise thing that the plan participants, parties contracted against, the recognition that this medical necessity is a question of judgment, some people are going to view it differently, we want to make clear that it's our discretion that controls, and that gives us entitlement to deferential review --

QUESTION: Mr. Roberts, some close to 40 States have laws like this?

MR. ROBERTS: Yes.

QUESTION: And there's legislation introduced, at least in Congress, to accomplish what?

MR. ROBERTS: My understanding of many of the pending bills is that they have an external review provision but, of course, it's a Federal one, and that is consistent with ERISA's goal of uniformity in claims processing and administration.

QUESTION: Do you know anything about the status of that pending legislation?

MR. ROBERTS: No.

QUESTION: No.

MR. ROBERTS: Other than at various times passage is imminent, and then it falls apart, but again it's a very different thing to say, this is the uniform Federal remedy, and to have, as Your Honor points out, 40 different remedies, if you're running a company that has a health care plan with operations in different States, the health plan can't be uniformly --

QUESTION: Are most of the State law provisions similar to the one in Illinois?

MR. ROBERTS: They all have differences. For example, in some States the independent external reviewer

is an administrative board. In Michigan, it consists of seven people in certain places. In some places it's not just one person, it's more than one person. Some places it consists of employee representatives as well as physicians, but it does change what the parties contracted for, and --

QUESTION: Why is that a more disturbing change than changes in what is the minimum required coverage?

MR. ROBERTS: Well, I don't know that it's more disturbing. It's different, yes. The impact on an HMO can be greater if the State law says, you must provide mental health coverage, this, this, and this, but then at least the employer looking at it knows what's at stake, and he knows that the remedy is going to be the remedy that is provided under Federal law, which is that they're going to enforce what I have agreed to provide under this plan, even if what I've agreed to provide is compelled by State law.

You know that you're not going to face all sorts of different remedies and in particular, here, if you contract for the broadest possible discretion, you know that when the review is undertaken your fiduciary decision will be reviewed with appropriate deference. That is taken away here. It's taken away by giving the independent external reviewer the authority to make a de

novo decision, so that what is set up are two very different remediary regimes.

The Federal regime, the fiduciary makes a decision with the broadest possible discretion. His obligation is to be faithful to the terms of the plan. That is reviewed in Federal court.

QUESTION: But it's not the fiduciary's decision, as I understand it. It's the insurance policy's decision.

MR. ROBERTS: Or someone to whom that discretion has been delegated under ERISA, and there's a provision in ERISA that allows them to say, this is the entity that is going to make the final decision. Under 503, that is a fiduciary decision, the final denial or grant of benefits. That's the Federal remedy.

The State remedy is, the independent external reviewer makes his or her decision, and that decision is binding and final. Those are two very different remedies, ERISA's remedies are supposed to be exclusive, and the decision below undermining that exclusivity should be reversed.

QUESTION: Mr. Roberts, before you sit down, would you just give me a moment of your views on whether or not it's appropriate to regard the HMO as an insurance company?

MR. ROBERTS: The HMO is properly regarded as an insurance company when it is engaged in the business of insurance. Just because it's an insurance company doesn't mean that all of its activities, including claims processing, for example, are necessarily the business of insurance.

QUESTION: Very well, Mr. Roberts.

Mr. Albers, we'll hear from you.

ORAL ARGUMENT OF DANIEL P. ALBERS

MR. ALBERS: Mr. Chief Justice, and may it please the Court:

Illinois section 4-10 is an insurance law that does not conflict with ERISA section 502 or this Court's decision in Pilot Life, and therefore it is enforceable to protect the interests of Illinois Insureds like Deborah Moran.

QUESTION: Does the Illinois law provide for review in Illinois State courts?

MR. ALBERS: The Illinois law does not provide one way or the other. Section 4-10 does not say that. This case was reviewed and was enforced by the Seventh Circuit as a 502 action.

QUESTION: But the action was originally brought in State court, was it not?

MR.ALBERS: I originally brought the action in

State court to enforce the independent review because the insurer was refusing to provide any independent review at all, and the two parts of the statute, the requirement that there be medical necessity, this review and then the actual enforcement of the decision, were parsed at the district court level and in the Seventh Circuit. Judge Conlon initially remanded the case after it was removed, finding that the medical necessity portion of the statute did not offend Pilot Life or section 502.

Back in State court, Judge Kinnaird in Chancery found that medical necessity did not offend 502 and ordered a medical necessity review. The medical necessity review determined that the procedure was medically necessary. It was then -- I then sought payment of the benefit, and that was removed to Federal court and Judge Conlon found that was a 502 action.

QUESTION: If the Seventh Circuit view is upheld by this Court, in the future would actions lie in State court to enforce this, or just under 502?

MR. ALBERS: I think consistent with the Court's 502 ruling in Pilot Life, it would be a 502 action to seek benefits. I think there's a different question with respect to whether it was just the enforcement of the statute which requires medical necessity. I don't think that then you're seeking the benefit, and I submit that it

was perfectly appropriate to send this case back to State court for that determination and that ruling, but ultimately, to get the benefit, I would suggest that that would have to come under 502, under the Court's reasoning in Pilot Life.

This case does not conflict with Pilot Life, as petitioner suggests. In addressing the conflict issue which has been raised, which I think is central to the decision the Court needs to make, I think the Court should consider the burdens that petitioner must meet to show that conflict. ERISA preemption is a defense.

QUESTION: Could the State provide for liquidated damages, do you think --

MR. ALBERS: You mean, damages other than the benefit itself?

QUESTION: -- under the reinsurance regulation exception?

MR. ALBERS: You mean, other than the benefit itself, Your Honor?

QUESTION: Uh-huh.

MR. ALBERS: I would submit, under your -- the Court's ruling which you wrote in Pilot Life, that it would probably be inappropriate to go beyond the specific damages that are permitted in ERISA, which is recovery of the benefit, and I think then under the statute you're

permitted to recover interest and attorneys's fees, and that is all Deborah Moran has ever sought in this case was the benefit that she was entitled to under the Illinois statute for what was determined to be a medically necessary procedure, which also saved her right arm.

QUESTION: How --

QUESTION: That's true, but the question is, who is to decide she has gotten what she was supposed to get, and the claim here is that that was supposed to be decided pursuant to one system of review, and the State has substituted a totally different --

MR. ALBERS: And under 514(b), the Savings Clause, the State has the right to do that. That does not offend ERISA in any way. Section 503 --

QUESTION: Isn't that what Pilot Life was all about?

MR. ALBERS: Pilot Life did not talk about who the decision-maker would be. Pilot Life talked about the enforcement of the benefit had to be in Federal court under 502. Pilot Life was a State common law cause of action which was not an insurance law in bad faith and in contract which sought compensatory and punitive damages beyond the benefit. The Court said, you can't do that, because that offends 502 and, by the way, all --

QUESTION: I see, so you think all it meant was

the last shot has to be in Federal court.

MR. ALBERS: I think it --

QUESTION: I assume the State could provide that all of these contract claims would be first reviewed in State court so long as it further provides that the ultimate judgment of the State court would only be enforceable by suit in Federal court. Would that be okay?

MR. ALBERS: I think that's -- if the State law provided for a judicial review in State court, I think that would offend 502. The State law does not provide for that.

QUESTION: Arbitration is not another means of review? I mean, I --

MR. ALBERS: No, I don't think arbitration is --

QUESTION: You don't think you change the remedy --

MR. ALBERS: No.

QUESTION: -- if you say the remedy is not a lawsuit but arbitration? I --

MR. ALBERS: The remedy --

QUESTION: I find that a startling proposition. Sure, arbitration has to be enforced in court, but I've always thought that that's a separate remedy. You ask, what's your remedy, is it a lawsuit or arbitration?

MR. ALBERS: And this gets down to the issue of what a remedy is, and I looked up remedy in Black's Law Dictionary, and it has two elements. It has the process, some courts have found, and it also has the result of the process, the enforcement, and I think in Pilot Life the Court was talking about the enforcement, not the means of reaching it.

QUESTION: Okay, consistent with that, in a shorthand kind of way we refer to this as an arbitration, or as an arbitration decision. Is the independent reviewer acting really as an arbitrator in the classic sense? I'm assuming that an arbitrator in the classic sense listens to evidence in arguments and decides which of those evidence and arguments is the better according to some legal standard.

I have assumed, contrast, that what the independent review here is doing is not only listening to other people, but making a medical judgment himself, as a physician. If the latter is true, then it doesn't seem to me that it is a classic example of arbitration, but I may be wrong on that, and I don't want to lead you in the direction of an analysis that ultimately will not pan out. Am I right in distinguishing true arbitration from this, or should we regard this as true arbitration imposed by State law?

MR. ALBERS: I think this is not -- I think you're right, and I think this is not true arbitration as imposed by State law. I think the Court found in Pegram that medical necessity decisions contain both elements of coverage determination and elements of a medical --

QUESTION: What is --

QUESTION: May I just ask one -- they did in that case, but my concern is, is that true here? In other words, what can you tell me about the terms under which the reviewer acts that says this is, and in part at least, or ultimately, an independent decision by the reviewer about medical necessity as opposed to an adjudication of which side has the better claim, which an arbitrator might make?

MR. ALBERS: The statute itself, 4-10, requires an independent review by a physician in the relevant specialty. The statute doesn't provide any further guidance with respect to how that review is going to be done. In this case, it was done de novo. It was done by supplying the relevant definition of medical necessity to a reviewer from the insurance contract certificate, and providing all the relevant medical records.

QUESTION: Does it matter under Illinois, under the Illinois law, whether there's an adequate treatment that's less expensive?

MR. ALBERS: No. It's de novo review by the independent reviewer.

QUESTION: And there's no element in it of determining whether there's a slightly less effective remedy, but with fewer risks and less costly? That's irrelevant?

MR. ALBERS: The statute doesn't address that. I think that if that was a part of the definition of medical necessity that was in the insurance contract document, that would be relevant to the reviewer's decision.

QUESTION: It can be in the insurance contract, those provisions? It wouldn't conflict with Illinois law?

MR. ALBERS: Illinois law does not define medical necessity, and so for our analysis we've assumed the only place that the reviewer could go would be to the plan documents and the plan document here is -- there is no plan document, but the relevant portion of the plan document is the insurance contract which defined medical necessity, and that's what the reviewer used, and that's my understanding of what they intended.

QUESTION: And how did they define it? What was the definition?

MR. ALBERS: There were a variety of factors to consider. What are the available treatments? Are they

accepted generally in the medical practice?

QUESTION: But wouldn't the --

MR. ALBERS: What are the risks?

QUESTION: I mean, the word necessity sounds like it means you have to have this, and if you had something that would be equally effective and less expensive, then it wouldn't be a medical necessity. Is this the general understanding of what necessity is, or -- you seemed to be saying earlier that it was something different.

MR. ALBERS: I'm not sure I understand.

QUESTION: I thought that --

MR. ALBERS: I'm sorry, Your Honor. I'm trying to --

QUESTION: You asked whether, suppose -- I think Justice O'Connor asked you, suppose there was effective treatment that was less expensive, would this particular treatment still be a medical necessity, and I thought you answered yes to that question.

MR. ALBERS: I think that's up to the judgment of the independent reviewing physician. He certainly can take into account whether there's an equally efficacious treatment available that's less expensive, and then reach his judgment as to which one he or she believes is medically necessary in that circumstance.

QUESTION: Could I come back to your colloquy with Justice Souter? The conclusion that you drew is that this is not really arbitration because it's a doctor. What would it take to make it a remedy of arbitration? Why isn't it arbitration? Suppose a lawyer -- suppose the Illinois law read just the way it reads now, except it wouldn't be a medical doctor who posses on this but, rather, a lawyer who would hear medical testimony from both sides. Would that, putting a lawyer in the shoes, convert it to arbitration?

MR. ALBERS: My understanding of what Justice Souter asked me was that it had the traditional elements of what we consider an arbitration, which is, you review the evidence from both sides, they have an opportunity to argue, and then you make a decision, and that's what I meant when I said it's not classic arbitration. It is like arbitration, in that you give it to a neutral third party who then makes their review.

QUESTION: There are no submissions to the doctor in this situation?

MR. ALBERS: The Illinois law does not provide -- and actually what -- for the specifics of that, what it does say is that the HMO must set up the independent review mechanism, and there is no authority in Illinois on what that must contain or not contain.

QUESTION: What does it contain? I would find it surprising if both sides didn't press upon the doctor there their view of the case. You mean, he just sort of walks in blind and --

MR. ALBERS: All I can tell you is what happened in this case, Your Honor. In this case, the HMO submitted a series of questions to the doctor, one of which was -- and it included a lot of the elements that Justice Ginsburg asked about and Justice Souter asked about with respect to, what are the available treatments, are they less expensive treatments, what are the risks, and so on, and then he was given all of the relevant medical records and given the definition of medical necessity, and he made a determination that this particular surgery was medically necessary.

QUESTION: And what about your client? Did you put any questions to the doctor?

MR. ALBERS: We did not, because they covered all the questions we thought were relevant.

QUESTION: You mean, you don't actually want to know how the system works in Illinois? I mean, I'm also quite surprised that in the Illinois system, which has been running for sometime, the patient wouldn't have an opportunity to say to the arbitrator, this is my side of it, and I would be equally surprised if the doctors who

think the other way don't have an opportunity to tell the arbitrator what their position is.

MR. ALBERS: There's --

QUESTION: Maybe I'm always surprised in a lot of things --

(Laughter.)

QUESTION: So tell me I should be surprised.

QUESTION: May I go back to Justice --

QUESTION: What is the answer, though? What is the answer? Do you not -- are you not familiar with the system in Illinois?

MR. ALBERS: Your Honor, I'm probably as familiar as any lawyer in Illinois.

QUESTION: Fine, if you're as familiar as anyone, and it's an ongoing system, and I think the --

MR. ALBERS: This is the only case.

QUESTION: This is the only case Illinois has ever had?

MR. ALBERS: This is the only legal case that's ever been brought under the medical necessity statute.

QUESTION: No, is this the only case in which the arbitration system has ever worked in Illinois?

MR. ALBERS: I have no data on that, and the State doesn't keep data on that. I did ask --

QUESTION: Do you accept that this is an

arbitration system, then? Do I understand that in your response to these questions? You think it is an arbitration system?

MR. ALBERS: I think it is an arbitration, and then it goes to a neutral third party --

QUESTION: Well, I would be amazed if people -- I mean, am I right to be amazed that you have a system where people can't make arguments --

MR. ALBERS: I --

QUESTION: -- or can't present their point of view to the arbitrator? I've never come across such a thing, and I take it --

MR. ALBERS: There's nothing in the law that precludes either one of the parties from --

QUESTION: Could I ask you a slightly different question, which is the thing that -- I'd very much appreciate, before your time expires, if you could just address for at least a minute or so what I think is a difficult aspect of the case. Why is this insurance?

That is, what I'm thinking is that, after all, every company that sells a product with a warranty is to that extent an insurer. Every credit card that says you can return defective merchandise is to that extent an insurer. Every manufacturer, even without a warranty, who accepts a product back because it's defective is an

insurer.

Yet Congress couldn't have meant in this Savings Clause to allow States to win conflicts that broadly, so why does this fall within the kind of insurer that must fall within this Savings Clause?

MR. ALBERS: I think the Court in Pegram -- and it wasn't the issue before the Court in Pegram, but said that HMO's act like insurers and transfer risks like insurers, and the Illinois statute defines an HMO as an entity that bears risk.

QUESTION: That's why I gave my example, because I wanted you to see that virtually every manufacturer of the United States is a insurer in that sense, and so is this the kind of thing that Illinois has traditionally regulated? Is it the kind of thing that other insurance commissioners have tended to regulate? What makes this an insurer different from General Motors?

MR. ALBERS: Yes to both those questions. The HMO Insurance Act is part of the Illinois Insurance Code, and I think that insurance law meets all the factors the Court has set forth in its prior decisions with respect to what constitutes an insurer.

QUESTION: What about a law firm that handles all of the client's legal business, just as an HMO handles all of the client's medical business, for a flat fee, and

there are firms that do this, especially in the labor field. Many unions just hire a firm to handle all of the union members' legal business for the whole year. Is that law firm, like this HMO, an insurer?

MR. ALBERS: I don't think so. That's -- it's not a --

QUESTION: What's the difference?

MR. ALBERS: They're not a traditional insurer.

QUESTION: One is providing legal services, and they don't know how much it's going to come to for the year, and the other one is providing medical services and they don't know how much it's going to come to for the year.

MR. ALBERS: Well, laws regulating them would not be directed to them as acting as insurers. They're not traditional insurers. They don't meet the common sense definition of what an insurer --

QUESTION: I don't think an HMO does, either. I --

MR. ALBERS: This law is limited to the insurance industry. It's limited to HMO's when they bear risk. It does transfer risk by the very operation of the statute. The Seventh Circuit and the Fifth Circuit agree that this is a statute which regulates insurance, and under this Court's precedents set forth in UNUM, the Court

doesn't ordinarily disturb that determination of State law, so I would -- I respectfully submit that it is an insurance company for purposes of what regulates insurance under 514(b).

QUESTION: Well, I think the question of what's insurance under ERISA is a Federal question, not a State.

MR. ALBERS: Yes, that's -- for purposes of 514(b), but you look at those factors, and one relevant factor is whether it -- whether the State considers it to be an insurer or whether it regulates it as an insurer, and in both situations it does here.

In conclusion, I would suggest, in response to Justice Souter's question to petitioner, that this case falls squarely between the Court's two precedents in Massachusetts, Metropolitan Life in Massachusetts and UNUM. It contains a procedural element of medical necessity, which is the relevant rule decision, just as the UNUM case determined that the notice prejudice rule was the relevant rule of decision, and it contains a substantive element, which is a mandated benefit term. Once the medical necessity determination is made, that is a mandated benefit, and I submit to accept petitioner's argument this Court would have to reverse its decisions in UNUM, in Metropolitan, and in FMC.

The effect -- I think Justice O'Connor raises

this issue, what would be the effect of such a ruling on voluntary agreements, and I agree with the proposition that if there's a conflict between independent review and 502, then the parties couldn't even agree to provide independent review, which would change the practice across the country, because it is being provided by self-insured plans and by HMO's.

Under 514(b), I submit that this is a State insurance law which looked to harmonize the effect of that law and affirmed the States can regulate insurance and can regulate insurers' medical necessity decisions by leaving those medical decisions to doctors, who should be making them.

If there's no other questions --

QUESTION: May I just ask, on the question of whether it's an insurance company, does the State insurance agency regulate the -- you, in fact, would say the contract between the employer, the sort of unnamed employer that Ray talks about, and the HMO, is an insurance policy?

MR. ALBERS: Yes.

QUESTION: Does the Illinois Insurance Commission regulate the terms of that policy in any respect, other than this 510 -- this 4-10(c) provision?

MR. ALBERS: Yes. There's an entire statute

which regulates the terms, and there are, for example, minimum benefit requirements for breast cancer treatments, for mental health coverage, there are requirements for minimum funding, for reserves, and so on, so there's all the traditional --

QUESTION: Is the policy that this HMO issued to this employer the same form policy it issues to many other purchasers of HMO services from it?

MR. ALBERS: I can only assume it is. I have no evidence on that, Your Honor.

QUESTION: Very well, Mr. Albers.

Mr. Kneedler, we'll hear from you.

ORAL ARGUMENT OF EDWIN S. KNEEDLER

ON BEHALF OF THE UNITED STATES, AS AMICUS CURIAEMR. KNEEDLER: Mr. Chief Justice, and may it please the Court:

The claim is made here that the section 4-10 of the Illinois HMO act conflicts with section 502(a). In considering that claim, it's important to focus on the language of exactly what 502(a) addresses, and it is set out on page 2 of the petition. 502(a) is empowered --

QUESTION: 502 of the petition?

MR. KNEEDLER: Of the petition, yes. It's entitled, "Persons Empowered to Bring a Civil Action," and then it itemizes -- it then continues, a civil action may be brought by various persons, and then it goes on to

describe the judicial relief that may be granted, awarded in a suit under section 502(a). In other words, the preemptive scope of section 502(a) has to do with causes of action, civil suits in court, and the judicial relief that may be awarded in court, and that is precisely the formulation that the Court used in Pilot Life itself.

At the conclusion of the Court's opinion in Pilot Life, the Court said in distinguishing Metropolitan Life, the Court said the Court in Metropolitan Life had no occasion to consider the question presented in this case, whether Congress might clearly express through 502(a) an intention that Federal, the Federal remedy provided by that provision displaced State causes of action, and that's what the question was about in UNUM.

Here, section 4 -- excuse me, in Pilot Life.

Here, section 4-10 of the Illinois HMO statute does not provide a State cause of action in court, and it does not provide any remedy or relief beyond what's available under the plan itself.

QUESTION: Well, you could look at it that way, or you could look at it that it provides, the State law provides a cause of action before this arbitrator.

MR. KNEEDLER: I don't think that's the way it --

QUESTION: You have a claim before the

arbitrator that you haven't gotten what is medically necessary, and the arbitrator shall resolve that cause of action just as, under ERISA, the court would have resolved what the contract said.

MR. KNEEDLER: I don't think that's the ordinary understanding of what a cause of action is. A cause of action is ordinarily regarded as something that you would enforce directly in court.

QUESTION: So the only remedies that you can't displace ERISA with are judicial remedies. You can provide for any other kind of relief?

MR. KNEEDLER: Well, I -- my point is, that's what section 502(a) addresses, and the analysis in Pilot Life was, what does 502(a) displace, and it's -- another important feature of Pilot Life is, the Court went through the various remedies that section 502(a) provides, and tellingly discussed this Court's decision in Russell in which the Court held that punitive damages were not available in a suit against a fiduciary based on claims processing, and the Court said it was not going to allow a State cause of action to displace Congress' judgment about damage remedies to allow and not to allow, or have --

QUESTION: Well, Mr. Kneedler, supposing the State provided for a very elaborate arbitration procedure, you know, with right to counsel, specified the way the

hearing should be conducted and so forth, but didn't say what would happen. It just said the view of the arbitrator would be final. That would not be preempted, in your view, by 502 because it doesn't contemplate judicial enforcement?

MR. KNEEDLER: Yes, and if it also did not provide for relief beyond that was available in the plan itself.

QUESTION: Well, supposing that after that you could just simply bring an action under 502?

MR. KNEEDLER: I think that would not be preempted. In fact, most States -- in this case, Illinois has not tightly regulated the form in which the independent review will occur, and that's consistent with the fact that these are highly judgmental medical judgments that medical professionals are looking at.

QUESTION: That may be, but I want to go back to the Chief Justice's question for a minute. Just assume the absurd example in which the State provided that there are going to be sort of 10 steps of arbitration and review between the initial denial by the plan fiduciary and the right to sue, so that someone would be tied up for months or years before the person could get into court.

In each instance, I'm assuming that it would not be a provision by the State of a cause of action in the

sense that you have been using it, and yet wouldn't you concede in that case that the State scheme was keeping people out of Federal court for enforcement so long that it would, in fact, be in conflict and would be preempted.

MR. KNEEDLER: I think the analysis there would be one of exhaustion of remedies under the plan, including those required --

QUESTION: And if the exhaustion was exhausting, wouldn't you say that the --

MR. KNEEDLER: Yes, it could be excused, and the Department of Labor's regulations, and they --

QUESTION: No, but there would be a preemption in that case.

MR. KNEEDLER: There would be a preemption, but the Department of Labor has addressed that under its claims processing regulations. Section 503 provides for a fair administrative processing of claims, and a separate --

QUESTION: Okay, but doesn't that mean, then, that your answers to the several questions on this should be, it ultimately is a question of degree, this requirement of one step in a review process doesn't reach the point, in effect, of excluding the Federal remedy?

MR. KNEEDLER: Right. It does not stand as an obstacle.

Another point that the Court stressed in Pilot Life was that the Congress struck a balance between the prompt and fair processing of claims and suits in court. Well, but arbitration and independent review, measures adopted by State insurance laws of this sort, are precisely designed to facilitate the prompt and fair and expeditious processing of claims without having to go to court, so it --

QUESTION: Mr. Kneedler, doesn't it give you a very different remedy -- I mean, to say that it isn't just a matter of delay, that isn't the problem here. The problem here is that under the plan, the plan manager's determination was to be given deference by the Federal court in deciding whether the plan had been complied with, whereas under the scheme set up by the State, his determination is not to be given deference. It's this third party who's been brought in who will have the last word, and unless that's arbitrary, the court will enforce what he says. How can that possibly be regarded as the same remedy that ERISA provided?

MR. KNEEDLER: Nothing in section 502 -- and this Court made this clear in Firestone -- specifies the standard of review. The Court therefore looked to background principles of law there, in trust law. The Court here might look to background principles of

arbitration law, and also to the terms of the plan.

State law, as Justice O'Connor pointed out, might well be able to say that that sort of provision for deference to the plan administrator's interpretation of the plan should not be given. That would be a classic regulation of State insurance law.

I want to mention one other point about the characterization of Pilot Life, and that is this Court's decision in UNUM. The Court there said, whatever the merits of UNUM's view of section 502(a)'s preemptive force, the issue is not implicated here. The Court then went on to say why, because Ward sued under 502(a)(1)(B) itself to recover benefits it was not a displacement of the Federal remedy, it was an invocation of the Federal remedy to recover benefits, and the Court said in that cause of action, the notice prejudice rule of California insurance law supplied the rule of decision.

So, too, here, in the cause of action under section 502(a)(1)(B) the State Illinois HMO law supplies the rule of decision, a procedure for an independent reviewer to give a quick, prompt review of the claim, and that independent reviewer's decision is -- then supplies the rule of decision that the HMO must comply with, and that is then subject to review in Federal court.

The claimant's right to go to court is not

frustrated. He can seek review of the arbitrator's decision, or, as we point out in our brief, he can bypass this procedure altogether and can go directly to court, and so 502(a)(1)(B) confers rights on claimants, not on plans. Nothing in the HMO act stands as an obstacle to the claimant's ability to go directly to court.

Another important point about UNUM is, the Court made clear that the processing of claims under an insurance policy, it is an integral part of that insurance policy, but at the same time States may regulate the process by which claims are adjudicated, and that is precisely what the State has done in this case. It has provided a familiar mechanism. 40 States now have provided for this external sort of review, and it is common in insurance and medical practice to provide by second opinions by physicians, so what has been provided here is a very familiar sort of approach.

One other point about section 502, it's patterned after section 301 of the LMRA, an arbitration preceding judicial review is a very familiar aspect of judicial review under section 301. Section 301 itself does not provide for any particular standard of review. You can have de novo breach of contract suits, as in the Bowen v. Postal Service case we mentioned in our brief, or highly deferential standards of review where the

particular issue has been committed to an arbitrable process.

502 has the same flexibility. It can have a direct de novo cause of action, as the Court contemplated in Firestone, or, where the parties' underlying agreement or contract provides for a separate resolution process, there is deference to that process under section 502.

QUESTION: Thank you, Mr. Kneedler.

Mr. Roberts, you have 4 minutes remaining.

REBUTTAL ARGUMENT OF JOHN G. ROBERTS, JR.

ON BEHALF OF THE PETITIONER

MR. ROBERTS: Thank you, Mr. Chief Justice.

My friend Mr. Kneedler again drew the analogy to the Labor Management Relations Act, and we are on common ground. That's a good analogy. He again stopped one step short. A State law that compelled the parties to a collective bargaining agreement to resolve their disputes in a particular manner, even arbitration, would surely be preempted under the Labor Management Relations Act and, to the extent this remedy is similar to arbitration, that same conclusion applies.

We heard that there's no interference with 502 because beneficiaries have the option. They can use the Federal remedy, or they can use the State remedy. The existence of an alternative remedy is, in fact, an

interference with section 502, and that test is that option with the beneficiary is peculiarly inappropriate when you're talking about preemption.

Preemption often is the result of a quid pro quo. We're going to give, say, employees a Federal remedy, but for the employers we're going to make it exclusive. To say that additional remedies are okay so long as the employee can still resort to the Federal remedy seems to ignore the typical dynamic of preemption.

And as far as the arbitration analogy goes, the fact that the plans may or may not be able to voluntarily adopt such a remedy doesn't mean the State can compel it. Nothing prevented the plan in Egelhoff from voluntarily opting the beneficiary designation rule at issue there. that didn't keep this Court from ruling that it was preempted. Nothing preempted the plan in Greater Washington Board of Trade from saying, we're going to provide the same level of benefit to people on Worker's Comp as to others, and yet a rule mandating that was preempted.

We're dealing here with a compelled alternative State law remedy that changes completely the standard of review available under the Federal remedy. It's not surprising the results under the two remedies came out differently. That additional remedy is preempted.

Thank you, Your Honor.

CHIEF JUSTICE REHNQUIST: Thank you, Mr. Roberts. The case is submitted.

(Whereupon, at 11:05 a.m., the case in the above-entitled matter was submitted.)