No. _____

In The
Supreme Court of the United States

INTEGRIS HEALTH, INC.,
an Oklahoma corporation,

Petitioner,

v.

ELIZABETH CATES, Individually, and
on behalf of others similarly situated,

Respondent.

On Petition For Writ Of Certiorari
To The Oklahoma Supreme Court

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

The Employee Retirement Income Security Act, 29 U.S.C. §§ 1001 *et seq*. ("ERISA"), expressly preempts any and all state laws that "relate to" an employee benefit plan. 29 U.S.C. § 1144(a). Neither an agreement that an employee benefit plan makes with a hospital for the provision of network plan benefits, nor the fact that the hospital is the defendant in a participant's action for those benefits, avoids ERISA express preemption. In holding otherwise with respect to putative class action state law claims, the Oklahoma Supreme Court purports to overturn decades of this Court's jurisprudence. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990).

The question presented is:

Whether the Oklahoma Supreme Court misapplied 29 U.S.C. § 1144(a) and disregarded this Court's precedent in holding that state law claims brought by a plan participant asserting rights to provider network benefits under an employee benefit plan do not "relate to" the plan for purposes of ERISA express preemption.

RULE 14.1(b) STATEMENT

Petitioner INTEGRIS Health, Inc., an Oklahoma corporation, was Defendant/Appellee before the Oklahoma Supreme Court.

Respondent Elizabeth Cates, individually, and on behalf of others similarly situated, was Plaintiff/Appellant before the Oklahoma Supreme Court.

RULE 29.6 DISCLOSURE

Petitioner, INTEGRIS Health, Inc. has no parent corporation; and, as a nonprofit entity, Petitioner has no stock that a publicly-held company could own.

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PETITION FOR A WRIT OF CERTIORARI TO THE OKLAHOMA SUPREME COURT

Petitioner, INTEGRIS Health, Inc., respectfully petitions for a writ of certiorari to review the final decree of the Oklahoma Supreme Court in this case.

OPINIONS BELOW

The opinion of the Oklahoma Supreme Court (App. 1-21) is reported at 2018 OK 9, 412 P.3d 98. The orders of the Oklahoma district court granting petitioner's motion to dismiss (App. 31-33) and dismissing the case upon denying reconsideration (App. 28-30) are unpublished.

JURISDICTION

The final decree of the Oklahoma Supreme Court was entered on January 30, 2018. The Oklahoma Supreme Court's initial opinion was rendered on June 19, 2017 (App. 22-27); but the court granted rehearing, vacated the initial opinion, and entered a new one that is the subject of this petition. The jurisdiction of this Court rests on 28 U.S.C. § 1257(a).

STATUTE INVOLVED

The express preemption provision of the Employee Retirement Income Security Act of 1974, 29 U.S.C.

§§ 1001 *et seq*. ("ERISA"), 29 U.S.C. § 1144(a), is set forth as follows:

> **(a) Supersedure; effective date**
>
> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

STATEMENT

Respondent ("Plaintiff") is a participant in an ERISA-governed employee benefit plan who seeks to enforce rights with respect to the provider network benefits under that plan. Petitioner ("Hospital") is a hospital who contracted with Plaintiff's plan to provide these network benefits. Plaintiff alleges medical services she received from Hospital for injuries she sustained in an automobile collision caused by a third party are "covered" under the plan for the "in-network discount." App. 38-39.

On the basis of her alleged plan rights and assignment to Hospital of benefits under her plan, Plaintiff seeks to avoid payment of full billed charges on Hospital's lien against her recovery from the third party at fault. She claims Hospital infringed upon her rights

and those of similarly situated individuals by allegedly not seeking and accepting payment from the ERISA plan and instead pursuing undiscounted payment from the plan participant. Plaintiff asserts putative class claims invoking state law theories of recovery, including for breach of contract, deceit (fraud), and violation of the Oklahoma Consumer Protection Act. App. 34-43.

Unlike the Oklahoma Supreme Court, the state district court got it right. Because Plaintiff's claims all are premised upon alleged rights under her ERISA plan and require for their resolution interpretation of plan terms and deference to the plan's administrative determinations, the district court correctly found the state law claims "relate to" the plan for purposes of ERISA express preemption. App. 31-33. The fact Plaintiff skipped the plan's review process, and pursued relief against the medical provider under its network agreement, does not sever the connection to the plan and avoid ERISA. Pursuant to its concurrent jurisdiction, 29 U.S.C. § 1132(e), the district court gave Plaintiff an opportunity to amend to assert a claim under ERISA, 29 U.S.C. § 1132(a)(1)(B), to recover benefits or enforce rights under her plan. Plaintiff declined and instead appealed the preemption ruling upon dismissal of her lawsuit. App. 28-30.

The Oklahoma Supreme Court reversed. At first, it invoked the wrong preemption doctrine (the jurisdictional doctrine of complete preemption). App. 22-27. When Hospital called attention to this error on rehearing, the Court tried again. It enlisted a new author,

vacated its initial opinion, and issued another opinion "reach[ing] the same result" (App. 2); but this time, the Court ventured into what it described as the "treacherous thicket" of ERISA express preemption (App. 8). The Court concedes that, pursuant to Hospital's recitation of Plaintiff's allegations, there is a "strong" argument Plaintiff's lawsuit is expressly preempted by ERISA. App. 9. To be sure, Hospital recited Plaintiff's allegations as written. Assuming that it would impact ERISA preemption, the Court *sua sponte* recast Plaintiff's claims as seeking different plan benefits. App. 10.[1] But the Court's version of this case is no less dependent on Plaintiff's assertion of a right to network benefits under her plan and no less subject to ERISA's express preemption mandate.

Oklahoma now stands apart, and as an example to other states, in allowing plan participants with network benefits disputes to bypass ERISA's uniform regime. This undermines the cooperative efforts of employers, medical providers, and insuring entities to make available affordable and quality care in the employment arena (the largest source of health care coverage in the United States) in an age of health care cost crisis. Under ERISA, such a dispute is governed by the terms and administrative determinations made under the plan subject to prompt, deferential judicial review and limited remedies. Now, a plan participant may pursue protracted state law litigation, including for

[1] The Court apparently found this revision justified based on its (mistaken but irrelevant) view that ERISA would deprive a plaintiff of a remedy in these circumstances, and because it did not perceive Hospital as a "traditional ERISA entity." App. 17-20.

recovery of extra-contractual and punitive damages, in a dispute over plan network benefits, since the Oklahoma Supreme Court deems arrangements for such benefits insufficiently "related to" the plan. This is the very result that ERISA was designed to avoid.

The Oklahoma Supreme Court has decided an important federal question in a way that conflicts with, and indeed is plainly contrary to, relevant decisions of this Court and the United States Courts of Appeals. Sup. Ct. R. 10(b), (c). The Court should grant certiorari and either summarily reverse the decision below or grant plenary review.

A. STATUTORY BACKGROUND

ERISA expressly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan[.]" 29 U.S.C. § 1144(a). Express preemption serves the purpose of ERISA to "promote the interests of employees . . . in employee benefit plans," *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137 (1990) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983)), by ensuring a "uniform body of benefits law" that "minimize[s] the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government," 498 U.S. at 142; *see also Gobeille v. Liberty Mut. Ins. Co.*, 136 S.Ct. 936, 944 (2016).

"Congress enacted ERISA to ensure that employees would receive the benefits they had earned, but Congress did not require employers to establish

benefit plans in the first place." *Conkright v. Frommert*, 559 U.S. 506, 516 (2010). This Court has therefore recognized that "ERISA represents a '"careful balancing" between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans.'" *Id*. at 517 (quoting *Aetna Health Inc. v. Davila*, 542 U.S. 200, 215 (2004) and *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987)). "Congress sought 'to create a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place.'" *Id*. (quoting *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996)). "ERISA 'induc[es] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred.'" *Id*. (quoting *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002)).

ERISA's regime requires a participant in an ERISA plan to channel a benefits dispute through the plan's internal administrative process. *Heimeshoff v. Hartford Life & Acc. Ins. Co*., 571 U.S. 99, 134 S.Ct. 604, 610 (2013). Upon exhausting the plan's process, the participant has a right to judicial review under ERISA's remedial provisions. *See* 29 U.S.C. § 1132(a). Beyond the kind of remedy available, ERISA only limits the kind of plaintiff who may pursue such remedy; there is no improper ERISA defendant. A quintessential ERISA plaintiff is a plan "participant or beneficiary" seeking "to recover benefits due to him" or "to

enforce his rights under the terms of the plan," 29 U.S.C. § 1132(a)(1)(B).

Judicial review of a benefits dispute defers to the decisions and interpretations of the plan administrator where the plan terms grant discretion. *Conkright*, *supra*, 559 U.S. at 516 (citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989)). And typically review is limited in scope to the materials compiled by the plan administrator, foreclosing traditional discovery. *Murphy v. Deloitte & Touche Grp. Ins. Plan*, 619 F.3d 1151, 1157 (2010). Relief is equitable in nature; a participant may not recover extra-contractual or punitive damages. *Aetna*, *supra*, 542 U.S. at 215.

In order to fulfill ERISA's purpose, express preemption is "deliberately expansive." *Pilot Life*, *supra*, 481 U.S. at 47; *see Aetna*, *supra*, 542 U.S. at 208. ERISA express preemption is "conspicuous for its breadth," *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990), "establish[ing] as an area of exclusive federal concern the subject of every state law that 'relate[s] to' an employee benefit plan governed by ERISA." *Id*. As such, this Court construes the words "relate to" broadly.

"'A law "relates to" an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan.'" *Ingersoll-Rand*, 498 U.S. at 139 (quoting *Shaw*, *supra*, 463 U.S. at 96-97). This Court has clarified that "where the existence of ERISA plans is essential to the law's operation . . . , that 'reference' will result in pre-emption.'" *Gobeille, supra,* 136 S.Ct. at 943 (quoting *Cal. Div. of Labor Standards*

Enforcement v. Dillingham Constr., N.A., Inc., 519 U.S. 316, 325 (1997)). And, a "connection with" an ERISA plan means the state law "'governs . . . a central matter of plan administration' or 'interferes with nationally uniform plan administration.'" *Id.* (quoting *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001)). Under these standards, state common law claims brought by a plan participant asserting rights with respect to benefits under the plan easily fall within the scope of ERISA express preemption. *See Pilot Life*, *supra*, 481 U.S. at 43-48; *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 62-63 (1987).

A claim's "reference to" or "connection with" an ERISA plan is not extinguished or severed from the plan because the claim is for network benefits that arise under the plan's agreement with a medical provider. To the contrary, such agreement *creates* the reference to and connection with the plan. Federal express preemption in the employee benefits arena follows by force of statute and is not negated by the contractual arrangements made to provide such benefits. *Coventry Health Care of Missouri, Inc. v. Nevils*, 137 S.Ct. 1190, 1199 (2017). Accordingly, a participant's claim that a network provider violated the participant's rights with respect to network benefits does not avoid ERISA express preemption. Though not a necessary predicate to express preemption, a network provider is a proper ERISA defendant; a participant can seek relief against said provider under ERISA's remedy "to recover benefits due to him" or "to enforce his

rights under the terms of the plan," 29 U.S.C. § 1132(a)(1)(B).

B. FACTUAL BACKGROUND

At all times relevant to this lawsuit, Plaintiff was a participant in the Oklahoma Lumbermen's Association Health Plan Plus (the "Plan"). App. 38-39. The Plan is a fund established by the employer members of the Oklahoma Lumbermen's Association ("OLA") for the purpose of providing medical benefits to their employees. App. 44-45, 65-69. As such, the Plan is an "employee welfare benefit plan" within the meaning of and governed by ERISA. *See* 29 U.S.C. §§ 1002(1), 1003(a). These facts are undisputed. App. 9.

(1) Plan Network Benefits and Administration. The Plan benefits include a provider network arrangement. The arrangement, as set forth by the Plan terms, gives Plan participants access to a "network" of medical providers who have agreed to provide services to Plan members pursuant to certain terms, including by accepting discounted fees for covered services. App. 48-49. Hospital was one such provider who entered into an agreement with the Plan ("Provider Agreement") to participate in the Plan's network arrangement. App. 38, 75-87.[2]

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[2] The Plan and Hospital contracted through the Plan's designated participating provider organization ("PPO"), First Health Life and Health Insurance Company (App. 48, 68), but the Provider Agreement is deemed to be between the Plan and Hospital (App. 86 at § 6.10).

Under the Provider Agreement, the Hospital and the Plan agree to defer to the Plan's material benefit terms and claims administration process described below:

(a) Discount Benefit. Hospital agrees to provide "Covered Services" to an individual properly identified as a Plan participant, and the Plan agrees to pay for these services at the discounted rates specified by the Provider Agreement. App. 79, 81-83 at §§ 2.1.1, 3.1.1, 3.2. Hospital agrees to accept the discounted amount as payment in full and forego seeking payment directly from the Plan participant for Covered Services paid by the Plan in accordance with the Provider Agreement. App. 82 at § 3.1.3. The Plan terms reflect this agreement. App. 48-50.

"Covered Services" within the meaning of the Provider Agreement are those that are "covered under the terms of the [Plan]." App. 76, 78 at §§ 1.2, 1.6. The Plan excludes from coverage services for injuries "that result from the action of a third party, whether or not such third party is able to reimburse the Covered Person for such care." App. 51 at ¶71. Notwithstanding exclusion, the Plan Administrator may exercise discretion to pay benefits for such services, subject to the Plan's right of subrogation, upon compliance by the Plan participant with the third party recovery provisions of the Plan. App. 51 at ¶71; App. 59-64.

(b) No Direct Billing Benefit. Hospital may seek payment for its services (other than for copayment, coinsurance, and/or deductible amounts)

directly from an individual properly identified as a Plan participant in two instances: (1) where the Plan fails to pay Hospital in accordance with the Provider Agreement or applicable federal law or regulation, provided Hospital has made reasonable effort to obtain payment from the Plan; or (2) where the services are not covered and (a) the Plan confirms that the specific services are not covered, (b) the Plan participant is advised in writing prior to the services being rendered that the services may not be covered, and (c) the Plan participant agrees to pay for such services after being so advised. App. 80-83 at §§ 2.9, 3.2. These terms supersede any contrary terms between Hospital and a Plan participant, including in Hospital's admission form. App. 81 at § 2.9.1.

(c) Claims Administration. Upon receipt of the participant's Plan identification card, Hospital agrees to contact the Plan and, except with respect to emergency services, obtain from the Plan prior authorization to perform services and confirmation with respect to participant eligibility and coverage. App. 83-84 at §§ 4.1, 4.2. After providing services, Hospital agrees to "submit its claims for reimbursement and encounter forms, as required by [the Plan]," and in turn "[the Plan] may reduce or deny payment for services which are not submitted for payment in accordance" therewith. App. 79, 82 at §§ 2.6, 3.1.4. As "required by the Plan," the participant, not the provider, is responsible to ensure claim submission. App. 52.

Upon submission of a claim, "the Plan Administrator has the final and ultimate responsibility for claim

decisions and payment of Plan benefits." App. 52; App. 65 ("The decisions of the Plan Administrator shall be final and binding on all interested parties."). In particular, the Provider Agreement makes clear that it is the Plan that has the "right and sole responsibility" to determine whether or not a service is covered. App. 83 at § 3.2. The Plan vests the Plan Administrator with full discretion and authority "to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits or the amount, manner and time of payment of any Plan benefits, to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan." App. 65.

If a claim is denied, a Plan participant is provided an opportunity for internal review of that decision under the Plan. App. 57-59. Hospital agrees to cooperate with and participate in the Plan's review process and abide by the decisions of the Plan Administrator therein. App. 85 at § 6.3. Upon exhaustion of the Plan's review process, the Plan participant has a right to judicial review under ERISA, 29 U.S.C. § 1132(a)(1)(B), to recover any benefits due or enforce rights under the Plan. App. 72.

(2) Hospital's Medical Services & Billing In This Case. Plaintiff received medical services (the "Services") provided by Hospital for injuries Plaintiff alleges she sustained in an automobile collision "which was not her fault." App. 38-39 at ¶¶12, 17. Upon admission to Hospital, Plaintiff executed an admission

form, wherein she assigned to Hospital her rights to payment of benefits under the Plan. App. 36 at ¶8(a); App. 3 at ¶3, n.5. Also pursuant to the admission form, Plaintiff was notified and agreed that she would be "responsible for the payment of all charges of the Hospital . . . that remain after any third party payment . . . which include . . . amounts for services or treatments that are not covered[.]" App. 4 at ¶3, n.6.

If the Services were covered under the Plan, as determined by the Plan Administrator, Plaintiff was entitled to the Discount Benefit. If the Services were provided for injuries "that result[ed] from the action of a third party" within the meaning of the Plan, the Services were excluded from coverage and Plaintiff was not entitled to the Discount Benefit. Pending a determination of coverage, Plaintiff could seek discretionary payment by the Plan in compliance with the Plan's third party recovery provisions, subject to the Plan's right of subrogation. Plaintiff was entitled to the No Direct Billing Benefit, even if the Plan Administrator determined the Services were not covered, if Plaintiff properly identified herself as a Plan participant and Hospital nonetheless failed to satisfy the conditions for directly billing Plaintiff.

The Services provided by Hospital to Plaintiff arising out of the automobile accident involved emergency and later non-emergency (physical therapy) care. While not relevant to Hospital's motion to dismiss on the ground of ERISA express preemption, there is a dispute of fact as to whether Plaintiff provided Plan identification to Hospital for the emergency care. In

any event, it is not disputed that Plaintiff provided her Plan identification with respect to the subsequent physical therapy portion of the Services, that Hospital submitted a claim under the Plan for payment of the Discount Benefit for this portion of the Services, and that the Plan denied the claim in October 2011 on the ground the Services are excluded from coverage under the third party liability exclusion.

Thereafter, in November 2011, Hospital sought reimbursement for both the emergency and physical therapy portions of the Services directly from Plaintiff (*via* a hospital lien) for its undiscounted billed charges. App. 38-39 at ¶17.

C. THE LAWSUIT

On January 30, 2012, Plaintiff filed a putative class action lawsuit in Oklahoma state district court. App. 34-43. Plaintiff claims Hospital's charges for the Services were "covered charges" under the Plan for which Hospital was required "to accept the discounted payment from [the Plan] as payment in full" (App. 38 at ¶¶14-15), and that Hospital should have sought reimbursement under the Plan "so that [Plaintiff] could receive an in-network discount for said bills" (App. 40-41 at ¶¶25, 27). Plaintiff asserts her claims on behalf of all "similarly situated" individuals, *i.e.*, residents of Oklahoma who received medical care from Hospital "as the result of injuries for which a third party was potentially responsible," which was "covered" under Hospital's "Provider or Participation Agreement" but for

which Hospital sought reimbursement from the individual anyway. App. 35 at ¶4. Plaintiff alleges on behalf of the putative class that Hospital "failed to submit the medical bills to the insurance company for payment of a pre-negotiated discounted price, and instead sought an amount in excess of the pre-negotiated discounted price directly from the class member." App. 36 at ¶8(a).

On the basis of this alleged conduct, Plaintiff, for herself and the putative class, asserts state law theories of recovery seeking damages for breach of contract, deceit, and violation of the Oklahoma Consumer Protection Act. App. 38 at ¶15; App. 40-41 at ¶¶25, 27. She also seeks an order for specific performance, forcing Hospital to submit its bills under the Plan and other employee benefit plans so that Plaintiff and the putative class members "can receive an in-network discount for said bills" (App. 40-41 at ¶¶23-26), a declaratory judgment that Hospital is required to submit its bills under the Plan and other employee benefit plans so that Plaintiff and each putative class member "receives an in-network discount for said bills" (App. 41-42 at ¶¶27-31), and injunctive relief enjoining Hospital from filing liens for full billed charges when it "should only bill [the plans] and accept payment from the [plans] as payment in full" (App. 42 at ¶¶32-33).

D. PROCEEDINGS IN THE FEDERAL DISTRICT COURT

Hospital timely removed the action to the U.S. District Court for the Western District of Oklahoma on the basis of federal question jurisdiction, pursuant to the doctrine of ERISA *complete* preemption. Hospital answered the lawsuit and asserted defenses, including on the basis of ERISA *express* preemption. On November 7, 2012, the district court denied Plaintiff's motion to remand to state court, finding all of Plaintiff's claims satisfied the test for complete preemption: (1) the claims could have been brought under ERISA's remedial provisions, and (2) no duty independent of ERISA was implicated. Plaintiff's state law action against Hospital was converted into an ERISA action under Section 1132(a)(1)(B) to recover benefits or enforce rights under the Plan. *Cates v. INTEGRIS Health, Inc.*, No. CIV-12-763-H, 2012 WL 5456093 (W.D. Okla. Nov. 7, 2012) (unpublished).

The case was reassigned to another judge, who ultimately countermanded the first judge's decision on complete preemption federal question jurisdiction and remanded to state court. *Cates v. INTEGRIS Health, Inc.*, No. CIV-12-763-F, 2014 WL 12493272 (W.D. Okla. Sept. 30, 2014) (unpublished). The new judge did so in reliance upon *Salzer v. SSM Health Care of Okla. Inc*., 762 F.3d 1130 (10th Cir. 2014), a case involving similar allegations and the same plaintiff's counsel herein. The Tenth Circuit in *Salzer* had held a claim alleging a right to "receive[ ] a discount for the medical services" billed was completely preempted under ERISA, *id*. at

1137,[3] a claim functionally indistinct from the claims herein. However, the federal district court perceived that the Tenth Circuit had criticized the complete preemption rationale of the first-assigned judge in this case. *Cates*, 2014 WL 12493272 at *5.[4] Taking the perceived criticism as direction to remand, the federal district court opined that, though Plaintiff's claims "may be *related to* the Plan" (the standard for ERISA *express* preemption) and Plaintiff may have a remedy under ERISA, the Provider Agreement created an independent legal duty so as to negate *complete preemption*. *Id*. at *4-5.

E. DISMISSAL BY STATE DISTRICT COURT

Upon remand, Hospital moved to dismiss Plaintiff's state law claims. Hospital urged that, whether or not the jurisdictional doctrine of *complete* preemption applied, the state law claims at issue unquestionably "related to" the ERISA plan, and thus were barred under the broader defensive doctrine of *express* preemption. The state district court agreed. On June 21, 2015, the court granted Hospital's motion, finding that "the

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[3] The *Salzer* court found other claims had not been shown to satisfy the complete preemption test, but this finding was based upon a lack of evidentiary support not at issue in this case. *Id.* at 1136, n.4.

[4] Contrary to the Oklahoma Supreme Court's understanding, and not relevant to the ERISA *express* preemption analysis before it, the Tenth Circuit in *Salzer* did *not* find that Plaintiff's state law claims in this case were too attenuated to support ERISA *complete* preemption, nor could it have, as this case was not before the court in *Salzer*. App. 5-6 at ¶5, n.13.

action's claims, all of which are asserted under state law, are 'related to' an employee benefit plan within the meaning of 29 U.S.C. § 1144(a); therefore these claims are expressly preempted by ERISA." App. 31-32. Exercising its concurrent jurisdiction, 29 U.S.C. § 1132(e), the court gave Plaintiff an opportunity to amend her lawsuit to assert a claim under ERISA. Plaintiff declined to amend, and the case was dismissed with prejudice October 15, 2015. App. 28-29.

F. THE OKLAHOMA SUPREME COURT DECISION

Plaintiff appealed the dismissal. On June 19, 2017, the Oklahoma Supreme Court issued a decision reversing the district court. App. 22-27. The decision erroneously was premised on the *complete* preemption standard used in federal court to determine removal jurisdiction, rather than the *express* preemption defense applied by the district court. App. 26-27 at ¶¶9-10. Hospital sought rehearing of the Court's initial decision to point out the error that the Court had relied upon the wrong preemption doctrine. On January 30, 2018, the court granted rehearing, vacated its initial opinion, and entered a new opinion, this time reaching the same result but based on an express preemption analysis. App. 1-21.

The Oklahoma Supreme Court concedes that, if Plaintiff's allegations as recited by Hospital are "correct," then Hospital's express preemption defense "is a strong one." App. 9 at ¶9. Those allegations, quoted

from the face of Plaintiff's complaint (that the Services were "covered" and entitled Plaintiff to the "in-network discount") plainly constitute a claim to the Discount Benefit discussed above. The Court, however, denies Plaintiff is seeking the Discount Benefit and reformulates Plaintiff's claim as based only on the No Direct Billing Benefit, *i.e.*, as a claim that Hospital did not follow the procedure for directly billing a Plan participant even for non-covered services. App. 10 at ¶10.[5]

The Court erroneously assumes that its redesign of Plaintiff's case extricates it from ERISA's preemptive reach, opining that the case can now be decided without reference to the Plan. App. 10 at ¶10. This mistaken premise is based on the Oklahoma Supreme Court's (i) rejection of this Court's expansive interpretation of ERISA express preemption, (ii) misplaced reliance upon the Seventh Circuit's decision in *Kolbe & Kolbe Health and Welfare Ben. Plan v. Med. College of Wis., Inc.*, 657 F.3d 496 (7th Cir. 2011), and (iii) irrelevant (and incorrect) assumption that ERISA preemption would leave Plaintiff without a remedy against Hospital, whom the court characterized as an untraditional ERISA entity. App. 14-21 at ¶¶15-21.

[5] Referencing commentary by Plaintiff's counsel at the hearing on Hospital's motion to dismiss, the Oklahoma Supreme Court stated that Plaintiff "isn't asking for [Hospital] to accept payment from her health [plan] for these bills, and she isn't looking for a discount." App. 10 at ¶10, n.31.

REASONS FOR GRANTING THE PETITION

I. THE OKLAHOMA SUPREME COURT'S FINAL DECISION THREATENS TO SERIOUSLY ERODE FEDERAL POLICY

The Oklahoma Supreme Court's decision is "final" for purposes of jurisdiction under 28 U.S.C. § 1257(a), notwithstanding "there are further proceedings in the lower state courts yet to come." *Cox Broadcasting Corp. v. Cohn*, 420 U.S. 469, 477 (1975). The finality requirement is satisfied where, as here, "the federal claim has been finally decided" and "later review of the federal issue cannot be had, whatever the ultimate outcome of the case." *Id*. at 481. The pendency of nonfederal grounds on which petitioner may later prevail detracts neither from finality nor the policy reasons for immediate review, since "reversal of the state court on the federal issue would be preclusive of any further litigation on the relevant cause of action." *Id.* at 482. "In these circumstances, if a refusal immediately to review the state-court decision might seriously erode federal policy, the Court has entertained and decided the federal issue[.]" *Id*. at 483.

Review in such circumstances is particularly appropriate on the question of federal preemption of state law, an issue preliminary to and separable from the merits. In *Belknap, Inc. v. Hale*, 463 U.S. 491 (1983), for example, the Court found a determination that state law claims in a labor dispute were not preempted by the National Labor Relations Act of 1935, 29 U.S.C. §§ 151 *et seq*. ("NLRA"), was final and reviewable, notwithstanding the state court had remanded the case to

proceed to trial on the merits: "The judgment . . . finally disposed of the federal preemption issue; a reversal here would terminate the state court action; and to permit the proceedings to go forward in the state court without resolving the preemption issue would involve a serious risk of eroding the federal statutory policy of requiring the subject matter of respondents' cause to be heard by the . . . Board, not by the state courts." *Id*. at 497 n.5 (internal quotes omitted). Thus, the Court held, its "jurisdiction to affirm or reverse . . . on the preemption issue, an issue which is not by any means frivolous, is clear." *Id*.[6]

A few years later, in *Ingersoll-Rand*, *supra*, the Court accepted certiorari review over the non-frivolous issue of ERISA express preemption. As in this case, the state's highest court had rejected the express preemption defense and remanded for further proceedings on the state law claims. This Court reversed, issuing a formative opinion confirming the broad scope of ERISA express preemption. 498 U.S. at 136-37. And just last year, in *Coventry, supra*, the Court granted certiorari to review the issue of express preemption under the Federal Employees Health Benefits Act of 1959, 5 U.S.C. §§ 8901 *et seq*. ("FEHBA"), ERISA's twin preempting state law claims "related to" health benefit plans for federal employees, 5 U.S.C. § 8902(m)(1). Akin to this case, *Coventry* involved putative class action allegations by a health plan participant that liens

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[6] *See also Construction Laborers v. Curry*, 371 U.S. 542, 548 (1963) (accepting certiorari jurisdiction over Georgia Supreme Court's judgment rejecting NLRA preemption).

against personal injury settlements violate state law. 137 S.Ct. at 1194. As herein, the Missouri Supreme Court in *Coventry* rejected the express preemption defense and remanded for proceedings under the state law claims. *Id*. at 1195-96. Comparing the breadth and purpose of FEHBA preemption with that of ERISA preemption, this Court reversed. *Id*. at 1196-99.

Here, the Oklahoma Supreme Court finally decided the question whether ERISA preempts Plaintiff's state law theories. This question is preliminary to and separate from the merits, and the issue effectively is unreviewable at a later stage. Moreover, failure immediately to review the decision might seriously erode federal policy. The case is set to proceed on putative class action theories in protracted litigation involving discovery, non-deferential judicial review of Plan administration, and exposure to extra-contractual and punitive damages. This flies in the face of the very purpose of ERISA that preemption is designed to protect – encouragement of the provision of employee benefits *via* assurance of a remedial system that is uniform, prompt, and limits judicial review and liability. Certiorari review is therefore both appropriate and necessary.

II. THE OKLAHOMA SUPREME COURT'S DECISION CONFLICTS WITH THIS COURT'S JURISPRUDENCE ON THE IMPORTANT FEDERAL QUESTION OF ERISA EXPRESS PREEMPTION AND IS PLAINLY ERRONEOUS

There are "compelling reasons" to grant certiorari review: the Oklahoma Supreme Court, the state court of last resort, has decided "an important federal question in a way that conflicts with relevant decisions of this Court," as well as with "decision[s] of . . . [the] United States court[s] of appeals[.]" Sup. Ct. Rule 10(b) & (c). The federal issue of preemption in and of itself is an important one; it regularly and recently has warranted this Court's review, including as set forth above. Moreover, the Oklahoma Supreme Court has decided the preemption issue in a way that impacts "an important and increasingly popular form of business organization"[7] in an age of health care cost crisis.[8] Employers and providers enter into network arrangements in order to make available affordable, quality care to the 150 million Americans who pay for health care through employee benefit plans.[9]

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[7] *Texaco, Inc. v. Dagher*, 547 U.S. 1, 5 (2006).

[8] Health care in the United States, which spends over $10,000 *per capita*, is the most expensive in the world. Bradley Sawyer & Cynthia Cox, THE HENRY J. KAISER FAMILY FOUNDATION, *How Does Health Spending In The U.S. Compare To Other Countries*? (Feb. 13, 2018).

[9] THE HENRY J. KAISER FAMILY FOUNDATION, 2017 EMPLOYER HEALTH BENEFITS SURVEY (Sept. 19, 2017). The arrangements employ a "narrow network" concept that restricts consumer choice to

Most important, the Oklahoma Supreme Court's construction of ERISA express preemption is contrary to well-established precedent. Indeed, it is simply erroneous and can be summarily corrected. On certiorari review of the Texas Supreme Court's rejection of ERISA express preemption nearly thirty years ago in *Ingersoll-Rand*, 498 U.S. 133, this Court set forth the relevant analysis. *See also Gobeille,* 136 S.Ct. 936. Generally, "the question whether a certain state action is pre-empted by federal law is one of congressional intent." *Ingersoll-Rand*, 498 U.S. at 137-38 (internal quotes omitted). "Where, as here, Congress has expressly included a broadly worded pre-emption provision in a comprehensive statute such as ERISA, [the] task of discerning congressional intent is considerably simplified." *Id*. at 138. "The text of ERISA's express pre-emption clause is the necessary starting point." *Gobeille*, 136 S.Ct. at 943.

ERISA's text provides that "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" are preempted. 29 U.S.C. § 1144(a). "The key to § 514(a) is found in the words 'relate to.'" *Ingersoll-Rand*, 498 U.S. at 138. This Court construes the words broadly, in order to effectuate ERISA's preemptive purpose. *Id.*; *Pilot Life,* 481 U.S. at 47; *Aetna,* 542 U.S. at 208. The term "relate to" is given its "broad common sense meaning." *Pilot Life*, 481 U.S.

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a range of providers offering covered services at reduced rates. *See* Julie A. Simer & J. Scott Schoeffel, *The Wide World of Narrow Networks: How Health Care Providers Can Adapt and Succeed*, 9 J. HEALTH & LIFE SCI. L. 9, 27 (Oct. 2015).

at 46. "Congress used those words in their broad sense, rejecting more limited pre-emption language that would have made the clause 'applicable only to state laws relating to the specific subjects covered by ERISA.'" *Ingersoll-Rand*, 498 U.S. at 138 (quoting *Shaw*, 463 U.S. 85, 98 (1983)).

A. Plaintiff's State Law Claims Are Expressly Preempted Because They Have A "Reference To" The Plan And/Or A "Connection With" The Plan

"Implementing these principles, the Court's case law to date has described two categories of state laws that ERISA pre-empts. First, ERISA pre-empts a state law if it has a 'reference to' ERISA plans." *Gobeille*, 136 S.Ct. at 943 (quoting *Dillingham*, 519 U.S. at 325). "Second, ERISA pre-empts a state law that has an impermissible 'connection with' ERISA plans[.]" *Id*. (quoting *Egelhoff,* 532 U.S. at 148); *see also Ingersoll-Rand*, *supra*, 498 U.S. at 139. "When considered together, these formulations ensure that ERISA's express pre-emption clause receives the broad scope Congress intended while avoiding the clause's susceptibility to limitless application." *Gobeille*, 136 S.Ct. at 943.

"Reference To" Preemption. "'[W]here the existence of ERISA plans is essential to the law's operation . . . , that "reference" will result in pre-emption.'" *Id*. at 943 (quoting *Dillingham*, 519 U.S. at 325). In this regard, ERISA plainly preempts a state common law

claim brought by a plan participant disputing rights with respect to benefits under an employee benefit plan; this kind of claim derives from and depends upon the very existence of the plan. *See Pilot Life*, 481 U.S. at 43-48; *Metro. Life*, 481 U.S. at 62-63.

This Court addressed "reference to" preemption of state common law claims in *Ingersoll-Rand*. The Court held, "[w]e have no difficulty in concluding that the cause of action which the Texas Supreme Court recognized here – a claim that the employer wrongfully terminated plaintiff primarily because of the employer's desire to avoid contributing to, or paying benefits under, the employee's pension fund – 'relate[s] to' an ERISA-covered plan within the meaning of § 514(a), and is therefore pre-empted." 498 U.S. at 140. The very "existence" of the plan was "a critical factor in establishing liability" under the plaintiff's state law claim. *Id*. at 139. "As a result," the state law cause of action related "to the essence of the [] plan itself." *Id*. at 140. "The Texas cause of action makes specific reference to, and indeed is premised on, the existence of a pension plan." *Id*. "[I]n order to prevail, a plaintiff must plead, and the court must find, that an ERISA plan exists and the employer had a pension-defeating motive in terminating the employment. Because the court's inquiry must be directed to the plan, this judicially created cause of action 'relate[s] to' an ERISA plan." *Id*.

As in *Ingersoll-Rand*, Plaintiff's claims herein are expressly preempted by ERISA. Plaintiff's "cause of action makes specific reference to, and indeed is premised on, the existence of" the Plan. *Id*. Plaintiff alleges

she was a participant in the Plan (App. 38-39 at ¶17); that Hospital's charges for the Services are "covered charges" under the Plan for which Hospital was required "to accept the discounted payment from [the Plan] as payment in full" (App. 38 at ¶¶14-15); and that Hospital should have submitted its bills for reimbursement under the Plan "so that [Plaintiff] could receive an in-network discount for said bills" (App. 40-41 at ¶¶25, 27).

As alleged, or as recast by the Oklahoma Supreme Court, Plaintiff cannot prevail in her action without proving her right to the network benefit under the Plan, whether the network benefit at issue is the Discount Benefit, the No Direct Billing Benefit, or both. Moreover, in proving this right, Plaintiff must consult the terms, communications with, claims procedure under, and coverage determinations of the Plan. That Plaintiff must prove, with respect to either/both the Discount Benefit and/or the No Direct Billing Benefit, that the Services are or are not covered under the Plan (a determination that is reserved to the discretion of the Plan Administrator and subject to exhaustion of the Plan's administrative review process) alone preemptively tethers any iteration of Plaintiff's claims to the Plan. Because "the court's inquiry must be directed to the plan," Plaintiff's action "'relate[s] to' an ERISA plan." *Ingersoll-Rand*, 498 U.S. at 140.

To be clear, the Oklahoma Supreme Court's appellate recharacterization of Plaintiff's claims does not avoid express preemption. The court acknowledges that, if the claims are alleged to seek the Discount

Benefit, Hospital's express preemption defense "is a strong one[.]" App. 37 at ¶9. But even as reconstructed by the court to only seek the No Direct Billing Benefit, Plaintiff's claims are preempted. The No Direct Billing Benefit is just as much a benefit under the Plan as the Discount Benefit that Plaintiff expressly seeks. It is part and parcel of the network arrangement; it is the network benefit applicable to services performed by network providers even if the services are not covered for the discount. And, in order to prove a right to the No Direct Billing Benefit, Plaintiff must show that she identified herself to Hospital as a Plan participant, that Hospital did not seek confirmation regarding coverage from the Plan, that Plaintiff followed the requisite claim process under the Plan, that either the Services were covered or not covered under the Plan as determined by the Plan Administrator, and that if not covered Hospital failed to notify her the Services may not be covered and obtain from her consent to payment in the event of non-coverage.[10]

The U.S. Court of Appeals for the First Circuit in *Harris v. Harvard Pilgrim Health Care, Inc.,* 208 F.3d 274 (1st Cir. 2000), properly applies this Court's "reference to" standard for express preemption in addressing circumstances similar to those the Oklahoma Supreme Court believes to be the crux of Plaintiff's lawsuit. In

[10] As the federal district court in this matter recognized, "[a]ccess to the PPO network [itself] is a benefit under plaintiff's plan," and Plaintiff's claims premised upon a right to this benefit "can only be determined by interpretation of the Plan's terms." *Cates v. INTEGRIS Health, Inc.*, 2012 WL 5456093 at *2, Case No. CIV-12-763-H (W.D. Okla. Nov. 7, 2012) (unpublished).

Harris, a plaintiff challenged the filing of a lien to recover payment for medical services provided to an ERISA plan participant involved in an accident caused by a third party. Specifically, the plaintiff in *Harris* alleged the lack of verification of non-coverage under the plan and inadequate disclosure of the intent to hold the participant responsible for full billed charges constituted unfair or deceptive trade practices under the law of Massachusetts. The court responded that "ERISA will be found to preempt state-law claims if the trier of fact necessarily would be required to consult the ERISA plan to resolve the plaintiff's claims," and held the claims expressly preempted. *Id*. at 281.

Contrary to the Oklahoma Supreme Court's suggestion, a plan's contract with a hospital for the provision of network benefits, such as the Participating Hospital Agreement here, does not avoid ERISA express preemption. The Participating Hospital Agreement is a contract, the sole purpose of which is to provide the network benefits under the Plan. As this Court found last year in *Coventry,* 137 S.Ct. 1190*,* a case involving similar circumstances to this case, federal express preemption in the employee benefit arena is a force of statute not negated by the contractual arrangements made to provide those benefits.

In *Coventry*, a FEHBA health plan participant contended that the contract between the plan's carrier and her federal government employer, which served as the vehicle to provide plan benefits, did not support the carrier's attempt to bill her directly *via* lien because the contract's reimbursement terms were contrary to

state law. *Id*. at 1195. The Missouri Supreme Court rejected the defendant's FEHBA express preemption defense. This Court reversed, aligning the purpose and preemptive scope of FEHBA and ERISA and reaffirming the broad reach of "related to" preemption. *Id*. at 1197. Addressing the plaintiff's argument that such preemptive power may not be exercised through a contract, the Court explained that the federal statute – "not the . . . contracts negotiated" for the provision of plan benefits – "triggers the federal preemption." *Id*. at 1194. Again comparing FEHBA and ERISA preemption, the Court expounded that "[m]any other federal statutes preempt state law in this way, leaving the context-specific scope of preemption to contractual terms." *Id*. at 1199.

The Oklahoma Supreme Court misreads *Kolbe & Kolbe Health and Welfare Ben. Plan v. Med. College of Wis., Inc*., 657 F.3d 496 (7th Cir. 2011) ("*Kolbe I*"), for the proposition that a provider network agreement is sufficient to overcome ERISA in circumstances such as those assumed by the court – where network services are provided to a plan participant but excluded from coverage. App. 14-15 at ¶15. In *Kolbe I*, an ERISA plan pursued a refund from a hospital of payment made for medical services to an individual who the plan later determined was not enrolled in the plan. *Id*. at 499-500. The plan sought refund under a theory that the hospital breached its provider agreement, by retaining a payment to which it could only be entitled if the services were provided to a plan participant. *Id*. at 504.

The Seventh Circuit in *Kolbe I* found the state law breach of contract claim was not expressly preempted by ERISA – *not* because the services were excluded from coverage – but because "it [wa]s *undisputed*" that the individual to whom services were provided was *not a plan participant*, and had not even been enrolled in the plan. *Id*. at 504 (emphasis added). The court held that the only issue was whether the provider agreement allowed refund for an undisputed payment error under those circumstances, which did not require any reference to the plan. *Id*. at 505. Here, on the other hand, regardless whether the Services are covered, it is undisputed that Plaintiff *is* a participant in the Plan, and is seeking network *benefits under* the Plan. However construed, Plaintiff's state law claims reference, depend upon, and cannot be resolved without consulting the Plan.

More significant, *Kolbe*'s subsequent history shows that the Seventh Circuit would fully support preemption on the facts of this case. On remand, the hospital defended the state contract claim by raising ERISA preemption again, but this time it belatedly presented evidence on summary judgment raising a material dispute as to whether the individual to whom it furnished services was a "plan participant." *See Kolbe & Kolbe Health and Welfare Ben. Plan v. Med. College of Wis., Inc*., 742 F.3d 751, 755 (7th Cir. 2014) ("*Kolbe II*"). The Seventh Circuit (via Posner, J.) held that such a factual dispute, had it been raised in time, *would* have resulted in ERISA preemption because its resolution required resort to *the plan*. "A contract

dispute that requires for its resolution an interpretation of an ERISA plan can be resolved only in accordance with ERISA[.]" *Id*. at 755. However, ERISA preemption was no longer properly before the district court on remand from *Kolbe I*, which was already law of the case. *Id*. at 756.

"Connection With" Preemption. Independently, "ERISA pre-empts a state law that has an impermissible 'connection with' ERISA plans[.]" *Gobeille, supra,* 136 S.Ct. at 943; *see also Ingersoll-Rand*, *supra*, 498 U.S. at 139. In looking to "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive" preemption, this Court has clarified that an impermissible "connection with" an ERISA plan means the state law "'governs . . . a central matter of plan administration' or 'interferes with nationally uniform plan administration.'" *Gobeille*, 136 S.Ct. at 943 (quoting *Egelhoff*, 532 U.S. at 148). "Connection with" preemption reaches those state law claims that do not clearly "reference" an employee benefit plan, consistent with an expansive interpretation of ERISA's text: "Under this 'broad common-sense meaning,' a state law may 'relate to' a benefit plan, and thereby be pre-empted, even if the law is not specifically designed to affect such plans, or the effect is only indirect." *Ingersoll-Rand*, *supra*, 498 U.S. at 139 (quoting *Pilot Life*, 481 U.S. at 47).

A common law claim brought by a participant pursuant to alleged rights to plan benefits not only references the plan but also clearly has a "connection with" the plan. There is nothing more central to health plan

administration than determining coverage and processing claims for payment of benefits offered under the plan. Plaintiff's lawsuit revolves around administration of the Plan's network benefits. The Plan established this arrangement and incorporated it into the terms of the Plan. The Participating Hospital Agreement is just a contractual vehicle by which to provide and administer the benefits. Said agreement expressly defers to the Plan's administrative determinations and procedure. Under either Plaintiff's Discount Benefit theory or the Oklahoma Supreme Court's No Direct Billing Benefit theory, the Plan must be consulted. And any determination regarding coverage must defer to the Plan Administrator. The network arrangement upon which Plaintiff premises her lawsuit is the "connection with" the Plan.[11]

[11] While the issue rarely arises in the context of a network arrangement, when it has, courts apply normative ERISA preemption principles, just as the state district court did in this case. *See Hornady Transp. LLC v. McLeod Health Serv., Inc*., 773 F.Supp.2d 622, 636 (D. S.C. 2011) ("To the extent the [network arrangement] and related [provider agreements] were incorporated into the Plan, whether by virtue of the ASA or references to the [network arrangement] in the Plan documents, the claims in this action relate to the administration of an employee benefit plan" and are preempted by ERISA).

B. Whether Plaintiff In Fact Had An ERISA Remedy And Whether Defendant Is In Fact A Traditional ERISA Entity Are Not Relevant To The ERISA Express Preemption Defense (Though Both Are True Here)

The Oklahoma Supreme Court apparently was motivated to revive this lawsuit by its understanding that ERISA express preemption leaves a plaintiff without a remedy in these circumstances and that such negates application of the defense. While irrelevant to preemption, the Court's understanding is incorrect. Plaintiff was not left without a remedy. Though Plaintiff's claims were expressly preempted as asserted under state law, they were cognizable under ERISA's remedial provision for recovery of benefits due or enforcement of rights under the Plan. 29 U.S.C. § 1132(a)(1)(B). Plaintiff could pursue an ERISA action in this regard against Hospital, either under Plaintiff's actual Discount Benefit theory or the Oklahoma Supreme Court's No Direct Billing Benefit theory. Indeed, upon finding Plaintiff's state law claims expressly preempted, the state district court gave Plaintiff an opportunity to amend her lawsuit to state a claim under ERISA, *in lieu* of dismissal of the entire action; Plaintiff declined.

But even if Plaintiff never had a cognizable claim under ERISA, this does not avoid the ERISA express preemption defense. The Oklahoma Supreme Court again seems to conflate the complete and express preemption standards. The test for complete

preemption is not satisfied unless "an individual, at some point in time, could have brought his claim under ERISA," 29 U.S.C. § 1132(a). *Aetna*, *supra*, 542 U.S. at 210. But this is not the test for express preemption, which only requires that state law claims be "related to" an ERISA plan. 29 U.S.C. § 1144(a). ERISA express preemption is an affirmative defense that may just leave a plaintiff without a remedy. The U.S. Court of Appeals in which Oklahoma sits, the Tenth Circuit, has made clear this is not relevant to and does not negate the defense.[12]

The Oklahoma Supreme Court also found relevant to its decision its understanding that Hospital is not a "traditional ERISA entity" so as to support application of the express preemption defense. The court's understanding, again, is incorrect. Hospital indeed is a traditional ERISA entity within the context of Plaintiff's claims. Plaintiff's claims assert the right to have Hospital seek and accept payment under the Plan or confirm non-coverage under the Plan. This right necessarily depends upon Hospital having and exercising an assignment of benefits from Plaintiff. A medical provider in this role is a traditional ERISA entity

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[12] *See Cannon v. Grp. Health Serv. of Oklahoma, Inc.*, 77 F.3d 1270, 1274 (10th Cir. 1996) (rejecting plaintiff's argument that "an exception to ERISA's express preemption clause exists when ERISA provides no remedy" as the "unavailability of a remedy under ERISA is not germane to [the express] preemption analysis").

because it stands in the shoes of the plan participant.[13] Moreover, Hospital is the Plan's network provider.

But even assuming otherwise, whether a defendant is a traditional ERISA entity is not germane to the express preemption analysis. Claims need only be "related to" the ERISA plan to be expressly preempted. 29 U.S.C. § 1144(a). Where state law claims have a "reference to" the ERISA plan, as addressed above, the inquiry is over. And where preemption is premised upon the claims having a "connection with" the plan, the relevant inquiry is not whether the defendant is a traditional ERISA entity but whether the claims affect or interfere with plan administration. *Gobeille, supra*, 136 S.Ct. at 943; *Egelhoff*, *supra*, 532 U.S. at 148.

The Oklahoma Supreme Court's reliance upon *Hospice of Metro Denver, Inc. v. Grp. Health Ins. of Oklahoma, Inc*., 944 F.2d 752 (10th Cir. 1991), is misplaced. In that case, the court found ERISA preemption did not apply to a misrepresentation claim brought *by* a hospital plaintiff against an insurance company defendant (*not* by a plan participant against a hospital). The hospital's misrepresentation claim did not implicate primary administrative functions under the plan. But this was because the hospital was not

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[13] *See Mem'l Hosp. System v. Northbrook Life Ins. Co*., 904 F.2d 236, 250 (5th Cir. 1990) ("As assignee, [hospital] stands in the shoes of [plan participant] and may pursue only whatever rights [plan participant] enjoyed under the terms of the plan. Such derivative claims invoke the relationship among the standard ERISA entities and clearly relate to a plan for preemption purposes.").

acting as a plan participant's assignee; rather, the hospital was seeking redress for the insurer's independent representation to the hospital. *Id*. at 753 n.2. Thus, the action was "distinct from an action *brought by a plan participant . . . seeking recovery of benefits* due under the terms of" the plan, which is preempted by ERISA. *Id*. at 756 (emphasis added).

The action here falls into the latter category of actions that the Tenth Circuit in *Hospice* deems preempted by ERISA. Plaintiff is a Plan participant (a principal ERISA entity), and she is seeking to enforce alleged network benefit rights under the Plan (another principal ERISA entity) against Hospital in its capacity as assignee and plan network provider (a principal ERISA entity). The lawsuit affects the relations among principal ERISA entities in that it implicates the most primary of health plan administrative functions – claim processing and determination with respect to benefits. That Plaintiff has chosen Hospital as a defendant does not alter the ERISA nature of the lawsuit.

SUMMARY REVERSAL IS WARRANTED

Summary reversal is warranted in light of the "obvious" nature of the error below. *See Gonzalez v. Thomas*, 547 U.S. 183, 185 (2006). This Court has summarily reversed the Oklahoma Supreme Court in analogous circumstances to vindicate supremacy of federal law. *See Nitro-Lift Techs., LLC v. Howard*, 568 U.S. 17,

20 (2012) (per curiam) ("The Oklahoma Supreme Court's decision disregards this Court's precedents.").

CONCLUSION

Hospital respectfully requests that the Court grant the petition for certiorari and summarily reverse in light of this Court's precedents that require express preemption of Plaintiff's putative class claims relating to an ERISA plan.

Respectfully submitted,

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