Fax

Name: Chris Jennings

From: Terri Shaw, DHHS/OS/ASPE
Date: January 11, 1999
Subject: Follow-Up from Medical Necessity Meeting
Pages: 3

cc: Devora Adler
Leslie Kramerich
Alice Weiss

To: Chris Jennings
Fr: Terri Shaw
Date: January 11, 1999
Re: Follow-Up from Medical Necessity Meeting

At our December 21 meeting on medical necessity issues, we said we would get back to you on the following three factual questions.

1. Do any states that have an external review process allow the plan to choose the external reviewer?

Georgetown University's Institute for Health Care Research and Policy studied 13 states' external review systems and found that all but one set standards to limit reviewers' conflict of interest. The following states allow the plan to pick reviewers:

- AZ: The plan picks reviewers on a case-by-case basis from a list of state-approved review entities. The chosen reviewer may have other business with the plan, but can't have a direct financial interest in or connection to the case under review.
- CA: The plan contracts with an accredited independent review organization (IRO) for all reviews and the IRO assigns each case to a review panel. Neither the IRO nor the reviewers may have any material professional, familial, or financial affiliation with the case under review.
- OH: The plan contracts with at least one IRO and the IRO assigns each case to a panel. Reviewers may not have any professional, familial, or financial affiliation with the plan.

In RI, the enrollee chooses the IRO from two state contractors and the IRO assigns the case to reviewers. In other states, the state health or insurance department either conducts the reviews itself, assigns cases to contracted IROs, or appoints review boards from a list of approved reviewers.

2. For Medicare, are CHDR's decisions binding on the plan?

Yes. Also, in 11 out of 13 states the external reviewer's decision is binding on the plan. In NJ the decision is not binding. Rather, the plan must notify the reviewing entity, the state agency, and the consumer within 10 business days re whether they will implement the reviewers' decision and, if not, the basis for not doing so. PA has recently changed its law. Under the old law, the decision was not binding, but no plan in seven years ever refused to follow the IRO's recommendation. Under the new law, the decision is binding unless "appealed to a court of competent jurisdiction, in which case there will be a rebuttable presumption in favor of the IRO's decision."

3. Do HIPAA's guaranteed renewal provisions apply to all plans/issuers, or just to small employers?

Rather than size of the group, guaranteed renewal protections are tied to insured status (self-insured versus fully-insured). All group issuers, regardless of the size of the group, must renew coverage at the plan sponsor's option. MEWAs must also guarantee renewal. However, self-insured plans do not have to guarantee renewal.

cc: Gary Claxton
Leslie Kramerich

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES

FAX COVER SHEET

To: Chris Jennings

From: Jon Traub

Re:

Fax Number:

Number of Pages to Follow: 17

COMMENTS

Congressman Ganske will be calling to talk to you about this possible change to PBR

Happy New Year!

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(712)

Proposed Revision to the ERISA provision in the Patients' Bill of Rights

To break the log-jam over health plan liability that helped prevent enactment of patient protection legislation in the 105th Congress, here is a possible alternative:

1. Patients who feel their health plan denied them medically necessary care could appeal their case through an internal review mechanism.

2. At the conclusion of that process, either the patient or the plan could submit the matter to an independent review panel for consideration if the medical care in question exceeded $100 or if it posed a threat to the life or health of the patient.

3. The external panel would:
   -- be fully independent from the health plan;
   -- be composed of clinical peers with appropriate medical expertise;
   -- be immune from civil or criminal conduct except in cases of malice or gross misconduct;
   -- conduct a *de novo* review;
   -- not be able to recommend treatments specifically excluded by the plan;
   -- hear evidence and statements from the parties (or their representatives); and
   -- render a timely decision that would be binding on the plan and not itself subject to judicial review, except if rendered as a result of fraud or misconduct or to enforce the decision of the panel.

4. Federal ERISA law would be amended to permit states to allow actions against health plans.

5. If the dispute had previously been submitted to an external review panel, the plan could not be held liable for punitive damages in a subsequent legal action.

6. Employers or plan sponsors would not be liable for damages unless they had discretionary decision-making authority to make coverage decisions and their action resulted in the complained of death or injury.

REVISION OF SECTIONS 133 AND 302 AND RELATED PROVISIONS) OF GANSKE/DINGELL SUBSTITUTE FOR H.R. 3605

(previously in file \P5\HEALTH\H4250\H3605.SUB)

[revisions indicated by ~~strike out~~ for deletions and *italics* for insertions]

SEC. 133. EXTERNAL APPEALS OF ADVERSE DETERMINATIONS.

(a) RIGHT TO EXTERNAL APPEAL.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide for an external appeals process that meets the requirements of this section in the case of an externally appealable decision described in paragraph (2), *for which a timely appeal is made either by the plan or issuer or by the participant, beneficiary, or enrollee, or a representative of any of them*. The appropriate Secretary shall establish standards to carry out such requirements.

(2) EXTERNALLY APPEALABLE DECISION DEFINED.—For purposes of this section, the term "externally appealable decision" means an appealable decision (as defined in section 132(a)(2)) if—

(A) the amount involved exceeds ~~a significant threshold~~ *$100*; or

(B) the patient's life or health is jeopardized as a consequence of the decision.

Such term does not include a denial of coverage for services that are specifically listed in plan or coverage documents as excluded from coverage.

(3) EXHAUSTION OF INTERNAL APPEALS PROCESS.—A plan or issuer may condition the use of an external appeal process in the case of an externally appealable decision upon completion of the internal review process provided under section 132, but only if the decision is made in a timely basis consistent with the deadlines provided under this subtitle.

(b) GENERAL ELEMENTS OF EXTERNAL APPEALS PROCESS.—

(1) CONTRACT WITH QUALIFIED EXTERNAL APPEAL ENTITY.—

(A) CONTRACT REQUIREMENT.—Subject to subparagraph (B), the external appeal process under this section of a plan or issuer shall be conducted under a contract between the plan or issuer and one or more qualified external appeal entities (as defined in subsection (c)).

(B) RESTRICTIONS ON QUALIFIED EXTERNAL APPEAL ENTITY.—

(i) BY STATE FOR HEALTH INSURANCE ISSUERS.—With respect to health insurance issuers in a State, the State may provide for external review activities to be conducted by a qualified external appeal entity that is designated by the State or that is selected by the State in such a manner as to assure an unbiased determination.

(ii) BY FEDERAL GOVERNMENT FOR GROUP HEALTH PLANS.—With respect to group health plans, the appropriate Secretary may exercise the same authority as a State may exercise with respect to health insurance issuers under clause (i). Such authority may include requiring the use of the qualified external appeal entity designated or selected under such clause.

(iii) LIMITATION ON PLAN OR ISSUER SELECTION.—If an applicable authority permits more than one entity to qualify as a qualified external appeal entity with respect to a group health plan or health insurance issuer and the plan or issuer may

select among such qualified entities, the applicable authority—

(I) shall assure that the selection process will not create any incentives for external appeal entities to make a decision in a biased manner, and

(II) shall implement procedures for auditing a sample of decisions by such entities to assure that no such decisions are made in a biased manner.

(C) OTHER TERMS AND CONDITIONS.—The terms and conditions of a contract under this paragraph shall be consistent with the standards the appropriate Secretary shall establish to assure there is no real or apparent conflict of interest in the conduct of external appeal activities. Such contract shall provide that the direct costs of the process (not including costs of representation of a participant, beneficiary, or enrollee) shall be paid by the plan or issuer, and not by the participant, beneficiary, or enrollee.

(2) ELEMENTS OF PROCESS.—An external appeal process shall be conducted consistent with

standards established by the appropriate Secretary that include at least the following:

(A) FAIR PROCESS; DE NOVO DETERMINATION.—The process shall provide for a fair, de novo determination. *In carrying out this subparagraph, the determination of medical necessity shall be made under the process without regard to the definition used by the plan or issuer. However, nothing in this sentence shall be construed as providing for coverage of items and services for which benefits are specifically excluded under the plan or coverage.*

(B) DETERMINATION CONCERNING EXTERNALLY APPEALABLE DECISIONS.—A qualified external appeal entity shall determine whether a decision is an externally appealable decision and related decisions, including—

(i) whether such a decision involves an expedited appeal;

(ii) the appropriate deadlines for internal review process required due to medical exigencies in a case; and

(iii) whether such a process has been completed.

(C) OPPORTUNITY TO SUBMIT EVIDENCE, HAVE REPRESENTATION, AND MAKE ORAL PRESENTATION.—Each party to an externally appealable decision *(directly or through an authorized representative or representatives, any of whom may be an attorney)*—

(i) may submit and review evidence related to the issues in dispute,

(ii) may use the assistance or representation of one or more individuals (any of whom may be an attorney), and

(iii) may make an oral presentation.

(D) PROVISION OF INFORMATION.—The plan or issuer involved shall provide timely access to all its records relating to the matter of the externally appealable decision and to all provisions of the plan or health insurance coverage (including any coverage manual) relating to the matter.

(E) TIMELY DECISIONS.—A determination by the external appeal entity on the decision shall—

(i) be made orally or in writing and, if it is made orally, shall be supplied to the parties in writing as soon as possible;

(ii) be binding on the plan or issuer;

(iii) be made in accordance with the medical exigencies of the case involved, but in no event later than 60 days (or 72 hours in the case of an expedited appeal *or, in the case of an appeal involving emergency circumstances, as soon as possible in accordance with the medical exigencies of the case, and in no event later than 24 hours*) from the date of completion of the filing of notice of external appeal of the decision;

(iv) state, in layperson's language, the basis for the determination, including, if relevant, any basis in the terms or conditions of the plan or coverage; and

(v) inform the participant, beneficiary, or enrollee of the individual's rights *(including any limitation on such rights)* to seek further review by the courts (or other process) of the external appeal determination.

(c) QUALIFICATIONS OF EXTERNAL APPEAL ENTITIES.—

(1) IN GENERAL.—For purposes of this section, the term "qualified external appeal entity" means, in relation to a plan or issuer, an entity (which may be a governmental entity) that is certified under paragraph (2) as meeting the following requirements:

(A) There is no real or apparent conflict of interest that would impede the entity conducting external appeal activities independent of the plan or issuer.

(B) The entity conducts external appeal activities through clinical peers.

[Note: The term "clinical peer", as defined in section 191(c)(2) of Dingell-Ganske, would be modified as follows:

(2) CLINICAL PEER.—The term "clinical peer" means, with respect to a review or appeal, a physician (allopathic or osteopathic) or other health care professional who holds a non-restricted license in a State *(or, for purposes of section 133, in a State in which the care is to be provided or in which the referral or recommendation for care is made)* and who is appropriately credentialed in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review or appeal and

includes a pediatric specialist where appropriate; except that only a physician may be a clinical peer with respect to the review or appeal of treatment *recommended or* rendered by a physician.

(C) The entity has sufficient medical, legal, and other expertise and sufficient staffing to conduct external appeal activities for the plan or issuer on a timely basis consistent with subsection (b)(3)(E).

(D) The entity meets such other requirements as the appropriate Secretary may impose.

(2) CERTIFICATION OF EXTERNAL APPEAL ENTITIES.—

(A) IN GENERAL.—In order to be treated as a qualified external appeal entity with respect to—

(i) a group health plan, the entity must be certified (and, in accordance with subparagraph (B), periodically recertified) as meeting the requirements of paragraph (1) by the Secretary of Labor (or under a process recognized or approved by the Secretary of Labor); or

(ii) a health insurance issuer operating in a State, the entity must be certified (and, in accordance with subparagraph (B), periodically recertified) as meeting such requirements by the applicable State authority (or, if the States has not established an adequate certification and recertification process, by the Secretary of Health and Human Services, or under a process recognized or approved by such Secretary).

(B) RECERTIFICATION PROCESS.—The appropriate Secretary shall develop standards for the recertification of external appeal entities. Such standards shall include a specification of—

(i) the information required to be submitted as a condition of recertification on the entity's performance of external appeal activities, which information shall include the number of cases reviewed, a summary of the disposition of those cases, the length of time in making determinations on those cases, and such information as may be necessary to assure the independence of the

entity from the plans or issuers for which external appeal activities are being conducted; and

(ii) the periodicity which recertification will be required.

(3) LIMITATION ON LIABILITY OF REVIEWERS.—No qualified external appeal entity having a contract with a plan or issuer under this part and no person who is employed by, or who has a fiduciary relationship with, any such entity or who furnishes professional services to such entity, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this section, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) if due care was exercised in the performance of such duty, function, or activity and there was no actual malice or gross misconduct in the performance of such duty, function, or activity.

(d) LIMITATION ON LEGAL RIGHTS.—

(1) IN GENERAL.—Subject to paragraph (2), the determination by an external appeals entity under this section is binding on the plan (and issuer, if

any) involved and on the participant, beneficiary, or enrollee involved and is not subject to judicial review.

(2) EXCEPTION.—The determination in an external appeals entity under this section may be vacated or modified by a court only under the same circumstances as the decision of an arbitrator may be vacated or modified under sections 10 and 11 of title 9, United States Code.

(3) LIMITATION ON PUNITIVE DAMAGES.—If a group health plan, or a health insurance issuer offering group health insurance coverage, follows the determination of an external appeals entity under this subsection, the plan or issuer is not liable for any punitive damages in any subsequent legal action in relation to the matter of such determination.

(4) CONSTRUCTION.—Nothing in this subsection shall be construed to prohibit any person from bringing an action in an appropriate court to enforce the decision of an external appeals entity under this section.

SEC. 302. ERISA PREEMPTION NOT TO APPLY TO CERTAIN ACTIONS INVOLVING HEALTH INSURANCE POLICYHOLDERS.

(a) IN GENERAL.—Section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) is amended by adding at the end the following subsection:

"(c) PREEMPTION NOT TO APPLY TO CERTAIN ACTIONS ARISING OUT OF PROVISION OF HEALTH BENEFITS.—

"(1) IN GENERAL.—Except as provided in this subsection, nothing in this title shall be construed to invalidate, impair, or supersede any cause of action brought by a plan participant or beneficiary (or the estate of a plan participant or beneficiary) under State law to recover damages resulting from personal injury or for wrongful death against any person—

"(A) in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health plan (as defined in section 733), or

"(B) that arises out of the arrangement by such person for the provision of such insurance, administrative services, or medical services by other persons.;

but only, in the case of a cause of action relating to an externally appealable decision (as defined in section 133(a)(2) of the Patients' Bill of Rights Act of 1999), if an external appeal was completed under section 133 of such Act with respect to the decision. In a cause of action described in the previous sentence for which an external appeal was completed, the plan or issuer is not liable for any punitive, exemplary, or similar damages if the plan or issuer followed the recommendation of the qualified external appeal entity involved. For purposes of this subsection, the term 'personal injury' means a physical injury and includes an injury arising out of the treatment (or failure to treat) a mental illness or disease.

"(2) EXCEPTION FOR EMPLOYERS AND OTHER PLAN SPONSORS.—

"(A) IN GENERAL.—Subject to subparagraph (B), paragraph (1) does not authorize—

"(i) any cause of action against an employer or other plan sponsor maintaining the group health plan (or against an employee of such an employer or sponsor acting within the scope of employment), or

"(ii) a right of recovery or indemnity by a person against an employer or other

plan sponsor (or such an employee) for damages assessed against the person pursuant to a cause of action under paragraph (1).

"(B) SPECIAL RULE.—Subparagraph (A) shall not preclude any cause of action described in paragraph (1) against an employer or other plan sponsor (or against an employee of such an employer or sponsor acting within the scope of employment) if—

"(i) such action is based on the employer's or other plan sponsor's (or employee's) exercise of discretionary authority to make a decision on a claim for benefits covered under the plan or health insurance coverage in the case at issue; and

"(ii) the exercise by such employer or other plan sponsor (or employee) of such authority resulted in personal injury or wrongful death.

"(3) CONSTRUCTION.—Nothing in this subsection shall be construed as permitting a cause of action under State law for the failure to provide an item or service which is not specifically excluded under the group health plan involved.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to acts and omissions occurring on or after the date of the enactment of this Act from which a cause of action arises.

In section 192(a), revise paragraph (1) as shown below:

(1) IN GENERAL.—Subject to paragraph (2), this title shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage, except to the extent that such standard or requirement prevents the application of a requirement of this title, *or which requires (in connection with any litigation against a health insurance issuer) that the dispute be first, or simultaneously, considered through an alternative dispute resolution system.*

U.S. Department of Labor

Pension and Welfare Benefits Administration
Washington, D.C. 20210

DATE: 12/11

TO: Chris Jennings

TELEPHONE: _____ **FAX:** _____

FROM: Leslie Kramerich

Office of the Assistant Secretary
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200 Constitution Avenue, NW - Room S2524
Washington, DC 20210
(202) 219-8233 - voice
(202) 219-5526 - fax

COMMENTS: FYI - Chris, if you'd like to talk about this, I'm at 219-8233. I'll leave for NY Tuesday morning. Thank you. Leslie

NUMBER OF PAGES INCLUDING COVER SHEET 3

Working for America's Workforce

DEC 11 '98

MEMORANDUM FOR THE DEPUTY SECRETARY
AND THE CHIEF OF STAFF

THROUGH: Meredith Miller

FROM: Leslie Kramerich

RE: PWBA's Participation in the Forum for Health Care Quality Measurement and Reporting -- **SEEKING CONCURRENCE WITH PWBA RECOMMENDATION PRIOR TO TUESDAY MEETING**

cc: Yvette Meftah

One of the recommendations made about a year ago by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry was the creation of a "Forum for Health Care Quality Measurement and Reporting". The Forum was to be a private sector entity which would "develop an effective and efficient way to focus incentives for quality improvement on national priorities while ensuring the public availability of information needed to support the marketplace and oversight efforts." A Quality Forum Planning Committee was formed to develop this recommendation. Meredith has been a committee member. The first committee meeting was convened on June 17, 1998, by the Vice President at the White House to highlight its importance. The committee has met every month and is now down to one of the final meetings it will have before finalizing the Forum's structure, so this is the time to clarify our future role in the Forum itself.

The committee meets Tuesday, December 15, 1998, to begin formalizing a structure for the Forum. Based on our discussions within PWBA and with our colleagues in the Solicitor's Office, **we recommend clarifying with the group that our role going forward will be that of observor**, and that we will be happy to inform the committee's work where our expertise is helpful and to be informed by their work but that we will not be a voting participant or member of the Forum.

We recommend making this distinction in order to preserve our ability to act independently of the ultimate recommendations of this private entity when it comes to, for example, taking enforcement actions against purchasers who fail to consider quality as part of their obligations to engage in prudent decision-making, or determining what sponsors of benefit plans must consider or report or disclose. We make the same effort to approach issues independently of the recommendations of our ERISA Advisory Council.

HHS has representatives on the committee who feel less reluctance than we do regarding continuing active participation as members of the Forum. That may be due, at least in part, to the fact that they are not only regulators but purchasers of health care. OPM and Veterans Affairs, too, may end up with voting roles. For us, though, as regulators who are already enforcing obligations to take quality into account when structuring health benefit arrangements as well as

enforcing obligations to disclose certain quality-related information to participants (in our proposed regulations updating the claims process), involvement as a decisionmaker in a private sector not-for-profit entity which plans to recommend reporting standards and endorse quality measurements and consumer protection measures may prove more problemmatic.

The analogy made by some within PWBA is to our independence on the pension side from entities which develop recommended measures and practices applicable there. For example, we would not "join" the Financial Accounting Standards Board to recommend and endorse measures of pension liability or requirements that those measures be reported to the SEC. A similar distance and independence is what we are recommending here.

We wanted to let you know of our recommendation so that we can discuss it on Monday if you have reservations or would like more information. Our plan at this point is for Leslie to attend as an observor and/or to send a health policy analyst in that capacity.

Gary
Mike
Sherrie / Harriet

JAFeldman 11/20/98 1:28 pm

No. 97-1868

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1997

UNUM LIFE INSURANCE COMPANY OF AMERICA, PETITIONER

v.

JOHN E. WARD

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

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

SETH P. WAXMAN
Solicitor General

JUDITH E. KRAMER
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QUESTIONS PRESENTED

1. Whether California's "notice-prejudice" rule, which prevents an insurance company from avoiding liability on the basis of an untimely notice or submission of proof unless the insurer has been substantially prejudiced by the delay, is a state lat that "regulates insurance" and is thereby saved from preemption by Section 514(b)(2)(A) of the Employee Retirement Security Act of 1974 (ERISA), 29 U.S.C. 1144(b)(2)(A), even assuming the rule itself does not spread risk and thus does not meet one of the three criteria identified by the Supreme Court for determining whether a law falls within the scope of that provision.

2. Whether the "notice-prejudice" rule is not preempted, despite the fact that the rule conflicts with the written terms of the ERISA plan in this case and thus purportedly conflicts with ERISA's civil enforcement scheme.

3. Whether a state common law rule of agency law, known as the Elfstrom rule, under which an employer may, in some circumstances, be deemed to be the agent of the insurance company, "relate[s] to" an ERISA plan within the meaning of ERISA's preemption provision, 29 U.S.C. 1144(a), when applied in an action by a plan participant to recover benefits under ERISA Section 502, 29 U.S.C. 1132.

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INTEREST OF THE UNITED STATES

This case presents questions concerning the scope of the preemption provision of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1144(a), as well as the scope of the provision that saves state insurance regulation from ERISA preemption. Id. § 1144(b)(2)(A). Because the Secretary of Labor has primary authority for enforcing and administering Title I of ERISA, see 29 U.S.C. 1002(13), 1136(b), the United States has a substantial interest in ensuring that ERISA preemption principles are appropriately applied.

STATEMENT

1. Respondent John E. Ward was president and chief executive officer of Management Analysis Company (MAC) until he resigned in May of 1992. Pet. App. 3a, 27a. During his nine years of employment with MAC, respondent had premiums deducted from his paycheck for long-term disability insurance under a

group policy issued by petitioner UNUM Life Insurance Co. to MAC. Id. at 28a. This disability policy insures the benefits provided under MAC's employee welfare plan, which is governed by ERISA. Id. at 2a.

In December 1992, respondent was diagnosed as suffering from diabetic neuropathy, which had for some time been causing him severe and disabling leg pain. Pet. App. 3a, 28a. In 1993, he applied for and received an award of state disability benefits, and shortly thereafter, a determination of eligibility for Social Security disability benefits. Ibid. Respondent forwarded a copy of this determination to MAC's human resources department to arrange for continuation of his health insurance coverage, but was not notified that he might obtain coverage under the long-term disability plan. Ibid.

In April 1994, while cleaning out a safety deposit box, he came across a booklet summarizing the disability plan, at which time he again contacted MAC's human resources department to inquire whether he might be covered. Ibid. He was informed by the company that he was covered and was given an application for long-term disability benefits, which he completed and returned to MAC. MAC completed the employer's portion of the application and forwarded it to petitioner on April 11, 1994. Id. at 3a, 28a-29a. Two days later, petitioner denied respondent's claim for benefits as untimely under the terms of the policy, which specifies that written proof of claim be given to petitioner not later than one year and 180 days after the onset of disability.

Id. at 3a, 4a-5a, 29a, 32a. On July 12, 1994, petitioner affirmed its denial, after respondent requested review of his claim. Id. at 3a; see id. at 29a (different date).

2. Respondent filed suit against the MAC plan and petitioner to recover benefits under Section 502 of ERISA, 29 U.S.C. 1132. Pet. App. 77a. The district court granted summary judgment for petitioner, agreeing that the claim for benefits was untimely under the terms of the plan. Id. at 32a-33a.

Respondent argued that the claim was timely under the Elfstrom rule, see Elfstrom v. New York Life Ins. Co., 432 P.2d 731 (Cal. 1967), a pre-ERISA state agency principle providing that where an employer administers an insured group health plan, it acts as the agent of the insurance company. In respondent's view, MAC acted as petitioner's agent for purposes of the disability insurance policy, and the notice respondent gave MAC therefore constituted timely notice of claim to petitioner. The district court rejected that argument on the ground that the Elfstrom rule is preempted by ERISA and is not saved as a law that "regulates insurance" under ERISA's insurance savings clause, 29 U.S.C. 1144(b)(2)(A). The court reasoned that the Elfstrom rule is not a saved insurance regulation for two reasons: it does not transfer risk and it is not an integral part of the policy relationship between the insurer and the insured, since California law specifically allows insurance contracts to define the extent of the employer's agency relationship with the insurance company. Pet. App. 30a-31a.

3. The Ninth Circuit reversed, on two grounds.

First, although the court agreed that the notice and proof of claim were clearly untimely under the express terms of the plan, Pet. App. 4a-5a, the court nevertheless held that the case should be remanded for further consideration of whether, under California's "notice-prejudice" rule, petitioner suffered actual prejudice from the untimely notice. Pet. App. 6a. The notice-prejudice rule provides that an insurer may not deny a claim as untimely unless it can show actual prejudice resulting from the delay. Id. at 5a-6a. In holding that ERISA does not preempt the notice-prejudice rule, the court relied on its recent decision in Cisneros v. UNUM Life Insurance Co. of America, 134 F.3d 939, 945-947 (9th Cir. 1998), petition for cert. pending, No. 97-1867.

Cisneros had held that the California notice-prejudice rule is saved from ERISA preemption as a law "which regulates insurance." 29 U.S.C. 1144(b)(2)(A). Noting that the rule dictates the terms of the insurance relationship and is specifically and exclusively applicable to insurance contracts, the court concluded in Cisneros that the rule is saved because it fits a common-sense understanding of insurance regulation. 134 F.3d at 945, citing Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724, 740-742 (1985). As this Court had done in Metropolitan Life, the Cisneros court also looked to the three factors that are used in determining whether a particular state law relates to the "business of insurance" under the

McCarran-Ferguson Act, 15 U.S.C. 1012.[1] The Cisneros court concluded that the notice-prejudice rule does not satisfy the first factor because it does not transfer or spread policyholder risk as required by that factor. But, the court held, that "imperfection" is not "dispositive," Cisneros, 134 F.3d at 945; the McCarran-Ferguson criteria are simply factors to be weighed in determining whether a law "regulates insurance." Id. at 946. Because the notice-prejudice rule creates a mandatory contract term and is applicable only to the insurance industry, the court determined that it clearly meets the other two McCarran-Ferguson Act factors, and that on balance it "regulates insurance" under Section 514(b)(2)(A) of ERISA. Id. at 945-947.

Second, in addition to remanding in light of Cisneros, the Ninth Circuit also held that the rule of state agency law announced in Elfstrom -- that "the employer is the agent of the insurer in performing the duties of administering group insurance policies," Pet. App. 9a -- is not preempted by ERISA Section 514(a), 29 U.S.C. 1144(a). Pet. App. 22a. The court concluded that the Elfstrom rule does not "relate to" employee benefit

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[1] The three factors are:

> [F]irst, whether the practice has the effect of transferring or spreading the policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.

Pilot Life, 481 U.S. at 48-49, quoting Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129 (1982).

plans under Section 514(a) because it does not govern the structure or administration of employee benefit plans or "provid[e] alternative enforcement mechanisms." Id. at 21a-22a (citation omitted). Moreover, reasoning that "[n]othing in [Section] 514(a) empowers a plan fiduciary to extend ERISA's preemptive reach by using policy language that negates agency law principles," the court declined to attach significance to the fact that the policy expressly provided that the employer should not be deemed to be the insurer's agent. Id. at 22a-23a. The court left to the district court on remand the question whether MAC in fact acted as an agent in administering petitioner's plan, particularly with respect to the receipt and forwarding of benefit claims. Id. at 24a-25a.

SUMMARY OF ARGUMENT

ARGUMENT

I. CALIFORNIA'S NOTICE-PREJUDICE RULE IS A LAW THAT "REGULATES INSURANCE" AND IS THEREFORE SAVED FROM PREEMPTION BY 29 U.S.C. 1144(B)(2)(A)

A. The Notice-Prejudice Rule "Relates To" ERISA plans

1. Under Section 514(a) of ERISA, 29 U.S.C. 1144(a), the provisions of ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." The California notice-prejudice rule does "relate to" ERISA plans. As stated by the court of appeals, the rule provides that "the insurer * * * may not deny benefits by reason of untimely notice or submission of proof of claim unless the insurer proves that it has suffered actual prejudice because of the delay." Pet. App. 5a-6a. That rule is equivalent to requiring each insurance policy -- including those issued to ERISA plans, see 29 U.S.C. 1002(1) (defining "employee welfare benefit plan" under ERISA to apply to plans providing benefit "through the purchase of insurance or otherwise") -- to contain a term prohibiting denial of benefits where prejudice cannot be shown.

In Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985), this Court addressed an analogous issue regarding the preemption under ERISA of a state law mandating that certain mental health benefits be provided to any state resident who is insured under certain types of policies. The Court held that that kind of mandated benefits law "relates to" ERISA plans insofar as it is sought to be applied to such plans. 471 U.S. at

739. Neither the fact that the state law was not inconsistent with any substantive provision of the plan, nor the fact that the state law applied widely to individuals and entities other than ERISA plans was sufficient to remove it from the preemptive force of ERISA's "relates to" language. Accord New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 663-664 (1995) ("Because regulated policies [in Metropolitan Life] included those bought by employee welfare benefit plans, we recognized that the law 'directly affected' such plans."); Shaw v. Delta Airlines, 463 U.S. 85, 97 (1983) (state disability law "which requires employers to pay employees specific benefits, clearly 'relate[s] to' benefit plans").

The same principle applies here. Although the notice-prejudice rule does not mandate that insurance policies issued to ERISA plans include any particular substantive benefit, its effect is similar to that of the laws at issue in Metropolitan Life or Shaw, because it in effect requires plans to include particular provisions (in this case, regarding the enforcement of claim filing deadlines) in their insurance contracts. Indeed, the argument that the statute "relates to" ERISA plans is stronger in this case than in Metropolitan Life or Shaw, since -- unlike the substantive benefits that an ERISA plan must offer, as to which the statute itself is silent -- ERISA itself contains some provisions regarding claims processing.[2] Accordingly, like

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[2] [very brief summary and citation of DOL's new regs regarding claims processing]

the rules at issue in Metropolitan Life or Shaw, the notice-prejudice rule "mandates employee benefit structures or their administration" when applied to ERISA plans. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 646 (1995). It therefore "relates to" such plans.

B. The Notice-Prejudice Rule Is Saved From Preemption By ERISA's Insurance Savings Clause

Under the "insurance savings clause" of ERISA, Section 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A), the general "relates to" criterion for preemption is qualified. The insurance savings clause provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance." 29 U.S.C. 1144(b)(2)(A). By saving such insurance regulation from preemption, ERISA "leaves room for complementary or dual federal and state regulation" of the insurance industry. John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank, 510 U.S. 86, 87 (1993). The ultimate question in determining whether a state law is saved from preemption under the insurance savings clause is whether the law "regulates insurance."

This Court has employed a two-stage analysis for deciding whether a state law "regulates insurance" in this context. First, the Court undertakes a "common-sense" examination of the state law at issue. Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 740 (1985). "A common-sense view of the word

'regulates' would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 50 (1987). Second, because a purpose of the insurance savings clause was "to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States," Metropolitan Life, 471 U.S. at 744 n.21, the three factors used to determine whether a state law regulates the "business of insurance" under the McCarran-Ferguson Act are also relevant to the ERISA determination. See note 1, supra.[3]

Under this two-tiered analysis, a state law that mandates benefits to be provided in an insured plan falls within the savings provision and is not preempted. Metropolitan Life, 471 U.S. at 746. On the other hand, a general state tort or contract law that applies to the insurance industry, but is not directed specifically at the industry, is not an insurance regulation falling within the savings provision and, to the extent it "relate[s] to" a plan, is preempted. Pilot Life, 481 U.S. at 50, 57.

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[3] A state law that purports to regulate insurance by "deem[ing]" a plan to be an insurance company is also outside the savings provision and subject to preemption. 29 U.S.C. 1144(b)(2)(B). As a result of that provision, self-insured plans are generally outside the scope of state insurance regulation. See, e.g., [cases]. Because this case does not involve a self-insured plan or an attempt to deem a plan to be an insurance company, this "deemer" clause is not at issue in this case.

1. The court of appeals correctly held that the notice-prejudice rule, as a matter of "common sense," is directed at the insurance industry. The court of appeals in this case relied on its recent decision in Unum Life Ins. Co. v. Cisneros, 134 F.3d 939 (9th Cir. 1998), to hold that the notice-prejudice rule is saved under the ERISA insurance savings provision. In Cisneros, the court had reasoned that the notice-prejudice rule, "by requiring the insurer to prove prejudice before enforcing proof-of-claim requirements, * * * dictates the terms of the relationship between the insurer and insured and so seems, as a matter of common sense, to 'regulate insurance.'" Id. at 945. The court also noted that "[t]he rule is directed specifically at the insurance industry and is applicable only to insurance contracts." Ibid. The Ninth Circuit's conclusion in Cisneros that the notice-prejudice rule satisfies an ordinary understanding of insurance regulation is correct.[4]

Petitioner belatedly argued in its reply brief at the certiorari stage of this case that the notice-prejudice rule "is nothing more than a basic principle of contract law which applies to all contracts, not merely insurance policies." Pet. Reply Br.

[4] The notice-prejudice rule is not unique to California insurance regulation. As one influential treatise has noted, "there is something approaching a consensus in regard to the general proposition that an insured's coverage should only be lost when the insurer has been prejudiced." Robert Keeton and Alan Widiss, Insurance Law: A Guide To Fundamental Principles, Legal Doctrines, and Commercial Practices, § 7.2, at 763 (1988). Indeed, if the rule were not saved by the insurance savings clause, it would nonetheless have to be decided whether the rule should be adopted as a matter of federal common law under ERISA itself.

5. Assuming that this issue is properly before the Court because it is "fairly included" in the questions presented, see Sup. Ct. R. 14.1(a), petitioner's argument should be rejected. Determining whether California's notice-prejudice rule is directed at the insurance industry narrowly, or is instead a "basic principle of contract law" recognized throughout a State's law, requires an analysis of the law of California. Petitioner offers no reason to disturb the conclusion of the court of appeals, which is presumed to be familiar with the law of the States in its circuit, that the notice-prejudice rule under California law is directed specifically at the insurance industry. See Sheridan v. United States, 487 U.S. 392, 401-402 (1988); Runyon v. McCrary, 427 U.S. 160, 181 (1976); Huddleston v. Dwyer, 322 U.S. 323, 237 (1944).

In any event, our survey of California law reveals no cases where the state courts apply the notice-prejudice rule as such outside the insurance area. Nor is this surprising, given that the rule is stated in terms of prejudice to an "insurer" resulting from untimeliness of notice. See Shell Oil Co. v. Winterthur Swiss Ins. Co., 12 Cal. App. 4th 715, 760 (Ct. App. 1993) ("California law is settled that a defense based on an insured's failure to give timely notice requires the insurer to prove that it suffered substantial prejudice."). Thus, even if petitioner is correct in viewing the notice-prejudice rule (like most insurance regulation) as having its roots in established common law contract doctrine, or more broadly as being a species

of harmless error doctrine, we agree with the Ninth and D.C. Circuits that, as it now exists, the rule of notice-prejudice "applies only to insurers." O'Connor v. UNUM Life Ins. Co. of Am., 146 F.3d 959, 964 (D.C. Cir. 1998); compare Security Life Ins. Co. of Am. v. Meyling, 146 F.3d 1184, 1189 (9th Cir. 1998) (California insurance code provision allowing rescission in the event of material misrepresentation merely codifies the common law remedy of rescission and is not an insurance regulation).[5]

2. The McCarran-Ferguson Act factors also suggest that the California notice-prejudice rule is a law that "regulates insurance" under ERISA. In its previous Cisneros decision, upon which the court in this case relied, the court of appeals considered the application of the McCarran-Ferguson Act factors to the California notice-prejudice rule. The court ruled that the notice-prejudice rule clearly satisfies two of the factors -- whether the rule is "an integral part of the policy relationship between the insurer and the insured" and whether the rule "is limited to entities within the insurance industry." See Cisneros, 134 F.3d at 946. Those conclusions are correct. By "effectively creat[ing] a mandatory contract term" that requires the insurer to prove prejudice before enforcing a timeliness-of-claim provision, the notice-prejudice rule "dictates the terms of

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[5] We note that state common law created by the decisions of state courts, such as the notice-prejudice rule, fits ERISA's literal definition of state law. 29 U.S.C. 1144(c)(1) and (2) ("[t]he term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law"). In many States, a similar notice-prejudice rule is codified in the state insurance code. See [citation for source on this].

the relationship between the insurer and the insured, and consequently, is integral to that relationship." Ibid. In addition, as discussed above, the notice-prejudice rule appears to be specifically tailored to the insurance industry and applies only in that context. The primary dispute in this case, however, concerns the other McCarran-Ferguson criterion -- whether the notice prejudice rule "has the effect of transferring or spreading a policyholder's risk."

a. The Cisneros court held that the notice-prejudice rule does not satisfy the McCarran-Ferguson "risk spreading" criterion. The court held that this criterion "refers to the risk of injury for which the insurance company contractually agreed to compensate the insured." 134 F.3d at 945-946. The court stated that, although "[t]he notice-prejudice rule does shift the risk of lost coverage as a result of late submission of proof," it "does not alter the allocation of risk for which the parties initially contracted, namely the risk of lost income from long-term disability." Ibid.

In our view, although the distinction the court of appeals attempted to draw between different types of risk spreading finds substantial support in the case law, it is ultimately unsatisfactory.[6] Insofar as the notice-prejudice rule shifts the

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[6] See Davies v. Centennial Life Ins. Co., 128 F.3d 934, 941 (6th Cir. 1997); Tingle v. Pacific Mut. Ins. Co., 996 F.2d 105, 108 (5th Cir. 1993); DeBruyne v. Equitable Life Assurance Soc'y of the United States, 920 F.2d 457, 469 (7th Cir. 1990); Smith v. Jefferson Pilot Life Ins. Co., 14 F.3d 562, 569 n.9 (11th Cir.), cert. denied, 513 U.S. 808 (1994); cf. O'Connor v. UNUM Life Ins. (continued...)

risk of late notice and stale evidence from the insured to the insurance company in some instances, it has the effect of raising premiums and spreading risk among policyholders. See United States Department of Treasury v. Fabe, 508 U.S. 491, 503-504 (1993) (in holding that the actual performance of a contract constitutes the "business of insurance" under the McCarran-Ferguson Act, the Court notes that "[w]ithout performance of the terms of an insurance policy, there is no risk-transfer at all."). Therefore, it could easily be found to satisfy the McCarran-Ferguson "risk spreading" criterion.

Moreover, although the court of appeals attempted to rely on this Court's decision in Metropolitan Life to support its distinction between "the risk for which the parties originally contracted" and the risk of late notice and stale evidence addressed by the notice-prejudice rule, its reliance was misplaced. The Court in Metropolitan Life held that a state law mandating the inclusion of certain mental health benefits in certain types of insurance policies tended to spread risks under the McCarran-Ferguson Act test. Just as in this case, however, the risk that was spread by the state rule -- the risk of mental illness -- was not a risk "for which the parties initially contracted," in the Ninth Circuit's phrase; the parties in Metropolitan Life specifically contracted only to spread other

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[6](...continued)
Co. of Am., 146 F.3d 959, 962 n.* (D.C. Cir. 1998) (noting that because policyholder conceded the point, it had no occasion to decide whether the notice-prejudice rule transfers or spreads policyholder risk).

kinds of health risk. Nonetheless, just as in this case, the state law at issue required them to spread an additional risk, and it was therefore found to satisfy the McCarran-Ferguson "risk spreading" criterion. It would appear that the same conclusion applies here.

b. The Court need not, however, determine the soundness of the court of appeals' conclusion that the notice-prejudice rule spreads risk under the McCarran-Ferguson factors. Even if the notice-prejudice rule does not spread the kind of risk addressed by the McCarran-Ferguson factors, the fact that it does not is not fatal to a claim that the rule nonetheless "regulates insurance" under ERISA. That is because, as the Ninth Circuit correctly held, "the McCarran-Ferguson factors are simply relevant considerations or guideposts, not separate essential elements of a three-part test that must each be satisfied for a law to escape preemption." Cisneros v. UNUM Life Ins. Co. of Am., 134 F.3d 939, 946 (9th Cir. 1998), petition for cert. pending, No. 97-1867.[7]

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[7] The Ninth Circuit's view is in line with that of the District of Columbia and Sixth Circuits, O'Connor v. UNUM Life Ins. Co. of Am., 146 F.3d 959, 963 (D.C. Cir. 1998); Davies v. Centennial Life Ins. Co., 128 F.3d 934, 940 (6th Cir. 1997); cf. Soniat v. Travelers Ins. Co., 538 So. 2d 210, 214-215 (La. 1989) (holding policy-cancellation provision saved under common-sense approach without resort to Pireno factors), while the Fifth Circuit is the only circuit to have directly held that all three factors are essential. CIGNA Healthplan of La., Inc. v. Louisiana, ex rel. Ieyoub, 82 F.3d 642, 650 (5th Cir.) ("[I]f a statute fails * * * to satisfy any one element of the three-factor Metropolitan Life test, then the statute is not exempt from preemption by the ERISA insurance savings clause."), cert. denied, 519 U.S. 964 (1996); accord Tingle v. Pacific Mut. Ins.

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Initially, this Court itself has made quite clear that the McCarran-Ferguson criteria were not intended to introduce a rigid three-part test. Although the Court stated in Group Life & Health Insurance Co. v. Royal Drug Co., 440 U.S. 205, 211-212 (1979), that risk-spreading is an "indispensable characteristic of insurance," it does not follow that regulation of the business of insurance always involves regulation of risk-spreading, either under the McCarran-Ferguson Act itself or under ERISA. Indeed, since its initial articulation of the three criteria in Royal Drug, the Court has been quite consistent in disavowing any attempt to use them as a rigid three-part test. That has been true both in cases directly applying the McCarran-Ferguson Act, such as Pilot Life, see 481 U.S. at 48, 49 (referring to the factors as "guide[s]" or "considerations [to be] weighed"), and in cases applying the ERISA insurance savings clause, see Metropolitan Life, 471 U.S. at 743 ("three criteria relevant to determining whether a particular practice falls within the

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Co., 996 F.2d 105, 108 (5th Cir. 1993) (holding statute preempted that "fails to satisfy at least one prong of the three part Metropolitan Life test"). Other courts have reached varying results that appear to depend on a more flexible analysis, not a rigid rule requiring state laws to satisfy each of the McCarran-Ferguson criteria to come within the ERISA insurance savings clause. See, e.g., Brewer v. Lincoln Nat'l Life Ins. Co., 921 F.2d 150, 153 (8th Cir. 1990) (common law rule not saved because it failed two factors), cert. denied, 501 U.S. 1238 (1991); Howard v. Gleason Corp., 901 F.2d 1154, 1158-1159 (2d Cir. 1990) (statutory provision not saved because it failed to meet common sense test and two factors); Kelley v. Sears, Roebuck & Co., 882 F.2d 453, 456 (10th Cir. 1989) (statute not saved because it failed two of three factors); Anschultz v. Connecticut Gen. Life Ins. Co., 850 F.2d 1467, 1469 (11th Cir. 1988) (state law that failed to meet two of McCarran-Ferguson factors is not saved).

'business of insurance'") (emphasis added). As the Court stated in Pireno, "[n]one of these criteria is necessarily determinative in itself." Pireno, 458 U.S. at 129. Indeed, in FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990), the Court found a state anti-subrogation provision to be an insurance law without any reference to the Pireno factors.

Moreover, the Court demonstrated that the insurance savings clause analysis embodies a balancing approach in Pilot Life. After determining that the state law in that case met neither a "common-sense" understanding of insurance nor the first McCarran-Ferguson factor, because it did not spread risk, id. at 50, the Court proceeded to address the other two factors as well. Id. at 50-51. That additional analysis would not have been necessary if petitioner were correct that a regulation must qualify under all three prongs.

Furthermore, the textual differences between the McCarran-Ferguson Act and the ERISA insurance savings clause suggest a somewhat broader scope for the insurance savings clause. The ERISA insurance savings clause saves any law that "regulates insurance," 29 U.S.C. 1144(b)(2)(A) -- a somewhat broader formulation than the McCarran-Ferguson Act's reference to laws "for the purpose of regulating the business of insurance." 15 U.S.C. 1012(b). Consequently, the stricter approach that may be necessary in McCarran-Ferguson Act cases to distinguish between the "business of insurance," which displaces federal antitrust and securities laws, and the "business of insurance companies,"

which may be subject to those laws, see SEC v. National Sec., Inc., 393 U.S. at 459, would not have controlling significance in the ERISA context.

Finally, the differing legal contexts in which the McCarran-Ferguson Act and the ERISA insurance savings clause operate suggest that, even if a rigid application of the McCarran-Ferguson criteria were appropriate elsewhere, a more flexible approach should be applied in the ERISA context. The McCarran-Ferguson Act was primarily directed toward drawing a line between a well-developed federal regulatory regime under the antitrust laws and the equally swell-developed state regulation of insurance; accordingly, a conclusion that the McCarran-Ferguson Act does not apply does not prohibit all regulation, but merely has the effect of subjecting an insurer to the federal regime. By contrast, a conclusion that a state law is not a law that "regulates insurance" under the ERISA insurance savings clause frequently has the opposite effect: it displaces a settled state scheme that has been found necessary to protect consumers and beneficiaries of insurance policies without subjecting insurers to any corresponding alternative scheme of substantive regulation. The Congress that enacted ERISA was deeply concerned with protecting the rights of plan participants. A too-rigid application of the McCarran-Ferguson criteria in the context of the ERISA insurance savings clause could easily result in depriving ERISA participants -- whom Congress sought to protect -

- of needed consumer protections without providing any alternative.

C. The Notice-Prejudice Rule Does Not Conflict With ERISA'S Civil Enforcement Provisions

Petitioner contends that, even if the notice-prejudice rule would be saved under the insurance savings clause, it is nonetheless preempted because it conflicts with a substantive provision of ERISA and with the written terms of the plan. Petitioner relies on Pilot Life, which it reads as having held that "ERISA would bar these [state] causes of action [for improper claims processing and failure to pay benefits] -- even if the 'saving' clause were applicable -- because they conflict with one of ERISA's substantive provisions, its exclusive civil enforcement scheme in [Section] 502(a)." Pet. 23, citing Pilot Life, 481 U.S. at 51-57. Petitioner is wrong, however, in both its premise and in the broader implications of its argument.

a. Petitioner's premise that a claim that conflicts with the written terms of a plan could not be a Section 502(a) claim for benefits -- and therefore must be a state cause of action for improper claims processing or failure to pay benefits -- is mistaken. In this case, the notice-prejudice rule is relevant not because it creates a separate state cause of action, but because it supplies a legal rule to be applied in an ordinary action under Section 502(a)(1)(B), 29 U.S.C. 1132(a)(1)(B), "to recover benefits due * * * under the terms of the plan." In this respect, this case is analogous to Metropolitan Life, which held a state law mandating certain insurance benefits to be saved and

thus fully applicable under Section 502. It is also analogous to FMC Corp., in which the Court concluded that a state anti-subrogation rule would be saved and therefore applied to an insured plan, notwithstanding that the state rule affected the plan's payment of benefits. Analytically, there is no distinction among a state mandated insurance benefit law, an anti-subrogation rule, or a notice-prejudice requirement; each kind of mandate must be viewed, as a matter of state insurance law, as incorporated into the terms of insured plans in that state and as rendering nugatory any conflicting provisions of such plans; none "conflicts with a substantive provision of ERISA." Pilot Life, 481 U.S. at 57 (referring to Metropolitan Life); cf. John Hancock, 510 U.S. at 99 n.9 ("[n]o decision of this Court has applied the saving clause to supersede a provision of ERISA itself").

In short, as the Court concluded in FMC Corp., 498 U.S. at 64, "if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts." Petitioner's argument to the contrary would virtually "read[] the saving clause out of ERISA entirely," Metropolitan Life, 471 U.S. at 741, since even the mandated benefits law at issue in Metropolitan Life would not be saved under such analysis.[8]

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[8] Contrary to petitioner's contention, Pet. 25, the notice-prejudice rule does not conflict with the requirement in Section 503 that plans must provide notice and the opportunity for review of denied claims, 29 U.S.C. 1133, or with the

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b. More fundamentally, the insurance savings clause should not be narrowed to exclude state claims and remedies clearly directed at insurance, merely because Congress generally intended Section 502(a) to be the exclusive means of obtaining redress for benefit denials by plans. We recognize that Pilot Life has generally been read to have just that effect.[9] As explained below, however, this portion of Pilot Life's rationale cannot be squared with the plain language of the insurance savings provision and was unnecessary to Pilot Life's holding that the law at issue there was not an insurance regulation within the meaning of that provision. Accordingly, if the Court reaches this issue, it should make clear that a state law that "regulates insurance" is saved from preemption by ERISA, even if its

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Secretary's regulation providing that "[a] claim is filed when the requirements of a reasonable claim filing procedure * * * have been met," 29 C.F.R. 2560.503-1(c), (d). Rather, the notice-prejudice rule complements the statute and regulation by providing a longer time to file a claim in the context of insured plans, if the insurer will not suffer prejudice thereby. Nor is petitioner correct in asserting (Pet. 25) that application of the notice-prejudice rule, contrary to a plan's express terms, conflicts with the statutory requirements that fiduciaries follow the written terms of the plan and pay benefits in accordance with those terms. 29 U.S.C. 1104(a)(1)(D), 1132(a)(1)(B). Those provisions could not reasonably be read to require fiduciaries to follow a plan's terms in contravention of applicable federal or state law.

[9] Most lower courts to have confronted the issue have concluded, like petitioner here, that Pilot Life requires the preemption of claims for benefits or remedies under state-law provisions that otherwise clearly constitute insurance law. See Kanne v. Connecticut Gen. Life Ins. Co., 867 F.2d 489, 493-494 (9th Cir. 1988), cert. denied, 492 U.S. 906 (1989); In re Life Ins. Co. of N. Am., 857 F.2d 1190, 1194-1195 (8th Cir. 1988) (citing district court cases); but see Franklin H. Williams Ins. Trust v. Travelers Ins. Co., 50 F.3d 144, 151 (2d Cir. 1995).

application in the ERISA context may create a new cause of action or remedy for a plan beneficiary.

In Pilot Life, the Court considered whether ERISA preempted state common law tort and contract causes of action for bad faith processing of a claim for benefits by an insurer. Analyzing the state law creating the cause of action at issue, the court initially concluded that (a) under a "common sense" view, it was not "specifically directed toward th[e insurance] industry," 481 U.S. at 50, and (b) it "at most meets one of the three criteria used to identify the 'business of insurance' under the McCarran-Ferguson Act," id. at 51. Those holdings were sound, they provided ample basis to conclude that the state law did not come within the ERISA insurance savings clause, and the Court's conclusion in Pilot Life that the state law was preempted was therefore correct.

In a succeeding portion of the Pilot Life opinion, however, the Court went on to consider whether its conclusion that the state law was preempted was supported by the exclusivity of the ERISA cause of action for plan benefits under Section 502(c). The Court concluded that it was, stating that "[t]he policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." 481 U.S. at 54. In that portion of its opinion, the Court did not advert to the language of the insurance savings

clause, but it relied heavily on Congress's intent, evident from the legislative history of ERISA, to federalize ERISA remedies in the same way that Section 301 of the Labor Mangement Relations Act, 29 U.S.C. 185(a), had federalized remedies for violations of collective bargaining agreements. See 481 U.S. at 54-56.

We do not disagree even with this portion of the Court's opinion in Pilot Life. It is certainly true that, outside the context of state laws that "regulate insruance" under the ERISA insurance savings clause, the exclusivity of the Section 502 civil enforcement provisions appropriately informs the Court's understanding of the scope of ERISA preemption. See, e.g., Travelers, 514 U.S. at 656-658 (alternative enforcement mechanisms generally preempted); Ingersoll-Rand, 498 U.S. at 142; cf. Mertens v. Hewitt Assocs., 508 U.S. 248, 253-254 (1993) (because of comprehensive enforcement scheme, Court will not infer additional federal causes of action). Indeed, Congress clearly intended the remedial provisions of ERISA to be exclusive of any generally applicable state-law remedies related to plans. H.R. Conf. Rep. No. 93-1280, at 327 (1974); see also Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 62-64, 66 (1987); Franchise Tax Bd. v. Construction Laborers Vacation Trust, 463 U.S. 1, 24 (1983).

But insofar as this portion of Pilot Life were read to suggest that ERISA Section 502 has the same preemptive force with respect to a state law cause of action or remedy that "regulates insurance" as it has with respect to one that does not do so, it

should be rejected. The text of the savings provision provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance." 29 U.S.C. 1144(b)(2)(A) (emphasis added). "[N]othing in this subchapter" includes Section 502 as well as Section 514(a), thus saving insurance regulations from the preemptive force of both provisions.[10] This Court recognized as much in Metropolitan Life, when it "declin[ed] to impose any limitation on the saving clause beyond those Congress imposed in the clause itself and in the 'deemer clause' which modifies it," and concluded that "[i]f a state law 'regulates insurance,' as mandated-benefit laws do, it is not preempted." Metropolitan Life, 471 U.S. at 746; cf. Pilot Life, 481 U.S. at 56-57 (Metropolitan Life clearly "rejected an interpretation of the [insurance] saving clause * * * that saved from pre-emption 'only

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[10] Of course, an insurance law that directly conflicts with any ERISA provision is preempted by virtue of the Supremacy Clause. See John Hancock, 510 U.S. at 99-100. Although the insurance savings clause "leaves room for complementary or dual federal and state regulation," ERISA "calls for federal supremacy when the two regimes cannot be harmonized or accommodated." John Hancock Mut. Life Ins. Co. v. Harris Trust Sav. Bank, 510 U.S. 86, 98 (1993). "[I]n the case of a direct conflict, federal supremacy principles require that state law yield." Id. at 100. Such conflict preemption occurs when it is impossible to follow both a federal and state mandate. See Boggs v. Boggs, 117 S. Ct. 1754, 1762 (1997), citing Gade v. National Solid Wastes Management Ass'n, 505 U.S. 88, 98 (1992). There is no inconsistency or direct conflict between a state law that "regulates insurance" by creating a new cause of action or remedy for an ERISA participant or beneficiary and ERISA's provision, in Section 502, of a different cause of action or remedy for the same plan beneficiary.

state regulations unrelated to the substantive provisions of ERISA'").

Moreover, insofar as the reasoning of this portion of Pilot Life derived from Congress's intent to pattern ERISA "exclusive remedy" preemption on LMRA Section 301 preemption, that intent fails to provide guidance when the state law at issue "regulates insurance." That is because LMRA Section 301 does not contain any exception analogous to ERISA's insurance savings provision. Thus, while Section 301 may provide a useful analogy in cases in which ERISA's broad "relates to" preemption is applicable, Congress's enactment of the insurance savings provision makes clear that it did not intend that analogy to be controlling where the state law is saved by the insurance savings clause. Thus, this Court need not conclude from the discussion of Section 502(a) in Pilot Life that a state law that "regulates insurance," and so comes within the literal terms of the savings clause, is nevertheless preempted.[11]

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[11] In a brief in support of the petition for certiorari in Pilot Life, the government argued "that since Congress intended the procedures it established in Section 502 to be the exclusive procedures for enforcing claims for benefits due under employee benefit plans, the states are barred from establishing alternative procedures." Br. for the United States as Amicus Curiae, Pilot Life Ins. Co. v. Dedeaux, No. 85-1043, at 18. We adhere to that conclusion in circumstances like those in Pilot Life, where a beneficiary brought a claim under a general "state common law cause of action," ibid., to obtain benefits under a plan, as well as other remedies. For the reasons given in text, however, the exclusive nature of the Section 502 remedy is necessarily qualified where a beneficiary brings a claim under a state law that "regulates insurance." Insofar as our analysis here differs from that which we offered at the certiorari stage in Pilot Life, it is worth noting that our thinking -- as that of

(continued...)

II. THE ELFSTROM RULE DOES "RELATE TO" ERISA PLANS WHEN IT IS APPLIED TO THEM, AND IT IS THEREFORE PREEMPTED

The court of appeals erred in concluding that the Elfstrom rule, as a general principle of state agency law, does not unduly interfere with plan administration and thus does not "relate to" an employee benefit plan in this instance. To the contrary, the Elfstrom rule "relate[s] to" plans within the meaning of Section 514(a), because, when applied in the context of deciding a claim for benefits under ERISA, it could directly interfere with the goal of national uniformity in plan administration.[12]

1. The Elfstrom rule, which pre-dates ERISA and which provides that "the employer is the agent of the insurer in performing the duties of administering group insurance policies," Elfstrom v. New York Life Ins. Co., 432 P.2d 731, 737 (Cal. 1967), probably cannot be said to explicitly refer to or be dependent on the existence of an ERISA plan. See Ingersoll-Rand, 498 U.S. at 139. But the application of the Elfstrom rule to

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[11](...continued)
the Court -- has been refined in light of the benefit of significant experience with ERISA preemption in the intervening 12 years. Specifically, it is now clear that preemption analysis must begin with the presumption that Congress did not intend to preempt state law, particularly in "fields of traditional state regulation." Travelers, 514 U.S. at 654-655. That presumption is particularly strong in the area of state insurance regulation, whose continued validity and application to ERISA plans Congress expressly provided for.

[12] In the same way, the notice-prejudice rule also "relate[s] to" the plan. Unlike the Elfstrom rule, however, notice-prejudice is a law regulating insurance that is saved from preemption, and any "disuniformities" that result from the application of the notice-prejudice rule "are the inevitable result of the congressional decision to 'save' local insurance regulation." Metropolitan Life, 471 U.S. at 747.

claims for benefits -- like those advanced by respondent in this case -- does have a direct effect on plan administration. In effect, it forces the employer, as plan administrator, to assume a role, with attendant legal duties and consequences, that it has not undertaken voluntarily. Compare De Buono, 117 S. Ct. at 1752-1753 (economic impact alone insufficient to "relate to" plan); Travelers, 514 U.S. at 662, 668 (same). That is especially troubling because, as petitioner points out (Pet. 28), state agency law varies from state to state, and it could easily be the case that one multi-state plan would be subject to contradictory agency principles depending on what state law is applied. See, e.g., First Nat'l Bank v. Nationwide Ins. Co., 278 S.E.2d 507, 514-515 (N.C. 1981) (North Carolina law "establishes that the employer-master policyholder is not ordinarily the agent of the insurer").Moreover, unlike a garnishment law like that at issue in Mackey, see 486 U.S. at 831-832, the effect on administration is not only substantial, but central and pervasive; it affects not merely the plan's bookkeeping obligations regarding to whom benefits checks must be sent, but instead regulates the basic services that a plan may or must provide to its participants and beneficiaries. Accordingly, application of the Elfstrom rule to claims for benefits like that of respondent is contrary to ERISA's goal of uniform federal

administration of employee benefit plans and thereby "relates to" ERISA plans.[13]

Although we believe that the Elfstrom rule is preempted, however, we are not suggesting that general agency principles, or indeed contract, corporate or even trust principles, have no place in deciding an ERISA benefits claim. In this respect, the analogy to LMRA Section 301 is instructive. As in cases under that statute and in the absence of pertinent regulations issued by the Department of Labor, see [citation for source of regulatory authority], the federal courts are required to develop a uniform "federal common law of rights and obligations," Pilot Life, 481 U.S. at 56, concerning the circumstances under which ERISA plans will be held to have acted as agents of insurance companies. See, e.g., Allis-Chalmers v. Lueck, 471 U.S. 202, 210 (1985)("[A] suit * * * alleging a violation of a provision of a

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[13] Although the issue apparently was presented to the district court, see Pet. App. 30a-31a, no party appears to be contending that the Elfstrom rule, although formulated in the context of insurance, is a state law that "regulates insurance" for purposes of the ERISA insurance savings clause. In our view, the Elfstrom rule is not a law that "regulates insurance," both because it is not specifically directed at insurance and for the additional reasons discussed by the district court, see Pet. App. 31a. The court of appeals described as "sound" and "comport[ing] with [the Ninth Circuit's] prior determination of the issue" a formulation that makes quite clear that the rule is not law directed specifically at insurers, but is instead an application of general principles of agency law: "as the employer assumes responsibility for more administrative or sales functions which are customarily performed by an insurer, a question of fact will arise as to the agency relationship between the insurer and the employer." Pet. App. 13a n.6 (quoting Paulson v. Western Life Ins. Co., 636 P.2d, 935, 939 (Or. 1981)). Cf. Pet. App. 24a (noting that "[t]he question ultimate for the district court is whether MAC acted for UNUM and under UNUM's control in receiving and forwarding long-term disability claims").

labor contract must be brought under § 301 and be resolved by reference to federal law."). In developing that federal common law, the courts certainly can look to state-law principles. Lyman Lumber Co. v. Hill, 877 F.2d 692, 693 (8th Cir. 1989). But, by subjecting plans to a federal common law standard, the statutory goal of consistent application in a multi-state setting can be achieved. See Shaw, 463 U.S. at 105. Given its roots in general principles of agency law, rules similar to the Elfstrom rule appear to be widespread in state law. See Pet. App. 12a (citing casees). Thus, on remand the courts below should consider whether the Elfstrom rule, or something like it, applies to the circumstances of this case as a matter of federal, not California, common law.[14]

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[14] See, e.g., Security Life Ins. Co. of Am. v. Meyling, 146 F.3d 1184, 1191 (9th Cir. 1998) (holding that rescission is an available remedy under the federal common law of ERISA); McClure v. Life Ins. Co. of N. Am., 84 F.3d 1129, 1135 (9th Cir. 1996) (adopting "reasonable expectations" doctrine as a matter of federal common law to aid in interpretation of ERISA insurance policies); City of Hope Nat'l Med. Ctr. v. HealthPlus, Inc., 156 F.3d 223, 228 (1st Cir. 1998) (applying federal common law principles of assignment in context of ERISA claim); Ford v. Uniroyal Pension Plan, 154 F.3d 613, 619 (6th Cir. 1998) (refusing to apply state law when calculating prejudgment interest award in context of successful ERISA benefits claim, but instead applying federal common law principles); Moriarty v. Glueckert Funeral Home, Ltd., 155 F.3d 859, 865-867 (7th Cir. 1998) (in case arising under ERISA and LMRA, court applied federal common law of agency in determining whether member of multi-employer association was bound by particular provision of collective bargaining agreement concerning contributions to employee benefit plan).

CONCLUSION

The judgment of the Ninth Circuit with respect to the applicability of California's notice-prejudice rule should be affirmed. The court's judgment with respect to the applicability of the Elfstrom rule, however, should be reversed.

Respectfully submitted.

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STATEMENT OF ALEXIS M. HERMAN, SECRETARY OF LABOR, ON SUPREME COURT CASE, *UNUM LIFE INSURANCE COMPANY*

"I am pleased by the brief just filed by the U.S. Government in an important Supreme Court case, *UNUM Life Insurance Company*, involving the Employee Retirement Income Security Act (ERISA), which the Department of Labor administers and enforces. Twelve years ago, the Government took a position in an earlier Supreme Court case (*Pilot Life Insurance Company*) that effectively curtailed the state insurance law remedies of patients whose health care claims had been mishandled by health care plans. The Government's brief in the *UNUM* case departs from the old, *Pilot Life* position. It is consistent with this Administration's view that ERISA should not be read to preempt state insurance laws that provide remedies to workers and their families who have been harmed by health plan decisions.

"It is important to note that, regardless of the interpretation of ERISA law, tens of millions of Americans in self-insured plans who are not covered by state insurance laws will still be without remedies unless new and long-overdue Federal legislation is passed and signed into law.

"As such we will continue to push for strong, enforceable bi-partisan Federal legislation to provide these protections."

Note to Editors

BACKGROUND

ERISA governs approximately 2.5 million private sector health plans that cover over 120 million Americans, and is the federal law intended to protect the health and pension benefits that employers voluntarily provide their workers.

In 1986, the Government argued to the Supreme Court in the Pilot Life case that ERISA barred the states from establishing procedures and remedies for enforcing claims for health care benefits because ERISA set forth the exclusive procedure for doing so. The brief filed by the Government on Friday departs from the views expressed in Pilot Life. In this Administration's view, ERISA should not be read to restrict the states' ability to provide insurance remedies for employees or their dependents who have been denied benefits by their employers' insured health care plans. Although there are other ways to decide this case, and the Court, therefore, may not have occasion to reach this issue, the brief alerts the Court that the Government's views regarding preemption have changed, and that we have serious doubts about the reasons stated in the Pilot Life decision for the Court's ruling.