No. 06-839

IN THE

Supreme Court of the United States

LOUISIANA HEALTH SERVICE & INDEMNITY CO., D/B/A
BLUE CROSS AND BLUE SHIELD OF LOUISIANA,
Petitioner,

v.

RAPIDES HEALTHCARE SYSTEM, ET AL.,
Respondents.

On Petition for Writ of Certiorari to the Court of Appeals for the Fifth Circuit

BRIEF FOR BLUE CROSS AND BLUE SHIELD OF ALABAMA, BLUE CROSS AND BLUE SHIELD OF KANSAS, INC., BLUE CROSS AND BLUE SHIELD OF NEBRASKA, BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA, BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA, BLUECROSS BLUESHIELD OF DELAWARE, BLUE CROSS BLUE SHIELD OF FLORIDA, INC., BLUECROSS BLUESHIELD OF MICHIGAN, CAREFIRST OF MARYLAND, INC., EXCELLUS HEALTH PLAN, INC., GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC., THE REGENCE GROUP, WELLMARK, INC., WELLPOINT, INC., AND AMERICA'S HEALTH INSURANCE PLANS, INC. AS AMICI CURIAE IN SUPPORT OF PETITIONER

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Blue Cross and Blue Shield of Alabama, BlueCross BlueShield of Delaware, Blue Cross Blue Shield of Florida, Inc., Blue Cross and Blue Shield of Kansas, Inc., BlueCross BlueShield of Michigan, Blue Cross and Blue Shield of Nebraska, Blue Cross and Blue Shield of North Carolina, Blue Cross and Blue Shield of South Carolina, CareFirst of Maryland, Inc., Excellus BlueCross BlueShield, Group Hospitalization and Medical Services, Inc., The Regence Group, Wellmark, Inc., and WellPoint, Inc. are or operate independent, locally owned Blue Cross and Blue Shield Plans. Through insurance arrangements and administrative services agreements with employers, employee benefits plans, and individual subscribers, they furnish health benefits to tens of millions of Americans. In most instances, the provision of these benefits is governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq*.

America's Health Insurance Plans, Inc. ("AHIP") is the national association representing the private health plan and insurer community. AHIP's mission is to advance health care quality and affordability through leadership in the health care community, advocacy, and the provision of services to its members. AHIP represents nearly 1,300 member companies that insure or administer health and other employee benefits to more than 200 million individuals, the majority of whom are covered through ERISA-governed plans.[1]

The Petition for a Writ of Certiorari presents questions concerning the states' power to regulate essential aspects of the administration of ERISA plans. The Fifth Circuit's

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[1] In accordance with Rule 37.6, the *amici* certify that counsel for a party did not author this brief in whole or in part and that no entity other than the *amici*, their members, or their counsel made a monetary contribution to the preparation or submission of the brief.

decision upholds -- against a preemption challenge -- a state law that requires ERISA plans to comply with an assignment of health benefits payments from plan participants to providers, even when ERISA plan provisions instruct differently. As such, the court of appeals' decision nullifies critical plan terms affecting claims payment. It also significantly undermines the ability of ERISA plans to create provider networks designed to contain plan costs and ensure quality care, since the promise of direct payment to a provider only upon joining a network is often the linchpin for a provider joining such a network. Given the decision's significant implications for ERISA plans, the *amici* -- as entities insuring and administering ERISA plans and the national association of health insurance plans -- have a strong interest in the Petition.

Counsel for the parties have consented to the filing of this *amicus* brief.

SUMMARY OF ARGUMENT

The Fifth Circuit's decision addresses an area now familiar to this Court and the lower courts: ERISA preemption. Specifically, the issue in the case is whether ERISA preempts Louisiana's law requiring health benefits plans, including ERISA plans, to accept assignments of rights to health benefits payments, when those assignments are from plan participants to hospitals. Because the Fifth Circuit's decision conflicts with the decisions of two other circuits, is counter to this Court's own precedents, and undermines the ability of ERISA plan sponsors, insurers, and administrators to create provider networks that are key to containing plan costs and ensuring quality care, the Court should grant the Petition.

1. The Fifth Circuit's decision created -- as it candidly noted -- a clear split among the circuits: the Eighth and Tenth Circuits had already addressed the same issue and found similar assignment laws preempted. The Fifth Circuit

attempted to play down the conflict by reasoning that the intervening decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995), somehow undercut the other circuits' determinations, but that analysis misreads *Travelers*. Indeed, contrary to the Fifth Circuit's reasoning, numerous courts well after *Travelers* have relied on and followed the Eighth and Tenth Circuits' holdings.

2. Not only is the Fifth Circuit's decision contrary to the rulings of other circuits, it conflicts with this Court's own precedents, in particular *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001), and *UNUM Life Insurance Co. v. Ward*, 526 U.S. 358 (1999), by overriding plan terms and jeopardizing national uniformity in plan administration. The decision also is inconsistent with this Court's holdings that a state law supplementing or interfering with ERISA's comprehensive enforcement scheme is preempted under ordinary conflict preemption principles. The assignment statute does not simply transfer the available ERISA cause of action from one party to another; it creates an *additional* remedy, solely in the hands of the provider, to enforce the state statute's assignment terms.

The Fifth Circuit's preemption holding cannot be salvaged, as the concurrence below attempted, through application of ERISA's insurance saving clause. As an initial matter, the concurrence's saving clause analysis does not obviate the split in the circuits that warrants this Court's attention, because the majority's opinion applies to self-funded plans exempted from the saving clause. Hence, the conflict with the Eighth and Tenth Circuits remains. In any event, the Louisiana assignment statute does not, under the applicable saving clause test, constitute an insurance regulation, principally because it does not affect the risk pooling arrangement between an insurer and an insured. The statute has little to do with the substantive insurance bargain between the insurer and the insured, but instead regulates

provider rights. And even if the assignment statute were a law regulating insurance under the saving clause, the statute would still be preempted because it conflicts with ERISA's exclusive enforcement mechanism.

3. The Fifth Circuit's decision threatens a cost-containment tool central to ERISA plans and, in fact, to the Nation's entire health care delivery system -- namely, preferred provider networks. Today, rather than offering health maintenance organization ("HMO") plans exclusively, employers rely on hybrid models -- the most common of which are known as "preferred provider organizations" -- that encourage consumers to choose from a large network of providers who have agreed to discounted prices for their services. Such organizations are now the most prevalent form of health benefits arrangement in the United States.

The Fifth Circuit's decision, however, casts a pall over the creation of preferred provider networks. A chief incentive for a provider to join such a network is the promise of direct payment by the plan, payment that otherwise would be sent to the patient from whom the provider would then have to collect. By holding that state law may require direct payment to any provider with an assignment, the Fifth Circuit has seriously compromised plans' ability to establish preferred provider networks, to the detriment of plans and their participants. That threat to a principal structural component of ERISA health benefits plans warrants this Court's review.

ARGUMENT

I. THE FIFTH CIRCUIT'S DECISION CREATES A CIRCUIT SPLIT THAT COMPLICATES THE ADMINISTRATION OF NATIONWIDE PLANS

The Court should grant the Petition in order to resolve a split among the circuits. As the Fifth Circuit expressly acknowledged, its ruling that ERISA does not preempt state

assignment laws conflicts with existing precedent from the Eighth and Tenth Circuits. *See La. Health Serv. & Indem. Co. v. Rapides Healthcare Sys.*, 461 F.3d 529, 539-40 (5th Cir. 2006), *petition for cert. filed*, 75 U.S.L.W. 3333 (U.S. Dec. 14, 2006) (No. 06-839).

In *Arkansas Blue Cross & Blue Shield v. St. Mary's Hospital, Inc.*, 947 F.2d 1341 (8th Cir. 1991), the Eighth Circuit determined that Arkansas' similar assignment statute was preempted under ERISA's express preemption clause, which provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to . . . [an ERISA] plan." 29 U.S.C. § 1144(a). For several reasons, the Eighth Circuit concluded that the Arkansas law "relates to" ERISA plans and consequently was preempted. First, it found that an assignment statute directly affects the structure of ERISA plans and the relationship between the primary ERISA entities (the plan, the plan fiduciaries, and the participants) by transferring to participants the power to decide who can receive payment of ERISA benefits. 947 F.2d at 1346. Second, it determined that the state statute affected plan administration, since it changed the procedures by which plans determined how benefits should be paid and subjected multi-state plans to conflicting assignment rules. *Id.* at 1347-48. Third, the Eighth Circuit concluded that the economic impact of assignment statutes was significant, for they eliminate health care providers' incentives to enter into provider networks and diminish plans' ability to reduce costs. *Id.* at 1348-49.

The Tenth Circuit, for its part, found a similar statute to be preempted because it conflicted with the structure and provisions of ERISA itself. It "interpret[ed] ERISA as [both] leaving the assignability of benefits to the free negotiations and agreement of the contracting parties" and "insist[ing] that the states not interfere with the parties' freedom of choice." *St. Francis Regional Med. Ctr. v. Blue Cross & Blue Shield*, 49 F.3d 1460, 1464 (10th Cir. 1995).

The Fifth Circuit took direct aim at these decisions, holding that Congress's silence on the assignability of health benefits indicated congressional intent to permit states to regulate assignment issues. 461 F.3d at 540. Counter to the other circuits' decisions, it also concluded that the "burden on plan administrators [was] minimal" even for multi-state plans, because Louisiana supposedly made it easy to recognize an assignment: "Louisiana requires all insurance claims to be submitted on a uniform claim form that includes space for indicating whether benefits have been assigned." *Id.* at 539.

Nonetheless, attempting to downplay the circuit split, the Fifth Circuit suggested that this Court's decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), somehow overruled the Eighth and Tenth Circuits' holdings *sub silentio*, by decrying "uncritical literalism" in applying ERISA's preemption clause. 461 F.3d at 540. But nothing about the *St. Mary's* or *St. Francis* decisions involves such "literalism." Both decisions conducted detailed analyses of the factors that this Court and lower courts have considered relevant to the "relate to" analysis under ERISA's preemption provision, including effects on plan administration, *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9-10 (1987), and consistency with ERISA's terms and structure, *Mackey v. Lanier Collection Agency & Service*, 486 U.S. 825, 832-40 (1988). *Travelers* did not abolish those factors, and indeed this Court has continued not just to apply them but to focus on them since then in ERISA preemption cases. *See, e.g.*, *Egelhoff v. Egelhoff*, 532 U.S. 141, 147-48 (2001) (statute impermissibly "relate[s] to" ERISA "because it interferes with nationally uniform plan administration" and "runs counter" to other ERISA provisions); *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 379 (1999) (rule "relates to" ERISA because it "would have a marked effect on plan administration"); *De Buono v.*

NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806, 816 (1997) (assessing effect on plan administration). Accordingly, *Travelers* did not overrule *St. Mary's* or *St. Francis* or undermine the Eighth and Tenth Circuits' reasoning, and the conflict between those decisions and the Fifth Circuit's ruling is irreconcilable.

In the same vein, the Fifth Circuit suggested that "[n]either the Eighth nor Tenth Circuits operated with the starting assumption that Congress did not intended [sic] to preempt state law in an area of traditional state regulations." 461 F.3d at 540. The Eighth and Tenth Circuits, however, acted fully in accord with the rule later articulated in *Travelers* and found that clear evidence of congressional intent to preempt the relevant field overcame any presumption to the contrary. For example, both decisions relied heavily on *Mackey*, where this Court considered the significance of congressional silence and held in that instance that such inaction favored a finding of no preemption; the Eighth and Tenth Circuits grappled with that holding but found the circumstances before them to warrant a different result than in *Mackey*. That is evidence not of some now-impermissible rush to find preemption, but of a careful cognizance that preemption was not to be assumed and certainly was in no manner automatic.

It is also significant that other courts have relied on the *St. Mary's* and *St. Francis* rulings, even after *Travelers*. *E.g.*, *City of Hope Nat'l Med. Ctr. v. Healthplus, Inc.*, 156 F.3d 223, 229 (1st Cir. 1998) ("ERISA leaves the assignability or non-assignability of health care benefits under ERISA-regulated welfare plans to the negotiations of the contracting parties."); *Bannister v. Sorenson*, 103 F.3d 632, 636 (8th Cir. 1996) (*St. Mary's* decision "sets forth an analytical structure for ERISA preemption claims that facilitates reasoned decision-making and appellate review"); *DeBartolo v. Blue Cross/Blue Shield*, 2001 U.S. Dist. LEXIS 18363, *12 (N.D. Ill. Nov. 8, 2001) (finding assignment

statute preempted); *see also Nat'l Rehabilitation Hosp. v. Manpower Int'l*, 3 F. Supp. 2d 1457, 1460 (D.D.C. 1998); *Fisher v. Building Serv. 32B-J Health Fund*, 1997 U.S. Dist. LEXIS 12886, *13 (S.D.N.Y. Aug. 27, 1997). Even the Fifth Circuit in a 2002 ruling, citing *St. Francis*, noted that "ERISA leaves the assignability of benefits to the free negotiations and agreement of the contracting parties." *Dallas County Hosp. Dist. v. Assocs.' Health & Welfare Plan*, 293 F.3d 282, 287 n.3 (5th Cir. 2002). These courts have found no inconsistency between *Travelers* and the Eighth and Tenth Circuit rulings.

The split among the circuits is particularly problematic because it raises the prospect that, until this Court sorts out the matter, plans operating in multiple states will be subject to inconsistent rules regarding assignment. State law would need to be followed in one circuit, but not in another. National uniformity in plan administration is one of ERISA's central objectives, *see infra* p. 9, adding urgency to the resolution of a circuit split on a key issue affecting plan administration.

II. THE FIFTH CIRCUIT'S DECISION CON-FLICTS WITH THIS COURT'S PRECEDENTS

A grant of certiorari would also enable this Court to reverse the Fifth Circuit's misapplication of the Court's ERISA preemption jurisprudence. The Fifth Circuit's holding cannot be reconciled with the Court's cases applying ERISA's express preemption clause, especially *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001), and similar decisions. Moreover, the Fifth Circuit erroneously found the Louisiana law to escape the rule now well established in the Court's precedents that state law remedies supplementing or altering ERISA's enforcement scheme conflict with, and are preempted by, ERISA. Finally, the concurring Judge's analysis of ERISA's saving clause, whereby she rationalized the result reached in the panel's principal opinion, cannot be

squared with this Court's (and lower court) decisions on the subject.

A. The Fifth Circuit Decision Is Inconsistent with the Court's Precedents Applying ERISA's Preemption Provision

The Fifth Circuit grappled with, but ultimately misapplied, one of the Court's most recent decisions applying ERISA's preemption provision -- *Egelhoff*. The state statute at issue in *Egelhoff* revoked the designation of a spouse as the beneficiary of non-probate assets, including ERISA plan benefits, upon dissolution of marriage. The Court found that the law impermissibly bound plan administrators "to a particular choice of rules for determining beneficiary status." 532 U.S. at 147. That was improper, this Court held, because it conflicted with ERISA's statutory requirements that *the plan* "'specify the basis on which payments are made to and from the plan'" and that the plan administrator follow the "'documents and instruments governing the plan.'" *Id.* (quoting 29 U.S.C. §§ 1102(b)(4), 1104(a)(1)). Hence, the state statute "govern[ed] the payment of benefits, a central matter of plan administration," and "related to" ERISA for purposes of preemption. *Id.* at 160.

Egelhoff's holding is controlling. Just as the state statute there prohibited plan administrators from following the terms of the plan in directing payment of benefits, and required that benefits be paid to a recipient other than the plan's designee, Louisiana's assignment statute overrides the terms of ERISA plans and redirects payment to third-party providers. In other words, it imposes a "choice of rules" on plans' determinations of who is to receive payments from ERISA plans: "[t]he administrators must pay benefits to the beneficiaries chosen by state law, rather than to those identified in the plan documents." *Egelhoff*, 532 U.S. at 147.

In reaching its preemption conclusion, the Court in *Egelhoff* also paid heed to ERISA's concern for "national uniform[ity]" in plan administration. *Id.* at 148. It was impermissible in *Egelhoff* for plans to be "subject to different legal obligations in different States," such that plan administrators would have to familiarize themselves with every state's statutes to determine whether a beneficiary designation was valid. *Id.* Louisiana's law has the same defects. Absent preemption of state assignment statutes, multi-state plans would be required to consult local law in order to determine whether to honor an insured's assignment, and choice-of-law rules requiring complex analyses of what state has the greatest interest in a given transaction would simply exacerbate the problem. *Cf. Egelhoff*, 532 U.S. at 149.

The Fifth Circuit dismissed these concerns about additional burdens on multi-state plans on the ground that Louisiana had created a "uniform claim form" with an option to indicate the assignment of benefits, thereby supposedly simplifying any task of complying with an assignment regime in Louisiana that differed from other states'. 461 F.3d at 539. But that hardly solves the problem, for plan administrators must still determine whether a given assignment is valid, is subject to any conditions, or has subsequently been revoked. They must also determine whether an assignment that does actually exist is invalid if the box in question is not checked. The outcome of these determinations may differ, depending on the particular state's assignment rules.

Nor can the decision below be harmonized with *UNUM Life Insurance Co. v. Ward*, 526 U.S. 358 (1999) -- a decision the Fifth Circuit nowhere addressed. In that case, again applying ERISA's preemption provision, this Court invalidated a California rule concerning agency relationships. The rule, adopted by the California courts in *Elfstrom v. N.Y. Life Insurance Co.*, 432 P.2d 731, 737 (1967) (en banc), held

that an employer automatically "act[s] as [the] . . . agent" of an insurer who pays claims, such that notice of a claim to the employer could operate as notice to the plan's insurer. *UNUM*, 526 U.S. at 377. The rule was directly contrary to the ERISA plan's language, which provided that, "'[u]nder no circumstances will the policyholder [*i.e.*, the employer] be deemed the agent of the . . . [insurer] without a written authorization.'" *Id.* (quoting ERISA plan).

This Court had no trouble finding that "the *Elfstrom* rule 'relates to' ERISA plans." *Id.* at 379. The Court said that "deeming the policyholder-employer the agent of the insurer would have a marked effect on plan administration." *Id.* It would compel the employer "to assume a role, with attendant legal duties and consequences, that it has not undertaken voluntarily." *Id.* "[I]t would affect not merely the plan's bookkeeping obligations regarding to whom benefits checks must be sent," but would "regulate the basic services that a plan may or must provide to its participants and beneficiaries," by requiring benefits payments when the employer, as opposed to the insurer, was timely notified of a claim. *Id.* (internal quotation marks omitted).

As in *UNUM*, the state law at issue here creates involuntary legal duties relating to plan administration. *Id.* at 378. In this case, the plan has not undertaken to pay providers outside of its network directly; indeed, it has renounced exactly such a policy through the plan language itself. Furthermore, Louisiana's law would not only and obviously alter "the plan's bookkeeping obligations regarding to whom benefits checks must be sent," it would also add to those services provided by the plan, in that the plan would now be required essentially to provide collection services to out-of-network providers. *Id.* at 379. Specifically, the plan contemplates a regime whereby participants are paid for services obtained from out-of-network providers, with the providers then having to undertake their own collection efforts to obtain

reimbursement from participants. The Louisiana assignment law makes the plan the collection vehicle for the provider, compelling the plan to transmit to the provider the funds that, under the plan's terms, belong to the participant. In sum, just as a state law forcing an ERISA plan to recognize an agency relationship between an employer and an insurer was preempted in *UNUM*, a state law compelling a plan to recognize an agency relationship (via an assignment) between a provider and participant is preempted.

B. The Fifth Circuit's Decision Disregards the Court's Conflict Preemption Rulings Involving ERISA's Enforcement Mechanism

Not only is the Louisiana assignment statute preempted under ERISA's preemption provision, it fails under ordinary conflict preemption principles, because it conflicts with ERISA's exclusive enforcement scheme. The Court most recently stated the applicable rule in *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004), where it declared: "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." *Accord Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 143-45 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54-46 (1987).

The Fifth Circuit erroneously determined that the Louisiana statute was consonant with ERISA's enforcement remedy. The court of appeals said that the state law survived, because it "merely passes the sole enforcement mechanism -- ERISA § 502 -- from patient to hospital; it does not impose any additional obligation, on the ERISA plan administrator, nor does it create additional or separate means of enforcement." 461 F.3d at 535.

But the Fifth Circuit misread the governing state statute. The assignment law states:

> When any insurance company, employee benefit trust, self-insurance plan, or other entity has notice of such assignment prior to such payment [made to the insured by the company, trust, or plan] any payment to the insured shall not release that entity *from liability to the hospital* to which the benefits have been assigned, nor shall such payment be a defense to *any action by the hospital* against the entity to collect the assigned benefits.

La. Rev. Stat. Ann. § 40:2010 (2004) (emphasis added).

The state law thus envisions, in at least some circumstances, an action by the hospital against the plan to collect benefits. Unless this would be an action for benefits under ERISA's enforcement scheme (in particular, under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B)), the assignment statute could not possibly be said to do anything other than create a remedy that "supplements" ERISA's remedial regime. *Aetna*, 542 U.S. at 209. Presumably, the Fifth Circuit believed that the hospital's remedy would be under state law, not under ERISA § 502.

And even if the Louisiana statute (and the Fifth Circuit in construing it) assumed the hospital's remedy for benefits would be under § 502, the assignment statute would fail because it establishes a damages standard not adopted in ERISA. *See UNUM*, 526 U.S. at 378 (criticizing Ninth Circuit for remanding to lower court to determine, in context of § 502 action, if "the claim was timely under *Elfstrom*"). Nowhere does ERISA articulate a damages rule that permits a party (such as the hospital) fully to collect benefits notwithstanding that another (such as the participant) has already recovered those benefits. If such a standard is to be read into ERISA, it is for federal courts applying a federal common law under ERISA to determine, not for a state legislature to mandate. *See Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 831 (2003) ("Congress 'expected'

courts would develop 'a federal common law of rights and obligations under ERISA-regulated plans'") (quoting *Pilot Life*, 481 U.S. at 56).

C. The Concurring Judge Misapplied the Court's Test Under ERISA's Saving Clause

Judge Owen's concurrence would have upheld the assignment statute on grounds that it regulates insurance and therefore comes within ERISA's saving clause, which provides that "nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A). Judge Owen, however, is mistaken, because the saving clause is inapplicable here.

As a threshold matter, it is important to note that, even if Judge Owen were correct, her analysis would not obviate the split in the circuits necessitating this Court's review. The "deemer clause" exception to the saving clause, 29 U.S.C. § 1144(b)(2)(B), exempts self-funded ERISA plans from the saving clause's "regulate insurance" analysis. This means that, to the extent a state statute "relates to" ERISA and applies to self-funded plans as opposed to insured plans, it is still preempted, whether or not the state law qualifies as a "saved" insurance regulation. *See FMC v. Holliday*, 498 U.S. 52, 61 (1990). The Louisiana assignment statute does not limit itself simply to insured plans. *See* La. Rev. Stat. Ann. § 40:2010 (including in its scope any "employee benefit trust" or "self-insurance plan"). Hence, the Fifth Circuit majority's preemption analysis would remain the law of the circuit with regard to self-funded plans even if Judge Owen's analysis were adopted as to insured plans. Since the majority's analysis is at odds with the competing Eighth and Tenth Circuit rulings, the split would remain, and Judge Owen's analysis cannot avoid the need to resolve that disagreement.

In any event, the assignment law is not a saved insurance regulation. Judge Owen cited, but then misapplied, the saving clause test enunciated by this Court in *Kentucky Association of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003). The most substantial problem with Judge Owen's analysis arises from *Miller*'s requirement that, to be considered an insurance regulation, a state law must "substantially affect the risk pooling arrangement between the insurer and the insured." *Id.* at 342. The state statute in *Miller* stated that an insured was entitled to payment for services from any provider who agreed to abide by a plan's payment terms (even if the provider was in a category otherwise excluded in the plan). In finding that law saved, the Court focused on the state statute's expansion of the plan's substantive coverage terms: "By expanding the number of providers from whom an insured may receive health services, AWP [*i.e.*, any-willing-provider] laws alter the scope of permissible bargains between insurers and insureds .... No longer may Kentucky insureds seek insurance from a closed network of health-care providers in exchange for a lower premium." *Id.* at 338-39.

The Louisiana assignment statute, by contrast, does not affect the scope of the risks accepted by the insured and the insurer. It does not address "whether or not an insurance company must cover claims" or "dictate to the insurance company the conditions under which it must pay for the risk that it has assumed." *Id.* at 339 n.3. Instead, it creates rights *for providers*. The plan is liable to a provider for failing to pay it directly, irrespective of whether the participant has received all that to which he or she is entitled under the plan. As a result, the Louisiana statute does not have "a substantial effect on the risk-pooling arrangement between *the insurer*

and insured," but on the balance of power between insurers and providers. *Id.* at 329 (emphasis added).[2]

Even if the Louisiana statute could be considered a law regulating insurance under *Miller*, it would still be preempted because, as already noted, the statute conflicts with ERISA's exclusive enforcement mechanism. This Court has noted in *Aetna* and elsewhere that ERISA's civil enforcement provision represents an "overpowering federal policy" that trumps even the saving clause: "even a state law that can arguably be characterized as 'regulating insurance' will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme." 542 U.S. at 217.

III. THE FIFTH CIRCUIT'S DECISION HAS FAR-REACHING PRACTICAL IMPLICATIONS

Important practical considerations strongly favor a grant of certiorari in this case. Many of the most common models for employer-based health insurance rely heavily on delicate and intricately negotiated relationships between plans and providers. Louisiana's assignment statute disrupts those relationships, with potentially profound consequences for the nation's health care system. In particular, the statute threatens the predominant health benefits arrangement currently adopted by ERISA plans: preferred provider organizations, or "PPOs."

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[2] Consistent with this conclusion, many lower courts since *Miller* have found that state statutes do not affect the risk pooling relationship if they do not directly affect the bargain between the insurer and insured, and these courts have so held even if the state laws focus on the rights for insureds as opposed to third parties. *E.g.*, *Barber v. UNUM Life Ins. Co. of Am.*, 383 F.3d 134, 143 (3d Cir. 2004); *Provident Life & Accident Ins. Co. v. Sharpless*, 364 F.3d 634, 641 (5th Cir. 2004); *Allison v. UNUM Life Ins. Co.*, 381 F.3d 1015, 1027 (10th Cir. 2004); *Kidneigh v. UNUM Life Ins. Co.*, 345 F.3d 1182, 1187 (10th Cir. 2003). Of course, the Louisiana law is more problematic than even these state laws because it does not focus on rights for insureds, but for providers who are not in any facet part of the risk-pooling bargain.

Over the past thirty years, the private sector has seen many changes to the health insurance environment. In Congress's view, traditional indemnity plans, which imposed no restrictions on a patient's choice of providers, did not meaningfully restrain costs. *See, e.g.*, S. Rep. No. 93-129, 3045, 3047 (1973). Therefore, starting in the 1970s, Congress encouraged the formation of health maintenance organizations ("HMOs"), whose hallmark is care provided by a closed panel of providers subject to strict "procedures to monitor utilization and control cost of basic and supplemental health services." 42 C.F.R. § 417.103(b) (implementing the Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e(c)(2)(D)). Many employers adopted HMOs in the 1980s, but the perception arose that the HMO model unduly limited patients' choice of providers. *See* "As Employers Look to Hang on to Workers, PPOs Gain Favor," Business First (Dec. 8, 2000).

In response, the employer-based market has since then developed a wide variety of health insurance options. Employers can now choose between traditional indemnity plans, HMOs, PPOs, point-of-service ("POS") plans, and numerous variants and combinations of these approaches. While offering greater patient freedom as to choice of providers, these plans are designed to encourage participants to use in-network providers who agree to discounted rates and other cost constraints. For example, PPOs utilize: (1) a "network of health care providers who have agreed to provide care to the PPO's patients, subject to contractually established reimbursement levels"; (2) incentives for patients to obtain services from the in-network providers; and (3) "repricing" features under which plans apply negotiated discounts to the in-network providers' claims. American Association of Preferred Provider Organizations, *PPO 101: A Comprehensive Overview of the PPO Industry* 30, 33, 35-36 (2005) [hereinafter "*PPO 101*"].

Other health plan models rely on in- and out-of-network distinctions as well. POS plans are a variation on HMOs that permit enrollees to seek care outside the HMO provider system, but impose higher deductibles and higher coinsurance. *See* Peter R. Kongsvedt, *Managed Care: What It Is And How it Works* 49 (2004). Likewise, traditional service plans arrange for a network of providers, with fewer restrictions than PPOs impose, creating a discount for services within the network. *Id.* at 40-41.

The beneficial effect of these health insurance arrangements on spiraling health care expenditures is now well-recognized. Commentators have noted that PPOs and similar products offer consumer choice while "address[ing] the issue of increasing hospital costs." Adrian Bull, "Let's Take the Market Forward," Financial Adviser, June 5, 2003; *accord* "As Employers Look to Hang on to Workers, PPOs Gain Favor," *supra*; "Managed Care Shifts Direction," Employee Benefit Plan Review (Feb. 2000); Lisa A. Krouse, "Managed Care and Workers' Compensation," 33 Tort & Ins. L.J. 849 (Spring 1998); Nancy Bader, "Retaining Freedom of Choice in a Managed Care Plan," Business & Health (Oct. 1993). Courts likewise have said it is "easy to see how health costs might be constrained" by the PPO model. *Washington Hosp. Ctr.*, 758 F. Supp. at 754; *accord Renfrew Ctr. v. Blue Cross & Blue Shield of Central N.Y., Inc.*, 1997 U.S. Dist. LEXIS 5088, at *9-*10 (N.D.N.Y. Apr. 10, 1997).

Assignment laws like Louisiana's jeopardize the viability of PPOs, POS plans, and other products that rely on network arrangements. A central incentive under these models for a provider to join the network and thereby agree to the discounted "reimbursement schedule and any other cost constraints" is the promise of "rapid, certain and direct payments from the insurer." *Washington Hosp. Ctr. Corp. v. Group Hosp. & Med. Servs., Inc.*, 758 F. Supp. 750, 754 (D.D.C. 1991). Louisiana's assignment law takes away that

incentive. Whereas an out-of-network provider would customarily need to turn to the patient (and the patient would receive direct payment from the plan) to collect for his or her services, Louisiana's law awards that provider the benefit of being in the network -- direct payment from the plan -- without requiring it to accept any of the obligations of in-network status (such as negotiated rates or other cost-containment measures). Consequently, under the assignment statute, providers have little if any incentive to join such networks. Were the Fifth Circuit's decision authorizing the application of laws like Louisiana's in the ERISA context allowed to stand, these network arrangements would be at risk.

Because it so seriously threatens the viability of products reliant on network arrangements, the Fifth Circuit's decision has momentous implications for the future of employer-based health insurance. The PPO has met with great success in the employer market, in no small measure because it has proven to be such a vital tool in the employers' struggle to hold down health care expenditures. The PPO is now the most prevalent health benefits offering in the United States, accounting for 61% of all individuals with employer-provided health insurance. *PPO 101*, at 6. The preemption question raised in this case thus affects the principal form of ERISA health benefits arrangement, one adopted because of its salutary effect on the difficult issue of containing health care costs.

Participants in ERISA plans will also be worse off if the Fifth Circuit's decision is permitted to stand. When creating their networks, health insurers can and do screen providers to ensure that members will receive high-quality care (*see PPO 101* at 35-36); destroying preferred provider arrangements necessarily means the loss of those credentialing and quality-assurance mechanisms beneficial to plans and participants alike. Moreover, providers are often required to "agree[] to accept payment by Blue Cross as full payment without

billing the patient for any balance" as a condition for participation in the network. *Washington Hosp. Ctr.*, 758 F. Supp. at 754. Participants benefit from these types of plans because "the insurer will pay for the entire cost of covered services (apart from any initial deductibles) instead of the lesser reimbursement available for use of non-participating hospitals." *Id.* Finally, the discounted rates for use of in-network provider (in plans that rely on the distinction between in- and-out-of-network providers) benefit both plans *and* participants.

In sum, the damage that the Fifth Circuit's decision portends for ERISA health benefits arrangements and to participant interests supports the granting of the Petition.

CONCLUSION

The Petition for a Writ of Certiorari should be granted.

Respectfully submitted,

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IN THE

Supreme Court of the United States

LOUSIANA HEALTH SERVICE & INDEMNITY CO., D/B/A
BLUE CROSS AND BLUE SHIELD OF LOUISIANA
Petitioner,

v.

RAPIDES HEALTHCARE SYSTEM, ET AL.,
Respondents.

On Petition for Writ of Certiorari to the Court of Appeals for the Fifth Circuit

CERTIFICATE OF SERVICE

I, Anthony F. Shelley, a member of the Bar of this Court, hereby certify that, on February 15, 2007, I caused three copies of the Brief for Blue Cross and Blue Shield of Alabama, et al. as Amici Curiae in Support of Petitioner, in the above-referenced case, to be served by first-class mail, postage pre-paid, on the following persons. I further certify that all parties requiring service have been served.

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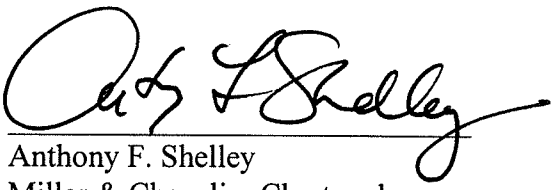

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