No. 09-38

In The

Supreme Court of the United States

HEALTHCARE SERVICE CORPORATION,

Petitioner,

v.

JULI A. POLLITT and MICHAEL A. NASH,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

Respondents agree that question 2 of the Petition is at issue. Question 1, however, assumes facts that are still at issue themselves.

1. Whether Respondents' lawsuit is preempted under the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. § 8902(m)(1).

1a. Whether Respondents' lawsuit challenges any enrollment and or health benefit determination.

1b. Whether the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-14, establishes an exclusively federal remedial scheme for Respondents' complaints.

2. Whether Petitioner was a federal officer for purposes of the Federal Officer Removal Statute, 28 U.S.C. § 1442(a)(1), when it took the actions for which it was sued.

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I. STATEMENT OF THE CASE

A. Overview

This is a case where Petitioner, an entity operating on a fixed fee to administer a program of insurance, streamlined its operations to the point where Respondents suffered injury as a result. It failed to reconcile its coverage records on a regular basis and recklessly launched collection efforts without proper justification. These were not fiduciary duties but common law tort duties to persons to whom harm was foreseeable. The power to offset recoverable amounts against current payments to medical providers was an instrumentality with which any reasonable and prudent person would have behaved more carefully than Petitioner did here. Respondents' complaint is a tort action that does not attempt to enforce any contract.

The fact that Petitioner may have been fulfilling a contractual obligation to the federal government when it did those things is of no importance. As long as Petitioner was not a federal officer, as it clearly was not, its tort obligations to innocent parties had to come before the contract. The damages that Respondents seek will not be taken from any fund maintained on behalf of the people of the United States but from Petitioner's profits.

B. Fact At Issue

The question still at issue in this lawsuit is the degree of control, if any, exercised by the United

States Department of Labor (DOL) over Petitioner's actions. Petitioner alleges that it was only following orders. Respondents argue that the weight of evidence available so far, including a very ambiguous sworn declaration by an employee of Petitioner, points to there having been no such orders. Respondents have twice requested evidence of correspondence between Petitioner and other parties that might shed more light on the matter, but the requests, along with a motion for discovery to the District Court, have not yet been honored. The Seventh Circuit has ordered the District Court to hold an evidentiary hearing on the matter.

C. The Lawsuit

On July 31, 2007 Petitioner began withholding money otherwise due to ten medical providers for Respondents' son. Letters to the providers explained that Respondents' son had been uninsured since 2004 and payments made on his behalf would have to be recovered. The money at stake was over $30,000. Petitioner sent Respondent Juli Pollitt copies of the letters, a "New" benefits card backdated to 2004, and that was all. She received no other correspondence at that time from any party. She was not told that there had been a "benefits denial" or an "enrollment determination," and was given no explanation of how this happened or how to challenge it. Petitioner offered providers the opportunity to appeal this action but made no such offer to her.

On September 10, Respondents sued Petitioner in state court for bad faith and for estoppel, based on Respondents' reliance on payments made by Petitioner. They did not raise the question of whether the son had been properly enrolled or whether such payments were ever correct. The son was not a party to the suit. Respondents were not asserting his rights but their own. Respondent Michael A. Nash, who was not insured under this plan, joined in the suit because of his obligation, by court order, to pay half of his son's uninsured medical expenses.

The prayer for relief in this lawsuit demanded not only damages for Petitioner's bad faith but also reenrollment of Respondents' son. No special justification was given for this latter demand, other than the same tort and estoppel theories as the rest of the complaint. Respondents did not invoke any contract language to support it.

After Respondents sued, Petitioner, for the first time, sought an enrollment determination from DOL, the federal agency offering the plan. DOL informed Petitioner that the boy had been insured all along.

Petitioner reenrolled the boy on October 3, 2007 and informed Pollitt of this on October 5. They then moved the case to federal court, informed the Court that the matter was moot and motioned to have it dismissed. The Court dismissed Respondents' complaint without prejudice and offered them the opportunity to submit an amended one.

Respondents took time to verify that, as of late November 2007, their credit standing was still at risk. None of the providers that they contacted had been repaid or even informed that they were going to be repaid. The providers continued to hold Respondents accountable for that money. Respondents then filed a hastily written amended complaint, which they replaced five days later with a more carefully worded one. It focused entirely on the allegations of bad faith in the first complaint, and left out the claim of estoppel and the demand for reenrollment. Once again, the injuries alleged were entirely to Respondents and their son was not a party.

The Court held no evidentiary hearing on the subject of federal direction, which Respondents had questioned, both in their amended complaint and in a later motion, and ignored Respondents' motion for discovery on that issue. Ten months later, in September of 2008, after many docket events, few of them initiated by Respondents, the Court issued an order of dismissal. This order contained a statement that Respondents had filed their first complaint on October 22, 2007, and that this was after they had been notified of their son's reenrollment. In fact, Respondents had filed nearly a month before such notification. That one statement was the major reason for Respondents' appeal.

II. REASONS FOR DENYING THE WRIT

A. Respondents' Complaint Is Not Preempted Under The Federal Employees Health Benefits Act

1. FEHBA Preemption Is Limited

The FEHBA preemption provision 5 U.S.C. § 8902(m)(1), requires that "The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede any State or local law or any regulation issued there under which relate to health insurance or plans."

In *Empire Health Choice Assurance, Inc. v. McVeigh*, 547 U.S. 677 (2006), this Court noted that "Section 8902(m)(1)'s text does not purport to render inoperative any and all state laws that in some way bear on federal employee-benefit plans . . . and given that 8902(m)(1) declares no federal law preemptive, but instead, term of an OPM-BCBSA negotiated contract, a modest reading of the provision is in order." 547 U.S. at 689.

2. Respondents' Complaint Challenges No Coverage Determination

There is no coverage question at issue in Respondents' lawsuit. All parties now agree that Respondents' son was always insured during the four years in question.

Petitioner cites 5 C.F.R. § 890.107(a) to argue that the demand for re-enrollment in Respondents' original complaint meant that their suit should have been brought against "the employing office that made the enrollment decisions," which Petitioner's argued was DOL. However, DOL had made no such decision. Respondents sued the party that was taking money from their son's doctors, for which the doctors were dunning them, because of that party's own enrollment decision.

3. Respondents' Complaint Challenges No Benefits Determination

This case is not a dispute over benefits. It is not about those things to which one may be entitled under the terms of a contract of insurance. The amount of damages Respondents seek does not depend in any way on what benefits might be due or might have been due to them or their son.

In fact, the case has never involved a denial of benefits. Petitioner acknowledged this fact when it offered Respondents no opportunity to appeal such a denial. At no time during the dispute have Respondents ever asked for a benefits determination. They have never asked any party, any court of law or any other party, to read any contract of insurance for them and tell them what they or their son might be entitled to under its provisions. They have also never asked for anything that might be theirs or their son's by virtue of how an insurance plan is written. The

estoppel recovery that they sought relied on benefit determinations made long ago and would have been the same, had those determinations been correct or not.

4. Respondents' Complaint Does Not Concern Payments With Respect To Benefits

This is the area where this case most resembles *Empire* and where FEHBA preemption might apply. Both cases stemmed from carriers seeking reimbursement from third parties that might be seen as "payments with respect to benefits." The same argument to the contrary, however, suggested by this Court in *Empire* would apply here as well.

> . . . a claim for reimbursement ordinarily arises long after "coverage" and "benefits" questions have been resolved, and corresponding "payments with respect to benefits" have been made . . . 8902(m)(1)'s words may be read to refer to entitlement (or lack thereof) to Plan payment for certain health-care services . . . and not to terms relating to the carrier's post payments right to reimbursement.

547 U.S. at 689.

In one respect, this case is even less of a federal matter than that one. In *Empire,* the subrogation recovery would have gone into a fund maintained on behalf of the federal government. In this case, Respondents' damages would come from Petitioner's profits and not from the fund.

The most important similarity with *Empire,* however, involved the final resolution of the matter. In that case this Court decided that even if preemption applied in reimbursement situations, it was "not sufficiently broad to confer federal jurisdiction," 547 U.S. at 689, and remanded the question of whether it applied to the state court. That is exactly what the 7th Circuit did here, "Whether 5 U.S.C. 8902(m)(1) . . . affects the suit, would be subject to the state court's consideration." *Pollitt v. Health Care Service Corporation*, 558 F.3d at 616 (7th Cir. 2009).

5. There Is No Circuit Split On Complete Preemption In The FEHBA Setting

The cases cited by Petitioner to support its view of FEHBA preemption usually have one thing in common. Someone received a benefits determination that he did not like and asked a court to read the contractual provision at issue and interpret it in a different way. Petitioner relies on one in particular to show a supposed circuit split, *Botsford v. Blue Cross Blue Shield of Montana*, 314 F.3d 390 (9th Cir. 2002). In that case, plaintiff wanted more reimbursement than the plan allowed for non-participating providers. Bruce Botsford was clearly asking the Court to give his insurance contract a different interpretation than the carrier had given it. Respondents are not doing that here.

Similar facts were present in other cases cited by Petitioner. In *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004), where plaintiffs sought reimbursement for certain non-covered medical services, and in *Bridges v. Blue Cross and Blue Shield Association*, 935 F. Supp. 37 (D.D.C. 1996), where plaintiff wanted a smaller co-insurance charge than he had paid. Those cases are all entirely consistent with this one. The law is the same. The facts are different.

B. FEHBA Establishes No Exclusive Remedy For Respondents' Complaints

1. FEHBA Establishes No Exclusive Remedy For Respondent Juli Pollitt's Complaint

In *Beneficial National Bank v. Anderson*, 539 U.S. 1 (2003), this Court stated the test for complete preemption was "whether Congress intended the federal cause of action to be exclusive." 539 U.S. at 7. This Court stated that only three statutes met this test, The Labor Management Relations Act of 1947, The Employee Retirement Income Security Act of 1974 and the National Bank Act of 1863, 539 U.S. at 7. Nowhere did it mention anything about FEHBA, which had been modified into its present form five years earlier in 1998.

In *Sullivan v. American Airlines*, 424 F.3d 267 (2d Cir. 2005), the Court further clarified the holding in *Beneficial*. Preemption was never intended to deny plaintiffs a forum for their complaints, and it is

essential that a statute allow them a federal one if it is going to be considered completely preemptive. "When a state-law claim is removed to federal court, because a section of the LMRA, ERISA or the National Bank Act preempts it, the district court may then adjudicate the claim on the merits under the relevant preemptive statute." 424 F.3d at 276.

The authority of the federal courts in disputes between FEHBA Carriers and covered persons is limited to reviewing OPM determinations 5 C.F.R. § 890.105(a)(1), 5 C.F.R. § 890.107(a), (c), (d)(3). OPM's authority, in turn, is limited to reviewing benefits denials by carriers. 5 C.F.R. § 890.105(a)(1), (e)(1). OPM has no authority to deal with tort claims or questions of estoppel, and therefore those kinds of disputes could not have been heard originally in federal court. As the Court put it in *Sullivan*, "Because such disputes cannot be brought in federal court in the first instance, federal courts may not take jurisdiction over them simply to dismiss them." 424 F.3d at 276. FEHBA therefore offered no exclusive remedy for Respondents' complaints.

2. FEHBA provides No Remedy At All For Respondent Michael A. Nash's Complaint

Respondent Michael A. Nash is in many ways similar to the plaintiff in *Cedars-Sinai Med. Ctr. v. National League of Postmasters*, 497 F.3d 972 (9th Cir. 2007). His financial interest in this matter is the

same as those of his Co-Respondent. He is not acting on behalf of anyone other than himself. However, because he is not a plan "covered individual" 5 C.F.R. § 890.101(a), he has no access to the FEHBA enforcement mechanism, 5 C.F.R. § 890.105(a)(1), (b)(1). Even if it is found that FEHBA somehow provides a remedy to his Co-Respondent it would still provide none to him and FEHBA preemption would not apply to him.

3. There Is No Circuit Split On The Test For Complete Preemption

The standard for complete preemption applied by the Seventh Circuit in this matter is the same as was applied in *Beneficial* and in all of the six circuits cited by Petitioner. Whether it is called "exclusive remedy" or "completely occupy," neither was met in this matter. None of the six cases actually found complete preemption. *Sullivan* was a perfect example. It denied removal in a case involving the Railway Labor Act, stating that no form of preemption, complete or any other, was appropriate in that matter. FEHBA does not offer an exclusive remedy for Respondent Juli A. Pollitt's complaint and none at all for Respondent Michael A. Nash. This case would have been decided the same way in any one of the circuits.

C. Petitioner Was Not A Federal Officer For Purposes Of Removal Jurisdiction

1. This Case Is Not Inconsistent With *Watson v. Phillip Morris Cos.*

The Federal Officer Removal Statute, 28 U.S.C. § 1442(a)(1) specifies that actions are removable if they are against "any officer (or any person acting under that officer) . . . sued . . . for any act under color of such office."

In *Watson v. Phillip Morris Cos.*, 551 U.S. 142 (2007), this Court discussed how one becomes such an officer. This Court said that a private firm's activities do not necessarily fall under this statue even if they are "highly supervised and monitored." 551 U.S. at 147. It defined "acting under" to include "helping the Government produce an item that it needs . . . performing a job that in the absence of a contract with a private firm, the government would have had to perform." 551 U.S. at 148.

Such "acting under" was found in *Isaacson v. Dow Chem. Co.*, 517 F.3d 129, 136 (2d Cir. 2008). The contractor's production of "Agent Orange" to win a war was considered a necessary government function.

Although it is a case dealing with immunity and not removal, Respondents are persuaded by the reasoning in *Houston Community Hospital v. Blue Cross Blue Shield of Texas*, 481 F.3d 265 (5th Cir. 2007). The Court cautioned that "Not every activity in which government might decide to engage is a function of government in private hands," 481 F.3d at

272, and that FEHBA Carriers (are) not exercising any governmental function because "it is not apparent that [the carriers] themselves perform any function that OPM is itself charged with performing." 481 F.3d at 270. Petitioner had no "official" duties and did nothing in any "official" capacity.

2. There Is No Circuit Split On Application Of The Federal Officer Removal Statute To Government Contractors

The standard the Seventh Circuit applied for who was a federal officer was consistent with *Watson, Isaacson* and *Houston*. The holding in *Isaacson* differs from this case for the same reason that it does from that in *Houston*. It applies the same law to a very different set of facts, one in which a necessary government function was being performed.

D. The Court Of Appeals Decision In No Way Undermines The FEHBA Program

1. Respondents' Complaint Does Not Undermine The Uniformity Of FEHBA Benefits

In *Blue Cross Blue Shield of Illinois v. Cruz*, 495 F.3d 510 (7th Cir. 2006), the Court examined the public policy issues Congress considered when it created preemption. It "wanted federal employees to have the same benefits under their health plan no matter what state they were in." 495 F.3d at 513. It

stated that the fact that one insured might receive more money from a provider because of a tort claim in addition to his benefit claim did not make the benefits any less uniform. "The benefits are uniform, though the net financial position of an insured who has a potential tort claim is not." 495 F.3d at 513.

The fact that some other state might have different rules on either bad faith or estoppel did not make benefits provided under this plan any less uniform. Nor is a state court determination on these subjects a benefits determination just because it might improve the financial position of a beneficiary.

2. Congress Never Intended To Eliminate Estoppel Or Bad Faith Claims

Respondents were never entirely certain exactly what happened here or that their son's disenrollment might not have been somehow justified under the terms of the plan. Estoppel is the obvious remedy in this kind of situation. It avoids all such questions. If Congress had intended to deny it to people in Respondents' position, and require them to confront that uncertainty, it would have said so when it established FEHBA preemption. The same can be said of Respondents' claim of bad faith. If Congress had intended to allow FEHBA carriers to conduct their business entirely without regard for those who might be injured by that conduct, it would have said that as well.

III. CONCLUSION

Petitioner should be denied a writ of certiorari.

Respectfully submitted,

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