No. 01-200

In the Supreme Court of the United States

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.,

Petitioner,

v.

PENNSYLVANIA HOSPITAL INSURANCE CO. AND THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND,

Respondents.

On Petition for a Writ of Certiorari to the Supreme Court of Pennsylvania

REPLY BRIEF FOR PETITIONER

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TABLE OF AUTHORITIES

Page(s)

Cases

TABLE OF AUTHORITIES—Continued

Page(s)

Statutes

Miscellaneous

REPLY BRIEF FOR PETITIONER

The petition in this case argued that the decision below conflicts with decisions of numerous federal courts of appeals. Respondents do not attempt to argue otherwise. The existence of a split of relevant authority and the importance of the question presented are undisputed. Respondents no longer question this Court's jurisdiction, as they once did unsuccessfully. See Pet. 1 n.1. Respondents do not urge that the pendency of proposed legislation should forestall a grant of certiorari, and the fate (as well as the relevance) of the proposed legislation remains highly uncertain. See, *e.g.*, *Stage Set for Patients' Rights Conference; Chambers to Spar Over Liability Language*, 70 U.S.L.W. 2135 (Aug. 28, 2001).

Respondents do make a halfhearted effort to explain away one Third Circuit case, and they argue the merits extensively. None of respondents' arguments should dissuade this Court from granting certiorari.

1. The petition argued that the decision below conflicts most specifically with decisions of the Third and Fifth Circuits, rendered after *Pegram* v. *Herdrich*, 530 U.S. 211 (2000), that construe *Pegram* not to overturn prior circuit law holding that state-law challenges to an HMO's administration of benefits under an ERISA-regulated plan are preempted, even if the administration-of-benefits determination may be characterized as a "mixed" decision that includes an element of medical judgment. Respondents ignore the relevant portion of the Fifth Circuit decision. As to the Third Circuit decision, *Pryzbowski* v. *U.S. Healthcare, Inc.*, 245 F.3d 266 (2001), respondents argue that it "facially conflicts impermissibly with * * * prior and binding Third Circuit panel decisions." Br. in Opp. 20. Yet, if respondents and the former Solicitor of Labor are right in their critical contention that *Pegram* radically narrowed the scope of ERISA preemption and called into question prior decisions holding that certain claims against HMOs *are* preempted, it is passing strange that the Third Circuit supposedly lurched in the *opposite* direction after *Pegram*.

Furthermore, respondents make no effort to explain why the distinctions Judge Sloviter, for a unanimous panel, drew between *Pryzbowski* and the prior decisions are incorrect. That is a particularly odd omission considering that Judge Sloviter was

the author of one of those prior decisions, *In re U.S. Healthcare, Inc.*, 193 F.3d 151 (1999), cert. denied, 530 U.S. 1242 (2000). The Third Circuit – unlike respondents and the Supreme Court of Pennsylvania – understands that a distinction must be drawn between cases in which what the plaintiffs attack is "essentially a medical determination that could be subject to a state-law malpractice action" (*Pryzbowski*, 245 F.3d at 272, summarizing the holding of *In re U.S. Healthcare*) and those in which the plaintiffs attack "the policy adopted by U.S. Healthcare (and many other HMOs) requiring beneficiaries either to use in-network specialists or to obtain approval from the HMO for out-of-network specialists," which "fall[s] within the realm of the administration of benefits" (*id*. at 273). See also 245 F.3d at 274-275.

Curiously, respondents suggest that this Court "could distinguish *Pryzbowski*, as involving a delay in making a benefit determination, and directly related to plan administration, as opposed to a negligent medical judgment concerning which independent provider was capable of supplying the care needed within the time it was needed." Br. In Opp. 3. *Pryzbowski* and the present case are identical in that both involve allegations that medical considerations should have overridden, but did not override, the HMO's preference for in-network providers, resulting in delay that allegedly harmed the subscriber. Thus, either *Pryzbowski* is right in holding that such allegations challenge benefits administration and are preempted by ERISA, or the decision below is right in holding that they somehow escape preemption. Both courts cannot possibly be right, and therefore *Pryzbowski* cannot be distinguished on the ground respondents propose.

2. Rather than make a serious effort to reconcile the decision below with any of the decisions – pre- and post-*Travelers*, pre- and post-*Pegram* – cited in the petition, respondents have chosen to devote almost all of their 22-page brief in opposition (with 21-page attachment) to arguing the merits. Although the merits are not the major factor bearing on the suitability of this case for a grant of certiorari, we will reply in kind.

a. We showed in the petition that, because the third-party complaint in this case challenged petitioner's decision about whether Mr. Pappas was eligible for ERISA plan benefits, the complaint directly "relate[s] to" such a plan, 29 U.S.C.

§ 1144(a), and impermissibly provides an alternative enforcement mechanism to the carefully drawn ERISA remedies in 29 U.S.C. § 1132(a). The state-law claims are therefore preempted. The Pennsylvania Supreme Court's decision in *Pappas I*, reaffirmed in *Pappas II*, that the claims survived – indeed, that *any and all* negligence actions against health maintenance organizations are outside ERISA's preemptive scope – conflicts with this Court's decisions in *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724 (1985); and *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85 (1983). See Pet. 12-16.

Respondents answer by accusing petitioner (and, by extension, all HMOs) of seeking "a declaration of immunity from negligence" (Br. in Opp. 16) and of hoping to "obliterate[] a traditional state field of law" (Br. in Opp. 17) and "eradicate state health care malpractice actions against service providers"(*ibid.*). But our position does not sweep nearly so broadly. If, for example, the alleged basis for liability of the HMO is that its own personnel committed medical malpractice in the course of treating a subscriber, there is no reason why the malpractice claims need implicate plan administration and no reason why ERISA should preempt them. See 98-1836 U.S. Br. 10, *quoted in* 01-200 Pet. 7. Those were the facts of *Pegram* v. *Herdrich*, in which the malpractice claims resulted in a judgment for the plaintiff and were not at issue in this Court. See 530 U.S. at 217. But trying to hold an HMO liable because it will not *pay for* out-of-network services is a different proposition entirely.

In this regard, respondents' reformulation of the question presented is not at all faithful to the record or to petitioner's arguments. According to respondents, this case involves "the negligence of HMO-employed health care services professionals in the performance of their *duties to provide or to arrange for* appropriate medical care for the beneficiaries of ERISA plans." Br. in Opp. i (emphasis added). But no employee of petitioner provided or had a duty to provide medical care for Mr. Pappas; petitioner contracted with third parties who provided medical care. Indeed, it is *respondents* who stand in the shoes of the medical providers who were allegedly negligent in this case and who have settled with the Pappases. Nor is it accurate to blur the distinction between arranging for medical care and paying for medical care. See *Danca* v. *Private Health Care Sys., Inc.*,

185 F.3d 1, 6 n.6 (1st Cir. 1999) (explaining that the benefits under an ERISA health plan are "the monetary payments for medical services, not the services themselves"), *quoted in* 98-1836 U.S. Br. 9-10. Nor, finally, does the record support the proposition that any "health care service professionals" employed by petitioner did anything more than determine what hospitals are in petitioner's network. See Pet. 11 n.3. Until it became convenient in *Pappas II* to assert (without record support) that this case involves an exercise of medical judgment, the Pennsylvania courts themselves emphatically read the record the opposite way. Pet. App. 50a ("the argument has never been advanced that the decision to withhold approval for transfer to Jefferson was at all related to medical considerations").

It is the decisions of the Pennsylvania Supreme Court – not petitioner's modest position – that would have a devastating and radical effect, harming HMOs by permitting flank attacks on managed-care providers, through state tort actions, in the face of the "congressional policy of promoting HMOs." *Pryzbowski*, 245 F.3d at 275 (citing *Pegram* for the proposition that the Court "reject[ed] claims attacking financial incentives behind HMO structure").

b. Atmospherics aside, respondents offer two main arguments on the merits. First, they say that *Pilot Life*, *Metropolitan Life*, and *Shaw* are no longer good law in view of what they call the "shift" in this Court's ERISA preemption jurisprudence. Br. in Opp. 10 (citing *New York State Conf. of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645 (1995); *California Div. of Labor Standards Enforcement* v. *Dillingham Construction*, 519 U.S. 316 (1997); and *DeBuono* v. *NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806 (1997)). Given the shift in ERISA paradigms, respondents say, *Pappas I* and *II* pose no conflict with this Court's governing decisions or those decisions of the federal courts of appeals that are faithful to them. Second, respondents say that *Pegram* v. *Herdrich* – which in fact concerned ERISA fiduciary status – actually endorsed a new rule concerning ERISA preemption, that "mixed" decisions of treatment and eligibility are not preempted. Because, they say, the decision at issue here was not, in fact, administrative, but rather "mixed," a challenge to it survives "consistent" (Br. in Opp. 13) with *Pegram*. Neither of those arguments has merit.

i. Respondents' principal argument is that the Pennsylvania Supreme Court's decision, though (respondents admit) inconsistent with *Pilot Life* and *Metropolitan Life* (and *Shaw*), is consistent with the Court's new-and-improved ERISA jurisprudence reflected in *Travelers* and *Dillingham* (and *DeBuono*). See Br. in Opp. 10-13. According to respondents, the "earlier," "original approach" of *Pilot Life*, *Metropolitan Life*, and *Shaw* (Br. in Opp. 10) "emphasized the general nature of the ERISA preemption clause's 'relates to' phrase" (*ibid.*). "In contrast," respondents argue, the "later approach" that this Court supposedly adopted in *Travelers*, *Dillingham*, and *DeBuono* (Br. in Opp. 11), along with the "restrictive approach" that the Court took in *Pegram* (Br. in Opp. 12), make it clear that *Pilot Life*, *Metropolitan Life*, and *Shaw* – though not, respondents acknowledge, in fact overruled (Br. in Opp. 11-12) – are effectively dead letters. See also Pet. App. 37a (Pennsylvania Supreme Court majority terming *Pilot Life*, *Metropolitan Life*, and *Shaw* "superannuated" and declining to follow them).

Respondents – like the Pennsylvania Supreme Court – have misread the law. As we noted in the petition (at 12-17), the Court has taken pains in its recent decisions to express, as in *Travelers*, "fidelity to the views expressed in our prior opinions on the matter." 514 U.S. at 668. In *DeBuono*, similarly, the Court noted that "[i]n our earlier ERISA pre-emption cases, it had not been necessary to rely on the expansive character of ERISA's literal language in order to find pre-emption because the state laws at issue in those cases had a clear 'connection with or reference to' * * * ERISA benefit plans." *Id.* at 813; see also *Dillingham*, 519 U.S. at 335 (Scalia, J., concurring) (noting that the majority opinion "does obeisance to all our prior cases"); *UNUM Life Ins. Co. of Am.* v. *Ward*, 526 U.S. 358 (1999).

In further support of their contention that *Pilot Life*, *Metropolitan Life*, and *Shaw* have been silently overruled, respondents point to the Court's decision in *Pegram*. Br. in Opp. 12. It is true, as respondents note, that the former Solicitor of Labor (whom respondents persistently but mistakenly refer to as "the Solicitor General") wrote in an amicus brief filed in *Pappas II* that *Pegram* had changed the government's views on the propriety of summary judgment here. In *Pappas I* the government had filed a brief in this Court stating that "the

blanket non-preemption rule announced by the Pennsylvania Supreme Court conflicts with the core holding of *Pilot Life*," 98-1836 U.S. Br. 6; in *Pappas II* the government suggested that the claims "may" have been preempted in light of *Pegram*, Br. in Opp. App. 4a, 9a-12a; see Pet. 8-9 (discussing government's remand brief).

The government jumped the gun: the *Pegram* opinion itself *reserved decision* on how claims for denials of benefits "interact[]" with "state law causes of action." 530 U.S. at 229 n.9. And the government's qualified *volte face* has found no sympathizers aside from the Pennsylvania Supreme Court. Respondents have cited no case, and we have found none, in which another court has read *Pegram* – which dealt with ERISA fiduciary status – to have radically altered the law governing the distinct question of ERISA preemption. In fact, courts have said just the opposite: that when it comes to preemption, *Pegram* changed nothing. See *Corporate Health Ins., Inc.* v. *Texas Dep't of Ins.*, 220 F.3d 641, 643 (5th Cir.), denying rehearing to 215 F.3d 526 (5th Cir. 2000), petition for cert. pending, No. 00-665; *Tran* v. *Kaiser Foundation Health Plan of Texas*, 2001 WL 1082418 (N.D.Tex. Sept. 7, 2001); *Howard* v. *Coventry Health Care of Iowa, Inc.*, 2001 WL 1013610 (S.D. Iowa July 20, 2001); Pet. 22-23 & n.7 (collecting additional cases).[*]

Aside from questioning the vitality of *Pilot Life*, *Metropolitan Life*, and *Shaw*, respondents make no attempt to refute our showing that the expansive holding of *Pappas I*, which was reaffirmed in *Pappas II*, conflicts with those decisions. Instead,

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[*] Respondents, the former Solicitor of Labor, and some commentators may be fond of invoking *Pegram* as a decision expanding the field of state law not preempted by ERISA, but not a single judge anywhere appears to have agreed. The only jurists who might be said to have agreed with any part of that reading of *Pegram* are the justices of the Pennsylvania Supreme Court in this case, yet that court had already – in *Pappas I* – read ERISA to preempt *no* "negligence claims against a health maintenance organization" (Pet. App. 39a), thus making it impossible for the field of non-preempted state law to get any broader. In *Pappas II*, those justices "adhere[d] to [their] original opinion" (Pet. App. 2a) yet simultaneously recognized that *Pegram*, if anything, *narrowed* their earlier holding by forcing them to labor to find a way (unsupported by the law or by the record) to call this case one involving a "mixed eligibility and treatment decision" (Pet. App. 13a).

respondents say that that broad rationale can be teased out of the Pennsylvania Supreme Court's opinions only through a "selective reading" of what was "arguably dicta" in *Pappas I* (Br. in Opp. 2 & n.1) and, in any event, was not even at issue in *Pappas II*. Both assertions are wrong. The Pennsylvania Supreme Court *held* in *Pappas I* that "negligence claims against a health maintenance organization do not 'relate to' an ERISA plan." Pet. App. 39a. The sentences in the opinion that follow (see *ibid.*) do not "clarify[]" (Br. in Opp. 2 n.1) that holding, or qualify it, or in any other way transform that sweeping holding into "dicta," arguable or otherwise. In *Pappas II*, moreover, the Pennsylvania Supreme Court expressly "adhere[d] to [its] original opinion and order" and "confirm[ed] [its] original disposition," Pet. App. 2a, 14a. The original disposition, and the subsequent one, cannot be reconciled with *Pilot Life*, *Metropolitan Life*, and *Shaw*, and no decision of this Court gave the court below authority to disregard those decisions. See *United States* v. *Hatter*, 121 S. Ct. 1782, 1790 (2001) ("'it is this Court's prerogative alone to overrule one of its own precedents'") (quoting *State Oil Co.* v. *Khan*, 522 U.S. 3, 20 (1997)).

ii. Respondents also argue that the alternative holding of *Pappas II* – that the decisions at issue in this case were "mixed" ones of treatment and eligibility, rather than eligibility alone – is consistent with *Pegram*. As we have explained, this argument depends on the assumption that *Pegram* is the binding decision concerning ERISA preemption. But it is not.

Aside from this error of law, respondents point to certain distinctions, but the distinctions make no difference. Respondents note that "[n]either the ERISA plan nor the employer" is a party "to this case." Br. in Opp. 13. This is true, but irrelevant. Whom the Pappases, or third parties, decided to sue has no bearing on the nature of the claims that were brought: claims attacking petitioner's decision whether Mr. Pappas was entitled to certain benefits under his health plan. Our point here – that the state-law claims that were brought challenged an administrative decision concerning coverage, and thus "relate to" the administration of an ERISA benefit plan and provide an alternative enforcement mechanism – is also true without regard to whether petitioner was the "administrator" of Mr. Pappas's plan, which is respondents' second distinction (Br. in Opp. 14) and as irrelevant as the first. "Administrator" is a defined term

in ERISA that may be important for some purposes, but it is not a term used in Section 502(a) or in Section 514, and the technical 29 U.S.C. § 1102(16)(a) definition of "administrator" (as opposed to the distinction between plan administration and direct delivery of medical services) does not play a substantive role in any of the preemption cases on which petitioner or respondents rely. Respondents then maintain that "the claim in this case does not directly implicate a provision of the employer's ERISA plan." Br. in Opp. 14. Again, it is unclear why respondents think their distinction matters to the analysis, but in any event the Solicitor General correctly explained to this Court in 1999 that "[t]he ERISA plan in this case was the arrangement by which The Charming Shoppes * * * purchas[ed] memberships in petitioner's HMO" and "[t]he intended benefit was coverage for the specific kinds of medical care specified in Group Master Contract between petitioner and The Charming Shoppes." 98-1936 U.S. Br. 9, citing Pa. Super. Ct. App. 158a. It is therefore impossible to understand the relationship between petitioner and Mr. Pappas, and accordingly impossible to understand whether petitioners' benefit determination might have been negligent, without reference to plan documents. Respondents' "argument misses the point, which is that * * * there simply is *no* cause of action if there is no plan." *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 140 (1990).

More significantly, according to respondents, the facts "suggest that the ultimate decision by the HMO's Medical Director was completely or predominately [*sic*] a medical determination." Br. in Opp. 4; see also *id.* at 15 (suggesting, with absolutely no support, that petitioner's decision had "medical treatment aspects"). The facts "suggest" no such thing. Respondents cite the deposition testimony of Dr. Steven Dickter, Mr. Pappas's treating physician, and a typed version of notes taken by an emergency medical technician (EMT) who treated Mr. Pappas at Mr. Pappas's home. Br. in Opp. 4. Dr. Dickter, however, was not employed by petitioner; in any event, he spoke *only* with petitioner's administrative (not medical) personnel. See Pet. 3 (citing Pa. Super. Ct. App. 67a-68a (deposition of Dr. Dickter at 47-52)). These administrative personnel, and not Dr. Leibowitz (petitioner's Medical Director), were the "HMO representatives" to which respondents refer. Br. in Opp. 4. The EMT was not employed by

petitioner either; he never had any contact with, and his notes make no mention of, petitioner or anyone associated with it. Pa. Super. Ct. App. 92a. *Nothing* in the record supports respondents' claim that the decision where to transfer Mr. Pappas had medical aspects at all. The decision at issue was whether Mr. Pappas's health plan would cover treatment at an out-of-network hospital – whether, that is, Mr. Pappas was or was not entitled to certain plan benefits. As courts have held on virtually identical facts, such a determination is administrative. See *Pryzbowski*, 245 F.3d at 274-275; see also *Calad* v. *Cigna Healthcare of Texas, Inc.*, No. 300-CV-2693-H, 2001 WL 705776 (N.D. Tex. June 21, 2001) ("claims arising from a delay or denial of benefits are ERISA-preempted"); Pet. 22 n.7 (citing other cases).

And suppose that the decision where to transfer Mr. Pappas was (in the formulation this Court used, outside the preemption context, in *Pegram*) a "mixed" one of treatment and eligibility, and thus, under *Pappas II*'s alternative rationale, not preempted. If so, such a result would conflict with the Fifth Circuit's decision in *Corporate Health Ins.*, where the court noted that "[w]e do not read *Pegram* to entail that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment." 220 F.3d at 643. It would also conflict with the Third Circuit's decision in *Pryzbowski* (not to mention the numerous district court decisions cited in the petition at 22 n.7). In fact, respondents themselves acknowledge, albeit grudgingly, that the "analysis and decision of the Third Circuit in *Pryzbowski* could be read to conflict with the analysis and decision of the Pennsylvania Supreme Court in *Pappas II*." Br. in Opp. 20.

The cases do conflict, and the Third Circuit got it right. As we explained in the petition (at 22-23), the Third Circuit rightly read *Pegram* as having been informed by Congress's determination to reject state-law assaults on the business justifications for HMOs. See 245 F.3d at 275 (noting that in *Pegram* the Court "reject[ed] claims attacking financial incentives behind HMO structure, in light of [the] congressional policy of promoting HMOs"). Endorsing negligence claims such as the one in *Pryzbowski*, that an HMO had wrongly delayed or denied benefits, "would open the door for legal challenges to core managed care practices (e.g., the policy of favoring in-network

specialists over out-of-network specialists)," 245 F.3d at 274-275 – precisely the legal challenges that Congress has deemed unwise (and hence unlawful). As a result, the Third Circuit held, even if a decision could be viewed as including "mixed" considerations of treatment and eligibility, a state-law challenge to such a decision is preempted. This Court should review the Pennsylvania Supreme Court's contrary holding.

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

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