Case No. 99-2574

IN THE
UNITED STATES COURT OF APPEALS FOR THE
SEVENTH CIRCUIT

DEBRA C. MORAN AND STATE OF ILLINOIS,

Plaintiffs-Appellants

v.

RUSH PRUDENTIAL HMO, INC.,

Defendant-Appellee.

Appeal from the United States District Court for the
Northern District of Illinois, Eastern Division
Case No. 98 C 442
The Honorable Suzanne B. Conlon, Judge Presiding

BRIEF OF *AMICI CURIAE* AMERICAN MEDICAL ASSOCIATION, ILLINOIS STATE MEDICAL SOCIETY, AND AMERICAN COLLEGE OF LEGAL MEDICINE IN SUPPORT OF PLAINTIFFS-APPELLANTS, DEBRA MORAN AND STATE OF ILLINOIS, AND SUPPORTING REVERSAL

Michael L. Ile
Anne M. Murphy
Leonard A. Nelson*
Office of General Counsel
American Medical Association
515 N. State Street
Chicago, IL 60610
(312) 464-5532
(312) 464-5846 (facsimile)

*Principal attorney

CORPORATE DISCLOSURE STATEMENT

Amici the American Medical Association and the Illinois State Medical Society are both Illinois not-for-profit corporations. *Amicus* the American College of Legal Medicine is a Delaware not-for-profit corporation. No *amicus* has a parent corporation, and no publicly held company owns 10% or more of the stock of any *amicus*.

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Leonard A. Nelson, Attorney for
Amici Curiae

TABLE OF CONTENTS

Corporate Disclosure Statement i

Table of Contents ii

Table of Authorities iii

Statement of Identity and Interest of *Amici* 1

Argument 2

I. Summary 2

II. The Illinois HMO Act Does not "Relate to" Employee Benefit Plans Covered by ERISA and is Therefore not Preempted by 29 U.S.C. § 1144(a). 3

A. The Illinois HMO Act Does not "Refer to" Employee Benefit Plans Covered by ERISA 4

B. The Illinois HMO Act Does not "Have a Connection With" Employee Benefit Plans Covered by ERISA. 6

1. The Illinois HMO Act Addresses Issues of State Concern in the *Only* Way They Can Effectively be Addressed – by State Statute 6

2. The Illinois HMO Act Does Not Conflict with the Specific Provisions of ERISA or with the Policies that Underlie ERISA 8

III. Even if 29 U.S.C. § 1132(a) Completely Preempts the Illinois HMO Act, Its Provisions Are Still Incorporated into the Rush Prudential Policy 12

IV. Conclusion 13

Proof of Service 14

TABLE OF AUTHORITIES

Cases

California Division of Labor Standards Enforcement v. Dillingham Construction, *N.A.*, 519 U.S. 316 (1997) 4, 5, 11

Fort Halifax Parking, Inc. v. Coyne, 482 U.S. 1 (1987) 9

Herdrich v. Pegram, 154 F. 3d 362 (7th Cir. 1998) 6, 8

New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., 514 U.S. 645 (1995) 3, 4, 5, 6, 9, 10, 11

Pilot Life Insurance Company v. Dedeaux, 481 U.S. 41 (1987) 11

Plumb v. Fluid Pump Service, Inc., 124 F. 3d 849 (7th Cir. 1997) 7

Rice v. Panchal, 65 F. 3d 637 12

Shaw v. Delta Airlines, Inc., 463 U.S. 85 (1983) 9

Washington Physicians Service v. Gregoire, 147 F. 3d 1039 (9th Cir. 1998) 10

Statutes

29 U.S.C. § 1002 5

29 U.S.C. § 1003 5

29 U.S.C. § 1132 12

29 U.S.C. § 1133 8

29 U.S.C. § 1144 .... *passim*

215 ILCS § 95/20 8

215 ILCS 125 1

215 ILCS § 125/1-2 5

215 ILCS § 125/4-10 .... *passim*

Other

D. Carrasquillo, et. *al.*, *A Reappraisal of Private Employers' Role in Providing Health Insurance*, 340 N. Engl. J. Med. 109 (1999) 5

Congressional Budget Office, 105th Congress, 2d Session *Cost Estimate, H.R. 3605/S.1890, Patients' Bill of Rights Act of 1998* (7/16/98) 10

Custer, William S., *Health Insurance Coverage and the Uninsured* *http://www.hiaa.org/news/news-state/custer.htm* 5

The Lewin Group, *Consumer Bill of Rights and Responsibilities Costs and Benefits: Information Disclosure and External Appeals,* prepared for the Presidential Advisory Commission on Consumer Protection And Quality in the Health Care Industry, (11/15/97) 10

Statement of Identity and Interest of *Amici*

Amicus the American Medical Association ("AMA"), an Illinois not-for-profit corporation, is an association of approximately 280,000 physicians who practice throughout the United States. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health, and these still remain its core purposes. Its members practice in all fields of medical specialization, and it is the largest medical society in the United States.

Amicus Illinois State Medical Society ("ISMS"), an Illinois not-for-profit corporation, is an association of over 11,000 physicians who reside or practice in the State of Illinois. ISMS was founded in 1840 to promote the science and art of medicine, protect the public health, elevate the standards of medical education, and unite the medical profession in the State of Illinois.

Amicus American College of Legal Medicine ("ACLM"), a Delaware not-for-profit corporation, is an organization of professionals concerned with issues arising at the convergence of law and medicine. ACLM's membership consists of approximately 1,400 professionals, including physicians and scientists in most specialties, management and employees in various healthcare fields, and plaintiff, defense, corporate and public interest attorneys. ACLM, founded in 1960, is the only national organization whose fellowship is generally comprised of individuals possessing both the medical and juris doctor degrees.

Amici file their brief because the Illinois Health Maintenance Organization ("HMO") Act, 215 ILCS 125, is a necessary counterweight to the excessive preoccupation shown by many HMOs with monetary savings at the expense of proper medical care. As a practical matter, an HMO decision to deny coverage for needed medical procedures frequently results in the patient's being unable to afford and thus having to forego treatment. Section 4-10 of the Illinois HMO

Act, 215 ILCS § 125/4-10 affords beneficiaries the right to have an HMO denial reviewed by an independent medical professional. This law helps rectify the imbalance between individual patients and powerful HMOs. The independent review right, the provision at issue in this suit, furthers *amici's* mission to protect public health, and *amici* wish to defend this statute against the lower court's finding of conflict preemption.[1]

ARGUMENT

I. Summary

A principal issue in this case is whether § 4-10 of the Illinois HMO Act, 215 ILCS § 125/4-10, is valid, or whether, as the district court held, that statute is preempted by § 514 of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144. ERISA § 514 does not preempt § 4-10, because the Illinois HMO Act does not "relate to" employee benefit plans covered by ERISA. The Illinois HMO Act does not "refer to" or "have a connection with" ERISA plans.[2]

[1] The AMA and ISMS file this brief as members of the Litigation Center of the American Medical Association and the State Medical Societies ("Litigation Center"). The Litigation Center was formed in 1995 as a coalition of the AMA and private, voluntary, nonprofit state medical societies to represent the view of organized medicine in the courts. Forty-nine state medical societies join the AMA as members of the Litigation Center. The member organizations, in addition to the AMA, are: Medical Association of the State of Alabama, Alaska State Medical Association, Arizona Medical Association, Arkansas Medical Society, California Medical Association, Colorado Medical Society, Connecticut State Medical Society, Medical Society of Delaware, Medical Society of the District of Columbia, Medical Association of Georgia, Hawaii Medical Association, Idaho Medical Association, Illinois State Medical Society, Indiana State Medical Association, Iowa Medical Society, Kansas Medical Society, Kentucky Medical Association, Louisiana State Medical Society; Maine Medical Association, MedChi, the Maryland State Medical Society, the Massachusetts Medical Society, Michigan State Medical Society, Minnesota Medical Association, Mississippi State Medical Association, Missouri State Medical Association, Montana Medical Association, Nebraska Medical Association, Nevada State Medical Association, New Hampshire Medical Society, Medical Society of New Jersey, New Mexico Medical Society, Medical Society of the State of New York, North Carolina Medical Society, North Dakota Medical Association, Ohio State Medical Association, Oklahoma State Medical Association, Pennsylvania Medical Society, Rhode Island Medical Society, South Carolina Medical Association, South Dakota State Medical Association, Tennessee Medical Association, Texas Medical Association, Utah Medical Association, Vermont State Medical Society, Medical Society of Virginia, Washington State Medical Association, West Virginia State Medical Association, State Medical Society of Wisconsin, and Wyoming Medical Society.

[2] The phrases "relate to", "refer to", and "have a connection with" are in quotation marks because their meaning cannot be derived solely from ordinary language or dictionary usage. In the context of ERISA preemption, these phrases are legal terms of art, whose meaning stems from certain Supreme Court holdings.

II. The Illinois HMO Act Does not "Relate to" Employee Benefit Plans Covered by ERISA and is Therefore not Preempted by 29 U.S.C. § 1144(a)

ERISA § 514(a), which was the basis of the district court's holding that the Illinois HMO Act was preempted, states, in relevant part, as follows:

> "[T]he provisions of [ERISA] shall supercede any and all State laws insofar as they may now or hereafter related to any employee benefit plan described in § 1003(a) of this title [20 U.S.C. § 1003(a)]." 29 U.S.C. § 1144(a)."

Until the watershed case of *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995) ("*Travelers*"), this section was read broadly in favor of preemption, and the words "relate to" were given their dictionary meaning. In *Travelers*, however, the Court recognized that, although the statutory text is expansive, such a reading would violate longstanding principals that limit federal preemption of state laws. Furthermore, a straightforward textual reading would lead to absurd results, because employee benefit plans would become immune from state regulation in areas far outside ERISA's remedial scope. Thus, the Court concluded:

> "We simply must go beyond the unhelpful text and the frustrating difficulty of defining its key term [relate to], and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." 514 U.S. at 656.

The Court held that, in areas involving traditional state regulation, there is a presumption against ERISA preemption. This presumption can be overcome only if a state law or regulation "refers to" or "has a connection with" an ERISA plan. As one of the areas that is presumed *not* preempted, *Travelers* referred to "general health care regulation, which historically has been a matter of local concern." 514 U.S. at 661.

The Illinois HMO Act clearly falls within the category of "general health care regulation", as well as the areas of consumer protection and insurance regulation. All of these are traditional areas of state law. Thus, the Illinois HMO Act is presumably not preempted.

Since the Illinois HMO Act neither "refers to" nor "has a connection with" employee benefit plans, the presumption of validity is not overcome, and the law is not preempted.

A. The Illinois HMO Act Does not "Refer to" Employee Benefit Plans Covered by ERISA.

California Division of Labor Standards Enforcement v. Dillingham Construction, *N.A.*, 519 U.S. 316 (1997), explicated the "refer to" part of the *Travelers* test. That case concerned a California statute, which required a contractor on a public works project to pay its workers at least the prevailing wage in the project's locale. However, the California law allowed an exception for workers who participate in an approved apprenticeship program. For such workers, but only for such workers, the law allowed contractors to pay less than the prevailing wage. The issue before the Court was whether ERISA preempted that portion of the California prevailing wage law which prohibited payment of less than the prevailing wage to apprentices training in an unapproved program.

The Court first noted that, under *Travelers*, the "relate to" requirement of § 514(a) requires a two-part inquiry: whether a law "refers to" an ERISA plan or whether it "has a connection with" an ERISA plan. The "refers to" part of the inquiry, in turn, depends on "[whether] a State's law acts immediately and exclusively upon ERISA plans … or [whether] the existence of ERISA plans is essential to the law's operation." 519 U.S. 324. The Court then made a detailed examination of the funding of California apprenticeship programs. It determined that, at least theoretically, the California apprenticeship programs could be funded in such a way that apprenticeship programs need not be ERISA plans. Thus, the California law, which apparently discriminated against unapproved apprenticeship programs, did not act "immediately and *exclusively*" on ERISA plans, and the existence of ERISA plans was not "essential" to the

law's operation. Accordingly, the law did not "refer to" ERISA plans within the *Travelers* meaning. Ultimately, the Court held, the California statute was not preempted.

The *Dillingham* "refer to" holding applies squarely to the case at bar. The preemption provision, 29 U.S.C. § 1144(a), refers to 29 U.S.C. § 1003(a). That statute, in turn, states that ERISA applies to "any employee benefit plan" involving interstate commerce. 29 U.S.C. § 1002, not surprisingly, defines "employee benefit plan" as a benefit plan established or maintained by employers for employees. Thus, an employment relationship is a necessary ingredient of ERISA coverage.

The Illinois HMO Act defines a "health maintenance organization" as "any organization formed … to provide or arrange for one or more health care plans under a system which causes any part of the risk of health care delivery to be borne by the organization or its providers." 215 § ILCS § 125/1-2 (9). Nothing in the Illinois HMO Act makes its coverage depend on an employment relationship. In fact, 6 percent of non-elderly Illinoisans purchase health insurance outside the employment context, Custer, William S., *Health Insurance Coverage and the Uninsured* http://www.hiaa.org/news/news-state/custer.htm, as does 7.1% of the entire American population. D. Carrasquillo, et. *al.*, *A Reappraisal of Private Employers' Role in Providing Health Insurance*, 340 N. Engl. J. Med. 109 (1999).

Therefore, when participants purchase HMO coverage outside an employer sponsored plan, a situation clearly within the ambit of the Illinois HMO Act, they fall outside ERISA coverage. As in *Dillingham*, the state law does not act "immediately and *exclusively*" upon ERISA plans, and the existence of ERISA plans is not "essential to the law's operation." Accordingly, the Illinois HMO Act does not "refer to" ERISA benefit plans, and it passes the first prong of the *Travelers* "relate to" test.

B. The Illinois HMO Act Does not "Have a Connection With" Employee Benefit Plans Covered by ERISA

Travelers holds that the determination of whether a state law "has a connection with" ERISA plans depends on more than "uncritical literalism" (*i.e.*, it depends on more than the dictionary definition of a "connection"). 514 U.S. at 656. Rather, such determination depends on the areas of concern addressed by the state law and the conflict that the law may pose to the objectives underlying the ERISA statute. If the state law is directed primarily to an area of traditional state regulation and does not burden employers' administration of employee benefit plans, it will not be preempted. 514 U.S. at 658-662. When the Illinois HMO Act is measured by these factors, the balance tilts strongly against preemption.

1. The Illinois HMO Act Addresses Issues of State Concern in the *Only* Way They Can be Effectively Addressed – by State Statute.

As noted *supra*, the Illinois HMO Act falls squarely within areas of the law that have historically been matters of state and local control – health care, consumer protection, and insurance regulation. In *Herdrich v. Pegram*, 154 F. 3d. 362, 374-375 (1998), this Court decried the inordinate emphasis that HMOs place on securing profits at the expense of patient needs and the resulting, pervasive decline in the quality of medical care. The case went on to declare that "market forces are insufficient to cure the deleterious effects of managed care on the health care industry." The corollary to *Herdrich's* commentary on the ineffectiveness of the free market is that the citizens of Illinois must rely on their state legislature to preserve their interest in quality health care and to counterbalance the HMO industry's excessive concern with profits.

Unless the independent review provisions of the Illinois HMO Act are found valid across the board, the people of Illinois will have no effective means of forcing HMOs to provide their contractually promised benefits. Since free market principles, as perceived by the Illinois General Assembly and as perceived by this Court in *Herdrich*, are insufficient, the people would,

without the Illinois HMO Act, have no way to protect themselves, save by petitioning Congress to change federal law.

Furthermore, Judge Conlon's rulings, which preserve the part of § 4-10 that requires HMOs to provide independent review but invalidate the part that actually requires HMOs to pay benefits based on the results of that review, defangs the law. The statute is of little or no benefit to policy holders if the independent review decision is not enforceable through monetary damages.

If, *arguendo*, this Court should reject *amici*'s "relate to" argument, the implications will be profound. Moran has raised three reasons why the lower court should be reversed: (i) the independent review provisions of the Illinois HMO Act are saved from preemption by 29 U.S.C. § 1144(b)(2)(A); (ii) the Illinois HMO Act is, under the language of the Rush Prudential insurance certificate, incorporated into her policy; and (iii) there are factual questions about the procedures that Rush Prudential employed to deny coverage in this case. *Amici* support Moran and believe that these arguments are compelling *for her*. However, her arguments are inadequate to address the law's application to all ERISA plan participants.

The savings clause, § 1144(b)(2)(A), preserves state laws that regulate insurance, but it provides small comfort to beneficiaries under self-insured plans that may fall under the "deemer" clause exception, 29 U.S.C. § 1144(b)(2)(B). The Rush Prudential certificate language applies only to beneficiaries of the Rush Prudential HMO. And, of course, the irregularities that Moran has observed in the handling of her claim will apply to her but to no one else.

Similarly, the State of Illinois, in a twist to Moran's second argument, contends that the Illinois Insurance Code is incorporated into the Rush Prudential policy, regardless of the contract terms, by force of law. The State relies primarily on *Plumb v. Fluid Pump Service, Inc,*, 124 F.

3d 849 (7th Cir. 1997), which addressed a different Insurance Code section than the one at bar, 215 ILCS § 95/20. This Court there held, without detailed discussion of the issue, that § 95/20 "related to" the insurance plan at issue but was saved from preemption by 29 U.S.C. § 1144(b)(2)(A). Although *amici* agree that the Illinois HMO Act should govern Moran's rights, whether by implicit incorporation into her policy or as an independent statute, it should also govern the rights of beneficiaries of self-insured plans. Unless the independent review law fails to pass the "relate to" test, a substantial portion of Illinois policy holders will go unprotected. *Hit and Miss: State Managed Care Laws* (Families USA Publication 98-104, 1998) (noting that approximately one-third of employer-provider health coverage is under self-insured plans).

Thus, Moran's arguments and the State's arguments, though legally sound, will not fully right the wrongs that this Court noted in *Herdrich*. Only legislation, applied to all HMO participants, can do that.

2. The Illinois HMO Act Does Not Conflict with the Specific Provisions of ERISA or with the Policies that Underlie ERISA.

There is no direct conflict between the requirements of ERISA and the obligations under § 4-10 of the Illinois HMO Act. The closest ERISA provision to § 4-10 is 29 U.S.C. § 1133(2), which states that participants in ERISA plans are entitled to "a full and fair review" of a benefit denial decision "[i]n accordance with regulations of the Secretary [of the Treasury]." This requirement, however, applies only to named fiduciaries under the benefit plan. Rush Prudential HMO is not a named fiduciary of Moran's plan.[3] Thus, the provisions of ERISA and the obligations of the Illinois HMO Act do not conflict. Any burdens that the Illinois HMO Act imposes on employers are indirect and are thus permitted under *Travelers*.

[3] Under *Herdrich v. Pegram*, 154 F. 3d 362 (1998), Rush Prudential may be a fiduciary, although not a named fiduciary, of the plan.

Moreover, the Illinois HMO Act is consistent with the spirit of ERISA as well as its letter. When ERISA was passed, health insurance companies rarely made payment decisions based on their preconception of "medical necessity", and it is hard to imagine that Congress could have meant to preclude state regulation of such decision making.

ERISA preemption is not intended to benefit insurance companies. It is, rather, intended to prevent varying state regulations from imposing such a burden on employers that they will be less likely to provide their employees with pension and welfare benefit plans or they will be inclined to institute plans with fewer benefits. *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 10 (1987), described the principles of ERISA preemption through the following language (quoting, in part, from *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983)):

> "Obligating the employer to satisfy the varied and perhaps conflicting requirements of particular state fair employment laws would make administration of a nationwide plan more difficult. Such a situation would produce considerable inefficiencies, which the employer might choose to offset by lowering benefit levels. ERISA's comprehensive preemption of state law was meant to minimize this sort of interference with the administration of employee benefit plans, so that employers would not have to administer their plans differently in each State in which they have employees."
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> ***
>
> A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." (Internal quotation marks and references to *Shaw* omitted.)

The Illinois HMO Act regulates insurance companies, but it does not, except in the most indirect and tenuous way, affect employers. To the extent that § 4-10 of the Illinois HMO Act creates additional expense to employers, such burden will be spread among all premium holders and will not be directly borne by a single employer. The inefficiencies and administrative burdens on employers, which might justify ERISA preemption, simply do not exist. "[L]aws with only an indirect economic effect on the relative costs of various insurance packages in a

given State are a far cry from those 'conflicting directives' from which Congress meant to insulate ERISA plans." *Travelers*, 514 U.S. 645, 662.

Washington Physicians Service Association v. Gregoire, 147 F. 3d 1039 (9th Cir. 1998), found the distinction between state laws that act on ERISA plans and state laws that act on service providers to ERISA plans to be dispositive. The court there upheld the Washington Alternative Provider Act, which requires HMOs and health care service contractors to provide non-traditional health care services, such as acupuncture, massage therapy, naturopathy, and chiropractic services, based on the following reasoning:

> "We read the [Alternative Provider] Act to operate only on health carriers that are distinct from ERISA plans, and with such a reading, it is simply false to say that the Act imposes an administrative burden on the plan or that it dictates certain benefit structures. The Act does not require employers to provide any particular welfare benefit to employees, and it does not impose any burden on the plan in administering any benefits it chooses to provide. All of these burdens fall on the health carrier.
>
> In the end, what saves the Act from ERISA preemption is that it does not have anything to do with employee benefit plans in particular. It is merely one of many state laws that regulates one of many products that an employee benefit plan might choose to buy. The Act regulates health insurance in a broad and neutral way, and only when that insurance is not provided by the plan itself. The mere fact that many ERISA plans choose to buy health insurance for their plan members does not cause a regulation of health insurance automatically to "relate to" an employee benefit plan – just as a plan's decision to buy an apple a day for every employee, or to offer employees a gym membership, does not cause all state regulation of apples and gyms to "relate to" employee benefit plans. After *Travelers*, the ERISA plans no longer have a Midas touch that allows them to degregulate every product they choose to buy as part of their employee benefit plan." 147 F. 3d at 1044.

Even the compliance cost to insurance companies will be negligible. The Lewin Group, *Consumer Bill of Rights and Responsibilities Costs and Benefits: Information Disclosure and External Appeals,* prepared for the Presidential Advisory Commission on Consumer Protection and Quality in the Health Care Industry, (11/15/97), estimates that an external appeals requirement, such as § 4-10 of the Illinois HMO Act, increases health insurance premiums by

less than 0.05%. The Congressional Budget Office report, *Cost Estimate, H.R. 3605/S.1890, Patient's Bill of Rights Act of 1998* (7/16/98), estimates that the establishment of a grievance procedure in health insurance plans, including the establishment of internal and external appeal rights (mechanisms more elaborate than those mandated by § 4-10 of the Illinois HMO Act) would, in the aggregate, raise premiums by 0.3%. This, it is difficult to conceive that the "independent second opinion" provision of the Illinois HMO Act, the statute here at issue, will impede employers' proclivity to provide health insurance or will create inefficiencies that could harm beneficiaries. Certainly, the impact of this statute will be less significant, by orders of magnitude, than the 13% and 24% surcharges that the *Travelers* Court found valid.

Amici acknowledge that certain of the language in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), as well as other pre-*Travelers* cases, suggests a different standard for § 514 preemption. *Travelers*, however, indicates that, while the decisions rendered in prior Supreme Court cases on ERISA preemption issues are still valid, the reasoning used to reach those decisions, being based largely on the "unhelpful text" of ERISA § 514, is not necessarily dispositive. *Travelers*, 514 U.S. at 656. The *Pilot Life* holding is distinguishable, because the claims there, which sought "damages for mental and emotional distress" as well as "punitive and exemplary damages", would, if allowed, have had a far greater impact on the administration and, ultimately, the financial viability of the benefit plan than could Moran's claim for insurance proceeds based on an independent review of a medical necessity decision. To the extent that the language of *Pilot Life* might suggest a broader holding, that language is superseded by *Travelers*.

As in the laws considered by *Travelers* and *Dillingham*, the Illinois HMO Act addresses areas of traditional state concern. The financial burden it places on ERISA plans is indirect and

minimal. Under the standards of *Travelers*, therefore, the Illinois HMO Act does not "have a connection with" or "relate to" ERISA plans, and it is not preempted by § 514.

III. Even if 29 U.S.C. § 1132(a) Completely Preempts the Illinois HMO Act, Its Provisions are Still Incorporated into the Rush Prudential Policy

Rice v. Panchal, 65 F. 3d 637 (7th Cir. 1995), holds that ERISA preemption embodies two concepts: "conflict preemption" under § 514(a), and "complete preemption" under § 502(a), 29 U.S.C. § 1132(a). Both the test for and the legal effects of these two types of preemption are different.

The State of Illinois brief, at pp. 13-18, argues that § 4-10 of the Illinois HMO Act is completely preempted by ERISA § 502(a). This means, according to the State, that the federal courts have jurisdiction over this dispute, and Moran's claim is based solely on her ERISA rights. The State also points out, however, that, notwithstanding such complete preemption, "Section 4-10 was automatically incorporated as a term of the plan at issue under fundamental insurance law." State brief at 18. Thus, Moran is still entitled to rely on the independent review provisions of the state statute.

Moran argues, at pp. 13-23 of her brief, that the district court lacked jurisdiction, because the Illinois HMO Act was not preempted. It therefore carries independent force, outside of its incorporation into the Rush Prudential plan.[4]

As discussed *supra*, the AMA agrees with both plaintiffs-appellants that § 4-10 of the Illinois HMO Act is enforceable. While it is significant to the parties and to the judicial system whether there is complete preemption under § 502(a), the effect on public health is relatively unimportant. *Amici*, therefore, take no position on this issue.

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[4] Moran, in the latter part of her brief, follows the State's "incorporation" argument, under the alternative hypothesis that the District Court may have jurisdiction.

IV. Conclusion

The Illinois HMO Act does not "refer to" ERISA plans, because it operates on HMOs that may be purchased outside the employer-employee context. It does not "have a connection with" ERISA plans, because it addresses areas of traditional state concern, it does not directly conflict with any specific ERISA requirements, and it does not burden employers or inhibit their decision to provide employee benefits. Accordingly, the Illinois HMO Act does not "relate to" employee benefit plans covered by ERISA, and it is not preempted under ERISA § 514. Additionally, the operation of the Illinois HMO Act is not barred by ERISA § 502. The district court should be reversed.

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Leonard A. Nelson, Attorney for
American Medical Association, Illinois
State Medical Society, and American
College of Legal Medicine, *Amicus Curiae*

Michael L. Ile
Anne M. Murphy
Leonard A. Nelson
Office of General Counsel
American Medical Association
515 N. State Street
Chicago, IL 60610
(p) 312-464-5532

Of Counsel:

Saul J. Morse, General Counsel
Illinois State Medical Society
600 S. Second Street, Suite 200
Springfield, IL 62704
(p) 217-528-5609

PROOF OF SERVICE

The undersigned declares under penalty of perjury, pursuant to 28 USC § 1746, that two copies of the foregoing *Amicus Curiae* Brief of the American Medical Association, the Illinois State Medical Society, and the American College of Legal Medicine were served upon each of the below-named parties on the date listed below, by causing the same to be deposited in the United States mail at 515 N. State Street, Chicago, Illinois in an envelope bearing sufficient postage, addressed to:

Daniel P. Albers
Barnes & Thornburg
200 West Madison – Suite 2610
Chicago, IL 60606

Jacqueline M. Zydeck
Assistant Attorney General
100 W. Randolph Street, 12th Floor
Chicago, IL 60601

James T. Ferrini
Clausen Miller, PC
10 South LaSalle Street
Chicago, IL 60603-1098

____
Leonard A. Nelson

Date: October ___, 1999