NO. 16-149

In the Supreme Court of the United States

COVENTRY HEALTH CARE OF MISSOURI, INC.,

Petitioner,

v.

JODIE NEVILS,

Respondent.

On Writ of Certiorari to the Supreme Court of Missouri

BRIEF OF THE MISSOURI ASSOCIATION OF TRIAL ATTORNEYS AS AMICUS CURIAE SUPPORTING RESPONDENT

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INTEREST OF AMICUS CURIAE[1]

The Missouri Association of Trial Attorneys (MATA), is a non-profit professional organization of approximately 1,400 trial attorneys in Missouri. MATA strives to promote the fair administration of justice, to preserve the integrity of the American adversary system, and to employ its members' knowledge and experience to advance the rights of all Missourians, and indeed, all Americans. Because its members frequently represent parties in personal-injury and product-liability suits that involve the recovery of medical expenses, MATA's members are aware of the vital role that Missouri's legal safeguards against insurer subrogation play in protecting the rights of injured parties and health care providers. MATA thus wishes to ensure that these protections—and similar state regulations around the country—remain robust. Accordingly, MATA has a strong interest in ensuring that the express preemption provision in the Federal Employee Health Benefits Act (FEHBA), 5 U.S.C. § 8902(m)(1), is interpreted to leave state restrictions on subrogation intact. This is the result that Congress intended, as a review of the Act's illuminating legislative history reveals. And it is the result that best respects the division of regulatory labor Congress envisioned when it enacted section 8902(m)(1).

SUMMARY OF THE ARGUMENT

States have traditionally operated with virtually unfet-

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[1] All parties have consented to the filing of this brief. No counsel for a party authored this brief in whole or in part, and no entity other than amicus or its counsel has made a monetary contribution to the preparation or submission of this brief.

tered authority to regulate the business of private insurance and the companies that provide it. Because of Congress's abiding respect for the states as separate sovereigns, and its familiarity with the states' institutional expertise that has developed over time, Congress seldom intrudes on the states' almost-exclusive domain in this regulatory sphere. And on those rare occasions when Congress determines that federal objectives must trump state regulatory efforts, Congress displaces state authority only as necessary to serve those specific objectives, otherwise leaving the states' regulatory powers intact. Congress's traditionally cautious approach has made assets of the states' greater insurance expertise and their greater sensitivity to local problems; both add critical oversight and accountability, and mitigate the potential conflicts that could otherwise arise from the implementation of Congress's federal objectives within the states' respective systems.

Congress employed this respectful approach in FEHBA's design. At the program's inception, Congress decided that FEHB carriers should submit fully to state regulatory authority. It later decided that preemption was necessary, but only upon realizing that FEHBA's goal of providing uniform benefits and coverage at affordable cost would be frustrated by state laws that mandated more than federal plans could provide. Even then, Congress targeted for preemption only those state laws causing the conflict. And Congress proceeded in a similarly limited fashion in amending FEHBA, when it expanded the FEHB program to allow certain managed-care arrangements, such as Preferred Physician Organizations (PPOs)—going no further than to preempt those specific state laws that would make such arrangements illegal.

Throughout these changes, deference to the states' superior capacities in regulating insurance remained Congress's guiding principle, and outside these narrow federal objectives, Congress left the states free to regulate FEHB carriers.

Congress intended for state restrictions on insurers' subrogation and reimbursement rights to fall within the wide swath of insurance-business regulation that Congress left to the states. These anti-subrogation laws were not mentioned among the list of specific state laws Congress slated for preemption when FEHBA's preemption provision was first enacted, and are different in kind from the laws on that list. Subrogation and reimbursement restrictions have no effect on the "benefits" or "coverage" the insurer promises to enrollees. They do nothing to absolve the insurer of its obligation to provide benefits. And the funds recovered through these processes bear absolutely no relationship to the insurers' initial benefits outlays, coming from a person completely outside the relationship between the government, insurer, and employee, and from sources that are kept separate from the insurers' initial outlays. And the recovered funds do not even necessarily go back to the insurers that paid out the initial benefits.

More fundamentally, however, the regulation of insurers' subrogation and reimbursement rights is reserved to the states because it implicates the federalist purpose lying at the heart of FEHBA's dual-regulatory design. Insurers' exercise of these rights has significant effects on the states' respective tort systems, and has serious implications for others outside the contractual insurance relationship, including injured employees, health-care provid-

ers, other creditors—and indeed, the tortfeasors themselves—all of whom might have competing claims to the same money. Deciding whether insurers' contractual subrogation and reimbursement rights should be enforced, or should instead give way to other priorities, requires carefully balancing these competing interests. Congress understood that the states' knowledge of their respective tort, insurance, and health-care systems, and the needs of the various players within each system, put the states in a better position to achieve the proper balance.

If any doubt existed about whether FEHBA's preemptive scope extended to state subrogation and reimbursement restrictions, it would have been better for OPM to have come to Congress to have those doubts dispelled. Over the course of the FEHBA's history, Congress has repeatedly demonstrated that it understands FEHBA's importance, and has proven time and again to be responsive to OPM's needs. On several occasions, OPM and its predecessors have come to Congress seeking additional powers. Congress has responded each time, granting the agencies the tools they needed to properly oversee and administer the program. Indeed, in other regulatory contexts, Congress has proven willing to go to even greater lengths than it did in FEHBA to craft preemption policy to fit agency needs—in some instances granting agencies the power to craft preemption policy *for themselves*, on a case-by-case basis. Congress has thus given every indication that it would have been willing to directly address section 8902(m)(1)'s preemptive effect on state anti-subrogation laws. Had it done so, OPM's position would stand on firmer constitutional footing.

ARGUMENT

I. Congress did not intend for FEHBA to preempt state restrictions on insurer subrogation and reimbursement rights.

State restrictions on insurers' subrogation and reimbursement rights existed long before Congress enacted FEHBA's preemption provision. And Congress was aware that these preexisting laws might apply to FEHBA plans. But Congress declined to include these laws within FEHBA's preemptive scope, deeming them to fall within the regulation of the business of insurance, a matter traditionally resting within the states' exclusive regulatory authority. Congress understood that FEHB carriers' exercise of their subrogation and reimbursement rights raises core federalism concerns, affecting different states in different ways, and Congress thought it better to allow the states to decide for themselves whether to allow these rights to be enforced, rather than grant FEHB carriers an exclusive right to shove aside all other comers at the tort-compensation trough.

A. Congress has left the states almost unfettered discretion to regulate private insurance.

For more than a century, insurance regulation has been dominated almost exclusively by the states, largely free from Congressional interference. John G. Day, Dep't of Transp., *Economic Regulation of Insurance in the United States* 10 (1970); Spencer L. Kimball, *Insurance and Public Policy* (1960); Kenneth J. Meier, *The Political Economy of Regulation: The Case of Insurance* 49-87 (1988).

Indeed, only once in our nation's history has state regulatory dominance over insurance been threatened, and that threat came from the Court, not Congress. In *United States v. South-eastern Underwriters Association*, 322 U.S. 533, 543 (1944), the Court threatened to federalize the business of insurance by determining it to be a matter of "interstate commerce," thus potentially within exclusive federal control under the Dormant Commerce Clause, *see* Martin H. Redish & Shane V. Nugent, *The Dormant Commerce Clause and the Constitutional Balance of Federalism*, 1987 Duke L.J. 569, 587-89 (1981). Congress reacted swiftly to this decision, to "restore the supremacy of the States in the realm of insurance regulation." *United States Department of the Treasury v. Fabe*, 508 U.S. 491, 500 (1993). It took less than a year for Congress to enact the McCarran-Ferguson Act, Pub. L. No. 79-15, 59 Stat. 33 (1945) (codified as amended at 15 U.S.C. §§ 1011-15 (1994)), in which Congress declared that "the continued regulation and taxation by the several states of the business of insurance is in the public interest," 15 U.S.C. § 1011. And the Act "explicitly suspended Commerce Clause restraints on state taxation of insurance and placed insurance regulation firmly within the purview of the several States." *Metro. Life Ins. Co. v. Ward*, 470 U.S. 869, 884 (1985).[2]

During this period of virtually unfettered freedom, the states developed regulatory systems that today provide critical oversight of private insurance companies. All

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[2] The McCarran-Ferguson Act provides, in relevant part, that "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, *** unless such Act specifically relates to the business of insurance." 15 U.S.C. § 1012(b).

states have laws licensing insurance companies, agents, and brokers. *Exemption of Federal Employees Health Benefits Program from Certain State Laws on H.R. 12114 Before the Subcomm. on Retirement and Emp. Benefits of the H. Comm. on Post Office and Civil Servs.*, 94th Cong. 40 (1976) (statement of Dick L. Rottman, President of the National Association of Insurance Commissioners (NAIC) (Hearing No. 94-69); see, e.g., NAIC, *Model Laws, Regulations, and Guidelines* (NAIC *Model Law*) § MDL-218 (Producer Licensing Model Act); *id.* § MDL-228 (Public Adjustor Licensing Model Act); *id.* § MDL-220 (Prevention of Illegal MEWAs & Other Illegal Health Ins. Model Regulation). States secure insurer solvency by mandating minimum reserves and requiring sound financial and reporting practices. Hearing No. 94-69, at 40. States have also enacted legislation to prevent insurers from engaging in unfair marketing and claims-handling practices. *Id.* at 40-41; e.g., NAIC Model Law § MDL-880 (Unfair Trade Practices Act); *id.* § MDL-900 (Unfair Claims Settlement Practices Act). And states have sought to ensure the availability of affordable insurance coverage by setting rates and policy terms. See generally Robert H. Jerry, II, *Understanding Insurance Law* 22 (2d ed. 1996); Spencer L. Kimball, *The Purpose of Insurance Regulation: A Preliminary Inquiry in the Theory of Insurance Law*, 45 Minn. L. Rev. 471, 482 (1961). The states enforce these regulatory commands through their own specialized regulatory bodies, armed with broad enforcement powers, and also by permitting civil actions against insurers in court. Hearing No. 94-69, at 41.

State dominance in insurance regulation is due, in part, to Congress's respect for the sovereignty that the states

possess "'concurrent with that of the Federal Government,'" *Gregory v. Ashcroft*, 501 U.S. 452, 457 (1991) (quoting *Tafflin v. Levitt*, 493 U.S. 455, 458 (1990)), and the recognition that insurance is one of the "areas of traditional state regulation" that Congress does not lightly tamper with. *Metro. Life Ins. v. Mass. Travelers Ins. Co.*, 471 U.S. 724, 740 (1985); see *id.* at 741; *Fort Halifax Packing Co., Inc. v. Coyne,* 482 U.S. 1, 19 (1987).

State dominance of insurance regulation also reflects Congress's understanding that the states possess special competence in insurance regulation that the federal government lacks. State legislators and regulators have developed relationships with the people and institutions impacted by their actions—including insurers, consumers, and, in the case of health insurance, health-care providers. Ronald Gift Mullins, *Strong Congressional Debate Role Urged for Industry Regulators*, J. Com., June 11, 1997 at 8A (quoting Josephine Musser).

The states' smaller geographic sphere of responsibility also enables them to provide closer, more personalized oversight, tailored to local assumptions, local problems, and individual communities' needs. NAIC, *1995 NAIC Annual Report* 15 (1996) ("[T]he states are closer to the consumers they are protecting and the industry they are regulating," which is why "states do a better job of regulating insurance than the federal government could."). And local expertise matters, because the insurance business has numerous "logical ties to the geographic, economic, and political structures of the states," that affect employers, health-care providers, and others. Hearing No. 94-69, at 43.

Recognizing these realities, Congress has consistently

sought to make use of state regulatory expertise in fashioning federal legislation regarding private insurance. Even where Congress has identified areas of "exclusive federal concern," *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990), or where "distinctly federal interests" are at play, *Empire Healthchoice Assurance, Inc. v. McVeigh*, 547 U.S. 677, 696 (2006), and determines it necessary to take over important areas of insurance regulation—whether to offer affordable comprehensive insurance to seniors, to expand health care access to all Americans, or to completely overhaul the regulation of employee benefit plans—Congress has still left the states with significant regulatory authority. And the unblemished core of that authority has always included the states' power to regulate the business practices of carriers that wanted to do business in their respective states.[3]

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[3] E.g., Medicare Prescription Drug Improvement and Modernization Act of 2003, Pub. L. No. 108-173, § 232(a)(3), 117 Stat. 2066 (subjecting private Medicare plans to "State licensing laws or State laws relating to plan solvency," 42 U.S.C. § 1395w-26(b)(3), a directive that the Centers for Medicare & Medicaid Services has interpreted to include "[s]tate environmental laws, laws governing private contracting relationships, tort law, labor law, civil rights laws and similar laws, Dep't of Health & Human Servs., Ctrs. For Medicare & Medicaid Servs., *Medicare Prescription Drug Benefit*, 69 Fed. Reg. 46,632, 46,696 (Aug. 3, 2004)); Patient Protection and Affordable Care Act, Pub. L. No. 11-148, § 1321(d), 124 Stat. 119 (2010) (PPACA) (providing that "[n]othing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title"); Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, § 514(b)(2)(A), 88 Stat. 829 (ERISA) (preserving any state law that "regulates insurance," 29 U.S.C. § 1144(2)(A), which "reserv[es] the business of insurance to the States," *Metro. Life*, 471 U.S. at 744 n.21).

B. FEHBA's dual-regulatory regime preserves the states' authority to regulate FEHB carriers' business practices.

Congress followed this tried-and-true dual-regulatory formula with FEHBA, striking a balance of federalism particularly slanted in favor of state regulatory authority. Congress extended FEHBA's preemptive reach to laws that would interfere with FEHB plan terms relating to "benefits" or "coverage." But Congress has left intact the states' authority to regulate *everything* else.

1. The Federal Employees Health Benefits Act of 1959.

When Congress first created the Federal Employee Health Benefit Plan in 1959, Pub. L. No. 86-382, 73 Stat. 708, to offer health benefits to federal employees, it sought to close a "wide gap" that existed between the "government, in its capacity of employer, and employers in private enterprise," that "almost universally" offered "contributory health benefit programs." H.R. Rep. No. 86-957, at 1-2 (1959) (J.A. 267-68). It sought to provide those health benefits in the same manner as private employers did, by "execut[ing] contracts" with private insurance carriers to administer FEHB plans, 5 U.S.C. § 8902(a); H.R. Rep. No. 86-957, at 3, (J.A. 269).

Congress viewed the state's ability to provide accountability and consumer protection as an important asset in this new program—which is unsurprising, given that the federal government was becoming a consumer of insurance. Accordingly, Congress did not "design[]" FEHBA to "regulate the insurance business" or to "override any state regulatory scheme." Report of the Comptroller General of the United States, B-164562, *Conflicts Between*

State Insurance Requirements and Contracts of the Federal Employees Health Benefit Carriers 15 (1975) (Comptroller General Report). Rather, because Congress recognized that "[a]ll states regulate the health insurance business in various" ways, S. Rep. No. 95-903, at 7 (1973) (J.A. 375); Hearing No. 94-69, at 3 (Statement of Thomas Tinsley, Director, Bureau of Retirement, Insurance, and Occupational Health) (same), it left to the states "the authority to both regulate and tax health insurance carriers operating under the [FEHB] program," in the same manner that they regulated other private insurers. Comptroller General Report at 15.

2. The Civil Service Reform Act of 1978.

In the "early years of the" FEHB program, subjecting the FEHB carriers to the states' complete regulatory authority "offered few if any problems." S. Rep. 95-903, at 7 (J.A. 375). But in the early 1970s, certain FEHB carriers encountered state laws that conflicted with the provisions in their plans. Comptroller General Report at 2-4. These "presented serious problems" for the program. S. Rep. 95-903, at 7 (J.A. 375). Complying with them would mean additional premium costs, which would make the program more expensive for "both the Government and enrollees," H.R. Rep. No. 94-1211, at 3 (1976), (J.A. 338). It also threatened the "uniformity of benefits" the government had promised to enrollees. *Ibid.* Some employees would get "benefits for which they did not contract," Hearing No. 94-69, at 2 (Statement of Thomas Tinsley), and others would end up "paying a premium based, in part, on the cost of benefits provided only to enrollees in other States." H.R. Rep. No. 94-1211, at 3 (J.A. 338); see also S. Rep. 95-903, at 9 (J.A. 379). This lack of uniformity was not only inequitable, but also put "carriers in serious jeopardy" of

losing their eligibility to provide insurance under the plan, S. Rep. 95-903, at 7 (J.A. 376), because eligible carriers are required to be "licensed to issue group health insurance in all the States and the District of Columbia," see 5 U.S.C. § 8902(a) & (b), and thus an insurer's failure to follow even one state's law could force it out of the FEHB program entirely, S. Rep. 95-903, at 7 (J.A. 376).

In keeping with its traditional respect for state insurance regulation, Congress took a targeted approach in addressing these conflicts. Congress first decided to act in February of 1975, after certain FEHB insurers had come to the Civil Service Commission (CSC) expressing concern about the impact that state-mandated benefit laws were having on their plans. H.R. Rep. No. 95-282, at 3 (1977) (J.A. 353-54); Comptroller General Report at 13-15. In response, the Honorable Richard C. White, Chairman of the House Subcommittee on Retirement and Employee Benefits, requested the Comptroller General of the United States to furnish a report identifying "those State health insurance requirements which conflict with contracts negotiated between the FEHB carriers and the Civil Service Commission." H.R. Rep. No. 94-1211, at 2 (J.A. 336); Comptroller General Report at 18-19, App. I. Representative White also asked the Comptroller to study the costs that would be incurred if FEHB plans were "changed to include all benefits" that enrollees were entitled to receive by state statute. Comptroller General Report at 19, App. I.

In response, the Comptroller, with the assistance of AETNA, one of the FEHB carriers, identified a set of 19 specific "[s]tate insurance laws, regulations, and Attorney's generals opinions" in 14 states that "conflict with contracts" of the FEHB carriers. Comptroller General

Report at 1, 5, 24. These included state mandates for health insurance carriers to cover chiropractic services, acupuncture, and treatment for mental illness and alcoholism, along with laws that mandated continuation of coverage, home health care, and maternity benefits. Comptroller General Report at 5-12, 21-24. One law from Maryland even mandated that health-insurance carriers cover benefits that might otherwise be provided under no-fault automobile insurance. *Id.* at 24. The Comptroller General estimated that premiums might have to increase by "as much as 5 percent" to cover the benefits mandated for the enrollees in these states, H.R. Rep. No. 95-282, at 4 (J.A. 355); see Comptroller General Report at iii, 18.

Accordingly, when Congress decided to amend FEHBA to add a preemption provision, it did so as a "direct result" of the Comptroller General's Report, Hearing No. 94-69, at 1, based on a detailed legislative record tied specifically to these laws.

The preemptive effort that resulted from this narrow, targeted investigative effort was likewise narrow and targeted. The CSC, the agency charged with implementing FEHBA at the time, did not request "complete preemption" of all state laws that might impact the plans. H.R. Hearing No. 94-69, at 4. And Congress provided only "a form of limited preemption," S. Rep. 95-903, at 7 (J.A. 375), which targeted "the various State conflicts" outlined in the Comptroller General Report, H. R. Rep. No. 94-1211, at 2 (J.A. 336).

As the Committee reports and hearing transcripts from this legislative effort reveal, Congress's sole objective in enacting FEHBA's preemption provision, 5 U.S.C. § 8902(m)(1), Act of Sept, 17, 1978, Pub. L. No. 95-368, 92

Stat. 606, was "to establish uniformity in benefits and coverage," and the only state laws and regulations it sought to preempt were "State or local laws pertaining to such benefits and coverage which are inconsistent with such contracts." H.R. Rep. No. 95-282, at 6 (J.A. 359). Congress thus targeted laws that would conflict with FEHB contractual provisions concerning "the nature or extent of coverage or benefits (including payments with respect to benefits)." 5 U.S.C. § 8902(m)(1) (1982). But Congress made clear that in doing so, it was pulling out only isolated pieces of the states' regulatory authority. State laws were preempted only "insofar as they pertain to benefits and coverage." H.R. Rep. No. 95-282, at 6; (J.A. 359). To Congress, this meant that section 8902(m)(1)'s preemptive scope would reach:

> State laws or regulations which specify types of medical care, providers of care, extent of benefits, coverage of family members, age limits for family members, or other matters relating to health benefits or coverage when such laws or regulations conflict with the provision of contracts under" the FEHBP.

H.R. Rep. 94-1211, at 4; J.A. 339; H.R. Rep. No. 95-282, at 4-5 (J.A. 356-57)—a list that was virtually identical to the list of laws regarding "benefits" compiled in the Comptroller General's Report. Comptroller General Report at 1. But according to Congress, "such a preemption" was "purposely limited," and would not "provide insurance carriers under the program with exemption from state laws and regulations governing other aspects of the insurance business, such as the payment of premium taxes and requirements for statutory reserves." H.R. Rep. No. 95-282, at 6;

(J.A. 359). As Senator Herbert Harris explained, the provision "limits itself solely to who is eligible for this Federal plan and what benefits are provided," and he cautioned: "I think we ought to make sure we don't get into the business of just overriding willy-nilly today or in the future the State's rights as far as the regulation of the industry is concerned." Hearing No. 94-69, at 14.

3. The Federal Employees Health Care Protection Act of 1998.

When Congress amended FEHBA's preemption provision in the Federal Employees Health Care Protection Act of 1998, Pub. L. No. 105-266, § 3(c), 112 Stat. 2363, 2366 (FEHCPA), it again had narrow goals in mind, and tailored its amendments to those specific aims. Congress moderately expanded upon section 8902(m)(1)'s preemption provision in two ways. The first addressed a series of cases in which courts had permitted claimants to skirt preemption of state tort claims by arguing they merely augmented the duties in the plans, and were thus not "inconsistent" with the plans. Brian Harr, *Legislative Reform: FEHBA's Preemption Clause: Is It a Model for Private Employers' Subsidized Health Care?*, 22 J. Legis. 267, 273 (1996) (discussing *Eidler v. Blue Cross Blue Shield United of Wisconsin*, 671 F. Supp. 1213, 1216-17 (E.D. Wis. 1987)). Congress deleted the language from section 8902(m)(1) that required a state law to be "inconsistent" with FEHB contract terms to be preempted, "thereby giving the federal contract provisions clear authority" over state law when those terms concerned benefits or coverage. S. Rep. No. 105-257, at 15 (1998) (J.A. 468).

Congress also revised FEHBA' preemption provisions as part of a larger effort within the Federal Employees

Health Care Protection Act to encourage "managed care programs," H.R. Rep. No. 105-374, at 16 (1997) (J.A. 416-17), such as PPOs, in which insurers enter contractual arrangements with providers to offer their services at discounted rates. Congress found these arrangements to provide "legitimate and valuable benefits" in the form of cost savings to "health care providers, carriers, and patients," S. Rep. 105-257, at 3 (J.A. 444). Congress determined that allowing these arrangements would "strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live." H.R. Rep. No. 105-374, at 9 (J.A. 403).

Permitting these PPO arrangements required preempting "State-mandated 'any-willing provider' statutes," *ibid.*, to the extent they applied to FEHBA plans. Such "any-willing provider" laws give plan beneficiaries the right to select their own health-care provider, and to require their insurance carrier to pick up the cost of the provider's services, on the same terms with doctors in the plan's network. Nat'l Conf. of State Legislatures, *State Roles in Health Reform Provisions Related to Insurance* (Oct. 2011), <http://bit.ly/2ibvq8I>. This obviously hampered efforts to create PPO network arrangements. To prevent these "cost-cutting initiatives from being frustrated" by these "any-willing-provider" laws, H.R. Rep. No. 105-374, at 9 (J.A. 403), Congress expanded section 8902(m)(1)'s preemptive scope to include not only contract terms relating to the "nature or extent of coverage or benefits," but also those relating to the "provision" of "coverage or benefits." 5 U.S.C. § 8902(m)(1). This change targeted for preemption laws that limited the "types of organization [that] can *provide* health care," S. Rep. No. 105-257, at 14-15 (emphasis added) (J.A. 468), thus displacing

state laws that would not allow plans that "provide[d]" benefits through such "managed care programs," H.R. Rep. No. 105-374, at 16 (J.A. 416-17).

Congress took pains to explain that this was only a very limited expansion of section 8902(m)(1)'s preemptive scope. The Senate's report specified that the change would only "affect states that have requirements governing what types of organization can provide health care when those requirements are different from those under federal contracts." S. Rep. No. 105-257, at 14-15 (J.A. 468). The amendments thus had no effect on state regulations concerning the business of FEHB insurers more generally.

Taken together, these benchmarks in FEHBA's development demonstrate that Congress understood the preemptive scope of section 3902(m)(1) to be quite limited, in keeping with Congress's traditional respect for state insurance regulation. And these acts show the care that Congress took in its preemption policy, displacing states' authority no further than necessary to achieve the specific objects it had in mind.

For instance, on more than one occasion, Congress has stressed the need to control costs as reason to amend FEHBA's preemptive scope—whether to avoid cost *increases* that would result from state-mandated benefits laws, H.R. Rep. No. 94-1211, at 3 (J.A. 338), and the administrative costs of complying with differing state laws, *ibid.*, or to promote cost *savings* by lifting restrictions on the types of organizations that could provide insurance, H.R. Rep. No. 105-374, at 9 (J.A. 403). But Congress's desire for cost-savings did not mean that it intended to provide FEHBA carriers with free-form immunity from any

state law that impact plan costs. After all, Congress explained that state laws regarding "premium taxes" were not to be preempted, H.R. Rep. No. 95-282, at 6 (J.A. 359), despite its awareness that allowing the states to impose such taxes added millions of dollars to the costs of the plans, up to $13 dollars per enrollee for some plans, Comptroller General Report at 20, App. II, and subjected the plans to the administrative costs of complying with the tax laws of 50 different states.

Likewise, the fact that Congress sought to provide uniformity in benefits and coverage through section 8902(m)(1), H.R. Rep. No. 94-1211, at 3 (J.A. 337), did not mean that it intended the "administration" of FEHB plans or benefits to be perfectly uniform. *Burkey v. Gov't Emp. Hosp. Ass'n*, 983 F.2d 656, 660 (5th Cir. 1993); OPM, Proposed Rule, *Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery*, 80 Fed. Reg. 932, 933 (Jan. 7, 2015) (Proposed Rule). Congress sought uniformity in benefits and coverage within plans because that was what it promised to employees, H.R. Rep. No. 94-1211, at 3 (J.A. 337). But in areas *other* than benefits or coverage, Congress was willing to bear the increased administrative burden of a federalist system, because those costs were outweighed by the benefits of oversight and localized decision-making that came with leaving the large part of the regulation of FEHB carriers to the states.

C. FEHBA carriers' subrogation and reimbursement rights concern insurance business practices that Congress reserved to the states.

State restrictions on subrogation are among the regulations regarding the business of FEHB insurers that Congress intended to remain within the province of the states after enactment of section 8902(m)(1). This conclusion follows not only from the absence of any relationship between these laws and the "benefits" or "coverage" of FEHB plans, 5 U.S.C. § 8902(m)(1), but also because state regulation of these insurer rights is necessary to fulfill the basic federalist purpose behind FEHBA's dual-regulatory structure.

1. Subrogation and reimbursement restrictions are not among the specific state laws Congress targeted for preemption.

Subrogation and reimbursement provisions have long been common in insurance contracts, and OPM's "longstanding practice" has been for "FEHB Program contracts and the applicable statement of benefits" to "require carriers to seek reimbursement and/or subrogation recoveries." Proposed Rule, 80 Fed. Reg. 931, 933. Even before FEHBA's preemption provision was enacted, many states, including Missouri, refused to enforce these contractual rights of insurers. *Jones v. Aetna Casualty & Sur. Co.*, 497 S.W.2d 809, 812 (Mo. App. 1973) ("[A]n insurer may not acquire part of the insured's rights against a tortfeasor (other than an uninsured motorist) by reason of payment of medical expense, *either by assignment or by subrogation.*") (emphasis added). See also, e.g., 36 Okl. St. Ann. tit. 36, § 6092 (1971) (imposing "[l]imitations on subrogation and setoff under medical coverage"); Kan.

Admin. Regs. § 40-1-20 (1966) (prohibiting subrogation clauses "for certain coverages"); *State Farm Fire & Cas. Co. v. Knapp*, 484 P.2d 180 (Ariz. 1971) (refusing to permit subrogation as an impermissible assignment of a personal injury claim); *Berlinski v. Ovellette*, 325 A.2d 239 (Conn. 1973) (invaliding subrogation provision in an automobile-insurance contract), overruled in *Westchester Fire Ins. Co. v. Allstate Ins. Co.*, 236 Conn. 362 (1996), overruled by statute, C.G.S. 38a-336b (denying insurers that provide uninsured-motorist coverage any right of subrogation against uninsured motorists); *Fifield Manor v. Finston*, 354 P.2d 107 (Ca. 1960); *State Farm Fire & Cas. Ins. Co. v. Farmers Ins. Exch.*, 489 P.2d 480 (Okl. 1971); *Wrightsman v. Hardware Dealers Mut. Fire Ins. Co.*, 147 S.E.2d 860 (Ga. 1966).

Congress was thus doubtless aware of these state anti-subrogation regulatory efforts when it passed section 8902(m)(1) into law, and thus understood that these restrictions might have an impact on FEHB plan terms. But these laws were not among "the various State conflicts" that Congress sought to preempt with section 8902(m)(1), H. R. Rep. No. 94-1211, at 2 (J.A. 336), although, at the time, these anti-subrogation laws were far more pervasive than the state-mandated benefits laws that were targeted for preemption. Anti-subrogation laws likewise go unmentioned in all of the committee reports and hearing testimony surrounding adoption and amendment of section 8092(m)(1). This complete absence of Congressional attention demonstrates that Congress has not "in fact faced" the question of whether FEHBA's preemptive reach extends to state restrictions on insurers' subrogation and reimbursement rights, reason alone to conclude that Con-

gress did not intend to intrude into this "traditionally sensitive area[]" of "the federal balance" between federal and state authority. *United States v. Bass*, 404 U.S. 336, 349 (1971).

2. Subrogation restrictions bear no relation to benefits or coverage as Congress understood them.

State restrictions on subrogation and reimbursement also bear no relationship to "benefits" or "coverage," as required for preemption under section 8902(m)(1). In *McVeigh*, the Court expressed concern about the "puzzling" nature of section 8902(m)(1), concluding that its provisions were ambiguous and subject to multiple "plausible constructions." 547 U.S. at 697-98. But when Congress enacted section 8902(m)(1), it did not understand these terms to be ambiguous, nor did it understand them to encompass state restrictions on subrogation and reimbursement.

Anti-subrogation laws have no connection to "coverage" as Congress used the term in section 8902(m)(1), because in that provision, Congress adopted an industry definition of that term—using it to refer to "who is eligible to participate," Hearing No. 94-69, at 14 (Statement of Peter Connell, Counsel, AETNA Life & Cas.), "and for how

long," *id.* (Statement of Daniel W. Pettengill, Vice President, Group Div., AETNA Life & Cas.).[4] There is no question that restrictions on subrogation and reimbursement rights have nothing to do with these aspects of the insurance relationship.

These laws do not have any connection to contractual "benefits" either. Not only are state restrictions on reimbursement or subrogation completely absent from the list of laws concerning "benefits" compiled in the Comptroller General's 1975 report, Comptroller General Report at 1, they are also different in kind from those included on that list. Each of the laws listed in the Comptroller General's Report relate to, and dictate, the "benefit structure" of the plan itself—the benefits initially given to plan enrollees. Hearing No. 94-69, at 4 (Statement of Thomas Tinsley).

Restrictions on subrogation or reimbursement, on the other hand, do not fit within this conception of benefits. They neither dictate nor constrain the insurer's obligation to provide benefits—which remains unchanged regardless of whether the insurer becomes entitled to a recovery later or not. And the cost-recovery mechanisms that these laws regulate are entirely distinct from the underlying benefits that create the reimbursement obligation. In-

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[4] References within the contemporaneous committee reports are consistent with Congress's adoption of this industry view. E.g., H.R. Rep. No. 95-282, at 1, J.A. 351 (providing that FEHBA provides "health insurance coverage for about 3 million Federal employees and annuitants and 6 million dependents); *id.* at 4, J.A. 356 (referring to "coverage of family members"); *id.* at 6, J.A. 360 (noting that the problems giving rise to section 8902(m)(1) began when states started mandating, among other things, the "family members to be covered, the age limits for family members, [and] extension of coverage").

deed, the later-in-time recoveries they provide never actually come out of the benefits that were initially provided by the insurer, see 5 C.F.R. § 890.101(f) (providing that payments to the insurer must come "out of the recovery" from a third-party). This is because these funds are not retained by the enrollee, but instead go to health-care providers that are under no obligation to pay them back.

Indeed, funds recovered via subrogation or reimbursement under FEHB plans do not even necessarily go back to the same insurer that paid out the benefits in the first place. Some recoveries are "required to be credited to the Employees Health Benefits Fund established by 5 U.S.C. § 8989, held by the Treasury of the United States," which is controlled by OPM, not the insurers. OPM Proposed Rule, 80 Fed. Reg. 932; FEHB Program Carrier Letter No. 2012-18, Pet. App. 117a.

Accordingly, restrictions on subrogation and reimbursement, like the contractual rights they regulate, bear no relationship to benefits. Instead, they are more akin to laws mandating "statutory reserves," H.R. Rep. 95-282, at 6 (J.A. 359), targeting the operating funds that insurers to *pay* benefits, which Congress decided do not "relate to" the "nature, provision, or extent of coverage," and thus fall within the laws relating to the "business of insurance" that Congress reserved to the states. 5 U.S.C. § 8902(m)(1).

3. Principles of federalism favor leaving regulation of subrogation and reimbursement rights to the states.

Preemption of subrogation and reimbursement restrictions would not only be inconsistent with FEHBA's statutory text, it would also disregard Congress's core federalist purpose behind its decision in FEHBA to leave

matters regarding the business of insurance to the states. This is because subrogation and reimbursement rights do not exist in isolation. These contractual rights can have larger impacts on states' tort systems. For example, in some jurisdictions, the "double recovery" that an insured might receive as the result of restrictions on subrogation might not be seen as a windfall, but instead as a trade-off for stricter limits on tort remedies. Accordingly, stripping away those restrictions might deprive injured parties of compensation that is necessary to make them whole. Moreover, insurers are not the only ones who rely on tort recoveries to recover costs. Injured parties, health care providers, and other creditors may all have competing claims to the money coming from the tortfeasor, and the tortfeasor herself may claim a right to retain that money. State regulators are in a better position than Congress to know whether allowing subrogation recoveries will upset the balance of these other interests within their respective health-care, insurance, and tort systems, and are in a better position to prioritize the competing interests involved in tort recoveries. This is a compelling reason why Congress intended for the matter of subrogation to be left to the states, not subjected to a single, inflexible, uniform federal rule.

Subrogation and reimbursement restrictions are also divorced from the other concerns that motivated Congress to create, and then amend, FEHBA's preemption provision. Restrictions on subrogation and reimbursement rights raise no risk of cross-subsidies—"paying a premium based, in part, on the cost of benefits provided only to enrollees in other States," H.R. Rep. No. 94-1211, at 3 (J.A. 338)—that motivated Congress to universalize

coverage and benefits through preemption. Whether injured parties are entitled to keep funds they receive based on duties entirely exterior to the insurance contract, from people who are not covered under the insurance contract, and who themselves are not receiving benefits under the contract, has no potential to create inequity—either in the premiums employees are forced to pay, or in the resulting benefits they are entitled to receive.

There is likewise no indication that an attempt to assert subrogation or reimbursement rights in contravention of state law will put "carriers in serious jeopardy" of losing their eligibility to provide insurance under FEHBA, S. Rep. 95-903, at 7 (J.A. 376). Indeed, Coventry has asserted its subrogation rights, and there is no indication that it is at risk of forfeiting its Missouri insurance license for doing so.

4. Promoting parity between the preemptive scopes of ERISA and FEHBA does not counsel in favor of preemption, but against.

Finally, it is often suggested that FEHBA and ERISA should be read together, *Pharm. Care Mgmt. Ass'n v. Rowe*, 429 F.3d 294, 299 n.2 (1st Cir. 2005) (per curiam), *Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 393-94 (9th Cir. 2002); see also, e.g., *Aybar v. N.J. Transit Bus Operations, Inc.*, 701 A.2d 932, 935-36 (N.J. App. Div. 1997), to ensure that federal employees "receive equal treatment with private-sector plans governed by ERISA." Pet. Br. at 12. It is also argued that adopting this principle of parity would cause subrogation and reimbursement restrictions to be preempted under this Court's decision in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

But ERISA's preemption provision, which "proport[s] to render inoperative any and all state laws that in some way bear on federal *employee-benefit plans*," *McVeigh*, 547 U.S. at 698 (citing 29 U.S.C. § 1144(a)), is materially broader than FEHBA's, which targets only those terms *within* a plan relating to "benefits" and "coverage," 5 U.S.C. § 8902(m)(1). These critical differences make it doubtful that Congress actually intended for them to be read together.

But in any event, any pursuit of parity between ERISA and FEHBA *should* require reading FEHBA's preemption provision narrowly, to preserve state authority to regulate insurers' subrogation and reimbursement rights. This is because ERISA's savings clause, like FEHBA's preemption clause, preserves an essential role for the states in regulating "the business of insurance," 29 U.S.C. § 1144(b)(2)(A), *Metro. Life*, 471 U.S. at 744 n.21, which this Court held "returns the matter of subrogation to state law," *Holliday*, 498 U.S. at 61. If subrogation is a matter reserved to the states under ERISA, then parity would require that the issue should also be left to the states under FEHBA.

Indeed, although the state anti-subrogation restriction at issue in *Holliday* fell outside the coverage of ERISA's savings clause in section 514(b)(2)(A), that result had nothing to do with the nature of the state law at issue in *Holliday*. It hinged instead on specifics about nature of the *plan* at issue in that case. There was no question that the anti-subrogation restriction at issue in *Holliday* was a "State law[] that directly regulat[ed] insurance," *Holliday*, 498 U.S. at 61, and thus within ERISA's "saving clause." Instead, the reason that the law was not "saved" had to do with a different part of ERISA—the "deemer

clause," *ibid.*, 29 U.S.C. § 1144(b)(2)(A). Under this "deemer clause," the self-funded employee benefit plans at issue in *Holliday* were not "deemed to be an insurance company" or "to be engaged in the business of insurance," and thus were exempt from the state laws regulating "insurance" that were saved from preemption under ERISA section 514(b)(2)(A). 498 U.S. at 61. As this Court noted, this "deemer" clause existed because "requir[ing] plan providers to design their programs in an environment of differing state regulations *** complicat[es] the administration of nationwide plans," *Holliday*, 498 U.S. at 60, and Congress considered this task, and its administrative costs, to be too much for normally smaller self-funded and self-insured plans to bear.

The outcome in *Holliday* thus depended upon the plan at issue, and illustrates nothing beyond Congress's intent to exempt very small self-insured plans from being forced to deal with the administrative burdens of applying with the varying laws of different states. But the FEHB program contains no equivalent to the self-insured plans at issue in *Holliday*. FEHB carriers must be large enough to be licensed in all 50 states and DC before they are qualified to offer FEHBA plans, and thus Congress understood that they would be already accustomed to modifying their administrative practices to comply with the varying laws of different jurisdictions.

Thus, putting the federal and private employees of Missouri and other states on equal footing (except for the small-subset in self-insured plans) would require respecting state protections against preemption, not preempting them.

II. OPM would have been better served asking Congress to explicitly preempt state regulation of insurers' subrogation and reimbursement rights.

If the past 60 years since the creation of the FEHB program have taught anything, it is that Congress has always understood the program to involve important interests, and has proven remarkably responsive to the needs of the agencies charged with running the program.

The 1959 reforms that led to the FEHBA were recommended by the CSC (the agency charged with administering the statute at that time), which thought the reforms "highly desirable." H.R. Rep. 86-957, at 18 (J.A. 301). And when Congress added FEHBA's preemption provision, it came after CSC "strongly urged" Congress to amend FEHBA to address laws that conflicted with plan terms. H.R. Rep. No. 95-282, at 6 (J.A. 359); Comptroller General's Report at 13-15. CSC insisted that preemption was in the best interest of the plan, and would enable the Commission to "administer the [FEHB] in a reasonable and efficient manner." H.R. Rep. No. 95-282, at 3 (J.A. 354-55). Congress thus provided CSC with exactly the preemptive power it requested.

When Congress later amended FEHBA's statutory provisions, at the insistence of OPM and others, it "provide[d] the Office of Personnel Management" (which had taken over administration of the FEHB) with substantially greater powers, giving it new ways to "fight[] waste, fraud, and abuse," H.R. Rep. 105-374, at 6 (J.A. 398), "reduce administrative burdens" on OPM, *id.* at 15; J.A. 469, offer PPO plans, and expand the types of underwriting organizations that OPM could use as carriers, *id.* at 9 (J.A.

456). Congress has thus repeatedly proven itself to be responsive to OPM's requests, and has consistently acted to give the agency the tools it needs to make the FEHB program operate as efficiently and effectively as possible.

Indeed, in other regulatory contexts, Congress has demonstrated even greater willingness to allow agencies to have a hand in crafting preemption policy. For instance, Congress has given the Secretary of Defense enormous power to preempt state laws in the implementation of the CHAMPUS Program, which allows military personnel and their dependents to access civilian health services in a program akin to an employer-provided health-care plan. Anderson et al., RAND Corp., Nat'l Def. Res. Inst., *Evaluation of the CHAMPUS Reform Initiative, Vol. 6: Implementation and Operation* 3-4 (1994). When Congress first explored the idea of using managed-care arrangements in CHAMPUS to control costs, it created a pilot program in two states, and granted blanket preemption of "State and local laws and local laws and regulations" for the provisions in the initial managed-care contracts in that pilot program. H.R. Rep. No. 103-200, 1993 WL 298896, at *298 (1993); see National Defense Authorization Act for Fiscal Year 1987, Pub. L. No. 99-661, §§ 701-03, 100 Stat. 3816 (1986); 10 U.S.C. § 1103(a) (1988).

But at the close of the Cold War, when the resulting draw-down in military personnel reduced the number of active-duty military physicians, Congress anticipated that the DOD would begin "moving toward greater reliance on [private] contractor support for the delivery of health care services" within CHAMPUS, H.R. Rep. No. 103-200, 1993 WL 298896, at *298, by expanding these managed-care programs. Congress decided that preemption should be

relaxed for these new managed-care programs, "believ[ing] that State and local government regulation of health plans operating within their purview generally provides added protection," H.R. Rep. No. 103-200, 1993 WL 298896, at *298. Accordingly, in a provision of the National Defense Authorization Act for Fiscal Year 1994, Pub. L. No. 103-160, § 715, 107 Stat. 1547, 1642 (1993), Congress provided that any state or local law that conflicted with CHAMPUS terms would be preempted "to the extent that the Secretary of Defense" decided that such law was "inconsistent with a specific provision in a contract or regulation," or determined that preemption is "necessary to implement or administer the provisions of the contract or to achieve any other important Federal Interest." 10 U.S.C. § 1103(a); H.R. Rep. No. 103-200, at *193. This gave considerable discretion to the Secretary of Defense to decide selectively, on a case-by-case basis, whether state law should give way to CHAMPUS plan terms, or vice-versa, and shows the lengths Congress will go—indeed, far farther than FEHBA—to craft preemption policy to fit specific agency needs.

Accordingly, if OPM felt that the scope of federal preemption needed to be expanded or clarified, it should have made its case to Congress, and Congress would have addressed the question directly. That would have been the better path, and would have ensured that preemption was actually what Congress intended.

CONCLUSION

The judgment of the Missouri Supreme Court should be affirmed.

Respectfully submitted,

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