

THOMAS, J., dissenting

SUPREME COURT OF THE UNITED STATES

No. 00–1021

RUSH PRUDENTIAL HMO, INC., PETITIONER *v.*
DEBRA C. MORAN ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF
APPEALS FOR THE SEVENTH CIRCUIT

[June 20, 2002]

JUSTICE THOMAS, with whom THE CHIEF JUSTICE,
JUSTICE SCALIA, and JUSTICE KENNEDY join, dissenting.

This Court has repeatedly recognized that ERISA’s civil enforcement provision, §502 of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U. S. C. §1132, provides the exclusive vehicle for actions asserting a claim for benefits under health plans governed by ERISA, and therefore that state laws that create additional remedies are pre-empted. See, *e.g.*, *Pilot Life Ins. Co. v. Dedeaux*, 481 U. S. 41, 52 (1987); *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U. S. 134, 146–147 (1985). Such exclusivity of remedies is necessary to further Congress’ interest in establishing a uniform federal law of employee benefits so that employers are encouraged to provide benefits to their employees: “To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits.” *FMC Corp. v. Holliday*, 498 U. S. 52, 60 (1990).

Of course, the “expectations that a federal common law of rights and obligations under ERISA-regulated plans would develop . . . would make little sense if the remedies available to ERISA participants and beneficiaries under §502(a) could be supplemented or supplanted by varying

THOMAS, J., dissenting

state laws.” *Pilot Life, supra*, at 56. Therefore, as the Court concedes, see *ante*, at 19, even a state law that “regulates insurance” may be pre-empted if it supplements the remedies provided by ERISA, despite ERISA’s saving clause, §514(b)(2)(A), 29 U. S. C. §1144(b)(2)(A). See *Silkwood v. Kerr-McGee Corp.*, 464 U. S. 238, 248 (1984) (noting that state laws that stand as an obstacle to the accomplishment of the full purposes and objectives of Congress are pre-empted).¹ Today, however, the Court takes the unprecedented step of allowing respondent Debra Moran to short circuit ERISA’s remedial scheme by allowing her claim for benefits to be determined in the first instance through an arbitral-like procedure provided under Illinois law, and by a decisionmaker other than a court. See 215 Ill. Comp. Stat., ch.125, §4–10 (2000). This decision not only conflicts with our precedents, it also eviscerates the uniformity of ERISA remedies Congress deemed integral to the “careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans.” *Pilot Life, supra*, at 54. I would reverse the Court of Appeals’ judgment and remand for a determination of whether Moran was entitled to reimbursement absent the independent review conducted under §4–10.

I

From the facts of this case one can readily understand why Moran sought recourse under §4–10. Moran is covered by a medical benefits plan sponsored by her husband’s employer and governed by ERISA. Petitioner Rush

¹I would assume without deciding that 215 Ill. Comp. Stat., ch. 125, §4–10 (2000) is a law that “regulates insurance.” We can begin and end the pre-emption analysis by asking if §4–10 conflicts with the provisions of ERISA or operates to frustrate its objects. See, *e.g.*, *Boggs v. Boggs*, 520 U. S. 833, 841 (1997).

THOMAS, J., dissenting

Prudential HMO, Inc., is the employer's health maintenance organization (HMO) provider for the plan. Petitioner's Member Certificate of Coverage (Certificate) details the scope of coverage under the plan and provides petitioner with "the broadest possible discretion" to interpret the terms of the plan and to determine participants' entitlement to benefits. 1 Record, Exh. A, p. 8. The Certificate specifically excludes from coverage services that are not "medically necessary." *Id.*, at 21. As the Court describes, *ante*, at 2–3, Moran underwent a nonstandard surgical procedure.² Prior to Moran's surgery, which was performed by an unaffiliated doctor, petitioner denied coverage for the procedure on at least three separate occasions, concluding that this surgery was not "medically necessary." For the same reason, petitioner denied Moran's request for postsurgery reimbursement in the amount of \$94,841.27. Before finally determining that the specific treatment sought by Moran was not "medically necessary," petitioner consulted no fewer than six doctors, reviewed Moran's medical records, and consulted peer-reviewed medical literature.³

²While the Court characterizes it as an "unconventional treatment," the Court of Appeals described this surgery more clinically as "rib resection, extensive scale-nectomy," and "microneurolysis of the lower roots of the brachial plexus under intraoperative microscopic magnification." 230 F. 3d 959, 963 (CA7 2000). The standard procedure for Moran's condition, as described by the Court of Appeals, involves (like the nonstandard surgery) rib resection with scale-nectomy, but it does not include "microneurolysis of the brachial plexus," which is the procedure Moran wanted and her primary care physician recommended. See *id.*, at 963–964. In any event, no one disputes that the procedure was not the standard surgical procedure for Moran's condition or that the Certificate covers even nonstandard surgery if it is "medically necessary."

³Petitioner thus appears to have complied with §503 of ERISA, which requires every employee benefit plan to "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under

THOMAS, J., dissenting

In the course of its review, petitioner informed Moran that “there is no prevailing opinion within the appropriate specialty of the United States medical profession that the procedure proposed [by Moran] is safe and effective for its intended use and that the omission of the procedure would adversely affect [her] medical condition.” 1 Record, Exh. E, p. 2. Petitioner did agree to cover the standard treatment for Moran’s ailment, see n. 2, *supra*; n. 4, *infra*, concluding that peer-reviewed literature “demonstrates that [the standard surgery] is effective therapy in the treatment of [Moran’s condition].” 1 Record, Exh. E, at 3.

Moran, however, was not satisfied with this option. After exhausting the plan’s internal review mechanism, Moran chose to bypass the relief provided by ERISA. She invoked §4–10 of the Illinois HMO Act, which requires HMOs to provide a mechanism for review by an independent physician when the patient’s primary care physician and HMO disagree about the medical necessity of a treatment proposed by the primary care physician. See 215 Ill. Comp. Stat., ch.125, §4–10 (2000). While Moran’s primary care physician acknowledged that petitioner’s affiliated surgeons had not recommended the unconventional surgery and that he was not “an expert in this or any other area of surgery,” 1 Record, Exh. C, he nonetheless opined, without explanation, that Moran would be “best served” by having that surgery,” *ibid*.

Dr. A. Lee Dellon, an unaffiliated physician who served as the independent medical reviewer, concluded that the surgery for which petitioner denied coverage “was appropriate,” that it was “the same type of surgery” he would have done, and that Moran “had all of the indications and

the plan has been denied,” and to “afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.” 29 U. S. C. §1133.

THOMAS, J., dissenting

therefore the medical necessity to carry out” the non-standard surgery. Appellant’s Separate App. (CA7), pp. A42–A43.⁴ Under §4–10, Dr. Dellon’s determination conclusively established Moran’s right to benefits under Illinois law. See 215 Ill. Comp. Stat., ch.125, §4–10 (“In the event that the reviewing physician determines the covered service to be medically necessary, the [HMO] *shall provide* the covered service” (emphasis added)). 230 F. 3d 959, 972–973 (CA7 2000).

Nevertheless, petitioner again denied benefits, steadfastly maintaining that the unconventional surgery was not medically necessary. While the Court of Appeals recharacterized Moran’s claim for reimbursement under §4–10 as a claim for benefits under ERISA §502(a)(1)(B), it reversed the judgment of the District Court based solely on Dr. Dellon’s judgment that the surgery was “medically necessary.”

II

Section 514(a)’s broad language provides that ERISA “shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan,” except as provided in §514(b). 29 U. S. C. §1144(a). This language demonstrates “Congress’s intent to establish the regulation of employee welfare benefit plans ‘as exclusively a federal concern.’” *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U. S. 645, 656 (1995) (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U. S. 504, 523 (1981)). It was intended to “ensure that

⁴Even Dr. Dellon acknowledged, however, both that “[t]here is no particular research study” to determine whether failure to perform the nonstandard surgery would adversely affect Moran’s medical condition and that the most common operation for Moran’s condition in the United States was the standard surgery that petitioner had agreed to cover. Appellant’s Separate App. (CA7), p. A43.

THOMAS, J., dissenting

plans and plan sponsors would be subject to a uniform body of benefits law” so as to “minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government” and to prevent “the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.” *Ingersoll-Rand Co. v. McClendon*, 498 U. S. 133, 142 (1990). See also *Egelhoff v. Egelhoff*, 532 U. S. 141, 148 (2001).

To be sure, this broad goal of uniformity is in some tension with the so-called “saving clause,” which provides that ERISA does not “exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.” §514(b)(2)(A) of ERISA, 29 U. S. C. §1144(b)(2)(A). As the Court has suggested on more than one occasion, the pre-emption and saving clauses are almost antithetically broad and “are not a model of legislative drafting.” *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U. S. 86, 99 (1993) (quoting *Pilot Life*, 481 U. S., at 46). But because there is “no solid basis for believing that Congress, when it designed ERISA, intended fundamentally to alter traditional pre-emption analysis,” the Court has concluded that federal pre-emption occurs where state law governing insurance “stands as an obstacle to the accomplishment of the full purposes and objectives of Congress.” *Harris Trust, supra*, at 99 (quoting *Silkwood*, 464 U. S., at 248).

Consequently, the Court until today had consistently held that state laws that seek to supplant or add to the exclusive remedies in §502(a) of ERISA, 29 U. S. C. §1132(a), are pre-empted because they conflict with Congress’ objective that rights under ERISA plans are to be enforced under a uniform national system. See, e.g., *Ingersoll-Rand Co.*, *supra*, at 142–145; *Metropolitan Life Ins. Co. v. Taylor*, 481 U. S. 58, 64–66 (1987); *Pilot Life, supra*,

THOMAS, J., dissenting

at 52–57. The Court has explained that §502(a) creates an “interlocking, interrelated, and interdependent remedial scheme,” and that a beneficiary who claims that he was wrongfully denied benefits has “a panoply of remedial devices” at his disposal. *Russell*, 473 U. S., at 146. It is exactly this enforcement scheme that *Pilot Life* described as “represent[ing] a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans,” 481 U. S., at 54. Central to that balance is the development of “a federal common law of rights and obligations under ERISA-regulated plans.” *Id.*, at 56.

In addressing the relationship between ERISA’s remedies under §502(a) and a state law regulating insurance, the Court has observed that “[t]he policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.” *Id.*, at 54. Thus, while the preeminent federal interest in the uniform administration of employee benefit plans yields in some instances to varying state regulation of the business of insurance, the exclusivity and uniformity of ERISA’s enforcement scheme remains paramount. “Congress intended §502(a) to be the exclusive remedy for rights guaranteed under ERISA.” *Ingersoll-Rand Co.*, *supra*, at 144. In accordance with ordinary principles of conflict pre-emption, therefore, even a state law “regulating insurance” will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA’s remedial scheme. See, e.g., *Pilot Life*, *supra*, at 54 (citing *Russell*, *supra*, at 146); *Harris Trust*, *supra*, at 99 (citing *Silkwood*, *supra*, at 248).

THOMAS, J., dissenting

III

The question for the Court, therefore, is whether §4–10 provides such a vehicle. Without question, Moran had a “panoply of remedial devices,” *Russell, supra*, at 146, available under §502 of ERISA when petitioner denied her claim for benefits.⁵ Section 502(a)(1)(B) of ERISA provided the most obvious remedy: a civil suit to recover benefits due under the terms of the plan. 29 U. S. C. §1132(a)(1)(B). But rather than bring such a suit, Moran sought to have her right to benefits determined outside of ERISA’s remedial scheme through the arbitral-like mechanism available under §4–10.

Section 4–10 cannot be characterized as anything other than an alternative state-law remedy or vehicle for seeking benefits. In the first place, §4–10 comes into play only if the HMO and the claimant dispute the claimant’s entitlement to benefits; the purpose of the review is to determine whether a claimant is entitled to benefits. Contrary to the majority’s characterization of §4–10 as nothing more than a state law regarding medical standards, *ante*, at 26–27, it is in fact a binding determination of whether benefits are due: “In the event that the reviewing physician determines the covered service to be medically necessary, the [HMO] *shall provide* the covered service.” 215 Ill. Comp. Stat., ch. 125, §4–10 (2000) (emphasis added). Section 4–10 is thus most precisely characterized as an arbitration-like mechanism to settle benefits disputes. See Brief for United States as *Amicus Curiae* 23 (conced-

⁵Commonly included in the panoply constituting part of this enforcement scheme are: suits under §502(a)(1)(B) (authorizing an action to recover benefits, obtain a declaratory judgment that one is entitled to benefits, and to enjoin an improper refusal to pay benefits); suits under §§502(a)(2) and 409 (authorizing suit to seek removal of the fiduciary); and a claim for attorney’s fees under §502(g). See *Russell*, 473 U. S., at 146–147; *Pilot Life Ins. Co. v. Dedeaux*, 481 U. S. 41, 53 (1987).

THOMAS, J., dissenting

ing as much).

There is no question that arbitration constitutes an alternative remedy to litigation. See, e.g., *Air Line Pilots v. Miller*, 523 U. S. 866, 876, 880 (1998) (referring to “arbitral remedy” and “arbitration remedy”); *DelCostello v. Teamsters*, 462 U. S. 151, 163 (1983) (referring to “arbitration remedies”); *Great American Fed. Sav. & Loan Assn. v. Novotny*, 442 U. S. 366, 377–378 (1979) (noting that arbitration and litigation are “alternative remedies”); 3 D. Dobbs, *Law of Remedies* §12.23 (2d. ed. 1993) (explaining that arbitration “is itself a remedy”). Consequently, although a contractual agreement to arbitrate—which does not constitute a “State law” relating to “any employee benefit plan”—is outside §514(a) of ERISA’s pre-emptive scope, States may not circumvent ERISA pre-emption by mandating an alternative arbitral-like remedy as a plan term enforceable through an ERISA action.

To be sure, the majority is correct that §4–10 does not mirror all procedural and evidentiary aspects of “common arbitration.” *Ante*, at 25–26. But as a binding decision on the merits of the controversy the §4–10 review resembles nothing so closely as arbitration. See generally 1 I. MacNeil, R. Spediel, & T. Stipanowich, *Federal Arbitration Law* §2.1.1 (1995). That the decision of the §4–10 medical reviewer is ultimately enforceable through a suit under §502(a) of ERISA further supports the proposition that it tracks the arbitral remedy. Like the decision of any arbitrator, it is enforceable through a subsequent judicial action, but judicial review of an arbitration award is very limited, as was the Court of Appeals’ review in this case. See, e.g., *Paperworkers v. Misco, Inc.*, 484 U. S. 29, 36–37 (1987) (quoting *Steelworkers v. American Mfg. Co.*, 363 U. S. 564, 567–568 (1960)). Although the Court of Appeals recharacterized Moran’s claim for reimbursement under §4–10 as a claim for benefits under §502(a)(1)(B) of ERISA, the Court of Appeals did not interpret the plan

THOMAS, J., dissenting

terms or purport to analyze whether the plan fiduciary had engaged in the “full and fair review” of Moran’s claim for benefits that §503(2) of ERISA, 29 U. S. C. §1133(2), requires. Rather, it rubberstamped the independent medical reviewer’s judgment that Moran’s surgery was “medically necessary,” granting summary judgment to Moran on her claim for benefits solely on that basis. Thus, as Judge Posner aptly noted in his dissent from the denial of rehearing en banc below, §4–10 “establishes a system of appellate review of benefits decisions that is distinct from the provision in ERISA for suits in federal court to enforce entitlements conferred by ERISA plans.” 230 F. 3d, at 973.

IV

The Court of Appeals attempted to evade the preemptive force of ERISA’s exclusive remedial scheme primarily by characterizing the alternative enforcement mechanism created by §4–10 as a “contract term” under state law.⁶ *Id.*, at 972. The Court saves §4–10 from preemption in a somewhat different manner, distinguishing it from an alternative enforcement mechanism because it does not “enlarge the claim beyond the benefits available in any action brought under §1132(a),” and characterizing it as “something akin to a mandate for second-opinion practice in order to ensure sound medical judgments.”

⁶The Court of Appeals concluded that §4–10 is saved from preemption because it is a law that “regulates insurance,” and that it does not conflict with the exclusive enforcement mechanism of §502 because §4–10’s independent review mechanism is a state-mandated contractual term of the sort that survived ERISA pre-emption in *UNUM Life Ins. Co. of America v. Ward*, 526 U. S. 358, 375–376 (1999). In the Court of Appeals’ view, the independent review provision, like any other mandatory contract term, can be enforced through an action brought under §502(a) of ERISA, 29 U. S. C. §1132(a), pursuant to state law. 230 F. 3d, at 972.

THOMAS, J., dissenting

Ante, at 22, 27. Neither approach is sound.

The Court of Appeals' approach assumes that a State may impose an alternative enforcement mechanism through mandated contract terms even though it could not otherwise impose such an enforcement mechanism on a health plan governed by ERISA. No party cites any authority for that novel proposition, and I am aware of none. Cf. *Fort Halifax Packing Co. v. Coyne*, 482 U. S. 1, 16–17 (1987) (noting that a State cannot avoid ERISA pre-emption on the ground that its regulation only mandates a benefit plan; such an approach would “permit States to circumvent ERISA’s pre-emption provision, by allowing them to require directly what they are forbidden to regulate”). To hold otherwise would be to eviscerate ERISA’s comprehensive and exclusive remedial scheme because a claim to benefits under an employee benefits plan could be determined under each State’s particular remedial devices so long as they were made contract terms. Such formalist tricks cannot be sufficient to bypass ERISA’s exclusive remedies; we should not interpret ERISA in such a way as to destroy it.

With respect to the Court’s position, Congress’ intention that §502(a) be the exclusive remedy for rights guaranteed under ERISA has informed this Court’s weighing of the pre-emption and saving clauses. While the Court has previously focused on ERISA’s *overall* enforcement mechanism and remedial scheme, see *infra*, at 6–7, the Court today ignores the “interlocking, interrelated, and interdependent” nature of that remedial scheme and announces that the relevant inquiry is whether a state regulatory scheme “provides [a] new cause of action” or authorizes a “new form of ultimate relief.” *Ante*, at 23. These newly created principles have no roots in the precedents of this Court. That §4–10 *also* effectively provides for a second opinion to better ensure sound medical practice is simply irrelevant to the question whether it, in fact,

THOMAS, J., dissenting

provides a binding mechanism for a participant or beneficiary to pursue a claim for benefits because it is on this latter basis that §4–10 is pre-empted.

The Court’s attempt to diminish §4–10’s effect by characterizing it as one where “the reviewer’s determination would *presumably* replace that of the HMO,” *ante*, at 23 (emphasis added), is puzzling given that the statute makes such a determination conclusive and the Court of Appeals treated it as a binding adjudication. For these same reasons, it is troubling that the Court views the review under §4–10 as nothing more than a practice “of obtaining a second [medical] opinion.” *Ante*, at 27. The independent reviewer may, like most arbitrators, possess special expertise or knowledge in the area subject to arbitration. But while a second medical opinion is nothing more than that—an opinion—a determination under §4–10 is a conclusive determination with respect to the award of benefits. And the Court’s reference to *Pegram v. Herdrich*, 530 U. S. 211 (2000), as support for its Alice in Wonderland-like claim that the §4–10 proceeding is “far removed from any notion of an enforcement scheme,” *ante*, at 27, is equally perplexing, given that the treatment is long over and the issue presented is purely an eligibility decision with respect to reimbursement.⁷

⁷I also disagree with the Court’s suggestion that, following *Pegram v. Herdrich*, 530 U. S. 211 (2000), HMOs are exempted from ERISA whenever a coverage or reimbursement decision relies in any respect on medical judgment. *Ante*, at 26, 30, n. 17. *Pegram* decided the limited question whether relief was available under §1109 for claims of fiduciary breach against HMOs based on its physicians’ medical decisions. Quite sensibly, in my view, that question was answered in the negative because otherwise, “for all practical purposes, every claim of fiduciary breach by an HMO physician making a mixed decision would boil down to a malpractice claim, and the fiduciary standard would be nothing but the malpractice standard traditionally applied in actions against physicians.” 530 U. S., at 235.

THOMAS, J., dissenting

As we held in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U. S. 724 (1985), a State may, of course, require that employee health plans provide certain substantive benefits. See *id.*, at 746 (holding that a state law mandating mental health benefits was not within ERISA's pre-emptive reach). Indeed, were a State to require that insurance companies provide all "medically necessary care" or even that it must provide a second opinion before denying benefits, I have little doubt that such *substantive* requirements would withstand ERISA's pre-emptive force. But recourse to those benefits, like all others, could be sought only through an action under §502 and not, as is the case here, through an arbitration-like remedial device. Section 4–10 does not, in any event, purport to extend a new substantive benefit. Rather, it merely sets up a procedure to conclusively determine whether the HMO's decision to deny benefits was correct when the parties disagree, a task that lies within the exclusive province of the courts through an action under §502(a).

By contrast, a state law regulating insurance that merely affects whether a plan participant or beneficiary may *pursue* the remedies available under ERISA's remedial scheme, such as California's notice-prejudice rule, is not pre-empted because it has nothing to do with §502(a)'s exclusive enforcement scheme. In *UNUM Life Ins. Co. of America v. Ward*, 526 U. S. 358 (1999), the Court evaluated California's so-called notice-prejudice rule, which provides that an insurer cannot avoid liability in cases where a claim is not filed in a timely fashion absent proof that the insurer was actually prejudiced because of the delay. In holding that it was not pre-empted, the Court did not suggest that this rule provided a substantive plan term. The Court expressly declined to address the Solicitor General's argument that the saving clause saves even state law "conferring causes of action or affecting remedies that regulate insurance." See *id.*, at 376–377, n. 7 (inter-

THOMAS, J., dissenting

nal quotation marks omitted). While a law may “effectively creat[e] a mandatory contract term,” *id.*, at 374 (internal quotation marks omitted), and even provide the rule of decision with respect to whether a claim is *out of time*, and thus whether benefits will ultimately be received, such laws do not create an *alternative enforcement mechanism* with respect to recovery of plan benefits. They merely allow the participant to proceed via ERISA’s enforcement scheme. To my mind, neither *Metropolitan Life* nor *UNUM* addresses, let alone purports to answer, the question before us today.

* * *

Section 4–10 constitutes an arbitral-like state remedy through which plan members may seek to resolve conclusively a disputed right to benefits. Some 40 other States have similar laws, though these vary as to applicability, procedures, standards, deadlines, and consequences of independent review. See Brief for Respondent State of Illinois 12, n. 4 (citing state independent review statutes); see also Kaiser Family Foundation, K. Politz, J. Crowley, K. Lucia, & E. Bangit, *Assessing State External Review Programs and the Effects of Pending Federal Patients’ Rights Legislation* (May 2002) (comparing state program features). Allowing disparate state laws that provide inconsistent external review requirements to govern a participant’s or beneficiary’s claim to benefits under an employee benefit plan is wholly destructive of Congress’ expressly stated goal of uniformity in this area. Moreover, it is inimical to a scheme for furthering and protecting the “careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans,” given that the development of a federal common law under

THOMAS, J., dissenting

ERISA-regulated plans has consistently been deemed central to that balance.⁸ *Pilot Life*, 481 U. S., at 54, 56. While it is true that disuniformity is the inevitable result of the Congressional decision to save local insurance regulation, this does not answer the altogether different question before the Court today, which is whether a state law “regulating insurance” nonetheless provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA’s remedial scheme. See, e.g., *id.*, at 54 (citing *Russell*, 473 U. S., at 146); *Harris Trust*, 510 U. S., at 99 (citing *Silkwood*, 464 U. S., at 248). If it does, the exclusivity and uniformity of ERISA’s enforcement scheme must remain paramount and the state law is pre-empted in accordance with ordinary principles of conflict pre-emption.⁹

⁸The Court suggests that a state law’s impact on cost is not relevant after *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U. S. 645, 662 (1995), which holds that a state law providing for surcharges on hospital rates did not, based solely on their indirect economic effect, “bear the requisite ‘connection with’ ERISA plans to trigger pre-emption.” But *Travelers* addressed only the question whether a state law “relates to” an ERISA plan so as to fall within §514(a)’s broad preemptive scope in the first place and is not relevant to the inquiry here. The Court holds that “[i]t is beyond serious dispute,” *ante*, at 7–8, that §4–10 does “relate to” an ERISA plan; §4–10’s economic effects are necessarily relevant to the extent that they upset the object of §1132(a). See *Ingersoll-Rand Co. v. McClendon*, 498 U. S. 133, 142 (1990) (“Section 514(a) was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government. Otherwise, the inefficiencies created could work to the detriment of plan beneficiaries”).

⁹The Court isolates the “plan” from the HMO and then concludes that the independent review provision “does not threaten the object of 29 U. S. C. §1132” because it does not affect the plan, but only the HMO. *Ante*, at 24, n. 11. To my knowledge such a distinction is novel. Cf. *Pegram*, 530 U. S., at 223 (recognizing that the agreement between

THOMAS, J., dissenting

For the reasons noted by the Court, independent review provisions may sound very appealing. Efforts to expand the variety of remedies available to aggrieved beneficiaries beyond those set forth in ERISA are obviously designed to increase the chances that patients will be able to receive treatments they desire, and most of us are naturally sympathetic to those suffering from illness who seek further options. Nevertheless, the Court would do well to remember that no employer is required to provide any health benefit plan under ERISA and that the entire advent of managed care, and the genesis of HMOs, stemmed from spiraling health costs. To the extent that independent review provisions such as §4–10 make it more likely that HMOs will have to subsidize beneficiaries' treatments of choice, they undermine the ability of HMOs to control costs, which, in turn, undermines the ability of employers to provide health care coverage for employees.

As a consequence, independent review provisions could create a disincentive to the formation of employee health benefit plans, a problem that Congress addressed by making ERISA's remedial scheme exclusive and uniform. While it may well be the case that the advantages of allowing States to implement independent review requirements as a supplement to the remedies currently provided under ERISA outweigh this drawback, this is a judgment that, pursuant to ERISA, must be made by Congress. I respectfully dissent.

an HMO and an employer may provide elements of a plan by setting out the rules under which care is provided). Its application is particularly novel here, where the Court appears to view the HMO as the plan administrator, leaving one to wonder how the myriad state independent review procedures can help but have an impact on plan administration. *Ante*, at 5–6, n. 3.