No. 00-

IN THE

# Supreme Court of the United States

JIMMY WALLACE MCNEIL,
as Independent Executor and Representative of the Estate of Michael Jay McNeil,

*Petitioner,*

v.

TIME INSURANCE COMPANY,

*Respondent.*

*On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit*

## PETITION FOR WRIT OF CERTIORARI

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## QUESTIONS PRESENTED

1. Whether Title III of the Americans with Disabilities Act, 12 U.S.C. § 12182, applies to discriminatory policy terms limiting insurance coverage sold by public accommodations?

2. Whether ERISA applies to and preempts petitioner's claims based on state-law duties otherwise applicable to the content of all health insurance sold in Texas and in this case sold in a context having no connection with the interstate labor market?

## PARTIES TO THE PROCEEDINGS BELOW

Plaintiff-appellant below, and petitioner in this Court, is Jimmy Wallace McNeil, as Independent Executor and Representative of the Estate of Michael Jay McNeil.

Also appearing as plaintiffs below were Michael Jay McNeil and Jimmy Wallace McNeil in his individual capacity as father of the decedent. Michael Jay McNeil is deceased and Jimmy Wallace McNeil does not appear in his individual capacity before this Court.

Defendant-appellee below, and respondent in this Court, is Time Insurance Company.

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## PETITION FOR WRIT OF CERTIORARI

Petitioner McNeil respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit.

Petitioner is the father and executor of the estate of decedent Dr. Michael Jay McNeil. In September 1994, Dr. McNeil was diagnosed with AIDS and was admitted to the hospital for treatment of pneumonia. Dr. McNeil died on March 1, 1995. Respondent Time Insurance Company (Time) was Dr. McNeil's health insurer. Time paid the first $10,000 of insurance claims submitted by Dr. McNeil but, based on a policy limit applicable to persons disabled with AIDS, denied coverage for over $400,000 of subsequent medical expenses. This petition involves whether such a

limitation violates the Americans with Disabilities Act (ADA) and whether state law barring such discrimination in insurance is preempted by ERISA.

## OPINIONS BELOW

This case was originally brought in Texas state court alleging various state-law claims based on discrimination in the provision of insurance coverage. Respondent Time removed the case to federal court based on alleged ERISA preemption, the Complaint was amended thrice to include certain federal claims, and eventually the district court granted motions for summary judgment and dismissal in favor of Time.

The district court's decision granting Time summary judgment on McNeil's claim under Title III of the ADA is unpublished and is reproduced as Appendix B (pages B1-B8). The district court's denial of reconsideration of that decision is unpublished and is reproduced as Appendix C (pages C1-C2). The district court's decision granting Time summary judgment on several state-insurance-law claims is unpublished, though electronically available at 1997 WL 182274, and is reproduced as Appendix D (pages D1-D11). The district court's denial of reconsideration of that decision is unpublished, though electronically available at 1997 WL 340952, and is reproduced as Appendix E (pages E1-E3). The district court's decision finding all of McNeil's state-law claims preempted by ERISA is published at 977 F. Supp. 424 and is reproduced as Appendix F (pages F1-F13). The district court's order dismissing all of McNeil's claims except those brought under ERISA is unpublished and is reproduced as Appendix G (page G1). The district court's denial of reconsideration on the ERISA issues is unpublished and is reproduced as Appendix H (page H1). The district court's order granting Time summary judgment on state-law claims relating to the failure to follow sound actuarial principles is unpublished and is reproduced as Appendix *I* (page *I*1). The district court's order dismissing the remaining ERISA claims

and entering final judgment is unpublished and is reproduced as Appendix J (pages J1-J2).

The Fifth Circuit's decision affirming the district court is published at 205 F.3d 179 and is reproduced as Appendix A (pages A1-A21). The Fifth Circuit's denial of petitions for rehearing and rehearing *en banc* is unpublished and is reproduced as Appendix K (pages K1-K2).

## JURISDICTION

The Fifth Circuit issued its decision in this case on February 24, 2000 and its order denying petitions for rehearing and rehearing *en banc* on June 28, 2000. On September 11, 2000, Justice Scalia extended the time for filing a petition for certiorari to and including November 27, 2000. This Court has jurisdiction to hear this petition pursuant to 28 U.S.C. § 1254(1)

## STATUTORY PROVISIONS INVOLVED

Section 302(a) of Title III of the ADA, 42 U.S.C. § 12182(a), provides:

> No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.

Section 501(c) of Title V of the ADA, 42 U.S.C. § 12201(c), provides, in relevant part:

> (c) Insurance
>
> Subchapters I through III of this chapter and title IV of this Act shall not be construed to prohibit or restrict--
>
> (1) an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or adminis-

> tering such risks that are based on or not inconsistent with State law;
>
> * * *
>
> Paragraphs (1), (2), and (3) shall not be used as a subterfuge to evade the purposes of subchapter I and III of this chapter.

The preemption provision of ERISA, 29 U.S.C. § 1144, provides, in relevant part:

> (a) Supersedure; effective date
>
> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.
>
> (b) Construction and application
>
> * * *
>
> (2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

## STATEMENT OF THE CASE[1]

Dr. McNeil was an optometrist residing and doing business in Texas. In 1994, he was half of a partnership known as Drs. Dickey & McNeil, Optometrists (the Partnership). The Partnership had only one employee – Ms. Jana Jay, the secretary. In April 1994, Dr. McNeil purchased and received from respondent Time a health insurance policy. The Partnership purchased from Time health insurance for its em-

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[1] Unless otherwise noted, the facts are taken from the Fifth Circuit and district court opinions, attached as Appendices A through J.

ployee, Ms. Jay. The premiums for Ms. Jay were paid for by the Partnership from Partnership funds, while Dr. McNeil paid the premiums for his own insurance from his personal funds. Dr. McNeil's policy provided lifetime maximum benefits of $2 million, contained no limitation on pre-existing conditions, but limited coverage for AIDS-related expenses to $10,000 during the first two years the policy was in effect. After two years the policy covered AIDS-related claims up to the full policy limit. Time's AIDS-based coverage limitation has no actuarial basis and was not based on any actual or anticipated experience.

In September 1994, Dr. McNeil was diagnosed with AIDS. Dr. McNeil was admitted to the hospital at that time, for treatment of pneumonia. Time paid the first $10,000 of insurance claims submitted by Dr. McNeil. After November 1994, however, Time denied all of Dr. McNeil's claims, asserting that the policy did not provide coverage beyond $10,000 for such claims. Over $400,000 of medical expenses for McNeil remain unpaid by Time.

Dr. McNeil died on March 1, 1995.

Before his death, Dr. McNeil sued Time in Texas state court for violations of various duties imposed by Texas law.[2] Time removed to federal court based on ERISA. Dr. McNeil's complaint was thereafter amended a number of times, ending with the Third Amended Complaint (hereinafter the Complaint). The Complaint challenged the AIDS-based limitation, claiming violations of various state-law duties governing the provision of insurance. In federal court, the Complaint also added claims for violation of the ADA and ERISA.

Through a series of decision, the district court granted summary judgment against or dismissed all of the claims in

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[2] After Dr. McNeil's death, the suit was continued by his father individually and as executor of Dr. McNeil's estate.

the Complaint. Regarding the ADA claim, the court held that Time's provision of insurance is not subject to Title III of the ADA. App. B4-B7. The court denied McNeil's motion for reconsideration. App. C2. Regarding certain state-law claims alleging violation of various insurance-specific duties, the court held that the AIDS-based limitation was enforceable, App. D4-D10, and again denied McNeil's motion for reconsideration. App. E3.

Thereafter the court tried the sole issue of whether an ERISA plan existed and dismissed all remaining state-law claims as being preempted by ERISA. App. F13, G1. The court denied McNeil's motion for reconsideration or a new trial. App. H1. The district court also entered a separate order granting Time's motion to dismiss various state-law claims that were based on Time's failure to follow sound actuarial principles. App. *I*1. On April 23, 1998 the court entered final judgment dismissing the remaining ERISA claims. App. J1-J2.

McNeil appealed.

The Fifth Circuit affirmed. Regarding McNeil's ADA claim, the court held that Title III does not "regulate the content of goods and services that are offered." App. A11. The court claimed that the "goods and services that the business offers exist *a priori* and independently from any discrimination," App. A11-A12, and that the "good" in this case is the insurance policy that Time offered to the members of the Texas Optometric Association," App. A15. There was no ADA violation, the court argued, because

> Time offered the policy to [Dr. McNeil] on the same terms as it offered the policy to other members of the association; that is, [Dr. McNeil] had non-discriminatory access to the good. Mr. McNeil has not alleged that Time interfered with his son's ability to enjoy that policy as it was written and offered to the non- disabled public.

App. A15. The court concluded that "[b]ecause Title III does not reach so far as to regulate the content of goods and services, and because it is undisputed this limitation for AIDS is part of the content of the good that Time offered, Mr. McNeil's Title III claim must fail." App. A15-A16. The Fifth Circuit refused to consider the contrary administrative construction of Title III by the Department of Justice, App. A11 n.8, and failed even to mention the unambiguous legislative history demonstrating that Congress understood and intended Title III to cover the content of insurance policies and provided a limited safe-harbor to that coverage.[3]

Regarding various of the state-law claims, the Fifth Circuit held that they were preempted by ERISA. The court began by holding that the insurance policy constituted an ERISA plan notwithstanding that Dr. McNeil paid his own premiums for his insurance, App. A17, and notwithstanding that the Partnership did nothing to "administer" the supposed plan, but rather merely paid the insurance premiums for Ms. Jay, the secretary, App. A19. The court also rejected the argument that ERISA was inapplicable because the supposed plan had no connection to any interstate labor or employment. Without analyzing the language of ERISA, the court asserted that because the Partnership purchased some glasses from

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[3] The court also held, App. A5, A7-A8, that Time did not violate part of the state insurance code providing that an insurer "may not * * * limit the amount, extent, or kind of coverage available to an individual * * * solely because of handicap or partial handicap, except where * * * based on sound actuarial principles or [where] related to actual or reasonably anticipated experience." Tex. Ins. Code Ann. Art. 21.21-3. Despite the policy's denial of coverage for identical treatments of identical illnesses (such as pneumonia) based exclusively on whether the insured had AIDS, the court stated that Time "was merely applying a term of the policy" and not limiting coverage "because of" handicap. App. A8. This confusion derives from the same error applied to the ADA claim, is thus bound up in the federal error, and, along with other state-law errors, would need to be revisited (or referred to the state courts) on remand once the ADA and ERISA errors were corrected.

other states and because the insurer was from out of state, the supposed plan fell within ERISA's jurisdictional ambit. App. A19.

Having found an ERISA plan, the court then found preemption of McNeil's state claims because such claims related to the right to receive benefits under the supposed plan. App. A21. The court dismissed the argument that the preemption inquiry "has been fundamentally altered by the Supreme Court's decision in *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co*., 514 U.S. 645 * * * (1995)," with the *non sequitur* that the "method of analysis we use today was well established before that decision, and it continues to be used today." App. A20 n.20 (comparing Fifth Circuit cases before and after *Travelers*). The court also rejected, without analysis, the argument that petitioner's state-law claims, based on duties created by Texas insurance law, were saved from preemption by ERISA's insurance savings clause, 29 U.S.C. § 1144(b)(2)(A), which provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance." App. A21.

McNeil petitioned for rehearing and rehearing *en banc*. After three months, the Fifth Circuit denied those petitions without explanation. App. K1.

This petition for certiorari followed.

## REASONS FOR GRANTING THE WRIT

Certiorari should be granted because the Fifth Circuit's holdings limiting the scope and protection of the ADA and expanding the scope and coverage of ERISA and ERISA preemption conflict with decisions from other circuits, conflict with decisions of this Court, and present important national issues that should be addressed by this Court.

## I. THE FIFTH CIRCUIT'S RESTRICTIVE INTERPRETATION OF THE ADA CONFLICTS WITH THE DECISIONS OF OTHER COURTS AND IS WRONG.

Title III of the ADA states, in relevant part, that "[n]o individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation." 42 U.S.C. §12182(a). Under the plain language, administrative construction, and legislative history of the ADA, an insurance office is a place of public accommodation, insurance coverage is a good, service, privilege or advantage of that place of public accommodation, and persons may be denied the full and equal enjoyment of insurance coverage by terms in an insurance policy that, without any sound actuarial basis, expressly discriminate in the amount of coverage available based on whether the insured has a specified disability.

### A. There Is a Circuit Split Regarding Title III's Application to Insurance.

The decision below that Title III does not apply to discriminatory policy terms restricting insurance coverage conflicts with *Pallozzi* v. *Allstate Life Ins. Co.*, 198 F.3d 28, 32 (CA2 2000) (as amended), where the Second Circuit held that the text of Title III makes it "clear" that it was "intended by Congress to apply to insurance underwriting." Indeed, the Fifth Circuit below expressly rejected the Second Circuit's holding in *Pallozzi*. App. A14-15 ("the Second Circuit read Title III to regulate content as well as access, a reading that we ultimately find unpersuasive").

While diverging from the Second Circuit, the court below reached the same result as the Third, Sixth, Seventh, and Ninth Circuits, each of which has refused to apply Title III to the substance of insurance policies. App. A14 & nn.12-13; see *Ford* v. *Schering-Plough Corp.*, 145 F.3d 601, 614 (CA3

1998) (insurance policy limiting coverage for mental disabilities did not violate Title III), *cert. denied*, 525 U.S. 1093 (1999); *Parker* v. *Metropolitan Life Ins. Co.*, 121 F.3d 106, 1012 (CA6 1997) (*en banc*) ("Title III does not govern the content of a LTD policy"), *cert. denied*, 522 U.S. 1084 (1998); *Doe* v. *Mutual of Omaha Ins. Co.*, 179 F.3d 557, 560 (CA7 1999) ("the content of goods or services offered by a place of public accommodation is not regulated"), *cert. denied*, 120 S. Ct. 845 (2000); *Weyer* v. *Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1115 (CA9 2000) ("Title III does not address the terms of the policies that [a carrier] sells."); see also *Lenox v. Healthwise of Kentucky, Ltd.*, 149 F.3d 453, 457 (CA6 1998) (Title III does not reach disparities in health insurance coverage and requires only removal of physical barriers to access).

In addition to the conflict between the circuits, numerous district courts have taken sides in the split. See *Wai* v. *Allstate Ins. Co.*, 75 F. Supp.2d 1, 8 (D.D.C. 1999) ("Title III's protections extend beyond physical access to insurance offices"); *Boots* v. *Northwestern Mut. Life Ins. Co.*, 77 F. Supp.2d 211, 215-216 (D.N.H. 1999) (Title III regulates "substance of an insurance policy"); *Conners* v. *Maine Medical Center*, 42 F. Supp.2d 34, 46 (D.Me. 1999) ("under the plain language of Title III, the Act would extend to the substance or contents of an insurance policy"); *Doukas* v. *Metropolitan Life Ins. Co.,* 950 F. Supp. 422, 425 (D.N.H. 1996) ("plain language of Title III" covers the "substance or contents of an insurance policy"). Furthermore, even in some circuits reaching the same results as the decision below, previous – and better-reasoned – district court opinions in those circuits had agreed with petitioner's construction of Title III. See *Doe* v. *Mutual of Omaha Ins. Co.,* 999 F. Supp. 1188, 1194 (N.D.Ill. 1998) ("Insurance offices are places of public accommodation and, as such, may not discriminate on the basis of disability in the sale of insurance contracts or in the terms or conditions of the insurance contracts they offer."),

*rev'd*, 179 F.3d 557, 560 (CA7 1999), *cert. denied*, 120 S. Ct. 845 (2000); *Cloutier* v. *Prudential Ins. Co. of America,* 964 F. Supp. 299, 302 (N.D.Cal. 1997) ("where underwriting lacks such [an actuarial or state-law] basis, it fails to comply with the ADA"); *Attar* v. *Unum Life Ins. Co. of America,* 1998 WL 574885, *2 (N.D.Tex. 1998) ("It seems plain to this Court that the Plaintiffs' insurance policy is a 'service' of Defendants' 'insurance office,' and thus falls squarely within the purview of Title III. … The statutory language draws no distinction between the content of a good, service, or privilege on the one hand, and access to a good, service, or privilege on the other."); *Chabner* v. *United of Omaha Life Ins. Co.,* 994 F. Supp. 1185, 1192 (N.D. Cal. 1998) ("the plain language of the statute supports a finding that insurance underwriting practices are covered by Title III"), *aff'd on other grounds, rev'd on issue in question*, 225 F.3d 1042 (CA9 2000).

This conflict among both the circuits and the district courts calls for resolution by this Court. The need for review in this case is magnified by the circumstance that the decision below is fundamentally wrong and thereby exempts from a federal remedial statute an entire class of public accommodations discriminating against the disabled in the provision of insurance coverage.

### B. The Exclusion of Discriminatory Insurance Terms from Coverage under Title III Is Erroneous.

The fundamental conceptual error of the Fifth Circuit was in conflating the terms of an insurance policy with the good or service of insurance coverage. By treating the policy "as it was written" as the good or service in question, App. A15, the court mistakenly concluded that the disability-based limitation was somehow inherent to the good or service and thus could not be challenged without altering the good or service provided. The real issue here is what constitutes the baseline product. The court merely assumed that the good or service was whatever the insurance company said it was. But the

good or service in question is insurance coverage generally, and the only limitations inherent in that good are those that are supported by sound actuarial principles and state insurance law. The facile notion that *any* policy term becomes inherent to the good or service and thus cannot be discriminatory would justify all manner of discrimination so long as it was written into the policy. Of course, this Court under the Rehabilitation Act has rejected just such an approach to discrimination in the context of non-tangible goods or services. *Alexander* v. *Choate*, 469 U.S. 287, 289 (1985), addressed a benefit limitation and recognized just this type of discrimination, noting that anti-discrimination legislation "'can obviously be emptied of meaning if every discriminatory policy is "collapsed" into one's definition of what is the relevant benefit'" and that "[t]he benefit itself, of course, cannot be defined in a way that effectively denies otherwise qualified handicapped individuals the meaningful access to which they are entitled * * *." 469 U.S. at 301 n.21 (citation omitted). The Fifth Circuit decision thus effectively conflicts with this Court's precedent under the Rehabilitation Act.

The Fifth Circuit's logic would countenance a limitation on payments if the recipient is or becomes blind, deaf, or crippled, and would even lead to the conclusion that incorporated limitations on payments to blacks, Catholics, or Jews are merely part of the policy, and hence the "good," offered equally to everyone. But the notion that one can merely redefine a good or service in discriminatory terms failed in the civil rights context (serving meals could not be redefined as serving meals to whites only) and is equally bankrupt when disinterred in support of discrimination against the disabled.

Furthermore, the Fifth Circuit is mistaken in its claim that the ADA does not require alterations in the substance of goods, services, or benefits. A public accommodation *is required* to make reasonable modifications to policies, practices, or procedures, or take other steps to prevent differential treatment of the disabled, unless the entity can prove that such

changes would "fundamentally alter the nature" of the entity's goods, services, or privileges. 42 U.S.C. §12182 (b)(2)(A)(ii) & (iii). The court's claim that §12182(b)(2)(A)(ii) has "nothing to do with the content of a good or service, only to non-physical access to those goods and services," App. A11 n.9, ignores subsection (A)(iii), which refers to altering goods or services, but provides a defense to such alteration if it would be "fundamental."[4]

In addition to the core conceptual error of the decision below, the Fifth Circuit also erred in the basic nuts-and-bolts task of statutory construction. The plain language of Title III covers discrimination by an insurance company in the provision of insurance coverage. Insurance coverage is among the "goods, services, facilities, privileges, advantages, or accommodations of [a] place of public accommodation" of which the disabled are guaranteed "full and equal enjoyment." 42 U.S.C. §12182(a).

The applicability of this straightforward language to the substance of insurance is confirmed by § 501(c) of the ADA, 42 U.S.C. §12201(c), a "safe harbor" that provides, in relevant part, that the ADA "shall not be construed to prohibit or restrict-- (1) an insurer * * * from underwriting risks, classifying risks, or administering such risks *that are based on or not inconsistent with State law*." (Emphasis added.) Underwriting and classifying risks are activities involving the definition or content of the insurance policy itself. There is no point to such a safe harbor if the ADA does not otherwise apply to the terms and conditions of insurance contracts. Cf. *Astoria Fed. Sav. and Loan Ass'n v. Solimino*, 501 U.S. 104, 112 (1991) ("we construe statutes, where possible, so as to avoid rendering superfluous any parts thereof").

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[4] In insurance, *fundamental* alteration of the product can only be measured according to sound actuarial principles. Where there is no actuarial basis for a restriction to begin with, the removal of that restriction would not be a "fundamental" alteration in the insurance product.

The Fifth Circuit argued that the "presence of this [safe harbor] provision merely suggests that insurers saw the potential for the construction that Mr. McNeil proposes and obtained special wording from Congress that partially exempted them." App. A12 n.10. The court also claimed that "it would be oxymoronic to interpret the 'safe harbor' for the insurance industry as ensuring more regulation of that same industry." *Id.* The only thing oxymoronic is the notion of a "partial[]" exemption from a problem that supposedly does not exist. The safe harbor does not result in greater regulation of insurance, it merely creates parity because all other public accommodations are required to make reasonable changes to their goods, services or benefits so long as those changes do not fundamentally alter those items. The safe harbor translates this basic ADA requirement into insurance language by defining fundamental alterations according to actuarial principles.

In addition to the plain language of the statute, both the administrative interpretation of Title III and the legislative history overwhelmingly confirm that discriminatory terms in insurance policies are subject to ADA scrutiny. See DOJ, Title III Technical Assistance Manual: Covering Public Accommodations and Commercial Facilities, §III-3.11000, at 19 (Nov.1993) ("Insurance offices are places of public accommodation and, as such, may not discriminate on the basis of disability in the sale of insurance contracts *or in the terms or conditions of the insurance contracts they offer*.") (emphasis added)[5]; 28 C.F.R. Part 36, App. B, at 601 (July 1, 1998 ed.) (ADA "reach[es] insurance practices by prohibiting differential treatment of individuals with disabilities in insurance

[5] As this Court has recently reaffirmed, DOJ is "the agency directed by Congress to issue implementing regulations, *see* 42 U.S.C. §12186(b), to render technical assistance explaining the responsibilities of covered individuals and institutions, §12206(c), and to enforce Title III in court, §12188(b)." *Bragdon* v. *Abbott,* 524 U.S. 624, 646 (1998). As such, the "Department's views are entitled to deference." *Id.*

offered by public accommodations unless the differences are justified"); H.R.Rep. No. 485(II), 101st Cong., 2d Sess., at 137 reprinted in 1990 U.S.C.C.A.N. 267, 419 ("Under the ADA, a person with a disability cannot be denied insurance *or be subject to different terms or conditions of insurance based on disability alone*, if the disability does not pose increased risks.") (emphasis added).

Time's AIDS-based limitation plainly discriminates. That Time gave non-disabled persons the same policy incorporating the AIDS limitation proves only that its discrimination was fully institutionalized. *See Alexander*, 469 U.S. at 301 n.21. An insured without AIDS would receive $2 million coverage for pneumonia or brain cancer. Dr. McNeil was limited to $10,000 in coverage for the identical conditions and treatments. Dr. McNeil was not denied coverage *for* AIDS; he was denied otherwise-available coverage *because he had AIDS*. That is discrimination, and it is forbidden by the ADA.

Because the decision below conflicts with a decision of the Second Circuit and with the decisions of numerous district courts, and because the decision below is riddled with error, this Court should grant the petition for certiorari.

## II. THE DECISION BELOW CONFLICTS WITH DECISIONS FROM THIS COURT AND NUMEROUS OTHER COURTS RECOGNIZING THE MUCH-NARROWED SCOPE OF ERISA PREEMPTION.

In a misapprehension of recent developments in ERISA law, the Fifth Circuit rejected the notion that ERISA preemption analysis "has been fundamentally altered by the Supreme Court's decision in *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co*., 514 U.S. 645 * * * (1995)." App. A20 n.20. It instead compared its own cases before and after *Travelers* and held that "method of analysis we use today was well established before that decision, and it continues to be used today." App. A20 n.20. But that fact that the Fifth Circuit has frequently fallen into error

does not validate its earlier misreading of the law, and in fact highlights the need for this Court to step in.

Whether state law "relate[s] to" an ERISA plan requires an extensive inquiry into both the nature of the law and the purposes of ERISA. The panel did none of that, but instead relied upon a simplistic and overbroad preemption formulation from a bygone era. In *Travelers*, this Court reversed a long trend of expansive ERISA preemption, and reemphasized the "starting presumption that Congress does not intend to supplant state law. * * * [W]e have worked on the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress. 514 U.S. at 654-55 (citations and quotation marks omitted).

The conclusion that *Travelers* changed nothing is wrong and conflicts with numerous decisions from this Court and from other circuits now reading ERISA preemption narrowly. *See, e.g., De Buono* v. *NYSA-ILA Medical and Clinical Servs. Fund,* 520 U.S. 806, 812-16 (1997) (rejecting court of appeals' "expansive and literal interpretation" and criticizing court for its "failing to give proper weight to *Travelers'* rejection of a strictly literal reading of" the ERISA preemption language); *California Div. of Labor Standards Enforcement* v. *Dillingham Construction, N.A., Inc.,* 519 U.S. 316, 325 (1997) (noting *Travelers'* rejection of "uncritical literalism" in interpreting the ERISA preemption language); *Abdu-Brisson* v. *Delta Air Lines, Inc.,* 128 F.3d 77, 82 (CA2 1997) ("The Supreme Court in addressing the preemption provisions of ERISA has been limiting preemption's reach."); *Coyne & Delany Co.* v. *Selman*, 98 F.3d 1457, 1466 (CA4 1996) (describing the "recent (and narrowing) interpretation of the scope of ERISA preemption in" *Travelers*); *Morstein* v. *National Ins. Servs., Inc.*, 93 F.3d 715, 721 (CA11 1996) (*en banc*) (characterizing *Travelers* as having "essentially turned the tide on the expansion of the preemption doctrine"), *cert. denied sub nom. Shaw Agency* v. *Morstein*, 519 U.S. 1092

(1997); *Egelhoff* v. *Egelhoff*, 989 P.2d 80, 86, 87 (Wash. 1999) (*en banc*) ("Recently, however, ERISA preemption analysis by the United States Supreme Court, as evidenced by [*Travelers*] has signaled a significant retreat from its expansive reading of § 1144(a)."; "effect of *Travelers* and its progeny favors a retreat from the expansive preemption doctrine this Court has previously followed"), *cert. granted*, 120 S. Ct. 2687 (2000) (No. 99-1529).

At a minimum, *Travelers* and its progeny set up a methodology for evaluating the preemptive effect of ERISA – a methodology that the panel inexplicably ignored. Each of the *Travelers* factors demonstrates that none of the state law relied upon by McNeil "relates" to an ERISA plan in the specific way that statutory term is now interpreted.

The laws invoked by McNeil go to the substance of insurance generally – whether or not purchased by an ERISA plan – and not to the procedures, administration, funding or anything else covered by ERISA. Here, Texas simply removed a particular health-care product – unfairly discriminatory insurance policies – from the market, making them unavailable for purchase by an ERISA plan or anybody else. That is no different than numerous other State actions restricting the products and services – marijuana or prostitution, for example – available for purchase regardless of whether an ERISA plan might wish to include such "benefits." Such health-care legislation was not meant to be preempted by ERISA. See *Boyle* v. *Anderson*, 68 F.3d 1093, 1109 (CA8 1995) ("*Travelers* and the other precedents cited in this litigation compel this court not to preempt a state's effort to serve as a 'laboratory of democracy' in the realm of health care."), *cert. denied*, 516 U.S. 1173 (1996).

In every way that counts, this case is like *Travelers*. Texas law "does not bind ERISA plans to anything," *Dillingham*, 519 U.S. at 332, as such plans are not obliged to provide their benefits through the purchase of insurance, but may do so "otherwise," 42 U.S.C. §1002(1). Insurance is not the

"plan" itself, but merely *one means* of providing the benefits under a plan. *See* 29 U.S.C. §1002(1). An ERISA plan thus may exclude whatever coverage it likes by self-insuring. The effect of that choice "is merely to provide some measure of economic incentive" to choose the non-discriminatory insurance option, *Dillingham*, 519 U.S. at 332.

The Fifth Circuit's error in preemption analysis is compounded by three related further errors. First, ERISA does not preempt state laws that "regulate[] insurance," and thus satisfy ERISA's insurance savings clause, 29 U.S.C. § 1144(b)(2)(A), even when such laws "relate to" an ERISA plan. The court offered only the unadorned conclusion that "none of the remaining state law claims satisfies these requirements. Thus, these state laws do not fall within the savings clause." App. A21. That conclusion was wrong and conflicts with *Unum Life Insurance Co. of America* v. *Ward,* 526 U.S. 358 (1999).

In *Unum*, this Court applied a more inclusive, "commonsense" approach to whether a law regulates insurance, and specifically rejected the more restrictive assertion that a law "must satisfy all three McCarran-Ferguson factors in order to 'regulate insurance.'" 526 U.S. at 373. The Court found that a rule met the common sense test if it "is directed specifically at the insurance industry and is applicable only to insurance contracts." *Id*. at 368. The Court then proceeded to hold that a court-made notice-prejudice rule applicable to insurance contracts came within the savings clause despite its similarity to general common-law contract rules requiring prejudice before imposing forfeiture. The "notice- prejudice rule is distinctive most notably because it is a rule firmly applied to insurance contracts, not a general principle guiding a court's discretion in a range of matters." 526 U.S. at 371. The approach and conclusion in *Unum* constitute an emphatic statement that ERISA's savings clause is more toothsome than some lower courts had previously held.

In this case, the *Unum* approach confirms that the state insurance code provisions and insurance-specific common-law doctrines are saved from preemption. That such law may bear some similarity to more general common-law principles is irrelevant because in Texas there are special and more stringent rules for insurance contracts and under insurance statutes that qualify as law regulating insurance. The myriad insurance code provisions self-evidently regulate insurance, and McNeil's various common-law claims go to the substantive terms of the insurance contract and are all based on duties created by insurance code provisions and insurance-specific cases. As this Court has held, "regulation regarding the substantive terms of insurance contracts falls squarely within the savings clause as laws 'which regulate insurance.'" *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 742-43 (1985); see also *Pilot Life Ins. Co.* v. *Dedeaux,* 481 U.S. 41, 48 n.1 (1987) ("Decisional law that 'regulates insurance' may fall under the saving clause."); *Hansen* v. *Continental Ins. Co.,* 940 F.2d 971, 982 (CA5 1991) ("In contracts of insurance generally, ambiguities are resolved against the drafter."); *Howard* v. *INA County Mut. Ins. Co.,* 933 S.W.2d 212, 219 (Tex.App.—Dallas 1996) ("Statutes bearing … defining the rights and liabilities of parties to insurance contracts become a part of the contract."). Each of the laws relied upon by McNeil "focuses on the insurance industry," 526 U.S. at 375 n.5, and each is saved.

Second, the Fifth Circuit essentially ignored the underlying purposes of ERISA and extended its jurisdictional reach to supposed "plans" having nothing to do with interstate labor markets or interstate employers. Not all entities that purchase insurance have a sufficient nexus to interstate commerce to fall under ERISA. *Meredith* v. *Time Ins. Co.*, 980 F.2d 352, 354 n.8 (CA5 1993). It is undisputed that the Partnership did not treat patients from out of state. The only connection to commerce was the Partnership's purchase of some glasses that came from out of state. That bare connection is insuffi-

cient to trigger ERISA. It is one thing to say that such sales could support specific jurisdiction over the sale of the glasses themselves, but it is too great a stretch to suggest such limited sales create general federal jurisdiction over everything done by the Partnership. ERISA coverage "is defined by the labor component of the business rather than its use of the instrumentalities of interstate commerce * * * or other criteria of interstate effect." *Sheffield* v. *Allstate Life Ins. Co.,* 756 F. Supp. 309, 310 (S.D.Tex. 1991).

The Partnership had only a single employee in Texas, and the Partnership's labor relations could have had no conceivable relation to interstate commerce. "ERISA addresses those employers whose labor disputes could affect interstate commerce." *Id.* And as for McNeil, it is simply silly to suggest that *he* could have a labor dispute with himself over the insurance he purchased for himself. As to anything involving McNeil's insurance, there is not even a scintilla of ERISA-relevant connection to commerce. This Court's recent precedents suggest that where there is doubt about the *relevant* commerce connection of an activity, a statute's jurisdictional reach should be read narrowly so as not to press the bounds of congressional power. See *Jones* v. *United States*, 529 U.S. 848 (2000) (narrowly construing reach of federal arson statute).

A narrow construction of ERISA's jurisdictional language makes ample sense in this case and fits hand-in-glove with the narrowing scope of ERISA preemption. If the mere purchase of some goods from out of state unbridled commerce authority over all aspects of a business, then nobody is immune: all businesses buy something – paper clips, toilet paper, or light bulbs – from out of state. The commerce power "may not be extended so as to embrace effects upon interstate commerce so indirect and remote." *NLRB* v. *Jones & Laughlin Steel Corp.,* 301 U.S. 1, 37 (1937); see *United States* v. *Lopez*, 514 U.S. 549, 567 (1995) (declining "to pile inference upon inference in a manner that would bid fair to convert congressional

authority under the Commerce Clause to a general police power of the sort retained by the States"). The Partnership's purchase of a minor quantity of glasses made outside of Texas lacks a "labor" connection and does not create federal authority under the commerce clause and ERISA.

Third, the Fifth Circuit employed an overly broad definition of an ERISA plan, and consequently extended ERISA coverage, and ERISA preemption, into areas in which it makes no sense. Thus, in this case, regardless of what the Partnership may have done for Ms. Jay, Dr. McNeil paid for his own insurance and was dealing with an insurance company selling policies otherwise subject to state insurance regulation, not an employee benefit administrator or anyone else that ERISA might wish to regulate. There is no administration of a fund, no interstate conflict to be avoided, and nothing at all different from the relationship between any individual insured and an insurance company. And even looking to the Partnership's relationship with its sole employee, beyond purchasing Ms. Jay's insurance, the Partnership did *nothing* that might establish an ERISA plan. It did not hire an administrator, it did not engage in any administrative activity itself, and it did not take any steps required under ERISA. To find that the Partnership administered a plan even as to Ms. Jay requires far more. *See generally, Fort Halifax Packing Co.* v. *Coyne,* 482 U.S. 1, 6-13 (1987) (discussing complexities of ongoing administrative activities that were the concern of ERISA, and distinguishing ministerial activity such as writing a check).

These three compounding errors affect the preemption issue by expanding potential ERISA preemption into areas in which it makes no sense, by causing ERISA to displace far more state law than Congress likely intended, and by minimizing the degree of federal interest at stake under the *Travelers* analysis. While each error standing alone is enough to warrant reversal, the combined effect of these errors, and their effect going forward, stand in serious conflict with this

Court's recent determinations that ERISA preemption had gotten out of hand and needed to be reigned in.

## III. THIS CASE RAISES IMPORTANT NATIONAL ISSUES THAT SHOULD BE RESOLVED BY THIS COURT.

The ADA and ERISA questions presented by this case are important national issues in that they affect vast quantities of people who purchase insurance and who have one or another form of disability. The Fifth Circuit's decision in this case affects huge population centers in Texas and Louisiana. The Third, Sixth, Seventh, and Ninth Circuits likewise cover a tremendous portion of this nation's population. Those circuits are in conflict with the approach in the Second Circuit, which likewise covers a tremendous population center as well as one of the Nation's major insurance centers (Hartford, Connecticut). The inconsistent application of the ADA between such large portions of the population calls for this Court's intervention to provide a unifying answer.

Similarly, the Fifth Circuit's apparent refusal to come in line with this Court's narrowed approach to ERISA preemption places it at odds with numerous other circuits who have recognized the change, and is an affront to the states and the state laws within the Fifth Circuit. As this Court has recognized so many times in the past, ERISA preemption is a recurring and problematic issue that warrants this Court's attention. Because the Fifth Circuit shows no sign of acknowledging the new methodology to such preemption, this Court should step in. At a minimum, this Court should hold the case pending its decision in *Egelhoff*, No. 99-1529, and then either grant, vacate, and remand in light of that case, or grant plenary review to so as to finally and definitively clarify the issue in the Fifth Circuit.

## CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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