

No. 09-38

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**In the  
Supreme Court of the United States**

HEALTH CARE SERVICE CORPORATION,

*Petitioner,*

v.

JULI A. POLLITT and MICHAEL A. NASH,

*Respondents.*

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

**BRIEF OF *AMICUS CURIAE* AETNA INC.  
IN SUPPORT OF PETITIONER**

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**INTEREST OF THE *AMICUS CURIAE***

Aetna Inc., through its operating subsidiaries (collectively “Aetna”), is one of the largest providers of health care benefits in the United States.<sup>1</sup> Aetna offers managed care plans, health savings accounts, and traditional indemnity coverage, along with dental, vision, behavioral health, and Medicare plans. Aetna offers federal employees and their dependents multiple health care plans under the Federal Employees Health Benefits Act, 5 U.S.C. §§ 8901-8914 (“FEHBA”). Aetna offers federal employees a consumer-driven/high-deductible health plan that operates in all fifty states and the District of Columbia, and comprehensive medical plans (commonly known as “HMOs”) that operate in fourteen states and the District of Columbia. In 2008, Aetna processed almost \$1.1 billion in health care benefits for covered federal employees and their dependents. In 2009, over 321,000 federal and postal employees and annuitants, plus their dependents, were enrolled in Aetna plans.

Aetna administers health benefits for federal employees and their dependents pursuant to standard form federal agency procurement contracts identical to petitioner’s procurement contract in all material respects. The Court’s decision, therefore,

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<sup>1</sup> Pursuant to Rule 37.6 of the Rules of this Court, *amicus* states that this brief was not authored in whole or in part by counsel for a party and that no person or entity, other than the *amicus curiae* and its counsel, made a monetary contribution to its preparation and submission. The written consents of the parties to the filing of this brief have been filed with the Court.

will have a significant financial and administrative impact on Aetna. Aetna, therefore, respectfully requests that the Court consider its views as to the first issue presented—whether FEHBA completely preempts state law claims challenging enrollment and health benefits decisions that are subject to the exclusively federal remedial scheme established in FEHBA.<sup>2</sup>

### **INTRODUCTION AND SUMMARY OF ARGUMENT**

At the time of removal to federal court, the complaint filed in this action attempted to assert state law claims for insurance coverage and benefits. The coverage and benefits sought in the complaint were claimed through respondent Juli Pollitt (“Ms. Pollitt”), a federal employee enrolled in a federal health benefit plan. Federal employee health care benefits were created and authorized by an act of Congress, are regulated by and contracted through the United States Office of Personnel Management (“OPM”), and provided through health benefit plan carriers (“carriers”). The tripartite relationship among federal employees, OPM, and carriers is exclusively governed by federal law. Federal law further provides the exclusive cause of action for any claim for coverage or benefits arising from that tripartite relationship. Thus, any state law claims by federal employees seeking health care coverage and benefits under a contract between

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<sup>2</sup> Aetna supports petitioner’s argument with respect to the second issue on appeal, but writes only with respect to the first issue.

OPM and a carrier are completely preempted and subject to removal to federal court.

As a matter of constitutional prerogative, Congress is invested with the exclusive authority to determine the benefits available to federal employees. Congress exercised that exclusive authority by enacting legislation authorizing health care benefits for federal employees. As part of that legislation, Congress delegated to OPM the authority to negotiate and regulate federal employee health benefit plans. Pursuant to this congressional delegation of authority, OPM adopted regulations requiring an employing federal agency to determine coverage (enrollment) and OPM to determine benefits. In order to close the loop on this three-party relationship, OPM also adopted regulations, consistent with FEHBA, mandating that carriers follow federal agency and OPM decisions with respect to coverage and benefits.

Consistent with this decision-making authority, and pursuant to the congressional delegation of authority, OPM adopted regulations establishing a detailed and reticulated scheme for federal employees to follow for resolving disputes concerning enrollment and benefits, including procedures for administrative review, available remedies, and judicial review. Indeed, the OPM regulations created an exclusive federal cause of action by allowing federal employees to seek judicial review of final coverage (enrollment) decisions made by the employing federal agency and final benefit decisions made by OPM. Based on the exclusive authority of

Congress to determine federal employee benefits, the tripartite relationship designed by Congress, the congressional delegation of authority to OPM to negotiate and regulate federal employee health benefits, and OPM's exercise of that authority, the Court should find the federal cause of action exclusive for any federal employee claiming health care coverage or benefits. The Court should further find any state law claims for coverage or benefits completely preempted.

The exclusivity of the federal cause of action is further supported by the incorporation of FEHBA and its regulations into the standard form contract between OPM and the carriers. Indeed, the FEHBA preemption provision expressly provides that “[t]he terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.” Given the incorporation of the exclusive federal remedial scheme into the OPM/carrier contracts, and the express preemption provision mandating that contract terms relating to coverage and benefits supersede state law, the Court should find complete preemption and sustain the removal to federal court.

**ARGUMENT**

A civil action filed in state court may be removed to federal court if the complaint sets forth a claim “arising under” federal law. *See* 28 U.S.C. § 1441(b). Whether a claim arises under federal law is typically determined from the “well-pleaded” allegations of the complaint. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 207 (2004). The complete preemption doctrine is an exception to the well-pleaded complaint rule. *See Beneficial Nat’l Bank v. Anderson*, 539 U.S. 1, 5 (2003). “[W]hen a federal statute wholly displaces the state-law cause of action through complete pre-emption,” the purported state law claim can be removed. *See id.* at 8. Such claims are removable because, “[w]hen the federal statute completely pre-empts the state-law cause of action, a claim which comes within the scope of that cause of action, even if pleaded in terms of state law, is in reality based on federal law.” *See id.* Indeed, the preemptive scope of federal law cannot be avoided by labeling a federal claim as a state law cause of action. *See Davila*, 542 U.S. at 214-15.

**I. RESPONDENTS' STATE LAW CLAIMS ARE COMPLETELY PREEMPTED BY FEHBA AND ITS REGULATORY SCHEME.**

**A. Congress Is Constitutionally Empowered With The Exclusive Authority To Determine The Benefits Available To Federal Employees And Delegated To OPM The Authority To Implement Necessary Regulations.**

Congress was authorized to enact FEHBA pursuant to Article I, Section 1, of the United States Constitution, granting legislative authority to Congress, and Article I, Section 8, the “Necessary and Proper” clause of the Constitution. *See* U.S. Const. art. I, § 1; § 8, cl. 18. Indeed, Congress specifically cited the Necessary and Proper Clause as the constitutional authority for the 1998 amendment to FEHBA. *See* H.R. Rep. No. 105-374, at 19 (1997).

The “Necessary and Proper” clause confers upon Congress the power “[t]o make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers, and all other Powers vested by this Constitution in the Government of the United States, or in any Department or Officer thereof.” *See* U.S. Const. art. I, § 8, cl. 18. At least since *McCulloch v. Maryland*, 17 U.S. 316 (1819), the Necessary and Proper Clause has been interpreted as authorizing Congress “to exercise its best judgment in the selection of measures to carry into execution the constitutional powers of government.” *See id.* at 420.

This Court similarly recognized that Congress, acting through the Necessary and Proper Clause, is empowered to make laws providing for the operation of the federal government. *See, e.g., United States v. Stanley*, 483 U.S. 669, 682 n.6 (1987) (acknowledging congressional authority under Necessary and Proper Clause “to make rules for the government and regulation of the Postal Service”). Similarly, courts have long recognized congressional power over the compensation and benefits available to federal employees. *See Kizas v. Webster*, 707 F.2d 524, 536 (D.C. Cir. 1983); *Puglisi v. United States*, 564 F.2d 403, 409 (Ct. Cl. 1977) (“Setting the pay of federal officers and employees is, historically and constitutionally, within Congress’s power.”).

Ordinary contract principles are inapplicable in determining federal employee compensation and benefits; the compensation and benefits available to federal employees is determined by federal statutes and regulations. *See Kizas*, 707 F.2d at 535 (rejecting claim that federal employees had vested contractual right in special hiring preference not found in federal statutes or regulations). In *Kizas*, the court explained how Title 5 of the United States Code provides the exclusive source of federal employee compensation:

Title 5 of the United States Code and its implementing regulations set forth in meticulous detail the compensation that attaches to positions in the government service. These provisions govern all

incidents of employee compensation, including basic salaries; salary increases; overtime, holiday and sick pay; life and health insurance benefits; retirement benefits; travel and subsistence allowances; and compensation for injury and unemployment.

*Kizas*, 707 F.2d at 536 (footnotes omitted).

FEHBA is part of Title 5 and “establishes a comprehensive program of health insurance for federal employees.” See *Empire HealthChoice Assurance, Inc. v. McVeigh*, 547 U.S. 677, 682 (2006). Congress enacted FEHBA to provide “a measure of protection for civilian Government employees against the high, unbudgetable, and, therefore, financially burdensome costs of medical services through a comprehensive government-wide program of insurance for Federal employees ..., the costs of which will be shared by the Government, as employer, and its employees.” H.R. Rep. No. 86-957 (1959), reprinted in 1959 U.S.C.C.A.N. 2913, 2914. Congress intended FEHBA to improve “the competitive position of the Government with respect to private enterprise in the recruitment and retention of competent civilian personnel” by providing federal employee health benefits similar to those available in the private sector. See *id.*

To implement this federal health benefit program, Congress empowered OPM to promulgate “regulations necessary to” effectuate FEHBA’s statutory requirements. See 5 U.S.C. § 8913(a); see

*also Mistretta v. United States*, 488 U.S. 361, 373-74 (1989) (upholding Congress’s authority to delegate power under broad general directives). OPM exercised its regulatory authority by promulgating extensive and comprehensive regulations. *See, e.g.*, 5 C.F.R. §§ 890.101 – 890.1308 (Federal Employees Health Benefits Program); 48 C.F.R. §§ 1601.101 – 1699.70 (Office of Personnel Management Federal Employees Health Benefits Acquisition Regulation).

The OPM regulations set forth in elaborate detail FEHBA’s administrative requirements, including the procedure for review of enrollment and benefit determinations, available causes of action, and remedies. *See* 5 C.F.R. §§ 890.104 – 890.107. These regulations have the preemptive force of federal law. *See Fid. Fed. Sav. & Loan Ass’n v. de la Cuesta*, 458 U.S. 141, 153 (1982) (“Federal regulations have no less pre-emptive effect than federal statutes.”); *see also Geier v. Am. Honda Motor Co.*, 529 U.S. 861, 872 (2000) (allowing “common-law actions that ‘actually conflict’ with federal regulations” would thwart “congressionally mandated objectives that the Constitution, through the operation of ordinary preemption principles, seeks to protect”). Moreover, since OPM was acting pursuant to a congressional delegation of authority, in an area where Congress alone had authority to act, the remedial scheme created by OPM should be deemed exclusive.

**B. The FEHBA Statutory Provisions And Related Regulations Establish A Clear Framework For Operation Of A Tripartite Contractual Relationship.**

To implement FEHBA, Congress authorized OPM to enter into federal procurement contracts with qualified “carriers” to offer health benefit plans to federal employees. *See* 5 U.S.C. § 8902(a) (power to contract). A “health benefits plan” is defined as a “group insurance policy or contract ... provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services.” *Id.* § 8901(6). A “carrier” means a voluntary association, corporation, partnership, or other nongovernmental organization ... engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts ....” *Id.* § 8901(7). OPM further established minimum standards carriers must satisfy to participate in the FEHBA program. *See* 48 C.F.R. § 1609.7001. In practice, OPM “enters into contracts with a handful of major insurance carriers.” *Empire*, 547 U.S. at 702 (Breyer, J., dissenting). The fact that Congress designed the FEHBA program with OPM entering into contracts with carriers, as opposed to individual federal employees contracting with carriers, is important, because this structure allows OPM to retain control over the federal health benefits program.

Congress not only dictated who OPM could contract with, but also specified the types of health benefit plans that carriers can offer, including

service benefit plans, indemnity benefit plans, employee organization plans, and certain comprehensive medical plans. *See* 5 U.S.C. §§ 8903, 8903a. Unlike traditional insurance arrangements regulated by state law, federal employees must select from plans approved by OPM and offered by carriers contracted with OPM. *See* 5 U.S.C. § 8905(a) (allowing federal employees to enroll in approved health benefit plans); § 8907 (requiring OPM to provide individuals with sufficient information to “exercise an informed choice among the types of plans” offered).

Unlike traditional insurance contracts, the terms of the standard contracts between OPM and the carrier are largely dictated by federal law. *See, e.g.,* 5 U.S.C. § 8902(d), (j). FEHBA, for example, requires each OPM/carrier contract to include “a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as [OPM] deems necessary or desirable.” *See id.* § 8902(d). FEHBA also authorizes OPM to prescribe reasonable minimum standards for health benefit plans offered by carriers. *See id.* § 8902(e); *see also* 5 C.F.R. § 890.201 (minimum standards for health benefit plans).

Congress further directed the inclusion of various contract provisions focusing on plan costs. The OPM/carrier contract, for example, must require carriers to undertake certain cost-containment measures in an effort to reduce benefit expenditures. *See* 5 U.S.C. § 8902(n). Additionally, each contract

must require the carrier to furnish reports to OPM and subject carriers to periodic audit by OPM. *See id.* § 8910.<sup>3</sup> FEHBA even governs the rates that can be charged for health benefit plans and mandates that rates “reasonably and equitably reflect the cost of the benefits provided.” *See id.* § 8902(i).

FEHBA further requires that every OPM/carrier contract contain a provision requiring the carrier “to pay for or provide a health service or supply in an individual case” if OPM determines the employee is entitled to benefits. *See* 5 U.S.C. § 8902(j). This provision resulted from a FEHBA amendment enacted by Congress in 1974. The amendment gave OPM the power to compel a carrier to pay benefits when OPM resolved a dispute in favor of the federal employee. *See Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 396 (9th Cir. 2002). The amendment’s legislative history suggests Congress intended to provide an administrative remedy for FEHBA disputes, without resort to the courts. *See id.*<sup>4</sup> Moreover, OPM’s authority to determine what benefits must be paid further differentiates OPM/carrier contracts from traditional state-regulated insurance policies.

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<sup>3</sup> The OPM Office of Inspector General conducts those audits and furnishes Congress with semi-annual reports summarizing its findings. *See* 5 U.S.C. App. 3, §§ 4(a)(1), 5.

<sup>4</sup> *See* H.R. Rep. No. 93-459, at 2-3 (1973) (describing the amendment as making “all final determinations by the Commission on claim disputes ... binding upon the carrier involved”); *id.* at 7 (stating that the amendment was designed to change the current law, which “forced [an employee with a meritorious claim] into the courts if he is to recover his judgment”).

The congressional decision to empower OPM to determine the right of federal employees to receive benefits is understandable, in part, because federal employee health benefits generally are paid from a government fund, not from a carrier's own funds. The FEHBA program is largely funded by a substantial federal government contribution, supplemented by employee payroll deductions. *See* 5 U.S.C. § 8906. The federal government pays approximately 75% of the plan "premiums" and the enrollee pays the rest. *See id.* § 8906(b). Unlike traditional insurance contracts, however, the contributions are not paid to the insurer. The contributions are paid into a dedicated Employees Health Benefits Fund maintained in the United States Treasury and administered solely by OPM. *See id.* § 8909(a). Carriers typically draw money from the fund to pay covered health care expenses. *See id.*; 48 C.F.R. § 1632.170. The money in the fund belongs to OPM—not the carrier. *See Empire*, 547 U.S. at 703 (Breyer, J., dissenting). The standard form contract also makes clear that the carrier will administer the plan in exchange for an adjustable service fee, which shall be the carrier's "total profit" under the contract. *See* J.A. 57 (CS 1039, § 3.7(a)).

Ordinarily, a carrier is not at risk when providing health plan benefits to federal employees. *See Empire*, 547 U.S. at 703 (Breyer, J., dissenting). "Rather, it earns a profit, not from any difference between plan premiums and the cost of benefits, but from a negotiated service charge that the federal agency pays directly." *Id.* Thus, the "carrier's only

role in this scheme is to administer the health benefits plan for the federal agency in exchange for a fixed service charge.” *Id.* at 704. A carrier participating in a FEHBA plan, therefore, functions more like a third-party administrator than a traditional insurer.

In addition to the congressionally mandated statutory requirements, OPM established extensive regulations governing FEHBA contract provisions, including the precise language that must be included in various OPM/carrier contract clauses. *See* 48 C.F.R. §§ 1652.000 – 1652.370. Moreover, every OPM/carrier contract incorporates the entire FEHBA statute and all FEHBA regulations by specific reference. *See, e.g.*, Court of Appeals App., at A49 (CS 1039, § 1.4(a)).<sup>5</sup> The express incorporation of the FEHBA statute and regulations into the standard form contract confirms that the statute and regulations were intended to govern the relationship between OPM, the carrier, and enrolled federal employees. *See Miller v. United States*, 233 U.S. 1, 15 (1914) (giving effect to federal regulation incorporated by reference in government contract); *Hercules Inc. v. United States*, 292 F.3d 1378, 1381

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<sup>5</sup> Section 1.4(a) of Contract No. CS 1039 was not included in the joint appendix. Section 1.4(a) provides as follows:

The applicable provisions of (1) chapter 89 of title 5, United States Code; (2) OPM’s regulations as contained in part 890 of title 5, Code of Federal Regulations; and (3) chapters 1 and 16 of title 48, Code of Federal Regulations constitute a part of this contract as if fully set forth herein, and the other provisions of this contract shall be construed so as to comply therewith.

(Fed. Cir. 2002) (federal acquisition regulations incorporated into government contract are controlling).

Indeed, the standard form contracts not only bind OPM and the carriers, but also bind any enrolled federal employees. Each standard form contract provides that “[b]y enrolling or accepting services under this contract, [enrollees] are obligated to all terms, conditions, and provisions of this contract.” *See* J.A. 36 (CS 1039, § 2.3(a)).

### **C. Federal Law Governs Federal Employee Eligibility And Enrollment In Federal Employee Health Benefit Plans.**

Instead of entering into individual contracts for health insurance with an insurer, a federal employee enrolls in a FEHBA plan by submitting appropriate forms to their employing federal agency. *See* 5 U.S.C. § 8905(a); 5 C.F.R. §§ 890.102, 890.301. FEHBA specifies the individuals eligible to enroll in federal health care benefit plans. *See* 5 U.S.C. § 8901(1) (defining employee); § 8901(5) (defining member of family); § 8905 (election of coverage); § 8905a (continued coverage); § 8906a (temporary employees); § 8908 (restored employees and survivor or disability annuitants). An employee may enroll in a plan either as an individual or for “self and family.” *See* 5 U.S.C. § 8905(a). Coverage for “self and family” generally is limited to the employee and the employee’s spouse (or former spouse) and unmarried dependent children who are under 22

years of age or incapable of self-support because of a mental or physical disability which existed before age 22. *See id.* §§ 8901(5), 8905(a). Thus, the question of whether a federal employee is eligible to enroll in a FEHBA plan is purely a question of federal law.

Congress vested OPM with authority to promulgate regulations that “shall provide for the beginning and ending dates of coverage of employees, annuitants, members of their families, and former spouses under health benefits plans.” *See* 5 U.S.C. § 8913(c). The OPM regulations provide that each employee is eligible to be enrolled in a health benefits plan “at the time and under the conditions prescribed” in the regulations. *See* 5 C.F.R. § 890.102(a). Moreover, OPM has discretionary authority to include and exclude certain classes of employees for purposes of FEHBA plan coverage. *See id.* § 890.102(e) (“[OPM] makes the final determination of the applicability of this section to specific employees or groups of employees.”).<sup>6</sup>

The regulations further define the actions affecting an individual’s FEHBA plan coverage – *i.e.*, “enroll,” “change the enrollment,” and “cancel” – as taking place at the specific direction of an agency

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<sup>6</sup> OPM, for example, recently promulgated a regulation extending FEHBA enrollment eligibility to former federal employees that accepted employment with a private corporation as part of the privatization of a former division of the Department of Defense. *See* 74 Fed. Reg. 66,565, 66,567 (Dec. 16, 2009) (to be codified at 5 C.F.R. § 890.111).

employing office, following submission to that office of the appropriate supporting documentation. *See* 5 C.F.R. § 890.101(a). The regulations define “employing office” as “the office of an agency to which *jurisdiction and responsibility* for health benefits actions for an employee ... have been delegated.” *See id.* (emphasis added). “Enroll” means “to submit to the employing office an appropriate request electing to be enrolled in a health benefit plan.” *See id.* “Enrolled” means “an appropriate request has been accepted by the employing office and the enrollment in a health benefits plan approved by OPM.” *See id.* Accordingly, the regulations clearly establish that federal authorities, not carriers, have the sole and exclusive responsibility for enrollment decisions.

The standard form contract specifically conditions both eligibility for enrollment and termination of enrollment on the OPM regulations and directs the employing office “having cognizance over the Enrollee” to “promptly furnish notification” to carriers of individual enrollment decisions. *See, e.g.,* J.A. 33-34, 42 (CS 1039, §§ 2.1(a), 2.4). Moreover, on a quarterly basis, each employing office must report to each carrier the names of all individuals enrolled in the carrier’s plan. *See* 5 C.F.R. § 890.110 (enrollment reconciliation). Neither FEHBA, nor the OPM regulations, nor the standard contract terms, authorizes carriers to enroll federal employees or alter the enrollment status of federal employees. Instead, carriers are provided enrollment information by the employing offices

responsible for making enrollment decisions. *See* J.A. 33 (CS 1039, § 2.1(a)(1)).

**D. Federal Law Provides The Exclusive Cause of Action For Enrollment And Benefit Disputes Arising Under A Federal Employee Health Benefit Plan.**

Although FEHBA does not specify a procedure for dispute resolution, Congress vested OPM with the power to promulgate necessary regulations. *See* 5 U.S.C. § 8913(a); *see also Household Credit Servs., Inc. v. Pfennig*, 541 U.S. 232, 239 (2004) (“[W]henver Congress has ‘explicitly left a gap for the agency to fill,’ the agency’s regulation is ‘given controlling weight unless [it is] arbitrary, capricious, or manifestly contrary to the statute.’” (quoting *Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 843-44 (1984))). The OPM, therefore, properly promulgated regulations creating a detailed and comprehensive remedial scheme to resolve disputes concerning enrollment and benefits. *See* 5 C.F.R. §§ 890.104 – 890.107. In fact, the standard form contracts explicitly set forth the administrative procedures and remedies established under the regulations for resolving such disputes. *See* 48 C.F.R. § 1652.204-72 (mandatory contract clause setting forth federal regulatory scheme for resolving enrollment and benefit disputes, including administrative procedures, remedies, and judicial review); *see also, e.g.*, J.A. 43-49 (CS 1039, § 2.8).

**1. Enrollment Disputes Are To Be Resolved By The Employing Federal Agency.**

The regulations pertaining to enrollment disputes authorize the employing office to make prospective and retroactive corrections of administrative errors. *See* 5 C.F.R. § 890.103(a). Specifically, the regulations permit employing offices to correct enrollment errors on a prospective basis at any time, *see id.* § 890.103(a), and retroactively upon an individual's timely reporting of the error, *see id.* § 890.103(c). Additionally, the regulations permit OPM to correct administrative enrollment errors when "equity and good conscience" demand. *See id.* § 890.103(b).

The regulations further establish a detailed administrative review procedure by which federal employees can seek reconsideration of an agency employing office's initial decision "denying coverage or change of enrollment." *See* 5 C.F.R. § 890.104. A federal employee initiates the administrative review procedure by filing a timely written request for reconsideration with the employing office that made the initial enrollment decision. *See id.* § 890.104(a) – (d). The employing office must conduct an independent review "designated at or above the level at which the initial decision was rendered." *See id.* § 890.104(c)(2). After reconsideration, the employing office must issue a written final decision fully setting forth its findings and conclusions. *See id.* § 890.104(e).

If a federal employee is dissatisfied with the employing office's decision after reconsideration, then the employee may seek judicial review. *See* 5 C.F.R. § 890.107(a). "A suit to compel enrollment under § 890.102 must be brought against the employing office that made the enrollment decision." *Id.* § 890.107(a). Indeed, the standard FEHBA contract sets forth verbatim the text of § 890.107(a) mandating that actions to compel enrollment be filed against the employing office making the enrollment decision. *See, e.g.,* J.A. 48 (CS 1039, § 2.8(g)). Accordingly, a lawsuit to compel enrollment under a FEHBA plan cannot be brought against a carrier, but must be filed against the appropriate employing office. *See id.* Since the employing office is always an agency of the United States, jurisdiction is proper in the federal courts. *See* 5 U.S.C. § 8912 (providing federal jurisdiction over civil actions or claims against the United States arising under FEHBA); 28 U.S.C. § 1442(a)(1) (providing for removal of civil actions brought against the United States or an agency thereof); *see also City of Cookeville v. Upper Cumberland Elec. Membership Corp.*, 484 F.3d 380, 390 (6th Cir. 2007) (holding § 1442(a)(1), as amended in 1996, expressly permits federal agency to remove civil action to federal court).

In sum, FEHBA contemplates no role for carriers in (i) enrollment decisions, (ii) correction of enrollment errors, (iii) reconsideration of enrollment decisions, or (iv) lawsuits to compel enrollment. Rather, the regulations set forth both administrative and judicial review procedures for the resolution of enrollment disputes. If, after pursuing an

administrative appeal, the employee is dissatisfied with the decision of the employing agency, then the exclusive cause of action is to seek judicial review by initiating an action to compel enrollment against the employing agency.

## **2. Benefit Disputes Are To Be Resolved By OPM.**

The OPM regulations also establish a detailed and comprehensive administrative remedy for resolving benefit disputes. *See* 5 C.F.R. §§ 890.105, 890.107(c) – (d). Health claims are initially submitted to the carrier and the carrier makes the initial benefit decision. *See id.* § 890.105(a)(1). If the carrier denies the claim, then a federal employee may ask the carrier to reconsider. *See id.* If the carrier affirms the denial or fails to timely respond to the request for reconsideration, then the federal employee may ask OPM to review the claim. *See id.* The regulations also establish time limits and other requirements for requesting reconsideration, time limits for a carrier and OPM to render their respective decisions, and the duties and responsibilities of a carrier and OPM when conducting an administrative review. *See id.* § 890.105. Significantly, federal employees “must exhaust both the carrier and OPM review processes specified in [§ 890.105] before seeking judicial review.” *See id.* § 890.105(a)(1); *see also* § 890.107(d)(1).

Once the administrative review process has been exhausted, a federal employee can seek judicial

review of OPM's final benefit decision. *See* 5 C.F.R. § 890.107(c). A claim seeking judicial review of the final benefit decision "must be brought against OPM and not against the carrier or the carrier's subcontractors." *See id.* Moreover, the recovery in such a case "shall be limited to a court order directing OPM to require the carrier to pay the amount of benefits in dispute." *See id.*; *see also* 5 U.S.C. § 8902(j) (requiring carrier to provide health benefit if OPM directs carrier to pay the claim). Notably, the evidence on judicial review is "limited to the record that was before OPM when it rendered its decision affirming the carrier's denial of benefits." *See* 5 C.F.R. § 890.107(d)(3).

As this Court has recognized, § 890.107(c) "channels disputes over coverage or benefits into federal court by designating a United States agency (OPM) sole defendant." *See Empire*, 547 U.S. at 686-87; *see also Empire HealthChoice Assurance, Inc. v. McVeigh*, 396 F.3d 136, 145 n.7 (2d Cir. 2005) (Sotomayor, J.). Indeed, the regulations adopted by OPM explicitly prohibit a claim against a carrier to recover health care benefits. *See Botsford*, 314 F.3d at 398 (holding remedies available under OPM's regulatory scheme are the "only intended remedies" under FEHBA).

At one time, OPM regulations required any lawsuit challenging a final OPM benefit decision be initiated against the carrier, not OPM. *See, e.g., Harris v. Mut. of Omaha Cos.*, 992 F.2d 706, 712 (7th Cir. 1993). In 1995, however, OPM issued interim regulations changing this requirement. The interim

regulations required any legal action arising from the denial of federal health benefits be brought against OPM, not a carrier rendering an initial benefit decision. *See* 60 Fed. Reg. 16,037 (Mar. 29, 1995) (interim regulations). In discussing the interim regulations, OPM clarified that the administrative review process established by the regulations “must be followed before legal action is pursued in the courts;” “the matter to be reviewed by a court upon appeal is the OPM decision affirming the carrier’s denial of benefits;” and the court’s review is “limited to an examination of OPM’s administrative decision to deny the claim for payment or services.” *See id.*<sup>7</sup>

On May 6, 1996, the interim regulations, with minor revisions, became final. *See* 61 Fed. Reg. 15,177 (May 6, 1996) (final regulations). In a discussion concerning the final regulations, OPM explained how the regulations were modified “to specify that court action is not to be brought against the carrier or the carrier’s subcontractors.” *See id.* “Since it is OPM’s decision, not the carrier’s, that is being contested, it is appropriate that OPM, rather than the carriers, be the focus of lawsuits related to denial of benefits.” *Id.* OPM further stated that, with respect to benefit disputes, its regulations never offered covered individuals a right of access to state courts, the right to seek monetary damages, or

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<sup>7</sup> An agency’s interpretation of its own regulation is entitled to judicial deference. *See Auer v. Robbins*, 519 U.S. 452, 461 (1997) (holding Secretary of Labor’s interpretation of own regulation is “controlling unless plainly erroneous or inconsistent with the regulation”) (internal quotations omitted).

the right to initiate a lawsuit without first seeking OPM review. *See id.* at 15,177-178. In OPM’s view, such actions “are not available to covered individuals under the FEHB program” given the express preemption provision in the statute. *See id.* at 15,178.<sup>8</sup>

### **3. FEHBA’s Express Preemption Provision.**

The FEHBA preemption provision was first enacted by Congress in 1977. The U.S. Civil Service Commission (“CSC”),<sup>9</sup> the predecessor to OPM, urged Congress to “establish uniformity of benefits and coverage” by enacting a preemption clause. *See* H.R. Rep. No. 95-282, at 6 (1977). In 1975, a Comptroller General report observed that states were becoming increasingly active in enacting and enforcing health insurance laws that conflicted with the terms of the contracts CSC was entering into under FEHBA, and expressed concern that this trend would lead to increased premium costs and “[a] lack of uniformity of benefits for all enrollees in the same health plan, since enrollees in some states would be paying a premium based, in part, on the

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<sup>8</sup> “[C]onsiderable weight should be accorded to an executive department’s construction of a statutory scheme it is entrusted to administer ....” *Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc.* 467 U.S. 837, 844 (1984) (footnote omitted).

<sup>9</sup> The CSC was the federal agency then serving as the FEHBA program administrator. Pursuant to the Civil Service Reform Act of 1978, Pub. L. 95-454, the CSC was abolished effective January 1, 1979. Responsibility for fulfilling the CSC’s various governmental functions was distributed among several agencies, including the newly created OPM.

cost of benefits provided only to enrollees in other states.” See S. Rep. No. 95-903, at 9 (1978). The Comptroller General, therefore, recommended that Congress “consider legislation to clarify whether state requirements should be permitted to alter terms of contracts negotiated pursuant to [FEHBA].” See *id.* In response to that recommendation, Congress proposed legislation “to establish uniformity in benefits and coverage under the [FEHBA] program.” H.R. Rep. No. 95-282, at 1. Commenting on that proposed legislation, the CSC adopted the following legal opinion of its general counsel:

[T]he supremacy clause creates an immunity from State interference of Federal operations. The principle underlying the need for national uniformity in the administration of Federal functions operate to supersede conflicts arising from State laws and apply with equal regard to the [CSC]’s administration of the [FEHBA] ... If the [CSC] is to have the free hand it needs to administer the [FEHBA], no other conclusion can be reached.

*Id.* at 7.

Notwithstanding CSC’s views, FEHBA’s original preemption clause was somewhat narrower in scope than the current provision. The prior provision preempted state and local laws and regulations that were “inconsistent with” the contractual provisions of FEHBA plans. See 5

U.S.C. § 8902(m)(1) (1997) (amended 1998). After some courts rejected complete preemption based on the “inconsistent with” language in the original preemption clause,<sup>10</sup> Congress broadened the provision in 1998 by deleting the phrase “to the extent that such law or regulation is inconsistent with such contractual provisions.” See *Botsford*, 314 F.3d at 393.

The FEHBA preemption clause now reads as follows:

The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8902(m)(1).<sup>11</sup> The legislative history relating to the 1998 amendment confirms the intent of Congress “that FEHB program contract terms which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) completely displace State or local law relating to health insurance or plans.” See H.R. Rep. No. 105-374, at 16 (1997). Accordingly, based on the

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<sup>10</sup> See *Rievley v. Blue Cross Blue Shield of Tenn.*, 69 F. Supp. 2d 1028, 1033 (E.D. Tenn. 1999) (collecting cases).

<sup>11</sup> Although some courts have found the FEHBA preemption clause similar to the ERISA preemption clause, see *Botsford*, 314 F.3d at 393-94, the FEHBA preemption provision contains no “savings clause,” and federal employee benefits is an area over which Congress has exclusive constitutional authority.

FEHBA preemption clause as it now reads, “state law—whether consistent or inconsistent with federal plan provisions—is displaced on matters of ‘coverage or benefits.’” *Empire*, 547 U.S. at 686. Thus, the purpose of the preemption clause—to “ensure uniform coverage and benefits under plans OPM negotiates for federal employees”—was advanced by the 1998 amendment. *See id.*

Since the FEHBA preemption provision was amended, nearly every reported decision holds state law claims relating to benefit disputes are completely preempted. *See Botsford*, 314 F.3d at 399 (state unfair trade practice claim completely preempted); *St. Mary’s Hosp. v. Carefirst of Md.*, 192 F. Supp. 2d 384, 390 (D. Md. 2002) (provider’s contract claims against carrier completely preempted); *Rievley v. Blue Cross Blue Shield of Tenn.*, 69 F. Supp. 2d 1028, 1037 (E.D. Tenn. 1999) (breach of contract, breach of fiduciary duty, and claim for bad faith denial of insurance benefits completely preempted); *Carter v. Blue Cross & Blue Shield of Fla., Inc.*, 61 F. Supp. 2d 1237, 1241 (N.D. Fla. 1999) (contract claim completely preempted); *Kight v. Kaiser Found. Health Plan of the Mid-Atl. States, Inc.*, 34 F. Supp. 2d 334, 342 (E.D. Va. 1999) (tortious interference of contract, fraud, and negligent failure to establish guidelines and procedures completely preempted). *But see Ramirez v. Humana, Inc.*, 119 F. Supp. 2d 1307, 1313 (M.D. Fla. 2000) (no complete preemption for various state law claims arising from alleged wrongful denial of benefits). This Court is called upon to definitively determine that federal employee health care

coverage and benefit disputes are subject to complete preemption and removable to federal court.

## **II. PERMITTING RESPONDENTS TO PROCEED IN STATE COURT WOULD UNDERMINE FEHBA.**

If this Court were to hold that the federal cause of action for federal employees seeking coverage and benefits under an OPM contract is not exclusive, then it is a near certainty no state court will reach a different result. In fact, the predictable initial result of such a holding would be state-by-state litigation associated with adjudicating claims by federal employees against carriers under contract with OPM. The cost of such litigation likely would be passed along to the federal government and federal employees in the form of higher administrative costs.

Another problem with not finding the federal remedy exclusive would be the likely patchwork of state court decisions directing administration and operation of FEHBA plans according to unique and varying interpretations of respective state law requirements. This, in turn, would devolve the current national and uniform administration of federal employee benefits by OPM into a state-by-state *ad hoc* benefit system. The additional administrative costs associated with this change in the FEHBA program likewise would be passed along to the federal government and federal employees. Given the already significant cost of health care in the United States, adding further administrative costs to the FEHBA program may push the cost of

health care beyond the reach of some federal employees. See Organization for Economic Co-Operation and Development, *Health Expenditure in Relation to GDP in Health at a Glance 2009: OECD Indicators* (2009), available at [http://www.oecdilibrary.org/oecd/sites/health\\_glance-2009-en/07/03/g7-02-01.html](http://www.oecdilibrary.org/oecd/sites/health_glance-2009-en/07/03/g7-02-01.html) (finding health care costs were 16.0% of GDP in the United States, compared to 10.1% in Canada, 8.4% in United Kingdom, and 8.9% on average for OECD states); J. Davidson, *Health Coverage Not Universal for Federal Workforce*, Washington Post, Sept. 18, 2009, at A23 (discussing inability of federal employees to afford health insurance and identifying rising health insurance costs and cap on government portion of premium as factors).

The tripartite relationship Congress established in FEHBA, with OPM contracting with the carriers, and the employees receiving benefits through the carriers, was not designed to operate on a state-by-state basis. Rather, the clear congressional intention was to have OPM administer a uniform federal program for the benefit of all federal employees.

Although any one federal employee may view their rights as best vindicated in state court under state law, from a national perspective, the remedial scheme implemented by OPM's regulations strikes an appropriate balance and makes the party responsible for rendering the relevant decision amenable to a lawsuit. Conversely, the lawsuit initiated in this action sought to compel the carrier

to violate federal law (or risk contempt) by requiring the carrier to enroll an individual in a FEHBA plan, when, at the time the complaint was filed, the employing federal agency had reached the opposite decision.

Moreover, if the federal remedial scheme were determined not to be exclusive, then the administrative remedial process may be cast aside whenever a federal employee concludes their interests are paramount to the systemic benefit of having enrollment and benefit issues first resolved by the employing agency or OPM. Although in any individual instance a federal employee might be able to argue her interests are better served in a different forum, no legitimate argument can be made that the comprehensive administrative and judicial procedures established by OPM, within the confines of the tripartite relationship directed by Congress, are either unfair or unreasonable.

The administrative procedures established by OPM with respect to enrollment and benefit decisions are designed to correct errors without resorting to costly litigation. If this Court were to determine the federal remedial scheme is not exclusive, then the administrative process and its attendant cost savings will be negated. Instead, federal employees will be able to compel carriers to incur significant litigation costs when, as apparently was the case here, a short administrative complaint would have resolved the issue without the need for any party to initiate litigation. *See* J.A. 97-98.

In sum, any one individual can claim a particular state law or process is most beneficial to her. The Court, however, should consider this issue from a national systemic perspective. From that perspective, the system is designed for the good of all federal employees and can operate as intended only if the Court concludes federal law provides the exclusive cause of action for federal employees seeking coverage or benefits under an OPM/carrier contract.

### CONCLUSION

For the foregoing reasons, the judgment of the United States Court of Appeals for the Seventh Circuit should be reversed.

Respectfully submitted,

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