SUPREME COURT OF THE UNITED STATES

Syllabus

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., ET AL. v. MILLER, COMMISSIONER, KENTUCKY DEPARTMENT OF INSURANCE

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT


Petitioner health maintenance organizations (HMOs) maintain exclusive “provider networks” with selected doctors, hospitals, and other health-care providers. Kentucky has enacted two “Any Willing Provider” (AWP) statutes, which prohibit “[a] health insurer [from] discriminat[ing] against any provider who is . . . willing to meet the terms and conditions for participation established by the . . . insurer,” and require a “health benefit plan that includes chiropractic benefits [to] . . . [p]ermit any licensed chiropractor who agrees to abide by the terms [and] conditions . . . of the . . . plan to serve as a participating primary chiropractic provider.” Petitioners filed this suit against respondent, the Commissioner of Kentucky’s Department of Insurance, asserting that the AWP laws are pre-empted by the Employee Retirement Income Security Act of 1974 (ERISA), which pre-empts all state laws “insofar as they . . . relate to any employee benefit plan,” 29 U. S. C. §1144(a), but saves from pre-emption state “law[s] . . . which regulat[e] insurance . . .,” §1144(b)(2)(A). The District Court concluded that although both AWP statutes “relate to” employee benefit plans under §1144(a), each law “regulates insurance” and is therefore saved from pre-emption by §1144(b)(2)(A). The Sixth Circuit affirmed.

Held: Kentucky’s AWP statutes are “law[s] . . . which regulat[e] insurance” under §1144(b)(2)(A). Pp. 3–12.

(a) For these statutes to be “law[s] . . . which regulat[e] insurance,” they must be “specifically directed toward” the insurance industry; laws of general application that have some bearing on insurers do not
qualify. E.g., Pilot Life Ins. Co. v. Dedeaux, 481 U. S. 41, 50. However, not all state laws "specifically directed toward" the insurance industry will be covered by §1144(b)(2)(A), which saves laws that regulate insurance, not insurers. Insurers must be regulated "with respect to their insurance practices." Rush Prudential HMO, Inc. v. Moran, 536 U. S. 355, 366. Pp. 3–4.

(b) Petitioners argue that the AWP laws are not “specifically directed” towards the insurance industry. The Court disagrees. Neither of these statutes, by its terms, imposes any prohibitions or requirements on providers, who may still enter exclusive networks with insurers who conduct business outside the Commonwealth or who are otherwise not covered by the AWP laws. The statutes are transgressed only when a “health insurer,” or a “health benefit plan that includes chiropractic benefits,” excludes from its network a provider who is willing and able to meet its terms. Pp. 4–6.

(c) Also unavailing is petitioners’ contention that Kentucky’s AWP laws fall outside §1144(b)(2)(A)’s scope because they do not regulate an insurance practice but focus upon the relationship between an insurer and third-party providers. Petitioners rely on Group Life & Health Ins. Co. v. Royal Drug Co., 440 U. S. 205, 210, which held that third-party provider arrangements between insurers and pharmacies were not “the ‘business of insurance’” under §2(b) of the McCarran-Ferguson Act. ERISA’s savings clause, however, is not concerned (as is the McCarran-Ferguson Act provision) with how to characterize conduct undertaken by private actors, but with how to characterize state laws in regard to what they “regulate.” Kentucky’s laws “regulate” insurance by imposing conditions on the right to engage in the business of insurance. To come within ERISA’s savings clause those conditions must also substantially affect the risk pooling arrangement between insurer and insured. Kentucky’s AWP statutes pass this test by altering the scope of permissible bargains between insurers and insureds in a manner similar to the laws we upheld in Metropolitan Life, UNUM, and Rush Prudential. Pp. 6–9.

(d) The Court’s prior use, to varying degrees, of its cases interpreting §§2(a) and 2(b) of the McCarran-Ferguson Act in the ERISA savings clause context has misdirected attention, failed to provide clear guidance to lower federal courts, and, as this case demonstrates, added little to the relevant analysis. The Court has never held that the McCarran-Ferguson factors are an essential component of the §1144(b)(2)(A) inquiry. Today the Court makes a clean break from the McCarran-Ferguson factors in interpreting ERISA’s savings clause. Pp. 9–12.

227 F. 3d 352, affirmed.

SCALIA, J., delivered the opinion for a unanimous Court.
JUSTICE SCALIA delivered the opinion of the Court.

Kentucky law provides that “[a] health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky state Medicaid program and Medicaid partnerships.” Ky. Rev. Stat. Ann. §304.17A–270 (West 2001). Moreover, any “health benefit plan that includes chiropractic benefits shall . . . [p]ermit any licensed chiropractor who agrees to abide by the terms, conditions, reimbursement rates, and standards of quality of the health benefit plan to serve as a participating primary chiropractic provider to any person covered by the plan.” §304.17A–171(2). We granted certiorari to decide whether the Employee Retirement Income Security Act of 1974 (ERISA) pre-empts either, or both, of these “Any Willing Provider” (AWP) statutes.
Petitioners include several health maintenance organizations (HMOs) and a Kentucky-based association of HMOs. In order to control the quality and cost of health-care delivery, these HMOs have contracted with selected doctors, hospitals, and other health-care providers to create exclusive “provider networks.” Providers in such networks agree to render health-care services to the HMOs’ subscribers at discounted rates and to comply with other contractual requirements. In return, they receive the benefit of patient volume higher than that achieved by nonnetwork providers who lack access to petitioners’ subscribers.

Kentucky’s AWP statutes impair petitioners’ ability to limit the number of providers with access to their networks, and thus their ability to use the assurance of high patient volume as the *quid pro quo* for the discounted rates that network membership entails. Petitioners believe that AWP laws will frustrate their efforts at cost and quality control, and will ultimately deny consumers the benefit of their cost-reducing arrangements with providers.

In April 1997, petitioners filed suit against respondent, the Commissioner of Kentucky’s Department of Insurance, in the United States District Court for the Eastern District of Kentucky, asserting that ERISA, 88 Stat. 832, as amended, pre-empts Kentucky’s AWP laws. ERISA pre-empts all state laws “insofar as they may now or hereafter relate to any employee benefit plan,” 29 U. S. C. §1144(a), but state “law[s] . . . which regulat[e] insurance, banking, or securities” are saved from pre-emption, §1144(b)(2)(A). The District Court concluded that although both AWP statutes “relate to” employee benefit plans under §1144(a), each law “regulates insurance” and is therefore saved from pre-emption by §1144(b)(2)(A). App. to Pet. for Cert. 64a–84a. In affirming the District Court, the Sixth Circuit also
concluded that the AWP laws “regulat[e] insurance” and fall within ERISA’s savings clause. *Kentucky Assn. of Health Plans, Inc. v. Nichols*, 227 F. 3d 352, 363–372 (2000). Relying on *UNUM Life Ins. Co. of America v. Ward*, 526 U. S. 358 (1999), the Sixth Circuit first held that Kentucky’s AWP laws regulate insurance “as a matter of common sense,” 227 F. 3d, at 364, because they are “specifically directed toward ‘insurers’ and the insurance industry. . . .”, id., at 366. The Sixth Circuit then considered, as “checking points or guideposts” in its analysis, the three factors used to determine whether a practice fits within “the business of health insurance” in our cases interpreting the McCarran-Ferguson Act. *Id.*, at 364. These factors are: “first, whether the practice has the effect of transferring or spreading a policyholder’s risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.” *Union Labor Life Ins. Co. v. Pireno*, 458 U. S. 119, 129 (1982). The Sixth Circuit found all three factors satisfied. 227 F. 3d, at 368–371. Notwithstanding its analysis of the McCarran-Ferguson factors, the Sixth Circuit reiterated that the “basic test” under ERISA’s savings clause is whether, from a common-sense view, the Kentucky AWP laws regulate insurance. *Id.*, at 372. Finding that the laws passed both the “common sense” test and the McCarran-Ferguson “checking points,” the Sixth Circuit upheld Kentucky’s AWP statutes. *Ibid.*

We granted certiorari, 536 U. S. 956 (2002).

II

To determine whether Kentucky’s AWP statutes are saved from preemption, we must ascertain whether they are “law[s] . . . which regulat[e] insurance” under §1144(b)(2)(A).
It is well established in our case law that a state law must be “specifically directed toward” the insurance industry in order to fall under ERISA’s savings clause; laws of general application that have some bearing on insurers do not qualify. *Pilot Life Ins. Co. v. Dedeaux*, 481 U. S. 41, 50 (1987); see also *Rush Prudential HMO, Inc. v. Moran*, 536 U. S. 355, 366 (2002); *FMC Corp. v. Holliday*, 498 U. S. 52, 61 (1990). At the same time, not all state laws “specifically directed toward” the insurance industry will be covered by §1144(b)(2)(A), which saves laws that regulate insurance, not insurers. As we explained in *Rush Prudential*, insurers must be regulated “with respect to their insurance practices,” 536 U. S., at 366. Petitioners contend that Kentucky’s AWP laws fall outside the scope of §1144(b)(2)(A) for two reasons. First, because Kentucky has failed to “specifically direct[t]” its AWP laws towards the insurance industry; and second, because the AWP laws do not regulate an insurance practice. We find neither contention persuasive.

A

Petitioners claim that Kentucky’s statutes are not “specifically directed toward” insurers because they regulate not only the insurance industry but also doctors who seek to form and maintain limited provider networks with HMOs. That is to say, the AWP laws equally prevent providers from entering into limited network contracts with insurers, just as they prevent insurers from creating exclusive networks in the first place. We do not think it follows that Kentucky has failed to specifically direct its AWP laws at the insurance industry.

Neither of Kentucky’s AWP statutes, by its terms, imposes any prohibitions or requirements on health-care providers. See Ky. Rev. Stat. Ann. §304.17A–270 (West 2001) (imposing obligations only on “health insurer[s]” not to discriminate against any willing provider); §304.17A–
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171 (imposing obligations only on “health benefit plan[s] that include chiropractic benefits”). And Kentucky health-care providers are still capable of entering exclusive networks with insurers who conduct business outside the Commonwealth of Kentucky or who are otherwise not covered by §§304.17A–270 or 304.17A–171. Kentucky’s statutes are transgressed only when a “health insurer,” or a “health benefit plan that includes chiropractic benefits,” excludes from its network a provider who is willing and able to meet its terms.

It is of course true that as a consequence of Kentucky’s AWP laws, entities outside the insurance industry (such as health-care providers) will be unable to enter into certain agreements with Kentucky insurers. But the same could be said about the state laws we held saved from pre-emption in *FMC Corp.* and *Rush Prudential*. Pennsylvania’s law prohibiting insurers from exercising subrogation rights against an insured’s tort recovery, see *FMC Corp.*, *supra*, at 55, n. 1, also prevented insureds from entering into enforceable contracts with insurers allowing subrogation. Illinois’ requirement that HMOs provide independent review of whether services are “medically necessary,” *Rush Prudential, supra*, at 372, likewise excluded insureds from joining an HMO that would have withheld the right to independent review in exchange for a lower premium. Yet neither case found the effects of these laws on noninsurers, significant though they may have been, inconsistent with the requirement that laws saved from pre-emption by §1144(b)(2)(A) be “specifically directed toward” the insurance industry. Regulations “directed toward” certain entities will almost always disable other entities from doing, with the regulated entities, what the regulations forbid; this does not suffice to place such
Petitioners claim that the AWP laws do not regulate

1Petitioners also contend that Ky. Rev. Stat. Ann. §304.17A–270 (West 2001) is not “specifically directed toward” insurers because it applies to “self-insurer or multiple employer welfare arrangement[s] not exempt from state regulation by ERISA.” §304.17A–005(23). We do not think §304.17A–270’s application to self-insured non-ERISA plans forfeits its status as a “law . . . which regulates insurance” under 29 U. S. C. §1144(b)(2)(A). ERISA’s savings clause does not require that a state law regulate “insurance companies” or even “the business of insurance” to be saved from pre-emption; it need only be a “law . . . which regulates insurance,” ibid. (emphasis added), and self-insured plans engage in the same sort of risk pooling arrangements as separate entities that provide insurance to an employee benefit plan. Any contrary view would render superfluous ERISA’s “deemer clause,” §1144(b)(2)(B), which provides that an employee benefit plan covered by ERISA may not “be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts . . .” That clause has effect only on state laws saved from pre-emption by §1144(b)(2)(A) that would, in the absence of §1144(b)(2)(B), be allowed to regulate self-insured employee benefit plans. Under petitioners’ view, such laws would never be saved from pre-emption in the first place. (The deemer clause presents no obstacle to Kentucky’s law, which reaches only those employee benefit plans “not exempt from state regulation by ERISA”).

Both of Kentucky’s AWP laws apply to all HMOs, including HMOs that do not act as insurers but instead provide only administrative services to self-insured plans. Petitioners maintain that the application to noninsuring HMOs forfeits the laws’ status as “law[s] . . . which regulate[e] insurance.” §1144(b)(2)(A). We disagree. To begin with, these noninsuring HMOs would be administering self-insured plans, which we think suffices to bring them within the activity of insurance for purposes of §1144(b)(2)(A). Moreover, we think petitioners’ argument is foreclosed by Rush Prudential HMO, Inc. v. Moran, 536 U. S. 355, 372 (2002), where we noted that Illinois’ independent-review laws contained “some overbreadth in the application of [215 Ill. Comp. Stat., ch. 125,] §4–10 [(2000)] beyond orthodox HMOs,” yet held that “there is no reason to think Congress would have meant such minimal application to noninsurers to remove a state law entirely from the category of insurance regulation saved from preemption.”
insurers with respect to an insurance practice because, unlike the state laws we held saved from pre-emption in Metropolitan Life Ins. Co. v. Massachusetts, 471 U. S. 724 (1985), UNUM, and Rush Prudential, they do not control the actual terms of insurance policies. Rather, they focus upon the relationship between an insurer and third-party providers—which in petitioners’ view does not constitute an “insurance practice.”

In support of their contention, petitioners rely on Group Life & Health Ins. Co. v. Royal Drug Co., 440 U. S. 205, 210 (1979), which held that third-party provider arrangements between insurers and pharmacies were not “the ‘business of insurance’” under §2(b) of the McCarran-Ferguson Act. ERISA’s savings clause, however, is not concerned (as is the McCarran-Ferguson Act provision) with how to characterize conduct undertaken by private actors, but with how to characterize state laws in regard to what they “regulate.” It does not follow from Royal Drug that a law mandating certain insurer-provider relationships fails to “regulate insurance.” Suppose a state law required all licensed attorneys to participate in 10 hours of

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2Section 2 of the McCarran-Ferguson Act provides:
“(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

“(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law. 59 Stat. 34, 15 U. S. C. §1012 (emphasis added).
continuing legal education (CLE) each year. This statute “regulates” the practice of law—even though sitting through 10 hours of CLE classes does not constitute the practice of law—because the state has conditioned the right to practice law on certain requirements, which substantially affect the product delivered by lawyers to their clients. Kentucky’s AWP laws operate in a similar manner with respect to the insurance industry: Those who wish to provide health insurance in Kentucky (any “health insurer”) may not discriminate against any willing provider. This “regulates” insurance by imposing conditions on the right to engage in the business of insurance; whether or not an HMO’s contracts with providers constitute “the business of insurance” under Royal Drug is beside the point.

We emphasize that conditions on the right to engage in the business of insurance must also substantially affect the risk pooling arrangement between the insurer and the insured to be covered by ERISA’s savings clause. Otherwise, any state law aimed at insurance companies could be deemed a law that “regulates insurance,” contrary to our interpretation of §1144(b)(2)(A) in Rush Prudential, 536 U. S., at 364. A state law requiring all insurance companies to pay their janitors twice the minimum wage would not “regulate insurance,” even though it would be a prerequisite to engaging in the business of insurance, because it does not substantially affect the risk pooling arrangement undertaken by insurer and insured. Petitioners contend that Kentucky’s AWP statutes fail this test as well, since they do not alter or affect the terms of insurance policies, but concern only the relationship between insureds and third-party providers, Brief for Petitioners 29. We disagree. We have never held that state laws must alter or control the actual terms of insurance policies to be deemed “laws . . . which regulat[e] insurance” under §1144(b)(2)(A); it suffices that they substantially affect the
risk pooling arrangement between insurer and insured. By expanding the number of providers from whom an insured may receive health services, AWP laws alter the scope of permissible bargains between insurers and insureds in a manner similar to the mandated-benefit laws we upheld in *Metropolitan Life*, the notice-prejudice rule we sustained in *UNUM*,3 and the independent-review provisions we approved in *Rush Prudential*. No longer may Kentucky insureds seek insurance from a closed network of health-care providers in exchange for a lower premium. The AWP prohibition substantially affects the type of risk pooling arrangements that insurers may offer.

III

Our prior decisions construing §1144(b)(2)(A) have relied, to varying degrees, on our cases interpreting §§2(a) and 2(b) of the McCarran-Ferguson Act. In determining whether certain practices constitute “the business of insurance” under the McCarran-Ferguson Act (emphasis added), our cases have looked to three factors: “first, whether the practice has the effect of transferring or spreading a policyholder’s risk; second, whether the practice is an integral part of the policy relationship between

3While the Ninth Circuit concluded in *Cisneros v. UNUM Life Insurance Co.*, 134 F. 3d 939, 945–946 (1998), aff’d in part, rev’d and remanded in part, *UNUM Life Ins. Co. of America v. Ward*, 526 U. S. 358 (1999), that “the notice-prejudice rule does not spread the policyholder’s risk within the meaning of the first McCarran-Ferguson factor,” our test requires only that the state law substantially affect the risk pooling arrangement between the insurer and insured; it does not require that the state law actually spread risk. See ante, at 8–9. The notice-prejudice rule governs whether or not an insurance company must cover claims submitted late, which dictates to the insurance company the conditions under which it must pay for the risk that it has assumed. This certainly qualifies as a substantial effect on the risk pooling arrangement between the insurer and insured.
the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.”

We believe that our use of the McCarran-Ferguson case law in the ERISA context has misdirected attention, failed to provide clear guidance to lower federal courts, and, as this case demonstrates, added little to the relevant analysis. That is unsurprising, since the statutory language of §1144(b)(2)(A) differs substantially from that of the McCarran-Ferguson Act. Rather than concerning itself with whether certain practices constitute “[t]he business of insurance,” 15 U. S. C. §1012(a), or whether a state law was “enacted . . . for the purpose of regulating the business of insurance,” §1012(b) (emphasis added), 29 U. S. C. §1144(b)(2)(A) asks merely whether a state law is a “law . . . which regulates insurance, banking, or securities.” What is more, the McCarran-Ferguson factors were developed in cases that characterized conduct by private actors, not state laws. See Pireno, supra, at 126 (“The only issue before us is whether petitioners’ peer review practices are exempt from antitrust scrutiny as part of the ‘business of insurance’” (emphasis added)); Royal Drug, 440 U. S., at 210 (“The only issue before us is whether the Court of Appeals was correct in concluding that these Pharmacy Agreements are not the ‘business of insurance’ within the meaning of §2(b) of the McCarran-Ferguson Act” (emphasis added)).

Our holdings in UNUM and Rush Prudential—that a state law may fail the first McCarran-Ferguson factor yet still be saved from pre-emption under §1144(b)(2)(A)—raise more questions than they answer and provide wide opportunities for divergent outcomes. May a state law satisfy any two of the three McCarran-Ferguson factors and still fall under the savings clause? Just one? What happens if two of three factors are satisfied, but not “securely satisfied” or “clearly satisfied,” as they were in
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UNUM and Rush Prudential? 526 U. S., at 374; 536 U. S., at 373. Further confusion arises from the question whether the state law itself or the conduct regulated by that law is the proper subject to which one applies the McCarran-Ferguson factors. In Pilot Life, we inquired whether Mississippi’s law of bad faith has the effect of transferring or spreading risk, 481 U. S., at 50, whether that law is integral to the insurer-insured relationship, id., at 51, and whether that law is limited to the insurance industry, ibid.4 Rush Prudential, by contrast, focused the McCarran-Ferguson inquiry on the conduct regulated by the state law, rather than the state law itself. 536 U. S., at 373 (“It is obvious enough that the independent review requirement regulates ‘an integral part of the policy relationship between the insurer and insured’” (emphasis added)); id., at 374 (“The final factor, that the law be aimed at a ‘practice . . . limited to entities within the insurance industry’ is satisfied . . . .” (emphasis added; citation omitted)).

We have never held that the McCarran-Ferguson factors are an essential component of the §1144(b)(2)(A) inquiry. Metropolitan Life initially used these factors only to buttress its previously reached conclusion that Massachusetts’ mandated-benefit statute was a “law . . . which regulates insurance” under §1144(b)(2)(A). 471 U. S., at 742–743. Pilot Life referred to them as mere “considerations [to be] weighed” in determining whether a state law falls under the savings clause. 481 U. S., at 49. UNUM emphasized that the McCarran-Ferguson factors were not “require[d]” in the savings clause analysis, and were only

4This approach rendered the third McCarran-Ferguson factor a mere repetition of the prior inquiry into whether a state law is “specifically directed toward” the insurance industry under the “common-sense view.” UNUM Life Ins. Co. of America v. Ward, 526 U. S. 358, 375 (1999); Pilot Life Ins. Co. v. Dedeaux, 481 U. S. 41, 50 (1987).
“checking points” to be used after determining whether the state law regulates insurance from a “common-sense” understanding. 526 U. S., at 374. And Rush Prudential called the factors “guideposts,” using them only to “confirm our conclusion” that Illinois’ statute regulated insurance under §1144(b)(2)(A). 536 U. S., at 373.

Today we make a clean break from the McCarran-Ferguson factors and hold that for a state law to be deemed a “law . . . which regulates insurance” under §1144(b)(2)(A), it must satisfy two requirements. First, the state law must be specifically directed toward entities engaged in insurance. See Pilot Life, supra, at 50, UNUM, supra, at 368; Rush Prudential, supra, at 366. Second, as explained above, the state law must substantially affect the risk pooling arrangement between the insurer and the insured. Kentucky’s law satisfies each of these requirements.

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For these reasons, we affirm the judgment of the Sixth Circuit.

It is so ordered.
STEVENS, J., dissenting

SUPREME COURT OF THE UNITED STATES

No. 99–1786

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, ET AL., PETITIONERS v. JANETTE KNUDSON AND ERIC KNUDSON

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

[January 8, 2002]

JUSTICE STEVENS, dissenting.

In her lucid dissent, which I join, JUSTICE GINSBURG has explained why it is fanciful to assume that in 1974 Congress intended to revive the obsolete distinctions between law and equity as a basis for defining the remedies available in federal court for violations of the terms of a plan under the Employee Retirement Income Security Act of 1974 (ERISA). She has also convincingly argued that the relief sought in the present case is permissible even under the Court’s favored test for determining what qualifies as “equitable relief” under §502(a)(3)(B) of ERISA. I add this postscript because I am persuaded that Congress intended the word “enjoin,” as used in §502(a)(3)(A), to authorize any appropriate order that prohibits or terminates a violation of an ERISA plan, regardless of whether a precedent for such an order can be found in English Chancery cases.

I read the word “other” in §502(a)(3)(B) as having been intended to enlarge, not contract, a federal judge’s remedial authority. Consequently, and contrary to the Court’s view in Mertens v. Hewitt Associates, 508 U. S. 248, 256 (1993), I would neither read §502(a)(3)(B) as placing a limitation on a judge’s authority under §502(a)(3)(A), nor shackle an analysis of what constitutes “equitable relief”
under §502(a)(3)(B) to the sort of historical analysis that the Court has chosen.

Nevertheless, *Mertens* is the law, and an inquiry under §502(a)(3)(B) now entails an analysis of what relief would have been “typically available in equity.” 508 U. S., at 256. This does not mean, however, that all inquiries under §502(a)(3) must involve historical analysis, as the Court seems to believe, e.g., ante, at 4–5. In *Mertens*, our task was to interpret “other appropriate equitable relief” under §502(a)(3)(B), and our holding thus did not extend to the meaning of “to enjoin” in §502(a)(3)(A). As a result, an analysis of tradition is unnecessary with respect to §502(a)(3)(A). Moreover, that section provides a proper basis for federal jurisdiction in the present case, as petitioners brought suit “to enjoin any act or practice which violates . . . the terms of [a] plan.” §502(a)(3)(A).

Not only is an inclusive reading of §502(a)(3) consonant with the text of the statute, but it accomplishes Congress’ goal of providing a federal remedy for violations of the terms of plans governed by ERISA. Contrary to the Court’s current reluctance to conclude that wrongs should be remedied,1 I believe that the historic presumption favoring the provision of remedies for violations of federal rights2 should inform our construction of the remedial provisions of federal statutes. It is difficult for me to


2 See, e.g., *Bivens v. Six Unknown Fed. Narcotics Agents*, 403 U. S. 388, 392 (1971) (“[W]here federally protected rights have been invaded, it has been the rule from the beginning that courts will be alert to adjust their remedies so as to grant the necessary relief” (quoting *Bell v. Hood*, 327 U. S. 678, 684 (1946)); 403 U. S., at 397 (“The very essence of civil liberty certainly consists in the right of every individual to claim the protection of the laws, whenever he receives an injury” (quoting *Marbury v. Madison*, 1 Cranch 137, 163 (1803)).
understand why Congress would not have wanted to provide recourse in federal court for the plan violation disclosed by the record in this case. Cf., e.g., Varity Corp. v. Howe, 516 U. S. 489, 512–513, 515 (1996) (“We are not aware of any ERISA-related purpose that denial of a remedy would serve”). It is thus unsurprising that the Court’s opinion contains no discussion of why Congress would have intended its reading of §502(a)(3) and the resulting denial of a federal remedy in this case. Absent such discussion, the Court’s opinion is remarkably unpersuasive.3

I respectfully dissent.

3 In a response to this dissent that echoes Tennyson’s poem about the Light Brigade—“Their’s not to reason why, Theirs but to do and die”—the Court states that it is “not our job to find reasons for what Congress has plainly done,” ante, at 13. Congress, of course, has the power to enact unreasonable laws. Nevertheless, instead of blind obedience to what at first blush appears to be such a law, I think it both prudent and respectful to pause to ask why Congress would do so.
JUSTICE GINSBURG, with whom JUSTICE STEVENS, JUSTICE SOUTER, and JUSTICE BREYER join, dissenting.

Today’s holding, the majority declares, is compelled by “Congress’s choice to limit the relief available under §502(a)(3).” Ante, at 13. In the Court’s view, Congress’ placement of the word “equitable” in that provision signaled an intent to exhume the “fine distinction[s]” borne of the “days of the divided bench,” ante, at 7, 10; to treat as dispositive an ancient classification unrelated to the substance of the relief sought; and to obstruct the general goals of ERISA by relegating to state court (or to no court at all) an array of suits involving the interpretation of employee health plan provisions. Because it is plain that Congress made no such “choice,” I dissent.

The Court purports to resolve this case by determining the “nature of the relief” Great-West seeks. Ante, at 10. The opinion’s analysis, however, trains on the question, deemed subsidiary, whether the disputed claim could have been brought in an equity court “[i]n the days of the divided bench.” Ante, at 7–11 (inquiring whether the claim is akin to “an action derived from the common-law writ of assumpsit” that would have been brought at law, or in-
stead resembles a claim for return of particular assets that would “lie in equity”). To answer that question, the Court scrutinizes the form of the claim and contrasts its features with the technical requirements that once governed the jurisdictional divide between the premerger courts. Finding no clear match on the equitable side of the line, the Court concludes that Great-West’s claim is beyond the scope of §502(a)(3) and therefore outside federal jurisdiction.

The rarified rules underlying this rigid and time-bound conception of the term “equity” were hardly at the fingertips of those who enacted §502(a)(3). By 1974, when ERISA became law, the “days of the divided bench” were a fading memory, for that era had ended nearly 40 years earlier with the advent of the Federal Rules of Civil Procedure. Those rules instruct: “There shall be one form of action” cognizable in the federal courts. Fed. Rule Civ. Proc. 2. Except where reference to historical practice might be necessary to preserve a right established before the merger, see, e.g., Curtis v. Loether, 415 U. S. 189, 195 (1974) (Seventh Amendment jury trial), the doctrinal rules delineating the boundaries of the divided courts had receded. See 4 C. Wright & A. Miller, Federal Practice and Procedure §1041, p. 135 (1987); C. Wright, Handbook on Law of Federal Courts §67, p. 282 (2d ed. 1970) (“[I]nstances in which the old distinctions continue to rule from their graves are quite rare.”).

It is thus fanciful to attribute to members of the 93d Congress familiarity with those “needless and obsolete distinctions,” 4 C. Wright & A. Miller, supra, §1041, at 131, much less a deliberate “choice” to resurrect and import them wholesale into the modern regulatory scheme laid out in ERISA. “[T]here is nothing to suggest that ERISA’s drafters wanted to embed their work in a time warp.” Health Cost Controls of Ill. v. Washington, 187 F. 3d 703, 711 (CA7 1999) (Posner, J.); cf. Mertens v. Hewitt
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*Associates*, 508 U. S. 248, 257, n. 7 (1993) (meaning of “equitable relief” in §502(a)(3) must be determined based on “the state of the law when ERISA was enacted”).

That Congress did not intend to strap §502(a)(3) with the anachronistic rules on which the majority relies is corroborated by the anomalous results to which the supposed legislative “choice” leads. Although the Court recognizes that it need not decide the issue, see ante, at 15–16, its opinion surely contemplates that a constructive trust claim would lie; hence, the outcome of this case would be different if Great-West had sued the trustee of the Special Needs Trust, who has “possession” of the requested funds, instead of the Knudsons, who do not. See ante, at 8–9 (constructive trust unavailable because “the funds to which petitioners claim an entitlement . . . are not in respondents’ possession”). Under that view, whether relief is “equitable” would turn entirely on the designation of the defendant, even though the substance of the relief Great-West could have obtained in a suit against the trustee—a judgment ordering the return of wrongfully withheld funds—is identical to the relief Great-West in fact sought from the Knudsons. Unlike today’s majority, I resist this “rule unjustified in reason, which produces different results for breaches of duty in situations that cannot be differentiated in policy.” *Moragne v. States Marine Lines, Inc.*, 398 U. S. 375, 405 (1970).

The procedural history of this case highlights the anomaly of upholding a judgment neither party supports,¹ one

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¹In the District Court, both parties sought decision on the amount Great-West was entitled to recoup under the Plan’s provision for recovery of benefits paid, and the court resolved that issue in the Knudsons’ favor. The Ninth Circuit, however, refused to review the District Court’s resolution of that question, holding instead that federal courts are without authority to grant any relief to parties in Great-West’s situation. Because neither party defended that ruling in this
that will at least protract and perhaps preclude judicial resolution of the nub of the controversy—\textit{i.e.}, what recoupment does the Plan’s reimbursement provision call for. Great-West named the Knudsons as defendants before Janet Knudson’s Special Needs Trust had been approved. There was no other defendant then in the picture. Seeking at that time to preserve the status quo, Great-West requested from the District Court preliminary injunctive relief to stop the Knudsons from disposing of the funds Hyundai paid to settle the state-court action. Only after the District Court denied that relief did the state court approve of, and order that the settlement funds be paid into, the Special Needs Trust. Great-West then moved for leave to amend its complaint to add the trustee as a defendant, but the District Court denied that motion without consideration in light of its judgment for the Knudsons on the merits. Had the District Court ruled differently on this peripheral issue, the majority would presumably reverse rather than affirm a disposition of this case that left in limbo the meaning of the Plan’s reimbursement provision. If that is so, then the Court’s decision rests on Great-West’s failure to appeal an interlocutory issue made moot by the District Court’s final judgment, an issue that, to all involved, must have seemed utterly inconsequential post judgment day.

The majority’s avowed obedience to Congress’ “choice” is further belied by the conflict between the Court’s holding and Congress’ stated goals in enacting ERISA. After today, ERISA plans and fiduciaries unable to fit their suits within the confines the Court’s opinion constructs are barred from a federal forum; they may seek enforce——
ment of reimbursement provisions like the one here at issue only in state court. Many such suits may be precluded by antisubrogation laws, see Brief for Maryland HMO Subrogation Plaintiffs as Amici Curiae 4–5, n. 2, others may be preempted by ERISA itself, and those that survive may produce diverse and potentially contradictory interpretations of the disputed plan terms.

We have recognized that Congress sought through ERISA “to establish a uniform administrative scheme” and to ensure that plan provisions would be enforced in federal court, free of “the threat of conflicting or inconsistent State and local regulation.” Fort Halifax Packing Co. v. Coyne, 482 U. S. 1, 9 (1987) (internal quotation marks omitted) (quoting 120 Cong. Rec. 29933 (1974)). The majority’s construction frustrates those goals by ascribing to Congress the paradoxical intent to enact a specific provision, §502(a)(3), that thwarts the purposes of the general scheme of which it is part. The Court is no doubt correct that “vague notions of a statute’s ‘basic purpose’ are . . . inadequate to overcome the words of its text regarding the specific issue under consideration.” Ante, at 16 (quoting Mertens, 508 U. S., at 261) (emphasis deleted). But when Congress’ clearly stated purpose so starkly conflicts with questionable inferences drawn from a single word in the statute, it is the latter, and not the former, that must give way.

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II

Unprepared to agree that Congress chose to infuse §502(a)(3) with the recondite distinctions on which the majority relies, I would accord a different meaning to the term “equitable.” Consistent with what Congress likely intended and with our decision in Mertens, I would look to the substance of the relief requested and ask whether relief of that character was “typically available in equity.” Mertens, 508 U. S., at 256. Great-West seeks restitution, a category of relief fully meeting that measure even if the remedy was also available in cases brought at law. Accordingly, I would not oust this case from the federal courts.

That Great-West requests restitution is beyond dispute. The relief would operate to transfer from the Knudsons funds over which Great-West claims to be the rightful owner. See Curtis, 415 U. S., at 197 (describing an award as restitutioinary if it would “requir[e] the defendant to disgorge funds wrongfully withheld from the plaintiff”); Porter v. Warner Holding Co., 328 U. S. 395, 402 (1946) (restitution encompasses a decree “ordering the return of that which rightfully belongs to” the plaintiff). Great-West alleges that the Knudsons would be unjustly enriched if permitted to retain the funds. See 1 D. Dobbs, Law of Remedies §4.1(2), p. 557 (2d ed. 1993) (“The fundamental substantive basis for restitution is that the defendant has been unjustly enriched by receiving some-
thing, tangible or intangible, that properly belongs to the plaintiff.”). And Great-West sued to recover an amount representing the Knudsons’ unjust gain, rather than Great-West’s loss. See 3 id., §12.1(1), at 9 (“Restitutionary recoveries are based on the defendant’s gain, not on the plaintiff’s loss.”).

As the majority appears to admit, see ante, at 10, our cases have invariably described restitutionary relief as “equitable” without even mentioning, much less dwelling upon, the ancient classifications on which today’s holding rests. See, e.g., Tull v. United States, 481 U. S. 412, 424 (1987) (restitution “traditionally considered an equitable remedy”); Mertens, 508 U. S., at 255 (restitution is a “remedy traditionally viewed as ‘equitable’”); Teamsters v. Terry, 494 U. S. 558, 570 (1990) (“[W]e have characterized [money] damages as equitable where they are restitutionary.”); Mitchell, 361 U. S., at 291–293 (District Court could exercise equitable authority under Fair Labor Standards Act to order restitution); cf. Moses v. Macferlan, 2 Burr. 1005, 1012, 97 Eng. Rep. 676, 681 (K. B. 1760) (“In one word, the gist of this kind of action is that the defendant, upon the circumstances of the case, is obliged by the ties of natural justice and equity to refund the money.”). These cases establish what the Court does not and cannot dispute: Restitution was “within the recognized power and within the highest tradition of a court of equity.” Porter, 328 U. S., at 402.

More important, if one’s concern is to follow the Legislature’s will, Congress itself has treated as equitable a type of restitution substantially similar to the relief Great-West seeks here. Congress placed in Title VII of the Civil Rights Act of 1964 the instruction that, to redress violations of the Act, courts may award, inter alia, “appropriate . . . equitable relief,” including “reinstatement or hiring of employees, with or without back pay.” 42 U. S. C. §2000e–5(g)(1) (1994 ed.). Interpreting this provision, we have
recognized that backpay is "a form of restitution," Curtis, 415 U. S., at 197; see Terry, 494 U. S., at 572, and that "Congress specifically characterized backpay under Title VII as a form of 'equitable relief,'" ibid. The Mertens majority used Title VII's "equitable relief" provision as the touchstone for its interpretation of §502(a)(3), see 508 U. S., at 255; today's majority declares, with remarkable inconsistency, that “Title VII has nothing to do with this case,” ante, at 14, n. 4. The Court inexplicably fails to offer any reason why Congress did not intend "equitable relief" in §502(a)(3) to include a plaintiff's "recover[y] of] money to pay for some benefit the defendant had received from him," ante, at 8 (internal quotation marks omitted), but did intend those words to encompass such relief in a measure (Title VII) enacted years earlier.\(^2\)

\(^2\)The Courts of Appeals have not aligned behind the Court's theory that Congress treated Title VII backpay as equitable "only in the narrow sense that" such relief is an "integral part" of the statutory remedy of reinstatement. Ante, at 14, n. 4. While some courts have employed the majority's rationale, others have adopted the position the Court denies: that Title VII backpay is restitutory and "therefore equitable," ante, at 13, n. 4. See, e.g., EEOC v. Detroit Edison Co., 515 F. 2d 301, 308 (CA6 1975) ("Back pay in Title VII cases is considered a form of restitution, not an award of damages. Since restitution is an equitable remedy a jury is not required for the award of back pay."), vacated on other grounds, 431 U. S. 951 (1977); Rogers v. Loether, 467 F. 2d 1110, 1121 (CA7 1972) ("It is not unreasonable to regard an award of back pay [under Title VII] as an appropriate exercise of a chancellor's power to require restitution. Restitution is clearly an equitable remedy.") (footnote omitted), aff'd, 415 U. S. 189 (1974). See also Hubbard v. EPA, 949 F. 2d 453, 462 (CADC 1991) ("Courts have recognized the equitable nature of back pay awards in a number of different contexts. Generally, these decisions hold that back pay constitutes the very thing that the plaintiff would have received but for the defendant's illegal action; back pay is thus seen to reflect equitable restitution.")., aff'd on other grounds, 982 F. 2d 531 (CADC 1992) (en banc).

Such a reading of §2000e–5(g)(1) accords with our recognition in
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I agree that “not all relief falling under the rubric of restitution [was] available in equity,” ante, at 7 (emphasis added); restitution was also available in claims brought at law, and the majority may be correct that in such cases restitution would have been termed “legal,” ante, at 8. But that in no way affects the answer to the question at the core of this case. Section 502(a)(3) as interpreted in Mertens encompasses those “categories of relief that were typically available in equity,” 508 U. S., at 256 (emphasis in original), not those that were exclusively so. Restitution plainly fits that bill. By insisting that §502(a)(3) embraces only those claims that, in the circumstances of the particular case, could be brought in chancery in times of yore, the majority labors against the holding of that case. Indeed, Mertens explicitly rejected a position close to the one embraced by the Court today; Mertens recognized that “[a]s memories of the divided bench, and familiarity with its technical refinements, recede further into the past, [an interpretation of §502(a)(3) keyed to the relief a court of equity could award in a particular case] becomes, perhaps, increasingly unlikely.” 508 U. S., at 256–257.

My objection to the inquiry the Court today adopts in

Teamsters v. Terry, 494 U. S. 558, 572 (1990), that “Congress specifically characterized backpay under Title VII as a form of ‘equitable relief.’” (Emphasis added). We were somewhat ambiguous in Curtis v. Loether, 415 U. S. 189, 197 (1974), about the rationale of the Courts of Appeals, reasoning that they had treated Title VII backpay as equitable because Congress had made backpay “an integral part of an equitable remedy, a form of restitution.” But we spoke with greater clarity in Terry, 494 U. S., at 570–571, explaining that we could find an “exception to the general rule” that monetary relief is legal, rather than equitable, in two situations: either “where th[e relief is] restitutionary,” a category into which we suggested Title VII backpay might fall, see id., at 572 (“backpay sought from an employer under Title VII would generally be restitutionary in nature”); or where “a monetary award [is] ‘incidental to or intertwined with injunctive relief,’” id., at 571 (quoting Tull v. United States, 481 U. S. 412, 424 (1987)).
spite of *Mertens* does not turn on “the difficulty of th[e] task,” *ante*, at 12. To be sure, I question the Court’s confidence in the ability of “the standard works” to “make the answer clear”; the Court does not indicate what rule prevails, for example, when those works conflict, as they do on key points, compare Restatement of Restitution §160, comment e, p. 645 (1936) (constructive trust over money available only where transfer procured by abuse of fiduciary relation or where legal remedy inadequate), with 1 Dobbs, Law of Remedies §4.3(2), at 595, 597 (limitation of constructive trust to “misdealings by fiduciaries” a “misconception”; adequacy of legal remedy “seems irrelevant”). And courts have recognized that this Court’s preferred method is indeed “difficult to apply,” *Ross v. Bernhard*, 396 U.S. 531, 538, n. 10 (1970), calling for analysis that “may seem to reek unduly of the study,” *Damsky v. Zavatt*, 289 F. 2d 46, 48 (CA2 1961) (Friendly, J.), “‘if not of the museum,’” *id.*, at 59 (Clark, J., dissenting).

Even if the Court’s chosen texts always yielded a quick and plain answer, however, I would think it no less implausible that Congress intended to make controlling the doctrine those texts describe. See *supra*, at 2–6. Our reliance on that doctrine in the context of the Seventh Amendment and Judiciary Act of 1789, see *ante*, at 12, underscores the incongruity of applying it here. It may be arguable that “preserving” the meaning of those founding-era provisions requires courts to determine which tribunal would have entertained a particular claim in 18th-century England. See *Grupo Mexicano*, 527 U.S., at 318–319; *Terry*, 494 U.S., at 593 (KENNEDY, J., dissenting) ("We cannot preserve a right existing in 1791 unless we look to history to identify it."). But no such rationale conceivably justifies asking that question in cases arising under §502(a)(3)(B), a provision of a distinctly modern statute Congress passed in 1974.

That the import of the term “equity” might depend on
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context does not signify a “rolling revision of its content,” ante, at 13, but rather a recognition that equity, characteristicly, was and should remain an evolving and dynamic jurisprudence, see Grupo Mexicano, 527 U. S., at 336–337 (GINSBURG, J., dissenting). Cf. Mertens, 508 U. S., at 257 (“[I]t remains a question of interpretation in each case which meaning [Congress] intended” to impart to the term “equitable relief.”). As courts in the common-law realm have reaffirmed: “Principles of equity, we were all taught, were introduced by Lord Chancellors and their deputies . . . in order to provide relief from the inflexibility of common law rules.” Medforth v. Blake, [1999] 3 All E. R. 97, 110 (C. A.); see Boulting v. Association of Cinematograph, Television and Allied Technicians, [1963] 2 Q. B. 606, 636 (C. A.) (“[A]ll rules of equity [are] flexible, in the sense that [they] develop[p] to meet the changing situations and conditions of the time.”); Pettkus v. Becker, [1980] 2 S. C. R. 834, 847, 117 D. L. R. (3d) 257, 273 (“The great advantage of ancient principles of equity is their flexibility: the judiciary is thus able to shape these malleable principles so as to accommodate the changing needs and mores of society.”). This Court’s equation of “equity” with the rigid application of rules frozen in a bygone era, I maintain, is thus “unjustifiabl[e]” even as applied to a law grounded in that era. Grupo Mexicano, 527 U. S., at 336 (GINSBURG, J., dissenting). As applied to a statute like ERISA, however, such insistence is senseless.

Thus, there is no reason to ask what court would have entertained Great-West’s claim “[i]n the days of the divided bench,” ante, at 7, and no need to engage in the antiquarian inquiry through which the majority attempts to answer that question. Nor would reading §502(a)(3) to encompass restitution render the modifier “equitable” “utterly pointless,” as the Court fears, ante, at 12. Such a construction would confine the scope of that provision to significantly “less than all relief,” ante, at 4 (quoting Mer-
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tens, 508 U. S., at 258, n. 8). Most notably, it would exclude compensatory and punitive damages, see id., at 255, which, “though occasionally awarded in equity” under the “clean up doctrine,” Reich v. Continental Casualty Co., 33 F. 3d 754, 756 (CA7 1994), were not typically available in such courts. See 1 S. Symons, Pomeroy’s Equity Jurisprudence §181, p. 257 (5th ed. 1941). That large limitation is indeed “unmistakable.” But cf. ante, at 12. In sum, the reading I would adopt is entirely faithful to the core holding of Mertens: “equitable relief” in §502(a)(3) “refer[s] to those categories of relief that were typically available in equity (such as injunction, mandamus, and restitution, but not compensatory damages).” 508 U. S., at 256.

*     *     *

Today’s decision needlessly obscures the meaning and complicates the application of §502(a)(3). The Court’s interpretation of that provision embroils federal courts in “recondite controversies better left to legal historians,” Terry, 494 U. S., at 576 (Brennan, J., concurring in part and concurring in judgment), and yields results that are demonstrably at odds with Congress’ goals in enacting ERISA. Because in my view Congress cannot plausibly be said to have “carefully crafted” such confusion, ante, at 16, I dissent.