

## ***RUSH PRUDENTIAL HMO, INC. v. MORAN: 21 OR BUST! DOES ERISA PREEMPTION GIVE HMOs THE POWER TO GAMBLE WITH OUR HEALTH?***<sup>†</sup>

*You never expected justice from a company, did you? They neither have a soul to lose, nor a body to kick.\**

### I. INTRODUCTION

“The American public doesn’t realize that the managed-care industry is the only industry in the country that has a congressionally mandated shield from liability.”<sup>1</sup> Well, all that is about to change. One hun-

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<sup>†</sup> *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002). The mnemonic ERISA stands for Employee Retirement Income Security Act, 29 U.S.C. § 1001-1461 (2000). In the health care industry, the term “Health Maintenance Organization” (HMO) has been defined as “a prepaid organized delivery system where the organization *and* the primary care physicians assume some financial risk for the care provided to its enrolled members. . . . In a *pure HMO*, members must obtain care from within the system if it is to be reimbursed.” Jonathan P. Weiner & Gregory de Lissovoy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. HEALTH POL. POL’Y & L. 75, 96 (1993). “The term ‘Managed Care Organization’ is used more broadly to refer to any number of systems combining health care delivery with financing.” *Rush*, 536 U.S. at 361 n.1. Illinois defines HMO as “any organization formed under the laws of this or another state to provide or arrange for one or more health care plans under a system which causes any part of the risk of health care delivery to be borne by the organization or its providers.” Health Maintenance Organization Act, 215 ILL. COMP. STAT. 125/1-2 et seq. (2000). The Court references the Illinois statute saying:

The Illinois definition of HMO does not appear to be limited to the traditional usage of that term, but instead it is likely to encompass a variety of different structures (although Illinois does distinguish HMOs from pure insurers by regulating ‘traditional’ health insurance in a different portion of its insurance laws).

*Rush*, 536 U.S. at 361 n.1. For purposes of the *Rush* opinion and for purposes of this Note, the term HMO is used as the state of Illinois and the parties in *Rush* used it; that is, to simply describe the structures covered by the Illinois Act. *Id.* For general information on HMOs see DONALD A. BARR, INTRODUCTION TO U.S. HEALTH POLICY: THE ORGANIZATION, FINANCING, AND DELIVERY OF HEALTH CARE IN AMERICA (Benjamin Cummings 2002); ARNOLD BIRENBAUM, MANAGED CARE: MADE IN AMERICA (Praeger 1997); THE MANAGED HEALTH CARE HANDBOOK (Peter R. Kongstvedt ed., 3rd ed. 2001); MANAGED CARE AND PUBLIC HEALTH (Paul K. Halverson, et al., eds., Aspen 1998); MANAGEMENT OF HEALTH CARE (Rosemary Stewart, ed., Ashgate/Dartmouth 1998); REGULATING MANAGED CARE: THEORY, PRACTICE, AND FUTURE OPTIONS (Stuart H. Altman, et al., eds., 1st ed. 1999).

<sup>\*</sup> Louis E. Boone, *Quotable Business* 224 (2d ed. 1999) (quoting Sydney Smith (1771-1845); Smith was an English clergyman and author).

1. William M. Welch, *The New Untouchables: Why You Can’t Sue Your HMO, 1974 Pen-*

dred seventeen and a half million<sup>2</sup> Health Maintenance Organization (HMO) patients have recently achieved a small victory toward forcing HMOs to “show them the money”<sup>3</sup> when it comes to providing and paying for medical care. The United States Supreme Court’s five-to-four decision in *Rush Prudential HMO, Inc. v. Moran* unexpectedly held that an independent medical review statute<sup>4</sup> was not preempted by ERISA.<sup>5</sup> The decision came as a shock to many HMOs who had become comfortable hiding behind the preemptive shield of ERISA.<sup>6</sup>

Section II, Part A of this Note will discuss the history of ERISA law, including a look at what Congress intended to achieve in enacting such a broadly preemptive doctrine.<sup>7</sup> Parts B and C will explain the complicated and highly technical provisions that make up ERISA as it pertains to health care benefits law.<sup>8</sup> Finally, Part D will navigate several key cases leading up to the *Rush* decision and explain how each case contributed to the Court’s decision.<sup>9</sup> Following the background of ERISA law, Section III will discuss the facts of the *Rush* case, charting the journey that brought this issue to the United States Supreme Court

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*sions Law Sparks Political Fire*, USA TODAY, June 19, 1998 (quoting Rep. Charles Norwood).

2. NATIONAL HMO 2000-2001 DIRECTORY, INTERSTUDY PUBLICATIONS (1997), available at [http://www.managedcareinfo.com/hmo\\_enrollment\\_-\\_managed\\_c.htm](http://www.managedcareinfo.com/hmo_enrollment_-_managed_c.htm).

3. JERRY MCGUIRE (Tristar Pictures 2000). A variation of the line “show me the money” that was a catch phrase in the popular 2000 motion picture, *Jerry McGuire*, used here to mean that HMOs will have to start paying for medical services that are deemed “medically necessary” under independent review statutes.

4. See *Rush*, 536 U.S. at 355. The independent review statute at issue in *Rush* was the Health Maintenance Organization Act which provided:

Medical Necessity—Dispute Resolution—Independent Second Opinion. Each Health Maintenance Organization shall provide a mechanism for the timely review by a physician holding the same class of license as the primary care physician, who is unaffiliated with the Health Maintenance Organization, jointly selected by the patient (or the patient’s next of kin or legal representative if the patient is unable to act for himself), primary care physician and the Health Maintenance Organization in the event of a dispute between the primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician. In the event that the reviewing physician determines the covered service to be medically necessary, the Health Maintenance Organization shall provide the covered service. Future contractual or employment action by the Health Maintenance Organization regarding the primary care physician shall not be based solely on the physician’s participation in this procedure.

215 ILL. COMP. STAT. 125/4-10 (2000).

5. *Rush*, 536 U.S. at 359.

6. See Welch, *supra* note 1. The term “preemptive shield” is used here to refer to ERISA’s preemptive provision which is described in great detail *infra* notes 22-28.

7. See *infra* notes 14-16 and accompanying text.

8. See *infra* notes 17-42 and accompanying text.

9. See *infra* notes 43-79 and accompanying text.

and taking the reader through the reasoning of the Court.<sup>10</sup> Section IV is an analysis of the *Rush* decision. The first part of the analysis explains why the *Rush* decision produced the correct outcome in view of five specific factors: (1) HMOs should not have the ability to reserve absolute discretion without limits; (2) the doctor-patient relationship has been destroyed in the managed care era; (3) there is no fear that patients will yield outrageous damage awards that would cause HMOs to go bankrupt; (4) *Pegram* still stands for the proposition that patients cannot sue HMOs for having a profit motive; and (5) the uniformity that Congress sought to maintain is still intact.<sup>11</sup> The second step in the analysis is to explain why some people worry that the decision in *Rush* is not enough to protect millions of patients.<sup>12</sup> Finally, in Section IV, Part C, there is a discussion of recent rulings interpreting and applying the rules supplied by the *Rush* Court.<sup>13</sup>

## II. BACKGROUND

### A. *The Road to ERISA*

Throughout the 1960's, stories of widespread mismanagement of employee pension funds were common among workers.<sup>14</sup> The problems increased until the 1970's, when it became clear that Congress needed to get involved.<sup>15</sup> Congressional emphasis on the need for comprehensive pension plan reform grew throughout the decade, eventually resulting in the Employee Retirement Income Security Act of 1974 (ERISA).<sup>16</sup>

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10. See *infra* notes 80-128 and accompanying text.

11. See *infra* notes 129-181 and accompanying text.

12. See *infra* notes 182-192 and accompanying text.

13. See *infra* notes 193-207 and accompanying text.

14. Cynthia Ransburg-Brown, *The Ultimate Jigsaw Puzzle: ERISA Preemption and Liability in the Utilization Review Process*, 28 CUMB. L. REV. 403 (1997) (stating that Congress envisioned a comprehensive regulatory scheme aimed at remedying the widespread mismanagement of pension funds); see also Jolee Ann Hancock, Comment, *Diseased Federalism: Health Care State Laws Fall Prey to ERISA Preemption*, 25 CUMB. L. REV. 383 (1994) (stating that pension funds, although widely used were not required by law to maintain specific investment levels).

15. David Gregory, *The Scope of ERISA Preemption of State Law: A Study in Effective Federalism*, 48 U. PITT. L. REV. 427, 443-44 (1987) (giving an overview of ERISA's formation, legislative history, and congressional intent). See generally BENJAMIN AARON, LEGAL STATUS OF EMPLOYEE BENEFIT RIGHTS UNDER PRIVATE PENSION PLANS (1961); M. BERNSTEIN, THE FUTURE OF PRIVATE PENSIONS (1964) (detailing private pension plan abuses); William J. Isaacson, *Employee Welfare and Pension Plans: Regulation and Protection of Employee Rights*, 59 COLUM. L. REV. 96 (1959) (explaining problems of the employee benefit systems); Ransburg-Brown, *supra* note 14, at 414-15 (giving an overview of ERISA's historical development).

16. See Gregory, *supra* note 15, at 445. ERISA is codified as 29 U.S.C. §§ 1001-1461 (2000). At least five bills in the 93d Congress contributed to the final ERISA legislation. Senate

### B. What is ERISA?

ERISA is a federal law that governs certain employee benefit plans.<sup>17</sup> Specifically, ERISA applies to two separate classes of employee benefit plans: (1) welfare benefit plans and (2) pension plans.<sup>18</sup> ERISA was enacted to “safeguard . . . the establishment, operation, and administration’ of employee benefit plans.”<sup>19</sup> It accomplishes this by es-

Bill 4 was reported by the Senate Finance Committee on April 18, 1973 and passed by the Senate on September 19, 1973. 119 CONG. REC. 30,428 (1973); S. REP. NO. 93-127 (1973). Two prior bills in the House of Representatives, H.R. 2 and H.R. 12,855, contributed to the compromise of final House bill that was passed on February 28, 1974. 120 CONG. REC. 4781-82 (1974). The Senate in turn passed its own amended version of H.R. 2 on March 4, 1974. A joint conference committee resolved discrepancies between the House and Senate versions. The Conference Report Bill, H.R. REP. NO. 93-1280 (1974), was submitted August 12, 1974. It passed the House on August 20, 1974 with only two dissenting votes and passed the Senate unanimously on August 22, 1974. President Ford signed the bill on September 2, 1974. Gregory, *supra* note 15, at 445 n.59.

17. See generally ERISA 20 YEARS LATER: A LOOK BACK, A LOOK AHEAD: THE PROCEEDINGS (Dallas L. Salisbury et al. eds., 1995); JOSEPH R. SIMONE, UNDERSTANDING ERISA, 2002: AN INTRODUCTION TO BASIC EMPLOYEE RETIREMENT BENEFITS (Practising Law Institute 2002); SUBCOMM. ON LABOR OF THE COMM. ON LABOR AND PUB. WELFARE, UNITED STATES SENATE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974: public law 93-406 (W.S. Hein 2000); U.S. Gen. Accounting Office, Employer-Based Health Plans : Issues, Trends, and Challenges Posed by ERISA (1995); Carole R. Gresenz, A FLOOD OF LITIGATION?: PREDICTING THE CONSEQUENCES OF CHANGING LEGAL REMEDIES AVAILABLE TO ERISA BENEFICIARIES (RAND 1999).

18. ALAN P. WOODRUFF, ERISA LAW ANSWER BOOK 1-2 (3d ed. 2001). Welfare benefit plan is defined in ERISA section 3(1) as,

[a]ny plan, fund or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training program, or day care centers, scholarship funds, or prepaid legal services . . .

*Id.* There is no need to include a definition of pension plan for the purposes of this Note; however for further information regarding pension plans, see Woodruff, *supra*.

19. Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 364 (2002) (quoting 29 U.S.C. § 1001(a) (2000)). 29 U.S.C. § 1001(a) states in relevant part:

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans . . . that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans . . . that owing to the inadequacy of current minimum standards . . . employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of

tablishing a “predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred.”<sup>20</sup>

While ERISA is an extremely complex set of rules and regulations, there are three main provisions necessary to understanding the *Rush* decision. These three provisions are: (1) the Preemption Provision, (2) the Savings Clause, and (3) the Civil Enforcement Provision. Subsection II. C will explain each provision and why poor legislative drafting resulted in heavy litigation of these provisions.<sup>21</sup>

### C. ERISA: A Poor Example of Successful Legislative Drafting

#### 1. The Preemption Provision<sup>22</sup>

An express preemption provision was written in the text of

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commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

*Id.*

20. *Rush*, 536 U.S. at 379. The “‘uniformity of decision . . . will help administrators . . . predict the legality of proposed actions without the necessity of reference to varying state laws.’” *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987) (citing H.R. REP. No. 93-533, at 12 (1973)). Woodruff writes:

Congress sought to free employee benefit plans from conflicting regulations by different states and ensure that plans and plan sponsors would be subject to a uniform body of benefit law. The goal was to minimize the administration and financial burden of complying with conflicting directives among states and between states and the federal government.

WOODRUFF, *supra* note 18, at 20-2; *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 113 (1990); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

21. *Rush*, 536 U.S. at 365. “The ‘unhelpful’ drafting of these antiphonal clauses occupies a substantial share of this Court’s time.” *Id.*

22. *See* U.S. CONST. art. VI; WOODRUFF, *supra* note 18, at 20-4. ERISA gets its preemption authority from the Supremacy Clause of the U.S. Constitution. WOODRUFF, *supra*, at 20-4. “Under the Supremacy Clause, state laws that interfere with or are contrary to federal law are invalidated.” *Id.* (citing *Gibbons v. Ogden*, 22 U.S. 1 (1824)). Congress may preempt an entire field of regulation:

Congress may expressly state that it intends to preempt a field. Preemption of an entire field of law may be inferred when the domain is one in which the scheme of federal regulation is comprehensive and “the federal interest is so dominant that the federal system will be assumed to preclude enforcement of state laws on the same subject.”

*Id.* at 20-4 (citing *Hillsborough County, Fla. v. Automated Med. Lab., Inc.*, 471 U.S. 707, 713 (1985), *quoted in* *Hodges v. Delta Airlines, Inc.*, 44 F.3d 334, 334 n.1 (5th Cir. 1995)).

When Congress has not completely displaced all systems of state regulation, federal preemption will be found on the specific issues for which there is an actual conflict between state and federal law and for which compliance with both is an impossibility.

*Id.* (citing *Fla. Lime & Avocado Growers Inc. v. Paul*, 373 U.S. 132 (1963)).

ERISA.<sup>23</sup> This provision provides that ERISA “shall supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.”<sup>24</sup> The preemption provision was called the “‘crowning achievement’ of [ERISA] legislation.”<sup>25</sup> The provision was meant to have a broad, sweeping and preemptive effect on state law related to employee benefit plans.<sup>26</sup> Despite the statements made by ERISA sponsors regarding the intended broad preemption powers, the final draft of ERISA left some room to debate the “relate to” phrase in

23. 29 U.S.C. § 1144(a) (2000).

24. *Id.* The ERISA preemption provision reads in full:

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

*Id.*

25. Gregory, *supra* note 15, at 456 (quoting Rep. John Dent, 120 CONG. REC. 29,197 (1974)).

Rep. Dent’s statement reads in relevant part:

Finally, I wish to make note of what is, to many, the crowning achievement of this legislation -- the reservation to Federal authority the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting State and local regulation . . .

120 CONG. REC. 29,197 (1974).

26. See *supra* note 24 (reading that “ERISA shall supercede any and all State laws.”); see also

120 CONG. REC. S29,933–42 (1974). Sen. Javits stated:

Both House and Senate bills provided for preemption of State law, but—with one major exception appearing in the House bill—they defined the parameters of preemption in relation to the areas regulated by the bill. Such a formulation raised the possibility of endless litigation over the validity of State action that might impinge on Federal regulation, as well as opening the door to multiple and potentially conflicting State laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme. Although the desirability of further regulation—at either State or Federal level—undoubtedly warrants further attention, on balance, the emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required—but for certain exceptions—the displacement of State action in the field of private employee benefit programs.

*Id.* at 29,942. Sen. Williams commented:

It should be stressed that with narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.

*Id.* at 29,933. See also *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45-46 (1987) (stating the express preemption provisions of ERISA are deliberately expansive). But see Catherine L. Fisk, *The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 HARV. J. ONLEGIS. 35, 52 (1996) (stating that while the legislative history of ERISA is voluminous, the actual historical evidence of congressional intent regarding preemption is sparse which shows that Congress gave little thought to preemption).

the preemption provision.<sup>27</sup> In general, the Court adheres to a broad interpretation of ERISA preemption, stating that a law “relates to” an employee benefit plan if the law “has a connection with or reference to such a plan.”<sup>28</sup>

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27. See Gregory, *supra* note 15, at 457. Gregory gives a comprehensive analysis of the pitfalls that would result if the phrase “relate to” truly meant that ERISA preempted all state laws regulating employee benefit plans. *Id.* The theories advanced to interpret “relate to” within § 1144(a) span the spectrum from very broad to very narrow. See William J. Kilberg & Catherine L. Heron, *The Preemption of State Law under ERISA*, 1979 DUKE L.J. 383 (1979). The broad interpretation would imply that the plain meaning should be used to determine if a state law “relates to” an employee benefit plan. See William J. Kilberg & Paul D. Inman, *Preemption of State Law Under ERISA: Drawing the Line Between Laws that Do and Laws that Do Not Relate to Employee Benefit Plans*, 19 FORUM 162 (1983). The narrow interpretation would require a direct conflict between the state law and ERISA. *Id.* See also Peter H. Turza & Lorraine Halloway, *Preemption of State Laws Under the Employee Retirement Income Security Act of 1974*, 28 CATH. U. L. REV. 163 (1979) (explaining preemption issues surrounding the unhelpful drafting of ERISA’s preemption provision). See generally David J. Brummond, *Federal Preemption of State Insurance Regulation Under ERISA*, 62 IOWA L. REV. 57 (1976) (discussing key issues of ERISA preemption); James D. Hutchinson & David M. Ifshin, *Federal Preemption of State Law Under the Employee Retirement Income Security Act of 1974*, 46 U. CHI. L. REV. 23 (1978) (discussing preemption provisions of ERISA).

28. Ransburg-Brown, *supra* note 14, at 417 (quoting from *Pilot Life*, 481 U.S. at 47). There is still some debate over what exactly should be made of the preemption provision; however, for the purposes of this Note these debates are irrelevant. See also Phyllis C. Borzi & Marc I. Machiz, *ERISA and Managed Care Plans: Key Preemption and Fiduciary Issues*, SF28 ALI-ABA 371, 374 (2000) (stating that “[w]hen Congress enacted ERISA, it intended to retain broad Federal regulatory authority over all employee benefit plans covered under the Act”); Jody L. Mikasen, et al., 60 AM. JUR. 2D *Pensions and Retirement Funds* §118 (2002). For further Court comments on the preemption provision, see *N.Y. Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 662 (1995), wherein the Court refused to preempt laws operating as an indirect source of merely economic influence on administrative decisions. See also, *Shaw v. Delta Airlines Inc.*, 463 U.S. 85, 100 n.21 (1983) (implying that ERISA requires a case by case evaluation of the state impact on the administration of an ERISA plan in order to invoke the powerful preemption clause). *Shaw* was decided in 1983 and introduced a two-prong analysis: “A state law ‘relates to’ an ERISA employee benefit plan if it ‘has a connection with’ or ‘reference to’ such a plan.” WOODRUFF, *supra* note 18, at 20-4. Some courts treated the “reference to” language from *Shaw* as an independent requirement, while other courts seem to merge the two prongs. *Id.* at 20-5. See *Travelers*, 514 U.S. at 645 (applying a “two-pronged analysis, holding first that the statute at issue did not ‘refer to’ ERISA plans and then concluding that it also did not have a sufficient ‘connection with’ such plans to warrant preemption”).

Nonetheless, if *Travelers* is to be read literally, it eliminates from preemption analysis only state statutes that make “reference to” ERISA plans. That does nothing to aid in determining when a state statute has a “connection with” an ERISA plan; for making that determination, it is still necessary to return to traditional preemption analysis. WOODRUFF, *supra* note 18, at 20-5. To see a variety of the tests that courts have used to determine whether a state law is subject to preemption, see *id.* at 20-5-20-6. For a more comprehensive view of *Travelers* see Borzi *supra*. But see Gregory, *supra* note 15, at 462 (discussing *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981) and stating that the Supreme Court had already “demonstrated a clear move toward articulating general preemption principles, rather than utilizing the individual case approach”).

## 2. The Savings Clause<sup>29</sup>

After establishing a broad preemptive power, Congress then added a Savings Clause that “reclaims” much of the ground covered by the preemption provision.<sup>30</sup> The Savings Clause reads, “nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance.”<sup>31</sup> This means that any law that regulates insurance will not be subject to ERISA preemption despite the broad language of the preemption provision. It is this contradiction that has often baffled the courts and led commentators to suggest that Congress amend the provisions to clarify its intentions.<sup>32</sup>

The Supreme Court has stated that as a result of the contradiction between the preemption clause and the savings clause, the Court has “‘no choice’ but to assume that ‘the ordinary meaning . . . accurately expresses the legislative purpose . . . .’”<sup>33</sup> Here, that means that state laws regulating insurance will not be preempted.<sup>34</sup> However, Congress did

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29. 29 U.S.C. § 1144(b)(2)(A)(2000).

30. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 364 (2002).

31. 29 U.S.C. § 1144(b)(2)(A)(2000). The saving clause reads in full, “nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.” *Id.* Insurance laws have proven to be the most significant of the three, both in terms of their substantive reach and the number of ERISA preemption challenges that have been raised. *See* ABA Section of Labor & Employment Law, *Employee Benefits Law 793-95* (2d. ed. 2000). It is only the “insurance” portion that will be discussed in this Note.

32. *Rush*, 536 U.S. at 364-65. “The ‘unhelpful’ drafting of these antiphonal clauses . . . occupies a substantial share of this Court’s time.” *Id.* (quoting from *Travelers*, 514 U.S. at 656) (internal citations omitted). *See, e.g.*, *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001); *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999) (holding that California’s notice prejudice rule “regulates insurance” within the meaning of ERISA’s saving clause and therefore was not preempted by ERISA); *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316 (1997); *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). In *Metro. Life*, the Court openly criticized the salient ERISA preemption clauses, stating that “[w]hile Congress occasionally decides to return to the State what it has previously taken away, it does not normally do both at the same time.” *Id.* at 740. The Court goes on to say in a footnote that “commentators have recommended that Congress amend the preemption provisions to clarify its intentions.” *Id.* at n.16 (citing Theodore Paul Manno, *ERISA Preemption and the McCarran-Ferguson Act: The Need for Congressional Action*, 52 *TEMP. L.Q.* 51 (1979); F. Okin, *Preemption of State Insurance Regulation by ERISA*, 13 *A.B.A. Forum* 652, 678 (1978)). The Court says that Congress is also aware of the problem and introduced a bill in 1979 to amend ERISA to provide that state mandated-benefit statutes are not preserved by the insurance savings clause. *Metro. Life*, 471 U.S. at 740 n.16. *See* S. 209, 96th Cong.; 125 *CONG. REC.* 933, 937 (1979). The bill was reported to the Senate but died without being debated. *See* S. Comm. On Labor and Human Res., 96 Cong., Leg. Calendar 108, 111 (final ed., Jan. 4, 1981).

33. *Rush*, 536 U.S. at 365 (quoting *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985) (stating that when congressional language seems to preempt everything and hardly anything at the same time, the Court must assume that the ordinary meaning is the correct interpretation)).

34. *See N.Y. Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995). “We have worked on the ‘assumption that the historical police powers of the States were not [meant] to be superseded by the Federal Act unless that was the clear and manifest purpose of



not provide the courts with guidelines to decide if a state law “regulates insurance” within the meaning of the savings clause.<sup>35</sup> In the absence of ERISA guidelines, the courts have traditionally used two major tests to decide whether a state law regulates insurance for the purposes of the savings clause: (1) a commonsense view<sup>36</sup> of the matter and (2) the McCarran-Ferguson factors.<sup>37</sup> These tests will be explained in greater detail in Subsection II. D of this Note.

### 3. The Civil Enforcement Provision

The Civil Enforcement Provision of ERISA dictates what remedies are available for participants under ERISA qualified plans.<sup>38</sup> This provision allows civil actions for six specific types of equitable relief.<sup>39</sup> Even if a court cannot figure out whether a state law was meant to be preempted under the preemption clause and the savings clause, it may still be preempted if it supplants or supplements the civil enforcement provision.<sup>40</sup> The Court has determined that Congress’ policy of creating a

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Congress.” *Id.* (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

35. See ABA Section of Labor & Employment Law, *supra* note 31, at 799.

36. See *infra* notes 49-50 and accompanying text.

37. See *infra* notes 52-57 and accompanying text.

38. 29 U.S.C. § 1132(a) (2000). The Civil Enforcement provision provides in relevant part: A civil action may be brought — (1) by a participant or beneficiary — (A) for the relief provided for in subsection (c) of this section, or (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan; (2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title [breach of fiduciary duty]; (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan; (4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title [information to be furnished to participants]; (5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter.”

*Rush*, 536 U.S. at 376 n.7.

39. *Id.* at 375-76. The Court goes on to say that the civil enforcement provision “amounted to an “interlocking, interrelated, and interdependent remedial scheme.”” *Id.* at 376 (quoting *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985)). The ramifications of this classification will be discussed later in this Note.

40. See *Pilot Life Ins. v. Dedeaux*, 481 U.S. 41, 56 (1987); *Rush*, 536 U.S. at 378. The petitioners in *Rush* argued that § 4-10 was preempted from creating a sort of “alternative remedy” to that which is allowed in ERISA’s civil enforcement provision. *Id.* at 377-78. It is clearly held in precedent that a state law cannot create new remedies that would not have been allowed under ERISA, but the Court in *Rush* did not find § 4-10 to be creating a new remedy. See *id.* at 376-81;

uniform system of federal remedies in the area of employee benefit plan law is so strong that *all* laws relating to employee benefit plans will be preempted if they provide remedies outside of those provided for in ERISA's civil enforcement provision.<sup>41</sup> This is true even if the court has already found that the law "regulates insurance" within the meaning of the savings clause.<sup>42</sup>

#### *D. The Court's Analysis of ERISA Provisions Prior to Rush*

Prior to the *Rush* decision, the Supreme Court struggled to interpret each of the key provisions of ERISA.<sup>43</sup> The two main points of contention in *Rush* center on defining what laws "regulate insurance" for pur-

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Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990) (finding that Texas's tort of wrongful discharge, turning on an employer's motivation to avoid paying pension benefits, conflicted with ERISA enforcement); Metro. Life Ins. Co. v. Taylor, 481 U.S. 58, 64 (1987) (holding that Congress had so completely preempted the field of benefits law that an ostensibly state cause of action for benefits was necessarily a creature of federal law removable to federal court); Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 148 (1985) (concluding that Congress had not intended causes of action under ERISA itself beyond those specified in §1132(a)).

41. *Rush*, 536 U.S. at 375-76. See also *supra* note 38 (listing the full text of the civil enforcement provision). Sometimes congressional intent is so clear that it overrides a statutory provision designed to save state law from being preempted. See *Am. Tel. & Telegraph Co. v. Cent. Office Tel., Inc.*, 524 U.S. 214, 226 (1998) (overriding policy of the filed-rate doctrine defeated a clause in the Communications Act of 1934 purporting to save the remedies now existing at common law or by statute); *Adams Express Co. v. Croninger*, 226 U.S. 491 (1913) (holding that the saving clauses would not sanction state laws that would nullify policy expressed in federal statute). See also *Pilot Life*, 481 U.S. at 54 (holding ERISA's civil enforcement remedies were intended to be exclusive). In *Pilot Life* the Court stated that the civil enforcement scheme of ERISA represented "a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." *Id.* "The civil enforcement provisions are of such 'extraordinarily preemptive power' that they override even the 'well-pleaded complaint' rule . . ." *Rush*, 536 U.S. at 376 (citing *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987)).

42. See *Pilot Life*, 481 U.S. at 54. The Court in *Pilot Life* adamantly argued for exclusive remedies under all ERISA governed plans:

The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. "The six carefully integrated civil enforcement provision found in [ERISA] as finally enacted. . . provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly." The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive. This conclusion is fully confirmed by the legislative history of the civil enforcement provision.

*Id.* (quoting *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)).

43. See *Gregory*, *supra* note 15; see generally WOODRUFF, *supra* note 18. As used here, "key provisions" indicate the preemption provision, the saving clause, and the civil enforcement provision.

poses of the savings clause and interpreting what laws “conflict” with the civil enforcement provision of ERISA.<sup>44</sup> The following subsections detail Supreme Court cases prior to *Rush* relevant to each of these arguments.<sup>45</sup>

### 1. *Metropolitan Life* Provides the Key to what “Regulates Insurance”

In *Metropolitan Life*, the Massachusetts Attorney General brought an action against an insurance company to enforce a Massachusetts statute setting forth mandatory minimum mental health care benefits<sup>46</sup> for inclusion in all insurance policies.<sup>47</sup> These types of statutes are often called “mandated benefits” statutes.<sup>48</sup> In this case, the Court begins the savings clause analysis by “stat[ing] the obvious,” that mandated benefit statutes “regulate[] the terms of certain insurance contracts,” and as such are saved from preemption by the savings clause as a law “which regu-

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44. See *Rush*, 536 U.S. at 365-386.

45. The decision in *Rush* stated that “[i]t is beyond serious dispute that under existing precedent § 4-10 of the Illinois HMO Act ‘relates to’ employee benefit plans within the meaning of [ERISA’s preemption provision] § 1144(a).” *Rush*, 536 U.S. at 365. The Court supports this contention by stating that the state law “bears indirectly but substantially on all insured benefit plans,” by requiring them to submit to an extra layer of review for certain benefit denials if they purchase medical coverage from any of the common types of health care organizations covered by the state law’s definition of HMO. *Id.* (quoting *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985)).

It is for the above stated reason that this Note does not go into detail on what cases led up to the conclusion that § 4-10 “relates to” an employee benefit plan. For further information on cases leading up to the holding in *Metropolitan Life*, see Gregory, *supra* note 15, at 459-70 (giving an overview of ERISA preemption of state law in the United States Supreme Court).

46. *Metro. Life Ins. Co. v. Massachusetts* 471 U.S. 724, 727 (1985). Specifically, the statute requires that a health insurance policy provide 60 days of coverage for confinement in a mental hospital, coverage for confinement in a general hospital equal to that provided by the policy for non-mental illness, and certain minimum outpatient benefits. *Id.* at 730.

47. *Id.* at 727. The term “all” is used specifically to refer to general insurance policies, an accident or sickness insurance policy, or an employee health care insurance plan that covers hospital and surgical expenses. *Id.*

48. *Id.* at 728. The first mandated benefit statutes regulating terms in group health insurance appeared in 1971 and 1972 prior to the enactment of ERISA. *Id.* at n.3. See generally Brummond, *supra* note 27. The Court goes on to say that according to the Health Insurance Association of America, twenty-six states have promulgated sixty-nine mandated benefit laws. *Metro. Life*, 471 U.S. at 730 n.10. See also *Wayne Chemical, Inc. v. Columbus Agency Service Corp.*, 426 F. Supp. 316, 324 n.8 (N.D. Ill. 1977) (citing statutes in 26 states), *aff’d as modified*, 567 F.2d 692 (7th Cir. 1977). Different states mandate a great variety of different kinds of insurance coverage. *Metro. Life*, 471 U.S. at 730 n.10. For example, many require alcoholism coverage, while others require certain birth defect coverage, outpatient dialysis coverage or reconstructive surgery for insured mastectomies. *Id.*

lates insurance.”<sup>49</sup> The Court calls this a “common-sense view of the matter.”<sup>50</sup>

After the insurers unsuccessfully argued that mandated benefit statutes are, in reality, a health law that merely operates on insurance contracts,<sup>51</sup> the Court supported its commonsense approach with an analysis under the McCarran-Ferguson Act.<sup>52</sup> The Court reasoned that ERISA’s

49. *Metro. Life*, 471 U.S. at 740. The Court goes on to say that this “common-sense view . . . is reinforced by the language of the subsequent subsection of ERISA, the ‘deemer clause,’ which states that an employee-benefit plan shall not be deemed to be an insurance company ‘for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.’” *Id.* at 740-41 (quoting 29 U.S.C. § 514(b)(2)(B) (2000), 29 U.S.C. § 1144(b)(2)(B) (2000)) (emphasis added).

50. *Metro. Life*, 471 U.S. at 740. See also WOODRUFF, *supra* note 18, at 20-32 (explaining the two-tier test used in *Metro. Life*).

51. *Metro. Life*, 471 U.S. at 741. The Court gave several reasons for rejecting this contention: The presumption is against preemption, and we are not inclined to read limitations into federal statutes in order to enlarge their pre-emptive scope. Further, there is no indication in the legislative history that Congress had such a distinction in mind. . . . This distinction reads the saving clause out of ERISA entirely, because laws that regulate only the insurer, or the way in which it may sell insurance, do not “relate to” benefit plans in the first instance. . . . There is no indication that Congress could have intended the saving clause to operate only to guard against too expansive readings of the general preemption clause that might have included laws wholly unrelated to plans.

*Id.* at 741-42. The Court goes on to say that this construction violates the plain meaning of the statutory language and renders redundant both the savings clause and the deemer clause. *Id.* at 742. “Moreover, it is both historically and conceptually inaccurate to assert that mandated-benefit laws are not traditional insurance laws.” *Id.* “[S]tate laws regulating the substantive terms of insurance contracts were commonplace well before the mid-70’s, when Congress considered ERISA.” *Id.* at 742. A variety of cases have addressed the question. *Id.* at 18. All have concluded that laws regulating the substantive content of insurance contracts are laws that regulate insurance, thus falling within the scope of the insurance savings clause. *Id.*

52. *Metro. Life*, 471 U.S. at 743. “Business of insurance” is the phrase used in the McCarran-Ferguson Act. 15 U.S.C. § 1011 *et seq.* (2000). The McCarran-Ferguson Act expresses congressional intent that states, not the federal government, be the primary regulators of insurance. Gregory, *supra* note 15, at 468.

Since the writing of this law review article, the Supreme Court has held that an analysis under the McCarran-Ferguson Act is not a requirement to finding a state law “regulates insurance” within the meaning of ERISA’s savings clause. *Kentucky Ass’n of Health Plans, Inc. v. Miller*, 123 S. Ct. 1471, 1479 (2003). In that opinion the Court stated:

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 [ERISA’s savings clause], it must satisfy two requirements. First, the state law must be specifically directed toward entities engaged in insurance. Second, [] the state law must substantially affect the risk pooling arrangement between the insurer and the insured.

*Id.* Essentially, the Supreme Court in *Miller* found that a decision regarding whether a state law “regulates insurance” within the meaning of ERISA’s savings clause should be based solely on the “common sense view of the matter” used in *Rush*. See *id.*; *Rush*, 536 U.S. at 356-66. Furthermore, any analysis using the McCarran-Ferguson Act will be relevant only to the extent that it bolsters a common sense view argument. See *Miller*, 123 S. Ct. at 1479. It is important to note that the decision in *Miller* does not seem to be overtly overruling *Rush*, but rather clarifying what role the

savings clause, “with its similarly worded protection of ‘any law of any State which regulates insurance,’ appears to have been designed to preserve the McCarran-Ferguson Act’s reservation of the business of insurance to the states.”<sup>53</sup> Under this rationale it made sense to use the McCarran-Ferguson factors to determine what activities constitute the business of insurance under the savings clause.<sup>54</sup>

The Act contains three criteria relevant to determining whether a particular practice refers to the “business of insurance.”<sup>55</sup> These three factors are: (1) whether the practice has the effect of transferring or spreading a policyholder’s risk; (2) whether the practice involves an integral part of the policy relationship between the insurer and the insured; and (3) whether the practice is limited to entities within the insurance industry.<sup>56</sup> After finding that the mandated benefit statute satisfied all

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McCarran-Ferguson Act plays when determining whether a state law regulates insurance for purposes of ERISA’s savings clause. *Miller* clearly acknowledges that *Rush* used the McCarran-Ferguson factors only as “guideposts” to “confirm [their] conclusion.” *Id.* Therefore, taking the McCarran-Ferguson factors out of the *Rush* decision would not change the ultimate ruling in *Rush*.

53. Troy Paredes, Note, *Stop-Loss Insurance, State Regulation, and ERISA: Defining the Scope of Federal Preemption*, 34 HARV. J. ON LEGIS. 233, 241 (1997) (quoting *Metro. Life*, 471 U.S. at 744 n.21). Paredes asserts that “[b]y saving state insurance regulation from preemption, Congress preserved and reaffirmed the role of the states as the primary regulators in the field of insurance, notwithstanding the leading congressional objective of federally uniform benefit plan regulations.” *Id.* See *Metro. Life*, 471 U.S. 724; JOHN J. LANGBEIN & BRUCE A. WOLK, PENSION AND EMPLOYEE BENEFIT LAW, 417 (2d ed. 1995) (asserting that the savings clause provision continues the federal policy entrenched in the McCarran-Ferguson Act of 1945, that is to defer to the states in the regulation of the insurance industry); Leslie C. Levin, Comment, *ERISA Preemption and Indirect Regulation of Employee Welfare Plans through State Insurance Laws*, 78 COLUM. L. REV. 1536, 1539-40 (1978).

54. See Paredes, *supra* note 53.

55. *Metro. Life*, 471 U.S. at 743. The Court felt that passing the McCarran-Ferguson test “strongly supports the conclusion that regulation regarding the substantive terms of insurance contracts falls squarely within the savings clause as laws ‘which regulate insurance.’” *Id.* at 742-43. “The McCarran-Ferguson Act was enacted by Congress in 1945 in response to the U.S. Supreme Court’s decision in *U.S. v. South Eastern Underwriters Ass’n*, 322 U.S. 533 (1944).” WOODRUFF, *supra* note 18, at 20-32. “In that case, the Court held that regulation of interstate insurance activity was within the Commerce Clause power of Congress.” *Id.* “Congress responded adversely to the Court’s decision, immediately enacting McCarran-Ferguson ‘to assure that the activities of insurance companies in dealing with their policyholders would remain subject to state regulation.’” *Id.* (quoting *S.E.C. v. Nat’l Sec., Inc.*, 393 U.S. 453, 459 (1969)).

56. *Metro. Life*, 471 U.S. at 743. See also *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982); *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979); WOODRUFF, *supra* note 18, at 20-33. While the holding in *Metropolitan Life* did not explicitly say that all three of the McCarran-Ferguson factors must be satisfied in order to avoid preemption by way of the savings clause, later Supreme Court rulings and district court rulings implied that all three McCarran-Ferguson factors must be satisfied in order to avoid preemption. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48-49 (1987) (finding that state law did not regulate insurance after concluding that law satisfied only one of the three McCarran-Ferguson factors); WOODRUFF, *supra* note 18, at 20-33 (“If a court finds that the state law in question fails either the commonsense test or any one . . .

three factors, the Court was convinced that, both historically and conceptually, mandated benefit statutes regulate insurance within the meaning of the ERISA savings clause.<sup>57</sup>

The holding in *Metropolitan Life* was significant because it stated a comprehensive method to determine whether a law “regulates insurance,” thus providing a precedent for subjecting state laws to analysis under both the commonsense test and the McCarran-Ferguson Act.<sup>58</sup>

## 2. *Russell* and *Pilot Life*: Remedies Cannot Conflict with ERISA

In *Rush*, the Court briefly discussed cases that helped lead to a decision about whether a particular law provides remedies that conflict with ERISA’s civil enforcement provision.<sup>59</sup>

*Massachusetts Mutual Life Ins. Co. v. Russell*<sup>60</sup> was the first Supreme Court case to conclude that Congress had not intended causes of action under ERISA beyond those specified in the civil enforcement provision.<sup>61</sup> *Russell* involved an employee benefit plan participant (Russell) who sued her benefit plan administrator (Massachusetts Mutual) for breach of fiduciary duty.<sup>62</sup> When Russell became temporarily disabled on account of a back injury, the Massachusetts Mutual disability com-

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criteria . . . the law fails to fall within the ERISA savings clause and is therefore preempted.”); *Texas Pharmacy Ass’n v. Prudential Ins. Co.*, 105 F.3d 1035 (5th Cir. 1997). Some courts have held prior to *Rush* that all three of the McCarran-Ferguson factors must be satisfied for a law to regulate insurance. *See CIGNA Healthplan of La., Inc. v. Louisiana*, 82 F.3d 642 (5th Cir. 1996). *But see Cisneros v. UNUM Life Ins. Co.*, 115 F.3d 669 (9th Cir. 1997) (holding that the McCarran-Ferguson factors were simply relevant considerations or guideposts and not essential elements of a three part test that must be satisfied for a law to escape preemption).

57. *Metro. Life*, 471 U.S. at 744. The Court noted that there was an absence of case authority suggesting that laws regulating the terms of insurance contracts could not be understood as laws that regulate insurance. *Id.* “In short, the plain language of the saving clause, its relationship to the other ERISA preemption provisions, and the traditional understanding of insurance regulation, all lead to the conclusion that mandated-benefit laws . . . are saved from preemption by the operation of the savings clause.” *Id.*

58. *See Gregory*, *supra* note 15; Paredes, *supra* note 53, at n.48. While many earlier cases asserted many of the same principles stated in *Metropolitan Life*, it is the latter that is most cited for the two-tier approach to the savings clause analysis. *See id.*

59. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 378-79 (2002). Recall that even if a law is “saved” from preemption by way of the savings clause, it might still be preempted if it provides a remedy that was specifically rejected in ERISA. *See supra* notes 37-41 and accompanying text.

60. *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985).

61. *Rush*, 536 U.S. at 378 (citing *Russell*, 473 U.S. at 148). *See, e.g.*, 120 CONG. REC. 29929 (1974); 120 CONG. REC. 29210-29211 (1974); H.R. REP. No. 93-533, 1, 9 (1973); *see also Russell*, 473 U.S. at 148 n.17 (stating that Congress was concerned that the cost of federal standards would discourage the growth of private pension plans).

62. *See Russell*, 473 U.S. at 136-37.

mittee terminated her benefits based on a report of an orthopedic surgeon indicating a lack of orthopedic illness.<sup>63</sup>

After Russell's psychiatrist submitted a report to the disability committee explaining that Russell suffered from physical manifestations of a psychosomatic disability, the plan administrator reinstated her benefits.<sup>64</sup> Although the plan paid all benefits to which Russell had been contractually entitled, Russell sued, alleging that the untimely processing of her claim by plan administrators had caused injury to her during the 132 days she had been temporarily terminated from the plan's benefits.<sup>65</sup> Russell's claim for breach of fiduciary duty was found to be governed by ERISA, and the Court of Appeals held that ERISA's provision for breach of fiduciary duty left room for compensatory and punitive damages.<sup>66</sup>

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63. *Id.* at 136.

64. *Id.* The disability committee discontinued her benefits based on the orthopedic surgeon's report that there was nothing physically causing the problems about which Russell complained. *See id.* After the psychiatrist's report clarified that the condition was caused by a mental strain and not a physical injury, the committee reinstated her benefits. *See id.* The benefits were terminated on October 17, 1979, and reinstated March 11, 1980. *Id.* Two days later, retroactive benefits were paid in full. *Id.* Russell later qualified for permanent disability benefits that were paid regularly. *Id.* at n.1.

65. *Russell*, 473 U.S. at 136-37. Among other allegations, Russell asserted that fiduciaries administering the plan were high ranking company officials who: (1) ignored readily available medical evidence documenting her disability; (2) applied unwarrantedly strict eligibility standards; and (3) deliberately took 132 days to process her claim in violation of regulations promulgated by the Secretary of Labor. *Id.* Russell claimed the interruption of benefit payments forced her disabled husband to cash out his retirement savings which, in turn, aggravated the psychological condition that caused Russell's back ailment. *Id.*

66. The case was originally brought in California Superior court, but then removed to United States District Court for the Central District of California where Massachusetts Mutual moved for summary judgment. *Russell*, 473 U.S. at 137. The district court granted the motion, holding that the state-law claims were preempted by ERISA and that "ERISA bars any claims for extra-contractual damages and punitive damages arising out of the original denial of plaintiff's claims." *Id.* (quoting App. To Pet. For Cert. 29a). ERISA establishes liability for breach of fiduciary duty by stating:

Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this title shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to *such other equitable or remedial relief as the court may deem appropriate*, including removal of such fiduciary.

*Id.* at 139 (emphasis added). The court of appeals conclusion focused on the language "such other equitable or remedial relief as the court may deem appropriate" to say that this gives the court a wide discretion to decide what damages should be awarded. *Id.* at 138. According to the court of appeals, the award of compensatory damages should remedy the wrong and make the aggrieved individual whole. *Id.* The court of appeals thought that this meant they could compensate for injuries sustained as the direct or proximate cause of the breach of fiduciary duty. *Id.* The court of appeals also thought that this meant that they could award punitive damages if it decided that the fiduciary acted with actual malice or wanton indifference to the rights of a participant. *Id.*

The case was submitted to the United States Supreme Court to review the compensatory and punitive damage components of the court of appeals' holding.<sup>67</sup> The Supreme Court held that any extra-contractual damages not explicitly included in ERISA's civil enforcement provision were deliberately omitted and could not be sustained.<sup>68</sup> Neither punitive nor compensatory damages were included in ERISA's civil enforcement provision.<sup>69</sup>

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67. *Russell*, 473 U.S. at 138. The Court found that there was no doubt that a claim for breach of fiduciary duty was available under ERISA. *Id.* at 140. Instead, the issue was whether a violation of this duty allowed damages to be recovered by a plan beneficiary or by the plan as a whole. *See id.* The Court found that the recovery pertained to the plan as a whole. *See id.* It supported this finding with the "text of [the provision], by the statutory provisions defining the duties of a fiduciary, and by the provisions defining the rights of a beneficiary." *Id.* The Court goes on to find that "[t]he only section that concerns review of a claim that has been denied . . . merely specifies that every plan shall comply with certain regulations promulgated by the Secretary of Labor." *Id.* at 143. The Secretary's regulations state that claim decisions should be made promptly, and that if a decision is not made within 120 days then the claim will be considered denied. *Id.* at 144. A claimant may then bring a civil action to have the merits of his application determined. *Id.* The civil enforcement provision thus governs the right of a beneficiary to bring an action to enforce his rights under the plan, and the civil enforcement provision says "nothing about the recovery of extra-contractual damages or about the possible consequences of delay in the plan administrators' processing of a disputed claim." *Id.* For the full text of the civil enforcement provision, see *supra* note 38.

68. *See Russell*, 473 U.S. at 148. The Court listed several factors that are relevant to determine if a private remedy is implicit in a statute that does not expressly authorize such remedy:

Is the plaintiff 'one of the class for whose *especial* benefit the statute was enacted,' that is, does the statute create a federal right in favor of the plaintiff?

Is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one?

Is it consistent with the underlying purposes of the legislative scheme to imply such a remedy for the plaintiff?

Is the cause of action one traditionally relegated to state law, so that it would be inappropriate to infer a cause of action based solely on federal law?

*Id.* at 145 n.13 (quoting *Cort v. Ash*, 422 U.S. 66, 78 (1975)) (internal citations omitted). The Court conceded that two of the factors were met, but it found that legislative intent and consistency with the legislative scheme were not met. *Id.* at 145. The Court went on to say, "unless this congressional intent can be inferred from the language of the statute, the statutory structure, or some other source, the essential predicate for implication of a private remedy simply does not exist." *Russell*, 473 U.S. at 145 (quoting *Northwest Airlines, Inc. v. Transport Workers*, 451 U.S. 77, 94 (1981)). The Court stated:

The six carefully integrated civil enforcement provisions found in [the civil enforcement provision] of the statute [ERISA] as finally enacted, however, provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly. The assumption of inadvertent omission is rendered especially suspect upon close consideration of ERISA's interlocking, interrelated, and interdependent remedial scheme, which is in turn part of a "comprehensive and reticulated statute."

*Id.* at 146 (quoting *Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 361 (1980)) (emphasis in original).

69. *See Russell*, 473 U.S. at 144.



Two years after *Russell*, the Court decided *Pilot Life Ins. Co. v. Dedeaux*.<sup>70</sup> In *Pilot Life*, an employee brought common law breach of contract and tort claims against the insurance company that issued his employer's group insurance policy.<sup>71</sup> Dedeaux sought "damages for failure to provide benefits under the insurance policy . . . general damages for mental and emotional distress [and] other incidental damages and punitive damages."<sup>72</sup> Dedeaux did not assert any of the causes of action available to him under ERISA.<sup>73</sup> The district court dismissed the action, holding that ERISA's preemption clause voided the state law claims.<sup>74</sup> The court of appeals reversed, finding that "ERISA's savings clause rescued [the] claims from ERISA preemption because the claims arose from state laws that regulate insurance."<sup>75</sup>

The Supreme Court agreed that ERISA does preempt common law claims arising from employment related insurance policies, but it held that these laws are not laws that "regulate insurance" within the meaning of the saving clause.<sup>76</sup> The Court used the two-tier approach identified in *Metro. Life*, but provided that under the commonsense inquiry a law

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70. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). In the same term that the Supreme Court decided *Pilot Life*, it also decided *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987). In *Taylor* the Court "upheld removal jurisdiction of a suit challenging the denial of disability benefits by an insurer—including damages and remedies unavailable under ERISA—based on Congress's clearly expressed intent that benefits claims under ERISA be found to arise under federal law." Phyllis C. Borzi, *Distinguishing Between Coverage and Treatment Decisions under ERISA Health Plans: What's Left of ERISA Preemption?*, 49 BUFF. L. REV. 1219, 1232 (2001). Although the Court in *Rush* mentions *Taylor* as a stepping stone to *Pilot Life*, it is not a principal case in the Court's analysis and will not be discussed in detail in this Note. See *Rush Prudential HMO, Inc., v. Moran*, 536 U.S. 355, 378 (2002). For a more detailed analysis of *Taylor*, see *id.*; Joyce Krutick Craig, *Managed Care Grievance Procedures: The Dilemma and the Cure*, 21 J. NAT'L ASSOC. ADMIN. L. JUDGES 336, 343-45 (2001); Ann H. Nevers, *ERISA Right to Sue: An RX for Health Care That Places Forum Over Substantive Consumer Rights*, 31 N.M. L. REV. 493, 501-02 (2001).

71. *Pilot Life*, 481 U.S. at 43. The complaint specifically contained three counts: "Tortious Breach of Contract;" "Breach of Fiduciary Duties;" and "Fraud in the Inducement." *Id.* Dedeaux injured his back in an employment related accident. *Id.* His employer had a long term disability benefit plan that was established by purchasing a group insurance policy from Pilot Life Ins. Co. *Id.* Pilot Life terminated Dedeaux's disability benefits after two years. *Id.* During the following three years, the benefits were reinstated and terminated by Pilot Life several times. *Id.*

72. *Pilot Life*, 481 U.S. at 43. The total amount of incidental and punitive damages sought was \$750,000. *Id.* at 44.

73. *Id.*

74. *Id.* See Donald T. Bogan, *Protecting Patient Rights Despite ERISA: Will the Supreme Court Allow States to Regulate Managed Care?*, 74 TUL. L. REV. 951, 992 (2000).

75. *Pilot Life*, 481 U.S. at 44. The court of appeals relied on the then recent holding in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). *Id.* In *Metropolitan Life*, the Court used a two-tier approach to decide that mandated benefit statutes regulate insurance within the meaning of the ERISA savings clause. See *supra* notes 46-48.

76. *Pilot Life*, 481 U.S. at 57; See Bogan, *supra* note 74, at 992-93.

must be specifically directed toward the insurance industry to pass the test.<sup>77</sup> The Court went on to support this notion by finding that the McCarran-Ferguson factors were not met.<sup>78</sup> This was enough to conclude that the claim was preempted by ERISA. In *Rush*, the Court described the holding in *Pilot Life* as “ERISA . . . not tolerat[ing] a diversity action seeking monetary damages for breach generally and for consequential and emotional distress, neither of which Congress had authorized in ERISA’s civil enforcement provision.”<sup>79</sup>

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77. *Pilot Life*, 481 U.S. at 50. The Court stated:

Certainly a common-sense understanding of the phrase “regulates insurance” does not support the argument that the Mississippi law of bad faith falls under the saving clause. A common-sense view of the word ‘regulates’ would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry. Even though the Mississippi Supreme Court has identified its law of bad faith with the insurance industry, the roots of this law are firmly planted in the general principles of Mississippi tort and contract law.

*Id.*

78. *Id.* at 51. The McCarran-Ferguson Act contains three criteria relevant to determining whether a particular practice refers to the “business of insurance.” These three factors are: (1) the practice has the effect of transferring or spreading a policyholder’s risk; (2) the practice involves an integral part of the policy relationship between the insurer and the insured; and (3) the practice is limited to entities within the insurance industry. *See supra* notes 52-57 and accompanying text. The Court distinguished *Pilot Life* from the mandated benefit laws at issue in *Metropolitan Life* by finding that common law bad faith actions do not effect the spreading of a policyholder’s risk. *Pilot Life*, 481 U.S. at 50. Furthermore, the Court held that the connection between the law and the insured-insurer relationship was “attenuated at best.” *Id.* at 50-51. The Court also stated:

In contrast to the mandated-benefits law in *Metropolitan Life*, the common law of bad faith does not define the terms of the relationship between the insurer and the insured; it declares only that, whatever terms have been agreed upon in the insurance contract, a breach of that contract may in certain circumstances allow the policyholder to obtain punitive damages. The state common law of bad faith is therefore no more ‘integral’ to the insurer-insured relationship than any State’s general contract law is integral to a contract made in that State.

*Id.* at 51.

79. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 378 (2002). The Court stated that in interpreting the saving clause they must consider not only the commonsense test and the McCarran-Ferguson factors but also “the role of the saving clause in ERISA as a whole.” *Pilot Life*, 481 U.S. at 51. “In expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy.” *Id.* (quoting *Kelly v. Robinson*, 479 U.S. 36, 43 (1989)). The Court, therefore, felt it necessary to look to legislative intent concerning the civil enforcement provisions of ERISA. *Id.* at 52. The Court went on to cite *Russell*, stating that the civil enforcement provision of ERISA provided no express authority for an award of punitive damages to a beneficiary. *Id.* at 53. Indeed,

[W]e decline[] to find an implied cause of action for punitive damages in that section, noting that “the presumption that a remedy was deliberately omitted from a statute is strongest when Congress has enacted a comprehensive legislative scheme including an integrated system of procedures for enforcement.” Our examination of these provisions made us “reluctant to tamper with an enforcement scheme crafted with such evident care as the one in ERISA.”

## III. STATEMENT OF THE CASE

Debra Moran was a beneficiary under a Rush Prudential HMO plan in Illinois.<sup>80</sup> In 1996, Debra began experiencing numbness in her right shoulder. She consulted her primary care physician, Dr. LaMarre,<sup>81</sup> who administered traditional and non-invasive treatments.<sup>82</sup> When those treatments failed to provide relief, Dr. LaMarre, pursuant to the HMO contract, advised Rush Prudential that Moran would be “best served” by a non-traditional treatment performed by a specialist who was not part of the plan of doctors.<sup>83</sup> Rush Prudential denied the request, and after Moran’s internal appeals, Rush Prudential affirmed the denial on the ground that the procedure was not “medically necessary.”<sup>84</sup>

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*Id.* at 54 (quoting *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985)). See also Borzi, *supra* note 70, at 1231 (giving an overview of some cases that have relied on *Pilot Life*). But see Bogan, *supra* note 74, at 995 (opining that the Court’s opinion in *Pilot Life* was flawed from the outset).

80. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002). The Illinois HMO Act defines a “Health Maintenance Organization” as “any organization formed under the laws of this or another state to provide or arrange for one or more health care plans under a system which causes any part of the risk of health care delivery to be borne by the organization or its providers.” 215 ILL. COMP. STAT. 125/1-2 et seq. (2000). For journals describing the facts of the *Rush* case see Katherine A. Hesse & Doris MacKenzie Ehrens, *Independent Physician Review of Medical Necessity*, BENEFITS Q., Oct. 1, 2002, at 70, available at 2002 WL 15992383; Carolyn J. Speck, *Abstracts of Significant Cases Bearing on the Regulation of Insurance*, J. INS. REG., Oct. 1, 2002, at 89, available at 2002 WL 24376181. See also Joan Biskupic, *Justices Weigh HMO Review; Ill. Case Questions the Rights of States to Resolve Disputes*, USA TODAY, Jan. 17, 2002.

81. Debra received her HMO coverage through her husband’s employer. *Rush*, 536 U.S. at 359. The HMO promised that Rush would provide them with “medically necessary” services. *Id.* Under the plan, a patient must choose a primary care physician from a list of physicians affiliated with Rush. *Id.* at 360. That physician is the one who decides whether treatment should be recommended to Rush as “medically necessary.” *Id.*

82. *Id.*

83. *Id.* Under the HMO contract, Rush would pay for medical services by an unaffiliated physician only if the services had been “authorized” both by the primary care physician and Rush’s medical director. *Id.*

84. *Id.* Under the plan, Rush is given broad discretion in deciding if something is “medically necessary.”

[A] service is covered as “medically necessary” if Rush finds: (a) [The service] is furnished or authorized by a Participating Doctor for the diagnosis or the treatment of a Sickness or Injury or for the maintenance of a person’s good health. (b) The prevailing opinion within the appropriate specialty of the United States medical profession is that [the service] is safe and effective for its intended use, and that its omission would adversely affect the person’s medical condition. (c) It is furnished by a provider with appropriate training, experience, staff and facilities to furnish that particular service or supply.

*Id.* Two surgeons affiliated with Rush Prudential HMO recommended a less drastic, less expensive surgery. Biskupic, *supra* note 80. While the suit was pending, Moran had surgery by the recommended specialist at her own expense and submitted the \$94,841.27 reimbursement claim to Rush. *Rush*, 536 U.S. at 362. Rush treated it as a renewed request for benefits and, after a new inquiry,

Moran then made a written demand for an independent medical review of her claim as was guaranteed by § 4-10 of Illinois's HMO Act.<sup>85</sup> When Rush failed to comply with the request, Moran filed suit in Illinois state court to force Rush to comply with the Act.<sup>86</sup> Rush removed the case to federal court arguing complete preemption under ERISA.<sup>87</sup>

The federal court remanded the case back to state court on Moran's motion, stating that the complaint requested independent review and therefore, there was no need for ERISA interpretation.<sup>88</sup> On remand, the state court enforced the statute and Rush was ordered to submit to review by an independent physician.<sup>89</sup> Dr. A. Lee Dellon, a reconstructive surgeon at Johns Hopkins Medical Center was the independent physician obtained to perform the review.<sup>90</sup> He concluded the non-conventional

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again denied the request as "medically unnecessary." *Id.* Moran was quoted explaining her decision, "I had terrible headaches. I couldn't use my arm. I couldn't live much longer like that." Biskupic, *supra*. Moran paid for this procedure by borrowing from her mother-in-law and maxing out credit cards. *Id.*

85. See *supra* note 4 and accompanying text. Forty-one states and the District of Columbia currently have independent review statutes similar to the one in Illinois. Wendy Mariner, *Who Governs HMOs?*, 170 N.J.L.J. 679 (2002); Biskupic *supra* note 80. See also William L. Reider, *Ruling Helps HMO Retirees*, S. FLA. SUN-SENTINEL, Oct. 7, 2002, at 23A available at 2002 WL 101348459 (discussing how some of these independent review statutes do not have the teeth that the Illinois statute has because they are either not offered to all the health care districts in a state or because they include little or no sanctions for failure to comport with them).

86. *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959, 964 (7th Cir. 2000) *aff'd*, 536 U.S. 355 (2002).

87. *Id.*

88. *Id.* The Court noted that "preemption is generally a defense and that, under the well-pleaded complaint rule, an anticipated federal defense could not be the basis for removal." *Id.* "Nonetheless, the district court also noted a 'completely preempted' state law claim could be removed, but the court explained, in the ERISA context, only state law claims that conflicted with ERISA's civil enforcement provisions were completely preempted by ERISA." *Id.* The district court concluded that Ms. Moran's request for specific performance was not a claim under ERISA's civil enforcement provisions and, therefore, was not completely preempted. *Id.* The district court left open the possibility that a "claim for reimbursement under § 4-10 of the HMO Act, in contrast to a request to have the independent review performed, might be a claim for benefits that would be completely preempted by ERISA's civil enforcement provisions." *Id.* However, the Supreme Court pointed out that this ruling may not have been appropriate because a suit to compel compliance with § 4-10 seemed the same as bringing suit to compel under 29 U.S.C. § 1132(a)(3). *Rush*, 536 U.S. at 363 n.2. The Court suggested that "alternatively, the proper course may have been to bring a suit to recover benefits due [since by this time Moran had already had the surgery and therefore, would ultimately be seeking compensation for the \$94,841 cost to her] alleging that the denial was improper in the absence of compliance with § 4-10." *Id.*

89. *Moran*, 230 F.3d at 964. The state court reserved the ruling on whether ERISA preempted the portion of § 4-10 requiring the HMO to cover the procedure in the event that the independent physician determines the procedure is medically necessary. *Id.* at 964-65.

90. *Id.* at 965. Dr. Dellon has been in practice since 1978. A. Lee Dellon M.D., Plastic and Reconstructive Surgery, available at <http://www.plasticsurgery.org/md/dellon.htm>. His education includes Johns Hopkins University, 1962-1966; Johns Hopkins School of Medicine, 1966-1970;

procedure had been “medically necessary” within the meaning of the plan.<sup>91</sup> Rush’s medical director refused to agree the procedure was medically necessary and again denied the claim.<sup>92</sup> Moran amended her complaint in state court to seek reimbursement based on the Illinois HMO Act § 4-10, which requires an HMO to pay upon the independent reviewer’s finding that the service was medically necessary.<sup>93</sup>

Rush again sought removal to federal court stating that the complaint was completely preempted by ERISA.<sup>94</sup> The federal district court agreed and granted summary judgment to Rush on the ground that ERISA preempted Illinois’ independent review statute.<sup>95</sup> The Court of

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Columbia-Presbyterian Hospital, 1970-1972; Raymond M. Curtis Hand Center, Hand Fellowship, 1977; National Cancer Institute, N.I.H., 1972-1974; John Hopkins Hospital: General and Plastic Surgery, 1974-1978. *Id.* He is board certified in plastic surgery and has added qualification in hand surgery. *Id.* Dr. Dellon’s practice philosophy statement reads:

Much of my practice deals with NERVE problems for which I have developed operations that are successful both in the HANDS AND FEET. I offer unique solutions for PAINFUL NEUROMAS, DIABETIC NEUROPATHY, NERVE COMPRESSION (including carpal, cubital, and tarsal tunnel syndrome, Morton’s neuroma, calcaneal nerve entrapment), and REFLEX SYMPATHETIC DYSTROPHY (RSD). Documentation of nerve problems is done with QUANTITATIVE SENSORY TESTING using NK devices. I also offer reanimation of the face for FACIAL PARALYSIS. I have also developed operations to relieve KNEE PAIN and SHOULDER PAIN after failed orthopedic procedures such as knee replacement and rotator cuff repair.

*Id.*

91. *Moran*, 230 F.3d at 964. Dr. Dellon decided that Dr. Terzis’s [non-conventional] treatment had been medically necessary based on the definition of medical necessity in Rush’s Certificate of Group Coverage as well as his own medical judgment. *Rush*, 536 U.S. at 362.

92. *Moran*, 230 F.3d. at 965. Under the plan, Rush would only pay for medical services by an unaffiliated physician if the services had been “authorized” by both the primary care physician and Rush’s medical director. *Rush*, 536 U.S. at 360 (emphasis added).

93. *Moran*, 230 F.3d at 965. The Illinois statute states in relevant part, “In the event that the reviewing physician determines the covered service to be medically necessary, the Health Maintenance Organization shall provide the covered service.” § 4-10; see *supra* note 4 and accompanying text.

94. *Rush Prudential HMO Inc. v. Moran*, 536 U.S. 355, 363 (2002). Rush argued complete preemption under ERISA’s civil enforcement provision, 29 U.S.C. § 1132(a), as construed by the Supreme Court in *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987) (holding that employee’s common law contract and tort claims were preempted by ERISA and fell within the provision establishing exclusive federal cause of action for resolution of suits by beneficiaries to recover benefits from covered plan). *Id.*

95. *Moran*, 230 F.3d at 965. The court relied on *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1487 (7th Cir. 1996). *Id.* *Jass* involved a plaintiff who brought a negligence action under Illinois law against an ERISA plan. *Jass*, 88 F.3d at 1485. The *Jass* court explained how they had previously analyzed complete preemption and conflict preemption. *Id.* The court held that a claim brought under ERISA § 502(a) provides the basis for complete preemption whereas § 514(a) provides the basis for conflict preemption. *Id.* ERISA § 502(a) is now 29 U.S.C. 1132(a), the civil enforcement provision and ERISA § 514(a) is now 29 U.S.C. § 1144(a), the preemption provision. See *supra* notes 38 and 24, respectively, and accompanying text. The court went on to give the three factors relevant to determining whether a claim is within the scope of § 502(a):

Appeals for the Seventh Circuit reversed the district court decision, finding that the Illinois HMO Act was a state law that “regulates insurance” under ERISA, 29 U.S.C. 1144(b)(2)(A), and is thus exempted from preemption.<sup>96</sup> The Supreme Court granted certiorari because the holding directly conflicted with the Fifth Circuit’s holding on a similar provision.<sup>97</sup>

The United States Supreme Court affirmed the Seventh Circuit’s ruling and upheld the Illinois statute.<sup>98</sup> The Court acknowledged that § 4-10 “relates to” employee benefit plans within the meaning of ERISA’s preemption provision since it “bears indirectly but substantially on all insured employee benefit plans.”<sup>99</sup> However, the Court nonetheless found that the statute is a law regulating insurance and, as such, is saved from ERISA preemption.<sup>100</sup> The Court’s analysis contained four main findings: first, that the Illinois statute “regulated insurance” within the

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(1) whether the “plaintiff [is] eligible to bring a claim under that section;” (2) whether the plaintiff’s “cause of action falls within the scope of an ERISA provision that the plaintiff can enforce via § 502(a);” and (3) whether the plaintiff’s “state law claim cannot be resolved without an interpretation of the contract governed by federal law.”

*Id.* (quoting *Rice v. Panchal*, 65 F.3d 637, 641, 644 (7th Cir. 1995)).

96. *Rush*, 536 U.S. at 363-64. The court of appeals agreed that Moran’s claim was completely preempted by ERISA so as to place it properly in federal court. *Id.* at 363. However, the saving clause allowed the finding that the law was valid regardless. *Moran*, 230 F.3d at 971 (rejecting the argument that the Illinois Act constituted an “alternative remedy” and emphasizing that the Illinois Act does not authorize a particular form of relief in state courts; rather, with respect to any ERISA health plan, the judgment of the independent reviewer is only enforceable in an action brought under ERISA’s civil enforcement scheme, 29 U.S.C. § 1132(a)). *See id.*

97. *Rush*, 536 U.S. at 364. The Supreme Court needed to resolve a split between the Fifth and Seventh Circuits involving the ERISA preemption of binding state external review programs. Matthew J. Binette, Comment, *Patients’ Bill of Rights: Legislative Cure-All or Prescription for Disaster?*, 81 N.C. L. REV. 653, 672 (2003). The Fifth Circuit in *Corp. Health Ins. v. Tex. Dept. of Ins.*, 215 F.3d 526 (5th Cir. 2000), ruled that a state cannot require a health plan to submit to a binding external review of its coverage decision without conflicting with ERISA. *Id.* “The circuit court reasoned that because such external review laws ‘relate to’ employee benefit plans, they were preempted by ERISA.” *Id.* Conversely, the Seventh Circuit held that the saving clause contained in ERISA exempts state insurance laws from ERISA preemption. *Id.* at 672-73.

98. *Rush*, 536 U.S. at 387. Justice Souter, writing for the Court, stated, “[t]o the extent that benefits litigation in some federal courts may have to account for the effects of § 4-10, it would be an exaggeration to hold that the objectives of § 1132(a) are undermined. The saving clause is entitled to prevail here.” *Id.*

99. *Id.* at 365 (quoting *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985)). The Court held that there was no real dispute as to whether the Illinois Act “relate[d] to” employee benefit plans within the meaning of § 1144(a). *Id.* Therefore, under that section, ERISA would preempt only if 29 U.S.C. § 1144(b)(2)(A) did not apply to “save” it from preemption. *See id.*

100. Mark C. Nielsen, *Piercing the Preemption Veil: Rush Prudential HMO v. Moran Opens the Door for Additional State Regulation of Managed Care Organizations*, 14 NO. 5 HEALTH LAW. 15 (2002).

meaning of ERISA's saving clause; second, that the statute did not conflict with ERISA by supplanting or supplementing its civil enforcement scheme; third, that the statute did not impose an arbitral adjudication scheme at odds with ERISA civil enforcement scheme; and fourth, that the statute did not conflict with ERISA by impermissibly depriving HMOs of deferential standard of review of benefits determinations.<sup>101</sup>

In making the determination that the Illinois Act "regulates insurance" within the meaning of ERISA's saving clause, the Court began with the "commonsense view of the matter" used in *Metropolitan Life* and *Pilot Life*.<sup>102</sup> According to the Court, the commonsense inquiry "focuses on 'primary elements of an insurance contract [ , which] are the spreading and underwriting of the policyholder's risk.'"<sup>103</sup> The Court found that the Illinois Act addresses these elements by defining "health maintenance organization" by reference to the risk that it bears.<sup>104</sup>

Rush argued that the Illinois Act was not "specifically directed toward the insurance industry," as *Pilot Life* had held it needed to be, because HMOs act as both providers and insurers.<sup>105</sup> The Court answered

101. See *id.*; *Rush*, 536 U.S. at 363-87.

102. *Rush*, 536 U.S. at 365-66. In *Metropolitan Life*, the Court formally introduced the "commonsense view of the matter." See *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985). However, it was *Pilot Life* that specified that when using the commonsense view of the matter, "a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." *Rush*, 536 U.S. at 366 (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987)). Each case is described in detail *supra* notes 47-57.

103. *Rush*, 536 U.S. at 366 (quoting *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211 (1979)).

104. 215 ILL. COMP. STAT., ch. 125, § 1-2(9) (2000). The statute reads in relevant part, "[a]n HMO provides or arranges for . . . health care plans under a system which causes any part of the risk of health care delivery to be borne by the organization or its providers." *Id.*; *Rush*, 536 U.S. at 366. See *supra* Section I. The Court found that, "[t]he defining feature of an HMO is receipt of a fixed fee for each patient enrolled under the terms of a contract to provide specified health care if needed." *Rush*, 536 U.S. at 367 (citing *Pegram v. Herdrich*, 530 U.S. 211, 218 (2000)). As an HMO assumes the financial risk of providing the benefits promised, and underwrites and spreads the risk among participants, *Rush* holds that HMOs are engaged in the "business of insurance." *Id.* The Court further explains:

"[I]f a participant never gets sick, the HMO keeps the money regardless, and if a participant becomes expensively ill, the HMO is responsible for the treatment . . ." The HMO design goes beyond the simple truism that all contracts are, in some sense, insurance against future fluctuations in price . . . because HMOs actually underwrite and spread risk among their participants . . . a feature distinctive to insurance.

*Id.* (quoting *Pegram*, 530 U.S. at 218-19). See RICHARD POSNER, *ECONOMIC ANALYSIS OF LAW* 104 (4th ed. 1992); see, e.g., *S.E.C. v. Variable Annuity Life Ins. Co.*, 359 U.S. 65, 73 (1959) (stating that the underwriting of risk is an "earmark of insurance as it has commonly been conceived of in popular understanding and usage"); *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 214 n. 12 (1979) (stating "unless there is some element of spreading risk more widely, there is no underwriting of risk").

105. *Rush*, 536 U.S. at 366. Rush contended that "seeing an HMO as an insurer distorts the

by saying “as long as providing insurance fairly accounts for the application of state law, the saving clause may apply.”<sup>106</sup> Moreover, the Court noted that Congress, in enacting the HMO Act of 1973, understood that HMOs would be acting as insurers by defining HMOs in part by reference to the risk and setting minimum standards for managing that risk.<sup>107</sup>

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nature of an HMO, which is . . . a healthcare provider too” and that the status as a healthcare provider “should determine its characterization, with the consequence that regulation of an HMO is not insurance regulation within the meaning of ERISA.” *Id.* Furthermore, Rush argued that the Illinois Act “sweeps too broadly with definitions capturing organizations that provide no insurance, and by regulating non-insurance activities of HMOs that do.” *Id.* at 370. “Rush points out that Illinois law defines HMOs to include organizations that cause the risk of health care delivery to be borne by the organization itself, or by ‘its providers.’” *Id.* (quoting 215 ILL. COMP. STAT. 125/1 -2(9) (2000)). In Rush’s view, the reference to “its providers” suggests that an organization may be an HMO under state law even if it does not bear risk itself, either because it has contracted the risk to others or because it has contracted only to provide “administrative” and other services for self funded plans. *Id.* at 370-71 (quoting *Brief for Petitioner*, at 38). The Court answers this argument by calling it an “unsound assumption[,]” that assumes an HMO is no longer an insurer when it arranges to limit its exposure. *Rush*, 536 U.S. at 371. The Court noted:

The problem with Rush’s argument is simply that a reinsurance contract does not take the primary insurer out of the insurance business . . . and capitation contracts do not relieve the HMO of its obligations to the beneficiary. The HMO is still bound to provide medical care to its members, and this is so regardless of the ability of physicians or third-party insurers to honor their contracts with the HMO.

*Id.* (internal citations omitted). The Court went on to hold that even if § 4-10 is overly broad, as Rush contended, by capturing HMOs that provide only administrative services to self funded plans, “the bare possibility (not the likelihood) of some over-breadth . . . 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.” *Id.* at 372. See Nielsen, *supra* note 100.

106. *Rush*, 536 U.S. at 367. The Court found Rush’s argument to be one without substance stating:

The answer to Rush[’s contention that it is an insurer and a healthcare provider] is, of course, that an HMO is both: it provides health care, and it does so as an insurer. Nothing in the saving clause requires an either-or choice between health care and insurance in deciding a preemption question, and as long as providing insurance fairly accounts for the application of state law, the saving clause may apply.

*Id.* The Court went on to say that there was “no serious question about [the fact that providing insurance fairly accounts for the application of state law] here, for it would ignore the whole purpose of the HMO style of organization to conceive of HMOs (even in the traditional sense) without their insurance element.” *Id.*

107. *Id.* at 367-69. The HMO Act of 1973 was “intended to encourage the development of HMOs as a new form of health care delivery system . . . and when Congress set the standards that the new health delivery organizations would have to meet to get certain federal benefits, the terms included requirements that the organizations bear and manage the risk.” *Rush*, 536 U.S. at 367-68; see Health Maintenance Organization Act of 1973, § 1301(c), 87 Stat. 916 (1973) (as amended, 42 U.S.C. § 300e(c) (1994)). The very text of the HMO Act of 1973 assumed that state insurance laws would apply to HMOs. *Rush*, 536 U.S. at 368. The Court stated, “[i]n other words, one year before it passed ERISA, Congress itself defined HMOs in part by reference to risk, set minimum standards for managing the risk, showed awareness that States regulated HMOs as insurers, and compared HMOs to ‘indemnity or service benefits insurance plans.’” *Id.* at 369 (quoting S. REP. NO. 93-129, at 30 (1973)). The Court went on to say that the conception of HMOs has not changed since the



The Court then analyzed this result under the three criteria of the McCarran-Ferguson Act used in *Metropolitan Life*.<sup>108</sup> The Court found that the second and third prongs were present which was requisite to a finding that the Illinois Act “regulates insurance” within the meaning of the saving clause and is, therefore, “saved” from preemption.<sup>109</sup> Specifically, the Court found it “obvious” that the independent review requirement regulates “an integral part of the policy relationship” by adding an extra layer of review when there is internal disagreement about an HMO’s denial of coverage.<sup>110</sup> Moreover, once it is established that HMO contracts are, in fact, contracts for insurance (which was decided under the commonsense test), it is clear that § 4-10 does not apply to entities outside of the insurance industry and thus meets the third prong of the McCarran-Ferguson factors.<sup>111</sup>

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HMO Act adoption.

Since passage of the federal Act, States have been adopting their own HMO enabling Acts, and today, at least 40 of them, including Illinois, regulate HMOs primarily through the States’ insurance departments. . . although they may be treated differently from traditional insurers, owing to their additional role as health care providers. Finally, this view shared by Congress and the States has passed into common understanding. HMOs (broadly defined) have “grown explosively in the past decade and [are] now the dominant form of health plan coverage for privately insured individuals.”

*Id.* (quoting Marsha R. Gold & Robert Hurley, *The Role of Managed Care “Products” in Managed Care “Plans,”* in CONTEMPORARY MANAGED CARE 47 (Marsha R. Gold, ed., 1998) (noting that the dominant feature of HMOs is the combination of insurer and provider)); Jonathan P. Weiner & Gregory de Lissovoy, *Rating a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. HEALTHPOL. POL’Y & L. 75, 83 (1993) (noting that the original form of the HMO was a single corporation employing its own physicians, but that the 1980’s saw a variety of other types of structures develop even as traditional insurers altered their own plans by adopting HMO-like cost control measures).

108. See 15 U.S.C. § 1012(b) (providing three criteria to find that a law regulates insurance). See *supra* notes 55-56 and accompanying text.

109. *Rush*, 536 U.S. at 373. The Court noted that under *UNUM Ins. Co. v. Ward*, 526 U.S. 358 (1999), the McCarran-Ferguson Factors were “guideposts” and a state law is not required to satisfy all three to be considered a law that “regulates insurance.” *Id.* The Court specifically left open whether Illinois’ external review statute satisfied the first McCarran-Ferguson factor by spreading the policyholder’s risk. *Id.*; Nielsen, *supra* note 100, at 17.

110. *Rush*, 536 U.S. at 373. The Court noted that “[t]he reviewer applies both a standard of medical care (medical necessity) and characteristically, as in this case, construes policy terms.” *Id.* “The review affects the ‘policy relationship’ between HMO and covered persons by translating the relationship under the HMO agreement into concrete terms of specific obligation or freedom from duty.” *Id.* The Court distinguished the independent review statute in *Rush* from the “peer review” at issue in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982), saying that the insurer’s resort to peer review in *Pireno* was simply “the insurer’s unilateral choice to seek advice if and when it cared to do so.” *Rush*, 536 U.S. at 374. The Court noted that “[t]he insurer’s contract for advice from a third party was of no concern of the insured, who was not bound by the peer review committee’s recommendation any more, for that matter, than the insurer was.” *Id.* In contrast, Illinois’ independent review statute provides a legal right to the insured, enforceable against the HMO. *Id.*

111. Nielsen, *supra* note 100, at 17 (finding an Act does not apply to entities outside of the

Based on the Court's findings regarding the commonsense analysis and the McCarran-Ferguson test, it was concluded that § 4-10 of the Illinois HMO Act "regulates insurance," and ERISA's saving clause "ostensibly forecloses preemption."<sup>112</sup>

Rush, however, argued in the alternative that even if a state law regulates insurance it may still be preempted if it allows for the kind of "alternative remedy" that *Pilot Life* held would not be allowed.<sup>113</sup> Rush argued that requiring an HMO to follow an external reviewer's judgment as to what constitutes a medically necessary service or treatment (as § 4-10 does) effectively operates as a form of binding arbitration that allows the decision maker to examine the claim *de novo*, supplanting judicial review available under ERISA.<sup>114</sup> While Rush's main contention was that the law allows remedies not available in ERISA's civil enforcement plan, the Court takes each part of the argument and rejects them one-by-one.<sup>115</sup>

First, the Court agrees that in ERISA law they have recognized the civil enforcement provision as being enacted to carry out Congress' clear intent that it provides the *only* remedies available under ERISA.<sup>116</sup>

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insurance industry does not mean that it applies to all entities within it either). See *Rush*, 536 U.S. at 374 (stating that the final factor of the McCarran-Ferguson test is satisfied for many of the same reasons that the law passes the commonsense test).

112. *Rush*, 536 U.S. at 375. See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 746 (1985) (stating "if a state law 'regulates insurance' . . . it is not pre-empted").

113. *Pilot Life* involved a statute that was found not to regulate insurance; however, the Court in *Pilot Life* went on to say in dictum that even if the statute had been found to regulate insurance it would still be preempted because it allowed for alternative remedies that were not found in ERISA. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). This is because Congress intended a "federal common law of rights and obligations" to develop under ERISA without embellishment by the states. *Id.* The *Rush* Court found that Rush and its *amici* interpreted *Pilot Life* wrongly by thinking it held that any law that presents a conflict with federal goals is simply not a law that "regulates insurance" regardless of how the insurance tests come out. *Rush*, 536 U.S. at 377 n.8.

114. *Rush*, 536 U.S. at 377-78.

115. *Id.* at 374-381.

116. *Id.* at 375-76. The Court describes Rush's argument as being a question of congressional intent, "which is sometimes so clear that it overrides a statutory provision designed to save state law from being preempted." *Id.* See *Am. Tel. & Telegraph Co. v. Cent. Office Tel., Inc.*, 524 U.S. 214, 227 (1998) (concerning a clause in the communications Act of 1934 purporting to save "the remedies now existing at common law or by statute" that was defeated by overriding policy of the filed rate doctrine); *Adams Express Co. v. Croninger*, 226 U.S. 491, 507 (1913) (saving clause will not sanction state laws that would nullify policy expressed in federal statute; "the act cannot be said to destroy itself"). The Court notes that in ERISA law they have "recognized one example of this sort of overpowering federal policy in the civil enforcement provisions. . . authorizing civil actions for six specific types of relief." *Rush*, 536 U.S. at 375-76. In *Massachusetts Mutual Life Ins. v. Rus-sell*, 473 U.S. 134 (1985), the Court said those provisions amounted to an "interlocking, interrelated, and interdependent remedial scheme." *Id.* at 146. Just under two years later, *Pilot Life* described that scheme as "represent[ing] a careful balancing of the need for prompt and fair claims settlement

However, the Court believed that Rush had overstated the rule expressed in *Pilot Life*.<sup>117</sup> The Court substantially narrowed the potential scope of *Pilot Life* by suggesting that only laws that provide a form of “ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA” would qualify as an “alternative remedy” described in *Pilot Life*.<sup>118</sup> The Court found that § 4-10 does not enlarge the claim beyond the benefits available in any action brought under ERISA’s civil enforcement provision because ultimate relief would still be limited to those remedies that ERISA authorizes in a suit for benefits.<sup>119</sup> The independent reviewer’s conclusion may make it easier for a beneficiary to succeed in an action brought under ERISA, but it will not change the scope of available remedies.<sup>120</sup>

The Court next addressed Rush’s contention that the state law unreasonably interfered with Congress’ intention to provide a uniform federal regime of “rights and obligations.”<sup>121</sup> The Court responded by say-

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procedures against the public interest in encouraging the formation of employee benefit plans.” *Pilot Life*, 481 U.S. at 54.

117. *Rush*, 536 U.S. at 378.

118. *See Nielsen, supra* note 99, at 17-18. “Any such provision patently violates ERISA’s policy of inducing employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred.” *Rush*, 536 U.S. at 379. The Court noted that up until this case, the inquiry as to whether state laws allow beneficiaries to obtain remedies outside of those provided in ERISA had been more straightforward. *Id.* at 378. *Pilot Life* involved a suit for money damages for breach and for consequential damages for emotional distress, both of which are clearly not included in ERISA’s civil enforcement provision. *See id.* Since *Pilot Life*, the Court has only found one other state law to “conflict” with ERISA’s civil enforcement provision in providing a prohibited alternative remedy. *Id.* at 379. That case involved a claim brought under Texas’s tort of wrongful discharge alleging that the employer’s motivation for discharging the plaintiff was to avoid paying pension benefits. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990). The Court said that they had “no trouble” finding the claim to be conflicting with ERISA enforcement because the state law converted the remedy from an equitable one under ERISA enforcement (available only in federal district courts) into a legal one for money damages (available in state courts). *Rush*, 536 U.S. at 379.

119. *See Rush*, 536 U.S. at 379-80. The Court acknowledges that independent review under § 4-10 may well “settle the fate of a benefit claim under a particular contract,” but says that in the end, if the HMO still refuses to pay, the beneficiary will be forced to pursue ERISA enforcement. *Id.* The judge enforcing the ERISA claim may look to the independent reviewer’s opinion to decide whether a breach has occurred, but this does not change the fact that the claim will still be brought as an equitable claim under ERISA. *See id.*; *UNUM Ins. Co. v. Ward*, 526 U.S. 358 (1999) (holding that a state law barring enforcement of a policy’s time limitation on submitting claims did not conflict with ERISA’s civil enforcement provision even though the state “rule of decision” may mean the difference between a success and failure for a beneficiary).

120. *See Rush*, 536 U.S. at 379-80. The Court likens the Illinois independent review statute to the claims-procedure rule that was sustained in *UNUM Ins. Co. v. Ward*, 526 U.S. 358 (1999). *Id.* at 380.

121. *Rush*, 536 U.S. at 381.

ing that “such disuniformities . . . are the inevitable result of the congressional decision to ‘save’ local insurance regulation.”<sup>122</sup> The Court conceded that a state might provide for a type of “review” that would so resemble an adjudication as to fall within *Pilot Life’s* definition of “alternative remedies” that unreasonably interfere with Congress’ intentions; however, the Court did not find that § 410 is such a review.<sup>123</sup> The Court acknowledged that § 410 is similar to common arbitration (which would provide an ultimate form of relief conflicting with ERISA), but distinguished § 410 by reasoning that the Illinois law did not “give the independent reviewer a free-ranging power to construe contract terms, but instead, confined review to a single term: the phrase ‘medical necessity.’”<sup>124</sup>

Finally, the Court rejected Rush’s contention that § 410 clashed with the civil enforcement provision by substituting a *de novo* standard of review for the deferential standard of review enjoyed by benefit plans in the past.<sup>125</sup> The Court answered this contention in no uncertain terms

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122. *Id.* (quoting *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985)). In a footnote the Court explained further:

[W]e do not believe that the mere fact that state independent review laws are likely to entail different procedures will impose burdens on plan administration that would threaten the object of 29 U.S.C. § 1132(a) [the civil enforcement provision]; it is the HMO contracting with a plan, and not the plan itself, that will . . . have to establish procedures for conforming with the local laws . . . . This means that there will be no special burden of compliance upon an ERISA plan beyond what the HMO has already provided for.

*Id.* at n.11.

123. *Rush*, 536 U.S. at 381-82.

124. *Id.* at 382-83. “[A]rbitration . . . render[s] a final and binding decision on the merits of the controversy and on the basis of proofs presented by the parties.” I. MACNEIL, R. SPEIDEL, & T. STIPANOWICH, 1 FEDERAL ARBITRATION LAW § 2.1.1 (1995) (internal quotations omitted). Arbitrators are generally able to hold hearings at which parties may submit evidence and conduct cross-examinations and arbitrators are generally vested with the power to subpoena witnesses and administer oaths. *Rush*, 536 U.S. at 382. The Court distinguishes § 410’s independent review because the reviewer does not have the same free ranging power to construe contract terms. *Id.* at 383. The Court likens this limitation to benefit determinations described in *Pegram v. Herdrich*, 530 U.S. 211 (2000). *Rush*, 536 U.S. at 383. In *Pegram*, the Court explained that “when an HMO guarantees medically necessary care, determinations of coverage ‘cannot be untangled from physicians’ judgments about reasonable medical treatment.’” *Id.* (quoting *Pegram*, 530 U.S. at 229). This is how the independent review statute works – the reviewer simply receives the medical records and comes to a “judgment of his own.” *Id.* The Court notes that the Act itself says nothing about requiring the reviewer to refer to the definition of medical necessity contained in the contract, but the Court assumes that there is always some degree of contract interpretation necessary. *Id.* at n.12.

125. *Rush*, 536 U.S. at 384-85. Rush argued that *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), recognized that an ERISA plan could be designed to grant “discretion” to a plan fiduciary who deserves deference from a court reviewing a discretionary judgment and that § 4-10 allows the reviewer to essentially review the judgment *de novo*. *Rush*, 536 U.S. at 384. Further, that *de novo* review will “carry great weight in a subsequent suit for benefits” under ERISA thus, it

saying, “ERISA provides nothing about the standard.”<sup>126</sup> “It simply requires plans to afford . . . *some* mechanism for internal review of a benefit denial. . . .”<sup>127</sup> Therefore, even if the Illinois statute does provide a *de novo* standard of review, it does not conflict with ERISA because ERISA does not specify what standard should be used.<sup>128</sup>

#### IV. ANALYSIS

##### A. *Why Rush is the Right Decision*

The majority decision in *Rush* balances congressional intent<sup>129</sup> while protecting patients’ rights and recognizing HMOs’ need to procure profit.

##### 1. “Discretionary Authority”<sup>130</sup> Needs Limits

Allowing HMOs to operate under contracts that reserve “discretionary authority”<sup>131</sup> without limits is unfair to health care recipients. When an HMO includes a provision that retains “discretionary authority” to make both health care and administrative decisions it effectively cements an “arbitrary and capricious” standard of review for itself in court.<sup>132</sup> Therefore, if the HMO contract grants discretionary authority

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“deprive[s] the plan of the judicial deference a fiduciary’s medical judgment might have obtained if judicial review of the plan’s decision had been immediate.” *Id.*

126. *Rush*, 536 U.S. at 385.

127. *Id.* (emphasis added).

128. *See id.* The Court stated: “Whatever the standards for reviewing benefit denials may be, they cannot conflict with anything in the text of the statute, which we have read to require a uniform judicial regime of categories of relief and standards of primary conduct, *not a uniformly lenient regime of reviewing benefit determinations.*” *Id.* (emphasis added). The Court added that their past holdings only indicated that when the statute was silent with respect to what review standards are available (which ERISA is), deferential review *could* be used if the ERISA plan itself provided that the “plan’s benefit determinations were matters of high or unfettered discretion.” *Id.* at 385-86. *See Firestone Tire*, 489 U.S. at 115.

129. ERISA was enacted to “safeguard . . . the establishment, operation, and administration’ of employee benefit plans.” *See supra* notes 14-19 and accompanying text. In enacting the civil enforcement provision, Congress intended to “provide a uniform federal regime of rights and obligations under ERISA.” *Rush*, 536 U.S. at 381 (internal quotations omitted).

130. *See infra* notes 131-132 and accompanying text.

131. The *Rush* Court explained that most HMOs can design HMO contracts to grant plan fiduciaries “discretion” in making benefit decisions. *See Rush*, 536 U.S. at 384. The Court, in *Firestone Tire & Rubber v. Bruch*, 489 U.S. 101, 115 (1989), held that when plans reserve this kind of discretion to its plan fiduciaries, the courts will judge the decision by a standard of deference. *Id.*

132. *See* Kristina B. Pett & Michael S. Metta, *Review of Benefits Determination Under Eleventh Circuit ERISA Law*, 32 FALL-BRIEF 40, 51 (2002). The Eleventh Circuit has held, “when conducting a review of an ERISA benefits denial under an arbitrary and capricious standard (sometimes

to HMO administrators, the HMO will prevail in any action brought under ERISA for review of benefit denials, so long as it is able to give some rational justification for its decision.<sup>133</sup> This is true even if the overwhelming weight of evidence favors the claimant.<sup>134</sup> Furthermore, when there is a reservation of discretion and the court reviews the decision under an arbitrary and capricious standard, most claims are settled in the summary judgment phase of litigation.<sup>135</sup> The summary judgment decision essentially denies patients the ability to effectively plead their case to a judge.<sup>136</sup>

Despite the fact that reservations of discretion can essentially “settle” potential litigation in favor of the HMO before a suit is ever brought, most HMO participants have little or no say as to the terms of their contracts.<sup>137</sup> Any first year law student will tell you that this is a clear case

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used interchangeably with an abuse of discretion standard), the function of the court is to determine whether there was a reasonable basis for the decision, based upon the facts as known to the administrator . . . .” *Jett v. Blue Cross & Blue Shield*, 890 F.2d 1137, 1139 (11th Cir. 1989). The Fourth Circuit has held that in discretionary review cases, a court may only reverse denial if there was a clear abuse of discretion. *Elliot v. Sara Lee Corp.*, 190 F.3d 601, 605 (4th Cir. 1999). “Under this abuse of discretion standard, the claim administrator’s decision will not be disturbed if it ‘is the result of a deliberate, principled reasoning process and if it is supported by substantial evidence.’” *Id.* (quoting *Brogan v. Holland*, 105 F.3d 158, 161 (4th Cir. 1997)). See also Roger C. Siske, et al., *What’s New in Employee Benefits: A Summary of Current Case and Other Developments*, SH006 A.L.I.-A.B.A. 1, 9 (2002).

133. Mark D. DeBofsky, *So You’re Stuck With ERISA . . . Now What?*, TRIAL MAG., Oct. 1, 2002, at 49, available at 2002 WL 15116063. A decision is found to be arbitrary and capricious “where the decision is in bad faith, not supported by substantial evidence, or erroneous on a question of law.” *Williamson v. UNUM Life Ins. Co.*, 943 F. Supp. 1226, 1228 (C.D. Cal. 1996) (citing *Nevill v. Shell Oil Co.*, 835 F.2d 209, 212 (9th Cir. 1987)); see also *Morton v. Smith*, 91 F.3d 867 (7th Cir. 1996) (stating an abuse of discretion found when a decision is “not just clearly incorrect but downright unreasonable”). “Further, an abuse of discretion may be found where an ERISA plan administrator makes a decision that ‘conflicts with the plain language of the plan.’” DeBofsky, *supra* (citing *Saffle v. Sierra Pac. Power Co.*, 85 F.3d 455, 458 (9th Cir. 1996)). See, e.g., *Dodson v. Woodmen of the World Life Ins. Soc’y*, 109 F.3d 436, 439 (8th Cir. 1997) (asserting that abuse of discretion may also be found in welfare benefit claims where the plan administrator seeks to place greater weight on the opinions of reviewing physicians than on the opinions of treating and examining doctors); *Donaho v. FMC Corp.*, 74 F.3d 894, 901 (8th Cir. 1996).

134. DeBofsky, *supra* note 133.

135. *Id.* “Indeed, usually there is no trial. In the typical situation - where there is a reservation of discretion and court review is deferential—most benefit claims under ERISA are resolved by summary judgment.” *Id.* Arbitrary and capricious cases are amenable to summary judgment resolution. See *Pett & Metta*, *supra* note 132, at 51. But see DeBofsky, *supra* note 133 (stating that “[i]f the standard of review is de novo, however, a ‘trial’ will consist of the court’s reviewing the claim record and weighing that evidence”).

136. See *supra* notes 132-133 and accompanying text.

137. See Richard Alexander, *When an Insurance Company Breaches its Contract*, Findlaw, available at [http://library.lp.findlaw.com/articles/file/00083/002875/title/Subject/topic.../contract-slaw\\_1\\_10](http://library.lp.findlaw.com/articles/file/00083/002875/title/Subject/topic.../contract-slaw_1_10).

of unequal bargaining power.<sup>138</sup> We don't allow this sort of unconscionable activity to be upheld in other routine contract situations, so why do we tolerate it in a field as important as American healthcare?<sup>139</sup>

The *Rush* decision gives states the opportunity to protect people by enacting legislation that prevents HMOs from contracting such broad discretion to itself when the participants have virtually no say in the matter.<sup>140</sup> The result is that state regulations barring HMOs from writing contracts that grant HMO administrators discretionary authority to interpret the HMO contract will effectively subject adverse benefit determi-

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138. See EDWARD J. MURPHY, ET AL., *STUDIES IN CONTRACT LAW* 342 (5th ed. 1997). See also Arthur M. Kaufman & Ross Babbitt, *The Mutuality Doctrine in the Arbitration Agreements: The Elephant in the Road*, 22 FALL FRANCH. L.J. 101, 104 (2002). "Procedural unconscionability goes to the failure in the bargaining process that leads to oppression or surprise due to unequal bargaining power." *Id.* (internal quotations omitted). "When one party has a substantially more powerful bargaining position, this prong investigates whether that party used its greater power in an unfair manner against the weaker actor." *Id.*

139. For examples of disapproval of contractual unconscionability, see Diane W. Savage, *Performance Warranties in Computer Contracts*, Findlaw, available at [http://library.lp.findlaw.com/articles/file/00009/003349/title/Subject/topic.../contractslaw\\_1\\_11](http://library.lp.findlaw.com/articles/file/00009/003349/title/Subject/topic.../contractslaw_1_11). The author gives an example of when Congress has stepped in to alleviate some of the potential abuses of large business. *Id.* An example of this is the Magnuson-Moss Act, enacted by Congress in 1975. *Id.* The Act was enacted in response to the widespread misuse by merchants of express warranties and disclaimers. *Id.* It forced merchants to contract by specific guidelines. *Id.* There is no equivalent protection to participants under insurance contracts. *Id.* An example of a situation that closely resembles HMO contract "negotiations" was seen in *A&M Produce Co. v. FMC Corp.*, 186 Cal. Rptr. 114, 124-25 (Cal. Ct. App. 1982), where the court held that a contract was unconscionable because the contract was a printed form contract, there was ample evidence of unequal bargaining power, and there was a lack of any real negotiation over contract terms. *Id.* This sounds an awful lot like the traditional insurance "negotiations." See Kaufman & Babbitt, *supra* note 138.

140. See *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 386 (2002). The *Rush* Court stated that "[independent review] prohibits designing an insurance contract so as to accord unfettered discretion to the insurer to interpret the contract's terms." *Id.* The Court went on to state that there is no difference between the mandated-benefits statutes and statutes prohibiting the denial of claims solely on the ground of un-timeliness which the Court had sustained in the past. *Id.* It should be noted that independent review statutes usually call for a reviewer to interpret the terms already written into a contract. See *id.* at 381 n.11. For example, in *Rush* the reviewer was called to decide what was "medically necessary" treatment because the HMO contract guaranteed that "medically necessary" treatment would be provided. *Id.* at 380. However, an HMO is under no obligation to make that kind of guarantee; therefore, if the contract had said nothing about guaranteeing "medically necessary treatments," then the reviewer would have had to find for the HMO under the terms of the contract. See *id.* at n.10. What this tells us is that HMOs may get around these independent review statutes by simply re-wording the insurance contracts to no longer guarantee medically necessary service. See *id.* Of course, one may think that no one would sign up with a contract like that, but it must be remembered that, unlike other free markets, changing insurance providers is not easy when most people are stuck with what their employer provides. See Joseph Luchok, *New Survey Shows Employment is Key Factor to Obtaining Health Coverage*, Health Insurance Association of America (2000), available at <http://www.hiaa.or/news/newsitem.cfm?ContentID=367> (stating that nearly seventy-four percent of workers are offered health insurance from their employers and nearly sixty-three percent accept it).

nations to *de novo* review by the courts.<sup>141</sup> Independent review statutes are an example of state regulations that have this effect.<sup>142</sup> This will allow patients to fully present their claims before a court and allow the court to determine the issue as though for the first time.<sup>143</sup> The dissent in *Rush* argues that the ultimate effect of *de novo* review will result in the courts ruling (in a subsequent suit for benefits) in accordance with the decision of the independent reviewer.<sup>144</sup> Ironically, if the dissent is correct, this effectively puts HMOs in the position that patients have been in for years. Instead of the HMO having the upper hand in court under a reservation of discretionary authority, the patient will now enjoy that same sort of discretion when the independent reviewer decides that a given procedure is medically necessary.<sup>145</sup>

## 2. Independent Review Helps Resuscitate the Doctor-Patient Relationship<sup>146</sup>

The net effect of independent review legislation is that it gives plan participants a vehicle to assert their own advocating powers. Once upon a time, doctors and patients had relationships built on trust.<sup>147</sup> Doctors were advocates for patients because they knew that if a patient was not

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141. Roger C. Siske, et al, *Selections from What's New in Employee Benefits - A Summary of Current Cases and Other Developments*, VMD1107 A.L.I.-A.B.A. 361 (Nov. 7, 2002).

142. See *Rush*, 536 U.S. at 384-86.

143. See BLACK'S LAW DICTIONARY 447 (7th ed. 1999). Black's defines hearing "de novo" as (1) A reviewing court's suspension of a lower court's findings and determination of the issue as though for the first time and (2) A new hearing of a matter, conducted as if the original hearing had not taken place. *Id.* In the case of HMO reviews, the "original hearing" would be the internal review by HMO administrators as provided in the HMO contract itself. See *Id.*

144. See *Rush*, 536 U.S. at 395-96. The dissent states that "[c]ontrary to the majority's characterization of § 4-10 as nothing more than a state law regarding medical standards, it is in fact a binding determination of whether benefits are due." *Id.* (citation omitted). *Rush* also argues, "[i]f a plan should continue to balk at providing a service the [independent] reviewer has found to medically necessary, the reviewer's determination could carry great weight in a subsequent suit for benefits under § 1132(a) [of ERISA]." *Id.* at 384 (footnote omitted).

145. See *supra* notes 131-134 and accompanying text.

146. For an extensive analysis of the importance of the doctor-patient relationship and why, under a managed care system of health care, we can not have it anymore, see *The Grand Unification Theory of Health Care*, YOUR DOCTOR IN THE FAMILY, available at <http://www.yourdoctorinthe-family.com/grandtheory/section12.htm> (giving a comprehensive analysis of why destroying the doctor-patient relationship is a necessary evil of managed care).

147. See *id.*; Megan H. Johnson, *The Routinization of Health Care and the Professional Calling*, Dialogues@RU, Spring 2002, available at [http://dialogues.rutgers.edu/students/m\\_johnson/m\\_johnson\\_I.html](http://dialogues.rutgers.edu/students/m_johnson/m_johnson_I.html). "Doctors can no longer do what they morally feel is best for their patients; rather, they must prescribe care with the wishes of cost-concerned HMOs in mind, and are sometimes forced to divert from their personal moral code in the name of business." *Id.*



satisfied, they could go to another doctor.<sup>148</sup> HMOs have virtually destroyed the doctor-patient relationship by forcing patients to see particular doctors and forcing doctors to perform particular procedures.<sup>149</sup> Although many doctors may be stuck with HMO rules, independent review statutes will allow patients to advocate for themselves the way doctors once advocated for them.<sup>150</sup> A recent North Carolina Law Review article suggests that it is the physician's oath, the HMO Act, and HMO contracting regulations that ensure patients will receive access to medically necessary procedures despite cost control measures taken by the HMO.<sup>151</sup> Independent review statutes are exactly the kind of "contract-

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148. See Johnson, *supra* note 147 (referencing the strained doctor-patient relationship and how HMO will help patients recapture some of their rights).

149. See David T. Gordon, *Hippocrates or Hypocrisy?*, N.U. MAGAZINE ONLINE, Jan. 2000, available at <http://www.numag.neu.edu/0001/health.html>. Gordon states:

In many cases, doctors working for managed care organizations are damned if they do, damned if they don't. They might work under gag orders, which forbid them to discuss with patients the full range of options for care. They might have their pay docked for playing it safe with a patient's health and ordering an extra night of hospitalization, an expense an HMO case manager might later deem unnecessary. They might be restricted in the amount of time they can spend with each patient, forcing abrupt and perhaps incomplete doctor-patient communication. Given the level of public distrust of managed care organizations, doctors might also encounter patients who are guarded and suspicious or who may exaggerate symptoms in an effort to secure a greater level of care. If patients feel they have to lie or to exaggerate their own symptoms they may cause a befuddled doctor to order up tests that honest communication would have rendered unnecessary. If either doctors or patients are dishonest, the result will likely be the same: sick people won't get the care they need.

*Id.* See also Amir Zaman, *Doctor-Patient Relationship Becoming More Businesslike*, WEAC NEWS, June 1996, available at <http://www.weac.org/News/JUNE96/Insure.htm> (opining that the relationship between doctors and patients is changing and discussing how one employee's longtime personal doctor refused to join her HMO thus forcing her to search for another doctor). "The doctor-patient relationship is getting very businesslike." *Id.* But see GAO Releases First Study of So-Called "Gag Rules," U.S. REP. POLICY COMM., Sept. 24, 1997, available at <http://rpc.senate.gov/~rpc/releases/1997/GAOgag-jt.htm> (relaying information regarding a study that casts doubt of impact on Doctor-Patient Relationship by indicating that gag clauses are not likely to impact a physician's practice).

150. See Tanya Albert, *Doctors Applaud Supreme Court's HMO Review Ruling*, AMEDNEWS, July 15, 2002, available at [http://www.ama-assn.org/sci-pubs/amnews/pick\\_02/gv120708.htm](http://www.ama-assn.org/sci-pubs/amnews/pick_02/gv120708.htm) (last visited Feb. 23, 2003). "It (the *Rush* decision) is a major victory for America's patients and their physicians." *Id.* (quoting American Medical Association President-elect Donald J. Palmisano, M.D.). Albert goes on to write that the decision will improve doctor-patient relationships. *Id.* Mark Rust, an attorney for Moran, stated that "[t]he decision will return some confidence to patients whose primary care physicians tell them a particular treatment is medically necessary while a physician from their health care plan tells them it is not." *Id.* "This ruling helps ensure that our patients get the best care possible." *Id.* (quoting Warren A. Jones, M.D., American Academy of Family Physicians president).

151. Matthew J. Binette, Comment, *Patient's Bill of Rights: Legislative Cu re-All or Prescription for Disaster?*, 81 N.C. L. REV. 653, 663 (2003) (explaining the history behind the HMO model of health care by and how HMO cost control measures are offset by physician's oath, HMO Act,

ing regulations” needed to counterbalance the cost control measures that are at the heart of HMO plans. They give patients an additional safeguard when dealing with HMO administrators that allows them to feel like they have some control over their own healthcare.

### 3. Patients are Not Being Given “Blank Checks”

Despite what HMO officials would have us believe, the decision in *Rush* will not give patients the right to unlimited damages under state laws. Opponents of state regulations of insurance for ERISA qualified plans adamantly contend that allowing states to interfere will result in high damage awards.<sup>152</sup> It is further argued that those damage awards will translate into one of two potential results: (1) higher health care costs that may cause employers to stop offering employer sponsored healthcare,<sup>153</sup> or (2) the bankruptcy of HMOs. This fear is greatly over-

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and regulations).

152. See HIAA Statement on Supreme Court Decision in *Rush Prudential HMO v. Moran*, June 20, 2002, available at <http://www.hiaa.org/news/newsitem.cfm?ContentID=19416>. The HIAA released a statement following the *Rush* decision stating:

The Supreme Court’s decision today will add greater cost and complexity to health insurance coverage. The nation’s health insurers have never opposed external review. On the contrary, we developed and used external review long before states required it. But having [fifty] different state standards governing how external review is practiced will mean people covered under a multi-state plan will not have the same benefits. The great danger is that with costs already skyrocketing, employers navigating varying state laws may be forced to reconsider whether they will offer health insurance for their employees.

*Id.* See also Richard L. Huber, *Expanding Liability Harmful* USA TODAY, Oct. 19, 1998, available at <http://pqasb.pqarchiver.com/USAToday> (estimating that expansion of liability alone could increase premiums as much as eight or nine percent). But see *HMOs Profits Increase 162% During First Quarter of 2002*, SPENCERNET, available at <http://www.spencernet.com/Archive/feature011503.html#Anchor14210> (giving statistics showing a recorded 868 million dollar profit for HMOs in 2002); *Managing to Make a Profit*, AMEDNEWS, March 18, 2002, available at [http://www.ama-assn.org/sci-pubs/amnews/pick\\_01/bicc0318.htm](http://www.ama-assn.org/sci-pubs/amnews/pick_01/bicc0318.htm) (giving a break-down of each major HMO’s profit for 2001).

153. See Harvard Law Review Assoc., *H. Preemption*, 116 HARV. L. REV. 412, 413 (2002).

This holding increases the costs of insuring funding employee benefit plans, a burden employers may easily avoid by switching to self-funded plans. Thus, *Moran*, in principle, expands the scope of state regulation by narrowing federal preemption of state insurance regulation but, in practice, may decrease the number of employee benefit plans subject to such regulation.

*Id.* See also *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 402 (2002). The dissent argued:

[T]he Court would do well to remember that no employer is required to provide any health benefit plan under ERISA and that the entire advent of managed care, and the genesis of HMOs, stemmed from spiraling health costs. To the extent that independent review provisions such as § 4-10 make it more likely that HMOs will have to subsidize beneficiaries’ treatments of choice, they undermine the ability of HMOs to control costs, which, in turn, undermines the ability of employers to provide health care coverage for employees.

stated in view of the *Rush* decision.

The majority in *Rush* held that any state law remedy that conflicts with ERISA's civil enforcement provision would be preempted by ERISA.<sup>154</sup> Thus, state laws may not allow damages that would not be allowed under ERISA. Punitive damages have clearly been held to be in direct conflict with ERISA's civil enforcement provision and thus preempted.<sup>155</sup>

Furthermore, HMOs argue that even if excessive damages aren't allowed, the mere fact that a patient can obtain external review will raise costs.<sup>156</sup> It is argued that the opinion of the independent reviewer is held

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*Id.* (Thomas, J., dissenting).

154. See *Rush*, 536 U.S. at 377. The Court stated:

Although we have yet to encounter a forced choice between the congressional policies of exclusively federal remedies and the "reservation of the business of insurance to the States," we have anticipated such a conflict, with the state insurance regulation losing out if it allows plan participants "to obtain remedies . . . that Congress rejected in ERISA."

*Id.* (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987) (internal citations omitted)).

155. See *Pilot Life*, 481 U.S. at 47. Note that the Court in *Rush* made a deliberate choice not to overrule *Pilot Life* because they agreed with the holding and the dictum of that case. *Id.* Rather, the Court chose to limit the applicability. See *Rush*, 536 U.S. at 381. The Court recognized that allowing such things as consequential and monetary damages for breach would simply be too far from the congressional intent to withstand preemption. *Id.* at 378. See also *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990) (holding that allowing a claim that essentially converted the remedy from an equitable one under ERISA to a legal one for money damages was preempted because it conflicted with ERISA's civil enforcement provision); Joyce Krutick Craig, *Managed Care Grievance Procedures: The Dilemma and the Cure*, 21 J. Nat'l Assoc. Admin. L. Judges 336, 345-47 (2001) (explaining that state law tort claims are preempted under ERISA); Steven Findlay, *Holding HMOs Accountable*, USA TODAY, Aug. 6, 1997, available at <http://pqasb.pqarchiver.com/USAToday> (stating that ERISA does not allow punitive damages); Amednews, *Are HMOs on the Down and Out?*, AMEDNEWS, Oct. 15, 2001, available at [http://www.ama-ssn.org/sci-pubs/amnews/pick\\_01/bicb1015.htm](http://www.ama-ssn.org/sci-pubs/amnews/pick_01/bicb1015.htm).

156. See Harv. L. Rev. Assoc., *supra* note 153, at 413. While the Harvard Law Review article repeatedly states that the holding in *Rush* will raise costs of insuring funding employee benefit plans, it does not specifically state why. See *id.* One can presume from the article that its authors believe *Rush* will open up employee benefit plans to new kinds of state regulations that, prior to *Rush* may have been assumed by states to be preempted by ERISA. See *id.* at 417-21. However, the authors do not elaborate on any particular type of state regulation that may result. See *id.* at 421. The article does discuss a few current state laws that are now being litigated in the federal courts, which the authors believe will not be preempted as a result of *Rush*; however, the authors have provided little to support the contention that states will suddenly adopt new state regulations merely as a result of the *Rush* opinion. See *id.* at 420-21. The authors carelessly and without any support argue that state legislatures can "reap political benefits from voting on legislation regulating unpopular HMOs." *Id.* at 420. Rather, legislatures can reap no benefits from driving up health care costs with unnecessary regulations; therefore, if regulations are accepted by the legislature, it is because the benefits of protecting human lives outweigh the potential increased costs. Similarly, Wendy Mariner writes that the decision "may encourage states to adopt insurance reforms beyond independent external review to protect patients." Wendy Mariner, *Who Governs HMOs?*, 170 N.J.L.J. 679 (2002) (emphasis added).

in high regard when the participant ultimately seeks ERISA's civil remedies, and if an independent reviewer finds the procedure to be "medically necessary," then it will result in a near absolute loss for the HMO in court.<sup>157</sup> This is the same argument that was made by the defense and rejected by the majority Court in *Rush*.<sup>158</sup> Surveys have shown that nationwide only an average of forty-five percent of health plan denials of coverage get overturned as a result of independent review statutes.<sup>159</sup> Furthermore, that same study shows that in the forty-one states that already have independent review statutes, only a small number of patients have actually pursued this avenue.<sup>160</sup> Rather, the mere knowledge that an HMO participant has the power to force an HMO to submit to independent review may be enough to influence how a health plan makes decisions earlier in the appeals process, thus eliminating the need for costly litigation altogether.<sup>161</sup>

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157. See *supra* notes 144-146.

158. See *Rush*, 536 U.S. at 384-86. But see *id.* at 396. The dissent in *Rush* disagreed and said: [T]he Court of Appeals did not interpret the plan terms or purport to analyze whether the plan terms or purport to analyze whether the plan fiduciary had engaged in the "full and fair review" of Moran's claim for benefits that §503(2) of ERISA, 29 U.S.C. § 1133(2), requires. Rather, it rubberstamped the independent medical reviewer's judgment that Moran's surgery was "medically necessary," granting summary judgment to Moran on her claim for benefits solely on that basis.

*Id.* (Thomas, J., dissenting).

159. Tanya Albert, *Few Patients Opt to Appeal HMO Denials*, AMEDNEWS, Apr. 8, 2002, available at [http://www.ama-assn.org/sci-pubs/amnews/pick\\_02/gvsa0408.htm](http://www.ama-assn.org/sci-pubs/amnews/pick_02/gvsa0408.htm). Here is how the states compare against the forty-five percent national average: Connecticut 72%; Rhode Island 69%; District of Columbia 67%; Maryland 67%; Georgia 63%; Virginia 60%; Texas 58%; Missouri 52%; Florida 50%; Hawaii 50%; Indiana 50%; Michigan 50%; New Mexico 50%; Colorado 48%; Kentucky 47%; Kansas 45%; Pennsylvania 44%; Tennessee 44%; New Hampshire 43%; Oklahoma 43%; Iowa 42%; California 40%; Montana 40%; Vermont 40%; New Jersey 39%; Maine 38%; New York 38%; Ohio 37%; Massachusetts 33%; Illinois 27%; Arizona 21%; Minnesota 21%. *Id.* The state laws were too new in Alaska, Delaware, Louisiana, Oregon, South Carolina, Utah, Washington, West Virginia, and Wisconsin to provide data. *Id.*

160. See Albert *supra* note 159. Only four thousand patients a year appeal HMO treatment decisions and denials. *Id.*

161. See Albert, *supra* note 159. Albert's article goes on to show that of the small number of patients who utilize the independent review statutes, on average, 45% of coverage denials were reversed nationwide. *Id.* That ranged from a low of 21% overturned in Arizona to a high of 72% in Connecticut. *Id.* Tim Maglione, an Ohio State Medical Association senior director of government relations, said: "The bigger picture shows it has a sentinel effect on the insurance company's decision. There is somebody watching over the HMOs, and that is causing the insurers to make better decisions." *Id.* The article gives several possible theories for the low use of the independent review laws, including criticism that the process is too complicated, the belief that there are not that many conflicts to begin with, and that there are too many hindrances to get through. *Id.* For example, in New Jersey, health plan members must endure a two-stage internal review process. Denial during the first stage can be done over the phone, rather than in writing; therefore, patients are sometimes confused about the decision. *Id.*

Despite *Rush*'s limitation on damage awards, HMO supporters still argue that the decision "undermines the cost-control function of HMOs by placing claims decisions outside the hands of HMOs, which internalize and, therefore, have an incentive to control the cost of providing health care."<sup>162</sup> No doubt, these same advocates will use studies showing increasing HMO costs to support the contention that *Rush* has caused the increases. I would advise caution before subscribing to this reasoning. First, health care costs have been on the rise long before the Supreme Court stepped in to allow state regulation. New technology, the aging baby boomers, and rising prescription drug and hospital costs are the major culprits of increased health care costs.<sup>163</sup> Second, unfortunately for the HMOs' argument, but fortunately for HMO executives, most of the big HMOs are very profitable.<sup>164</sup> The average American should find it ironic that HMOs cry threats of bankruptcy from the hilltops while a single chief financial officer for an HMO enjoyed a near sixteen million dollar salary in 2002.<sup>165</sup> While state regulations may increase costs, these are not the costs that are going to drive HMOs out of business.<sup>166</sup>

#### 4. *Pegram* is Still Good Law: You Can't Sue Your HMO for Having a Profit Motive

*Pegram* involved an HMO beneficiary who sued her HMO and physician alleging medical malpractice and fraud.<sup>167</sup> Specifically, the

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162. Harv. L. Rev. Assoc., *supra* note 153, at 417.

163. Julie A. Jacob, *Employers can Expect Another Year of Rising Premiums*, AMEDNEWS, Nov. 4, 2002, available at [http://www.ama-assn.org/sci-pubs/amnews/pick\\_02/bisc1104.htm](http://www.ama-assn.org/sci-pubs/amnews/pick_02/bisc1104.htm). A health care market leader for Hewitt Associates, which conducted the annual survey, "projects that costs for preferred-provider, point-of-service and indemnity plans will increase an average of 15%, while costs for HMOs will rise 16%." *Id.* This data suggests that HMO costs are rising at almost the same rate as the costs of other systems of health care. *Id.*

164. *See HMOs Profits Increase 162% During First Quarter of 2002*, Jan. 15, 2003 available at <http://www.spencernet.com/Archive/feature011503.html#Anchor-14210> (last visited Feb. 20, 2003). In the first three months of 2002, the nation's HMOs reportedly made an \$868 million profit, representing a 162% increase over the same period in 2001. *Id.* *See also Managing to Make a Profit*, AMEDNEWS, March 18, 2002, available at [http://www.ama-assn.org/sci-pubs/amnews/pick\\_02/bicc0318.htm](http://www.ama-assn.org/sci-pubs/amnews/pick_02/bicc0318.htm) (providing a chart of revenue, financial results, per-share profit, and medical-loss ratios).

165. *News in Brief*, AMEDNEWS, May 6, 2002 available at [http://www.ama-assn.org/sci-pubs/amnews/pick\\_02/bibf0506.htm](http://www.ama-assn.org/sci-pubs/amnews/pick_02/bibf0506.htm) (last visited Mar. 3, 2003). Reports come from the Securities and Exchange Commission filing. *Id.*

166. *See id.*

167. *Pegram v. Herdrich*, 530 U.S. 211, 215 (2000). Cynthia Herdrich suffered a ruptured appendix after her HMOs physician ordered her to wait eight days so she could schedule an ultrasound at an HMO clinic. Jamie L. Armitage, *Case Note: Pegram v. Herdrich: HMO Physicians as Fiduci-*

plaintiff alleged that a

provision of medical services under the terms of [her HMO], rewarding its physician owners for limiting medical care, entailed an inherent or anticipatory breach of an ERISA fiduciary duty, since these terms created an incentive to make decisions in the physician's self-interest, rather than the exclusive interest of plan participants.<sup>168</sup>

The question was whether an HMO, acting through its physicians, was performing fiduciary acts in making eligibility and treatment decisions.<sup>169</sup> The *Pegram* Court believed that "rationing of medical care is at the heart of managed care, and Congress through its encouragement of HMOs had long sanctioned such rationing."<sup>170</sup> As a result, the Court

*aries*, 5 DEPAUL J. HEALTH CARE L. 341, 348 (2002). Herdrich's health care provider consisted of three different entities which operated together to form a pre-paid health insurance plan that provided medical and hospital services. *Id.* Herdrich was covered under a plan subscription provided by her husband's employer, State Farm Insurance Company. *Id.* Herdrich's physician, Lori Pegram, was a physician who contracted under the Carle plan. *Id.* The events leading up to the *Pegram* lawsuit began when Herdrich went to see Dr. Pegram complaining of pain in the middle of her groin. *Pegram*, 530 U.S. at 215. Six days later Dr. Pegram discovered an inflamed mass in Herdrich's abdomen. *Id.* However, after finding the mass, Dr. Pegram did not order an ultrasound diagnostic procedure at the local hospital, but instead she scheduled Herdrich to have the procedure eight days later at a facility staffed by Carle. *Id.* Before the eight days expired, Herdrich's appendix ruptured, causing peritonitis. *Id.*

168. *Pegram*, 530 U.S. at 216. Financial incentives are said to be a key to managed care cost-control efforts. Julie Appleby, *Ruling Helps HMO Stock, But More Cases in Wings*, USA TODAY, June 13, 2000, available at <http://pqasb.pqarchiver.com/USAToday>. "Doctors are often paid a set amount per patient, per month, whether or not that patient needs treatment." *Id.* "Proponents say that that gives doctors an incentive to keep patients healthy, while critics say it means patients get short-changed." *Id.* The *Pegram* Court observed that:

These cost controlling measures are commonly complemented by specific financial incentives to physicians, rewarding them for decreasing utilization of health-care services, and penalizing them for what may be found to be excessive treatment. Hence, in an HMO system, a physician's financial interest lies in providing less care, not more.

Thomas L. Knight, *Pegram v. Herdrich – The Supreme Court HMO Case: While the Supreme Court Allowed the HMOs to Win a Battle, It May Have Set Them Up to Lose the War*, DCBA BRIEF ONLINE, September 2000, available at <http://www.dcba.org/brief/sepissue/2000/art10900.htm> (quoting *Pegram*, 530 U.S. at 219 (citation omitted)). "The Court acknowledged that the only check on the influence of the physician's financial interest to provide less care is the doctor's professional obligation to provide the covered services with a reasonable degree of skill and judgment in the patient's interest." *Id.*

169. See *Pegram*, 530 U.S. at 217; *Supreme Court Rules on Suing MCOs Under ERISA*, MEDICAL AND PUBLIC HEALTH LAW SITE, available at [http://biotech.law.lsu.edu/cases/hmo/2000\\_US\\_herdrich\\_review.htm](http://biotech.law.lsu.edu/cases/hmo/2000_US_herdrich_review.htm).

170. Borzi & Machiz, *supra* note 28, at 408. See also Armitage, *supra* note 167. In order to carry out the goal of increasing profits and minimizing expenses, some HMOs have instituted cost containment procedures that provide physicians financial incentives to curtail referrals to specialists or non-HMO physicians, to reduce testing, and to choose the cheapest form of treatment available. See *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 591 (1st Cir. 1993) (stating that "HMOs often can provide healthcare at lower cost by stressing preventative care, controlling costs,

found that the HMO had no fiduciary duties to its member patients when making eligibility or mixed eligibility and medical decisions.<sup>171</sup> The decision in *Rush* does not change the holding in *Pegram*.<sup>172</sup> An HMO patient still cannot sue their HMO simply because the HMO provides fi-

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and driving hard bargains with doctors or hospitals (who thereby obtain more patients in exchange for reduced charge.”). Primary care physicians are used as “gatekeepers” to monitor the care of the enrollees by approving or disapproving the referral of care such as seeing specialists or the length of the patients hospital stay. *Id.* It is common for some HMO physicians to deny referrals or fail to prescribe tests in order to preserve their year end bonuses and capitation benefits. James P. Duffy, Note, *HMO Doctors as ERISA Fiduciaries: A Bankruptcy Perspective*, 8 AM. BANKR. INST. L. REV. 125, 129-30 (2000). “The practice of discouraging usage of expensive services, and thus making health care particularly inconvenient for the ill, is openly discussed as a legitimate technique among health care managers. A 1994 article in *Journal of Health Care Marketing* is particularly interesting in this regard. This article praises several useful techniques that HMOs have developed for discouraging the use of (or “demarketing”) costly health care services.” *The Grand Unification Theory of Health Care: Portrait of a Modern HMO*, (2000), available at [http://www.yourdoctorinthefamily.com/grandtheory/section5\\_4.htm](http://www.yourdoctorinthefamily.com/grandtheory/section5_4.htm). The article explains:

Decreasing accessibility to services . . . can be accomplished by “managing” the information distributed to patients regarding services available and how to access them. For example, an organization might excessively promote less-costly preventive procedures . . . and repress information about other elective and/or expensive services. In addition, providers can strategically locate and number specific services to make them easy (e.g., primary care) or difficult (e.g., specialists) to utilize. Furthermore, lag periods . . . also serve as containment strategies. Lags may be affected by the need for referrals, limited number of contracted specialists, restricted or inconvenient appointment availability, and increased office-visit waiting periods.

*Id.* (quoting Borkowski NM, *Demarketing of Health Services*, JOURNAL OF HEALTH CARE MARKETING 1994;14:12). Some examples previously litigated include a baby suffering from injuries in childbirth after the HMO denied the mother a much needed ultrasound because of a testing policy, and a primary care physician whose patient died because he dissuaded him from visiting a cardiologist in order to preserve the physician’s minimum referral award. *Shea v. Esentsten*, 107 F.3d 625, 626-628 (8th Cir. 1997). Although courts have sanctioned some cost reduction systems, courts have held that they do not need to be disclosed unless the patient asks directly about them. *Id.* The Supreme Court did acknowledge that rationing might have been done poorly in [*Pegram*], but nonetheless found that rationing is fundamental to managed care and that it was approved by Congress. MEDICAL AND PUBLIC HEALTH LAW SITE, *supra* note 169.

171. The Court’s specific holding in *Pegram* was that Congress did not intend the fiduciary obligation of ERISA (the federal act regulating federally funded benefit plans) to apply to HMO treatment decisions under an ERISA benefit plan. Therefore, a patient cannot bring a claim for breach of fiduciary duty under that ERISA provision for a treatment decision which injures the patient. Knight, *supra* note 168. Knight goes on to describe the holding as “pretty narrow” because “most medical negligence attorneys have not tried to bring any ERISA breach of fiduciary duty claims.” *Id.* Knight explains that this is “understandable, since, in all probability the remedies would be those under the ERISA fiduciary provision, and they would not really help the clients” because they are limited to civil remedies. *Id.* Although the decision is beneficial to HMOs, there is nothing in the decision that forecloses patients from bringing traditional medical negligence claims against doctors and hospitals. *Id.*

172. See *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 359-387 (2002). The decision in *Pegram* “was not about preemption, but about the scope of the fiduciary rules.” Borzi & Machiz, *supra* note 28, at 409.

nancial incentives or has a profit seeking motive.

### 5. Uniformity is Still an Accomplished Objective<sup>173</sup>

It is well established that a main objective of ERISA was to establish a uniform set of regulations with respect to employee welfare benefits.<sup>174</sup> This objective has not been lost in *Rush's* majority opinion.<sup>175</sup> State regulations are still not permitted to supplant or supplement ERISA's civil enforcement provisions.<sup>176</sup> This maintains a degree of uniformity in relation to actual claims that can be brought against HMOs. Congress could not have intended that there be no variation in state regulations because variations are a predictable result of preserving power to the states through the savings clause.<sup>177</sup>

Furthermore, forty-two states already have independent review statutes, suggesting that the presence of these statutes is practically uniform across the country.<sup>178</sup> While the actual procedures may differ

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173. Justice Clarence Thomas, writing for the dissent in *Rush*, argued that the majority ruling "eviscerate[d] the uniformity of ERISA remedies." *Rush*, 536 U.S. at 389. See Janet L. Holt, *Supreme Court Approves State Review of HMO Decisions; Congress Stalls*, TRIAL MAG., Sept. 1, 2002, at 12 available at 2002 WL 15116022. "[Moran's] attorney Joshua Spielberg . . . [said] 'HMOs dress up their opposition to health care legislation in an argument that ERISA should preempt state laws for the sake of uniformity' . . . 'But what they really want is total control.'" *Id.*

174. Joshua Michael Kaye, Comment, *Closing the Lid on Pandora's Box: ERISA Preemption of Tort Actions Against Managed Care Organizations in State Courts*, 54 U. MIAMI L. REV. 373, 385-386 (2000). "Looking to ERISA's legislative history, the Court noted that Congress' aim 'was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.'" *Id.* (quoting *N.Y. Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 659 (1995)). See also *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987) (quoting H.R. REP. No. 93-533, 1, 12 (1973)); Bogan, *supra* note 74, at 980 (quoting congressmen as saying that the purpose of ERISA was to eliminate conflicting and inconsistent state and local regulation); Paredes, *supra* note 53, at 237 (stating "[t]o achieve its objective, Congress established in ERISA various uniform standards to regulate benefit plans[]").

175. See *Rush*, 536 U.S. at 374-87. "Whatever the standards for reviewing benefit denials may be, they cannot conflict with anything in the text of the statute, which we have read to require a uniform judicial regime of categories of relief and standards of primary conduct, not a uniformly lenient regime of reviewing benefit determinations." *Id.* at 385. "[W]e hold that the feature of § 4-10 that provides a different standard of review with respect to mixed eligibility decisions from what would be available in court is not enough to create a conflict that undermines congressional policy in favor of uniformity of remedies." *Id.* at 386 n.17.

176. *Id.* at 377. "[T]he state insurance regulation [will] los[e] out if it allows plan participants 'to obtain remedies . . . that Congress rejected in ERISA.'" *Id.* (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987)).

177. *Rush*, 536 U.S. at 381. "Such disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation. Arguments as to the wisdom of these policy choices must be directed at Congress." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724,747 (1985).

178. See Albert, *supra* note 159.



across the states, these procedures are not likely to impose burdens on plan administration.<sup>179</sup> “It is the HMO contracting with a plan, and not the plan itself, that will be subject to these regulations, and every HMO will have to establish procedures for conforming with the local laws, regardless of what [the] Court may think ERISA forbids.”<sup>180</sup> This means that there will be no “special burden of compliance upon an ERISA plan beyond what the HMO has already provided for.”<sup>181</sup>

### B. *Rush* Only Slows the Bleeding for Some

Many commentators express concern that *Rush* is hardly the “cure all” for which patients have hoped.<sup>182</sup> For one thing, there are people in eight states that do not have access to independent review statutes.<sup>183</sup> Second, *Pegram* may still be an insurmountable obstacle to filing a suit against an HMO.<sup>184</sup> Third, many HMOs can get around review statutes by avoiding overt denials.<sup>185</sup> For example, HMO plans may give physicians incentives for avoiding referrals that may have led to a recommendation that the HMO did not want to pay for.<sup>186</sup> Fourth, many patients are not aware of the independent review statutes or find them too confus-

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179. American Assn. of Health Plans President and CEO Karen Ignagni said health plans had a history of supporting external review laws and would continue to do so. But, she said the association is unhappy with the ruling because it doesn’t provide patients with uniform, national standards and guidelines for external review: “From our perspective it’s a setback for patients.”

*Id.* However, Ron Pollack, executive director of FamiliesUSA, opposes such statements saying, “[t]he only way to establish a federal review right . . . is through federal legislation, and ‘the managed care industry has consistently opposed passage of a national patients’ bill of rights.’” Holt, *supra* note 173.

180. *Rush*, 536 U.S. at 381 n.11. “[A]lthough the added compliance cost to the HMO may ultimately be passed on to the ERISA plan,” the Court has held before “that such ‘indirect economic effects’ are not enough to preempt state regulation even outside of the insurance context.” *Id.* (quoting *N.Y. Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) (internal citations omitted)). The Court notes that it is possible for a state to enact a kind of independent review that might result in a burden so high as to undermine the purpose of uniformity, but they declined to answer that question because the Illinois statute was not such a statute. *Id.*

181. *Rush*, 536 U.S. at 381 n.11.

182. See, e.g., Nevers, *supra* note 70; Albert, *supra* note 150; Holt, *supra* note 173; *Supreme Court Won’t Fix All ERISA Woes*, AMEDNEWS, Feb. 12, 2001, available at [http://www.ama-assn.org/sci-pubs/amnews/amm\\_01/edsa0212.htm](http://www.ama-assn.org/sci-pubs/amnews/amm_01/edsa0212.htm).

183. See Albert, *supra* note 159. See also, Albert *supra* note 150; Holt, *supra* note 173. Albert goes on to point out that the *Rush* decision only covers the 73 million patients in health plans that carry the insurance risk. *Id.* There are 56 million more patients in self-funded plans that are not guaranteed anything by the *Rush* decision. *Id.*

184. See *supra* notes 167-172 and accompanying text.

185. Holt, *supra* note 173.

186. See *id.* See also *Pegram v. Herdrich*, 530 U.S. 211 (2000) (holding that you cannot sue an HMO for having a profit-seeking motive).

ing to provide effective assistance.<sup>187</sup> Finally, in a footnote, the *Rush* Court discretely suggests how HMOs can completely avoid problems.<sup>188</sup> While explaining the role of the court in enforcing independent review statutes, the majority points out that *Rush* chose to guarantee “medically necessary services,” and it is for that reason that *Rush* was obligated to provide the service under the Illinois statute.<sup>189</sup> “But insurance contracts do not have to contain such guarantees.”<sup>190</sup> The majority goes on to specify how insurance contracts might be written to avoid making such guarantees for experimental treatments, and they suggest that even if the contracts are not modified, the reviewer’s judgment could still potentially be challenged as inaccurate or biased.<sup>191</sup> While this footnote has seemingly gone unnoticed by *Rush* commentators, one can be certain that it has not gone unnoticed by HMO providers. In the end it seems certain, as many patient advocates have noted, “the right to review . . .

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187. See *Holt*, *supra* note 173. See also *Albert*, *supra* note 150 (stating that the media attention generated by the ruling in *Rush* has created an awareness among patients and physicians who did not realize they had an external review right).

188. See *Rush*, 536 U.S. at 380 n.10.

189. *Id.* In explaining the role of the court in enforcing independent review statutes, the Court stated:

This is not to say that the court would have no role beyond ordering compliance with the reviewer’s determination. The court would have the responsibility, for example, to fashion appropriate relief, or to determine whether other aspects of the plan (beyond the “medical necessity” of a particular treatment) affect the relative rights of the parties. *Rush*, for example, has chosen to guarantee medically necessary services to plan participants. For that reason, to the extent § 4-10 may render the independent reviewer the final word on what is necessary, *Rush* is obligated to provide the service.

*Id.* (citation omitted).

190. *Id.*

191. *Rush*, 536 U.S. at 380 n.10. Specifically, the Court said that not all insurance contracts guarantee medically necessary services. *Id.*

Some, for instance, guarantee medically necessary care, but then modify that obligation by excluding experimental procedures from coverage. Obviously, § 4-10 does not have anything to say about whether a proposed procedure is experimental. There is also the possibility, though we do not decide the issue today, that a reviewer’s judgment could be challenged as inaccurate or biased, just as the decision of a plan fiduciary might be so challenged.

*Id.* For an example of an insurance contract that excludes experimental procedures, see *Tillery v. Hoffman Enclosures, Inc.*, 280 F.3d 1192, 1199 (8th Cir. 2002) where the court denied an ERISA plan beneficiary’s claim for medical expense for bowel transplant surgery on the basis that the surgery was experimental and the plan’s exclusion for experimental procedures was reasonable. The court found that the decision was reasonable because: (1) Denial was consistent with goal of plan to maximize benefits to all covered persons; (2) Exclusion for experimental procedures did not render plan’s coverage for medically necessary procedures meaningless; (3) Denial did not conflict with any substantive or procedural requirements under ERISA; (4) Beneficiary’s request was the first and only request for bowel transplant under the plan; and (5) The plan expressly excluded experimental procedures. *Id.* at 1199-1200.

will not be secure until Congress passes a national patient's bill of rights."<sup>192</sup>

### C. The Future for State Laws that Regulate HMOs

#### 1. Bad-Faith Statutes in the Aftermath of the *Rush* Decision

The Eastern District of Pennsylvania has recently issued conflicting opinions on whether Pennsylvania's bad faith statute was preempted by ERISA in light of the Supreme Court's ruling in *Rush*.<sup>193</sup> Plaintiffs were excited by the decision in *Rosenbaum v. UNUM Life Ins. Co*<sup>194</sup> that held ERISA does not preempt a bad faith claim.<sup>195</sup> Senior U.S. District Court

192. Holt, *supra* note 173. "All this means that 'passage of a national patients' bill of rights is critical . . . [w]e need to create a federal right to review of HMO treatment decisions that applies to everyone, irrespective of where they live.'" *Id.* (quoting Ron Pollack, Executive Director of FamiliesUSA). There are other patient protection activities that have evolved to "promote cost effective, quality, accessible health care through non-judicial forums." Nevers, *supra* note 70, at 535. Nevers lists several kinds of activities that are designed to fill in the gaps until a national system of health care steps in. *See id.* The list includes the "use of health care ombudsman to resolve complaints and improve access to care or dispute resolution processes such as mediation." *Id.* However, Nevers also points out that the right to sue is not what we should be striving for because it only provides remedies "after poor care has been rendered but is limited in effectuating excellent medical care at the time services are rendered." *Id.*

193. Donald P. Carleen, *Preempting Pennsylvania's Bad Faith Statute*, N.Y.L.J., Oct. 18, 2002, at 3. Carleen writes:

While the Eastern District had previously – and consistently – held that the statute did not survive preemption, the tide began to shift after two Supreme Court decisions held that certain state laws relating to employee benefit plans nevertheless fall within ERISA's saving clause as 'regulations of insurance.' Although it appears that the Eastern District is quickly reassuming its original position in favor of ERISA preemption, the recent conflict in the district may ultimately provide the Supreme Court with an opportunity to dispel any uncertainty on the scope of ERISA's saving clause and to confirm the exclusivity of the civil enforcement scheme provided under the federal statute.

*Id.* *See also* Andrew Brownstein, *Federal Judges Spar Over Whether ERISA Allows Punitive Damages*, 38-NOV TRIAL 84 (2002); Shannon P. Duffy, *Will 3rd Circuit Resolve ERISA Issue?* THE LEGAL INTELLIGENCER, Sept. 20, 2002, at 3; Shannon P. Duffy, *Dueling Rulings: Federal Judges Contradict Each Other in ERISA Decisions*, BROWARD DAILY BUS. REV., Aug. 26, 2002, at 9; David S. Senoff, *ERISA and Bad Faith: Strange Bedfellows or a Perfect Match?* *Rosenbaum Makes Insurers Liable for their Actions*, THE LEGAL INTELLIGENCER, Sept. 12, 2002, at 6.

194. *Rosenbaum v. UNUM Life Ins. Co.*, No. 01 -6758 (E.D.Pa. July 29, 2002).

195. Duffy, *3rd Circuit*, *supra* note 193. The lawyer for the plaintiff in *Rosenbaum* commented, "[I]t's a brand new day." *Id.* The Pennsylvania bad faith statute provides that in an action arising under an insurance policy,

if the court finds that the insurer has acted in bad faith toward the insured, the court may take all of the following actions: (1) Award interest on the amount of the claim from the date the claim was made by the insured in an amount equal to the prime rate of interest plus three percent. (2) Award punitive damages against the insurer. (3) Assess court costs and attorney's fees against the insurer.

42 PA. CONS. STAT. § 8371 (1998).

Judge Clarence Newcomer relied on *UNUM Life Ins. Co. of America v. Ward* and the decision in *Rush* to hold that the bad faith statute “regulates insurance” for the purposes of the saving clause.<sup>196</sup> Unfortunately, Newcomer did not address the potential conflict between the remedies available under ERISA and those available under the bad faith statutes.<sup>197</sup>

Newcomer’s avoidance of the potential conflict between remedies in ERISA and remedies available from bad faith statutes became the distinguishing factor when U.S. District Court Judge Ronald L. Buckwalter decided *Sprecher v. Aetna U.S. Healthcare Inc.*<sup>198</sup> Buckwalter held the bad faith law was preempted by ERISA because it provided for punitive damages.<sup>199</sup> Buckwalter wrote, “because Pennsylvania’s bad faith statute provides a form of ultimate relief in a judicial forum that adds to the judicial remedies provided by ERISA, it is incompatible with ERISA’s exclusive enforcement scheme.”<sup>200</sup>

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196. *Rosenbaum*, No. 01-6758 (E.D.Pa. July 29, 2002). See generally *Rush Prudential HMO Inc. v. Moran*, 536 U.S. 355 (2002) (using the McCarran-Ferguson factors to analyze a state statute); *UNUM Ins. Co. v. Ward*, 526 U.S. 358 (1999) (applying the Commonsense / McCarran-Ferguson Test). Newcomer stated that there was a “new trend in the federal law” toward relaxing the McCarran-Ferguson factors. Brownstein, *supra* note 193, at 85. He went on to say that the Justices in those cases “explained that the savings clause can protect a state law from preemption even if it does not meet all three factors of the McCarran-Ferguson test when deciding whether the regulation fits within the business of insurance.” Duffy, *Dueling Rulings*, *supra* note 193. Newcomer found that the Pennsylvania bad faith statute satisfied the second and the third factors by creating a mandatory contract term providing the insured with the right to pursue special remedies. Carleen, *supra* note 193. Furthermore, Newcomer distinguished the bad faith statutes from the statute at issue in *Pilot Life*, finding that the bad faith statute was directed specifically for use by the insurance industry. *Id.*

197. Many patient’s rights supporters seem to have forgotten that *Rush* also restated that a law providing an alternative remedy to those available in ERISA would be preempted despite being a law that “regulates insurance” within the meaning of the savings clause. *Rush*, 536 U.S. at 355. Judge Newcomer probably came to the wrong holding as a result of ignoring this important portion of *Rush* because allowing punitive damages will be most likely be considered an “alternative remedy” that conflicts with ERISA’s civil enforcement provision based on the Court’s dictum in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987) (declining to find an implied cause of action for punitive damages in the civil enforcement provision).

198. *Sprecher v. Aetna U.S. Healthcare Inc.*, No. 02-00580 (E.D.Pa. Aug. 19, 2002).

199. *Id.* at 7.

200. *Id.* at 7 (finding that the bad faith statute fell within the *Pilot Life* categorical preemption). See also Duffy, *Dueling Rulings*, *supra* note 193. In addition to the fact that the bad faith statute provided remedies not available in ERISA, Buckwalter also took issue with Newcomer’s classification of bad faith statutes as “regulating insurance” within the meaning of the saving clause. *Id.* While agreeing that the *UNUM* decision and the *Rush* decision relaxed the standard regarding the McCarran-Ferguson factors, Buckwalter disagreed that the bad faith statutes even met two of the factors. *Id.* Buckwalter argued that the Justices in *Ward* held California’s notice-prejudice rule met the McCarran-Ferguson’s second factor because it effectively created a mandatory contract term and thus, dictated the terms of the relationship. *Id.* And in the *Rush* decision, the Justices held that

It appears that Buckwalter's view is the majority view of his colleagues on the federal bench in Philadelphia. In *Kirkhuff v. Lincoln Technical Inst. Inc.*, Judge Harvey Bartle, who concurred in the *Sprecher* opinion, also held that Pennsylvania's bad faith statute was preempted by virtue of ERISA's exclusive remedial scheme.<sup>201</sup> Furthermore, Judge Michael Baylson, ruling in *Bell v. UNUM Provident Corp.*, and Judge Jay C. Waldman, ruling in *Smith v. Continental Casualty Co.*, took issue with Newcomer's reliance on the *Ward* and *Rush* decisions.<sup>202</sup>

## 2. Why *Sprecher* and *Kirkhuff* Correctly Interpret *Rush*

Commentators are calling on the Supreme Court to answer the question of what the dictum of *Pilot Life* and *Rush* really referred to.<sup>203</sup>

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the Illinois law was not preempted because it required HMOs to provide a mechanism for review by an independent physician when the patient's primary care physician and HMO disagreed about the medical necessity of a treatment by the primary care physician. *Id.* *Rush* found that this review affected the "policy relationship" between HMOs and covered persons because it provided a legal right to the insured and enforceable against the HMO. *Id.* By contrast, Buckwalter said that the bad faith statute does not alter the terms of the contract between the insurer and the insured because insurers already have an obligation to act in good faith. *Id.* It does not change the bargain between the insured and the insurer. *Id.* *But see* Senoff, *supra* note 193.

While it has long been established that insurers in Pennsylvania owe a duty of good faith to their insureds, until the passage of the bad faith statute there existed no cause of action to enforce that duty. After the passage of the bad faith statute, insureds in Pennsylvania were given the right to seek redress for an insurer's bad faith acts and obtain the remedies proscribed. Accordingly, the statute had the effect of "providing a legal right to the insured, enforceable against" the insurer to seek redress for the insurer's bad faith, which was not contained in the insurance policy itself. By creating a right to bring a cause of action against the insurer for damages, the bad faith statute created a new mandatory contract term.

*Id.*

201. *Kirkhuff v. Lincoln Technical Inst., Inc.*, 221 F. Supp. 2d 572 (E.D.Pa. 2002).

202. *See* *Bell v. UNUMProvident Corp.*, 222 F. Supp. 2d 692, 699-700 (E.D.Pa. 2002) (distinguishing *Pilot Life* because it specifically concerned bad-faith claims while *Ward* and *Rush* did not). Judge Baylson also noted that "there [was] not a whisper in either *Ward* or *Rush* which purport[ed] to overrule *Pilot Life*." *Id.* at 700. *See also* *Smith v. Continental Casualty Co.*, No. 02-1915 at 7 (E.D.Pa. Sept. 13, 2002) (noting that the "pronouncement in *Pilot Life* that ERISA provides a comprehensive civil enforcement scheme which is intended to be exclusive was left intact and indeed reinforced by the Court's later opinions in *UNUM* and *Rush*."). *But see* Senoff *supra* note 193 (stating that *Pilot Life* is not as "on point" as some believe because *Pilot Life* involved bad faith statutes generally, while Pennsylvania's bad faith statute is directed specifically towards the insurance industry).

203. *See* Browstein, *supra* note 193. At this point, the plaintiff lawyers in both *Kirkhuff* and *Sprecher* are asking for immediate appeals to the Third Circuit. Duffy, *supra* note 193. In *Sprecher*, the motion is unopposed. *Id.* Aetna's lawyer, Burt M. Rublin, said in his brief that he believes immediate appeal makes sense. *Id.* "The mere fact that this court found preemption to exist, while a contrary conclusion was reached three weeks earlier . . . has itself created uncertainty and confusion concerning the recurring issue of whether the bad faith statute is preempted by ERISA." *Id.*

Despite Newcomer's apparent disregard for the section of the Supreme Court's decision in *Rush* addressing conflicts between state laws and ERISA's civil enforcement provision, the Court's holding is clear: A state law that relates to an employee benefit plan and allows remedies outside those provided by ERISA's civil enforcement provision will be preempted by ERISA.<sup>204</sup> Bad faith statutes directed toward employee benefit plans, regardless of whether they fall within the saving clause, will be preempted if they allow remedies outside of ERISA's civil enforcement provision.<sup>205</sup> The bad faith statutes at issue in the Eastern District of Pennsylvania allow punitive damages and thus are clearly within the province of *Pilot Life's* rule.<sup>206</sup> It is easy to see how statutes allowing for remedies that closely resemble arbitration-like remedies or remedies that have an unclear effect on the recovery available to a plaintiff may eventually force the Supreme Court to decide a more specific holding.<sup>207</sup> However, those statutes are not currently being litigated. In light of the *Rush* decision, it seems that *Sprecher* and *Kirkhuff* got it right and Newcomer needs to re-read the *Rush* decision.

## V. CONCLUSION

Both sides of the independent review debate are passionate about what they feel is or should have been the correct outcome of *Rush*. One thing on which we can all agree is that when you or a loved one is ill, you want to know that you're receiving the best healthcare possible. Years ago, HMOs seemed to be a way of reducing health care costs

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204. *Rush*, 536 U.S. at 377 (stating that the state insurance regulation would be preempted if it allows plan participants to obtain remedies that Congress rejected in ERISA). The Court spent a tremendous amount of time on this section of the opinion and it is hard to understand how Judge Newcomer could simply disregard eleven full pages of discussion. *See id.* at 376-387.

205. *See id.*

206. *See id.* at 378-380. *See supra* notes 70-79 regarding the holding in *Pilot Life*. The *Rush* Court also discussed why the Texas tort of wrongful discharge, turning on the employer's motivation to avoid paying pension benefits, conflicted with ERISA. *Id.* at 379. The law provided for a legal remedy of money rather than the purely equitable ones provided in ERISA. *Id.* The Court stated, "[a]ny such provision patently violates ERISA's policy of inducing employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Id.*

207. *See Rush*, 536 U.S. at 376-387. Laws providing arbitration-like remedies present a much tougher question in view of the very fine line drawn by the majority in *Rush*. *Id.* The line becomes less clear when considering the dissent's argument that, while § 4-10 does not resemble all aspects of arbitration, the decision of the independent reviewer is enforceable through a subsequent judicial action in the same way as arbitration decisions. *Id.* at 395-96. Furthermore, the dissent argues that because the Court of Appeals' review was so limited, it has the same effect as an arbitration hearing and, thus, should be treated like one. *Id.* Arbitration constitutes an alternative remedy to litigation and thus conflicts with ERISA. *Id.* (citing *Air Line Pilots v. Miller*, 523 U.S. 866 (1998)).

while still providing quality health care. It is clear that the HMO system of care has not lived up to its original potential. For years HMOs enjoyed the discretionary authority to make mixed eligibility and health care decisions without justifying their actions to anyone. Finally, states were forced to regulate HMOs in order to protect patients. Independent review statutes play a role in evening out the playing field of health care by allowing patients to obtain a "second opinion" when an HMO denial seems unreasonable.

An insurance contract is probably the most important contract a person can ever enter into. It is the only contract that could someday be the difference between life and death. State independent review statutes give patients some ability to be sure that they are getting the care guaranteed under the contract for which they "bargained." While forcing HMOs to provide guaranteed care may increase costs, the cost increases will probably not have a significant link to *Rush's* decision permitting state independent review statutes to remain in effect. Potential cost increases are limited by *Rush's* holding that alternate remedies beyond those provided in ERISA will not be permitted. This eliminates the fear of excessive punitive damage awards. Furthermore, *Pegram* protects HMOs from suits merely attacking their profit seeking motives.

While the *Rush* decision will not be the end of the HMO debate, there is no doubt that it is a small victory for patients who find themselves at odds with their HMO. One thing that we should all think about as we go on to debate the HMO question is: If requiring HMOs to provide necessary services to patients means that HMOs will not succeed, then perhaps that is an indication that it never really worked in the first place.

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