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**SHOULD YOUR ERISA REMEDY DEPEND
UPON YOUR GEOGRAPHY?: AN ANALYSIS
OF RUSH PRUDENTIAL HMO, INC. V.
MORAN**

Amanda M. Schulz

INTRODUCTION

Congress passed the Employee Retirement Income Security Act of 1974 (ERISA), in response to the proliferation of employee welfare and pension benefit plans during the middle part of the twentieth century.¹ Concerned with the increasingly interstate nature of such plans and their effect on the well-being of millions of the nation's citizens, Congress sought to protect employees and their dependents through disclosure and vesting requirements and safeguards with respect to the establishment, operation and administration of the plans.² Concurrent with these goals, ERISA seeks to provide uniformity, predictability and equity through federal law rather than allowing employee welfare and pension benefit plans to be governed by the laws of fifty different states.³ States, however, concomitant with their police powers, have enacted laws governing insurance and other employee benefit plans that occasionally conflict with the provisions of ERISA. As a result, the courts must decide which statute controls.

The Supremacy Clause of the United States Constitution provides that when a federal law conflicts with a state law the federal law will control.⁴ The federal law in this situation is said to preempt the state law.⁵ The United States Supreme Court has ruled on the preemptive

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1. 29 U.S.C. § 1001 (2000).
 2. *Id.*
 3. *Id.*
 4. U.S. CONST. art. VI, cl. 2.
 5. Barron's Law Dictionary, 383 (1996).

effect of ERISA on several occasions.⁶ ERISA is rare among federal statutes in that it explains the extent of its preemption of state law. In section 514(a), the law provides that “the provisions of [title I] and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan”⁷ covered under ERISA. However, state laws that “relate to” ERISA plans are saved from preemption if they “regulate insurance” under ERISA’s saving clause.⁸ ERISA’s deemer clause further limits this exception from preemption by providing that an employee benefit plan may not “be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance.”⁹

During the first twenty years of ERISA’s enactment the Supreme Court espoused a broad reading of “relate to” preemption under section 514.¹⁰ More recently, the Court acknowledged that its prior attempts to construe the phrase “relate to”, provided an insufficient dividing point in determining whether a particular state law ought to be preempted by ERISA.¹¹ In applying “relate to” preemption and the saving and deemer clauses, many recent decisions focus primarily on Congressional intent.

Despite the Supreme Court’s attempts to clarify preemption issues, a split developed in the Circuit Courts regarding state laws which require independent external review of medical necessity determinations made by Health Maintenance Organizations (HMOs). At present over forty states and the District of Columbia have laws requiring such independent reviews.¹² As a result, the Supreme Court granted certiorari¹³ to resolve the conflict between the circuits.

6. See generally *infra* notes 11, 31, and 33.

7. 29 U.S.C. § 1144(a) (2000).

8. *Id.*

9. 29 U.S.C. § 1144(a)(2)(B) (2000).

10. See *Corporate Health Ins., Inc. v. Texas Department of Ins.*, 215 F.3d 526, 532-33 (5th Cir. 2000).

11. See *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995).

12. See ALASKA STAT. § 21.07.050 (Michie 2001); ARIZ. REV. STAT. ANN. § 20-2537 (West 2000); CAL. INS. CODE § 10169 (West 2001); COLO. REV. STAT. § 10-16-113.5 (2000); CONN. GEN. STAT. § 38a-478n (2001); DEL. CODE ANN., tit. 16, § 9119 (2000); D.C. CODE § 32-571.7 (2000); 2000 Fla. Laws ch. 00-257; GA. CODE ANN. § 33-20A-32 (2000); HAW. REV. STAT. § 432E-6 (2000); 215 ILL. COMP. STAT 125/4-10 (2000); IND. INS. CODE ANN. § 27-13-10.1-1 (West 2000); IOWA CODE ANN. § 514J (West 2000); KAN. STAT. ANN. § 40-22a13 (2000); KY. REV. STAT. ANN. § 304.17A-623 (Michie 2001); LA. REV. STAT. ANN. § 22:3081 (West 2000); ME. REV. STAT. ANN., tit. 24-A, § 4312 (West 2000); MD. CODE ANN., INS. § 15-10A-01 (2001);

First, this Note examines some of the jurisprudence regarding ERISA preemption. Second, this Note discusses the Supreme Court's recent cases analyzing the effect of ERISA's preemption provisions as they relate to state laws. Third, this Note considers the opinion reached by the Fifth Circuit in *Corporate Health Insurance, Inc. v. Texas Department of Health*.¹⁴ Fourth, this Note analyzes the Seventh Circuit's recent decision in *Moran v. Rush Prudential HMO, Inc.*,¹⁵ that created a split in the circuits, and argues that the Seventh Circuit provided an analysis that relied on flawed reasoning. Finally, this Note discusses the decision of the United States Supreme Court in *Rush Prudential HMO, Inc. v. Moran*¹⁶ and concludes that it allows ERISA remedies that are dependent upon geography.

II. PRIOR LAW

A. The ERISA Statute

ERISA regulates certain pension benefit and employee welfare plans. The law extends to plans that "through the purchase of insurance or otherwise [provide] medical, surgical, or hospital care or benefits" for plan participants and beneficiaries.¹⁷ ERISA does not require employers to provide any given number of minimum benefits.

MASS. GEN. LAWS ANN. ch. 1760, § 14 (Law. Co-op. 2001); MICH. COMP. LAWS § 550.1907 (2001); MINN. STAT. § 62Q.73 (2000); MO. REV. STAT. § 376.1385 (2000); MONT. CODE ANN. § 33-37-102 (2000); N.H. REV. STAT. ANN. § 420-J:5 (2000); N.J. STAT. ANN. § 26:2S-11 (West 2001); N.M. STAT. ANN. § 10.17.24 (Michie 2000); N.Y. INS. LAW § 4904 (McKinney 1999); N.C. GEN. STAT. § 58-50-62 (1999); OHIO REV. CODE ANN. § 1751.84 (Anderson 2001); OKLA. STAT. tit. 63, § 2528.3 (2000); 2001 Or. Laws ch. 266, § 8; 40 PA. CONS. STAT. § 991.2162 (1998); R.I. GEN. LAWS § 23-17.12-10 (2001); S.C. CODE ANN. § 38-71-1970 (Law Co-op. 2000); TENN. CODE ANN. § 56-32-227 (2001); TEX. INS. CODE ANN. § 21.58A (Vernon Supp. 2001); UTAH CODE ANN. § 31A-22-629 (2000); VT. STAT. ANN. tit. 8 § 4089 (2001); VA. CODE ANN. § 38.2-5901 et. seq. (Michie 2001); WASH. REV. CODE ANN. § 48.43.535 (West 2001); W. VA. CODE § 33-25C-6 (2001); and WIS. STAT. § 632.835 (2000).

13. *Rush Prudential HMO, Inc. v. Moran*, 533 U.S. 948 (2001).

14. *Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 215 F.3d 526 (5th Cir. 2000).

15. *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959 (7th Cir. 2000).

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

17. 29 U.S.C. § 1002(1) (2000).

Rather, it controls the administration of benefit plans¹⁸ through the imposition of reporting and disclosure directives,¹⁹ funding standards,²⁰ participation and vesting requirements²¹ and fiduciary responsibilities for plan administrators.²² In addition to providing for these administrative oversight functions, ERISA imposes criminal sanctions and sets up a civil enforcement plan.²³ Finally, ERISA preempts some state law.²⁴

Section 514(a) provides that ERISA “shall supersede any and all State laws insofar as they...relate to any employee benefit plan” covered by the statute.²⁵ However, under ERISA’s savings clause, state laws that ‘relate to’ employee benefit plans can nonetheless be saved from preemption if they ‘regulate insurance.’²⁶ Through this mechanism state insurance laws are saved from preemption.

This result is consistent with the McCarran-Ferguson Act which provides that “the continued regulation...by the several States of the business of insurance is in the public interest.”²⁷ In *Metropolitan Life Ins. Co. v. Massachusetts*,²⁸ the Supreme Court applied a three-factor analysis based on the McCarran-Ferguson Act to determine the scope of the savings clause. The three factors are: first, “whether the practice has the effect of transferring or spreading a policyholder’s risk; second, whether it is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities in the insurance industry.”²⁹ These factors need not all be met in order to determine that a particular law regulates insurance.³⁰ Though the factors are “considerations weighed,”³¹ the Court has directed that “none of these criteria is necessarily determinative in

18. *Id.* § 1001(b).

19. *Id.* §§ 1051-1061.

20. *Id.* §§ 1081-1086.

21. *Id.* §§ 1051-1061.

22. *Id.* §§ 1101-1114.

23. *Id.* §§ 1131-1145.

24. *Id.* § 1144.

25. *Id.* § 1144(a).

26. *Id.* § 1144(b)(4).

27. 15 U.S.C. § 1011 (2000).

28. 471 U.S. 724 (1985).

29. *Id.* at 743.

30. *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982).

31. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 49 (1987).

itself.”³² Using these factors, if a particular practice constitutes the business of insurance, it is saved from preemption and left to state regulation.³³

Finally, even if a state law is saved using the saving clause and the McCarran-Ferguson factors, it may still be preempted if it falls under ERISA’s deemer clause. The deemer clause provides that for purposes of applying the saving clause, a plan cannot “be deemed to be an insurance company or other insurer, . . . or be engaged in the business of insurance.”³⁴ The Supreme Court interpreted this clause to mean that a state law initially saved from preemption through the saving clause is ultimately preempted to the extent that it relates to plans not funded through insurance.³⁵

B. *The Evolution of ‘Relate to’ Preemption*

During the first twenty years after the enactment of ERISA, the provision regarding ‘relate to’ preemption was construed broadly to reach any state law having a connection with, or reference to, covered employee plans.³⁶ However, recent cases have prompted the Supreme Court to recognize that its prior attempts to construe the phrase ‘relate to’ provide little guidance in deciding preemption cases because “really, universally, relations stop nowhere.”³⁷ In essence, the Court recognized that nearly any state law in this area would be preempted as having a connection with or some reference to an ERISA plan.

In 1995 the Supreme Court decided *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*³⁸ In this case, the Court determined that it must “look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.”³⁹ In *Travelers Insurance Co.*, a New York law required hospitals to collect additional charges for services provided to patients covered by commercial carriers and other HMOs but not for services provided to patients covered under Blue Cross/Blue Shield plans.⁴⁰ The law further imposed a surcharge on

32. *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982).

33. *Metropolitan Life v. Massachusetts*, 471 U.S. 724 (1999).

34. 29 U.S.C. § 1144 (b)(2)(B) (2000).

35. *See FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

36. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *See also* *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125 (1992).

37. *Travelers Ins. Co.*, 514 U.S. at 655.

38. *Id.*

39. *Id.* at 656.

40. *See id.* at 649.

HMOs that “varie[d] depending on the number of eligible Medicaid recipients an HMO has enrolled.”⁴¹ The purpose of the additional charges was to encourage the HMOs to admit more Medicaid patients to their plans.⁴²

The Court of Appeals for the Second Circuit ruled that the charges “relate[d] to ERISA because they impose a significant economic burden on commercial insurers and HMOs. They therefore have an impermissible impact on ERISA plan structure and administration.”⁴³ The Supreme Court rejected the Second Circuit’s approach and observed that the indirect, economic burdens in *Travelers Insurance Co.* did “not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself”⁴⁴ but rather simply affected the costs and benefits of selecting one plan over another.⁴⁵ As a result, the Supreme Court held that the New York statute was not preempted by ERISA.⁴⁶

Three years later in *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*⁴⁷ the Supreme Court was again called upon to rule on the preemption of a state statute by ERISA. *Dillingham* involved a challenge to a California law requiring public works contractors to pay a prevailing wage while allowing lower wages for apprenticeship programs.⁴⁸ A unanimous Supreme Court held that the law was not subject to preemption because it constituted only the regulation of an underlying industry of which the employers were members.⁴⁹ The Court rooted its holding in the “assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.”⁵⁰

Four months after the Court’s decision in *Dillingham*, the Court upheld another state law that had been challenged under ERISA.⁵¹ In *DeBuono v. NYSA-ILA Medical & Clinical Services Fund* the

41. *Id.* at 650.

42. *See id.*

43. *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 721 (2d Cir. 1993).

44. *Travelers Ins. Co.*, 514 U.S. at 659.

45. *Id.* at 660.

46. *Id.* at 645.

47. *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*, 519 U.S. 316 (1997).

48. *Id.*

49. *Id.* at 334.

50. *Id.* at 325.

51. *DeBuono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997).

Supreme Court upheld a New York statute exacting a tax on gross receipts for patient services at health care facilities.⁵² The Court held that the state law was not the type of law Congress intended ERISA to preempt.⁵³ Rather, it deemed the statute to be one of many “state laws’ of general applicability that impose some burdens on the administration of ERISA plans but nevertheless do not ‘relate to’ them within the meaning of the governing statute.”⁵⁴ Once again, the Court’s resolution turned on Congressional intent.

In analyzing the Congressional objectives in passing the ERISA statute, the Court has made several findings. In *Ingersoll-Rand v. McClendon*,⁵⁵ the Court found that in passing section 514(a), Congress intended:

to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government..., [and to prevent] the potential for conflict in substantive law... requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.⁵⁶

One of the Act’s sponsors, Representative Dent, further described Congress’ objective as “to eliminat[e] the threat of conflicting and inconsistent State and local regulation.”⁵⁷ Senator Williams reiterated the point saying that “with the narrow exceptions specified in the bill, the substantive and enforcement provisions . . . 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.”⁵⁸ Thus, as the Supreme Court pointed out, “the basic thrust of the preemption clause, then, was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.”⁵⁹

52. *Id.*

53. *DeBuono*, 520 U.S. at 816.

54. *Id.* at 815.

55. 498 U.S. 133 (1990).

56. *Travelers Ins. Co.*, 514 U.S. at 656-57 (quoting *McClendon*, 498 U.S. at 142).

57. 120 CONG. REC. 29197 (1974).

58. *Id.* at 29933.

59. *Travelers Ins. Co.*, 514 U.S. at 657.

C. The Fifth Circuit's View

Against the background discussed in the previous section, the United States Court of Appeals for the Fifth Circuit was called upon to rule on a Texas statute allowing independent review of medical necessity determinations made by HMOs.⁶⁰ At issue in *Corporate Health Insurance, Inc. v. Texas Department of Health* was a statute that purported to regulate the managed health care field in three ways.⁶¹ The law, Texas Senate Bill 386,⁶² first created a cause of action against managed care entities failing to meet an ordinary standard of care for health care treatment decisions.⁶³ The statute provides that an HMO has “a duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care.”⁶⁴ Second, the Texas law provided protection for physicians from retaliation by HMOs and from indemnity clauses they may seek to impose.⁶⁵ The anti-indemnification provision of the statute prohibited the inclusion of indemnification provisions in contracts of physicians and other medical providers that would hold an HMO harmless for its own acts.⁶⁶ The anti-retaliation provision prevented an HMO from dropping or refusing to renew a doctor’s contract when he or she advocates medically necessary, yet expensive, treatment for patients.⁶⁷

The third provision at issue in the Texas law established an independent review procedure whereby patients could challenge medical necessity decisions made by HMOs.⁶⁸ Specifically, the law provided that patients can appeal “adverse determinations,” which it defined as “[a] determination by [an HMO] or utilization review agent that the health care services furnished or proposed to be furnished to

60. *Corporate Health Ins., Inc. v. Texas Dep’t of Ins.*, 215 F.3d 526 (5th Cir. 2000).

61. *Id.* at 531.

62. Codified at TEX. CIV. PRAC. & REM. CODE § 88.001 et seq. (1999); TEX. INS. CODE ANN. art. 20A.09(e) (West Supp. 2003).

63. TEX. CIV. PRAC. & REM. CODE § 88.001 et seq. (1999)

64. *Id.* § 88.002(a).

65. *Id.* § 88.002(4)(g).

66. *See Id.* § 88.002(g).

67. *Id.* § 88.002(f).

68. *Id.*

an enrollee are not medically necessary or are not appropriate.”⁶⁹ Additionally, the law requires the HMO to comply with the determination made by the independent reviewer.⁷⁰ The Fifth Circuit dealt with each provision in turn.

As to the first provision, the court did not agree with the argument that in providing liability against HMOs for negligence, the law ‘relate[d] to’ an ERISA plan, affected its administration, and was therefore preempted.⁷¹ The court approved of Texas’ interpretation that the statute “avoided the difficult genre of cases complaining of medical care and service by excluding a duty to provide treatment not covered by the plan.”⁷² As the court explained, the statute allowed suits for negligence claims against doctors and imposed vicarious liability on HMOs for that negligence.⁷³ According to the court, “ERISA preempts malpractice suits against doctors making coverage decisions in the administration of a plan, but it does not insulate physicians from accountability to their state licensing agency or association charged to enforce professional standards regarding medical decisions.”⁷⁴

Using similar reasoning, the court rejected the preemption of the anti-indemnification and anti-retaliation portions of the Act.⁷⁵ As the court pointed out in the following excerpt, those portions of the statute were not the sort of regulation Congress meant ERISA to preempt.

The anti-retaliation and anti-indemnity provisions complement the Act’s liability provisions by realigning the interests of managed care entities and their doctors. The liability and indemnity provisions force the managed care entity to share in its doctors’ risk of tort liability; the anti-retaliation provision avoids the situation in which the doctor must choose between satisfying his professional responsibilities and facing retaliatory action by the managed care entity. Together, the provisions thus better preserve the physician’s independent judgment in the face of the managed care entity’s incentives for cost containment. Such a scheme is again the kind of quality of care regulation that has been left to the states.⁷⁶

69. TEX. INS. CODE ANN. art. 20A.12A(a)(1) (1997).

70. *Id.* art. 21.58A § 6A(3).

71. *Corporate Health*, 215 F.3d at 534.

72. *Id.*

73. *Id.*

74. *Id.* at 534-35.

75. *Id.* at 535-36.

76. *Id.* at 536.

Finally, the court analyzed the independent review provisions included in the statute.⁷⁷ Under the state statute, an insured patient may appeal a “determination by [an HMO] or utilization review agent that the health care services furnished or proposed to be furnished to an enrollee are not medically necessary or are not appropriate.”⁷⁸ The act goes on to require that the HMO comply with the determination made by the independent review agent.⁷⁹ The court held that ERISA preempted these sections of the statute because they provide for an administrative scheme governing coverage determinations.⁸⁰ Such an attempt to provide for a state administrative scheme “is squarely within the ambit of ERISA’s preemptive reach.”⁸¹

The court further addressed whether the statute was nonetheless saved under ERISA’s saving clause.⁸² The court applied the three-factor test interpreting the saving clause that the Supreme Court fashioned in *Metropolitan Life Insurance v. Massachusetts*.⁸³ The three factors, known as the *McCarran-Ferguson*⁸⁴ factors ask the following: “(1) whether the practice has the effect of transferring or spreading the policyholder’s risk; (2) whether it is an integral part of the policy relationship between the insured and the insurer; and (3) whether the practice is limited to entities in the insurance industry.”⁸⁵ The state statute in question need not satisfy each factor in order to be saved from preemption.⁸⁶ The court determined that the second and third prongs of the test were satisfied because the provisions in question “are integral to the policy relationship and regulate the insurance industry.”⁸⁷ Thus, the court found that the requirements of the saving clause were met.⁸⁸

The court, however, continued its analysis and stated that even if the provisions would be saved under the saving clause, they may still be preempted if found to conflict with a substantive provision of ERISA.⁸⁹

77. *Id.*

78. TEX. INS. CODE ANN. art. 20A.12A(a)(1).

79. *Id.* art. 21A.58A § 6A(3).

80. *Corporate Health*, 215 F.3d at 537.

81. *Id.*

82. *Id.* See also 29 U.S.C. § 1144(b)(2)(A) (2000).

83. 471 U.S. 724 (1999).

84. 15 U.S.C. § 1011 (2000).

85. *Corporate Health*, 215 F.3d at 537.

86. See *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358, 373 (1999).

87. *Corporate Health*, 215 F.3d at 538.

88. *Id.*

89. *Id.*

Under the Supreme Court's holding in *Pilot Life Insurance Co. v. Dedeaux*,⁹⁰ "[judicial] understanding of the saving clause must be informed by the legislative intent concerning [ERISA's] civil enforcement provisions."⁹¹ In *Pilot Life*, "[t]he Court interpreted Congress' intent regarding the exclusivity of ERISA's enforcement scheme very broadly, concluding that the scheme preempts not only directly conflicting remedial schemes but also supplemental state law remedies."⁹² Since the scheme provided for in the Texas statute created an alternative remedy for obtaining benefits under an ERISA plan, the court found that it directly conflicted with ERISA's exclusive remedy and could not therefore be saved by the saving clause.⁹³

The Fifth Circuit's analysis in *Corporate Health*⁹⁴ ultimately brings the observer back to the conclusion espoused by the Supreme Court in *Travelers*,⁹⁵ *Dillingham*⁹⁶ and *DeBuono*.⁹⁷ In determining ERISA preemption issues the courts should focus primarily upon the legislative intent behind the enactment of the statute. As the next section will discuss, the Court of Appeals for the Seventh Circuit departed from this focus in *Moran v. Rush Prudential HMO, Inc.*⁹⁸

III. THE SEVENTH CIRCUIT'S DEPARTURE

A. Factual Background

Beginning in 1996, Debra Moran began experiencing loss of function, numbness, pain and decreased mobility in her right shoulder.⁹⁹ Ms. Moran visited Dr. Arthur LaMarre, her primary care physician under her HMO plan, seeking treatment for these symptoms.¹⁰⁰ Rush Prudential is the HMO provider for Ms. Moran's plan.¹⁰¹

90. 481 U.S. 41 (1987).

91. *Id.* at 52.

92. *Corporate Health*, 215 F.3d at 538-39 (citing *Pilot Life*, 481 U.S. at 56).

93. *Id.* at 539.

94. *Id.*

95. *Travelers Ins. Co.*, 514 U.S. 645.

96. *Dillingham*, 519 U.S. at 316.

97. *DeBuono*, 520 U.S. at 806.

98. *Moran*, 230 F.3d at 959.

99. *Id.* at 963.

100. *Id.*

101. *Id.*

Initially, Dr. LaMarre treated Moran's ailments with physiotherapy and other conservative treatments, but these methods did not alleviate her symptoms.¹⁰² While under Dr. LaMarre's care, Ms. Moran obtained the name of an out-of-network physician specializing in micro-reconstructive surgery.¹⁰³ Ms. Moran submitted a request to Rush for a referral to consult with this physician, but her request was denied.¹⁰⁴ Despite this, Ms. Moran arranged to be examined by the out-of-network physician, Dr. Julia Terzis.¹⁰⁵ Dr. Terzis diagnosed Ms. Moran with brachial plexopathy and thoracic outlet syndrome (TOS), a nerve compression syndrome caused by the compression of nerves in Ms. Moran's brachial plexus.¹⁰⁶ While these conditions are generally treated with therapy, surgery becomes necessary if symptoms persist;¹⁰⁷ the standard surgical procedure involves the complete removal of the uppermost rib or removal with scalenectomy - the removal of the rib and the attached muscle.¹⁰⁸ The surgery recommended by Dr. Terzis, however, was more involved and thus more expensive.¹⁰⁹ Dr. Terzis recommended that Ms. Moran undergo the standard procedure as well as an additional procedure performed during the operation known as microneurolysis.¹¹⁰ After having Ms. Moran consult with two plan doctors who recommended only the standard TOS surgery, Dr. LaMarre formally asked Rush to approve Dr. Terzis' surgery for Ms. Moran in October 1997.¹¹¹

Though Ms. Moran complied with all of Rush's internal petition and request requirements in order to have the surgery performed, Rush denied approval for the surgery.¹¹² In January 1998, Ms. Moran made a written demand to Rush seeking its compliance with section 4-10 of Illinois' Health Maintenance Organization Act (HMO Act).¹¹³ The HMO Act requires HMOs to provide an independent physician review when a patient's primary care physician disagrees with an HMO about

102. *Id.*

103. *Id.*

104. *Id.*

105. *Id.*

106. *Id.*

107. *Id.*

108. *Id.*

109. *Id.*

110. *Id.*

111. *Id.*

112. *Id.* at 963-64.

113. *Id.* at 964; *See also* 215 ILL. COMP. STAT. ANN. 125/4-10 (2000).

the medical necessity of a proposed treatment.¹¹⁴ When Rush did not respond to Moran's demand to comply with the statute, Moran elected to undergo Dr. Terzis' surgery at her own expense.¹¹⁵ Afterwards, Moran submitted the bill to Rush and filed a complaint in Illinois circuit court seeking a court order requiring Rush to comply with section 4-10.¹¹⁶ Rush removed the case to federal court citing the statute's conflict with ERISA, and the case made its way through the federal courts.¹¹⁷

The District Court agreed with Rush that ERISA preempted Moran's claims and granted summary judgment.¹¹⁸ When the case reached the Seventh Circuit, the court determined that section 4-10 of the HMO Act related to an ERISA plan.¹¹⁹ The court determined that the HMO Act was saved from preemption, however, under ERISA's saving clause because it "regulate[d] insurance" under a common sense understanding and met two of the McCarran-Ferguson factors.¹²⁰ The court held that, "as a matter of common sense, § 4-10 of the HMO Act regulates insurance because the law is directed at the HMO industry as insurers" even though "the law does not affect the entire insurance industry in Illinois."¹²¹ In discussing the McCarran-Ferguson factors, the Seventh Circuit held that section 4-10 met the second factor because it "creates a mandatory term in the insurance contract and, thus, changes the bargain between insurer and insured."¹²² The court considered the third factor satisfied because "the section applies only to HMOs acting as insurers."¹²³ The court then briefly pointed out that the deemer clause was inapplicable in the case because the plan at issue is an insured plan, not a self-funded plan.¹²⁴

In addressing the issue that was the undoing of the Texas statute in *Corporate Health Insurance, Co. v. Texas Dep't of Health*¹²⁵, the court ruled that section 4-10 of the HMO Act could not be characterized as

114. See *Id.* § 125/4-10.

115. *Moran*, 230 F.3d at 964.

116. *Id.* at 964.

117. *Id.* at 964-66.

118. *Id.* at 962.

119. *Id.* at 968-69.

120. *Id.* at 969.

121. *Id.*

122. *Id.* at 970 (internal citations omitted).

123. *Id.*

124. *Id.*

125. *Corporate Health*, 215 F.3d 526.

conflicting with ERISA by creating an alternative remedial scheme.¹²⁶ According to the court's reasoning,

Rather than providing an alternative remedy for Ms. Moran to recover benefits, § 4-10 of the HMO Act simply establishes an additional internal mechanism for making decisions about medical necessity and identifies who will make that decision in those instances when the HMO and the patient's primary care physician cannot agree on the medical necessity of a course of treatment. Rather than eliminate the review procedures established by the plan, it simply adds to the contract, by operation of law, an additional dispute resolving mechanism when, despite exhausting the internal review system otherwise provided by the plan, there remains a disagreement between the plan's own experts and the attending physician on the issue of medical necessity.¹²⁷

Though its analysis nearly mirrored that of the Fifth Circuit up to this point, the Seventh Circuit departed from the reasoning in *Corporate Health* on this critical issue. The court in *Corporate Health* felt that the independent review provision of the Texas law set up a separate remedial scheme through which members could seek to enforce plan benefits already due them.¹²⁸ According to its view, this separate scheme conflicted with ERISA and was thus preempted. In contrast, the Seventh Circuit reasoned that a similar independent review provision in the Illinois HMO Act simply added a new contractual term to the plan as a matter of law and thus escaped preemption. The next section of this Note analyzes the Seventh Circuit's reasoning in *Moran* and concludes that it is flawed.

B. The Independent Review Provision of the Illinois HMO Act is not Saved By ERISA's Saving Clause

Moran contends that ERISA's saving clause saves section 4-10 of the HMO Act from preemption. In determining whether a particular law regulates insurance under the saving clause, courts must first look to a common sense reading of the law,¹²⁹ then look to the three McCarran-Ferguson factors, and, finally, analyze whether the questioned law directly conflicts with the remedial scheme ERISA establishes.¹³⁰

126. *Moran*, 230 F.3d at 971.

127. *Id.* at 971-72.

128. *Corporate Health*, 215 F.3d at 538.

129. *Ward*, 526 U.S. at 367.

130. *See, e.g., Corporate Health*, 215 F.3d 526.

As Moran accurately points out, the Illinois law regulates insurance as a matter of common sense.¹³¹ Section 4-10 applies to HMO's, "entities that are engaged in the business of health insurance."¹³² Because the law is aimed at the insurance industry, it regulates insurance under a common sense understanding of the term.

Moran's analysis of the McCarran-Ferguson factors also correctly determines that section 4-10 regulates insurance.¹³³ The second factor is met because section 4-10 is integral to the policy relationship between Rush and Moran. The third factor is satisfied because the provision applies to HMOs acting as insurers.¹³⁴

Though Moran is correct up to this point, the analysis with regard to a direct conflict with an ERISA provision, is flawed. Even if a statute is saved from preemption under the saving clause using the McCarran-Ferguson factors, it may still be preempted if it can be shown that it conflicts with a substantive provision of ERISA.¹³⁵ The Supreme Court has held repeatedly that its understanding of the saving clause "must be informed by the legislative intent concerning [ERISA's] civil enforcement provisions."¹³⁶ The Court has interpreted the preemptive effect of ERISA very broadly, allowing it to reach not only those remedial schemes that directly conflict with its provisions but also those that seek to supplement them.¹³⁷

C. The Independent Review Provision of the HMO Act Conflicts with ERISA's Exclusive Remedial Scheme

Though the Seventh Circuit held that the independent review provisions of the HMO Act merely provide an additional internal decision-making mechanism that serves as an added contract term, it is clear that this is not the case. Section 4-10 of the HMO Act provides an additional and alternative remedy through which individuals can obtain benefits through an ERISA plan and should therefore be

131. *Brief for Respondent* at 9, *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002)(No. 00-1021) [hereinafter *Respondent's Brief*].

132. *Wash. Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039, 1045 (9th Cir. 1998), *cert. denied*, 525 U.S. 1141 (1999).

133. *Respondent's Brief*, *supra* note 131, at 25. (Though Moran erroneously finds the first factor to be met, this fact is not fatal to the overall determination using the McCarran-Ferguson factors because not all three factors need be met.)

134. *Corporate Health*, 215 F.3d at 538.

135. *UNUM*, 526 U.S. at 375.

136. *Pilot Life*, 481 U.S. at 52.

137. *Id.* at 56.

preempted because it conflicts with ERISA's exclusive remedial scheme.

As the Supreme Court previously noted, "[o]ne of the principal goals of ERISA is to enable employers 'to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits.'"¹³⁸ That goal is accomplished in large part through ERISA's exclusive remedies. Section 502(a) of ERISA provides an exclusive federal remedy for a plan beneficiary seeking "to recover benefits due to him under the terms of his plan" or "to enforce his rights under the terms of the plan."¹³⁹ The Court has upheld the exclusivity of this remedy, holding that:

Congress clearly expressed an intent that the civil enforcement provisions of ERISA § 502(a) be the exclusive vehicle for actions for ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits, and that varying state causes of action for claims within the scope of § 502(a) would pose an obstacle to the purposes and objectives of Congress.¹⁴⁰

Along with this exclusive vehicle, Congress intended that a body of federal common law would be developed to handle issues involving rights and obligations under ERISA plans.¹⁴¹ In the next section, this Note will discuss the Supreme Court's decision and analyze how it subverts Congress' goal of creating a uniform mechanism through which plan beneficiaries can enforce their rights.

IV. THE DECISION OF THE SUPREME COURT

The Supreme Court narrowly upheld the HMO Act in *Rush Prudential HMO, Inc. v. Moran*.¹⁴² The majority of the Court ruled that the statute fell within ERISA's saving clause. However, the majority departed from the reasoning espoused in its prior case law by holding that the HMO Act does not conflict with ERISA's exclusive remedies. The Court explained that the HMO Act does not conflict with ERISA because it "provides no new cause of action under state

138. *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001) (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987)).

139. 29 U.S.C. § 1132(a)(1)(B) (2000).

140. *Pilot Life*, 481 U.S. at 52.

141. 120 CONG. REC. 29942 (1974) (statement of Sen. Javits).

142. *Moran*, 536 U.S. at 355.

law and authorizes no new form of ultimate relief.”¹⁴³ The Court reasoned that the Act is not preempted because “the relief ultimately available [under it] would still be what ERISA authorizes in a suit for benefits under § 1132(a).”¹⁴⁴

Here the Court’s reasoning is flawed. Though the ultimate relief may be the same (i.e., the receipt of, or reimbursement for, medical services), the relief that was really at issue in this case is the mechanism whereby Moran can obtain that ultimate relief. That mechanism is the independent review procedure authorized by the HMO Act that the dissent characterizes as a “arbitration-like [procedure] to settle benefits disputes.”¹⁴⁵ Viewed in this manner, it is not the receipt of benefits, but the “arbitration [mechanism that] constitutes an alternative remedy to litigation.”¹⁴⁶

Section 4-10 of the HMO Act attempts to supplant ERISA’s exclusive remedies and should therefore have been preempted. Debra Moran sought ultimately to receive the benefits she believed were “medically necessary” and therefore due to her under the plan as it was written.¹⁴⁷ The HMO Act does not give Ms. Moran any additional benefits under the plan; it simply provides her with a different way to recover plan benefits. By allowing an appeal to an independent reviewing physician, the Act does not provide for additional care or medical services under the plan. Rather, it provides an additional mechanism to force Rush to provide the care that Moran believes is already covered under the plan. Based on Congressional intent and case law, the only permissible manner in which to enforce rights through an ERISA plan is through ERISA’s section 502(a)(1)(B).

Now that the Court has ruled otherwise, an ERISA plan participant’s remedy is subject to variation based upon his or her geography. Participants in the same ERISA-governed plan living in different states will be afforded different remedies with regard to the same plan, and will ultimately receive different levels of treatment for similar conditions. Debra Moran and others in Illinois will receive independent review of HMO decisions, and thus the surgery recommended by Dr. Terzis, while participants in the same ERISA plan from other states will not. Plan administrators are now unable to

143. *Id.* at 2167.

144. *Id.*

145. *Moran*, 536 U.S. at 355, 395. (Thomas, J. dissenting).

146. *Id.*

147. *Brief for Petitioner at 21*, *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) (No. 00-1021).

develop “a uniform set of administrative practices”¹⁴⁸ because they “face the prospect that numerous other States [will] impose their own distinct requirements – a result squarely inconsistent with the goal of ERISA preemption.”¹⁴⁹

Over forty states and the District of Columbia currently have laws providing for independent reviews of medical necessity decisions.¹⁵⁰ Now that the Supreme Court has ruled for Moran, ERISA plan administrators have to conform to the requirements of these differing state laws. Requiring this of plan administrators will only serve to ultimately increase the expense of operating a plan and may discourage employers from offering plans at all. As the Court in *Fort Halifax* stated, the resulting “patchwork scheme of regulation” will cause “considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them.”¹⁵¹ This unfortunate result runs counter to public policy.

Many can empathize with Ms. Moran’s position. Like anyone would, she sought to undergo the medical procedure and obtain the treatment that she believed would be most likely to relieve her symptoms. However, in permitting her to obtain that treatment,¹⁵² by using the remedy created in Section 4-10 of the Illinois HMO Act, the Supreme Court has made it likely that ultimately fewer Americans will be able to afford healthcare coverage.¹⁵³

VI. CONCLUSION

The Supreme Court has erroneously upheld Section 4-10 of the Illinois HMO Act which provides an additional remedial scheme for patients insured under ERISA plans. The Court ruled in Moran’s favor over a strong dissent.¹⁵⁴ The court’s analysis is premised on flawed logic and a skewed reading of legislative history.

As previously demonstrated in this Note, the Congressional Record reveals an intent by Congress to preempt the field through its enactment of the substantive and enforcement mechanisms provided

148. *Id.* at 17.

149. *Fort Halifax*, 482 U.S. at 17.

150. *See supra* note 12.

151. *Fort Halifax*, 482 U.S. at 11.

152. *See Moran*, 536 U.S. 355, 402. (Thomas, J., dissenting).

153. *Id.* at 388-402.

for in the ERISA statute¹⁵⁵. The Illinois statute at issue in *Rush Prudential* clearly provides an additional mechanism whereby insured patients can enforce their rights under insurance plans. In doing so, the Illinois statute clearly runs counter to Congressional intent.

While states have the right to exercise their traditional police powers, states cannot act in any situation where the federal government has preempted the field. ERISA was enacted to provide uniformity among insurance and benefit plans, thus reducing the costliness of the administration of such plans. Section 4-10 of Illinois' HMO Act runs counter to ERISA's purpose and creates the problems ERISA was designed to prevent. Now that employee benefit and welfare plan administrators are forced to conform to the laws of fifty different states, their costs will necessarily rise. These increased costs will eventually be passed on to plan employers and participants. Escalated costs may become so high that employers no longer offer healthcare plans.¹⁵⁶ This result is contrary to public interest.

Case law and Congressional intent point toward upholding a system that provides uniformity, ease of administration and lower costs for all involved. Until Congress finds a need either to enact an independent review provision in a federal patients bill of rights, or to provide for legislation allowing the states to supplement ERISA individually, the exclusive remedies ERISA affords should have been permitted to remain intact.¹⁵⁷

154 See 120 CONG. REC. 29197 and 120 CONG. REC. 29933

155 See *Fort Halifax*, 482 U.S. at 11.

156 See *Moran*, 536 U.S. 355, 402. (Thomas, J., dissenting)..

