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NOTES

"SAVING" EXTERNAL REVIEW FROM THE CLAWS OF ERISA PREEMPTION UNDER CORPORATE HEALTH V. TEXAS DEPARTMENT OF INSURANCE

Lisa M. Campbell+

Historically, employers who provided health benefits to their employees did so through insured health plans and fee-for-service arrangements.¹ States traditionally regulated the insurers and protected participants and beneficiaries of health insurance.² With the evolution of various managed care arrangements, states have attempted to regulate these new entities.³ However, the managed care organizations' (MCO) accountability to participants for health care decisions greatly depends on whether the employer's health benefit plan is covered under the Employee Retirement Income Security Act of 1974 (ERISA).⁴

¹ J.D. Candidate, May 2001, The Catholic University of America, Columbus School of Law.
² See Phyllis C. Borzi and Marc I. Machiz, ERISA and Managed Care Plans: Key Preemption and Fiduciary Issues, ALI-ABA Course of Study 1, 2 (2000).

+ See Phyllis C. Borzi and Marc I. Machiz, supra note 1, at 3.

⁴ See Parver & Martinez, supra note 1, at 225 (noting that ERISA covers group benefit plans that provide medical benefits to employees); infra note 44-50 and accompanying text (discussing ERISA preemption of employee benefit plans). Under ERISA, participants in a group

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Over the past few years, bills protecting health care consumers have dominated the agenda of both state and federal legislatures.\(^5\) Enacting measures to protect health care consumers invariably has been one of the most burdensome tasks.\(^6\) This process requires lawmakers to balance the interests of both high-quality and affordable health care for consumers against cost-containment for employers and managed care organizations.\(^7\) In addition, MCOs may not be subject to state health care regulations because they offer an employee benefit plan that falls under ERISA.\(^8\)

More recently, commentators have agreed with the aggrieved patients' claims against MCOs regarding health care decisions, and argue that "[a]s states continue to tackle issues relating to the quality of health care and its delivery mechanisms, the potential for ERISA to preempt state efforts to improve health access and outcomes is always a concern."\(^9\) Some state health care protection laws include a provision for independent external review of a MCO's treatment decisions, which the MCOs argue

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5. Tracy E. Miller, *Center Stage on the Patient Protection Agenda: Grievance and Appeal Rights*, 26 J.L. MED. & ETHICS 89, 89 (1998) (regarding the shift to managed care as a public concern that spurred legislation to offer patient protections).


7. Id. at 238 (blaming the present quandary on employer-based health insurance, which became an essential part of an employer's benefit package).

8. Id. at 240. Since 1974, ERISA has protected participants and beneficiaries in employee benefit plans by imposing disclosure and reporting requirements, establishing standards of conduct for fiduciaries of plans, and providing remedies. See 29 U.S.C. § 1001(b); see also Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 44-46 (1987) (examining ERISA's provisions to determine the preemptive effect Congress intended). Participants and beneficiaries who bring suit against MCOs argue that ERISA's preemption provision, which preempts state law claims that "relate to" an employee benefit plan, unfairly limits their rights and shields plans from state regulation. See Borzi & Machiz, *supra* note 1, at 2-3.

9. Borzi & Machiz, *supra* note 1, at 3 (discussing that as the states attempt to regulate managed care entities, employers, insurers, and providers have begun to challenge state action by raising the issue of ERISA preemption).
are preempted by ERISA.\textsuperscript{10}

Generally, independent external review functions as a grievance procedure that assesses a MCO's denial of medical care.\textsuperscript{11} Independent external review takes a significant step toward MCO accountability.\textsuperscript{12} This mechanism offers an independent appeals process for the review of a denial of health benefits and generally takes place after an internal review of the denial.\textsuperscript{13} Objectivity and neutrality are the essential characteristics of an independent external review.\textsuperscript{14}

Independent external review is a relatively new process in the administration of managed care.\textsuperscript{15} Given the lack of clarity on the subject of ERISA preemption of external review, the legal community has expressed concern about whether the states properly control independent review provisions under insurance and contract law.\textsuperscript{16} Unfortunately, the courts must grapple with

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\begin{itemize}
\item 10. Id; infra note 44-50 and accompanying text (examining ERISA preemption of benefit plans). MOLLY STAUFFER AND RACHEL BEVINS MORGAN, 2001 STATE BY STATE GUIDE TO MANAGED CARE LAW § 5-1 (Donald R. Levy ed., 2001) (noting that there are 38 states that have independent external review laws).
\item 11. See Ginsberg, supra note 6, at 237 (describing Maryland's Health Insurance-Complaint Process for Adverse Decisions and Grievances Act, which establishes a two-tiered grievance process: an internal review conducted by an HMO, followed by an external review process developed by the state); see also STAUFFER AND MORGAN, supra note 10, at § 5-1 (highlighting the features of various state independent review provisions).
\item 12. See Ginsberg, supra note 6, at 242 (describing external review as an opportunity for patients and doctors to challenge an insurer's decision to deny care).
\item 13. Id. (noting that a patient or physician may file an external appeal after the internal review process approves a denial of care). HMO grievance statutes generally require challenges of adverse determinations to be completed within designated time periods to facilitate the review before an injury to the patient occurs. See id. at 241-42.
\item 14. See Amber M. Fischer, Note, The Viability of Congressional Efforts To Create an Effective Appeals Process for Health Care Consumers, 38 BRANDEIS L.J. 89, 98 (1999) (stating that an external review provision may require that the internal review process be completed before initiating the external review).
\item 15. See Ginsberg, supra note 6, at 240. In 1978, Michigan became the first state to initiate an external review process to settle disputes between plan members and managed care entities. Id. Within the past few years, the number of states with independent external review has nearly doubled. Compare Borzi & Machiz, supra note 1, at 3 (noting that twenty states provide for external review of managed care plan decisions), with STAUFFER AND MORGAN, supra note 10, at § 5-1 (acknowledging that thirty-eight states provide for independent external review).
\item 16. Moran v. Rush Prudential HMO, Inc., 230 F.3d 959, 969-70 (7th Cir.
this ambiguous area of the law while some state insurance consumer protection schemes, such as external review, fail to survive ERISA preemption.  

The tension between state laws granting patients the right to have an independent review of a medical necessity decision and longstanding judicial interpretation of ERISA preemption as exclusively regulating plan administration decisions forms the crux of the issue. This tension collided recently in the case of Corporate Health Insurance v. Texas Department of Insurance. Corporate Health Insurance argued that ERISA's general preemption clause preempted the Texas Health Care Liability Act (THCLA). The district court determined that ERISA and the Federal Employees Health Benefit Act (FEHBA) preempted the provision of the THCLA that established an independent review process. On appeal, the Fifth Circuit affirmed the district court's determination.

2000) (holding that the independent review provisions of the Illinois HMO Act are, by law, incorporated into the plan as a part of the insurance contract).

17. See Corporate Health Ins., Inc. v. Tex. Dep't of Ins., 215 F.3d 526, 538-39 (5th Cir. 2000) (holding that the external review provisions of the Texas Health Care Liability Act (THCLA) create an alternative scheme through which plan participants may seek benefits and, therefore, conflicts with ERISA's exclusive remedy).

18. Ginsberg, supra note 6, at 240 (determining that "holding an HMO liable for harmful denials of care remains extremely difficult").

19. See Borzi & Machiz, supra note 1, at 3-4 (discussing that ERISA preemption challenges have been initiated against state external review laws).

20. See Corporate Health, 215 F.3d at 538-39 (analyzing Corporate Health's challenge to the THCLA's external review provisions).

21. See generally Corporate Health Ins., Inc. v. Tex. Dep't of Ins., 12 F. Supp. 2d 597, 602 (S.D. Tex. 1998) (holding that ERISA and the Federal Employees Health Benefit Act (FEHBA) preempted the THCLA); see also The Health Care Liability Act, TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-88.003 (Vernon Supp. 2001) (The THCLA's three main protections for health care consumers include: (1) The Act allows individuals to sue a MCO for failure to exercise ordinary care in making health care treatment decisions; (2) The Act protects physicians from indemnity clauses and from retaliation by HMOs for advocating medically necessary care for patients; and (3) The Act establishes procedures for an independent review process for adverse benefit determinations); ERISA, 29 U.S.C. § 1001(b) (West 1985 & Supp. 1998); Federal Employees Health Benefit Act, 5 U.S.C. § 8902(m)(1) (West 1987 & Supp. 1996); ERISA § 514(a), 29 U.S.C. § 1144(a) (1994) (stating that ERISA "shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan").

22. Corporate Health, 12 F. Supp. 2d at 625, 629 (holding that ERISA (and FEHBA) preempted the independent review provisions of the THCLA because they "improperly mandate the administration of employee benefits and therefore, connect[ion] with ERISA plans"). The district court also held that ERISA (and FEHBA) preempted the anti-retaliation and indemnification clauses.
court's decision, but analyzed the issue differently and held that
ERISA preempted an independent review scheme governing
coverage determinations.23

First, the appeals court determined that the independent
review provision "related to" ERISA plans.24 The court then
analyzed the independent review provision to determine if it
regulates the insurance business, and concluded that it affected
the insurance industry and, therefore, fell under ERISA's
exemption provision, which the court referred to as the "savings"
clause.25 Notwithstanding survival from ERISA preemption
under the "savings" clause, the court went on to determine
whether ERISA still preempted the independent review
provisions because they conflicted with a substantive provision
of ERISA.26 The court held that the independent review
provisions of the THCLA conflicted with ERISA's exclusive
remedy and, therefore, even if the provision fell under the
"savings" clause, ERISA would nevertheless preempt the
provision.27 The Fifth Circuit heard the State of Texas's petition
for panel rehearing.28 In July 2000, the court denied the motion

because they mandated certain benefit structures and, therefore, have a
"connection with" ERISA plans. Id. at 627-28. In contrast, the court
determined that ERISA (and FEHBA) did not preempt the provisions of the
THCLA that hold managed care entities liable for failing to exercise an ordinary
care standard for health care treatment decisions. Id. at 620.

23. Corporate Health, 215 F.3d at 539 (holding that ERISA (and FEHBA)
preempted the unlimited independent review provision because they created an
"alternative mechanism" through which a plan member can receive benefits
and, therefore, conflicted with ERISA's exclusive remedy). The Fifth Circuit
reversed the district court in part and held that ERISA did not preempt the
anti-retaliation and anti-indemnity provisions. Id. at 536.

24. Id. at 537 (stating that "an attempt to impose a state administrative
regime governing coverage determinations is squarely within the ambit of
ERISA's preemptive reach").

25. Id. at 537-38 (determining that the independent review provisions met
the common sense test of the insurance savings clause and satisfied two prongs
of the McCarran-Ferguson test; thus, the provisions were saved from
preemption).

26. Id. at 538 (stating that "our analysis does not end here, however,
because even if the provisions would otherwise be saved, they may nonetheless
be preempted if they conflict with a substantive provision of ERISA").

27. Id. (finding that the independent review provisions "establish a quasi-
administrative procedure for the review of such denial and bind the ERISA plan
to the decision of the independent review organization"). The Fifth Circuit
severed the independent review provisions that conflicted with ERISA and
FEHBA from the THCLA. Id. at 540.

28. Corporate Health Ins., Inc. v. Tex. Dep't of Ins., 220 F.3d 641, 644-45
for panel rehearing and petition for rehearing *en banc*.  

Although this ruling applies to the Fifth Circuit, the impact of the court's decision on the future of independent external review of insurance companies and managed care entities' coverage decisions remains uncertain. This decision raises important health care reform questions because many states have enacted similar external review provisions. This recurring issue has generated a split among the circuits. Congress also recognizes the significance of independent review. Recent congressional efforts to enact a Federal Patients' Bill of Rights, which includes external review provisions, exemplifies the importance of these processes for the protection of health care consumers. The preemption of the THCLA's independent review provision will most likely trigger new apprehensions about the future of the

(5th Cir. 2000) (upholding the original panel decision, which provided that the external review provisions of the THCLA bind the plan to pay for treatment that the independent review mandates and, therefore, creates an alternative mechanism for benefits). The Texas Department of Insurance argued that rehearing should be granted on the basis of the recent Supreme Court decision, *Pegram v. Herdrich*, 530 U.S. 211 (2000), in which the Court held that mixed eligibility and treatment decisions were not fiduciary acts under ERISA. Id. at 643.

29. *Id.* at 643, 645 (reasoning that *Pegram* is not interpreted as saving all state law claims that are based on a "mixed question of eligibility and treatment").

30. See Marc I. Machiz, *The Case for Seeking Supreme Court Review of Corporate Health*, 9 Health L. Rep. (BNA) 1186 (July 27, 2000) (stating that unless Congress passes legislation, the issue of ERISA preemption of external review is likely to recur, because current federal law provides no external review provisions).

31. *Id.*; see also Ginsberg, *supra* note 6, at 244-45 (acknowledging that in light of *Corporate Health*, amendments to ERISA may be necessary to legitimize state external review laws, specifically if external review binds the plan).

32. *See Corporate Health*, 215 F.3d at 538-39 (holding that the independent review provisions create a mechanism through which plan members may seek benefits due, and thus, conflicts with ERISA). But see Moran v. Rush Prudential HMO, 230 F.3d 959, 969-70 (7th Cir. 2000) (holding that independent review does not conflict with ERISA by creating an alternative remedy because it is incorporated into the insurance contract as an additional dispute resolution mechanism). In *Moran*, Judges Posner, Coffey, Easterbrook, and Wood noted that the majority opinion "creates a square conflict with another circuit, [which] is very probably unsound, and will affect an enormous number of cases." *Id.* at 973 (Posner, J., dissenting).

33. *See Fischer, supra* note 14, at 90 (noting that, in 1997, President Clinton supported the Patients' Bill of Rights, which included an external review system).
states' role in enforcing external review laws.\textsuperscript{34}

This Note examines the THCLA's independent review protection scheme in the context of ERISA preemption, and particularly the issues brought to light in the panel decision of \textit{Corporate Health Insurance v. Texas Department of Insurance}. First, this Note presents an overview of the THCLA's independent review provisions. In order to place independent review in its proper context within ERISA preemption, this Note discusses case law interpreting ERISA preemption, specifically the "savings" clause provision. Further, this Note briefly examines the most relevant cases leading up to \textit{Corporate Health}, which discuss the "savings" clause under ERISA. This Note will then analyze \textit{Corporate Health} and its likely impact on independent review provisions. Emphasizing the impact of \textit{Corporate Health}, this Note addresses the current split between the Fifth and Seventh Circuits regarding ERISA's preemption of independent review. Finally, this Note concludes that major flaws exist in the Fifth Circuit's preemption analysis of independent review provisions in \textit{Corporate Health}, including the court's primary reliance on dicta in \textit{Pilot Life Insurance Co. v. Dedeaux}, a Supreme Court opinion, and its failure to properly consider a recent Supreme Court case, \textit{Pegram v. Herdrich}.

\section*{I. The Tension Between State Independent Review Laws and ERISA Preemption}

\subsection*{A. The Texas Health Care Liability Acts’s Independent Review Provisions}

The statute challenged in \textit{Corporate Health} was the THCLA.\textsuperscript{35}

\begin{itemize}
\item [34.] See Machiz, supra note 30, at 1188 (noting that it is likely that the issue of ERISA preemption of external review provisions will recur because of its public significance).
\item [35.] The Health Care Liability Act, TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-88.003 (Vernon Supp. 2001). Two provisions other than the independent review provisions of the THCLA that the court discussed, but that are not essential to this analysis, are the liability provisions and the anti-retaliation and anti-indemnification provisions. \textit{Corporate Health}, 215 F.3d at 534-36. The liability provisions create a cause of action for damages against insurance carriers, HMOs, or other managed care entities for their own substandard treatment decisions or those of their agents. See §§ 88.002(a), (b). The anti-retaliation and anti-indemnification provisions prohibit insurance carriers, HMOs, or other managed care entities from terminating their business arrangements with providers if the providers advocate on behalf of patients,
\end{itemize}
The THCLA amended the Texas Health Maintenance Organization (HMO) Act\textsuperscript{36} to grant HMO members the right to a review by an independent review organization (IRO).\textsuperscript{37} An IRO reviews an HMO's decision to deny coverage for medical treatment based on its determination that the procedure is not medically necessary or appropriate.\textsuperscript{38}

The THCLA requires HMO complaint procedures to notify an enrollee of the right to appeal an adverse determination to an IRO and to advise the enrollee of the procedure for such an appeal.\textsuperscript{39} In addition, the THCLA provides that evidence of coverage under a health care plan must describe the HMO's methods of resolving complaints, “including the enrollee's right to appeal denials of an adverse determination . . . to an [IRO].”\textsuperscript{40}

The THCLA also states that the IRO provisions governing utilization review agents\textsuperscript{41} apply to an HMO.\textsuperscript{42} Under these provisions, the HMO must comply with the IRO's determination of medical necessity, thus, the IRO's determination binds the HMO regarding the determination that care is medically necessary or not appropriate.

An "adverse determination" is a "determination by [an HMO] . . . that the health care services furnished or proposed to be furnished to an enrollee are not medically necessary or are not appropriate." \textit{id. art.} 20A.12A(a)(1).

See also id. art. 20A.12A(b)(1) (defining terms relevant to this section).

Id. art. 20A.09(e)(4) (setting forth the text of the Act).
necessary.\textsuperscript{43}

\section*{B. ERISA Preemption: The Shield Limiting State Law Protections}

\subsection*{1. ERISA's "Relates to" Test}

ERISA, a comprehensive federal statute, regulates employee pension and welfare plans.\textsuperscript{44} ERISA's expansive regulation of employee welfare and pension benefit plans extends to group health plans that provide health care or benefits for plan participants or their beneficiaries through the purchase of insurance.\textsuperscript{45} To accomplish this goal, Congress retained broad federal regulatory authority by enacting the ERISA preemption provision.\textsuperscript{46} The Supreme Court described the ERISA preemption provision as having three distinct parts: the "preemption" clause, the "savings" clause, and the "deemer" clause.\textsuperscript{47}

The preemption clause in ERISA § 514(a) preempts any state law that "relates to" an employee benefit plan.\textsuperscript{48} Congress failed to define "relates to" in ERISA, and the Supreme Court historically applied ERISA § 514(a) broadly.\textsuperscript{49} The Court has

\begin{itemize}
\item \textsuperscript{43} \textit{Id.} art. 21.58A(6A)(3). This provision requires that a utilization review agent must "comply with the independent review organization's determination with respect to the medical necessity or appropriateness of health care items and services for an enrollee." \textit{Id.}
\item \textsuperscript{44} ERISA § 3(3), 29 U.S.C. § 1002(1) & (2)(A) (1994). An employee pension plan is "any plan, fund, or program . . . established or maintained by an employer or by an employee organization . . . [that] provides retirement income to employees, or results in a deferral of income by employees for periods extending to the termination of covered employment or beyond." \textit{Id.} § 1002(2)(A). An employee welfare benefit plan is defined as a plan, fund, or program established by an employer or employee organization, or both, to provide benefits such as medical, surgical, or hospital care, sickness or disability, accident or death benefits. \textit{Id.} § 1002(1).
\item \textsuperscript{45} \textit{Id.} § 1002(1).
\item \textsuperscript{46} ERISA, § 514(a), 29 U.S.C. § 1144(a) (1994).
\item \textsuperscript{47} See, \textit{e.g.}, Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 732-33 (1985).
\item \textsuperscript{48} 29 U.S.C. § 1144(a). ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." \textit{Id.} If a state regulation in any way "relates to" an ERISA plan, ERISA preemption is raised by providers or insurance entities to escape liability and remove the case to federal court where the remedies are more limited. See Borzi & Machiz, \textit{supra} note 1, at 3.
\item \textsuperscript{49} See, \textit{e.g.}, Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 139-40 (1990) (concluding that ERISA preempts the wrongful discharge claim because it
interpreted "relates to" by giving it a "common sense meaning," finding that a state law relates to an employee benefits plan "if it has a connection with or reference to such a plan."

Over time, the Court has explored the expansive character of ERISA preemption and limited its broad sweep. In New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., the Supreme Court recognized that prior attempts to construe the phrase "relates to" does not give the Court "much help [in] drawing the line" to ascertain whether ERISA preempts a state law. In Travelers, a New York statute required hospitals to collect surcharges from patients covered by a commercial insurer and certain HMOs, but not from patients insured under Blue Cross/Blue Shield plans. The Supreme

relates to pension benefits, as well as to the pension plan itself); FMC Corp. v. Holliday, 498 U.S. 52, 58 (1990) (holding that ERISA preempts a Pennsylvania antisubrogation law because it "relates to" employee benefit plans); Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 829 (1988) (holding that ERISA preempted the Georgia garnishment statute because the law expressly referred to ERISA plans); Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97 (1983) (holding that state laws making unlawful plan provisions that discriminate and requiring plans to provide specific benefits "relate to" employee benefit plans).

50. Shaw, 463 U.S. at 95-97 (holding that Congress intended for ERISA’s broad preemption provision to preempt any state law that "relate[d] to" an employee benefit plan, not merely those state laws that directly conflicted with a substantive provision in the federal statute). In Shaw, the Court noted the broad scope of the preemption clause and held that the New York Human Rights Law and that State’s Disability Benefits Law related to welfare plans governed by ERISA. Id. at 97. The phrase "relates to" was given its broad common sense meaning so that a state law "relate[s] to" a benefit plan "in the normal sense of the phrase, if it connects with or refers to such a plan." Id. The preemption provision was intended to displace all state laws that fall within its jurisdiction, even including state laws that are consistent with ERISA’s substantive requirements. Id. at 98-99. For more case law interpretations see generally supra note 49 and accompanying text.


53. Id. at 655 (reasoning that "if 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for 'really, universally, relations stop nowhere') (quoting H. James, Roderick Hudson xli (New York ed., World’s Classics (1980)).

54. Id. at 649. Several commercial insurers brought this action to invalidate the surcharge statutes. Id. at 651-52.
Court held that the surcharges did not "relate to" employee benefit plans because Congress did not intend to insulate laws with an "indirect economic effect on the relative costs of various health insurance packages" and, therefore, ERISA did not preempt them.\(^55\)

The Court limited the preemption landscape and clarified that in determining whether ERISA preempts a state law, a court should begin by presuming that Congress did not want to preempt a state's historic police powers in areas such as medical care, unless a "clear and manifest" intent to the contrary exists.\(^56\) Any other conclusion would bar all state regulations of hospital costs, and preempt all laws with indirect economic effects on ERISA plans.\(^57\) Later cases adopted Travelers's

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55. Id. at 662. The Court carefully emphasized its holding did not suggest that ERISA preempted only direct regulation. See id. at 666.

56. Id. at 654-55, 661 (citing Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230 (1947)). The trend established by Travelers, which moved away from a presumption in favor of ERISA preemption continued in De Buono v. NYSA-ILA Medical & Clinical Services Fund. See De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806 (1997). The Court, once again, limited the scope of ERISA's preemption powers. See id. at 809. In De Buono, the Court considered "whether the opaque language in ERISA's § 514(a) preclude[d] New York from imposing a gross receipts tax on the income of medical centers operated by ERISA funds." Id. (footnote omitted). The Court noted that prior to Travelers, it had been unnecessary to explore the expansive character of ERISA's preemption language because the state laws at issue in prior cases had a clear connection to ERISA plans. Id. at 813. The majority in De Buono concluded that the New York law in question was one of the "myriad state laws of general applicability that impose[d] some burdens on the administration of ERISA plans, but nevertheless do not 'relate to' them within the meaning of the governing statute." Id. at 815.

In California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., the Supreme Court reinforced some of the crucial points of its decision in Travelers. See California Div. of Labor Standards Enforcement v. Dillingham Constr., 519 U.S. 316 (1997). In Dillingham, the Court employed the same analytic approach it used in Travelers, and held that California's prevailing wage law neither refers to nor has a "connection with" ERISA plans, does not "relate to" ERISA plans and, thus, is not preempted by ERISA. See id. at 334. Similar to New York's hospital surcharge regulation in Travelers, California's apprenticeship standards and the wages paid on state public works have long been regulated by the states. Id. at 330. The Dillingham Court reasoned that "pre-emption of traditionally state-regulated substantive law in those areas where ERISA has nothing to say would be 'unsettling.'" Id.

57. See Travelers, 514 U.S. at 664-65 (acknowledging that the finding of ERISA preemption for the hospital surcharges would be "unsettling" because several states, at the time of the enactment of ERISA regulated hospital charges).
presumption against ERISA preemption.  

2. ERISA "Savings" Clause: Exception to ERISA Preemption

ERISA's insurance "savings" clause substantially qualifies preemption. The "savings" clause functions so that ERISA does not preempt a state law if it regulates the insurance, banking, or securities industries. To assist in further defining the insurance exception, the Court looked to Congress's indication in the McCarran-Ferguson Act that federal laws do not preempt state laws that "regulat[e] the business of insurance." The McCarran-Ferguson Act does not contain language suggesting any limitation on the definition of the "business of insurance." In Metropolitan Life Insurance Co. v. Massachusetts, the Supreme Court interpreted the scope of the McCarran-Ferguson Act and identified three criteria relevant to determining whether a particular practice falls within ERISA's "business of insurance."

Metropolitan Life involved a Massachusetts statute that required insurers to provide a specified package of mental health benefits to any Massachusetts resident who was insured under a general insurance policy, an accident or sickness insurance policy, or an employee health-benefit plan. The Court rejected the insurer's argument that Congress only intended to save

58. See supra note 56 and accompanying text.
60. 29 U.S.C. § 1144(b)(2)(A). Nothing in ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities." Id.; see also Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 758 (1985) (holding that a Massachusetts statute mandating mental health benefits coverage "related to" ERISA plans, but was nevertheless saved from preemption by operation of the savings clause).
65. See id. at 743 (citing Union Labor Life Ins. Co. v. Pireno, 458 U.S. id. 119, 129 (1982)) (holding that application of the McCarran-Ferguson Act criteria suggests that mandated benefit laws amount to state regulation of the "business of insurance" and, therefore, saved it from preemption); see also Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979).
traditional insurance laws, not health laws that are implemented through insurance contracts.\textsuperscript{67} Instead, the Court referred to cases interpreting the scope of the McCarran-Ferguson Act to determine the meaning of the "business of insurance."\textsuperscript{68} The criteria the Court developed include: "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry."\textsuperscript{69}

More recently, the Court returned to the question of whether a challenged state law regulated the "business of insurance" and focused on the issue of whether a state law must satisfy all three McCarran-Ferguson factors, as well as meet the common sense test, in order to be saved from preemption.\textsuperscript{70} In \textit{UNUM Life Insurance Co. of America v. Ward},\textsuperscript{71} the Court "reject[ed] [the] assertion that a state regulation must satisfy all three McCarran-Ferguson factors in order to 'regulate insurance' under ERISA's saving clause."\textsuperscript{72} \textit{UNUM Life Insurance} involved an action to recover disability benefits.\textsuperscript{73} The plaintiff received no information about obtaining coverage under the disability plan, even though he notified the human resources department about his disability in a timely fashion.\textsuperscript{74} The plaintiff later found a booklet describing his right to receive disability benefits and applied for coverage under the disability policy.\textsuperscript{75} The

\textsuperscript{67} \textit{Id.} at 741.

\textsuperscript{68} \textit{See generally} supra note 65 and accompanying text.

\textsuperscript{69} \textit{Metropolitan Life}, 471 U.S. at 743 (quoting Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129 (1982)).

\textsuperscript{70} UNUM Life Ins. Co. of Am. v. Ward, 526 U.S. 358, 373-74 (1999) (holding that a state regulation is not required to satisfy all three McCarran-Ferguson factors in order to regulate insurance).

\textsuperscript{71} 526 U.S. 358 (1999).

\textsuperscript{72} \textit{Id.} at 373. The Court "has[ ]indicated that the McCarran-Ferguson factors are 'considerations [to be] weighed' in determining whether a state law regulates insurance." \textit{Id.; see also} Cisneros v. \textit{UNUM Life Ins. Co.}, 134 F.3d, 939, 946 (9th Cir. 1998) (looking to the McCarran-Ferguson factors as "guideposts, not separate essential elements . . . that must each be satisfied" to save the state's law).

\textsuperscript{73} \textit{UNUM}, 526 U.S. at 363. The disability benefit in dispute was a long-term group disability policy issued by UNUM to Management Analysis Company (MAC), the company that employed the plaintiff. \textit{Id.} at 364.

\textsuperscript{74} \textit{Id.} at 365.

\textsuperscript{75} \textit{Id.}
insurance company denied the plaintiff coverage because he failed to comply with the plan's notice requirement in a timely manner.\(^{76}\)

The plaintiff sued for benefits under ERISA § 502.\(^{77}\) The Court ruled that California's notice-prejudice rule, which precludes any insurer from denying a claim for benefits on the grounds of timeliness unless the insurer proves that it has been prejudiced by the untimely filing, did not conflict with ERISA § 502(a) even though the effect of the rule was to bind the plan to pay benefits.\(^{78}\) In addition, the insurance company argued that the notice prejudice rule conflicted with ERISA § 503.\(^{79}\) The Court held that this rule did not conflict with ERISA § 503 because it allowed a greater time period to file than the federal law and, therefore, complements ERISA.\(^{80}\)

3. The "deemer" clause

The "deemer" clause limits the "savings" clause and prevents states from circumventing the general prohibition on state

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\(^{76}\) Id.

\(^{77}\) Id. The relevant ERISA provision states that a civil action may be brought by a participant or beneficiary to recover benefits due to him under the terms of his plan. See ERISA § 502(a), 29 U.S.C. 1132(a) (1994).

\(^{78}\) UNUM, 526 U.S. at 377. California's notice-prejudice rule states that "[a] defense based on an insured's failure to give timely notice [of a claim] requires the insurer to prove that it suffered substantial prejudice." Id. at 366. In UNUM, the Court refers to amicus curiae by the Solicitor General of the United States in which the Solicitor General qualified the argument advanced in Pilot Life that ERISA § 502 is exclusive. Id. at 377. The Solicitor General asserted that the discussion of ERISA § 502(a) in Pilot Life "does not in itself require that a state law that 'regulates insurance,' and so comes within the terms of the savings clause, is nevertheless preempted if it provides a state-law cause of action or remedy." Id. at 377 n.7 (quoting Brief of Amicus Curiae Solicitor General of the United States at 25, UNUM Life Ins. Co. of Am. v. Ward, 526 U.S. 358 (1999) (No. 97-1868)). The Solicitor General went on to note that "the insurance savings clause, on its face, saves state law conferring causes of action or affecting remedies that regulate insurance, just as it does state mandated-benefit laws." Id. The Court in UNUM contended that they need not address the Solicitor General's argument because the plaintiff in this case sued under ERISA § 502(a)(1)(B) for benefits due, "and seeks only the application of saved state insurance law as a relevant rule of decision in his § 502(a) action." Id.

\(^{79}\) Id. at 377; see also ERISA § 503, 29 U.S.C. § 1133 (1994) (requiring welfare benefit plans to provide notice and opportunity for review of denied claims).

\(^{80}\) See UNUM, 526 U.S. at 377.
regulation of employee benefit plans. The "deemer" clause prevents states from regulating employee benefit plans under the guise of regulating insurance.

4. ERISA's Limited Remedial Scheme

ERISA also establishes a civil enforcement scheme. ERISA's civil enforcement scheme is the remedial scheme ERISA-plan participants and beneficiaries utilize to bring a cause of action for improper denial of a claim for benefits. Under the civil enforcement provisions of ERISA's § 502(a), a plan participant or beneficiary may sue to recover benefits due under the plan, enforce the participant's rights under the plan, or clarify rights to future benefits.

The Supreme Court took a two-step approach to ERISA preemption analysis in Pilot Life Insurance Co. v. Dedeaux, a disability case involving § 502 and § 514 of ERISA that struck down a Mississippi bad faith law providing remedies and other protections for consumers. The plaintiff in Pilot Life brought three state common law tort and contract actions against Pilot Life Insurance Company asserting bad faith processing of his

81. See ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (1994). The deemer clause provides that "an employee benefit plan . . . shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies." Id.

82. See id.


84. Id.; see also Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 52-53 (1987) (determining that ERISA's civil enforcement scheme is "sandwiched between two other ERISA provisions relevant to enforcement of ERISA and to the processing of a claim for benefits under an employee benefit plan"). ERISA § 501 authorizes criminal penalties for violations of the reporting and disclosure provisions of ERISA. ERISA § 501, 29 U.S.C. § 1131 (1994). ERISA § 503 requires every employee benefit plan to comply with Department of Labor regulations by notifying any participant or beneficiary who is denied benefit claims as well as affording a reasonable opportunity for review of the decision denying the claim. ERISA § 503, 29 U.S.C. § 1133 (1994).

85. ERISA § 502(a)(1)(b), 29 U.S.C. § 1132; see also Pilot Life, 481 U.S. at 53 (determining that relief under ERISA § 502(a) "may take the form of accrued benefits due, a declaratory judgment on entitlement to benefits, or an injunction against a plan administrator's improper refusal to pay benefits").


87. See id. at 48, 57 (determining that ERISA preempted the Mississippi Bad Faith law because it related to an ERISA plan and was not saved by the insurance savings clause).
benefit claims and seeking general and punitive damages. The Court determined that the common law causes of action, based on alleged improper processing of a claim for benefits under an employee benefit plan, undoubtedly satisfied the criteria for the "relates to" test under the first prong of preemption in ERISA § 514(a). The Court then considered whether the Mississippi law regarding bad faith "regulates insurance" and was thus saved from preemption by ERISA § 514(b)(2)(A). The Court first considered the common sense understanding of the "savings" clause, and found that it was unable to determine whether these laws would affect only the insurance industry. The Court then looked to the McCarran-Ferguson Act factors defining the "business of insurance," and concluded that the state law met none of the McCarran-Ferguson criteria. The Court determined, therefore, that the state cause of action asserting improper processing of a claim for benefits under an ERISA-regulated plan was not saved as a law regulating the "business of insurance" by ERISA § 514(b)(2)(A), and, therefore, was preempted by ERISA § 514(a).

Although this finding sufficiently resolved the matter, the Court went on to discuss whether ERISA § 502(a) was an exclusive remedy provision. The Court reasoned that Congress

88. Id. at 43. In the original complaint, the plaintiff asserted three causes of action: tortious breach of contract; breach of fiduciary duties; and fraud in the inducement. Id. The plaintiff sought damages for failure to provide benefits under the policy, general damages for mental and emotional distress and other incidental damages, and punitive and exemplary damages. Id. at 43.

89. Id. at 48.

90. Id.; see also id. at 48 & n.1 (explaining that the savings clause covers "any law of any State:" and "[t]he term ‘State law’ includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State") (quoting 29 U.S.C. §§ 1144(c)(1)-(2) (1994)).

91. Id. at 50 (describing the common sense view of the word "regulates" as "a law that must not just have an impact on the insurance industry, but must be specifically directed toward that industry").

92. Id. (finding that the roots of the Mississippi law of bad faith are "firmly planted in the general principles of Mississippi tort and contract law").

93. Id. at 50-51; see supra note 65 and accompanying text.

94. See Pilot Life Ins. Co., 481 U.S. at 50-51 (determining that the Mississippi common law of bad faith "does not effect a spreading of policyholder risk"; "does not define the terms of the relationship between the insurer and the insured"; and "has developed from general principles of tort and contract law").

95. Id. at 57 (concluding that ERISA preempted the Mississippi common law of bad faith because it failed the savings clause test).

96. Id. at 52. "The conclusion that § 502(a) was intended to be exclusive is
did not intend to provide remedies to ERISA beneficiaries in addition to those specified in ERISA § 502(a). The Court relied on the "clear expression of congressional intent that ERISA’s civil enforcement scheme be exclusive."

5. "Mixed Eligibility Decisions"

The most recent Supreme Court decision interpreting ERISA, though not a preemption case, is Pegram v. Herdrich. Dr. Pegram examined plaintiff Herdrich and discovered a large, supported, first, by the language and structure of the civil enforcement provisions, and, second, by legislative history . . . ." Id.; see also Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134, 146 (1985) (observing that "[t]he six carefully integrated civil enforcement provisions found in § 502(a) of ERISA . . . provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly"); ERISA § 502(a), 29 U.S.C. § 1132(a) (1994 & Supp. 1999). Section 1132(a) provides that:

A civil action may be brought
(1) by a participant or beneficiary (A) for the relief provided for in subsection (c) of this section [concerning requests to the administrator for information], 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 subsection, 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; (6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), or (6) of subsection (i) or (l) of this section.

Id.; see also Pilot Life Ins. Co., 481 U.S. at 54 (extending this finding by determining that "[t]he 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").


inflamed mass in her abdomen. Dr. Pegram ordered diagnostic testing eight days later at the HMO's affiliated hospital several miles away, rather than the same day at a local hospital. Before her appointment at the HMO hospital, Herdrich's appendix ruptured and caused a severe abdominal infection. Herdrich claimed that under ERISA's fiduciary provisions, the HMO's physician financial incentives scheme violated ERISA's fiduciary requirements. Herdrich argued that these incentives encouraged doctors to make medical decisions that financially benefited the doctors at the expense of their patients.

The Court unanimously held that mixed treatment and eligibility decisions by an HMO, acting through its physicians, are not fiduciary acts under ERISA, and, therefore, ERISA does not preempt these decisions. The Pegram decision exemplifies the Court's continued redevelopment of the boundaries of ERISA preemption.

II. CORPORATE HEALTH: TEARING DOWN A STATE CONSUMER PROTECTION SCHEME

Corporate Health Insurance sued the Texas Department of Insurance (the Department) in Corporate Health v. Texas Department of Insurance. Corporate Health Insurance sought

100. Id. at 215.
101. Id.
102. Id.
103. Id. at 216.
104. Id. at 213.
105. Id. at 237.
106. George Parker Young, Analysis & Perspective: ERISA Federal Preemption of HMO Lawsuits: New Case Law, 9 Health L. Rep. (BNA) 1267 (Aug. 10, 2000). The "redevelopment of ERISA preemption analysis [began] with Justice Souter's earlier unanimous opinion in Travelers, followed by the Court's DeBuono and Dillingham decisions (the Trilogy)." Id.; see also supra note 56 and accompanying text.
107. 12 F. Supp. 2d 597, 602 (S.D. Tex. 1998). The plaintiffs included Corporate Health Insurance, Inc., Aetna Health Plans of Texas, Inc., Aetna Health Plans of North Texas, Inc., and Aetna Life Insurance Company (hereinafter "Corporate Health"). See id. The defendants included the Texas Department of Insurance, Elton Bomer, Commissioner of the Texas Department of Insurance, and Dan Morales, Attorney General of the State of Texas, in their official capacities. See id. In response to Corporate Health's challenge to the THCLA, the Department filed a motion to dismiss for failure to state a claim and to dismiss suit against the Department and the Commissioner as improper
a declaration that ERISA and FEHBA preempted the THCLA, and an injunction against enforcement of the Act. The Department argued that the THCLA "regulates the quality of care provided by HMO[s] operating in Texas," in contrast to regulating how HMOs make coverage determinations or structure benefit plans that are governed by ERISA.

Corporate Health argued that ERISA preempted the THCLA because it "relates to" an employee benefit plan, defined as having a connection with an ERISA plan. The plaintiffs claimed that the THCLA has a "connection with" ERISA plans by imposing liability on ERISA plans, mandating and administering the structure of plan benefits, binding administrators to independent review decisions, and creating an alternative remedy.

The district court concluded that independent review of adverse benefit determinations amounted to an improper administration of benefits and that ERISA preempted the IRO provisions. A three-judge panel of the Fifth Circuit reviewed...
the decision and affirmed in part and reversed in part.\footnote{113}

A. Fifth Circuit Holds That ERISA Preempts the IRO Provisions

The Fifth Circuit panel addressed the issue of whether ERISA preempted the THCLA's provisions for independent review.\footnote{114} The court analyzed the IRO provisions as two distinct parts: limited independent review and unlimited independent review.\footnote{115} The limited independent review provisions require an independent review in order for a patient to sue an entity.\footnote{116} The

ERISA preemption so long as the suit challenges the quality of care received, and is not made in the context of a benefit determination. \textit{Id.} at 620.

\footnote{113. Corporate Health Ins., Inc. v. Tex. Dep't of Ins., 215 F.3d 526, 540 (5th Cir. 2000). On appeal, the Department argued that Corporate Health lacked standing to challenge the THCLA's liability provisions because it had not suffered the requisite injury. \textit{Id.} at 532. The Department conceded that Corporate Health had standing to challenge the other provisions. \textit{Id.} Corporate Health contended that it had standing because the THCLA's liability provision exposes it to suits by private parties and the Attorney General. \textit{Id.} The Texas Court of Appeals affirmed the district court's decision, upholding the liability provisions of the THCLA, and recognized that the liability provision only allowed claims that challenge the quality of health care, not a coverage dispute, and, thus, are not preempted by ERISA. \textit{Id.} at 535. The court agreed with the Department's argument that the THCLA excluded a duty to provide treatment for benefits not covered by the plan. \textit{Id.} at 534. The court stated that the liability provisions do not relate to ERISA plans because they are indifferent to whether the plan operates under ERISA and their operation does not rely on the existence of an ERISA plan. \textit{Id.} Congress did not intend for ERISA to supplant state law regulating the quality of medical care. \textit{Id.} at 535.

The second question the court addressed asked whether ERISA preempted the anti-retaliation and anti-indemnification provisions of the THCLA. \textit{Id.} at 535-36. Corporate Health argued that these provisions dictated the administration and structure of ERISA plans because they would limit their ability to contract with doctors. \textit{Id.} at 536. The court disagreed and held that these provisions regulate the terms on which the health care provider contracts with its agents, in contrast to mandating entities to provide substantive levels of coverage. \textit{Id.} Moreover, the court determined that this quality of care regulation has traditionally been left to the states. \textit{Id.} Thus, the court reversed the district court's decision and held that ERISA did not preempt the anti-retaliation or the anti-indemnification provisions. \textit{Id.} at 540.

\footnote{114. \textit{Id.} at 536.}

\footnote{115. \textit{Id.} at 536-37; see also \textsc{Tex. Civ. Prac. \\ & Rem. Code Ann. § 88.003 (Vernon Supp. 2001)} (describing limited independent review); \textsc{Tex. Ins. Code arts. 20A.09(e), 20A.12A (Vernon Supp. 2001)} (listing amendments to the HMO Act); \textsc{Tex. Ins. Code arts. 21.58A, §§ 6(b), 6A (Vernon Supp. 2001)} (including amendments to the Utilization Review Agent Act) (describing unlimited independent review).

\footnote{116. \textit{Corporate Health}, 215 F.3d at 536; see also \textsc{Tex. Civ. Prac. \\ & Rem. Code Ann. § 88.003 (requiring "affected" insureds to exhaust all applicable...}
limited independent review also restricts itself to claims for which patients may sue under the liability provisions.\textsuperscript{117} The court held that ERISA did not preempt the limited independent review provisions because any duty for independent review imposed on the managed care entities is limited to the extent of the liability provisions.\textsuperscript{118}

The second classification of independent review is the unlimited independent review provisions.\textsuperscript{119} Such provisions add procedures to allow consumers to appeal adverse coverage determinations and to bind the independent review organization’s determination of medical necessity on the managed care entity.\textsuperscript{120} The court interpreted this provision to allow a patient who was denied coverage to appeal to an external organization, thereby imposing a state administrative scheme that governs coverage determinations.\textsuperscript{121} Foregoing detailed analysis explaining how the independent review provision “relates to” an ERISA plan, the court concluded that this determination places the independent review provision “squarely within the ambit of ERISA’s preemptive reach.”\textsuperscript{122} This approach was reminiscent of the Supreme Court’s broad reading of the “relates to” analysis that would preempt virtually any state law.\textsuperscript{123}

\textsuperscript{117} Corporate Health, 215 F.3d at 536. The limited independent review provision describes the patient’s complaint as “the claim,” which allows independent review only of claims for which patients may bring suit under the liability provisions. \textit{Id.; see also} \textsc{Tx. Civ. Prac. \\& Rem. Code Ann. \S 88.003.}

\textsuperscript{118} Corporate Health, 215 F.3d at 536-37. In addition, the 1999 amendments to this provision make the review “voluntary on the entity’s part.” \textit{Id.} at 537. The entity, therefore, could not argue that the provision conflicts with its duties under ERISA. \textit{Id.; see also} \textsc{Tx. Civ. Prac. \\& Rem. Code Ann. \S\S 88.003(a), (c).}

\textsuperscript{119} Corporate Health, 215 F.3d at 537; \textsc{Tx. Ins. Code arts. 20A.09(e), 20A.12A (including amendments to the HMO Act); Tx. Ins. Code arts. 21.58A, \S\S 6(b), 6A (including amendments to the Utilization Review Agent Act).}

\textsuperscript{120} Corporate Health, 215 F.3d at 537. \textit{See} \textsc{Tx. Ins. Code art. 20A.12A(a)(1) (Vernon Supp. 2001) (defining adverse determination); Tx. Ins. Code art. 21.58A \S 6A(3) (requiring the utilization review agent to comply with the independent review organization’s determination).}

\textsuperscript{121} Corporate Health, 215 F.3d at 537.

\textsuperscript{122} \textit{Id.}

\textsuperscript{123} \textit{See} Young, \textit{supra} note 106, at 1277 [suggesting that “without very much analysis at all, [Judge Higginbotham] simply concludes that the IRO regime ‘is squarely within the ambit of ERISA’s preemptive reach’”).}
The court continued the preemption analysis to determine if
the independent review provisions fell under ERISA's "savings"
clause as laws regulating the "business of insurance." The
court applied the common sense test and considered the three
McCarran-Ferguson factors as guideposts. The court
determined that the independent review provisions met the
"savings" clause's common sense test because they aimed at
insuring entities and regulating the insured-insurer
relationship. In addition, the provisions satisfied two of the
three McCarran-Ferguson factors, which was sufficient to fall
under the "savings" clause.

The court took the analysis one step further, suggesting that
even if the independent review provisions would be saved, they
may still be preempted if they conflict with a substantive
 provision of ERISA. The court relied on the Supreme Court's
Pilot Life decision, in which the Court interpreted Congress's
intent regarding the exclusivity of ERISA's enforcement scheme
to preempt not only remedial schemes that directly conflict with
ERISA, but supplemental state law remedies as well. Accordingly, the Corporate Health court held that ERISA
preempted the unlimited independent review provisions because
they created an "alternative mechanism through which plan
members may seek benefits due them under the terms of the
plan," and Congress intended ERISA § 502(a) to be the exclusive

124. Corporate Health, 215 F.3d at 537.
125. Id.; see also UNUM Life Ins. Co. of Am. v. Ward, 526 U.S. 358, 374
(1999) (considering whether the rule regulates insurance as a common sense
matter, and looking to the three McCarran-Ferguson factors as guideposts);
Metropolitan Life Ins. v. Massachusetts, 471 U.S. 724, 744 n.21 (1985)
(interpreting the savings clause as Congress's intentional reservation of state
insurance regulation under the McCarran-Ferguson Act).
126. Corporate Health, 215 F.3d at 538. The common sense test measures
whether the law is specifically directed toward the insurance industry and
considers whether it plays an integral part in the policy relationship between
the insured and the insurer. UNUM Life, 526 U.S. at 368.
127. Corporate Health, 215 F.3d at 538 (noting that these factors are integral
to the policy relationship between the insurer and insured and they regulate the
insurance industry).
128. Corporate Health, 215 F.3d at 538.
130. Corporate Health, 215 F.3d at 538-39 (relying on the Pilot Life Court,
which interpreted Congress's intent regarding the exclusivity of ERISA's
enforcement scheme very broadly). ERISA's enforcement provisions are set out
at 29 U.S.C. §1132; see also supra note 96 and accompanying text.
remedy.  

B. Petition for Rehearing Denied: A Primer for Supreme Court Review

Following the Fifth Circuit's decision, the Department petitioned for a rehearing and a rehearing en banc, but a quorum of the Fifth Circuit denied the request. The Department argued that the Fifth Circuit misunderstood the IRO provisions and failed to consider the Supreme Court's recent decision in Pegram. As Judge Higginbotham noted, while the Department's argument is "not without some persuasive force, it does not comport with our view of the record." The court held that because the IRO process binds HMOs to provide benefits that the IRO mandates, the IRO's decision supersedes the medical judgment of the HMO's physician or the treating physician as to the determination of medical necessity.

III. LIMITING HMO ACCOUNTABILITY: THE POTENTIAL IMPACT OF CORPORATE HEALTH

A. Conflicting Decisions Create Uncertainty Over External Review

The Fifth Circuit's decision in Corporate Health is of extreme importance. This decision could compel courts to subject

131. Corporate Health, 215 F.3d at 538-39 (determining that the independent review provisions "establish a quasi-administrative procedure for the review of such denial and bind the ERISA plan to the decision of the independent review organization"). The court addresses the FEHBA preemption as it did the ERISA preemption, holding that the provisions of the THCLA that do not "relate to" ERISA plans, likewise would not "relate to" any FEHBA plans. Id. at 539. Consequently, the FEHBA plans would preempt the independent review provisions that would be preempted under ERISA. Id. Finally, the court determined that the IRO provisions are so independent that they are severable from the remainder of the THCLA. Id. at 540.

132. Corporate Health Ins. Co. v. Tex. Dep't of Ins., 220 F.3d 641, 645 (5th Cir. 2000) (affirming the original panel decision that the IRO provisions conflicted with ERISA's exclusive remedy and cannot be saved by the savings clause).

133. Id. at 643.

134. Id. at 644.

135. Id.

136. Young, supra note 106, at 1279 (characterizing this issue as important because several states have independent review statutes, and Corporate Health directly conflicts with the Supreme Court's decision in Pegram).
other states’ external review provisions to close scrutiny.\textsuperscript{137} Following the Fifth Circuit’s decision, the Seventh Circuit, in \textit{Moran v. Rush Prudential},\textsuperscript{138} held that ERISA did not preempt an Illinois independent review statute.\textsuperscript{139} The Seventh Circuit’s \textit{Moran} decision directly contravenes the Fifth Circuit’s decision in \textit{Corporate Health}.\textsuperscript{140} The Seventh Circuit held that the independent review mechanism in the Illinois HMO Act was part of the insurance contract and, therefore, not preempted under ERISA.\textsuperscript{141} In addition, the Sixth and Eighth Circuits are in conflict with the Fifth Circuit because they have held that state insurance laws become part of an ERISA plan, but may only be enforced with an ERISA suit.\textsuperscript{142} Congress could act to alleviate this conflict by enacting a Patients’ Bill of Rights to protect health care consumers through external review provisions, as well as amending ERISA to provide a cause of action for state law remedies.\textsuperscript{143}

The Fifth Circuit’s \textit{Corporate Health} decision could damage existing external review laws.\textsuperscript{144} This decision affects the states’ rights to enforce their insurance laws and to protect the health

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137. \textit{Id.} As of October 26, 2000, thirty-eight states plus the District of Columbia have some form of independent external review process, binding or non-binding. Petition for Writ of Certiorari to the Supreme Court of the United States at 27, \textit{Montemayor v. Corporate Health Ins., Inc.}, (2001) (No. 00-665) (on file with \textit{Catholic University Law Review}).

138. 230 F.3d 959 (7th Cir. 2000).

139. \textit{Id.} at 969 (holding that ERISA’s savings clause applied to Illinois’s independent review provisions and saved the law from ERISA preemption).

140. \textit{Id.} at 973 (Posner, J., dissenting) (acknowledging that the Seventh Circuit’s decision “creates a square conflict with another circuit, [which] is very probably unsound, and will affect an enormous number of cases”); see also Petition for Writ of Certiorari to the Supreme Court of the United States at 14, \textit{Montemayor} (No. 00-665) (arguing that the Seventh Circuit’s decision in \textit{Moran} directly conflicts with the Fifth Circuit’s decision in \textit{Corporate Health}); Chad Bowman, \textit{Illinois HMO External Review Law Upheld by Federal Court Against ERISA Challenge}, 00 Pension & Benefits Daily (BNA) No. 205, at 1 (Oct. 23, 2000) (on file with \textit{Catholic University Law Review}) (noting the direct conflict between the Fifth and Seventh Circuits).

141. \textit{Moran}, 230 F.3d at 969-70.

142. Donatelli v. Home Ins. Co., 992 F.2d 763, 765 (8th Cir. 1993) (holding that a saved insurance law will govern the interpretation of the insurance contract, but does not affect preemption of the state law remedies); Ruble v. UNUM Life Ins. Co. of Am., 913 F.2d 295, 297 (6th Cir. 1990) (holding that the terms of the insurance contract are modified by the saved insurance law, but nonetheless enforcement of the policy is under ERISA).

143. Fischer, \textit{supra} note 14, at 90.

144. Machiz, \textit{supra} note 30, at 1186.
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of their citizens. The Fifth Circuit’s reasoning contains several significant flaws.

B. Corporate Health Misinterprets Pilot Life

The Supreme Court could address concerns regarding ERISA preemption more efficiently by clarifying two of its important and relevant decisions. First, the Court should answer specific unresolved questions regarding Pilot Life and ERISA’s exclusive remedy, specifically whether ERISA is the sole enforcement mechanism for aggrieved patients’ claims. Second, the Court should clarify relevant language in Pegram v. Herdrich that commentators have interpreted to hold that mixed eligibility decisions made by physicians concerning both coverage and medical treatment necessarily involve the assessment of medical facts and should be resolved under state law.

1. Qualification of the Solicitor General’s Argument in Pilot Life

In Corporate Health, the Fifth Circuit held that ERISA preempted the external review provision of the THCLA despite the court’s determination that the law fell under ERISA’s...


146. See Petition for Writ of Certiorari for the Supreme Court of the United States at 17-22, Montemayor v. Corporate Health Ins., Inc., (2001) (No. 00-665); see also Machiz, supra note 30, at 1186-89 (analyzing the Texas Department of Insurance’s petition); Young, supra note 106, at 1277-78 (analyzing the IRO in relation to the ERISA “savings” clause).

147. See Petition for Writ of Certiorari for the Supreme Court of the United States at 18-19, Montemayor (No. 00-665) (arguing that by accepting certiorari, the Supreme Court could have the opportunity to address the interpretations of Pilot Life and Pegram, and thereby determine the impact of these decisions on Corporate Health).

148. Pilot Life, 481 U.S. at 52 (determining whether ERISA § 502(a) provides the exclusive remedy that preempts state insurance law remedies that the savings clause would otherwise save).


151. Id. at 229, 235; see, e.g., Machiz, supra note 30, at 1187 (summarizing the arguments that the Texas Department of Insurance presented in its rehearing petitions in light of Pegram).
insurance “savings” clause. The court reasoned that because the independent review provisions conflicted with a substantive provision of ERISA, ERISA preempted the independent review law.

In *Pilot Life*, the Court determined that Mississippi’s bad faith law was not an insurance law subject to ERISA’s “savings” clause. This finding sufficiently resolved the issue for the specific cause of action, but the Court continued to discuss whether ERISA contained an exclusive remedy provision. In amicus curiae for *Pilot Life*, the Solicitor General of the United States argued that Congress intended § 502(a) of ERISA to be the exclusive remedy for participants and beneficiaries claiming improper processing of benefit claims. The Solicitor General concluded that state causes of action under § 502(a) would interfere with Congress’s intent that ERISA’s remedy be exclusive. The Court, in *Pilot Life*, agreed and determined that the language and structure of ERISA § 502(a) and Congress’s intent for it to have the same exclusive remedy provision as § 301 of the Labor-Management Relations Act of 1947 (LMRA).

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153. Id. The court relied on dicta in the Supreme Court’s *Pilot Life* decision. *Id.*; see also *Pilot Life*, 481 U.S. at 50.
154. *Pilot Life*, 481 U.S. at 50 (determining that Mississippi’s law of bad faith does not fit within the common sense understanding of “regulates insurance” or the McCarran-Ferguson factors).
155. See *id.* at 51-52 (finding that the understanding and interpretation of the savings clause must be informed by legislative intent concerning the civil enforcement provisions provided by ERISA § 502(a), 29 U.S.C. § 1132(a)).
156. *Id.* at 52, 54 (concluding that Congress intended for ERISA’s civil enforcement remedies to be exclusive as indicated by the deliberate care with which Congress drafted ERISA’s civil enforcement remedies and the balancing of policies); see also Brief for the United States as Amicus Curiae at 18-19, UNUM Life Ins. Co. of Am. v. Ward, 526 U.S. 358 (1999) (No. 97-1868) (arguing that the notice-prejudice rule does not conflict with ERISA’s civil enforcement scheme); supra note 96 and accompanying text.
157. See *Pilot Life*, 481 U.S. at 52 (claiming that state causes of action for claims under ERISA § 502(a) would “pose an obstacle to the purposes and objectives of Congress”); see also Brief for the United States at 18-19, UNUM Life (No. 97-1868).
supported this analysis.\(^{159}\)

Subsequently, in *UNUM Life Insurance*,\(^{160}\) the Solicitor General qualified his argument in *Pilot Life* by highlighting that the law at issue in that case was not a law regulating insurance.\(^ {161}\) The Solicitor General also explained that § 301 of LMRA, the statute considered the model to ERISA § 502(a) in *Pilot Life*, “does not contain any statutory exception analogous to ERISA’s insurance savings provision.”\(^ {162}\) In essence, the Solicitor General contended that the relevant sections of ERISA and LMRA are two statutes with different provisions.\(^ {163}\) The LMRA, unlike ERISA, does not exempt certain laws from its preemption provisions.\(^ {164}\) The Solicitor General concluded that ERISA’s insurance “savings” clause explicitly “saves state law conferring causes of action or affecting remedies that regulate insurance, just as it does state mandated-benefits laws.”\(^ {165}\)

The Court in *UNUM Life Insurance* acknowledged the Solicitor General’s qualified argument, but clarified that *UNUM Life Insurance* does not raise this issue, and the Court consequently does not need to address the Solicitor General’s argument to reach the proper conclusion.\(^ {166}\) The Court further clarified that *Pilot Life* did not interpret the “savings” clause.\(^ {167}\) In sum, the Court did not disagree with the Solicitor General’s qualified argument, but left open the possibility of consideration in a future case.\(^ {168}\)

Now is the perfect time for the Court to return to *Pilot Life* and

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\(^{159}\) *Pilot Life*, 481 U.S. at 52. The Court determined that “Congress’ specific reference to § 301 of the LMRA to describe the civil enforcement scheme of ERISA makes clear its intention that all suits brought by beneficiaries or participants asserting improper processing of claims under ERISA-regulated plans be treated as federal questions governed by [ERISA] § 502(a).” *Id.* at 56.


\(^{161}\) *Id.* at 376 n.7.

\(^{162}\) Brief for the United States at 25, *UNUM Life* (No. 97-1868).

\(^{163}\) See *id.*

\(^{164}\) *Id.*

\(^{165}\) *Id.* at 23; see also *UNUM Life*, 526 U.S. at 377 n7.

\(^{166}\) *UNUM Life*, 526 U.S. at 377 n.7.

\(^{167}\) *Id.* (clarifying that *Pilot Life* “concerned Mississippi common law, [which] creat[ed] a cause of action for bad faith breach of contract, law not specifically directed to the insurance industry and therefore not saved from ERISA preemption”).

\(^{168}\) See *id.*
clarify its interpretation of the exclusivity of ERISA § 502(a). The Court must clarify language that is not essential to the holding in Pilot Life because it already has determined that ERISA preempted the Mississippi bad faith law by concluding that it did not fall under the "savings" provision. Consequently, the Court could clarify Pilot Life without overturning it. Essentially, the Court needs to acknowledge that the exclusivity of ERISA § 502(a) remains separate from the insurance "savings" clause analysis.

This is an important distinction because of the way in which the Fifth, Ninth, and Eleventh Circuits have interpreted Pilot Life. These courts interpreted Pilot Life to hold that ERISA § 502 precludes the operation of the "savings" clause when state insurance law remedies are at issue. These courts, however, have failed to recognize that the insurance "savings" clause is a distinct exemption from preemption and not subject to other sections of ERISA.

2. Interpretation of ERISA’s "Savings" Clause

ERISA's "savings" clause completely exempts laws that regulate insurance. The express language of the "savings" clause states that "nothing in this subchapter [ERISA] shall be construed to exempt or relieve any person from any law of any

169. See Petition for Writ of Certiorari to the Supreme Court of the United States at 18-19, Montemayor (No. 00-665); see also Machiz, supra note 30, at 1186-87 (noting that the "conflict" preemption portion of Pilot Life "stands on shaky ground"); Young, supra note 106, at 1279 (stating Corporate Health "begs for review" by the United States Supreme Court).

170. See Petition for Writ of Certiorari to the Supreme Court of the United States at 18-19, Montemayor (No. 00-665).

171. Machiz, supra note 30, at 1188-89 (addressing the various avenues available for attacking Pilot Life); Young, supra note 106, at 1277-78.

172. See Corporate Health Ins., Inc. v. Tex. Dep't. of Ins., 215 F.3d 526, 538-9 (5th Cir. 2000) (holding that the IRO provisions of the THCLA interfere with the exclusivity of ERISA § 502 as discussed in Pilot Life); Kanne v. Connecticut Gen. Life Ins. Co., 867 F.2d 489, 494 (9th Cir. 1988) (concluding that a group health policy was part of the ERISA plan, and, therefore, the state common and statutory law claims against the insurer were preempted); Anschultz v. Connecticut Gen. Life Ins. Co., 850 F.2d 1467, 1469 (11th Cir. 1988) (holding that claims by the insured against the insurer for damages under Florida law for alleged wrongful denial of long term disability benefits were preempted).

173. See supra note 172 and accompanying text.


175. See id.; Machiz, supra note 30, at 1188.
State which regulates insurance. The Corporate Health court held that ERISA did not preempt the independent review provisions of the THCLA under the “savings” clause analysis. The court should have stopped there, but instead, became distracted by the language in Pilot Life, which suggested that ERISA be the exclusive remedy. The language in Pilot Life contradicts the express language of the “savings” clause, which provides that nothing in ERISA may interfere with the regulation of insurance, including ERISA § 502’s remedial scheme. Congress explicitly included the “savings” clause to save laws that regulate insurance from ERISA preemption. The exclusion is not limited to only state laws that do not create another remedy. The “savings” clause analysis, therefore, is inconsistent with the holding in Corporate Health. By accepting certiorari, the Court has the opportunity in Montemayor v. Corporate Health Insurance, Inc. to revisit Pilot Life and reconsider the conclusion that ERISA § 502 should be the exclusive remedy.

3. Congressional Intent

In Corporate Health, the Fifth Circuit found that ERISA preempted the independent review provisions even though the state law in question regulated insurance, and the court concluded that the state law fell under the “savings” clause exception in ERISA. Nevertheless, the court based its holding

177. Corporate Health, 215 F.3d at 538 (finding that the IRO provisions satisfied the common sense test for regulating insurance and two of the McCarran-Ferguson factors). The court found that failure to meet all three of the McCarran-Ferguson factors “is not fatal to Texas’s saving clause claim.” Id.
178. Id. at 538-39 (concluding that “even if the [IRO] provisions would otherwise be saved, they may nonetheless be preempted if they conflict with a substantive provision of ERISA”).
179. Machiz, supra note 30, at 1188.
180. See Petition for Writ of Certiorari to the Supreme Court of the United States at 12, Montemayor (No. 00-665).
182. See Corporate Health, 215 F.3d at 538-39; see also supra note 176 and accompanying text; Petition for Writ of Certiorari to the Supreme Court of the United States at 12, 14-15, Montemayor (No. 00-665).
183. Id.
on Pilot Life's description of "field preemption." The Pilot Life Court determined that even if the "savings" clause saved a cause of action, ERISA could still preempt the law if it conflicted with Congress's express intent that the remedies contained in ERISA be exclusive.2

When Congress passed ERISA in 1974, it explicitly intended to create an exemption provision for state insurance regulatory schemes.3 This "field preemption" undermines the entire purpose of the "savings" clause by preempting insurance provisions that Congress intended to fall under the "savings" clause, virtually rendering the "savings" clause meaningless.4

In addition, Pilot Life contends that Congress clearly intended for ERISA's supposedly comprehensive remedial scheme to be exclusive.5 A textual reading of this ERISA provision provides no support for this conclusion.6 The "provision merely creates a cause of action to enforce the terms of a plan which can include an insurance policy or HMO subscription agreement; its words say nothing about exclusivity."7

In addition, a 1989 House Budget Committee report reveals Congress's dissatisfaction with the Supreme Court's Pilot Life opinion.8 This dissatisfaction stems from the numerous complaints and inquiries it received about improper denial of medical claims.9 Some complaints have alleged that Pilot Life, which interprets ERISA as preempting state laws that allow remedies in connection with claims for benefits, denies legal recourse to participants in and beneficiaries of ERISA plans.10 The 1989 House Budget Committee similarly believes that "the legislative history of ERISA . . . support[s] the view that Congress

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185. Id.; Pilot Life, 481 U.S. at 52.
186. Pilot Life, 481 U.S. at 52.
187. 29 U.S.C. § 1144(b)(2)(A) (1994); see also supra notes 175-83 and accompanying text.
188. Young, supra note 106, at 1277-78.
189. Pilot Life, 481 U.S. at 52 (relying on the language and structure of § 502(a), as well as legislative history).
190. See ERISA § 502(a), 29 U.S.C. 1132(a) (1994); see also supra note 96 and accompanying text.
191. Machiz, supra note 30, at 1188; see also 29 U.S.C. § 1132(a).
193. Id.
194. Id.
intended for the courts to develop a Federal common law with respect to employee benefit plans, including the development of appropriate remedies, even if they are not specifically enumerated in section 502 of ERISA. The Committee concluded that federal courts have the authority to provide remedies based on the specific facts of cases before them, even if the remedy is not enumerated in ERISA. For these reasons, the Supreme Court should revisit this issue and clarify its holding in Pilot Life, while simultaneously enforcing state health care consumer protection schemes.

C. Corporate Health in Light of Pegram v. Herdrich

The District court in Corporate Health misinterpreted the Supreme Court’s decision in Pegram v. Herdrich. Commentators read Pegram to hold that coverage and medical necessity decisions, which are so inextricably combined, constitute “mixed eligibility” decisions. These “mixed eligibility decisions . . . involve the exercise of medical judgment to determine the treatment a patient needs.” Pegram held that medical necessity decisions are medical in nature and the states are free to regulate those decisions through their medical malpractice laws. External review provisions allow an independent physician unaffiliated with the MCO to decide whether care is medically necessary. Although Pegram is not

195. Id. at 1948; see also Radici v. Associated Ins. Co., 217 F.3d 737, 743-44 (9th Cir. 2000) (discussing House Report 101-247 on COBRA benefits).

197. See Petition for Writ of Certiorari to the Supreme Court of the United States at 21, 26-27, Montemayor (No. 00-665); see also Machiz, supra note 30, at 1186, 1188 (noting that many states have adopted external review mechanisms, and ERISA does not provide comparable consumer protection); Young, supra note 106, at 1279.
198. Corporate Health, 220 F.3d at 643 (concluding that Pegram did not protect state law claims from preemption if they are a mixed eligibility decision); Pegram v. Herdrich, 530 U.S. 211, 237 (holding that the HMO’s mixed treatment and eligibility decisions were not subject to ERISA’s fiduciary standards).

199. Young, supra note 106, at 1267, 1269-70.
200. Petition for Writ of Certiorari to the Supreme Court of the United States at 22, Montemayor (No. 00-665); see also Pegram, 530 U.S. at 228.
201. Pegram, 530 U.S. at 235.
a preemption case, the Court noted that Congress did not intend for ERISA to preempt general state health care regulation.\textsuperscript{203} The Court's analysis impacts independent review processes because the review addresses the central issue of health care regulation: whether medical treatment is necessary.\textsuperscript{204}

Under Pegram’s analysis, the states should be free to regulate these decisions with their independent review provisions.\textsuperscript{205} Pegram clarifies ERISA's preemption provision by suggesting that ERISA does not preempt laws providing for review of coverage decisions based on medical judgment.\textsuperscript{206} Therefore, the Corporate Health court incorrectly held that ERISA preempted the IRO provisions because these “mixed eligibility decisions” are the decisions that the IRO process reviews.\textsuperscript{207} The IRO provisions of the THCLA address the critical issue of whether treatment is medically necessary.\textsuperscript{208}

\section*{IV. CONCLUSION}

The function of independent review for the benefit of health care consumers in the insurance community is critical. Concern that ERISA thwarts valuable health care protections is increasing, thereby making health care consumers more vulnerable to denials of care and an ineffective appeals process. As the managed care environment becomes more complex, adequate steps must be taken to hold managed care entities accountable for their decisions to deny treatment.

Unless ERISA is amended, state law must take the steps to hold MCOs accountable. The Corporate Health decision reflects the clash between legitimate state consumer protection schemes

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\textsuperscript{203} Pegram, 530 U.S. at 237.
\textsuperscript{204} See Petition for Writ of Certiorari to the Supreme Court of the United States at 21-22, Montemayor (No. 00-665).
\textsuperscript{205} Pegram, 530 U.S. at 235.
\textsuperscript{206} Id. at 236.
\textsuperscript{207} Corporate Health, 220 F.3d at 643-44; Pegram, 530 U.S. at 235-36.
\textsuperscript{208} Petition for Writ of Certiorari to the Supreme Court of the United States at 25, Montemayor (No. 00-665) (citing Pegram, 120 S. Ct. at 2154). “The purpose of the IRO process is to decide whether the MCO correctly determined the appropriate medical response to a given patient's constellation of symptoms.” DALLEK & POLLITZ, supra note 202, at 1, 9.
for independent review and the powerful and overwhelming effect of ERISA preemption. Effectively clarifying ERISA preemption and the effect of the “savings” clause, specifically in *Pilot Life*, remains a feasible solution, which would end this conflict.  

209. Petition for Writ of Certiorari to the Supreme Court of the United States at 12, *Montemayor* (No. 00-665).