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HMOs, ERISA’s “RELATE TO” PREEMPTION AND A PATIENT’S RIGHT TO AN EXTERNAL REVIEW OF MEDICAL NECESSITY DECISIONS AND THE IMPLICATIONS OF FIELD AND CONFLICT PREEMPTION*

L. Darnell Weeden**

INTRODUCTION

More than a generation ago in 1974, the United States Congress passed a law called the Employee Retirement Income Security Act (ERISA) to advance the rights of employees.¹ ERISA was generally perceived as legislation that was designed to protect an employee’s economic investment in an employer provided benefit plan.² Legal commentators Stempel and Magdenko recently observed that in the beginning neither

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*This article was written prior to the Supreme Court’s decision in Rush Prudential HMO, Inc. v. Moran, available at 2002 WL 1337696.

**Professor, Thurgood Marshall School of Law, Texas Southern University; B.A., J.D., University of Mississippi. I would like to thank Anya Anga, Reference Librarian at Thurgood Marshall Law School for her support and assistance. I would also like to thank Kimberly M. Westley, Research Assistant at Thurgood Marshall School of Law, Class of 2003, for her valuable comments concerning earlier drafts of this article. This project was supported by a grant from the Texas Southern University Research Center.


²29 U.S.C. § 1001(a) “The Congress finds that... the continued well-being and security of millions of employees and their dependents are directly affected by these [benefit] plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations” Id.
friend nor foe of the new ERISA law conceived that it had any implications for employer furnished health care benefits.\(^3\)

In 1983, nine years after ERISA became the law of the land, the Supreme Court adopted the view that Congress intended for ERISA’s preemption impact to be liberally applied to any employer furnished benefits.\(^4\) The Supreme Court’s historical expansive preemption rationale in Shaw holds that a state law is under ERISA’s preemption restrictions if it is in any way related to an employees’ benefit plan.\(^5\) On its face, ERISA’s preemption rationale appears to apply to “any state laws” that relate to an employee benefit plan\(^6\) not specifically excluded from coverage by ERISA.\(^7\)

\(^{3}\) See Jeffery W. Stempel & Nadia von Magdenko, Doctors, HMOs, ERISA and the Public Interest After Pegram v. Herdrich, 36 TORT & INS. L.J. 687, 688 & n.6 (2001).


We have no difficulty in concluding that the Human Rights Law and Disability Benefits Law ‘relate to’ employee benefit plans. The breadth of § 514(a)'s 29 U.S.C.§ 1144 (a) pre-emptive reach is apparent from that section's language. A law ‘relates to’ an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan. Employing this definition, the Human Rights Law, which prohibits employers from structuring their employee benefit plans in a manner that discriminates on the basis of pregnancy, and the Disability Benefits Law, which requires employers to pay employees specific benefits, clearly ‘relate to’ benefit plans. We must give effect to this plain language unless there is good reason to believe Congress intended the language to have some more restrictive meaning. Id. at 96-98.

\(^{5}\) Id.

\(^{6}\) 29 U.S.C. § 1144 (a). “(a) Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.” Id.

\(^{7}\) Shaw, 463 U.S. at 96-97. “State laws regulating insurance, banking, or securities are exempt from this [ERISA] pre-emption provision as, are generally applicable state criminal laws.” Id. at 85. See 29 U.S.C.§ 1144(b)(2)(A) which provides “Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.” See 29 U.S.C.§ 1144(b)(2)(B) that provides “Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks,
Because ERISA’s preemption rationale includes medical decisions about whether a particular course of treatment is medically necessary, it is important to develop legal theories to limit the preemption’s deadly effects on precluding states from granting its citizens a patient’s bill of rights against HMOs. One commentator stated in 1999 that she believed the Supreme Court retreated from its comprehensive version of ERISA’s preemption purpose to a less extensive application of the statute’s “relates to language.”\(^8\) I am not sure those commentators who believe that the Supreme Court has sent a clear signal of hope that it is prepared to limit the impact that preemption has on medical treatment decisions by HMOs is justified. However, I agree with the conclusion of Stempel and Magdenko\(^9\) that the Supreme Court’s recent decision in *Pegram v. Herdrich\(^{10}\)* may suggest, in a rather obscure manner, that HMOs operating under an ERISA plan may nevertheless be liable for damages in a traditional state law torts cause of action for its involvement in a decision about medical treatment.\(^{11}\)

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\(^8\) Dawn Lauren Morris, Comment, *ERISA Preemption, HMOs And The Denial of Benefits Claims*, 59 La. L. Rev. 961, 963 (1999). “The Court has moved from its broad and expansive interpretation of ERISA preemption to a narrower construction of the ‘relates to’ terminology in the preemption clause. This interpretation has served to narrow the gap, and it has opened the door for state and federal courts to recognize theories of liability against HMOs, including those for claims of denial of benefits.” *Id.* at 963.

\(^9\) Stempel and Magdenko, supra note 3, at 717-725.

\(^10\) *Id.* (citing *Pegram v. Herdrich*, 120 S.Ct 2143 (2000)).

\(^11\) *Id.*. Pegram both gives and takes away from HMOs. On the one (obvious) hand, the decision is helpful to HMOs in that it relieves them of possible fiduciary obligation and liability under the ERISA statute that provides for penalties and counsel fees for prevailing plaintiffs. On the other (less obvious) hand, the decision suggests that HMOs should not be immune from otherwise valid state law claims against health care providers or physicians for negligence, misrepresentation, or fraud simply because the HMO is providing its services as a vendor under an ERISA plan.

The HMO making mixed or purely medical decisions is indistinguishable from the treating physician, at least as concerns ERISA. Also, we now conclusively know that the Court has no absolute objection to physician liability under these circumstances. The Court noted without disapproval that Herdrich’s original malpractice claim was tried to a jury and resulted in a $35,000 award. The Court also noted that states vary regarding whether to “allow malpractice actions against HMOs,” suggesting that there is no ERISA bar to such state law tort actions against HMOs.

*Id.* (citations omitted)
Two years ago, in 2000, two federal appeals courts, the Fifth Circuit, and Seventh Circuit reached opposite conclusions about the reach of ERISA’s preemptive arm on state laws providing for a separate and independent inspection of an HMO’s denial of a proposed medical treatment plan. One commentator appropriately characterized the issue presented before the two circuits as whether a state’s legal process for granting independent review of an HMO’s medical treatment decisions is preempted by ERISA. On June 29, 2001, the Supreme Court granted certiorari in Rush Prudential HMO, Inc. v. Moran to decide whether a state’s granting a patient an independent review procedure when the HMO has denied him/her medical treatment is permissible under ERISA. On January 16, 2002, the Supreme Court heard oral argument in Rush Prudential HMO, Inc. v. Moran.

Part I of this article presents the facts and procedural setting for the legal disputes discussed by the Fifth Circuit in Corporate Health Insurance v. Texas Department of Insurance with an analysis of ERISA’s “relate to” preemptive reach. Part II of this article provides a brief analysis of the Seventh Circuit decision in Moran v. Rush Prudential HMO, Inc. Part III examines a copy of the transcript of the oral argument before the Supreme Court in Rush Prudential HMO, Inc. v. Moran for insights on how the court decided these. The epic battle
between a right to review an HMO's denial of medical treatment and a federal preemptive interest in protecting an HMO's right to make a profitable treatment decision free of independent review is ironic because the purpose of ERISA was to protect employee rights. After the holdings in the two aforementioned cases, employees now fear the ERISA legislation. I believe the ERISA preemption battle is a question of how to accommodate reasonable necessary profits for a company involved in providing medical services while assuring that there is a fair review process for determining when a treatment is medically necessary.

CORPORATE HEALTH INSURANCE V. TEXAS DEPARTMENT OF INSURANCE

Facts and Procedural History
On May 22, 1997, Texas law changed the legal playing field for those involved in the managed care industry in the state. The Texas legislature recently enacted new law expanding the rights of individuals against HMOs. Although I consider the new legislation a patient's bill of rights, the new law provides important protections for doctors against HMOs as well. Under the new law, a Texas patient has a right to sue HMOs that are negligent in making "health care treatment decisions." The right to sue your HMO provision in the law was characterized by the Fifth Circuit as the liability portion of the law. A second part of the law called the "independent review requirement" gives patients certain procedural rights while obtaining an independent review of whether a health care treatment is medically necessary. A third section of the law is designed to protect doctors who engage in the practice of advocating their patient's right to appropriate medical

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WL 1576954 (Amicus Brief); 2001 WL 1590504 (Amicus Brief); 2001 WL 1673395 (Amicus Brief). Id.

20TEX. CIV. PRAC. & REM. CODE ANN. § 88.001 et seq. (Vernon 2002). This law became effective on May 22, 1997.

21Corporate Health, 215 F.3d at 530.

22Id.

23Id.
treatment from both an HMO ordained indemnity clause and an HMO ordered retaliation. 24

The plaintiffs in this litigation challenged a state's ability to regulate the conduct of HMOs and other managed care operators that provide health related services under an ERISA sponsored plan because of ERISA's preemption rationale. 25 The plaintiffs argue that the Texas law 26 is unconstitutional because it is "preempted by ERISA's general preemption clause ...[that] preempts all law relating to any employee benefit plan." 27 The plaintiffs also advanced the theory that the Texas law was unconstitutional because it was preempted by the Federal Employees Health Benefit Act (FEHBA) 28

At the district court level all parties involved in the lawsuit filed cross motions requesting summary judgment. 29 The federal district court granted some of the cross motions for summary judgment while denying others. 30 The federal trial court held that neither ERISA nor the FEHBA preempted the liability sections of the Texas law. 31 However, in the district court opinion, the anti-retaliation, anti-indemnification, and independent review sections of the Texas law were held unconstitutional because they were preempted by ERISA. The plaintiffs and the defendants filed an appeal challenging the Fifth Circuit district court's decision. 32 Defendant Texas tried unsuccessfully to convince the Fifth Circuit that Plaintiff Aetna lacked standing to challenge the new liability sections, which gave Texans the right to sue managed care organizations for failure to provide reasonable medical treatment because it had not yet been sued. 33 Aetna was able to rebuke Texas' standing challenge because the new liability section of the law gave the State Attorney General, as well as private parties, the right to sue Aetna

24 Corporate Health, 215 F.3d at 530.
25 Id. at 531.
27 Corporate Health, 215 F.3d at 531-532 (citing 29 U.S.C. § 1144(a)).
28 Id. at 531-532 (citing 5 U.S.C. § 8901 et seq.).
29 Id. at 532.
30 Id.
31 Id.
32 Corporate Health, 215 F.3d at 532; See Corporate Health Ins., Inc. v. Texas Dept. of Ins., 12 F. Supp. 2d 597 (S.D. Tex. 1998).
33 Corporate Health, 215 F.3d at 532.
if it violated the law. According to the Fifth Circuit, potential exposure to state regulatory legal liability is enough to establish the required threatening injury for purposes of Article III standing.

Analyzing ERISA's "Relate to" Preemptive Reach
The Fifth Circuit acknowledged that from 1974 to 1994 it construed section 1144(a) of ERISA's "relate to" language in a comprehensive manner based on its understanding of relevant Supreme Court precedent about the long reach of ERISA's preemption arm. The Fifth Circuit correctly indicated that the Supreme Court, in a trilogy of cases, rejected the rationale for its comprehensive application of the preemption rule in ERISA cases. The Fifth Circuit suggested ERISA's extensive use of the preemption rationale was based on the unacceptable notion that if a state law or policy in any way related to an employer sponsored benefit it was preempted because of the relate to language contained in 29 U.S.C. § 11449(a).

In Travelers, the first opinion in a Supreme Court triplet, a New York law obligated hospitals to collect certain surcharges from HMOs based on the number of Medicaid recipients they enrolled. In Travelers, the Supreme Court was asked to decide whether ERISA preempts "the state provisions for surcharges on bills of patients whose commercial insurance coverage is purchased by employee health-care governed by ERISA, and for surcharges on HMO's insofar as their membership fees are paid by an ERISA plan." The Court held the

34 Corporate Health, 215 F.3d at 532.
35 Id. On the Attorney General's right of action, see Tex. Ins. Code Ann. art. 21.21 § 15(a); Tex. Bus. & Com. Code Ann. § 17.47. Relevant provisions imposing liability include Tex. Ins. Code Ann. art. 21.21-2 § 2(b)(5) (unfair and deceptive to compel policyholders to institute suits to recover amounts due); art. 21.21 § 4(10)(ii) (prohibiting the failure to pay claims when liability has become reasonably clear); Id. at art. 21.21-2(B)(4) (same)." Id. n.6.
36 Corporate Health, 215 F.3d at 532.
38 Corporate Health, 215 F.3d at 532.
40 Travelers, 514 U.S. at 649. "New York law also imposes a surcharge on HMO's, which varies depending on the number of eligible Medicaid recipients an HMO has enrolled,
The Supremacy Clause allows Congress to preempt state law with express language, by implication or when there is a conflict between federal and state law. In *Travelers*, Justice Souter stated the Supreme Court always engages in the presumption that Congress did not intend to “supersede the state historic police powers” in the absence of a clear and manifest statement from Congress that it intended to preempt state law. In *Travelers* the Supreme Court made it clear that preemption was a question of Congressional intent. It is now clear that the Court made a serious error in *Shaw* by giving section 1144(a)’s language such a broad literal reading that it makes any attempt to evaluate Congress’ preemption intent on simple “relate to” words a “mere sham.” In its preemption intent analysis in *Travelers*, the Supreme Court abandoned the “uncritical literalism” in interpreting ERISA’s “relate to” words contained in section 1144(a) in favor of considering Congress’ policy goals in enacting the ERISA law. The *Travelers* Court did what was necessary and proper by asserting that it would no longer be guided by ERISA’s “unhelpful text” in deciding ERISA’s preemptive intent. In *Travelers* the Court concluded that the objectives of the ERISA law would serve as the best guide for deciding which set of state laws Congress intended to survive ERISA under 29 U.S.C. 1144(a).

In *Ingersoll-Rand Co. v. McClendon*, an employee sued his past employer in a wrongful discharge action. The employee believed he

but which may run as high as 9% of the aggregate monthly charges paid by an HMO for its members' in-patient hospital care . . . . This assessment is not an increase in the rates to be paid by an HMO to hospitals, but a direct payment by the HMO to the State's general fund.” *Id.* at 650.

41 *Travelers*, 514 U.S. at 650.
42 *Id.* at 654. (cites omitted). The Supremacy Clause is found in the U.S. Const. Art. VI.
43 *Travelers*, 514 U.S. at 655 (quoting Rice v. Santa Fe Elevator Corp. 331 U.S. 218, 230 (1947)).
44 *Id.*
45 *Shaw*, 463 U.S. at 96-98.
46 *Travelers*, 514 U.S. at 655.
47 *Id.* at 656.
48 *Id.*
49 *Travelers*, 514 U.S. at 656.
was unlawfully discharged because his employer did not want to add to the employee's pension money. The *Ingersoll-Rand* Court held that ERISA preempted the employee's wrongful discharge claim under Texas law.\(^{51}\) The Court in *Ingersoll-Rand* identified the congressional goal of statute 29 U.S.C. § 1144(a) as follows:

"was 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. Otherwise, the inefficiencies created could work to the detriment of plan beneficiaries. (cites omitted) Allowing state based actions like the one at issue here would subject plans and plan sponsors to burdens not unlike those that Congress sought to foreclose through [29 U.S.C. § 1144(a).] Particularly disruptive is the potential for conflict in substantive law. It is foreseeable that state courts, exercising their common law powers, might develop different substantive standards applicable to the same employer conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement."\(^{52}\)

One could argue that in *Ingersoll-Rand*, the Court is not really concerned with the actual affect of the wrongfully discharged Texas law on ERISA's federal policy interests.\(^{53}\) In fact *Ingersoll-Rand* stated it took "for granted that state laws which are 'specifically designed to affect employee benefit plans' are pre-empted under [29 USC §1144(a).]"\(^{54}\) In *Travelers*, the Court suggested that it would not virtually automatically preempt "all state laws" affecting employee benefits "on the theory that they indirectly relate to ERISA plans" because doing so would allow a limitless long arm of preemption.\(^{55}\) The Court's commentary rejected an opportunity to interpret the limiting language out of section 1144(a)'s preemption theory because it would

\(^{51}\)Id.

\(^{52}\)Id.

\(^{53}\)Id.

\(^{54}\)Id. at 140 (quoting Mackey v. Lanier Collection Agency & Services, Inc. 486 U.S. 825, 829 (1988)).

\(^{55}\)Travelers, 514 U.S. at 661.
otherwise violate basic principles of statutory interpretation.\textsuperscript{56} The Travelers Court limited the reach of ERISA’s preemption by reasoning that a state law will not be held to relate to an employee benefit plan for ERISA preemption purposes unless it substantially affects federal interests in an employee benefit plan.\textsuperscript{57}

On April 12, 2001, a federal district court opinion\textsuperscript{58} appeared to give ERISA’s preemption a liberal application without identifying a substantial federal interest requiring preemption. In Brander, the litigation entailed an argument concerning calculations of the plaintiff’s benefits covered by an ERISA long-term disability policy bought from the defendant, a life insurance company.\textsuperscript{59} The defendant contended that it was entitled to a summary judgment because the plaintiff’s causes of action were preempted under ERISA.\textsuperscript{60} The defendant insurance company in Brander maintained that it was entitled to summary judgment because plaintiff’s state law claims were preempted under ERISA because they “relate[d] to” an employee benefit plan.\textsuperscript{61} The plaintiff in Brander cited the Travelers opinion to make a general policy argument that the Supreme Court rejected the expansive “relate to” preemptive rationale of ERISA.\textsuperscript{62}

I believe the federal district court in Brander improperly rejected plaintiff’s assertion that Travelers held that any law bearing indirectly but substantially on an insured benefit plan is preempted under ERISA because it relates to the employee’s benefit plan.\textsuperscript{63} If however, the Brander plaintiff is asserting that “laws that regulate only the insurer, or the way in which it may sell insurance” do not relate to employee benefit plans in a normal sense, then the plaintiff has misunderstood the policy rationale behind the Travelers Court insurance regulation discussion.\textsuperscript{64} The Travelers Court simply articulated that insurance laws, which do not substantially affect a federal interest in ERISA

\begin{thebibliography}{9}
\bibitem{56}Id.
\bibitem{57}Id. at 662-664.
\bibitem{59}Id. at 1222.
\bibitem{60}Id.
\bibitem{61}Id.
\bibitem{62}Id. at 1224.
\bibitem{63}Brander, 152 F.Supp.2d. at 1224 (citing Travelers 514 U.S. at 663).
\bibitem{64}Brander, 152 F.Supp.2d. at 1224.
\end{thebibliography}
exclusivity "do not relate to benefit plans in the first instance" and therefore, are not preempted even in the absence of ERISA's Savings Clause.

The Brander holding that the plaintiff's claim is preempted under ERISA is fatally flawed because the court failed to recognize Travelers' new bright line test for "relate to" claims, namely whether the employee benefit plan has a substantial effect on an exclusive federal interest. In Brander, the court placed an undue reliance on the Shaw court's liberal use of "relate to" to include any benefit plan that has a plausible connection or reference to such a plan. Travelers modified the Shaw test by stating that a law will be considered as related to an employee plan if in the pragmatic sense of the phrase it has a substantial effect on the federal interest in the uniformity of an interstate benefit. The basic message of Travelers is that indirect economic influence of a state law that does not substantially effect on the federal interest in providing uniformity to an employee benefit plan does not relate to the plan and may not be preempted.

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65 Travelers, 514 U.S. at 664 (citing Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 741 (1985)).
66 See 29 U.S.C. § 1144(b)(2)(A). "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." Id.
67 Travelers, 514 U.S. at 668.
68 That said, we do not hold today that ERISA pre-empts only direct regulation of ERISA plans, nor could we do that with fidelity to the views expressed in our prior opinions on the matter. We acknowledge that a state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and that such a state law might indeed be pre-empted under § 514. But as we have shown, New York's surcharges do not fall into either category; they affect only indirectly the relative prices of insurance policies, a result no different from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate.

Id. (citations omitted).
69 Brander, 152 F.Supp.2d at 1224.
70 Travelers, 514 U.S. at 664
71 Id. at 660.

Indeed, to read the pre-emption provision as displacing all state laws affecting costs and charges on the theory that they indirectly relate to ERISA plans that purchase insurance policies or HMO memberships that would cover such services would effectively read the limiting language in S
In Brander, the federal court correctly stated that the policy objective of the Supreme Court in Travelers was "avoiding the slippery slope of applying ERISA preemption to all state regulations that have only an indirect economic effect on an ERISA benefit plan." Although the Brander Court recognized the policy goals of the Supreme Court in Travelers of limiting ERISA's preemption in areas traditionally regulated by the state, Brander failed to clearly apply Travelers substantive affect on a federal uniformity preemption test to ERISA's "relate to" language.

I think the federal court in Brander ruled against the plaintiff because he "[sought] direct enforcement of the provisions of his ERISA benefit plan, not through ERISA's exclusive enforcement provisions, but through state causes of action." Under Travelers one could argue a plaintiff is not required to use ERISA's exclusive enforcement provisions unless it is first determined that the employee benefit relates to the plan because it has a substantial effect on a substantive federal preemptive interest requiring uniformity.

514(a) out of the statute, a conclusion that would violate basic principles of statutory interpretation and could not be squared with our prior pronouncement that "[p]re-emption does not occur ... if the state law has only a tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability."

District of Columbia v. Greater Washington Bd. of Trade, 506 U.S., at 130 n. 1, (internal quotation marks and citations omitted).

While Congress's extension of pre-emption to all "state laws relating to benefit plans" was meant to sweep more broadly than "state laws dealing with the subject matters covered by ERISA [,] reporting, disclosure, fiduciary responsibility, and the like," Shaw, 463 U.S., at 98, and n. 19, nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern, see Hillsborough County v. Automated Medical Laboratories, Inc., 471 U.S., at 719; 1 B. Furrow, T. Greaney, S. Johnson, T. Jost, & R. Schwartz, Health Law §§ 1-6, 1-23 (1995)."

Travelers, at 661-662.

71Brander, 152 F.Supp.2d at 1225.
72Id. at 1224-1225.
73Id. at 1225.
74Travelers, 514 U.S. at 668.
Dillingham Reveals ERISA’s “Relate to” Language is Virtually an Illusory Limit on Preemption

In 1997, two years, after its decision in Travelers, the Supreme Court revisited the issue of when an employee benefit plan relates to ERISA for purposes of preemption in the Dillingham opinion, the second of a trilogy. In Dillingham, California law obligated an employer hiring employees on a public works project to pay them the prevailing local wages. A public works employer was not required to pay prevailing local wages to employees participating in an authorized apprenticeship program. The Dillingham Court was asked to decide whether ERISA’s preemption policies under the statute displaced a state prevailing wage law that forbid a public works employer from paying apprentice wages to its employees participating in an unauthorized training program. The Supreme Court held because the state prevailing wage law did not relate to an employee benefit plan it was not preempted under ERISA.

Justice Thomas, writing for the Court in Dillingham, had a difficult time articulating an appropriate limitation for determining when a state law does not “relate to” an ERISA plan because of the statutory “relate to” test adopted by the Supreme Court in prior opinions. It is not logically possible to posit an acceptable limit for the phrase “relate to” because “everything is related to everything

139; Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47-48, (1987); Shaw, 463 U.S., at 98. We acknowledge that a state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and that such a state law might indeed be pre-empted under § 514. But as we have shown, New York’s surcharges do not fall into either category; they affect only indirectly the relative prices of insurance policies, a result no different from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate.”

Id.

75Dillingham, 519 U.S. 316.
76Corporate Health, 215 F.3d at 532 & n.8.
77Dillingham, 519 U.S. at 319.
78Id.
79Id. at 319.
80Id.
81Dillingham, 519 U.S. at 316-17.
The relate to "statutory text provides an illusory test [for preemption] unless the Court is willing to decree a degree of preemption that no sensible person would have intended." A futuristic Court would heed the prophetic warning of Justice Scalia with Justice Ginsburg concurring that the Court will not bring clarity to the issue of implied ERISA preemption until it admits that an expansive "relate to" theory is "doomed to failure."

In an ERISA disclosure case the Court said "[w]hen a plan provision as interpreted had the effect of denying an application for benefits unreasonably, or as it came to be said, arbitrarily and capriciously, courts would hold that the plan as "structured" was not for the sole and exclusive benefit of the employees, so that the denial of benefits violated 29 U.S.C. § 186(c)

I think it would greatly assist our function of clarifying the law if we simply acknowledged that our first take on this statute was wrong; that the "relate to" clause of the pre-emption provision is meant, not to set forth a test for pre-emption, but rather to identify the field in which ordinary field pre-emption applies—namely, the field of laws regulating "employee benefit plan[s] described in section 1003(a) of this title and not exempt under section 1003(b) of this title," 29 U.S.C. § 1144(a). Our new approach to ERISA pre-emption is set forth in John Hancock Mut. Life Ins. Co. v. Harris Trust and Sav. Bank, 510 U.S. 86, 99 (1993): "We discern no solid basis for believing that Congress, when it designed ERISA, intended fundamentally to alter traditional pre-emption analysis." I think it accurately describes our current ERISA jurisprudence to say that we apply ordinary field pre-emption, and, of course, ordinary conflict pre-emption. See generally Silkwood v. Kerr-McGee Corp., 464 U.S. 238, 248 (1984) (explaining general principles of field and conflict pre-emption); Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230 (1947) (field pre-emption); Florida Lime & Avocado Growers, Inc. v. Paul, 373 U.S. 132, 142-143 (1963) (conflict preemption). Nothing more mysterious than that; and except as establishing that, "relates to" is irrelevant."

Id. at 336.

ERISA's virtually limitless phrase of "relate to" is used to preempt states from their role of protecting the health of citizens without a manifest demonstration of implied preemption, the relate to phrase has the effect of unreasonably or arbitrarily violating the states reserve powers under the Tenth Amendment. I would argue that using "relate to" language as a basis for establishing ERISA preemption flunks the requirement that a decision maker may not implement a law that is arbitrary because it does not have a reasonably acceptable purpose under implied preemption. When a real consequence of the relate to

Id. at 109-110.


The Supreme Court has delineated three categories of preemption: Express, implied 'field,' and implied 'conflict' preemption. Express preemption, as the phrase suggests, occurs when Congress explicitly manifests their intent to displace state regulation. As the Supreme Court recently explained, because 'pre-emption fundamentally is a question of congressional intent . . . when Congress has made its intent known through explicit statutory language, the court's task is an easy one.' Absent an express congressional declaration of intent, two types of implied preemption may be present. Implied 'field' preemption exists when a scheme of federal regulation is purported to be so pervasive as to evidence Congress's intent to occupy the field, or where it is reasonable to conclude that 'Congress left no room for the States to supplement) the regulation. Implied 'conflict' preemption exists when either state law 'stands as an obstacle to the accomplishment and execution' of Congress's purposes and objectives in enacting legislation, or when compliance with both federal and state law would be a 'physical impossibility.'

Id. (citations omitted).

7 U.S. CONST. amend X. "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." Id.

8 Pegram v. Herdrich, 530 U.S. 211, 237 (2000). To be sure, New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 654-655 (1995), throws some cold water on the preemption theory; there, we held that, in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose. But in that case the convergence of state and federal law was not so clear as in the situation we are positing; the state-law standard had not been subsumed by the standard to be applied under ERISA. We could struggle with this problem, but first it is well to ask, again, what would be gained by opening the federal courthouse doors for a fiduciary malpractice claim, save for possibly
prerequisite of ERISA denies the states their right to grant their citizens a right to appeal an HMO's denial of a claim without demonstrating traditional implied preemption, all an HMO defendant has to do to acquire federal jurisdiction and federal preemption is simply allege that the plaintiff's state law complaint is precluded because it relates to an employee benefit. The McCreary comment points out that the basis of federal jurisdiction for all ERISA claims is dubious at best. It would be a tremendous set back to federal and state regulations to expand ERISA's preemptive reach into health care without a clear statement from Congress since the health care field has been traditionally regulated by the states.

The irony of the Court's opinion in *Dillingham* is while Justice Thomas is forced to admit that the Court has "long acknowledged that ERISA's preemption provision is clearly expansive," he has to engage in cerebral word structures to limit the unintended wide scope of ERISA's preemptive impact. In *Dillingham*, the Court discusses its two prong study for deciding whether a law is preempted by ERISA's "relate to" requirement. The Court states a law relates to a covered benefit plan for purposes of 29 U.S.C. § 11449(a) "if it [1] has a connection with or [2] reference to such a plan." The reference to test and the connection to standard for deciding whether a law should be

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It thus became a relatively simple matter for a plaintiff to obtain federal jurisdiction over his claim of wrongful denial of benefits by asserting only that he was a participant in the plan and was denied benefits, these assertions being sufficient to make out a prima facie case of 'structural defect' in the plan itself. Despite the dubious foundation for the exercise of federal jurisdiction, the arbitrary and capricious standard, developed by the cases interpreting it under section 302 of the Taft-Hartley Act, has been expressly adopted as the governing ERISA standard.”

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Id. at 324 (quoting *Travelers*, 514 U.S. at 655).

*Travelers*, 514 U.S. at 654-655.

*Travelers*, 514 U.S. at 655.

*Travelers*, 514 U.S. at 655.

*Travelers*, 514 U.S. at 655.

*Travelers*, 514 U.S. at 655.

*Travelers*, 514 U.S. at 655.

*Travelers*, 514 U.S. at 655.

*Travelers*, 514 U.S. at 655.
preempted by ERISA are just as illusory as the relate to test it attempts to give substance to. If “everything is related to everything else,” it is easy to advance the theory that everything is connected with everything else and that nothing can exist without reference to something else. Although I believe the reference to inquiry used by Justice Thomas is not very helpful in deciding when ERISA’s 29 U.S.C. 1144(a) preemption applies, I have elected to provide you with five examples listed by the Court as a basis for ERISA’s reference to preemption.

"[1] we have held pre-empted a law that ‘impos[ed] requirements by reference to [ERISA] covered programs,’; [2] a law that specifically exempted ERISA plans from an otherwise generally applicable garnishment provision;[3] and a common-law cause of action premised on the existence of an ERISA plan. [4] Where a State's law acts immediately and exclusively upon ERISA plans or [5] where the existence of ERISA plans is essential to the law's operation. [cites omitted]"

A law without any reference to an ERISA plan is preempted if it shows a “connection with ERISA plans." The Court in Dillingham stated that to decide whether the state law has a preemptive connection under ERISA, it has to compare the objectives of the ERISA statute with Congress’ intent not to undermine the traditional scope of state law while considering “the effect of state law on ERISA plans.” I think it would have been very useful if the Court had followed Justice Scalia’s lead and acknowledged that the “relate to” language and its off springs, “refer to” and “connect to”, are not relevant for deciding ERISA preemption. In the Supreme Court’s current ERISA

95 Id. at 335 (Scalia, J., Ginsburg, J., concurring).
96 Id. “But applying the ‘relate to’ provision according to its terms was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else. Accord, New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 655 (1995).” Id.
97 Id. at 324-325.
98 Dillingham, 519 U.S. at 325.
99 Id. “Rather, to determine whether a state law has the forbidden connection, we look both to "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans. (citing Travelers, 514 U.S. at 658-659.) Id.
100 Id. at 336. (Scalia, J., Ginsburg, J., concurring).
The Supreme Court has provided two common methods for allowing Congress to preempt laws enacted by the state. If Congress signals intent to occupy a specific field, all state laws within the scope of the field are preempted. When Congress fails to completely replace state law in a field, state laws are preempted if they in fact conflict with federal law. A conflict for preemption purposes exists if it is impossible to comply with both state and federal legal requirements. State law also creates a preemptive conflict if it impairs the goals of Congress. In Dillingham, a simple traditional preemption analysis without any reference to the "relate to" language reveals that preemption is not necessary because Congress did not signal an intent under ERISA to occupy the entire field of "state apprenticeship training standards or state prevailing wage laws." A state law requiring employers working on public projects to pay wages equal to that paid for similar projects in the local community in the private sector does not conflict with federal law because the state law is following the federal example. It is not impossible for a California
public contractor to comply with a state law that is not remotely connected to "the areas with which ERISA is expressly concerned—"reporting, disclosure, fiduciary responsibility and the like." If the Dillingham Court had held California's prevailing wage and apprenticeship training laws were preempted under ERISA, it would have been an improper use of preemption because the Court's decision, rather than state law, impairs federal policy by denying a state the ability to implement an express federal policy. Under a clearly articulated traditional implied preemption analysis, Dillingham would have avoided any discussion of ERISA's "relate to" language and held California's prevailing wage laws and apprenticeship standards neither conflicted with federal policy nor impaired federal objectives under ERISA as they were not preemptive employee benefits plans.

projects equal wages paid in the project's locale on similar, private construction jobs. California, in 1937, adopted a similar statute, which requires contractors who are awarded public works projects to pay their workers "not less than the general prevailing rate of per diem wages for work of a similar character in the locality in which the public work is performed." Under both the Davis-Bacon Act and California's prevailing wage law, public works contractors may pay less than the prevailing journeyman wage to apprentices in apprenticeship programs that meet standards promulgated under the National Apprenticeship Act, 50 Stat. 664, as amended, 29 U.S.C. § 50 (known popularly as the Fitzgerald Act). In most circumstances, California public works contractors are not obliged to employ apprentices, but if they do, the apprentice wage is only permitted for those apprentices in approved programs.

Id. at 319-320.

109Id. at 330 (citing Travelers, 514 U.S. at 661, (quoting Shaw, 463 U.S. at 98)).

110Id. at 331 & n.7. "Were we to hold § 1777.5 preempted "[t]hat result 'would leave States without the authority to do just what Congress was expressly trying to induce them to do by enacting the Fitzgerald Act.' " Brief for United States as Amicus Curiae 22 (internal quotation marks and brackets omitted)." Id.

111Dillingham, 519 U.S. at 331. "We could not hold pre-empted a state law in an area of traditional state regulation based on so tenuous a relation without doing grave violence to our presumption that Congress intended nothing of the sort. We thus conclude that California's prevailing wage laws and apprenticeship standards do not have a "connection with," and therefore do not "relate to," ERISA plans." Id. at n.7.
In *De Buono v. NYSA-ILA Medical & Clinical Services Fund* ERISA's "Relate To" Language is Evaluated Under the Normal Presumption Against Preemption

On June 2, 1997, the Supreme Court decided an ERISA preemption issue in the *De Buono v. NYSA-ILA Medical & Clinical Services Fund* opinion, the last one of a trilogy. This decision came after the Supreme Court had decided a similar preemption issue less than four months earlier in *Dillingham*. In *De Buono*, the Court held that hospitals handled by ERISA's had the same tax liability as other similarly situated hospitals. The Court in *De Buono* characterized the narrow legal issue in the case as a question of whether "the opaque language in ERISA's §514(a) precludes New York from imposing a gross receipts tax on the income of medical centers operated by ERISA funds." The Court held that ERISA's blurred "relate to" language under 29 U.S.C. § 1144(a) would not preclude the state of New York from collecting its tax.

The New York General Assembly enacted tax legislation to produce more money for a state Medicaid program that was quickly running out of money. The new tax legislation called, Health Facility Assessment (HFA), required hospitals, residential health care facilities, and diagnostic treatment centers to pay a tax on all the gross receipts produced by patient services. Any money collected under HFA was deposited into New York's general revenue fund. The plaintiffs were trustees of a fund that managed a self-insured welfare benefit plan for several employers. Initially the plaintiffs paid the HFA tax, but they stopped paying the tax and filed suit to prohibit future assessments and to seek reimbursement for all the previously paid assessments. The plaintiff's cause of action stated that because the HFA law relates

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112 *De Buono*, 520 U.S. 806.
113 *Dillingham*, 519 U.S. 316.
114 *De Buono*, 520 U.S. at 809.
115 Id.
116 Id.
117 Id. at 809-810.
118 *Id.* & n. 3 (citing N.Y. PUB. HEALTH LAW § 2807-d (McKinney Supp.1992)).
119 *De Buono*, 520 U.S. at 810.
120 *De Buono*, 520 U.S. at 810.
121 *Id.*
to the fund under ERISA’s 29 U.S.C. § 1144(a) language HFA is preempted. The trial court rejected the plaintiff’s claim of ERISA preemption because HFA was a general tax with an incidental impact on an employee benefit plan.

The decision of the trial court was reversed by the United States Court of Appeals for the Second Circuit. The Second Circuit believed HFA related to the fund since HFA “reduced the amount of Fund assets that would otherwise be available to provide plan members with benefits, and could cause the plan to limit its benefits, or to charge plan members higher fees.” In De Buno, the Supreme Court appropriately reversed the holding that HFA was preempted because the Second Circuit erred by improperly relying “substantially on an expansive and literal interpretation of the words relate to under 29 U.S.C.C. § 1144(a).” By not adopting Travelers rejection of a strictly literal reading of 29 U.S.C.C. § 1144(a) and its virtually limitless expansive construction of the phrase “relate to” the Second Circuit committed reversible error.

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122 Id.
123 Id.
124 De Buono, 520 U.S. at 811.
125 Id. at 812.
126 Id. at 812.
127 Id. at 813.

The first petition for certiorari in this case was filed before we handed down our opinion in New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995). In that case we held that ERISA did not pre-empt a New York statute that required hospitals to collect surcharges from patients covered by a commercial insurer but not from patients insured by a Blue Cross/Blue Shield plan. Id. at 649-651. After deciding Travelers, we vacated the judgment of the Court of Appeals in this case and remanded for further consideration in light of that opinion. 514 U.S. 1094 (1995). On remand the Court of Appeals reinstated its original judgment. The court distinguished the statute involved in Travelers on the ground that—by imposing a tax on the health insurance carriers who provided coverage to plans and their beneficiaries—it had only an indirect economic influence on the decisions of ERISA plan administrators, whereas the HFA “depletes the Fund's assets directly, and thus has an immediate impact on the operations of an ERISA plan,” NYSA- ILA Medical and Clinical Services Fund v. Axelrod, M. D., 74 F.3d 28, 30 (1996). We granted the New York officials' second petition for certiorari, 519 U.S. 926 (1996), and now reverse.

Id.
126 De Buono 520 U.S. at 812-813.
127 Id. at 813.
In *De Buono* the Supreme Court acknowledged that it was not necessarily relying on an expansive interpretation of ERISA's relate to language in its early preemption cases because the state law in previous opinions presented an unclouded "connection with or reference to ERISA Benefits plans."\(^{128}\)

Although the *De Buono*\(^{129}\) Court suggests that the Supreme Court did not rely on an expansive and literal interpretation of "relate to" in *Shaw*,\(^{130}\) I disagree with the Court because, in a literal sense, the phrases a "connection with" or "reference to" is the functional equivalent of the "relate to" language.\(^{131}\) All three phrases, "connected with", "reference to", and "related to" are fatally flawed attempts to limit ERISA's preemption because omnipresent connections and infinite references "like universal relations stop nowhere."\(^{132}\) The Court in *De Buono*,\(^{133}\) citing *Travelers*,\(^{134}\) wisely conceded that ERISA's expansive "relate to" language did not alter the established presumption that in the absence of explicit language to that effect or conflict with goals "Congress does not intend to supplant state law."\(^{135}\) I believe the "connected with" and "reference to" language is just as problematic as the phrase "relate to" for ERISA preemption purposes and as a result all three phrases fail to overcome the presumption against preemption.

In order to overcome the normal presumption against preemption in ERISA cases, the Supreme Court should abandon its "connected to" test and its "reference to" experiment and return to its traditional field and conflict preemption analysis as strongly recommended by Justices

\(^{128}\) *Id.* at 813 (citing *Shaw*, supra note 4 at 96-97).

\(^{129}\) *Id.*

\(^{130}\) *Id.* at 813 (citing *Shaw*, supra note 4 at 96-97.)

\(^{131}\) *Shaw*, 463 U.S. at 96-97. "A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Id.* at 96-97 (citing and Black's Law Dictionary 1158 (5th ed. 1979) (quoting Black's Law Dictionary "'Relate. To stand in some relation; to have bearing or concern; to pertain; refer; to bring into association with or connection with'") *Id.* at n.16.

\(^{132}\) *De Buono*, 520 U.S. at 813 (quoting H. James, Roderick Hudson xli (New York ed., World's Classics 1980)).

\(^{133}\) *Id.* at 813.

\(^{134}\) *De Buono*, 520 U.S. at 813.

\(^{135}\) *Id.* (citing *Travelers* 514 U.S. at 654.)
Scalia and Ginsburg in *Dillingham*. The Court concludes that HFA is not preempted because it "is one of 'myriad 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." Under a traditional preemption analysis, the Supreme Court could simply find that HFA is not preempted because there is insufficient evidence since Congress intended to prohibit the HFA, a tax revenue, from operation in the field where hospitals are regulated. Under traditional conflict preemption, the Court could candidly hold that HFA is preempted because it does not conflict with any of the goals of the ERISA law. From a conflict preemption perspective, HFA is one of a "myriad state laws of general applicability that impose burdens on the administration of general applicability that impose burdens on the administration of ERISA plans but nevertheless do not" require either conflict preemption or field preemption because they do not have any substantial effect on any relevant federal policy. In my opinion, the HFA is a hospital tax that does not relate to ERISA for preemption purposes because it does not have any substantial effect on any federal interest to overthrow the normal presumption against preemption.

136 *Dillingham*, 519 U.S. at 336 (Scalia, J., Ginsburg, J., concurring).
137 *De Buono*, 520 U.S. at 816.
138 Id. at 814-15.
140 *De Buono*, 520 U.S. at 815-16. "A consideration of the actual operation of the state statute leads us to the conclusion that the HFA is one of "myriad 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. See *Travelers*, 514 U.S. at 668; *Dillingham* 519 U.S. at 333-334." Id.
141 Id. at 816. "Any state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute." Id. "As we acknowledged in *Travelers*, there might be a state law whose economic effects, intentionally or otherwise, were so acute 'as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers' and such a state law 'might
An Analysis of the Fifth Circuit’s Approach to the ERISA Trilogy in Corporate Health Insurance

The Fifth Circuit’s major premise about the Supreme Court’s ERISA trilogy of *Travelers*, *Dillingham*, and *De Buono* is imperfect because it is a highly debatable legal theory for that court to conclude that the trilogy represents a return to traditional preemption analysis. For example, in *Dillingham*, Justice Scalia in a concurring opinion with Justice Ginsburg, stated they believed the Court had abandoned its “relate to” preemption jurisprudence and returned to general rules of field and conflict preemption. While attempting to narrow the scope of ERISA’s relate to preemption rationale, the Supreme Court never expressly rejected its “relate to” preemption in ERISA cases and returned to traditional field/conflict analysis of preemption in all cases impacting employee benefit plans under 29 U.S.C § 1144(a). Unlike the Fifth Circuit, I believe in the trilogy where the Supreme Court expressly resolved whether federal policy interests preempted state law for ERISA purposes by its “relate to” “connect with” “reference to” theory of preemption rather than stating an unequivocal return to traditional implied field/conflict preemption.

This discussion will limit its analysis of ERISA’s “relate to” preemption rationale to the Texas “statute’s independent review of determinations” by HMOs to deny a request for treatment as not medically necessary. The Texas code gives one the right to an independent review of an HMO claim denial in different code sections. Under the Texas civil code patients are required to follow an independent review process before they are permitted to sue an HMO in court. The Texas civil code “allows independent review only of claims for which patients may bring suit under the liability

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142 *Corporate Health*, 215 F.3d 526.
143 *Dillingham* 519 U.S. at 336.
144 *De Buono*, 520 U.S. 806.
146 *Corporate Health* 215 F3d. at 536.
147 *Id.*
148 *Id.* (citing see TEX. CIV. PRAC. & REM. CODE ANN. § 88.003 (Vernon’s 2002)).
provisions. As such, the review provisions are not preempted.\textsuperscript{149} The Fifth Circuit was of the opinion that since the independent review of HMO claim denials under the Texas civil code statute was voluntary for an HMO, an HMO is precluded from alleging that the review provision "is at odds with its duties under ERISA."\textsuperscript{150}

In its insurance code Texas law provides a much more liberal independent review procedure.\textsuperscript{151} The Texas Insurance Code permits patients to appeal "adverse determinations."\textsuperscript{152} An adverse determination under the insurance code was described by the court as "[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."\textsuperscript{153} Under the provisions of the Texas Insurance Code, it is mandatory for the utilization review agent to follow the "independent review organization's determination of medical necessity."\textsuperscript{154} The Fifth Circuit concluded that granting a patient the right to appeal a denial of coverage by an HMO to an independent party is preempted under ERISA.\textsuperscript{155} "Such an attempt to impose a state administrative regime governing coverage determinations is squarely within the ambit of ERISA's preemptive reach."\textsuperscript{156}

The Fifth Circuit rejected the position that the mandatory provision of the Texas independent review law was saved from ERISA

\textsuperscript{149}\textit{Id.}

\textsuperscript{150}\textit{Id.} at 536-37 (citing Tex. Civ. Prac. & Rem. Code § 88.003(a) and (c)).

\textsuperscript{151}\textit{Corporate Health} 215 F3d. at 537. (citing \textit{TEX. INS. CODE} art. 20A.09(e) (codified in 1997 at 20A.09(a)(3)) and 20A.12A (amendments to the Texas Health Maintenance Organization Act); 21.58A § 6(b) and (c) and § 6A (amendments to the Utilization Review Agent Act)). \textit{Id.} at n.38.

\textsuperscript{152}\textit{Id.}

\textsuperscript{153}\textit{Corporate Health} 215 F3d. at 537. (citing \textit{TEX. INS. CODE} art. 20A.12A(a)(1) (codified in 1997 in slightly amended form at 20A.12(c)(1))

\textsuperscript{154}\textit{Id.} (citing \textit{TEX. INS. CODE} art Art. 21.58A § 6A(3)). "The provision refers specifically to 'utilization review agents' for insurers and administrators. HMOs are directed to follow the rules applicable to utilization review agents." \textit{Id.} at n.40.

\textsuperscript{155}\textit{Id.}

\textsuperscript{156}\textit{Id.} "This preemption does not reach three provisions of the Act codified in the Insurance Code which do not create a right to independent review: Tex. Ins. Code art. 21.58C (setting forth general standards and rules for independent review organizations); 21.58A § 8(f) (confidentiality provision); and 20A.12(a) and (b) (making minor changes to preexisting provision)" \textit{Id.} at n. 42.
preemption under the savings clause.\textsuperscript{157} One major federal goal of the savings clause is to allow the states to continue to regulate the insurance industry under the McCarran-Ferguson Act.\textsuperscript{158} Under the Fifth Circuit's analysis, the Texas law providing for independent review of an HMO's medical necessity decision is an exception to ERISA's savings clause because otherwise saved provisions are preempted if they "conflict with a substantive provision of ERISA."\textsuperscript{159} Although the Fifth Circuit appears to concede that the Texas independent review law does not create a substantive cause of action for patients, it unfortunately applies \textit{Pilot Life}'s expansive "relate to"

\begin{footnotes}
\item[157] Id. at 539.
\item[158] \textit{Corporate Health} 215 F3d. at 537. The McCarran-Ferguson Act states, in pertinent part: "The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business." 15 U.S.C. § 1012(a).
\item[159] Id. at 538. (quoting \textit{Pilot Life v. Dedeaux}, 481 U.S. 41, 52 (1987)).

In the present case, moreover, we are obliged in interpreting the saving clause to consider not only the factors by which we were guided in \textit{Metropolitan Life}, but also the role of the saving clause in ERISA as a whole. On numerous occasions we have noted that "[I]n expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy."' \textit{Kelly v. Robinson}, 479 U.S. 36, 43 (1986), quoting \textit{Offshore Logistics, Inc. v. Tallentire}, 477 U.S. 207, 221 (1986) (quoting \textit{Mastro Plastics Corp. v. NLRB}, 350 U.S. 270, 285 (1956) (in turn quoting \textit{United States v. Heirs of Boisdore}, 8 How. 113, 122 (1849))). Because in this case, the state cause of action seeks remedies for the improper processing of a claim for benefits under an ERISA-regulated plan, our understanding of the saving clause must be informed by the legislative intent concerning the civil enforcement provisions provided by ERISA § 502(a), 29 U.S.C. S 1132(a). The Solicitor General, for the United States as amicus curiae, argues that Congress clearly expressed an intent that the civil enforcement provisions of ERISA § 502(a) be the exclusive vehicle for actions by 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. Brief for United States as \textit{Amicus Curiae} 18-19. We agree. The conclusion that § 502(a) was intended to be exclusive is supported, first, by the language and structure of the civil enforcement provisions, and second, by legislative history in which Congress declared that the pre-emptive force of § 502(a) was modeled on the exclusive remedy provided by S 301 of the Labor Management Relations Act, 1947 (LMRA), 61 Stat. 156, 29 U.S.C. § 185."
\item[161] Id. at 51-52.
\end{footnotes}
ERISA preemptive rationale to the procedural review issue presented in Corporate Health Insurance. The Court in Pilot Life stated "that state laws related to ERISA may also fall under the saving clause—was not focused on any particular relationship or conflict between a substantive provision of ERISA and a state law." The Fifth Circuit’s reliance on Pilot Life to support an ERISA “relate to” conflict based preemption is misplaced because the Court in Pilot Life refused to apply ERISA’s savings clause to an employee’s common law tort and contract claims because those claims simply did not regulate insurance under Mississippi law. In Pilot Life, the Supreme Court did not apply ERISA savings clause because of the common sense understanding of the “McCarran-Ferguson Act factors defining the business of insurance” since Mississippi was not regulating insurance when it recognized the plaintiff-employee’s cause of action. The Fifth Circuit rejected the Texas independent review procedure as an unacceptable alternative mechanism because it gave the employees the identical relief offered under 29 § 1132(a)(1)(B) of ERISA.

The Fifth Circuit’s analysis is problematic because ERISA’s exclusive enforcement remedy fails to provide any substantive protection for employee health benefit because Congress did not intend to allow ERISA’s relate to rationale to preempt a state’s traditional role of regulating employee health benefits in the absence of traditional conflict preemption. As Justice Scalia stated in a concurring opinion in Dillingham that ERISA’s “relate to” rationale was not properly understood as a “test for preemption” but the “relate to” threshold was a

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160 Corporate Health, 215 F.3 at 539.
162 Id. at 49. “In the present case, the considerations weighed in Metropolitan Life argue against the assertion that the Mississippi law of bad faith is a state law that ‘regulates insurance.’ As early as 1915 the Mississippi Supreme Court had recognized that punitive damages were available in a contract case when ‘the act or omission constituting the breach of the contract amounts also to the commission of a tort.’ See Hood v. Moffett, 109 Miss. 757, 767, 69 So. 664, 666 (1915) (involving a physician’s breach of a contract to attend to a woman at her approaching ‘accouchement.’)” Id.
163 Id. at 57.
164 See 29 § 1132(a)(1)(B). “A civil action may be brought—by a beneficiary— for the relief 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....”
165 Dillingham, 519 U.S. at 336 (Scalia, J., Ginsburg, J. concurring); See 29 U.S.C. § 1132 to review ERISA enforcement process.
starting point for identifying traditional field/conflict preemption.\textsuperscript{166} The Fifth Circuit's conclusion that the Texas "independent review provisions conflict with ERISA's exclusive remedy and cannot be saved by the saving clause" is not based on solid analysis because of the Fifth Circuit's failure to adequately demonstrate that it was applying traditional conflict preemption principles recommended by Justice Scalia.\textsuperscript{167} The Fifth Circuit's ERISA conflict rationale is not sufficiently supported by its conclusion that the savings clause in \textit{Pilot Life} "[did] not operate if the state law at issue creates an alternative remedy for obtaining benefits under ERISA."\textsuperscript{168} Unlike the Fifth Circuit, I think the rationale for the Court's holding in \textit{Pilot Life} is the simple fact that ERISA's savings clause was not triggered in \textit{Pilot Life} because Mississippi was not regulating insurance.\textsuperscript{169} It is conceded that the alternative remedy served as a basis for ERISA preemption in \textit{Pilot Life}, since the alternate remedy issue was not relevant to the savings clause exception to preemption once the Court determined that the state of Mississippi was not regulating insurance.\textsuperscript{170}

### A BRIEF ANALYSIS OF THE SEVENTH CIRCUIT DECISION IN \textit{MORAN V. RUSH PRUDENTIAL HMO, INC.}

#### Facts

In \textit{Moran v. Rush Prudential},\textsuperscript{171} and under the Illinois HMO Act,\textsuperscript{172} an HMO must comply with a patient's request for "an independent physician review when there is a disagreement over whether a course of treatment is medically necessary between a patient's primary care physician and the HMO."\textsuperscript{173} If the independent reviewer concludes that the treatment is necessary, the HMO is obligated to pay for the

\textsuperscript{166}Id. at 336 (Scalia, J., Ginsburg, J. concurring).
\textsuperscript{167}Id.
\textsuperscript{168}Corporate Health, 215 F.3d at 539.
\textsuperscript{169}Pilot Life, 481 U.S. at 49.
\textsuperscript{170}Id. at 41.
\textsuperscript{171}Moran, 230 F.3d at 962.
\textsuperscript{172}Id. (citing Section 4-10 of Illinois' Health Maintenance Organization Act ("the HMO Act"), 215 ILL. COMP. STAT. ANN. 125/1-1 et seq.).
\textsuperscript{173}Id.
treatment under the Illinois HMO Act.\textsuperscript{174} Debra Moran, the plaintiff/appellant was insured by a medical benefits plan offered by her spouse's employer.\textsuperscript{175} Her rights under the fully insured health care plan presented issues to be decided under ERISA.\textsuperscript{176} Rush, the defendant/appellee was the HMO provider for this employee benefit plan.\textsuperscript{177} The plan granted Rush "the broadest possible discretion...to determine which benefits the participants are entitled to receive."\textsuperscript{178} The plan's member certificate informed those insured under the plan that Rush would not pay for those treatments deemed not "medically necessary".\textsuperscript{179}

Ms. Moran's primary care doctor and a Rush-affiliated physician, Dr. Arthur LaMarre, requested that Rush authorize Dr. Terzis, an out of the network surgeon, to perform microneurolysis surgery on Ms. Moran.\textsuperscript{180} In a letter, Dr. LaMarre advised Rush that his patient, Ms. Moran, would be "best served" by having Dr. Terzis perform a complicated microneurolysis surgery.\textsuperscript{181} Rush rejected Dr. LaMarre's advice for his patient and denied coverage for the microneurolysis surgery.\textsuperscript{182}

In a letter to Ms. Moran, Rush responded that its reasons for denying coverage for Dr. Terzis' proposed surgery was because it was not medically necessary under the plan.\textsuperscript{183} After denying coverage for the proposed microneurolysis surgery, Rush further responded that it would only cover the standard, less complicated, TOS surgery by a network surgeon.\textsuperscript{184} After rejecting Rush's offer for the standard surgery, Ms. Moran presented an appeal to Rush's Membership Advisory Committee that was unsuccessful because the committee affirmed Rush's denial of her claim.\textsuperscript{185} "In February 1998, Dr. Terzis

\textsuperscript{174} Id.
\textsuperscript{175} Id.
\textsuperscript{176} Moran, 230 F.3d at 962.
\textsuperscript{177} Id.
\textsuperscript{178} Id.
\textsuperscript{179} Id.
\textsuperscript{180} Id. at 963.
\textsuperscript{181} Moran, 230 F.3d at 963
\textsuperscript{182} Id.
\textsuperscript{183} Id. at 963-64.
\textsuperscript{184} Moran, 230 F.3d at 964.
\textsuperscript{185} Id.
performed the microneurolysis surgery on Ms. Moran. The surgery took nearly 14 hours with a postoperative care cost of $94,841.27. Ms. Moran paid for the surgery herself."

In January 1998, prior to her microneurolysis surgery, Ms. Moran asked Rush to adhere to the requirements of § 4-10 of the HMO Act. Section 4-10 of the HMO Act requires the HMO to establish a procedure “for a review by an independent physician when the patient’s primary care physician and HMO disagree about the medical necessity of a treatment proposed by the primary care physician.” Under Section 4-10 of the HMO Act an HMO is obligated to provide the proposed treatment if the reviewing physician determines that the proposed treatment is medically necessary. After Rush failed to act on Ms. Moran's request for it to obey the requirements of section 4-10 of the HMO Act she filed a complaint in Illinois circuit court requesting an independent physician to review the denial of her claim for microneurolysis surgery.

Rush was successful in having Ms. Moran’s state court claim for independent review removed to federal district court on an ERISA preemption theory. Following extended procedural litigation, as well as a remand to state court and another removal by Rush, the district court granted summary judgment to Rush. The district court decided that Ms. Moran’s § 4-10 claim of the HMO Act was preempted by ERISA. The federal district court affirmed Rush's decision to deny Ms. Moran request for the microneurolysis surgery. Ms. Moran filed an appeal with the United States Court of Appeals for the Seventh Circuit to challenge the decision of the district court. The Seventh Circuit reversed.

\[186\] Id.
\[187\] Id. (see 215 ILL. COMP. STAT. ANN. 125/4-10).
\[188\] Id.
\[189\] Moran, 230 F.3d at 964.
\[190\] Id.
\[191\] Id. at 964-66
\[192\] Id. at 965
\[193\] Id. at 966
\[194\] Moran, 230 F.3d at 959.
\[195\] Id.
Brief Analysis of the Right to Independent Review and ERISA's
Saving Clause

The Seventh Circuit uses the 29 U.S.C. §1144(a) "relate to" theory to
decide whether § 4-10 of the Illinois HMO Act is preempted.196 Under
the relate to preemption theory, the Seventh Circuit concludes that § 4-
10 of the HMO "relates to" ERISA plans because its provisions have a
connection with such plans."197 Because § 4-10 of the Illinois HMO
Act creates uncertainty for ERISA plan administrators about possible
conflicting state legal requirements, the HMO Act is connected with the
ERISA plan.198 Any state law that is connected to an ERISA plan is
automatically deemed to relate to the plan based on 29 U.S.C. § 1144(a)
preemption rationale.199 Under § 4-10 all HMOs are required to furnish
an independent review process and to pay a disputed claim if the
independent reviewer agrees with the primary care physician's
determination that the procedure is medically necessary.200 Since § 4-10
of the HMO Act dictates that an HMO provide an employee a benefit of

196Id. at 968.
197Moran, 230 F.3d at 959.

To determine whether § 4-10 of the HMO Act 'relates to' ERISA plans, we
begin by looking at the state statute. Section 4-10 provides, in relevant
part: Each Health Maintenance Organization shall provide a mechanism for
the timely review by a physician holding the same class of license as the
primary care physician, who is unaffiliated with the Health Maintenance
Organization, jointly selected by the patient (or the patient's next of kin or
legal representative if the patient is unable to act for himself), primary care
physician and the Health Maintenance Organization in the event of a
dispute between the primary care physician and the Health Maintenance
Organization regarding the medical necessity of a covered service proposed
by a primary care physician. In the event that the reviewing physician
determines the covered service to be medically necessary, the Health
Maintenance Organization shall provide the covered service. 215 ILL.
COMP. STAT. ANN. 125/4-10. From the text of the HMO Act it is
apparent that the law does not make 'reference to' an ERISA-governed
employee benefit plan; no mention is made of ERISA plans, and the law
applies to HMOs regardless of whether a patient's coverage is through an
ERISA plan. Cf. Travelers, 514 U.S. at 656 (noting that the law in
question in that case did not make 'reference to' ERISA plans because the
law's provisions applied regardless of whether the coverage was 'secured
by an ERISA plan, private purchase, or otherwise').

Id.
198Id. at 968-969. (citing FMC Corp. v. Holliday, 498 U.S. 52, 59 (1990).
199Dillingham, 519 U.S. at 324.
200Moran, 230 F.3d at 969.
independent review, it is in reach of ERISA's relate to preemption theory.\textsuperscript{201}

In \textit{UNUM Life Insurance Co. v. Ward}, the plaintiff John E. Ward filed suit because he was denied disability benefits under an insurance policy controlled by ERISA and issued by defendant UNUM Life Insurance Company of America (UNUM).\textsuperscript{202} Because Plaintiff Ward sent proof of his claim to UNUM after the time limit set in the policy had expired the defendant UNUM rejected his claim.\textsuperscript{203} In \textit{Ward} the California's "notice-prejudice" rule stated that an insurer cannot avoid liability simply by proof of an untimely claim unless the insurer demonstrates that it was prejudiced by the delay.\textsuperscript{204} The Supreme Court in \textit{Ward} held that California's notice-prejudice rule was saved from ERISA preemption because under California law the notice-prejudice rule was a regulation of insurance.\textsuperscript{205} The Seventh Circuit relying on \textit{Ward} held that a state law that "relates to" an ERISA plan may avoid preemption provided that the law regulates insurance as defined in ERISA's savings clause, 29 U.S.C. § 1144(b)(2)(A).\textsuperscript{206} After evaluating the three McCarran-Ferguson factors the Seventh Circuit concluded § 4-10 qualified for the ERISA savings clause because it regulated insurance based on a common sense application of the

\textsuperscript{201}Id.
\textsuperscript{203}Id. at 363.
\textsuperscript{204}Id. at 364 (quoting Ward v. Management Analysis Co. Employee Disability Benefit Plan, 135 F.3d 1275,1280 (1998)).
\textsuperscript{205}Id.
\textsuperscript{206}Moran, 230 F.3d at 969.

To determine whether a state law 'regulates insurance' within the meaning of the saving clause, we first ask 'whether, from a "common-sense view of the matter,"' the contested prescription regulates insurance.' Next, we consider 'three factors employed to determine whether the regulation fits within the "business of insurance" as that phrase is used in the McCarran-Ferguson Act.' Of these three factors, the first is 'whether the practice has the effect of transferring or spreading a policyholder's risk.' The second factor is 'whether the practice is an integral part of the policy relationship between the insurer and the insured.' And the third is 'whether the practice is limited to entities within the insurance industry.' A state law may fall within the saving clause even if it cannot satisfy all three of the McCarran-Ferguson factors.'

\textit{Id.} at 969. (citations omitted).
relevant factors. Section 4-10 of the HMO Act meets two McCarran-Ferguson factors because under Illinois law the HMO Act is (1) an "integral part" of the relationship between the insured and insurer, and (2) the law is said to be limited to the insurance industry because it only applies to HMOs acting as insurers.

Brief Discussion of When ERISA's Saving Clause Fails to Save a State Law from Preemption

Although § 4-10 of the HMO Act as an insurance regulation would normally be protected by ERISA's saving clause the Act is subject to preemption if the law conflicts with a substantive provision of ERISA. Rush tried unsuccessfully to convince the Seventh Circuit that § 4-10 of the Illinois HMO Act was preempted because it conflicted with 29 U.S.C. § 1132(a)(1)(B) civil enforcement scheme.

The Seventh Circuit agreed with Rush that the Fifth Circuit recently analyzed "an independent review statute from Texas that is quite similar to § 4-10 of the Illinois' HMO Act." The Fifth and Seventh

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207 Moran, 230 F.3d at 969.
208 Id.

"It is fundamental insurance law that "existing and valid statutory provisions enter into and form a part of all contracts of insurance to which they are applicable, and, together with settled judicial constructions thereof, become a part of the contract as much as if they were actually incorporated therein."

Plumb, 124 F.3d at 861 (quoting 2 Lee R. Russ & Thomas F. Segalla, Couch on Insurance 3d § 19:1, at 19-2 to 19- 4 (1996)). The provisions of § 4-10 of the HMO Act, therefore, are substantive terms of all insurance policies in Illinois by operation of law. When a law mandates a contract term between parties, whether that term is characterized as creating a 'procedural' or 'substantive' right, that law is 'integral' to the insurer/insured relationship."

Id. at 969.
209 Id. at 969.
210 Id. at 970 (citing Pilot Life, 481 U.S. at 157.)
211 Id.
212 Moran, 230 F.3d at 970.

The Texas independent review statute, like § 4-10 of the HMO Act, essentially 'allow[s] a patient who has been denied coverage to appeal to an outside organization.' Id. at 537. The law requires HMOs to provide a mechanism for patients to obtain an independent review of the need for a course of treatment. Specifically, the court explained, the Texas statute states that patients may appeal "adverse determinations," which are defined as determinations that a health care service is not 'medically necessary' or
Circuits drew very different conclusions about a patient’s right to independent review under comparable statutes. The Seventh Circuit believed the Fifth Circuit’s rationale for holding that the Texas independent review law was preempted because the law created an impermissible alternative state remedy for enforcing ERISA plan benefits that conflicted with ERISA’s exclusive federal remedy under 29 U.S.C. § 1132(a) for enforcing ERISA plan benefits. Their colleagues in the Fifth Circuit apparently believed that the Texas independent review law was a state regime for reviewing ERISA plan benefits claims on the issue of medical necessity and not a plan for establishing the required terms of an insurance contract, according to the Seventh Circuit.

After discussing the Fifth Circuit’s approach to the Texas independent review law, the Seventh Circuit stated “§ 4-10 of the Illinois HMO Act cannot be characterized as creating an alternative remedy scheme that conflicts with § 502(a). The independent review scheme created by the Illinois statute is not tantamount to the relief offered under § 502(a)(1)(B). …[T]he provisions of § 4-10 of the HMO Act have been incorporated into Ms. Moran’s insurance contract.” In my opinion the Seventh Circuit is correct in stating the purpose of § 4-10 of the HMO Act is not to conflict with federal policy of an exclusive federal ERISA remedy. Section 4-10 candidly requires each HMO in Illinois regulated by insurance under the McCarran-Ferguson factors to give each patient the substantive right to an independent review on the issue of medical necessity when there is a dispute

\[\text{appropriate, }\] to an independent reviewer. \textit{Id.} (quotation marks and citations omitted). Moreover, under the Texas statute, the HMO must ‘comply’ with the independent reviewer's determination of medical necessity. \textit{Id.} (quotation marks and citation omitted)."

\textit{Id.} at 970-71.

\textit{Moran}, 230 F.3d at 971.

\textit{id.}

\textit{id.} (citing Corporate Health Ins., Co. v. Texas Dept' of Ins., 220 F.3d 641, 644 (5th Cir.2000) (petition for rehearing denied at 220 F.3d. 644).

\textit{id.} at 971.

\textit{Id.} at 971.

\textit{215} ILL. COMP. STAT. ANN. 125/1-1 et seq.). Section 4-10 of Illinois' Health Maintenance Organization Act ("the HMO Act").

between the primary care physician and the patient’s HMO.\textsuperscript{220} Ms. Moran’s lawsuit should not be preempted on the procedural misunderstanding that she is seeking to enforce a substantive right different from that provided under ERISA’s enforcement provisions.\textsuperscript{221} Ms. Moran’s lawsuit properly understood is simply a painful attempt "to enforce rights" and "to recover benefits" under ERISA’s enforcement provisions of 29 U.S.C. § 1132(a)(1)(B).\textsuperscript{222}

The Seventh Circuit’s analysis of the relevant Supreme Court precedent support its conclusion that § 4-10 of the HMO Act is an insurance contract requirement for HMOs providing insurance benefits in Illinois and is saved from ERISA preemption because the HMO Act regulates insurance.\textsuperscript{223} The Supreme Court’s decision in \textit{Pilot Life}\textsuperscript{224} does not apply to the Illinois HMO law because unlike the Mississippi law that did not regulate insurance the Illinois law actually regulates insurance.\textsuperscript{225} It is precisely because HMOs like Rush desire to act as unregulated insurers when they deny their patients the right to an independent review of an insurance benefit deemed medically necessary that Rush has challenged the HMO Act.\textsuperscript{226} Ms. Moran is simply fighting with Rush, an insurance company, about a denied insurance benefit sponsored by her employer. The power reserved to the states under the Tenth Amendment\textsuperscript{227} allows Illinois to grant its insured citizen employees a right to have an internal dispute concerning medical necessity between the HMO and the HMO’s physician, resolved by an independent medical expert.\textsuperscript{228}

\textsuperscript{220}Moran, 230 F.3d at 971.
\textsuperscript{221}Id. at 971-972.
\textsuperscript{222}Id. "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."Id.
\textsuperscript{223}Id. at 972.
\textsuperscript{224}Pilot Life, 481 U.S. at 49.
\textsuperscript{225}Moran, 230 F.3d at 971
\textsuperscript{226}Id. at 959.
\textsuperscript{227}U.S. CONST. amend X, supra note 79.
\textsuperscript{228}Moran, 230 F.3d at 959.
In the *Moran v. Rush* decision the Seventh Circuit reached the right result under ERISA's flawed expansive "relate to" preemption theory articulated by the Court in *Shaw v. Delta Airlines, Inc.*, by holding that it was exempted from the "relate to" preemption under ERISA's saving clause because the Illinois HMO Act regulated insurance. The Seventh Circuit's rationale for upholding the Illinois HMO law is much stronger if the Seventh Circuit articulates that the HMO Act is truly exempted from preemption because of the lack of implied field and conflict preemption by Congress. It is proper for the Seventh Circuit to acknowledge ERISA's "relate to" jurisprudence, but in legal reality "relate to" is not a separate test for preemption, according to the accurate observations of Justices Scalia and Ginsburg. Properly understood, "relate to" is a factor to help the court consider whether the ordinary implied field or conflict preemption test applies to § 4-10 of the Illinois HMO Act. The Seventh Circuit could have help clarify ERISA jurisprudence by holding that since Congress has not expressly or implicitly preempted state laws regulating traditional insurance contracts incidentally involving employer sponsored health plans, the express federal power given to states to regulate insurance precludes preemption.

There is no Congressional intent to override its grant of power to the states to regulate insurance under McCarran–Ferguson because of a

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229 *Id.*
230 *Shaw*, 463 U.S. at 85.
231 *Id.*
232 L. Darnell Weeden, *An HMO Does Not Owe An ERISA Fiduciary Duty To Its Employee Beneficiaries: After Pegram v.Herdrich, Who Will Speak For The Working Class?*, 23 W. New Eng. L. Rev. 381, 397 (2002). "Jacobson and Pomfret make an insightful and convincing argument that the Supreme Court has committed significant error by 'its misinterpretation of ERISA's legislative history' in its preemption theory. They argue that the Court's treatment of ERISA's preemptive legislative history is flawed for three reasons: (1) failure to consider ERISA's broad purposes, (2) failure to limit ERISA's preemption clause to ordinary field and conflict preemption, and (3) mischaracterization of ERISA as an 'intricate, comprehensive statute.' *Id.* (footnotes omitted).
233 *Dillingham*, 595 U.S. at 336 (Scalia, J., Ginsburg, J. concurring).
234 *Id.*
general conflict with ERISA.\textsuperscript{236} In the absence of a congressional desire to occupy the insurance field in the managed care industry, this court will not preempt a state insurance law requiring an independent review of disputes between an HMO and its insured.\textsuperscript{237} In \textit{Moran v. Rush} the Seventh Circuit's chief role was to determine whether under the facts of the case, § 4-10 of the Illinois HMO Act "was an obstacle to the accomplishment and execution of the full purposes and objectives of Congress' goals" for ERISA under traditional field and conflict preemption.\textsuperscript{238}

Because of the lack of evidence of implicit traditional field/conflict preemption the Court should not allow hypothetical ERISA's "relate to" preemption theories to reject the considered judgment of "at least 38\textsuperscript{239} states that provide patients with the right to an external review based on a medical claim denial. The Supreme Court should avoid holding unconstitutional the patient rights laws of more than three-fourth of the states granting "disgruntled patients a right to appeal to a state board of physicians if their HMO has refused to pay for medical treatment. If the board rules the medical treatment was needed, it can force the HMO to pay for it."\textsuperscript{240} The right of independent external review of a denial of a medically necessary treatment is too important for the Supreme Court to take away from the great majority of American states without express congressional preemption. Before the Seventh Circuit in \textit{Moran v. Rush},\textsuperscript{241} the HMO insurance company failed its basic traditional required duty to even meet the ordinary garden-variety field/conflict preemption.\textsuperscript{242}

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\textsuperscript{236}Hines v. Davidowitz, 312 U.S. 52 at 67.
\textsuperscript{237}Id.
\textsuperscript{238}Id.
\textsuperscript{240}Id. at *32.
\textsuperscript{241}\textit{Moran}, 230 F.3d at 959.
\textsuperscript{242}\textit{Dillingham}, U.S. 519 at 336 (Scalia, J., Ginsburg, J. concurring).
It was my original hope that I would be able to reach a very definite conclusion about how the Supreme Court would likely resolve the issues presented in *Rush Prudential HMO, Inc. v. Moran*243 after writing parts I and II of this article and then reading the transcript. I must admit that I am not able to predict in any clear and convincing way what the Court’s ultimate rationale will be for its results in this case, but I am persuaded that the Court will affirm the decision of the Seventh Circuit. Now, the $64,000 question is why I think the Court will affirm the decision of the lower appellate court. What you are reading below are some of my reactions to reading the transcript of the oral argument.244

As stated at oral argument by Mr. Roberts counsel for petitioner/defendant Rush, some ERISA cases are “exceedingly complicated.”245 I agree with Mr. Roberts’ conclusion that this case is not a complicated one under the rationale of *Pilot Life*, but my rationale for conceding that this case is not complicated under *Pilot Life* is contrary to Mr. Roberts. Mr. Roberts told the Court that *Pilot Life* held “that ERISA's civil enforcement provisions were the exclusive remedy for improper processing of a claim for benefits under an ERISA-regulated plan. The Illinois independent external review law at issue in this case affords a different remedy for a beneficiary dissatisfied with an HMO's denial of benefits. The Illinois law is therefore preempted.”246 Mr. Roberts argument for ERISA exclusive preemption is seriously incoherent with traditional conflict/field preemption law. The exclusive civil remedy theory in processing ERISA claims is not automatically triggered under *Pilot Life* as Mr. Roberts appears to suggest. Under either the expansive ERISA relate to preemption or traditional conflict/field preemption, ERISA’s preemption is triggered by a demonstrated conflict in the

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244 *Id.*

245 *Id.* *3.*

246 *Id.*
proposed remedies. There is no demonstrated implied conflict between § 4-10 of the Illinois HMO Act and the congressional goal of ensuring that employees obtain employer sponsored health insurance benefits in a federal forum because the state is simply providing employees with a mandated insurance benefit through its insurance regulations. *Pilot Life* is distinguishable from the instant case because Mississippi, unlike Illinois, was not regulating insurance and the only way to enforce the remedy in *Pilot Life* was through causes of actions that did not qualify as regulating insurance under relevant state and federal law. The dissenting opinion before the Seventh Circuit in *Moran v. Rush* took the view that Illinois was neither regulating insurance nor following the proper procedure to secure entitlements under ERISA plans.\(^\text{247}\)

It may be stated under *Pilot Life* that improper claims for ERISA benefits are likely to conflict with ERISA’s exclusive enforcement provisions and therefore are equally likely to be preempted. However one does not improperly process a claim under ERISA for preemption

\(^{247}\text{Moran 230 F.3d at 973-974 (Posner, with whom Coffey, Easterbrook, and Wood join dissenting).}\)

The law in this case, like the materially identical law held preempted by the Fifth Circuit, is not a general regulation of insurance, or even of health insurance; it is a regulation of HMOs, which are the service providers under a great many ERISA medical-benefits plans. The law establishes a system of appellate review of benefits decisions that is distinct from the provision in ERISA for suits in federal court to enforce entitlements conferred by ERISA plans. 29 U.S.C. § 1132(a)(1)(B). By doing so, the law interferes with the federally specified system for enforcing such entitlements. The suit for breach of contract envisaged by the statute becomes a suit for judicial review of the independent physician’s decision. The Illinois law thus adds heavy new procedural burdens to ERISA plans. These burdens do not come without cost. The expense of an arbitration by the independent physician could easily equal the expense of the medical treatment that the HMO had refused to authorize. Piling on costs in the administration of ERISA plans will shrink benefits and deter some employers from offering health insurance at all. In addition, the Illinois law obviously is intended (responding to the recent torrent of criticisms of HMOs) to tilt the administration of those plans in favor of participants by giving them an additional remedy while not giving any additional remedy to the plan. The law undermines the statutory purpose of federal uniformity in the administration of ERISA plans. If such laws are permissible, the rights of participants in an ERISA plan will change as they are transferred by their employer from state to state, even though they are nominally under the same plan.”

*Id.*
purposes by simply enforcing a mandated insurance benefit under state law in federal court. When an employee seeks to enforce a state mandated insurance benefit provided by his employer in federal court, he/she is only attempting to use a state procedural device to enforce her federal interest in making sure that her employment benefits are neither undermined nor denied. The verb "readjust"248 is an appropriate characterization of the noun remedy249 in this situation because all § 4-10 of the Illinois law did was mandate an HMO insurer to submit a medical necessity dispute between the primary care physician and the HMO insurer for adjustment. When the medical necessity for external review issue is processed for review, the HMO insurer is required to follow the recommendation of the reviewer only in those limited circumstances where the external reviewer agrees with the primary care physician. When the external reviewer agrees with the recommendation of the HMOs primary care physician on the issue of medical necessity, § 4-10 of the Illinois HMO law only mandates that the HMO insurer internally readjust its medical necessity determination and follow the recommendation of an external reviewer. If the HMO fails to follow the internal readjustments recommended by the external reviewer under § 4-10, then a person may sue the HMO for "breach of contract as envisaged by the statute"250 (29 U.S.C. S 1132(a)(1)(B)) for its failure to honor its contractual obligation to treat those conditions deemed medically necessary under state law.

Throughout the oral argument, the Supreme Court appeared to be unnecessarily preoccupied with the issue of whether § 4-10 of the HMO law and the external review provision in effect creates some type of arbitration process. For example, the Court addressed the following question to Mr. Albers, counsel for the respondent/plaintiff Moran.

"QUESTION: ...In other words, what can you tell me about the terms [where] the reviewer acts and says this is, and in part at least, or ultimately, an independent decision by the reviewer about medical necessity as opposed to an adjudication of which side has the better claim, which an arbitrator might make?"251

249Id. "Remedy the means by which a right is enforced." Id.
250Moran, 230 F.2d at 973.
2512002 WL 63589 *22 for transcript in Rush Prudential HMO, Inc. v. Moran.
The true public policy goal of § 4-10 of the HMO law in granting a right to external review is not to create a system of arbitration, but to readjust the contractual bargaining power benefit between health insurance and health care consumers. Mr. Albers, responding to a question from the Court says, “This law § 4-10 is limited to the insurance industry. It's limited to HMO's when they bear risk. It does transfer risk by the very operation of the statute. The Seventh Circuit and the Fifth Circuit agree that this is a statute [an external review law] which regulates insurance.”

CONCLUSION

During oral argument the Court presented the following to counsel for the petitioner defendant, Mr. Roberts: “Well, we had a case, *U-N-U-M v. Ward*, and held that any statute that effectively creates a mandatory contract term and regulates only insurance companies is an insurance law under the Savings Clause.” I believe at the end of this ERISA day the Supreme Court will probably conclude that § 4-10 of the Illinois HMO Act is not preempted by ERISA because it regulates insurance and that external review provision does not conflict with ERISA enforcement provision by readjusting the internal processing of benefits. The Supreme Court should affirm the decision of the Seventh Circuit in *Moran v. Rush* and I am predicting it shall find the Illinois external review law is not preempted. I hope the Court will take this opportunity to state that ERISA preemption must meet the standard of ordinary field/conflict preemption in order to be valid.

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252*Id.* at *28.
253*Id.* at *8.