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BNA, Inc.

Health Plan & Provider REPORT

Volume 8 Number 28
Wednesday, July 10, 2002
ISSN 1528-9435

Analysis & Perspective

U.S. Supreme Court

ERISA 'Root Bound' in the States' Garden: Highlights of Rush Prudential HMO, Inc. v. Moran

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The U.S. Supreme Court's June 20 closely divided 5-to-4 opinion upholding the U.S. Court of Appeals for the Seventh Circuit in *Rush Prudential HMO, Inc. v. Moran* (*Rush Prudential*) can be read to generally maintain current practice for independent review rights with respect to participants enrolled in state regulated group health plan insurance arrangements.

The Supreme Court held that the Illinois independent review law was "saved" from Employee Retirement Income Security Act preemption because it was "garden variety insurance regulation" that merely mandated a "second opinion" in the case of benefit denials, and did not supplement or supplant the remedies afforded to employer-provided benefit plan participants under federal law pursuant to the civil enforcement provisions of section 502 of ERISA.

Broadens the Regulatory Differences Between Insured and Self-Insured ERISA Plans

The Supreme Court confirmed that *insured* ERISA plans are subject to state independent review laws *similar to* the Illinois independent review law. The application of the opinion is viewed as limited to "insured" arrangements because: the Illinois independent review law was determined to be "insurance regulation"; the opinion compared the Illinois independent review law to a state law "benefit mandate" that is permitted only as "insurance regulation"; and the opinion acknowledges that ERISA's "deemer" clause provides an exception to the insurance "savings" clause that forbids states from regulating self-funded plans as insurers.

Forty-one states and the District of Columbia have enacted laws providing "covered persons" or "enrollees" of health plans with mechanisms for external review of benefit denials made by managed care plans. These state laws vary greatly, for example, with respect to the types of denials that are subject to external review, the composition of independent review panels, the nature of external review determinations as binding on the health plan, the treatment of emergency care, the application of the terms and conditions of the insurance contract to the independent review, state control of the choice of review entity, and other factors.

Because the *Rush Prudential* opinion is specific to the structure of the Illinois law, other state independent review laws must be carefully reviewed.

Illinois Independent Review Is Permissible 'Garden Variety' State Benefit Mandate

Although the majority opinion in *Rush Prudential* basically "blessed" current law, the high court went beyond the rationale relied upon by the Seventh Circuit in a manner that raises serious concerns about future and expansive "benefit mandate" regulation by the states. Interestingly, however, the majority opinion notes that the Illinois independent review law does not appear to require the reviewer to reference the plan's definition of "medical necessity," but *assumes* that some degree of contract interpretation is required under the law.

Importantly, the Illinois law might not be characterized as a "mandated benefit" law and thus "saved" if no interpretation were required. Citing the high court's prior decision in *SEC v. National Securities, Inc.*, the majority underscores that the fundamental principle of "insurance

regulation" is the interpretation of insurance contracts, which is at the "core" of the business of insurance. The Illinois independent review law is incorporated as part of the insurance contract only by "operation of law" and not as a textual component of the contract itself. A question arises in the case of a state independent review law that defines "medical necessity" in a manner that is different from the contract term.

The majority opinion's introduction of the concept that independent review is merely another "garden variety insurance regulation" is somewhat novel. This is because the typical "species" of state benefit mandates have consisted mainly of requirements that certain medical items and services be "covered" and paid for by the insurance plan, or that certain medical "providers" must be included in the insurer's network. This expansion can be expected to encourage aggressive state regulatory activity with respect to imposing other new types of procedural "benefit mandates" on *insured* ERISA arrangements that will encourage more litigation in this area.

ERISA's Civil Enforcement Provisions Remain As the Exclusive Remedy

The majority opinion reaffirms that ERISA's civil enforcement remedies under section 502 are exclusive with respect to group health plan benefit disputes and have such preemptive force as to override ERISA's express savings clause for insurance regulation. Citing the high court's prior decision in *Pilot Life Insurance Company v. Dedeaux*, the majority opinion in *Rush Prudential* concluded that the Illinois independent review law was "saved" from preemption because it was not incompatible with ERISA's enforcement scheme and did not allow plan participants to obtain remedies that the Congress rejected in ERISA. The Supreme Court did not appear to find it important that the independent reviewer's decision was "binding" on the insurer and thus on the employee benefit plan.

The majority opinion concluded that the Illinois independent review law did not enlarge the claim for benefits beyond the benefits available in any action brought under ERISA's civil enforcement provisions. Even though the independent reviewer would replace the ERISA plan's determination of "medical necessity" with a binding determination, the relief ultimately available to the claimant would remain subject to the relief authorized by ERISA's section 502. The court observed that the procedure set forth in the Illinois independent review law did not fall

within the parameters of *Pilot Life* because it did not provide a form of ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA.

Arbitration-Like Independent Review Laws May Be Preempted by ERISA

The majority opinion found that the Illinois independent review law was not "common arbitration" and so did not violate the exclusive remedies of ERISA's civil enforcement scheme. However, the court did speculate that a state might provide for a type of independent reviewthat would so resemble an adjudication as to supplant judicial enforcement and fall within *Pilot Life's* bar. The Illinois independent review law was "saved" because it was removed from any notion of an enforcement scheme, and did not expand "adjudication" beyond the Courts so as to establish alternative remedies.

The Supreme Court's opinion, however, appears to ignore the "binding" nature of the independent reviewer's decision. Failure to follow the reviewer's determination would weigh heavily against the plan in any subsequent lawsuit. Thus, the reviewer's decree would appear to "settle" the benefit dispute for all practical purposes.

The Illinois law is viewed by the majority as a second-opinion practice that is designed to ensure sound medical judgments, and it is not like "common arbitration". The Illinois law was found not to give the independent reviewer "free ranging" power to construe contract terms but was limited to "medical necessity" determinations. In addition, the reviewer did not hold the kind of conventional evidentiary hearing that is common in arbitration. Instead, the Court found that the independent reviewer simply received medical records from the parties and made an independent professional judgment.

Administrative Services Only Are Not Subject to Illinois Independent Review Law

The majority opinion characterized as "implausible" the hypothesis that the Illinois independent review law would apply to and bind the "pure administrator." This is because the majority opinion relies on the provisions of the Illinois independent review law that "assumes" the

HMO that is subject to the law is a "provider" and not a "mere arranger." The majority opinion concludes that the Illinois law requires that the subject HMO must "provide" the covered service if the independent reviewer finds it to be "medically necessary" and so would not cover a "non-insurer" administrator and thus run afoul of the insurance savings clause.

It is unclear how the majority opinion uses the term "provider" and "provides" in its review of the Illinois independent review law. In a technical sense, it is the treating physician that is the "provider" and who, for example, "provides" the medical service unless the HMO is a staff model arrangement. Most HMOs are more properly characterized as providing "coverage and payment" for the medical items services of medical providers. The Illinois law appears to mean that the HMO must "provide" the health care "plan"; however, this concept is not clearly defined in either the state law or the court's majority opinion.

Furthermore, the majority opinion confuses matters by stating that HMOs acting as "pure administrators" or as a "matchmaking" HMO (one that provides administrative services to self-funded plans and also access to networks of affiliated physicians) would be considered an "entity within the insurance industry" for purposes of applying one or more of the three McCarran-Ferguson "factors" to determine whether a state law regulates the business of insurance. One of those "factors" requires that a permissible state insurance law to be targeted or limited to "entities within" the insurance industry.

Thus, the Court concludes that a "matchmaking" HMO is an "entity" within the insurance industry that could be subject to "insurance" regulation but did not appear to fall within the scope of the Illinois independent review law. As a result, this discussion in the majority opinion will likely encourage additional state regulatory activity aimed at "pure administrators" that will surely spawn more of the ERISA controversies which the opinion's author, Justice David H. Souter, appears to lament as occupying "a substantial share of this Court's time."

The Court goes on to make a distinction between an HMO and "the employee benefit plan" itself, declaring that the Illinois independent review law applies only to the HMO and not "the plan." Therefore, the Court concludes, the state law is not likely to impose differing burdens on plan administrators and so, does not violate ERISA's purpose to provide for uniform plan administration. This conclusion fails to

appreciate the real world arrangement of employer-provided group health plans.

ERISA Claims Procedure Requirements May Have Preemptive Force

The majority opinion notes that the decision in *Rush Prudential* does not address the issue of whether ERISA's claims procedure rules under section 503 carry the same preemptive force as the remedies provisions of section 502.

Arguably, because ERISA's section 503 claims procedure requirements have been read to require the exhaustion of the internal appeals process before the remedies under section 502 may be invoked, the claims procedures are an "interlocking, interrelated, and interdependent" part of ERISA's exclusive remedial scheme. State independent review laws interfere and conflict with ERISA's public policy purpose to balance the need for prompt and fair "claims settlement" procedures against the public interest of encouraging the formulation of employee benefit plans.

The *Rush Prudential* Court appears also to narrow the reach of *Pilot Life* in that the "conflict" preemption result of that decision does not stand for a broader principle that substantive conflicts with any other provision of ERISA is preempted. According to the *Rush Prudential* majority, *Pilot Life* can only be read as interpreting the preemptive force of the civil enforcement provisions of section 502. But this Souter opinion appears to forget the Souter opinion in *New York State Conference of Blue Cross & Blue Shield v. Travelers Insurance Company,* that the basic thrust of the preemption clause was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans. *See also, Egelhoff v. Egelhoff.*

The majority goes on to muse an answer to its note that the majority opinion is not asked to consider the preemptive force of section 503, and speculates that there appears to be no "conflict" between the Illinois independent review law and the requirement that plans must provide for an internal appeals process of benefit denials. This is because, the Court notes, the Illinois law only requires "extra review" once the plan's internal process is completed. Additionally, the Court concludes that there is no conflict in removing fiduciary "discretion" by

imposing the independent reviewer's binding decision on the plan. This is because, the Court notes, ERISA does not require that such decisions be "discretionary," and that plan terms alone cannot displace the savings clause.

The majority opinion's musing, however, ignores authorities previously cited in the opinion with respect to the possible preemptive force of other substantive ERISA provisions under the "Supremacy Clause." Again reiterating *Pilot Life,* the Supreme Court describes ERISA's remedies provisions as an "interlocking, interrelated, and interdependent remedial scheme" that represented a "careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." Based upon that stated public policy purpose, the Supreme Court held that the civil enforcement provisions are of such extraordinary preemptive power that they override the insurance savings clause of ERISA.

The court has left the status of ERISA's section 503 statutory right to review by an appropriate named fiduciary, and the application of *federal* claims procedure rules, for another day. This issue may be raised in the Fifth Circuit's reconsideration of *Corporate Health Insurance, Inc., et al v. Texas Department of Insurance*. On June 24, the Supreme Court issued a summary disposition of the Texas Insurance Commissioner's petition for certiorari, granting the petition, vacating the earlier judgment of the Fifth Circuit and remanding the case to the appeals Court for further consideration in light of *Rush Prudential*.

A Deferential Standard of Review for Benefit Denials Depends Upon Contract Terms

The majority opinion in *Rush Prudential* holds that the Illinois independent reviewer's binding *de novo* determination could carry "great weight" in a subsequent suit for benefits and could deprive the plan administrator of any judicial "deference" to the prior exercise of "discretion" in the benefit determination. The court declares that this is because the statutory text of ERISA does not set forth requirements with respect to the standard of review in the case of benefit denials, even though the statute does require a uniform judicial regime of types of relief.

The majority opinion appears to "bless" state independent review laws that prohibit the design of an insurance contract that accords "unfettered discretion" to the insurer to interpret the plan's "medical necessity" provision. The Supreme Court reasons that this is because the Illinois law does not implicate ERISA's civil enforcement scheme and is no different from other types of substantive regulation of insurance contracts that has been permitted under ERISA such as mandated benefit laws. The Court states further that nothing in ERISA requires that benefit determinations be so "discretionary" in the first place and that it is a matter of plan terms or contract design.

In addition, the opinion notes that the Illinois independent review law operates *before* judicial review. The majority opinion, thus, distinguishes the court's prior ruling in *Firestone Tire & Rubber Co. v. Bruch,* which recognized that an ERISA plan could be designed to grant "discretion" to a plan fiduciary and that the fiduciary's judgment was deserving of deference from a reviewing Court. This appears to narrow the reach of *Firestone* somewhat and invites states to regulate the use of "discretionary clauses" in insurance contracts. Finally, the majority opinion also invites lower Courts to more closely scrutinize "conflict of interest" issues per *Firestone*, in cases where the exercise of discretion involves a "mixed eligibility decision"--another "novel" (and ambiguous) concept pioneered by the Supreme Court in *Pegram v. Herdrich.*

Medical Care 'Quality' Decisions Remain Subject to Traditional State Regulation

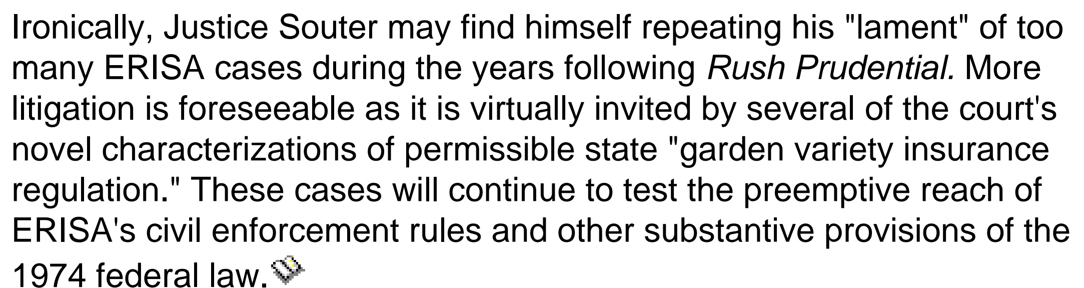
A final point of the majority opinion in *Rush Prudential* is that the "quality" of health care is a subject of traditional state regulation wherein there is no ERISA preemption. The Supreme Court found comfort in the Illinois independent review law that the independent examiner must be a physician with credentials similar to those of a primary care physician and the physician reviewer is confined to review only the plan's term of "medical necessity" that is used to define the services covered under the contract. Citing Justice Souter's previous majority opinion in *Pegram*, the *Rush Prudential* notes again that this aspect may implicate a feature of HMO benefit determinations involving ambiguous "mixed eligibility" decisions.

The majority opinion explained again that when an HMO guarantees "medically necessary" care, coverage determinations cannot be

untangled from physicians' judgments about reasonable medical treatment. The majority opinion then notes that the Illinois independent review law requires the physician reviewer to exercise independent "medical judgment" in deciding what "medical necessity" requires. Thus the *Rush Prudential* majority appears to clarify that a determination involving both "medical judgment" and a "coverage" determination, which is made by the same physician reviewer, is a "mixed" decision that is less "insurance" regulation and more the subject of the type of traditional state regulation of "health care" quality and medical malpractice law that is not preempted by ERISA.

Conclusion--Status Quo Is Preserved, for Now

The immediate impact of the *Rush Prudential* decision is a narrow one--that the Illinois independent review law is "saved" from the reach of ERISA's preemptive "roots" as a 'garden variety' state benefit mandate. This generally preserves the status quo with respect to the rights of participants enrolled in state regulated group health plan insurance arrangements. However, the court also set forth the parameters with respect to permissible state independent review laws--they must be grounded upon the 'core' principle of insurance contract interpretation; and they must not replace or supplement ERISA's exclusive civil enforcement provisions.



Ironically, Justice Souter may find himself repeating his "lament" of too many ERISA cases during the years following *Rush Prudential.* More litigation is foreseeable as it is virtually invited by several of the court's novel characterizations of permissible state "garden variety insurance regulation." These cases will continue to test the preemptive reach of ERISA's civil enforcement rules and other substantive provisions of the 1974 federal law.

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